VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Atlanta, Georgia

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ACRONYMS AND ABBREVIATIONS

COVERS	Control of Veterans Records System
FY	Fiscal Year
NOD	Notices of Disagreement
OIG	Office of Inspector General
PTSD	Post-Traumatic Stress Disorder
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VACOLS	Veterans Appeals Control and Locator System
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, Atlanta, Georgia

Why We Did This Review

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

What We Found

The Atlanta VARO staff correctly processed post-traumatic stress disorder claims. VARO performance was generally effective in establishing correct dates of claim in the electronic record and correcting errors identified by the Veterans Benefit Administration's Systematic Technical Accuracy Review program staff.

However, the VARO lacked effective controls and accuracy in processing temporary 100 percent disability evaluations and lacked accuracy in processing traumatic brain injury and herbicide exposure-related claims. Overall, VARO staff did not accurately process 45 (38 percent) of the 120 disability claims we reviewed. Controls over processing Notices of Disagreement for appealed claims, completing Systematic Analyses of Operations, handling mail, and final competency determinations need strengthening.

What We Recommended

We recommended VARO management implement controls to ensure the staff establishes suspense diaries for the temporary 100 percent disability reevaluations and follow up on reminder notifications as appropriate. We also recommended VARO management provide refresher training and establish an additional level of review for traumatic brain injury rating decisions to ensure accurate benefit payments.

Additionally, VARO management needs to strengthen controls to ensure timely recording of Notices of Disagreement in the Veterans Appeals Control and Locator System. VARO management should also monitor controls to ensure timely and complete preparation of Systematic Analyses of Operations and proper mail handling.

Agency Comments

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

(original signed by:)

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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 February 2011, the OIG conducted an inspection of the Atlanta 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 90 (7 percent) of 1,245 disability claims related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and herbicide exposure that VARO staff completed from July through September 2010. In addition, we reviewed 30 (4 percent) of 731 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months, generally the longest period a temporary 100 percent disability evaluation may be assigned under VA policy without review.

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

RESULTS AND RECOMMENDATIONS

1. Disability Claims Processing

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

Finding 1 VARO Staff Need To Improve Disability Claims Processing Accuracy

The Atlanta VARO needs to improve the control and accuracy of processing temporary 100 percent disability evaluations, TBI residual disability claims, and herbicide exposure-related disability claims. VARO staff incorrectly processed 45 (38 percent) of the total 120 disability claims reviewed. We advised VARO management regarding the inaccuracies noted during our inspection and they agreed with our assessments and initiated corrective measures to address them.

The table below reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Atlanta 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	24	6	18
PTSD	30	0	0	0
TBI	30	16	10	6
Herbicide Exposure-Related Disabilities	30	5	3	2
Total	**120**	**45**	**19**	**26**

Source: VAOIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 24 (80 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 needing surgery or specific treatment. At the end of a mandated period of convalescence or the cessation

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

Based on analysis of available medical evidence, 6 of the 24 processing inaccuracies identified affected veterans' benefits—5 involved overpayments totaling $287,067 and 1 involved an underpayment of $2,769. Examples of the most significant overpayment and underpayment follow:

- A Rating Veterans Service Representative (RVSR) granted service connection for prostate cancer and noted the veteran would need reexamination in December 2003; however, the staff did not schedule the examination. Our review of VA medical treatment records showed the veteran's condition had improved and he was no longer entitled to receive temporary 100 percent disability benefits. As a result, VA overpaid the veteran a total of $154,436 over a period of 6 years and 4 months.
- An RVSR did not compensate a veteran for erectile dysfunction as a residual disability of prostate cancer, as required. As a result, VA underpaid the veteran a total of $2,769 over a period of 2 years and 5 months.

The remaining 18 inaccuracies had the potential to affect veterans' benefits. In 17 cases, we could not determine if the evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to reevaluate each case. In the remaining case, VSC staff incorrectly established a reexamination date several months beyond the mandatory reexamination date.

Delays in scheduling the reexaminations ranged from approximately 4 months to 8 years and 3 months. An average of 3 years and 8 months elapsed from the time staff should have scheduled the medical examinations until the date of our inspection—the date staff ultimately took corrective actions to obtain the necessary medical evidence.

For temporary 100 percent disability evaluations, including confirmed and continued evaluations where rating decisions do not change 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 the diary matures, the electronic system generates a reminder notification alerting VSC staff to schedule the reexamination.

The two most frequent types of processing inaccuracies resulted from human error. The most frequent processing inaccuracy noted in 13 (54 percent) of

the 24 inaccuracies involved VSC staff not establishing suspense diaries to notify that VA reexaminations needed to be scheduled. The second most frequent processing inaccuracies noted in 9 (38 percent) of the 24 inaccuracies involved VSC staff not following up on established reminder notifications or proposed actions to reduce benefits.

