VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office St. Louis, Missouri

May 20, 2011
11-00519-172

ACRONYMS AND ABBREVIATIONS

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
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, St. Louis, Missouri

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 St. Louis VARO staff correctly processed post-traumatic stress disorder disability claims, properly established the correct dates of claim in the electronic record, and ensured staff corrected errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review Program. The VARO was generally effective in recording Notices of Disagreement for appealed claims and timely in completing Systematic Analyses of Operations.

VARO management lacked effective controls and accuracy in processing temporary 100 percent disability evaluations, traumatic brain injury claims, and herbicide exposure-related claims. Overall, VARO staff did not accurately process 38 (32 percent) of the 117 disability claims reviewed. Management also lacked effective controls over handling mail and processing final competency determinations.

What We Recommended

We recommended St. Louis VARO management implement controls to ensure Veterans Service Center staff establish suspense diaries to request the medical reexaminations for temporary 100 percent disability reevaluations as needed.

In addition, we recommended VARO management implement oversight plans to ensure staff return inadequate medical examination reports to healthcare facilities to obtain the evidence needed to support traumatic brain injury claims rating decisions, improve accuracy and quality review of herbicide exposure-related claims processing, and ensure staff obtain supporting medical evidence in cases involving court declarations of incompetency. Finally, we recommended VARO management strengthen controls to ensure proper mail handling.

Agency Comments

The Director of the St. Louis 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 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 January 2011, the OIG conducted an inspection of the St. Louis 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 87 (10 percent) of 855 disability claims related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and herbicide exposure that the VARO completed from July through September 2010. In addition, we reviewed 30 (7 percent) of 411 rating decisions where the 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 VARO Director's comments on a draft of this report. Appendix C provides criteria 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 Needs To Improve Disability Claims Processing Accuracy

The St. Louis VARO needs to improve the accuracy of disability claims processing. VARO staff incorrectly processed 38 (32 percent) of the total 117 disability claims reviewed. VARO management agreed with our findings and initiated action to correct the inaccuracies identified.

The following table reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the St. Louis 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	20	4	16
PTSD	30	0	0	0
TBI	27	14	2	12
Herbicide Exposure-Related Disabilities	30	4	2	2
Total	**117**	**38**	**8**	**30**

Source: VA OIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 20 (67 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 cessation of

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

For temporary 100 percent disability evaluations, including those where rating decisions do not change a veteran's payment amount (confirmed and continued evaluations), VSC staff must input suspense diaries in VBA's electronic system. A diary is a processing command that establishes a date when VSC staff must schedule a medical reexamination. When a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the reexaminations.

Based on analysis of available medical evidence, 4 of the 20 processing inaccuracies affected veterans' benefits—3 involved overpayments totaling $117,856 and 1 involved an underpayment totaling $1,536. Details of the most significant overpayment and the underpayment follow.

- A Rating Veterans Service Representative (RVSR) correctly continued a temporary 100 percent disability evaluation for a veteran's prostate cancer and established a reminder for a future medical reexamination. However, VARO staff failed to take action on the reminder notification by scheduling the medical reexamination or establishing a new date for the reexamination as required. Medical evidence we reviewed showed the cancer was no longer active, warranting no more than a 20 percent disability evaluation. As a result, VA overpaid the veteran $57,648 over a period of 2 years.
- An RVSR did not grant a veteran special monthly compensation based on the loss of use of a creative organ as required. As a result, VA underpaid the veteran $1,536 over a period of 1 year and 4 months.

The remaining 16 inaccuracies had the potential to affect veterans' benefits. Following are summaries of those inaccuracies.

- In 11 cases, VSC staff did not schedule the follow-up medical reexaminations needed to determine whether the temporary 100 percent disability evaluations should continue.
- In two cases, RVSRs requested medical reexaminations beyond the date of our inspection. However, VSC staff did not establish suspense diaries to alert them of the needed VA medical reexaminations.
- In one case, an RVSR failed to identify a future medical reexamination date in the rating decision; therefore, VSC staff did not establish the suspense diary.
- In one case, an RVSR correctly continued the 100 percent disability evaluation, which did not require a future medical reexamination. However, in making this decision, the RVSR did not consider entitlement

to the additional benefit of Dependents' Educational Assistance as required by VBA policy.

