VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office New York, New York

July 28, 2011
11-00516-240

ACRONYMS AND ABBREVIATIONS

COVERS	Control of Veterans Records System
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, New York, New York

Why We Did This Review

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

What We Found

New York VARO staff correctly established dates of claim in the electronic record. VARO performance was generally effective in processing herbicide exposure-related claims and correcting errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program staff.

However, the VARO lacked effective controls and accuracy in processing some disability claims. Inaccuracies identified with processing temporary 100 percent disability evaluations resulted from human error when staff did not schedule future medical reexaminations as required. Inaccuracies related to traumatic brain injury and post-traumatic stress disorder claims resulted from staff using insufficient medical examinations to make final disability determinations. Overall, VARO staff did not accurately process 30 (31 percent) of the 98 disability claims we reviewed. The VARO instituted a new practice to improve claims processing accuracy by prescreening compensation and pension medical examinations to ensure they are adequate to support rating decisions.

VARO management did not have a mechanism in place to determine if VSC staff processed Notices of Disagreement for appealed claims within VBA's 7-day standard or produced complete and timely Systematic Analyses of Operations. VSC staff did not always use VBA's Control of Veterans Records System to process search mail. Moreover, reallocation of staff to a high priority national project resulted in untimely final competency determinations.

What We Recommended

We recommended VARO management strengthen controls over processing Notices of Disagreements, completing Systematic Analysis of Operations, handling mail, and completing final competency determinations timely.

Agency Comments

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

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

TABLE OF CONTENTS

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 veteran 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 April 2011, the OIG conducted an inspection of the New York 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 68 (20 percent) of 344 disability claims related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and herbicide exposure that VARO staff completed from October through December 2010. In addition, we reviewed 30 (9 percent) of 316 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 New York 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 New York VARO needs to improve the control and accuracy of processing temporary 100 percent disability evaluations, TBI residual disability claims, and PTSD claims. VARO staff incorrectly processed 30 (31 percent) of the total 98 disability claims reviewed. We advised VARO management regarding the inaccuracies noted during our inspection. 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 New York 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
Traumatic Brain Injury Claims	8	5	0	5
Post-Traumatic Stress Disorder Claims	30	4	2	2
Herbicide Exposure-Related Disabilities Claims	30	1	0	1
Total	**98**	**30**	**6**	**24**

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 upon 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.

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.

Based on analysis of available medical evidence, 4 of the 20 processing inaccuracies identified affected veterans' benefits and involved overpayments totaling $250,087. The most significant overpayment occurred when a Rating Veterans Service Representative (RVSR) granted service connection for prostate cancer and noted the veteran would need reexamination in October 2006; however, VSC staff did not schedule the required VA 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 $122,465 over a period of 3 years and 11 months.

The remaining 16 inaccuracies had the potential to affect veterans' benefits. We could not determine if the evaluations would have continued because the veterans' claims folders did not contain the medical evidence needed to reevaluate each case.

Delays in scheduling the reexaminations ranged from approximately 2 months to 11 years and 8 months. An average of 2 years and 4 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.

The processing inaccuracies we identified were the result of human error. The most frequent processing inaccuracy noted in 13 (65 percent) of the 20 inaccuracies occurred when VSC staff did not establish suspense diaries in the electronic record. Without suspense diaries, VSC staff do not receive reminder notifications to schedule required VA reexaminations.

The second most frequent processing inaccuracies noted in 7 (35 percent) of 20 inaccuracies occurred when VSC staff did not schedule mandatory reexaminations once they received reminder notifications. Additionally, staff did not take final action to reduce temporary 100 percent disability evaluations after the mandated 60-day due process period. For example, VARO staff properly notified a veteran they would reduce the temporary 100 percent disability to 10 percent disabling due to improvement in the condition. However, after a mandated 60-day due process period, VARO staff did not take action to reduce the disability evaluation as required. As a result, VA overpaid the veteran approximately $25,500 over a period of 10 months.

VARO management did not provide adequate oversight to ensure VSC staff entered suspense diaries or took appropriate follow-up actions on reminder notifications and proposed reductions. 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 286 claims remaining from our universe of 316 claims selected for review. In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations*, (Report Number 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each evaluation had a future exam date entered in the electronic record. Therefore, we made no additional recommendations for improvement in this area.

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 five (63 percent) of eight TBI claims. All of these processing inaccuracies had the potential to affect veterans' benefits. For all five claims, RVSRs prematurely granted or continued service connection evaluations for TBI-related residuals based on insufficient VA medical examination reports.