These inaccuracies occurred because VARO management did not provide adequate oversight to ensure VSC staff entered suspense diaries or took action on reminder notifications. Because effective controls were not in place, temporary 100 percent disability evaluations could have continued uninterrupted over the course of the veterans' lifetimes. As such, veterans did not always receive correct benefits payments.

We provided the VARO with 701 claims remaining from the universe of 731 reviewed. The Acting Under Secretary for Benefits has agreed to review all temporary 100 percent disability evaluations and ensure each evaluation has a future exam date entered in the electronic record. The Acting Under Secretary explained that VBA's national review plan entails use of three medical diagnostic codes to comprise a sample for testing whether future examination dates are established in the electronic record. Those diagnostic codes relate to Non-Hodgkin's Lymphoma, Malignant Neoplasms of the Genitourinary System, and Post-traumatic Stress Disorder.

Further, the Acting Under Secretary stated, "the remainder of the cases will be identified through a batch process, and VBA will establish the appropriate future diary controls electronically." The Acting Under Secretary for Benefits has agreed with a corresponding recommendation in our national report, *Veterans Benefits Administration: Audit of 100 Percent Disability Evaluations*, (Report Number 09-03359-71, January 24, 2011).

PTSD Claims

In accordance with VBA policy, VARO staff correctly processed all 30 PTSD claims we reviewed. We make no recommendations for improvement in this area.

TBI Claims

The Department of Defense and VBA commonly define a TBI as traumatically induced structural injury or physiological disruption of brain function caused by an external force. The major residual disabilities of TBI fall into three main categories: physical, cognitive, and behavioral. VBA policy requires that staff evaluate these residual disabilities.

VARO staff incorrectly processed 16 (53 percent) of 30 TBI claims. Based on analysis of medical evidence, 10 of the 16 inaccuracies affected veterans' benefits—7 involved overpayments totaling $68,921 and 3 involved underpayments totaling $22,638. The remaining six inaccuracies had the potential to affect veterans' benefits. Examples of the most significant overpayment and underpayment follow:

- An RVSR incorrectly used symptoms associated with a coexisting mental condition to assign a 40 percent evaluation for a TBI residual disability. As a result, VA overpaid the veteran $19,492 over a period of 1 year and 10 months.
- An RVSR under evaluated the residuals of a veteran's TBI and assigned a 10 percent evaluation; however, the VA examination report provided medical evidence supporting a 40 percent evaluation. As a result, VA underpaid the veteran a total of $9,752 over a period of 1 year and 11 months.

Examples of the six TBI inaccuracies that had the potential to affect veterans' benefits follow:

- In four cases, RVSRs incorrectly evaluated TBI related disabilities because they used inadequate medical examination reports. Neither VARO staff nor we can ascertain all residual disabilities related to TBI claims without an adequate or complete medical examination.
- In one case, an RVSR did not assign a separate disability evaluation for migraine headaches even though the VA examiner provided this diagnosis. This inaccuracy did not affect the veteran's current disability percentage; however, it may affect future evaluation percentages.
- In one case, an RVSR determined the TBI related disability improved and a future reexamination was required to assess the current level of the disability. However, VSC staff did not establish the future reexamination date in the electronic record. Because a reexamination date did not exist in the electronic record, the disability evaluation may have continued without further review for an indefinite period.

A review of the VARO's training schedule revealed RVSRs did not receive training on evaluation of TBI residual disabilities during Fiscal Year (FY) 2010. Interviews with VARO management confirmed staff last received TBI training in December 2008 despite VBA issuing new training materials and guidance in January 2009. In addition, VARO management and staff stated other VSC priorities took precedence over TBI training. As a result, veterans did not always receive correct benefit payments.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 5 (17 percent) of 30 herbicide exposure-related claims we reviewed. Three of the five processing inaccuracies affected veterans' benefits—two involved underpayments totaling $79,428 and one involved an overpayment of $25,364. Examples of the most significant underpayment and overpayment follow:

- An RVSR incorrectly assigned a 0 percent evaluation for a veteran's chronic lymphatic leukemia. According to VBA policy, a veteran diagnosed with this condition warrants a 100 percent disability

evaluation. As a result, VA underpaid the veteran a total of $55,128 over a period of 2 years.

- An RVSR incorrectly continued an evaluation of 40 percent for diabetes. However, the VA medical examination results supported an evaluation of 20 percent. As a result, VA overpaid the veteran a total of $25,364 over a period of 9 years and 8 months.