- In one case, an RVSR incorrectly denied entitlement to the additional benefit of Dependents' Educational Assistance for a veteran with an incurable disease.

We could not determine if 12 of the 16 temporary 100 percent disability evaluations above would have continued because the veterans' claims folders did not contain the medical evidence needed to reevaluate each case. An average of 2 years and 9 months elapsed from the time staff should have scheduled medical reexaminations until the date of our inspection—the date staff ultimately ordered the medical reexaminations to obtain the necessary medical evidence. The delays ranged from 10 months to 7 years and 1 month.

The most frequent error noted in 11 (55 percent) of the 20 temporary 100 percent disability evaluations occurred when VARO staff did not properly establish suspense diaries for future VA medical reexaminations. Ten of these errors involved confirmed and continued evaluations. VSC supervisors stated staff might be rushed due to the large volume of work and overlook entering the suspense diary for medical reexamination. VARO management had no procedures or oversight measures in place to ensure staff input the diaries in VBA's electronic record system to generate reminder notifications to schedule the reexaminations. As such, VARO staff did not always timely schedule medical reexaminations as required.

PTSD Claims

VARO staff correctly processed all 30 PTSD claims we reviewed. Therefore, we made no recommendations for improvement in this area.

TBI Claims

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

VARO staff incorrectly processed 14 (52 percent) of 27 TBI claims. Two of the processing inaccuracies affected veterans' benefits. Following are summaries of these inaccuracies.

- An RVSR incorrectly granted separate disability evaluations for a veteran's service-connected PTSD and TBI-related residuals, resulting in a total disability evaluation of 40 percent. Because the examiner was not able to state whether the symptoms were related to PTSD or residuals of TBI, the RVSR should have granted a single disability evaluation, which would have resulted in a total disability evaluation of 50 percent. As a

result, the veteran was underpaid $3,172 over a period of 1 year and 1 month.

- An RVSR incorrectly evaluated a veteran's residual TBI-related disability as 10 percent disabling. The medical examination results showed subjective symptoms warranting no more than a 0 percent disability evaluation, entitling the veteran to healthcare for the condition but no monetary compensation. As a result, the veteran was overpaid $2,848 over a period of 1 year and 4 months.

Following are details on the remaining 12 TBI inaccuracies that had the potential to affect veterans' benefits.

- In 10 cases, RVSRs prematurely evaluated TBI-related residual disabilities using inadequate medical examinations. According to VBA policy, when a medical examination does not address all required elements, VSC staff should return it to the clinic or healthcare facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain all of the residual disabilities related to TBI without an adequate or complete medical examination.
- In one case, an RVSR incorrectly continued a 70 percent evaluation for TBI-related residual disabilities. The medical examiner attributed the symptoms to the veteran's service-connected PTSD, not the TBI-related residual disabilities. Because of the veteran's multiple service-connected disabilities, this error did not affect the veteran's monthly benefits, but it may affect future evaluations for additional benefits.
- In one case, an RVSR correctly deferred a decision for TBI-related residual disabilities due to an inadequate medical examination. VBA policy requires VSC staff set-up a control mechanism, known as an end product, which must remain in place until all decisions on the claim are completed. In this case, VSC staff did not continue the end product and no mechanism was in place to ensure control of the deferred TBI-related residual disabilities decision. If not for our inspection, VARO staff might not have completed all evaluations of the TBI-related disabilities.