According to VBA policy, when a medical examination report does not address all required elements, VSC staff should return it to the issuing clinic or healthcare facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without adequate or complete medical evidence.

VARO management stated despite instructions to do otherwise, RVSRs were reluctant to return insufficient examination reports to VA medical facilities, as the process was time-consuming and would further delay claims processing. Errors occurred as a result, and veterans may not have received correct benefit payments.

In March 2011, the VSC released a Quality and Training Plan that included provisions for improving the quality of VA medical examination reports. For example, management dedicated one full-time employee to pre-screen VA examination reports for completeness before sending them on to the RVSRs who ultimately decide the claims. In instances where the screeners find the examination reports insufficient, the screeners should return them to VA facilities for correction. VSC managers indicate prescreening VA examination reports prior to the disability evaluation process helps ensure VSC staff use quality VA examinations. Additionally, the VARO has begun tracking insufficient VA examinations for trend analysis and training purposes. Since the processing errors we identified occurred prior to the implementation of the Quality and Training plan, we made no recommendation for improvement in this area. We will assess the effectiveness of the VARO's actions to screen examination reports in future reviews.

PTSD Claims

VARO staff incorrectly processed 4 (13 percent) of 30 PTSD claims. Two of these inaccuracies affected veterans' benefits. Following are examples of these inaccuracies.

- An RVSR did not grant special monthly compensation, as required by VBA policy, to a veteran with a single service-connected disability evaluated as 100 percent disabling and separate disabilities evaluated as 60 percent disabling or more. As a result, VA underpaid the veteran a total of $1,280 over a period of 4 months.
- An RVSR incorrectly granted service connection for PTSD effective May 3, 2010, which predated the veteran's claim—received on June 23, 2010. As a result, VA overpaid the veteran $433 over a period of one month.

The remaining two inaccuracies had the potential to affect veterans' benefits. In both cases, RVSRs prematurely granted service connection for PTSD using insufficient medical examination reports. The RVSRs should have returned the VA examinations to the VA facility because the VA examiners did not provide required links between the current diagnoses and military service, as required by VBA policy.

Processing inaccuracies for PTSD claims occurred because VARO staff used VA medical examination reports that were insufficient for decision-making

purposes. As discussed above, the VARO recently implemented measures to ensure RVSRs only use quality VA examinations. Because it was too soon for us to assess the effectiveness of these changes, we made no recommendation for improvement in this area.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed one (3 percent) of 30 herbicide exposure-related claims we reviewed. In this case, VSC staff did not establish the suspense diary necessary to generate a reminder notification to schedule a medical reexamination. We did not consider the error rate significant and determined the VARO is generally following VBA policy when processing herbicide exposure-related claims. As such, we made no recommendation for improvement in this area.

2. Data Integrity

Dates of Claim

We analyzed claims folders to determine if VARO staff were 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 correct dates of claim in the electronic record for all 30 claims we reviewed; therefore, we made no recommendation for improvement in this area.

Notices of Disagreement

We reviewed claims folders to determine if VARO staff timely recorded Notices of Disagreement (NOD) 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 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 moves through the appellate process expeditiously.

Finding 2 Controls Over Recording Notices of Disagreement Need Strengthening

The Appeals Team did not always record 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 11 (37 percent) of the 30 NODs we reviewed. It took staff an average of 14 days to record these 11 NODs in VACOLS. According to the VSC workload management plan, responsibility for recording NODs rests with the Appeals Team. NODs are delivered to the Appeals Team daily where staff are required to enter the NODs within 2-3 days, several days earlier than VBA's 7-day standard. However, based on our interviews with VSC managers and staff, we concluded no controls were in place to monitor or track timeliness to ensure compliance with the local policy.

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 service to claimants.

Recommendation

1. We recommend the New York 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 and amended the Workload Management Plan to reflect that Claims Assistants will record NODs within 2 days of receipt at the regional office. Further, the Director informed us that the Appeals Team Coach will provide oversight of NODs by using operation reports and VACOLS to ensure all Claims Assistants record NODs within the station goal of 2 days.

OIG Response

The Director's comments and 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 Systematic Technical Accuracy Review (STAR) staff. The STAR program is VBA's multifaceted quality assurance program to ensure that veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that VARO staff take corrective action on errors that STAR staff identify. In general, VARO staff followed VBA policy regarding the correction of STAR errors.