In all five processing errors, RVSRs incorrectly applied the rating criteria for herbicide exposure-related disabilities. These errors occurred because the VARO's rating quality review process lacked oversight to ensure staff conducted accurate quality reviews sufficient to identify local training needs related to rating accuracy. In October 2010, VSC staff compared the rating accuracy from their local reviews to that of VBA's national reviews for fiscal year 2010. Management determined local quality reviews were cursory and did not accurately reflect the VARO's rating accuracy.

In an effort to improve quality, VARO management sought assistance from VBA's Compensation and Pension Service, which deployed an assistance team to the VARO. VARO management also sent three employees to train with Systematic Technical Accuracy Review (STAR) program staff to learn how to conduct accurate quality reviews.

Additionally, in November 2010, VSC management created a Quality and Training Team to provide unified training and oversight to address quality deficiencies. As this team had only been in place for a short period and the inaccuracies we identified occurred prior to its establishment, we were unable to assess the team's effectiveness in reducing or eliminating quality deficiencies; therefore, we make no recommendation.

Recommendations

1. We recommend the Atlanta VA Regional Office Director implement controls to ensure staff establish suspense diaries for temporary 100 percent disability reevaluations.
2. We recommend the Atlanta VA Regional Office Director implement controls to ensure staff take appropriate follow-up actions on reminder notifications for temporary 100 percent disability reevaluations.
3. We recommend the Atlanta VA Regional Director ensure Rating Veteran Service Representatives receive refresher training on how to evaluate disabilities related to traumatic brain injuries.
4. We recommend the Atlanta VA Regional Office Director require traumatic brain injury claims undergo an additional level of review (two signatures) to ensure adequate medical examinations and accurate rating evaluations prior to finalizing benefit payments decisions.

Management Comments

The VARO Director concurred with our recommendations for improving disability claims processing. The Director informed us staff received training on the proper procedures for inputting suspense diaries. Further, VSC management is updating the workload management plan to outline responsibilities for reviewing and processing follow-up actions on reminder notifications for temporary 100 percent disability reevaluations. RVSRs on the Triage Team are required to review the notifications to determine if evaluations require future medical examinations. The Director stated the VSC would monitor compliance with future medical examination procedures through its local quality assurance review process.

VSC management provided refresher training on the proper procedures for processing claims related to traumatic brain injuries. Further, the Director informed us VSC management disseminated a memorandum mandating second signature reviews for all traumatic brain injury claims. A Quality and Training team will have responsibility for reviewing traumatic brain injury claims prior to completing award decisions.

OIG Response

Management's comments and planned actions are responsive to the recommendations.

2. Data Integrity

Dates of Claim

We analyzed claims folders to determine if VARO staff was following VBA policy to establish dates of claim in the electronic record. 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 an incorrect date of claim in the electronic record for 1 (3 percent) of the 30 claims we reviewed. Generally, VARO staff followed VBA policy when establishing dates of claim so we make no recommendation for improvement in this area.

Notices of Disagreement

We reviewed claims folders to determine if VARO staff timely recorded 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 veterans' appeals, as well as manages the pending appeals workload. VBA policy states staff must create a VACOLS record within 7 days of receiving an NOD. Accurate and timely recording of an NOD is required to ensure an appeal moves through the appellate process expeditiously.

Finding 2 Controls Over Recording Notices of Disagreement Need Strengthening

The Appeals Team did not have controls in place to ensure staff recorded NODs in VACOLS within VBA's 7-day standard. This occurred because management did not provide adequate oversight to ensure VARO staff entered NODs in line with the standard. Untimely recording of NODs in VACOLS affects data integrity and misrepresents VARO performance.

VARO staff exceeded VBA's 7-day standard for 21 (70 percent) of the 30 NODs we reviewed. It took staff an average of 29 days to record these 21 NODs in VACOLS. According to the VARO workload management plan, responsibility for recording NODs belonged to the Appeals Team. Because of a shortage of staff in the Appeals Team, the responsibility shifted to the Triage Team. During May through November 2010, the Triage Team began controlling NODs in a separate VBA electronic record. Once recorded in that system, staff forwarded the NODs to the Appeals Team to enter into VACOLS. This practice created unnecessary delays in entering NODs into VACOLS within the 7-day standard.

VSC management was not aware of these unnecessary delays in entering NODs until early November 2010. At that time, management added additional staff to the Appeals Team and reiterated its responsibility for entering NODs. Because both teams were using two systems to control NODs, a backlog in NOD inventory occurred.

Although VARO management indicated the backlog had been resolved, we determined management needed additional controls to ensure staff record NODs in VACOLS within the 7-day standard. Management agreed with our assessment in this area.

Data integrity issues due to untimely recording of NODs make it difficult for VARO and senior VBA leadership to accurately measure and monitor VARO performance. For example, unnecessary delays in controlling NODs affect national performance for NOD inventory and timely completion of appeals. Further, VBA's National Call Centers rely upon accurate VACOLS information to provide quality customer service to claimants.