Generally, errors associated with TBI claims processing occurred because RVSRs used VA medical examinations that were inadequate for decision-making purposes. RVSRs stated they did so because they felt pressured to rate cases quickly. VSC management similarly attributed the errors to increased demands to meet VARO production goals. Further, VSC training employees were aware RVRSs found TBI claims complex and confirmed the RVSRs' practice of making decisions on inadequate examinations. As a result, veterans did not always receive correct benefit payments.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 4 (13 percent) of 30 herbicide exposure-related claims reviewed. Two of the four processing inaccuracies affected veterans' benefits with underpayments totaling $16,184. Following are summaries of the two underpayments.

- An RVSR granted a 60 percent disability evaluation for residuals of lung cancer due to herbicide exposure; however, medical evidence showed active cancer warranting a 100 percent disability evaluation. The increased evaluation for the active cancer also entitled the veteran to additional special monthly compensation benefits based on multiple disabilities. As a result, the veteran was underpaid $14,072 over a period of 8 months.
- An RVSR failed to grant entitlement to an additional special monthly benefit as required based on the loss of use of a creative organ. As a result, the veteran was underpaid $2,112 over a period of 1 year and 10 months.

Following are details on the remaining two herbicide exposure-related inaccuracies that had the potential to affect veterans' benefits.

- An RVSR did not address several of the veteran's claimed disabilities, to include service connection for herbicide exposure-related disabilities. The RVSR's failure to address all disabilities claimed did not affect monthly benefits but may affect future evaluations.
- An RVSR failed to consider service connection for a diabetes-related complication diagnosed in VA treatment records. The RVSR should have requested a medical examination to rate this case. Neither VARO staff nor we can ascertain all of the residual disabilities related to diabetes without an adequate or complete medical examination.

Generally, errors in processing herbicide exposure-related claims resulted from inadequate quality review. VSC training supervisors responsible for local quality review reported their staff did not identify any errors in herbicide exposure-related claims processing similar to those found during our inspection. Additionally, VARO management indicated errors occurred due to an increased emphasis on production goals. As a result, veterans did not always receive correct benefits payments.

Recommendations

1. We recommend the St. Louis VA Regional Office Director implement controls to ensure staff establish suspense diaries for temporary 100 percent disability reevaluations.
2. We recommend the St. Louis VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives return inadequate medical examination reports to healthcare facilities to

obtain the evidence needed to support traumatic brain injury claims rating decisions.

3. We recommend the St. Louis VA Regional Office Director develop and implement a plan to improve accuracy and oversight of herbicide exposure-related claims processing.

Management Comments

The VARO Director concurred with our recommendations. In response to recommendation 1, the Director agreed the electronic system should automatically populate future exam dates. Additionally, the Director stated the VARO would follow the national review plan developed by VBA in response to our national report, *Veterans Benefits Administration: Audit of 100 Percent Disability Evaluations,* (Report Number 09-03359-71, January 24, 2011).

In response to recommendations 2 and 3, the Director stated VSC's Policy, Analysis, Star Review, and Training Team provided training to RVSRs on processing TBI-related claims in February 2011 and diabetes in March 2011. The team will also conduct additional training sessions on TBI in July 2011 and August 2011. Further, VSC management will add TBI examination issues to its agenda for their quarterly meetings with Compensation and Pension Service at the local VA Medical Centers. In April 2011, the Policy, Analysis, Star Review, and Training Team will have training on Agent Orange and follow-up training on diabetes. The Director stated Decision Review Officers are completing a second review of herbicide exposure-related decisions and RVSRs who made inaccurate decisions will receive feedback and mentoring.

OIG Response

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

A draft of this inspection report included an additional recommendation that the VA Regional Office Director review the remaining temporary 100 percent disability evaluations identified but not included in our inspection sample to determine if reevaluations are required and take appropriate action. We have removed the recommendation from this individual VARO inspection report since the Acting Under Secretary for Benefits has already concurred 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).

The Acting Under Secretary for Benefits has agreed to review <u>all</u> 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."