VARO staff did not correct one (4 percent) of the 23 files that contained errors identified by VBA's STAR program from October through December 2010. In this instance, VARO staff erroneously reported to the STAR program that they had completed the corrective action identified. We do not

consider the error rate significant, so we made 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 each Systematic Analysis of Operations (SAO). 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 SAOs annually.

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 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 4 (33 percent) of the 12 SAOs were not compliant with VBA policy. Specifically, 3 of the 12 required SAOs were untimely and 1 was incomplete (missing required elements). SAOs were untimely because VSC management did not have a formal process for requesting and documenting extension requests for these internal reviews. While VARO management told us they granted extensions to VSC staff, they advised they did so verbally rather than in writing.

For example, the Claims Processing Timeliness SAO was completed more than 3 months past the due date; however, VSC staff did not update the data used for analysis in this SAO to reflect current inventory and processing timeliness—both critical elements in workload decisions. Consequently, the recommendations resulting from the SAO may no longer be applicable.

Recommendation

2. We recommend the New York VA Regional Office Director develop and implement a plan for staff to address all required elements of Systematic Analyses of Operations and complete them in accordance with the VARO's annual schedule.

Management Comments

The VARO Director concurred with our recommendation and now requires VSC staff to submit in writing all requests to complete SAOs past their scheduled due dates. Further, the VSC created a compliance checklist to ensure staff complete all required sections of the SAOs.

OIG Response The Director'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 New York VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. The VARO mailroom staff processed mail according to VBA policy; therefore, we made no recommendation for improvement in this area.

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 over which VA has jurisdiction, does not refer to a claim for benefits, and/or does not have a return address.

Staff incorrectly handled 2 (7 percent) of 30 pieces of military file mail we reviewed. In both instances, staff did not request and review the claims folders to determine proper action, as required. Due to the infrequency of such inaccuracies, we made no recommendation for improvement in this area.

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. VBA defines search mail as active claims-related mail waiting to be associated with a veteran's claims folder. Additionally, VBA policy states VSC staff will route and process mail requiring action according to established procedures. This includes outgoing mail to other VA facilities, known as interoffice mail.

Finding 4 Control of Veterans Service Center Mail Management Procedures Need Strengthening

VSC staff did not always process mail according to VBA and local policy. We identified errors in the management of 22 (20 percent) of 110 individual pieces of mail we reviewed. VARO management did not have sufficient oversight to ensure staff properly handled search mail and outgoing

interoffice mail as prescribed. Consequently, decision makers may not always have all available mail in the claims file when making disability or eligibility determinations, and claimants may not always receive prompt and accurate benefits.

Search Mail

For 15 (30 percent) of 50 pieces of search mail reviewed, VSC staff did not properly use COVERS to ensure accurate and timely processing of search mail. The most frequent inaccuracy occurred when VSC staff did not retrieve search mail and associate the mail with the relevant claims files as required, even though COVERS contained electronic notices of pending search mail requests. Following are examples of other types of search mail inaccuracies we found during our review.

- On March 2, 2011, the VARO received medical evidence to support a pending claim for compensation. Staff properly placed the mail in the search mail bin; however, they did not annotate the existence of that mail in COVERS. Without this annotation, other employees were unaware that the mail was waiting to be associated with a claims folder. As a result, this mail could have remained in the holding bin until purged by VSC staff. At the time we discovered it, the mail had been in the VARO for 42 days without action taken on the veteran's claim.
- On March 8, 2011, the VARO received a claim for compensation and placed this mail in a search mail bin; however, VSC staff did not establish this claim in the electronic record. As a result, VSC staff did not know that this claim existed until we informed them. At the time of our discovery, this mail had been in a search bin for 22 days without any action taken on the veteran's claim.

The VSC had two search mail points–one located in the Triage Team and one located within the Appeals Team. While the VSC's workload management plan addressed oversight of search mail in Triage, the plan did not require oversight of search mail located in the Appeals Team. Additionally, VSC management told us they had been conducting periodic reviews of the mail control points; however, we determined these reviews were not sufficient to ensure all search mail was associated with the relevant veterans' claims folders as required.

Outgoing Interoffice Mail

We found 5 (17 percent) of 30 pieces of outgoing interoffice mail had been incorrectly or untimely processed. Interoffice mail is mail awaiting transfer to another VARO. Following are examples of these inaccuracies.

- On May 22, 2008, the VARO received an NOD from a veteran. Although the New York VARO maintained jurisdiction to process this mail, VARO staff improperly prepared the mail for transfer to another office. If we had not identified the mail processing error, the veteran

would have suffered an additional delay with the appeal. Neither VARO management nor we could ascertain why this mail went unprocessed for approximately 3 years.

