VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Seattle, Washington

September 8, 2011
11-00515-266

ACRONYMS AND ABBREVIATIONS

C&C	Confirmed and Continued
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
STR	Service Treatment Record
TBI	Traumatic Brain Injury
VACOLS	Veterans Appeals Control and Locator System
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, Seattle, Washington

Why We Did This Review

The Veterans Benefits Administration has a nationwide network of 57 VA Regional Offices (VAROs) that process claims and provide services to veterans. We conducted this inspection to evaluate how well the Seattle VARO accomplishes this mission.

What We Found

Seattle VARO staff were generally effective in processing post-traumatic stress disorder and herbicide-related claims, correcting errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program, and ensuring Systematic Analyses of Operations were timely and complete.

However, the VARO lacked effective controls and accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations resulted from human error when staff did not schedule required future medical reexaminations. Errors in processing traumatic brain injury claims were due to inadequate training. Overall, staff did not accurately process 34 (28 percent) of the 120 disability claims we reviewed.

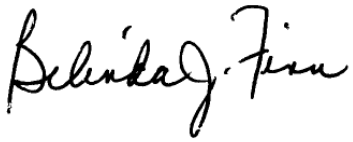
VARO management did not have mechanisms in place for Veterans Service Center staff to accurately establish dates of claim or timely process Notices of Disagreement for appealed claims within the Veterans Benefits Administration's 7-day standard. In addition, management directives lacked procedures for ensuring proper mail handling.

What We Recommended

We recommended the Seattle VARO Director develop and implement a plan to assess the effectiveness and adequacy of Rating Veterans Service Representative training related to processing traumatic brain injury claims. Management needs to strengthen controls over establishing dates of claim, processing Notices of Disagreement, and handling claims-related mail. Moreover, management needs to ensure staff receive training on how to use the Control of Veterans Records System to manage mail.

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.



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 May 2011, the OIG conducted an inspection of the Seattle VARO. The inspection focused on four protocol areas examining nine operational activities. The four protocol areas were disability claims processing, data integrity, management controls, and workload management. We did not examine eligibility determinations because the Veterans Benefits Administration (VBA) has centralized all Western Area fiduciary activities at the Salt Lake City VARO.

We reviewed 90 (14 percent) of 622 disability claims related to traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), and herbicide exposure that the VARO completed from January through March 2011. In addition, we reviewed 30 (6 percent) of 494 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 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, TBI, PTSD, and herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

Finding 1 Disability Claims Processing Accuracy Could Be Improved

The Seattle VARO lacked controls and accuracy in processing claims for temporary 100 percent disabilities and TBI. VARO staff incorrectly processed 34 (28 percent) of the total 120 disability claims reviewed. VARO management agreed with our assessments and initiated action to correct the inaccuracies identified.

The table below reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Seattle 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	17	3	14
Traumatic Brain Injury Claims	30	12	4	8
Post-Traumatic Stress Disorder Claims	30	2	2	0
Herbicide Exposure-Related Claims	30	3	3	0
Total	**120**	**34**	**12**	**22**

Source: VA OIG Analysis

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 17 (57 percent) of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a service-connected disability following surgery or when specific treatment is needed. At the end of a

mandated period of convalescence or 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 (C&C) 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 a suspense diary matures, the electronic system generates a reminder notification alerting VSC staff to schedule the reexamination.

Our analysis of available medical evidence showed that 3 of the 17 processing inaccuracies involved overpayments to veterans totaling $97,981. The most significant overpayment occurred when VARO staff did not schedule a medical reexamination for a veteran's prostate cancer as required. VA treatment records revealed the condition improved and the veteran was no longer entitled to receive a temporary 100 percent disability evaluation. As a result, VA overpaid the veteran $59,283 over a period of 1 year and 9 months.

The remaining 14 inaccuracies had the potential to affect veterans' benefits. Following are descriptions of the inaccuracies we identified.

- In 12 cases, VSC staff did not establish or improperly canceled reminder notifications in the electronic record. We could not determine if these temporary 100 percent disability evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to reevaluate each case.
- The two remaining inaccuracies occurred because staff did not promptly schedule reexaminations once they received the reminder notifications.

These processing inaccuracies were the result of human error. The most frequent inaccuracy occurred in 8 (47 percent) of 17 cases when VARO staff did not properly establish suspense diaries in the electronic record. Without suspense diaries, VSC staff do not receive reminder notifications to schedule required VA medical reexaminations.