Recommendation

5. We recommend the Atlanta VA Regional Office Director develop and implement a plan to provide adequate oversight to ensure staff timely record Notices of Disagreement in the Veterans Appeals Control and Locator System.

Management Comments

The VARO Director concurred with our recommendation. The Director stated VSC management amended the mail flow process to daily direct appeals-related mail to the appeals team for processing. Further, VSC staff

will enter NODs into VACOLS within two business days upon receipt of the mail. The Director informed us a tracking spreadsheet was created for VARO management to monitor timeliness and trends in NOD processing.

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

3. Management Controls

Systematic Technical Accuracy Review We assessed management controls to determine if VARO management adhered to VBA policy regarding correction of errors identified by VBA's STAR staff. The STAR program is VBA's multifaceted quality assurance program to ensure that veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that VARO staff take corrective action on errors that the STAR staff identifies. In general, VARO staff followed VBA policy regarding the correction of STAR errors.

VARO staff did not correct 1 (4 percent) of the 28 errors identified by VBA's STAR program from July through September 2010. In this instance, VARO staff erroneously reported to the STAR that they had completed the corrective action identified by STAR program staff. We do not consider the error rate significant, so we make no recommendation for improvement in this area.

Systematic Analysis of Operations We assessed whether VARO management had controls in place to ensure complete and timely submission of SAOs. An SAO is a formal analysis of a VSC organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish an annual SAO schedule designating the staff required to complete the SAOs by specific dates. The Veterans Service Center Manager is responsible for ongoing analysis of VSC operations, including completing 12 annual SAOs.

Finding 3 Improved Oversight Needed To Ensure SAOs are Timely and Complete

VARO staff did not always ensure SAOs were timely and complete. This occurred because VARO management did not provide adequate oversight to ensure VSC staff completed SAOs timely (according to the annual schedule) and addressed all required elements. As a result, VARO management may not have adequately identified existing and potential problems for corrective action to improve VSC operations.

Our analysis revealed 5 (42 percent) of the 12 SAOs were not compliant with VBA policy. Specifically, 3 of the 12 required SAOs were incomplete, 1 was untimely and incomplete, and 1 was untimely. Senior VARO leadership informed us that previous VSC management completed cursory reviews with little analysis regarding SAOs completed in FY 2010. In October 2010, senior VARO leadership recognized this weakness and established a local VARO policy, which increased oversight of SAOs. As this policy change has only been in place for a short period and the inaccuracies occurred prior to October 2010, we were unable to assess the effectiveness of these changes.

We identified several operational areas where, by not providing adequate oversight to ensure complete SAOs, VARO management did not identify VSC operational problems for corrective action. For example, had management thoroughly completed the Division Management SAO, they might have determined RVSRs had not received refresher training on procedures for processing TBI and herbicide exposure-related claims in FY 2010.

Recommendation

6. We recommend the Atlanta VA Regional Office Director monitor the effectiveness of implementation of the new Systematic Analyses of Operations policy to ensure that analyses are completed and all required elements addressed.

Management Comments

The VARO Director concurred with our recommendation. To ensure SAO completeness and support oversight of the SAO process, the VARO will utilize an SAO submission cover sheet that outlines all required elements. The director had noted that management granted extensions for those SAOs that did not meet the annual SAO completion schedule. Further, VSC managers will receive training on the proper procedures for completing SAOs, with emphasis on the importance of performing quality analyses.

OIG Response

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

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 Atlanta VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division.

Finding 4 Controls Over Mail Processing Need Strengthening

VARO mailroom staff did not always date-stamp mail the same day it arrived at the mailroom as required. This occurred because VARO management lacked adequate oversight to ensure staff processed and date-stamped mail daily. As a result, beneficiaries may not have received accurate benefit payments.

On February 1, 2011, we observed mail received in the mailroom on January 31, 2011, but not processed or date-stamped until the next business day—a practice that can negatively affect veterans' benefits payments. Generally, a benefit payment date is the first of the month following the date stamped on the incoming claim. For example, if mailroom staff properly date stamp claims-related mail received on January 31, the benefits would be payable on February 1. However, if mailroom staff improperly date-stamp this same mail on February 1, the payment date would be March 1, and VSC staff would unintentionally underpay the beneficiary by 1 month.

Mailroom supervisors and staff informed us the VARO normally receives an increased amount of claims-related mail from Veterans Service Organizations on the last business day of each month. In addition, the mailroom staff indicated they observe increased amounts of mail on Mondays. In both situations, staff stated they usually did not process or date-stamp remaining mail until the following business day. Once we notified staff that mail received on January 31, 2011, had not been properly date-stamped, they took immediate corrective action.