- On October 20, 2010, the VARO received a veteran's pension claim, which VSC staff should have routed to a Pension Management Center. However, at the time of our inspection, VSC staff were in the process of misrouting the mail to a VA national storage facility. If we had not identified the mail processing error, additional delays in processing the claim would have occurred.

Although the VSC workload management plan did not contain guidance delineating responsibility for review of interoffice outgoing mail, VSC management informed us they performed "spot checks" of this mail. Management informed us, and we confirmed, they did not document the results of those reviews. Supervisors of several teams that send outgoing mail also told us they do not conduct reviews to determine whether staff properly route the mail to the correct locations.

Recommendation

3. We recommend the New York VA Regional Office Director implement a plan for increased oversight to ensure VSC staff process mail according to VBA policy and local procedures.

Management Comments

The VARO Director concurred with our recommendation and reassigned responsibility for mailroom activities to the VSC. The Director assigned additional staff to the VSC to ensure proper processing of all mail. Further, the Director indicated the VSC conducts weekly reviews of all search mail bins to ensure the proper use of COVERS to control and process this mail.

OIG Response

The Director's comments and actions are responsive to the recommendation.

5. Eligibility Determinations

Competency Determinations

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

Finding 5 Controls Over Competency Determinations Need Strengthening

VARO staff unnecessarily delayed making final decisions in 4 (36 percent) of 11 competency determinations completed from October through December 2010. The delays ranged from 14 to 100 days with an average completion time of 59 days. The delays occurred because of staffing shortages due to competing priorities for rating staff within the VSC. The risk of incompetent beneficiaries receiving benefits payments without fiduciaries assigned to manage those funds increases when 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 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.

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.

Using VBA's newly defined 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 100 days. During this period, the veteran received $8,469 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.

The VSC's workload management plan indicated staff should work these types of claims on a priority basis; however, we confirmed that additional, conflicting guidance from VARO management had established a higher priority for VSC rating staff. Specifically, the VSC assigned 11 of 17 RVSRs to work high profile, time-sensitive claims related to a national project. As a result, the VSC was limited to using the remaining six RVSRs to process all other claims requiring rating decisions for the VSC. Further, management stated that in addition to competency claims processing, the VSC had a multitude of other competing priorities for rating staff to address. Due to the processing delays this created, incompetent beneficiaries received

benefits payments for extended periods despite being incapable of managing these funds effectively.

Recommendation

4. We recommend the New York VA Regional Office Director implement a plan to allocate resources to complete final competency determinations timely.

Management Comments

The VARO Director concurred with our recommendation and implemented a process change to ensure timely completion of this work without allocating additional resources. The Director assigned Team Coaches the responsibility for ensuring competency determinations receive expedited processing. Coaches are required to review workload reports weekly to identify and place special emphasis on cases involving competency determinations. Further, the Director requires Team Coaches to provide VSC management weekly status reports on competency determinations pending longer than 60 days.

OIG Response

The Director's comments and actions are responsive to the recommendation.

Appendix A VARO Profile and Scope of Inspection

Organization

The New York Regional Office administers a variety of services and benefits including Compensation and Pension and Vocational Rehabilitation and Employment. Other services include specially adapted housing grants, benefits counseling, fiduciary services, and outreach to homeless, elderly, minority, and women veterans.

Resources

As of January 2011, the New York VARO had a staffing level of 210 full-time employees. Of these, the VSC had 172 employees (82 percent) assigned.

Workload

As of March 2011, the VARO reported 12,977 pending compensation claims. The average time to complete these claims was 257.1 days—approximately 82 days more than the national target of 175 days. As reported by STAR, the accuracy of compensation rating-related issues was 75.1 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 68 (20 percent) of 344 disability claims related to PTSD, TBI, and herbicide exposure that the VARO completed from October through December 2010. For temporary 100 percent disability evaluations, we selected 30 (9 percent) of 316 existing claims from VBA's Corporate Database. We provided the VARO with 286 claims remaining from our universe of 316 for their review. The 316 claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months or longer as of March 2, 2011.

We reviewed the 12 mandatory SAOs completed in Fiscal Years 2010 and 2011. Additionally, we reviewed 11 available competency determinations and 23 files that contained errors identified by VBA's STAR program from October to December 2010. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR assessments include a review of work associated with claims requiring rating decisions. STAR staff review original claims, reopened claims, and claims for increased evaluations. 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.