While the Acting Under Secretary for Benefits' national review plan differs from the approach we previously recommended in a draft of this VARO inspection report, we believe the intent is the same. Removing the recommendation from our draft inspection report will allow VBA time to implement its national plan for reviewing all temporary 100 percent disability evaluations to correct processing errors. The target completion date is September 30, 2011, as the Acting Under Secretary for Benefits previously indicated.

We have requested from VBA's Office of Field Operations a copy of both VBA's national review plan for sample testing using the diagnostic codes specified above, as well as a documented explanation of its batch process for identifying the remaining cases and establishing appropriate future diary controls electronically. We will use such information to monitor implementation progress and gauge effectiveness of VBA's national review plan approach as we move forward in conducting our individual VARO inspections. Based on the magnitude of errors and associated financial risks we have identified in temporary 100 percent disability evaluation processing to date, we have an ongoing responsibility to exercise continued oversight in this area.

2. Data Integrity

Effective Dates

We analyzed claims folders to determine if the VARO is following VBA policy to establish correct effective dates. Generally, an effective date indicates when entitlement to a specific benefit arose. VA regulations state the effective date of benefits is the claim receipt date or the date evidence revealed the disability existed, whichever is later.

VARO staff incorrectly established effective dates for 2 (2 percent) of 117 disability claims we reviewed. Both errors affected veteran's benefits and involved overpayments totaling $11,748. Details on the effective date errors follow.

- An RVSR incorrectly granted service connection for a veteran's prostate cancer effective July 29, 2008, the date the VARO received the claim. Medical evidence showed a diagnosis of the condition on November 3, 2008. As a result, the veteran was overpaid $6,384 over a period of 4 months.

- An RVSR incorrectly granted service connection for prostate cancer effective September 6, 2006, approximately 2 months prior to actual receipt of the claim. This occurred because the veteran had a claim pending for other disabilities at the time the VARO received the veteran's claim and supporting evidence of prostate cancer on November 8, 2006. As a result, the veteran was overpaid $5,364 over a period of 2 months.

Because we found only two inaccuracies, we determined the VARO is generally following VBA policy regarding effective dates. As such, we made no recommendations for improvement in this area.

Dates of Claim

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

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

Notices of Disagreement

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

VARO staff exceeded VBA's 7-day standard for 1 (3 percent) of 30 NODs we reviewed. As a result, we determined the VARO is generally following VBA policy regarding NODs and we made no recommendation for improvement in this area.

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 Systematic Technical Accuracy Review (STAR) staff. The STAR program is VBA's multi-faceted quality assurance program to ensure veterans and

other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires the VARO take corrective action on errors identified by STAR.

VARO staff adhered to VBA policy by taking corrective action on all 18 errors identified by STAR from July through September 2010. Therefore, we made no recommendations 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 Systematic Analyses of Operations (SAOs). An SAO is a formal analysis of an organizational element or operational function of the VSC. 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 completion of 12 annual SAOs. The VSC completed all 12 SAOs timely; however, 1 (8 percent) of the 12 SAO's did not address all required elements. Because we determined VSC management generally followed VBA policy, we made no recommendation for improvement in this area.

4. Workload Management

Mail Room 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 4–6 hours of receipt at the VARO. The St. Louis VARO assigns responsibility for mailroom activities (including the processing of incoming mail) to the Support Services Division. Mailroom staff were timely and accurate in processing, date stamping, and delivering VSC mail to the Triage Team control point daily. As a result, we determined the VARO Support Services mailroom is following VBA policy. Therefore, we made no recommendation for improvement in this area.

Triage Mail Processing Procedures

We assessed the VSC's Triage Team mail processing procedures to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. VARO staff are required to use VBA's tracking system, Control of Veterans Records System (COVERS), to electronically track veterans' claims folders and control search mail. VBA policy 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 upon receipt. VBA policy allows the use of a storage area,

known as the Military File, to hold mail temporarily when staff are not able to identify an associated claims folder in the system.