VARO management contended that what we observed was an anomaly and improper date-stamping did not happen often. VARO management also reported that mailroom staff is subject to monthly quality assurance reviews that included a review to ensure staff correctly date-stamped mail.

Triage Mail Processing Procedures

We assessed the VSC Triage Team's mail-processing procedures to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. VBA policy indicates that oversight to ensure staff use available plans and systems is the most important part of workload management. It also states that effective mail management is crucial to the success and control of workflow within the VSC.

VBA policy requires that staff use the Control of Veterans Records System (COVERS), an electronic tracking system, to track claims folders and search mail. Additionally, VBA policy states VSC staff will route and process mail requiring action according to established procedures. VBA defines search mail as active claims-related mail waiting to be associated with a veteran's claims folder. Conversely, drop mail requires no processing action.

Military File Mail

VBA policy allows the use of a storage area, known as the Military File, for VSC staff to store mail temporarily. Typically, the mail stored in this area pertains to matters which VA has jurisdiction or the mail does not refer to a claim for benefits and/or does not have a return address. The VARO generally processed military file mail correctly. Staff incorrectly handled 1 (4 percent) of 24 pieces of military file mail we reviewed. In this one instance, the veteran had an inactive claims file, which was located at a national storage facility; therefore, staff should have forwarded the mail to that facility, as required by VBA policy. Due to the infrequency of such inaccuracies, we make no recommendation for improvement in this area.

Finding 5 Control of Triage Mail Management Procedures Need Strengthening

The Triage Team did not always process mail according to VBA and local policy. This occurred because the VSC management did not follow mail-handling policies for search mail as written in the VARO workload management plan or the Triage Team Mail Flow Procedures. Additionally, these local procedures did not contain oversight measures to ensure Triage staff accurately categorized drop mail. Consequently, RVSRs may not always have all available mail in the claims file when making disability determinations and claimants may not always receive prompt and accurate benefits.

VSC staff did not correctly process or control 42 (40 percent) of 104 individual pieces of mail reviewed. Specifically, we identified weaknesses associated with the management of search mail, drop mail, unprocessed mail, and unlabeled mail. Following are descriptions of discrepancies we noted in each of these categories.

Search Mail

For 17 (57 percent) of 30 pieces of search mail reviewed, VSC staff did not properly use COVERS to ensure timely processing. In 11 of these 17 cases, staff did not retrieve search mail and associate the mail with claims files as required, even though COVERS contained electronic notices of pending search mail requests. Following are examples of inaccuracies we found during our search mail review:

- VARO staff delayed a widow's claim for pension benefits by approximately two weeks when Triage staff placed the mail on search rather than forwarding the claim to a Pension Management Center, as is required by VBA policy. Staff took no action on this claim until we identified it during our inspection.
- VARO staff placed a claim for benefits on search; however, the veteran's claims file was located in the VARO file storage area. VBA policy states mail is ready for search status after staff have attempted to associate it

with a claims folder. In this case, Triage staff did not fulfill requirements to associate the mail with the claims file, which was located in a file bank at the VARO. This mail remained on search for approximately 75 days, during which time staff took no action on the claim. We alerted Triage staff of the processing inaccuracy during our inspection.

VSC management acknowledged weaknesses associated with mail processing. The workload management plan required Triage Team supervisors to ensure staff complied with search mail policies. Supervisors were to accomplish this by using COVERS to review mail placed in a search status for greater than 30 days. Triage Team management stated they had not reviewed search mail because of other priorities.

Drop Mail

We found 7 (23 percent) of 30 pieces of mail that had been erroneously marked as drop mail. Generally, this means staff did not correctly categorize drop mail and take action as required. Following are examples of action mail found in drop mail bins:

- On December 8, 2010, the VARO received income information for a pension claim. VARO staff delayed this pension claim by approximately 2 months because the mail was marked for drop and not forwarded to the Pension Management Center as required by VBA policy.
- On August 26, 2010, VSC staff received evidence from a veteran indicating he had remarried. Instead of placing the claim under control in the electronic record and adjusting the veteran's benefits, VSC staff sent this mail to be associated with the claims file and took no further action. As a result, the VARO delayed the veteran's claim approximately 6 months.

Local VSC mail handling procedures did not contain any measures for management oversight of drop mail to ensure staff properly categorized this type of mail. Management said they occasionally performed reviews of drop mail and found similar errors; however, they were unable to identify the staff that improperly processed the mail. Management could not identify the responsible employee because Triage staff did not properly annotate the mail with the employee's mail symbol, initials, and the date reviewed, as required by VBA policy.