We reviewed dates of claim for those claims pending at the VARO during our on-site inspection. NODs reviewed had been pending processing between 31-60 days at the VARO at the time of our inspection. Further, we reviewed mail in various processing stages within the VARO mailroom and the VSC, including interoffice mail pending transfer to another VARO.

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: July 7, 2011

From: Director, VA Regional Office New York, New York (306/00)

Subj: Inspection of the VA Regional Office, New York, New York

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

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

2. Questions may be referred to the Veterans Service Center Manager, Laurie Clay, at (212) 807-3412.

(Original signed)

Sue Malley
Director

Attachment

Recommendation 1: Recommend the New York 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.

RO Response: Concur.

The Workload Management Plan has been refined to reflect that all identified Notice of Disagreements (NODs) would be placed under control within 2 days of receipt on station. The Appeals Team Claims Assistants (CAs) will be responsible for pulling all folders for review to identify valid NODs and ensuring Veterans Appeals Control and Locator System (VACOLS) is updated. The Appeals Team coach is responsible for tracking this workload by utilizing VETSNET Operations Report (VOR) and VACOLS to ensure all NODs from this point forward meet the above timeliness requirements.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 2: Recommend the New York VA Regional Office Director develop and implement a plan for staff to address all required elements of Systematic Analysis of Operations and complete them in accordance with the VARO's annual schedule.

RO Response: Concur.

The NYRO publishes a Systematic Analysis of Operations (SAO) schedule each year. The Director's Office has established a tracking spreadsheet that identifies the SAO, due date, and any extensions requested and granted. Although the findings identified three SAOs that were not timely, verbal extensions had been granted. It is now the policy of both the Director's Office and the VSC to request and respond in writing.

The VSC has incorporated a M21-4, Chapter 5 compliance checklist to ensure SAOs are properly completed prior to submission to the Director's Office.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 3: Recommend the New York VA Regional Office Director implement a plan for increased oversight to ensure VSC staff process mail according to VBA policy and local procedures.

RO Response: Concur.

The VSC conducts weekly reviews of all search mail bins to ensure that all search mail is placed on search in Control of Veterans Records System (COVERs). Reviews are also conducted to ensure that all mail is placed under end product control, if appropriate. Additionally, the Director's Office has implemented periodic reviews to determine compliance in this area. Findings are shared with the VSC management as well as the File and Mail Control Center management staff.

The mailroom function has been assigned to the VSC and has been reorganized. Additional staff has been assigned to ensure processing of all mail to include transfer of mail to other VA regional offices and medical centers. VSC management, to ensure the mailroom is compliant, conducts weekly reviews of this area.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 4: Recommend the New York VA Regional Office Director implement a plan to allocate resources to complete final competency determinations timely.

RO Response: Concur in part.

The Regional Office has implemented a process change to ensure timely completion of this work without allocating additional resources. A VOR report is prepared each Wednesday identifying all End Product (EP) 600s, with emphasis placed on any cases involving incompetency issues. Each Integrated Team coach is responsible for ensuring that all EP 600 cases involving incompetency issues are expedited. To ensure compliance, each week the Integrated Teams are required to provide a status on each case pending 60 or more days.

The Veterans Benefits Administration recommends closure of this recommendation.

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 Claims	**Determine whether VARO staff properly processed claims for PTSD.** (38 CFR 3.304(f))		X
3. Traumatic Brain Injury Claims	**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. Dates of Claim	**Determine whether VARO staff properly recorded dates of claim in the electronic record.** (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)	X	
6. Notices of Disagreement	**Determine whether VARO staff properly entered NODs into VACOLS.** (M21-1MR Part I, Chapter 5)		X
Management Controls			
7. Systematic Technical Accuracy Review	**Determine whether VARO staff properly corrected STAR errors in accordance with VBA policy.** (M21-4, Chapter 3, Subchapter II, 3.03)	X	
8. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)		X
Workload Management			
9. Mail Handling Procedures	**Determine whether VARO staff properly followed VBA mail handling procedures.** (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)		X
Eligibility Determinations			
10. Competency Determinations	**Determine whether VAROs properly assessed beneficiaries' mental capacity to handle VA benefit payments.** (M21-1MR Part III, Subpart v, Chapter 9, Section A) (M21-1MR Part III, Subpart v, Chapter 9, Section B) (Fast Letter 09-08)		X

CFR=Code of Federal Regulations, M=Manual, MR=Manual Re-write
Source: OIG

Appendix D OIG Contact and Staff Acknowledgments

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