Finding 2 Triage Team Mail Management Procedures Need Strengthening

Triage Team staff did not consistently manage search mail according to VBA policy. For 5 (17 percent) of 30 pieces of search mail, VSC staff did not properly use COVERS to ensure timely processing and adequate control of search mail. The most significant error identified during our inspection occurred when the VARO received a veteran's claim for disability benefits on August 11, 2010, and did not place this mail on search so it could be associated with the claims folder. As a result, a processing delay of approximately 5 months occurred.

Triage Team staff did not always follow VBA's drop mail policy. Thirteen (43 percent) of 30 pieces of mail were incorrectly placed in drop mail holding areas without review or processing. The most egregious error occurred when the VARO received a claim for additional compensation payments on September 29, 2010 based on the veteran having dependents, and incorrectly sent it to the file storage area. By the time of our inspection in January 2011, no one had taken any action on this claim.

Triage Team staff did not always manage mail in the cabinets labeled "Military File-No Record Bin" according to VBA policy. Sixteen (53 percent) of 30 items reviewed were incorrectly stored in these cabinets. The most substantial error occurred when the VARO received a claim for death benefits on July 27, 2010, and incorrectly placed it in the Military File-No Record cabinet. By the time of our inspection in January 2011, the VARO had not taken any action on this claim.

The above errors occurred because of lack of supervisory oversight to ensure timely and accurate movement of mail throughout the VSC. Triage Team employees complete reviews of search mail; however, supervisors did not provide oversight to ensure search mail was properly marked in COVERS. In addition, the station's workload management plan did not clearly define drop mail or the use of the Military File. Triage Team supervisors and employees stated they were unsure of the requirements for control of the Military File. Further, VSC training staff reported they did not perform consistent quality reviews of Triage Team management of search, drop, or Military File mail.

Untimely association of mail with veterans' claims folders can cause delays in processing disability claims. As a result, beneficiaries may not receive accurate and timely benefit payments.

Recommendations

4. We recommend the St. Louis VA Regional Office Director implement a plan to ensure management oversight of search mail and amend the workload management plan to incorporate procedures for oversight and control of drop and Military File mail.

Management Comments

The VARO Director concurred with our recommendation. The Director stated management updated the Triage team's search mail procedures, developed Standard Operating Procedures, and revised the Workload Management Plan.

OIG Response

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

5. Eligibility Determinations

Competency Determinations

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

Finding 3 Controls Over Competency Determinations Need Strengthening

VARO staff unnecessarily delayed making final decisions in 7 (41 percent) of the 17 competency determinations completed from July through September 2010. The delays ranged from 36 to 131 days, with an average completion time of 54 days. Delays occurred because VSC managers were not aware of timeliness standards and the VSC does not prioritize completion of these types of cases. The risk of incompetent beneficiaries receiving benefit payments without fiduciaries assigned to manage those funds increases when VSC staff do 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 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 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 we identified occurred when VARO staff unnecessarily delayed a final incompetency decision for a veteran for approximately 4 months. During this period, the veteran received $11,096 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 staff responsible for overseeing and processing final competency determinations stated they were unaware of VBA's policy requiring immediate action and therefore did not prioritize these cases. Supervisory staff reported they did not manage incompetency decisions separately from other types of claims and made decisions on all claims in order of the dates the VSC received them. As a result, incompetent beneficiaries received benefits payments for extended periods despite being determined 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 10 of 17 determinations in 21 days.

VBA policy states when a court finds a veteran incompetent, the VARO must obtain additional medical evidence to support the court's incompetency determination. VBA policy requires review of all medical evidence related to incompetency prior to making a final competency determination. Judicial findings by a court with respect to the competency of a veteran are not binding upon VBA decisions. They are compelling evidence, but not a sole source of evidence.

VARO staff incorrectly processed 6 (35 percent) of 17 competency determinations. In five of the six cases, they did not complete a formal, documented, decision before appointing the fiduciaries. The incorrect process resulted from VSC staff's unawareness of VBA's policy on obtaining medical evidence to support court determinations of incompetency. As a result, VSC staff prematurely deemed veterans incompetent and may have incorrectly denied their right to independently handle their financial affairs.