Unprocessed Mail

The Triage Team had approximately 3,400 pieces of unprocessed mail dating back to October 2010. Staff correctly date-stamped the mail and identified it as either pending claims or service treatment records. However, we found 13 (87 percent) of 15 pieces of this mail had either delayed the processing of pending claims or had the potential to affect claimants' benefits. Following are examples of what we found:

- One piece of mail was a veteran's statement describing stressful in-service events to support a pending claim for PTSD. Because this evidence was not associated with the file, the RVSR prematurely denied the claim.
- One packet of mail contained forms to support a pending dependency claim. The claim had been waiting for a decision since its receipt on November 23, 2010. Additionally, we verified in the electronic record that the National Call Center was unable to provide the veteran with confirmation these forms had been received or the status of the claim.

According to VARO management, the accumulation of unprocessed mail occurred because initially VSC management only had five claims assistants assigned to process this mail. In November 2010, the backlog of unprocessed mail totaled approximately 6,100 pieces. Management decided to realign this work so all claims assistants assigned to the Triage Team could help process this mail. By the time of our inspection in February 2011, staff had reduced the unprocessed mail to approximately 3,400 pieces. Considering the improvement made in this area, we make no recommendations.

Unlabeled Mail

We observed the Triage Team had an unlabeled mail bin containing claims-related mail for 25 claimants. Based on our sample, mishandling of 4 (80 percent) of 5 pieces of this unlabeled mail had the potential to affect veterans' benefits. Examples included processed benefits claims, correspondence, administrative decisions, and original service treatment records.

Although staff had processed these documents, they had not associated them with claims folders as required by VBA policy. As a result, these documents may not be available for review by VARO staff for future claims, which could negatively affect veterans' benefits. For example, if a veteran submits a claim for compensation and the service treatment records are in an unlabeled mail bin, an RVSR may make a decision on the claim without the benefit of these essential documents.

Recommendations

7. We recommend the Atlanta VA Regional Office Director develop and implement controls to ensure Support Services Division staff meet Veterans Benefits Administration's requirement that all veteran-related mail be processed, date-stamped, and routed or action taken on the same day received.
8. We recommend the Atlanta VA Regional Office Director implement a plan to increase oversight to ensure Triage staff process mail according to VBA policy and local procedures.

Management Comments

The VARO Director concurred with our recommendations to improve mail-handling procedures. The Director told us that to address mail surges on the last business day of the month, mailroom staff will change their tours of duty to ensure all mail is date-stamped the same day it is received. Further, the mailroom supervisor has implemented a monthly quality assurance checklist to monitor compliance of each individual responsible for processing mail.

The Director informed us VSC management will convene weekly meeting with Triage supervisory staff to ensure search mail processing is compliant with the VSC workload management plan. VSC management amended the workload management plan to require Triage supervisory staff to review drop-mail on a weekly basis. In addition, management provided training to staff to reinforce and ensure compliance with VBA mail handling policies.

OIG Response

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

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, which is a third party who assists in managing funds for an incompetent beneficiary. We reviewed competency determinations completed by the VSC Decision Team to ensure staff completed them accurately and timely. Delays in making these determinations ultimately affect the Fiduciary Unit's ability to be timely in appointing fiduciaries.

Finding 6 Controls Over Competency Determinations Need Strengthening

VARO staff unnecessarily delayed making final decisions in 9 (30 percent) of 30 competency determinations completed from July through September 2010. The delays ranged from 18 to 673 days, with an average completion time of 113 days. If we do not consider the 673-day outlier, processing time would average 43 days. The delays occurred because the VSC workload management plan did not contain procedures emphasizing immediate completion of incompetency determinations. The risk of incompetent beneficiaries receiving benefit payments without fiduciaries assigned to manage those funds increases when the staff does not complete competency determinations immediately.

VBA policy requires staff to obtain clear and convincing medical evidence that a beneficiary is incapable 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 the 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.

In the absence of a definition of "immediate," we allowed 14 calendar days after the 65-day due process period to determine if staff were timely in completing a competency decision. We considered this a reasonable period to control, prioritize, and finalize these types of cases.

Using our interpretation of immediate, 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 51 days. During this period, the veteran received $6,954 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.

VARO management was aware of VBA's policy requiring immediate action to determine whether a beneficiary is incompetent; however, management stated they did not have a definition of "immediate." VARO staff responsible for overseeing and processing final competency determinations stated they were unaware of VBA's policy to immediately process competency determinations and did not prioritize these cases.

In October 2010, in a Compensation and Pension Service Bulletin, VBA reinforced the importance of immediately completing competency determinations and mandated VAROs update workload management plans to identify responsibility for managing the determinations. Despite this guidance, the Atlanta VSC workload management plan lacked procedures to immediate completion of incompetency determinations and oversight of the process. As a result, incompetent beneficiaries received benefit payments for extended periods despite being incapable of managing these funds effectively.