For those cases requiring future reexaminations, delays ranged from 5 months to 12 years and 4 months. An average of 2 years and 11 months elapsed from the time staff should have scheduled these medical reexaminations until the date of our inspection—the date staff ultimately took corrective actions to obtain the necessary medical evidence.

VARO management did not provide adequate oversight to ensure VSC staff entered suspense diaries for C&C rating decisions. In November 2009, VBA provided guidance reminding VAROs about the need to add suspense diaries in the electronic record for C&C rating decisions. However, VARO management did not have a local policy in place requiring VSC staff to review the electronic record for C&C rating decisions to determine the need for future reexaminations. Because effective controls were not in place, a temporary 100 percent disability evaluation could continue uninterrupted over the course of a veteran's lifetime.

We provided the VARO with a list of 464 claims remaining from our universe of 494 temporary 100 percent disability evaluations selected for review. In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations*, (Report No. 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. We will follow-up on VBA's efforts in this area during future inspections. Therefore, we made no additional recommendation for improvement in this area.

TBI Claims

The Department of Defense and VBA commonly define a TBI as a 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 staff to evaluate these residual disabilities.

VARO staff incorrectly processed 12 (40 percent) of 30 TBI claims we reviewed. Our analysis of available medical evidence showed 4 of the 12 processing inaccuracies affected veterans' benefits—two resulted in underpayments totaling $10,512, and two resulted in overpayments totaling $7,134. Following are details on the most significant underpayment and overpayment.

- A Rating Veterans Service Representative (RVSR) incorrectly assigned a 10 percent evaluation for a TBI-related disability. The VA medical examination report provided evidence that the severity of the disability warranted a 40 percent evaluation. As a result, VA underpaid the veteran $8,784 over a period of 1 year and 6 months.
- An RVSR incorrectly assigned a 10 percent evaluation for a TBI-related disability. During the VA medical examination, the veteran provided the physician with subjective complaints of a TBI-related disability and the RVSR assigned an evaluation based on those complaints. The RVSR overlooked the VA examiner's objective findings in the examination report that related the symptoms to a coexisting mental condition and not

a TBI. As a result, VA overpaid the veteran $4,305 over a period of 1 year and 3 months.

The remaining eight cases had the potential to affect veterans' benefits. Following are descriptions of these inaccuracies.

- In four cases, RVSRs prematurely evaluated TBI-related disabilities using insufficient 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 health care facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain all residual disabilities related to TBI claims without adequate or complete medical evidence.
- In the remaining four cases, RVSRs incorrectly applied rating criteria when evaluating TBI-related disabilities. For example, in two cases, RVSRs did not assign separate evaluations for disabilities diagnosed by VA examiners. In the remaining two cases, the improper evaluations occurred when RVSRs over-evaluated symptoms. RVSRs based evaluations on the veterans' reported history rather than the results of VA examination findings. The inaccuracies did not affect the veterans' existing disability evaluations but may affect future evaluations for additional benefits.

Generally, these errors occurred because TBI training did not ensure RVSRs had the skills needed to make accurate disability determinations. For example, training staff developed an internal test to assess how well RVSRs comprehended TBI claims processing policies. Results of the test revealed RVSRs had difficulty identifying insufficient TBI medical examination reports that they needed to return to physicians for correction to support their rating decisions. VARO management did not implement controls, such as additional quality reviews to ensure claims processing accuracy, or more frequent TBI training to ensure RVSRs were proficient in identifying insufficient medical examination reports. Because of the TBI claims processing errors, veterans did not always receive accurate benefits payments.

PTSD Claims

VARO staff incorrectly processed 2 (7 percent) of 30 PTSD claims we reviewed. Both of the errors affected veterans' benefits, resulting in overpayments totaling $7,728. Following are descriptions of these inaccuracies.

- An RVSR erroneously granted service connection for PTSD effective January 2010. An earlier rating decision in September 2004 had already granted service connection for PTSD. As a result, by the time of our

inspection VA had overpaid the veteran $4,304 over a period of 1 year and 4 months.

- An RVSR incorrectly granted service connection for PTSD without medical evidence diagnosing the veteran with this condition. As a result, VA overpaid the veteran $3,424 over a period of 1 year and 4 months.

Because we did not consider the frequency of errors significant, we determined the VARO generally followed VBA policy when processing PTSD claims. Therefore, we made no recommendation for improvement in this area.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 3 (10 percent) of 30 herbicide exposure-related claims we reviewed. All three of the processing inaccuracies affected veterans' benefits—two resulted in underpayments totaling $3,224, and one resulted in an overpayment of $1,600. Following are descriptions of these inaccuracies.

