VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office San Diego, California

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ACRONYMS AND ABBREVIATIONS

C&C	Confirmed and Continued
COVERS	Control of Veterans Records System
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
TTO	Temporary Transfer Out
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, San Diego, California

Why We Did This Review

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

What We Found

San Diego VARO staff provided adequate outreach to homeless shelters and service providers. However, the VARO lacked accuracy in processing disability claims. Errors in processing temporary 100 percent disability evaluations occurred when staff did not schedule required medical reexaminations. Issues related to traumatic brain injury claims resulted from staff using insufficient medical examination reports to make final disability determinations. Further, errors in herbicide exposure-related claims processing occurred when staff did not address all related issues or residuals of primary disabilities. Overall, VARO staff did not accurately process 42 (53 percent) of 79 disability claims we sampled as part of our inspection. These results do not represent the overall accuracy of disability claims processing at this VARO.

VARO staff did not always correct errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program. Further, they did not always include all mandatory analyses or complete all elements of Systematic Analyses of Operations. VARO staff did not properly process mail or accurately address Gulf War veterans' entitlement to mental health treatment. Delays occurred in processing claims pending more than 365 days when staff did not request adequate supporting evidence or timely follow up on past due actions.

What We Recommend

The San Diego VARO Director should implement a plan to ensure staff accurately process temporary 100 percent disability evaluations as well as traumatic brain injury and herbicide exposure-related disability claims. Further, the Director should ensure staff address errors identified by the VBA's Systematic Technical Accuracy Review program and complete all required elements of Systematic Analyses of Operations.

The Director should ensure staff accurately process all mail and address Gulf War veterans' entitlement to mental health treatment. Further, the Director should ensure staff timely process aging claims to avoid further delays.

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.

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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 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 whether 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 2012, the OIG conducted an inspection of the San Diego VARO. The inspection focused on five protocol areas examining eight operational activities. The five protocol areas were disability claims processing, management controls, workload management, eligibility determinations, and public contact. Additionally, we conducted a special review of the VARO's 10 oldest pending disability claims available for review at the time of our inspection.

We reviewed 49 (16 percent) of 313 disability claims related to traumatic brain injury (TBI) and herbicide exposure that VARO staff completed from July through September 2011. In addition, we reviewed 30 (7 percent) of 415 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 benefits inspection team focused on disability claims processing related to temporary 100 percent disability evaluations, TBI, and herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

Finding 1 San Diego VARO Staff Could Improve Disability Claims Processing Accuracy

The VARO lacked controls and accuracy in processing claims for temporary 100 percent evaluations, TBI, and herbicide exposure-related disabilities. Due to inadequate controls, VARO staff incorrectly processed 42 (53 percent) of the total 79 disability claims we sampled and overpaid $335,764 and underpaid $25,717 in benefits payments. VARO management agreed with our assessment and began to correct the errors identified.

Because we sampled claims related to specific conditions, these results do not represent the universe of disability claims processed at this VARO. At the time of our inspection, the Veterans Benefits Administration's (VBA) target for accuracy was 92 percent. As reported by VBA's Systematic Technical Accuracy Review (STAR) as of October 2011, the overall accuracy of the VARO's compensation rating-related decisions was 81.7 percent—10.3 percentage points below the 92 percent target. VBA revised the national accuracy target to 87 percent. The table below reflects processing errors by the San Diego VARO.

Table 1

San Diego VARO Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Disability Evaluations	30	23	5	18
Traumatic Brain Injury Claims	19	9	1	8
Herbicide Exposure-Related Disability Claims	30	10	6	4
Total	**79**	**42**	**12**	**30**

Source: VA OIG analysis of VBA's disability claims files

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 23 (77 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 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 (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 medical reexamination. As a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the medical reexamination.

Available medical evidence showed that 5 (22 percent) of 23 processing errors we identified affected veterans' benefits. These errors involved overpayments totaling $319,255 and underpayments totaling $20,531. Following are descriptions of the most significant over and underpayments.

- The most significant overpayment occurred when VARO staff did not take action to schedule an "immediate" medical reexamination for a veteran's malignant melanoma as directed in a 2006 VA disability decision. VA treatment records and Department of Defense records indicated the veteran's cancer was in remission and that he did not need to receive additional treatment after leaving military service. VA continued processing monthly benefits and ultimately overpaid the veteran $155,644 over a period of 5 years and 6 months.
- The most significant underpayment occurred when a Rating Veterans Service Representative (RVSR) did not establish entitlement to special monthly compensation as required based on the veteran having both a temporary 100 percent evaluation and additional service-connected disabilities independently evaluated as 60 percent disabling or more. VA underpaid the veteran $14,285 over a period of 3 years and 9 months. We provided information on this underpayment to VARO officials who agreed to take corrective action.