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 the expiration of the due process period. VBA plans to implement this new policy nationwide in June 2011. Therefore, we made no recommendation to the Director of the VARO regarding this issue. The VARO processed 20 of 28 determinations in 21 days.

In addition to processing delays, we identified two instances where VSC staff did not follow VBA policy when determining if beneficiaries were competent to handle VA funds. In both cases, staff did not prepare rating

decisions proposing the beneficiaries were incompetent and affording them the mandatory due process period. Because staff did not follow VBA policy, prematurely appointed fiduciaries received $38,938. Due to the infrequency of these processing inaccuracies, we make no recommendation for improvement in this area.

Appendix A VARO Profile and Scope of Inspection

Organization

The Atlanta VARO is responsible for delivering nonmedical VA benefits and services to veterans and their families in Georgia. The VARO fulfills these responsibilities by administering compensation and pension benefits, home loan guaranty, education, vocational rehabilitation and employment assistance, and outreach activities.

Resources

As of December 2010, the Atlanta VARO had a staffing level of 775 full-time employees. Of these, the VSC had 330 employees (43 percent) assigned.

Workload

As of January 2011, the VARO reported 29,111 pending compensation claims. The average time to complete these claims was 183.4 days—approximately 8 days more than the national target of 175 days. As reported by STAR, the accuracy of compensation rating-related issues was 75.6 percent, which is below the 90 percent target set by VBA.

Scope

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

Our review included 90 (7 percent) of 1,245 disability claims related to PTSD, TBI, and herbicide exposure that the VARO completed from July through September 2010. For temporary 100 percent disability evaluations, we selected 30 (4 percent) of 731 existing claims from VBA's Corporate Database. We provided the VARO with the 701 claims remaining from the universe of 731. The 731 claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months or longer as of November 14, 2010.

We reviewed 30 available competency determinations and 28 errors identified by VBA's STAR program during the period from July through September 2010. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STARs assessments include a review of work associated with claims requiring rating decisions. STAR staff reviews original claims, reopened claims, and claims for increased evaluation. Further, they review appellate issues that involve a myriad of veterans' disabilities claims.

Our process differs from STAR as we review specific types of disability claims such as PTSD, TBI, and herbicide exposure that require rating decisions. In addition, we review rating decisions and awards processing involving temporary 100 percent disability evaluations.

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 Inspections.* 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

Memorandum

Date: May 4, 2011

From: Director, Southern Area

Subj: Inspection of the VA Regional Office, Atlanta, Georgia

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

1. Attached are the Atlanta VARO's comments on the OIG Draft Report: Inspection of the VA Regional Office, Atlanta, Georgia.

2. Questions may be referred to Lakeisha Henderson-Bell at 615-695-4074.

(Original signed)

Keith J. Thompson
Southern Area Director

Attachment

Directors Comments and Responses
OIG Draft Report
Atlanta VA Regional Office

Recommendation 1: We recommend the Atlanta VA Regional Office Director implement controls to ensure staff establish suspense diaries for temporary 100 percent disability reevaluations.

Response: Concur.

Atlanta RO management staff identified the root cause of lapsed suspense diaries for temporary 100 percent reviews to be a training deficiency. Therefore, training on proper procedures for reviewing and determining when a future exam is warranted was completed on April 20, 2011. This training included the mechanics of inputting diaries into the corporate database when a determination has been made that a future examination is warranted. Compliance with future examination procedures has been emphasized as part of the local quality review process. A local Systematic Analysis of Operations (SAO) will be added to the annual schedule to monitor progress. The first SAO will be completed no later than June 15, 2011.

Recommendation 2: We recommend the Atlanta VA Regional Office Director implement controls to ensure staff take appropriate follow-up actions on reminder notifications for temporary 100 percent disability reevaluations.

Response: Concur.

The Veterans Service Center's (VSC) workload management plan is being updated to outline responsibilities for reviewing and processing follow-up actions on reminder notifications for temporary 100 percent disability reevaluations. Rating Veterans Service Representatives (RVSRs) on the Triage team are required to review notifications and determine if an exam is warranted. RVSRs submit their lists to their immediate supervisor weekly. As mentioned above, training has been conducted to ensure employees are aware of proper procedures. The workload management plan will be finalized by May 31, 2011.

Recommendation 3: We recommend the Atlanta VA Regional Office Director ensure Rating Veterans Service Representatives receive refresher training on how to evaluate disabilities related to traumatic brain injuries.

Response: Concur.

Refresher training on procedures for processing claims related to traumatic brain injuries was delivered to all RVSRs and Decision Review Officers on March 9, 2011. Additionally, due to the complexity of traumatic brain injury cases, this training will be conducted not less than bi-annually.