Recommendations

5. We recommend the St. Louis VA Regional Office Director implement controls to ensure staff obtain and review current medical evidence in all cases involving court declarations of incompetency.

Management Comments

The VARO Director concurred with our recommendation. The Director stated management provided training on the proper processing of court declarations of incompetency. Further, the Policy, Analysis, Star Review, and Training Team will conduct accuracy reviews to ensure staff are following procedures.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

The St. Louis VARO is responsible for delivering non-medical VA benefits and services to veterans and their families. The VARO fulfills these responsibilities by administering compensation and pension benefits, vocational rehabilitation and employment assistance, and outreach activities.

Resources

As of September 30, 2010, the St. Louis VARO had a staffing level of 670.5 employees. Of these, the VSC had 263 employees (39 percent) assigned.

Workload

As of December 31, 2010, the VARO reported 11,692 pending compensation claims. The average time to complete these claims was 153.6 days, which was 21.4 days better than the national target of 175 days. As reported by STAR staff, the accuracy of compensation rating-related decisions was 84.6 percent, which was 5.4 percent below the 90 percent VBA target. The accuracy of compensation authorization-related processing was 96.3 percent, which was 0.3 percent better than the national target of 96 percent.

Scope

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

Our review included 87 (10 percent) of 855 claims related to PTSD, TBI, and herbicide exposure-related disabilities that the VARO completed from July through September 2010. For temporary 100 percent disability evaluations, we selected 30 (7 percent) of 411 existing claims from VBA's Corporate Database. We provided the VARO with the 381 claims remaining from the universe of 411. These claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months.

We reviewed all 18 errors identified by VBA's STAR program from July through September 2010. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR's measurements include a review of work associated with claims that require a rating decision. STAR staff review original claims, reopened claims, and claims for increased evaluation. Further, they review appellate issues that involve a myriad of veterans' disability claims.

Our process differs from STAR in that we review specific types of claims issues such as PTSD, TBI, and herbicide exposure-related disabilities 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: April 20, 2011

From: Director, VA Regional Office St. Louis, Missouri

Subj: Inspection of the VARO St. Louis, Missouri

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

1. Attached are the St. Louis VARO's comments on the OIG Draft Report: Inspection of VARO St. Louis.

2. Questions may be referred to Aaron Givens, Veterans Service Center Manager, at 314/552-9801.

(Original Signed)

DAVID UNTERWAGNER
Director

Attachment

ST LOUIS RO RESPONSE TO OIG DRAFT REPORT OF 4/4/11

Recommendation 1: We recommend the St. Louis VA Regional Office Director review the 381 temporary 100 percent disability evaluations remaining from our universe of 411 to determine if medical reevaluations are required and take appropriate action.

St Louis RO Response: Does Not Concur. In response to OIG Report, "Audit of 100 Percent Evaluations," dated January 24, 2011, VBA developed a national plan to review 100 percent evaluation cases, which was accepted by OIG. Therefore, the Regional Office will follow the national review plan.

Recommendation 2: We recommend the St. Louis VA Regional Office Director implement controls to ensure staff establishes suspense diaries for temporary 100 percent disability reevaluations.

St Louis RO Response: Concur. We agree that the electronic system should automatically populate future exam dates. In response to OIG Report, "Audit of 100 Percent Evaluations," dated January 24, 2011, VBA developed a national plan to review 100 percent evaluation cases, which was accepted by OIG. Therefore, the Regional Office will follow the national review plan.