The remaining 18 (78 percent) of 23 errors had the potential to affect veterans' benefits. In most cases, we could not determine whether the evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to reevaluate each case.

The most frequent processing errors noted in 8 (35 percent) of 23 cases occurred when VARO staff did not establish suspense diaries in the electronic record; 6 of the 8 errors involved C&C rating decisions. As a result, VARO staff did not receive reminder notifications to schedule the required VA medical reexaminations. The other two errors occurred when RVSRs did not document the need for mandatory medical reexaminations as required.

VARO management did not provide adequate oversight to ensure VSC staff entered suspense diaries to schedule medical reexaminations for C&C rating decisions. In November 2009, VBA provided guidance reminding VAROs about the requirement to input the suspense diaries in the electronic record. However, VARO management did not have a mechanism in place to ensure VSC staff complied. As such, veterans may not always receive correct benefits payments.

For those cases requiring medical reexaminations, delays ranged from approximately 4 months to 11 years and 7 months. An average of 3 years and 8 months elapsed from the time staff should have scheduled the medical reexaminations until the date of our inspection—the date staff ultimately took corrective actions to obtain the necessary medical evidence.

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 had a future medical examination date entered in the electronic record. Then, in September 2011 VBA provided each VARO with a list of temporary 100 percent disability evaluations for review by March 2012. The Western Area office further required each VARO under its jurisdiction to report results of their reviews by January 2012, and to have all actions completed by March 2012.

On January 6, 2012, the San Diego VARO completed its review of VBA's temporary 100 percent disability evaluations. We determined the VARO did not take appropriate actions in 17 (22 percent) of 78 claims that involved temporary 100 percent disability evaluations for prostate cancer. VARO management erroneously reported to the Western Area office that staff had requested VA medical reexaminations to determine whether the veterans' disabilities warranted the continued evaluations. However, evidence in the veterans' claims folders revealed VARO staff had not requested the medical reexaminations, nor had staff put controls in place to manage these cases.

Without the VA medical examinations reports, neither the VARO nor we can determine if the temporary 100 percent disability evaluation should continue. VARO managers concurred with our finding regarding these reporting errors

and stated they would double check their review responded to VBA to ensure accuracy.

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 that staff evaluate these residual disabilities.

VARO staff incorrectly processed 9 (47 percent) of 19 TBI claims. One of these processing errors affected a veteran's benefits—the remaining eight errors had the potential to affect veterans' benefits. In the one case, an RVSR did not enter the required codes to a disability decision to pay the veteran additional benefits for special monthly compensation for erectile dysfunction related to a TBI. Because of this error, the veteran was underpaid $1,539 over a period of 1 year and 4 months. Additionally, in the same decision document, the RVSR did not establish a separate evaluation for TBI-related migraine headaches, as required.

Of the nine errors identified, five cases had a second level of review; however, the reviewers also did not identify the errors. The VARO provided TBI training in June 2011. We confirmed that each of the RVSRs responsible for these nine processing errors attended this training.

The most frequent processing errors identified occurred in 5 (56 percent) of the 9 cases when RVSRs used insufficient medical examinations to evaluate TBI-related disabilities. According to VBA policy, when a medical examination report does not address all required elements, VARO staff should return it to the issuing clinic or health care facility as insufficient for rating purposes. VARO management confirmed that RVSRs are encouraged to evaluate disabilities on the totality of the evidence available. Neither VARO staff nor we can ascertain TBI-related disabilities without sufficient or complete medical evidence.

Most of the RVSRs we interviewed indicated TBI regulations and policies were complex when TBI and mental conditions co-existed. Generally, errors occurred when staff did not understand VBA policy, did not return examination reports to VA medical facilities as insufficient, and used their own interpretations of the reports to make TBI claims decisions. As a result, veterans may not always receive correct benefits payments.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 10 (33 percent) of 30 herbicide exposure-related claims. Our analysis of available medical evidence showed 6 of the 10 processing errors affected veterans' benefits—3 resulted in overpayments totaling $16,509 and 3 resulted in underpayments totaling $3,647. The remaining four processing errors had the potential to affect veterans'

benefits. Details on the most significant overpayment and underpayment follow.

- An RVSR correctly established service connection for ischemic heart disease; however, the RVSR used an incorrect effective date to start paying the veteran disability compensation. According to VA regulations, when a claimant submits a claim within 1 year of a legislative change, VA may authorize benefits from the date of the legislative change, if the veteran is eligible. An overpayment occurred because the medical evidence did not show a diagnosis of ischemic heart disease prior to the legislative change and therefore, the veteran was not eligible for an earlier payment date. As a result, VA overpaid the veteran $14,076 over a period of 6 months.
- An RVSR did not grant a veteran special monthly compensation for a residual disability of diabetes mellitus. As a result, VA underpaid the veteran $1,539 over a period of 1 year and 4 months. We provided information on this underpayment to VARO officials who agreed to take corrective action.