- An RVSR incorrectly assigned a veteran a non-compensable evaluation for residuals of prostate cancer. Medical evidence showed the severity of two residual disabilities warranted a combined 30 percent evaluation. As a result, VA underpaid the veteran $1,880 over a period of 5 months.
- An RVSR did not grant a veteran special monthly compensation for a residual disability related to diabetes mellitus. As a result, VA underpaid the veteran $1,344 over a period of 1 year and 2 months.
- An RVSR incorrectly granted entitlement to special monthly compensation based on multiple disabilities, one of which was unrelated to a herbicide disability. According to VBA policy, the veteran was not entitled to special monthly compensation. As a result, VA overpaid the veteran $1,600 over a period of 5 months.

The three inaccuracies identified were a result of human error. Because we did not identify a systemic trend associated with processing these claims, we made no recommendation for improvement.

Recommendation

1. We recommend the Seattle VA Regional Office Director develop and implement a plan to assess the effectiveness of Rating Veterans Service Representative training related to processing traumatic brain injury claims.

Management Comments

The VARO Director concurred with our recommendation and provided TBI training to RVSRs and Decision Review Officers on June 7-8, 2011. To gauge the effectiveness and adequacy of training, VARO staff reviewed 218 TBI claims completed since June 2, 2011. The internal review revealed 17 claims processed in error and demonstrated approximately 93 percent

effectiveness in rating those TBI cases. The Director informed us VARO staff would perform another Independent Rating Review (IRR) for TBI claims in October 2011, to continue the assessment of the effectiveness and adequacy of TBI training.

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

2. Data Integrity

Dates of Claim We analyzed claims folders to determine if the VARO was following VBA policy on establishing 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.

Finding 2 Insufficient Controls Over Recording Correct Dates of Claim

VSC staff did not always record correct dates of claim in the electronic record. This occurred because VARO management did not provide standardized training to staff responsible for establishing dates of claim. Consequently, veterans were at risk of receiving inaccurate benefits payments.

VSC staff did not accurately record 5 (17 percent) of the 30 dates of claim we reviewed. These incorrect dates ranged from 6 to 146 days. For example, in two cases VSC staff used mail submitted by veterans to establish claims in the electronic record. In both cases, the claims had previously been submitted and reviewed, but misclassified as mail requiring no action. If not for our review, VSC staff may have processed these claims using incorrect dates, which could have resulted in these veterans receiving inaccurate benefits.

Management acknowledged it did not provide standardized training for claims assistants and file clerks—staff typically responsible for establishing claims in the electronic record. Instead, supervisors individually trained their team members independent of other teams. This approach led to inconsistent practices in establishing dates of claim in the electronic record.

Incorrect dates in the electronic record affect data integrity and misrepresent VARO performance. Data integrity issues make it difficult for senior VBA leadership to assess VARO performance accurately. Further, by not ensuring staff record correct dates of claim, the risk of veterans receiving inaccurate benefits payments increases.

Recommendation

2. We recommend the Seattle VA Regional Office Director develop a plan to provide standardized training to claims assistants and file clerks on the proper procedures for establishing dates of claim in the electronic record.

Management Comments

The VARO Director concurred with our recommendation. Claims Assistants and File Clerks received training on the proper procedures for establishing dates of claim and routing of mail in June 2011. Further, the Director created a plan to provide recurring standardized training to Claims Assistants and File Clerks.

OIG Comments

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

Notices of Disagreement

We analyzed claims folders to determine whether the VARO was 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 veterans' appeals 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.

Finding 3 Insufficient Controls Over Recording Notices of Disagreement

The Appeals Team did not always control NODs in VACOLS within VBA's 7-day standard. VARO staff exceeded VBA's standard for 12 (40 percent) of the 30 NODs we reviewed. These delays ranged from 9 to 39 days. Staff took an average of nearly 18 days to record the 12 NODs in VACOLS.

This occurred because VARO management was unaware of VBA's national timeliness standard. The VSC workload management plan did not provide staff with guidance regarding any timeliness standard for recording NODs in the electronic record. Further, the plan lacked an oversight mechanism for supervisors to review this type of work.

As of April 2011, VBA performance reports showed the average time for the VARO to complete an NOD was 329.4 days. The VARO exceeded the national average of 182 days by approximately 147 days.