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

St Louis RO Response: Concur. After the IG site visit, our VSC Policy, Analysis, Star Review and Training (PAST) Team conducted rating training in February, 2011. During the training, the PAST Team addressed traumatic brain injury (TBI) issues, and answered questions with the goal of improving our quality in this critical, high profile area. Two additional TBI training classes are scheduled during this fiscal year (July 18, 2011, and August 15, 2011). The last one is specifically designated for ordering TBI exams. These comprehensive training sessions will improve our TBI rating determinations. VSC leadership meets with the Compensation and Pension Service at VA Medical Centers within our catchment area quarterly. Addressing TBI examination issues has been added as a regular agenda item. Our next meetings are scheduled in the third quarter when we visit the Leavenworth, Columbia, and Poplar Bluff Medical Centers. We will address the inadequate TBI medical examination issue and countermeasures to improve them.

Recommendation 4: We recommend the St. Louis VA Regional Office Director develop and implement a plan to improve accuracy and oversight of herbicide exposure-related claims processing.

St Louis RO Response: Concur. The PAST Team administers mandatory special issues training and records the completion of training. We completed diabetes training for the RVSRs

in March 2011. We assigned an exercise, and scheduled follow-up diabetes training on April 13, 2011. We also conducted an Agent Orange training review on April 19, 2011. For RVSRs needing additional guidance, the DROs provide mentoring. The processing of herbicide exposure-related claims is currently specialized in teams with DRO's second-signing the rating decisions. Employees who receive errors called during the quality review process will receive feedback and mentoring by a member of the training team. Aggregate data will be reviewed to determine any group training that should be conducted.

Recommendation 5: We recommend the St. Louis VA Regional Office Director implement a plan to ensure management oversight of search mail and amend the workload management plan to incorporate procedures for oversight and control of drop and Military File mail.

St. Louis RO response: Concur. The Triage team's search mail procedures have been rewritten since the site visit. Standard Operating Procedures (SOPs) have been developed and distributed appropriately, to reflect the new changes.

The Triage portion of the Workload Management Plan was revised to reflect the changes to the new search mail procedures as to incorporate procedures for oversight and control of drop and Military File mail. This was completed on April 15, 2011.

Recommendation 6: We recommend the St. Louis VA Regional Office Director implement controls to ensure staff obtain and review current medical evidence in all cases involving court declarations of incompetency.

St Louis RO Response: Concur. Training was provided to the Post Determination and Fiduciary teams on how to process court declarations of incompetency. They have been trained to request the medical evidence at the time the court order is received and the field examiner is establishing the fiduciary. We have provided training to the RVSRs, regarding VBA's policy on court orders of incompetency. The PAST team will review these claims for accuracy to determine the procedures are being followed.

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 Code of Federal Regulations (CFR) 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (Manual (M) 21-1 Manual Rewrite (MR) Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Post-Traumatic Stress Disorder	**Determine whether VARO staff properly processed claims for PTSD.** (38 CFR 3.304(f))	X	
3. Traumatic Brain Injury	**Determine whether VARO staff properly processed service connection for all residual disabilities related to in-service TBI.** (Fast Letter (FL) 08-34 and FL 08-36, Training Letter 09-01)		X
4. Herbicide Exposure-Related Claims	**Determine whether VARO staff properly processed claims for service connection for disabilities related to herbicide exposure.** (38 CFR 3.309) (FL 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)		X
Data Integrity			
5. Dates of Claim	**Determine whether VARO staff properly recorded the correct dates of claim in the electronic record.** (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)	X	
6. Notices of Disagreement	**Determine whether VARO staff properly entered NODs into VACOLS.** (M21-1MR Part I, Chapter 5)	X	
Management Controls			
7. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)	X	
8. 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	
Workload Management			
9. Mail Handling Procedures	**Determine whether VARO staff properly followed VBA mail handling procedures.** (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)		X
Eligibility Determinations			
10. Competency Determinations	**Determine whether VAROs properly assessed beneficiaries' mental capacity to handle VA benefit payments.** (M21-1MR Part III, Subpart v, Chapter 9, Section A) (M21-1MR Part III, Subpart v, Chapter 9, Section B) (FL 09-08)		X

Source: VA OIG

Appendix D OIG Contact and Staff Acknowledgments

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