Recommendation 4: We recommend the Atlanta VA Regional Office Director require traumatic brain injury claims undergo an additional level of review (two signatures) to ensure

adequate medical examinations and accurate rating evaluations prior to finalizing benefit payments decisions.

Response: Concur.

A VSC memorandum mandating second signatures for traumatic brain injury claims was disseminated to VSC employees on April 25, 2011. Quality and Training team subject matter experts are responsible for reviewing these claims prior to award promulgation. The findings of their reviews will be utilized to identify future training topics.

Recommendation 5: We recommend the Atlanta VA Regional Office Director develop and implement a plan to provide adequate oversight to ensure staff timely record Notices of Disagreement in the Veterans Appeals Control and Locator System.

Response: Concur.

The appeals team supervisor and personnel have been trained on proper procedures and timeliness standards for the control of Notices of Disagreement (NOD). Additionally, local procedures have been modified to strengthen compliance and oversight.

The mail flow process has been amended to direct appeals mail to the appeals team daily. RO personnel enter NODs in Veterans Appeals Control and Locator System (VACOLS) within two business days upon receipt of the mail. Additionally, a tracking spreadsheet was created and implemented March 1, 2011, to identify NODs received, the date received by VARO, the date received by the appeals team, and the date recorded in VACOLS. This allows RO management to monitor timeliness and address root causes of issues identified.

Recommendation 6: We recommend the Atlanta VA Regional Office Director monitor the effectiveness of implementation of the new Systematic Analyses of Operations policy to ensure that analyses are completed and all required elements addressed.

Response: Concur in part.

Atlanta RO management does not dispute that four FY10 SAOs did not contain all elements required by VBA's manual. To improve these controls, an SAO submission cover sheet, which outlines all required elements, has been implemented. This allows RO management to ensure that all required topics are covered in the analysis. For the untimely SAOs in question, local deadline extensions were granted during the year and all FY10 SAOs were completed and submitted timely. The Atlanta RO Director has reinforced the importance of thorough reviews in the completion of SAOs. Additional training with VSC supervisors and managers specific to SAOs is scheduled for May 16, 2011. The training will encompass the manual references and emphasize the quality of the analyses to ensure maximum benefit to the division.

Recommendation 7: We recommend the Atlanta VA Regional Office Director develop and implement controls to ensure Support Services Division staff meet Veterans Benefits

Administration's requirement that all veteran-related mail be processed, date-stamped, and routed or action taken on the same day received.

Response: Concur.

Mail processing is compliant with VBA policy as it relates to the receipt, date stamping, and timely routing of incoming mail. To address mail surges on the last business day of each month, co-located Veterans Service Officers (VSOs) submit mail documents to the Public Contact area to be date-stamped and routed to the Triage team. To ensure all mail is date-stamped same day, mailroom staff will change their tours of duty to remain on site until all mail is received. Additionally, the mailroom supervisor has implemented a monthly quality assurance checklist to ensure each individual employee is compliant in the processing, date stamping, routing, and action taken on mail.

Recommendation 8: We recommend the Atlanta VA Regional Office Director implement a plan to increase oversight to ensure Triage staff process mail according to VBA policy and local procedures.

Response: Concur.

In order to strengthen local oversight of search mail and compliance with the workload management plan, VSC management convenes weekly meetings with the Triage supervisory staff. During these meetings, workload management compliance is discussed to ensure search mail is reviewed as outlined. The VSC daily report has been amended to provide the amount of search and drop mail, as well as the oldest piece daily. This allows daily monitoring and oversight by VSC management.

Additionally, the VSC workload management plan is being updated. The supervisory personnel over Triage will be responsible for reviewing the oldest drop-mail weekly. All drop mail over 60 days will be associated with the claims file during the week. The workload management plan will be finalized by May 31, 2011. Lastly, training was conducted on February 7, 2011, to reinforce and ensure compliance with VBA policy. All drop mail is annotated with the employee's initials, date, and mail symbol. Additional training will be conducted with Triage personnel to outline the difference between pull and drop mail. Spot checks will be conducted by management to ensure mail is coded properly.

Appendix C Inspection Summary

10 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) (M21-1MR 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 claims for service connection for all residual disabilities related to in-service TBI were properly processed.** (Fast Letters 08-34 and 08-36, Training Letter 09-01)		X
4. Herbicide Exposure-Related Claims	**Determine whether VARO staff properly processed claims for service connection for 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 whether VARO staff properly recorded correct dates of claim in the electronic records.** (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)	X	
6. Notice 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) (Fast Letter 09-08)		X

Abbreviations for this Table: CFR-Code of Federal Regulations, M-Manual, MR-Manual Re-write
Source: VA OIG

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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