Untimely recording of NODs makes it difficult for VARO and senior VBA leadership to accurately measure and monitor VARO performance. Further, VBA's National Call Centers rely upon VACOLS information to provide accurate customer service to claimants. Unnecessary delays in controlling

NODs affect national performance measures for NOD inventory and appeals management timeliness.

Recommendation

3. We recommend the Seattle VA Regional Office Director amend the Workload Management Plan to incorporate clear instructions and oversight mechanisms for recording Notices of Disagreement within the Veterans Benefits Administration's 7-day standard.

Management Comments

The VARO Director concurred with our recommendation and amended the Appeals Team SOP on May 16, 2011. The Director assigned responsibility for establishing the VACOLS record within 7 days to Claims Assistants. Further, management amended the Workload Management Plan to reflect the 7-day standard.

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 whether 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 veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that VAROs take corrective action on errors identified by STAR.

VARO staff did not correct 1 (6 percent) of 17 claims files that contained errors identified by STAR program staff from October through December 2010. In this instance, VARO staff reported to STAR they would complete the corrective action when they received the claims folder from a remote storage location; however, we saw no indication that staff ever requested the claims folder. Because VARO management generally followed VBA policy regarding correction of STAR errors, we did not consider the error rate significant and made no recommendation for improvement in this area.

Systematic Analyses of Operations

We assessed whether VARO management had adequate 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. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish annual SAO schedules designating the staff required to complete the SAOs by specific dates.

VARO management generally followed VBA policy by ensuring SAOs were timely and complete. Because only 1 (9 percent) of 11 required SAOs was

incomplete, we did not consider the error rate significant. As such, 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 to 6 hours of receipt at the VARO. The Seattle VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. VARO mailroom staff processed, date-stamped, and delivered all VSC mail to the mail control points as required. Therefore, we made no recommendation for improvement in this area.

Integrated Team Mail Processing Procedures

VBA has embarked on a multi-year transformation of veterans' claims processing and benefits delivery. As part of this transformation, VBA is pursuing new business concepts with the goal of improving the speed, accuracy, and consistency of claims decisions rendered to veterans and their families. One of the outcomes of this initiative has been the integrated team model. In March 2011, based on VBA guidance, the VSC reorganized from the previous Claims Processing Improvement business model to this new model, where teams are comprised of members with various skill sets from across the VARO. For example, an integrated team consists of supervisory staff, claims assistants, RVSRs, and Veterans Service Representatives collectively assigned to process portions of selected VSC's compensation claims.

We assessed the integrated 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.

Further, 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 veterans' claims folders. Conversely, drop mail requires no immediate action upon receipt. VBA policy allows the use of a storage area, known as the Military File, to hold mail temporarily when staff are unable to identify associated claims folders in the system. Typically, mail stored in this area pertains to matters over which VA has jurisdiction, does not refer to a claim for benefits, or does not include a return address.

Finding 4 Oversight Needed for Proper Processing and Control of Veterans Service Center Mail

VSC staff did not correctly process or control 52 (41 percent) of 128 pieces of search, drop, and Military File mail according to policy. Existing local directives did not incorporate a requirement for supervisory reviews, lacked specific procedures for processing search and drop mail, and needed to be updated to reflect mail-processing procedures in the new integrated team model. Consequently, RVSRs did not always have all available mail in the claims folder when making disability determinations and claimants possibly did not always receive prompt and accurate benefits.

Search Mail

For 30 (58 percent) of 52 pieces of search mail reviewed, VSC staff did not properly use COVERS to ensure accurate and timely processing. Staff did not retrieve 17 of the 30 pieces of search mail and associate it with claims folders even though COVERS contained electronic notices of the pending search mail requests. Staff did not place 10 pieces of mail on search in COVERS at all. For the remaining three pieces of mail, staff did not follow policy and attempt to locate related claims folders that had been misplaced. Following are descriptions of discrepancies we found during our review of search mail.

- In November 2010, the VARO received Service Treatment Records (STRs) to support a veteran's pending original claim. VSC staff did not control these records in COVERS until March 2011, nearly 4 months after the VARO received them. Additionally, staff did not associate this mail with the claims folder despite receiving an electronic notification in COVERS that the records were available at the VARO. At the time of our inspection, this evidence had not been associated with the veteran's claims folder for approximately 6 months.
- In January 2011, a veteran submitted a claim for disability compensation. VSC staff did not place this claim on search in COVERS so they could associate the mail with the claims folder. Staff were unaware of the claim until we identified it during our inspection. As a result, staff unnecessarily delayed processing this claim by approximately 3 months.

Drop Mail

We found 6 (18 percent) of 34 pieces of mail that had been improperly processed as drop mail. Generally, this means staff did not correctly categorize and take action on this mail as required. Following are descriptions of discrepancies we found during our review.

- In March 2011, VSC staff received additional STRs submitted by a veteran's military reserve unit. VSC staff improperly sent these STRs to be associated with the claims folder at an off-site, inactive file storage facility. According to VBA policy, VSC staff should have requested the

veteran's claims folder for review to determine if the additional STRs would have changed the previous disability decision.

- In April 2011, VSC staff received a new claim for benefits. VSC staff improperly sent this mail to the Federal Records Center instead of placing the claim under control in the electronic record for subsequent processing. This new claim for benefits would have remained unprocessed had we not identified it during our inspection. As a result, staff had unnecessarily delayed processing the claim by 29 days.

Military File Mail

VSC staff incorrectly handled 16 (38 percent) of 42 pieces of Military File mail we reviewed. Following are examples of discrepancies we identified during our review.

- On August 6, 2010, a veteran provided responses to a VSC questionnaire regarding risk factors related to a disability benefits claim. VSC staff misrouted this mail, which remained unassociated with the claims folder for 285 days until discovered during our inspection.
- On August 9, 2010, a veteran submitted private medical evidence to support a pending benefits claim for service-connected hearing loss. VSC staff misrouted this mail, which remained unassociated with the claims folder for 282 days until discovered during our inspection.

In both cases, if the mail had not ultimately been associated with the claims folders, RVSRs would not have had all available evidence to support their rating decisions and claimants may not have received accurate benefits.

VSC management confirmed weaknesses associated with mail processing controls. For example, the Workload Management and Mail plans did not incorporate specific procedures for oversight of search, drop, and Military File mail processing. When interviewed, some supervisors acknowledged they were not properly using COVERS to manage mail. Further, supervisors did not consistently check their team's search mail points to determine if staff deleted COVERS searches without retrieving the mail.

VARO management stated local directives did not ensure oversight of mail processing procedures under the new integrated team model. For example, an outdated COVERS user plan assigned responsibility for maintaining, controlling, attaching, and deleting all search mail to Triage, a team that no longer existed under the integrated team model. Without up-to-date procedures, supervisors were unaware of their responsibilities for ensuring accurate and timely mail processing in their teams.

Recommendations

4. We recommend the Seattle VA Regional Office Director amend the Workload and Mail Management plans to provide increased monitoring

of processes associated with handling and controlling Veterans Service Center mail under the new Integrated Team model.

5. We recommend the Seattle VA Regional Office Director provide up-to-date procedures to Veterans Service Center management and staff on the proper use of the Control of Veterans Records System to manage mail.

Management Comments

The VARO Director concurred with our recommendations to improve mail processing. The Director amended the Workload Management Plan that provided mail handling procedures and supervisory oversight for claims establishment. Further, VSC management and staff received training on the proper use of COVERS to assist with managing mail.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

The Seattle VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Washington State, nine counties in Idaho (Nez Perce, Clearwater, Latah, Lewis, Shoshone, Benewah, Kootenai, Boundary, and Bonner), and British Columbia, Canada. The VARO fulfills these responsibilities by administering compensation and pension benefits, vocational rehabilitation and employment assistance, and outreach activities.

Resources

As of May 2011, the Seattle VARO had a staffing level of 591 full-time employees. Of these, the VSC had 232 employees (39 percent) assigned.

Workload

As of July 2011, the VARO reported 19,053 pending compensation claims. The average time to complete these claims was 184.9 days, which exceeded the national target of 175 days by 9.9 days. As reported by STAR staff, accuracy of compensation rating-related issues was 81.8 percent, which was below the 90 percent target set by VBA.

Scope

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

Our review included 90 (14 percent) of 622 disability claims related to TBI, PTSD, and herbicide exposure that the VARO completed from January through March 2011. For temporary 100 percent disability evaluations, we selected 30 (6 percent) of 494 existing claims from VBA's Corporate Database. We provided the VARO with a list of 464 claims remaining from the universe of 494 for further review. These claims represented instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months.

We analyzed the 11 mandatory SAOs completed in fiscal years 2010 and 2011. Additionally, we reviewed 17 claims files containing errors identified by VBA's STAR program during the period of October through December 2010. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR measurements include a review of work associated with claims that require 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' disability claims.

Our process differs from STAR as we review specific types of claims for disabilities such as TBI, herbicide exposure, and PTSD 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 onsite inspection. NODs reviewed had been pending processing between 31 and 60 days at the VARO. Further, we reviewed mail in various processing stages within the VARO mailroom and the VSC.

We completed our review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.* 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: August 12, 2011

From: Director, VA Regional Office Seattle (346/00)

Subj: Inspection of the VA Regional Office, Seattle, Washington

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

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

2. Please feel free to contact me at (206) 220-6246 with any questions or concerns regarding our reply.

(original signed by:)

Patrick C. Prieb
Director

Attachment

Office of the Inspector General – Site Visit May 2011

IG Recommendations:

Recommendation 1: We recommend the Seattle VA Regional Office Director develop and implement a plan to assess the effectiveness and adequacy of Rating Veterans Service Representative (RVSR) training related to processing traumatic brain injury (TBI).

RO Comments: Concur.

In response to OIG draft report "Inspection of the VA Regional Office Seattle, Washington," dated August 5, 2011, the Office of Field Operations issued second signature guidance for traumatic brain injury claims on May 31, 2011. Therefore, the Regional Office will follow this national guidance. In addition, training was provided on June 7, 2011 and June 8, 2011 for all RVSRs and Decision Review Officers (DROs) on TBI.

To gauge the effectiveness and adequacy of our recent training, we reviewed 218 TBI claims for second signature since June 2, 2011. Our review noted 17 errors demonstrating 92.5% effectiveness in rating these cases. TBI training will be an ongoing concentration and we will conduct a local Independent Rating Review (IRR) on TBI claims on October 26, 2011, to continue our assessment of the effectiveness and adequacy of our TBI training.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 2: We recommend the Seattle VA Regional Office Director develop a plan to provide standardized training to claims assistants and file clerks on the proper procedures for establishing dates of claim in the electronic record.

RO Comments: Concur.

A total of 10 hours of group training was conducted from June 13 through 17, 2011 for claims assistants and file clerks. The topics trained were date of claim establishment, control time and proper routing of mail. A plan to provide recurring standardized training to claims assistants and file clerks was created on August 10, 2011. This training includes proper procedures for establishing dates of claim.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 3: We recommend the Seattle VA Regional Office Director amend the Workload Management Plan to incorporate clear instructions and oversight mechanisms for recording Notices of Disagreement within the Veterans Benefits Administration's 7-day standard.

RO Comments: Concur.

An amended Appeals Team SOP was finalized on May 16, 2011, which identifies that the claims assistants are responsible for establishing the VACOLS record within seven days. In addition, an amended Workload Management Plan was issued on August 10, 2011 addressing this item.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 4: We recommend the Seattle VA Regional Office Director amend the Workload and Mail Management plans to provide increased monitoring of processes associated with handling and controlling Veterans Service Center mail under the new Integrated Team model.

RO Comments: Concur.

The Workload Management Plan was amended on May 12, 2011. It describes the current mail handling procedures for the Integrated Teams and requires supervisory oversight for claims establishment, COVERS compliance and search mail auditing.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 5: We recommend the Seattle VA Regional Office Director provide up-to-date procedures to Veterans Service Center management and staff on the proper use of the Control of Veterans Records System (COVERS) to manage mail.

RO Comments: Concur:

At the time of the OIG visit the VSC had just reorganized into integrated work teams. The Triage team under the CPI model had previously controlled all mail activity. As a transition to the integrated work teams, each POD received a distribution of the mail along with experienced claims assistants to manage that mail. Training was provided to VSC management and staff on Covers mail handling and procedures on June 7-8, 2011 and June 13-17, 2011. An updated COVERS VSC compliance memorandum was issued on August 12, 2011 to strengthen mail-processing controls.

The Veterans Benefits Administration recommends closure of this recommendation.

Appendix C Inspection Summary

Nine Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. Temporary 100 Percent Disability Evaluations	**Determine whether VARO staff properly processed 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. 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
3. Post-Traumatic Stress Disorder Claims	**Determine whether VARO staff properly processed claims for PTSD**. (38 CFR 3.304(f))	X	
4. Herbicide Exposure-Related Claims	**Determine whether VARO staff properly processed claims for service connection for herbicide exposure-related disabilities**. (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 Reviews	**Determine whether VARO staff properly corrected STAR errors in accordance with VBA policy**. (M21-4, Chapter 3, Subchapter II, 3.03)	X	
8. Systematic Analyses 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

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

Appendix D Office of Inspector General Contact and Staff Acknowledgments

Office of Inspector General Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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