Most of the errors we identified occurred when RVSRs did not address complications of herbicide exposure-related disabilities or assigned incorrect dates to begin paying benefits for ischemic heart disease. Generally, the errors resulted from a lack of training on these subjects. Training records revealed the VARO did not provide training to staff on how to address complications of herbicide exposure-related disabilities in FY 2011. Further, management informed us, and we confirmed, RVSRs that established the incorrect effective dates had not received training on this topic. As a result of these errors, veterans may not have received correct benefit payments.

Recommendations

1. We recommend the San Diego VA Regional Office Director conduct a second review to ensure that staff accurately report to the Western Area office corrective actions taken on all temporary 100 percent disability evaluations subject to review.
2. We recommend the San Diego VA Regional Office Director develop and implement a plan to ensure staff return insufficient medical examination reports to health care facilities to obtain the evidence needed to support decisions on traumatic brain injury claims.
3. We recommend the San Diego VA Regional Office Director develop and implement a plan to ensure staff receive training on establishing effective dates and addressing complications of herbicide exposure-related disabilities.

Management Comments

The VARO Director concurred with our recommendations. The VSC initiated a second review of all temporary 100 percent disability evaluations

on the list received from VBA's Western Area Office in January 17, 2012. The Director stated staff completed the final review in April 2012.

The VARO Director provided us with a copy of an April 2012 insufficient examination action plan the VARO implemented after our inspection. According to the plan, VARO staff will identify and submit insufficient medical examinations to an examination coordinator. The coordinator will request addendums to insufficient examinations, complete an examination tracker designed to track the status of each examination, and follow-up with Veterans Health Administration staff to ensure timely return of claims folders to the VARO. Managers will perform monthly reviews of the examination tracker to ensure compliance.

In March 2012, RVSRs completed training regarding the proper procedures for establishing effective dates for claims. The Director informed us staff would complete training by the end of May 2012 on addressing complications of herbicide exposure-related disabilities.

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

2. 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 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.

Finding 2 Oversight Needed To Ensure Accurate Reporting of Corrective Actions Taken by VARO Staff

VARO staff did not correct 4 (31 percent) of 13 claims files containing errors that STAR program staff identified from July through September 2011. These errors occurred because of a lack of oversight to ensure accurate reporting to STAR program staff on corrections made. As a result, VARO management did not ensure veterans were receiving accurate benefit payments.

A VSC manager reported to STAR staff that VSC staff took corrective actions in all four cases containing STAR errors; however, our review of the claims folders revealed otherwise. For example, STAR staff determined an RVSR prematurely denied service connection for a veteran's left knee condition. STAR staff advised the VARO that a VA medical examination

and opinion were required to support this rating decision. In response to the error, a VSC manager reported staff requested the VA medical examination and opinion on November 1, 2011, but medical examination results were not available. However, VARO staff did not request the medical examination and opinion. VARO staff also did not refute the error with STAR staff.

The VARO's Workload Management Plan, dated January 31, 2011, outlined procedures for correcting STAR errors; however, managers noted the plan was outdated and needed revision. VARO managers stated supervisory staff were required to return STAR error cases to the individuals who made them. Upon addressing the errors, the responsible individuals were to report their corrective actions to VARO managers. Neither the outdated Workload Management Plan nor the practice of returning the STAR errors for correction included oversight and verification measures.

Recommendation

4. We recommend the San Diego VA Regional Office Director develop and implement a plan to ensure action is taken to correct errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program.

Management Comments

The VARO Director concurred with our recommendation and revised the Workload Management Plan in March 2012. The Quality Review Team is now responsible for verifying that staff take corrective actions on errors identified by VBA's STAR staff.

OIG Response

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

Systematic Analysis of Operations

We assessed whether VSC management had adequate controls in place to ensure complete and timely submission of each Systematic Analysis of Operations (SAO). We also considered whether VSC staff used adequate data to support the analyses and recommendations identified within each SAO. 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 an annual SAO schedule designating the staff required to complete the SAOs by specific dates. The VSC manager is responsible for ongoing analysis of VSC operations, including completing 11 mandated SAOs annually.

Finding 3 Improved Oversight Needed To Ensure Complete Systematic Analyses of Operations

Eight (73 percent) of 11 SAOs were incomplete, missing several required elements and supporting analyses, or not done at all. These errors occurred because VSC management did not provide adequate oversight to ensure VSC staff completed all annual SAOs as required by VBA policy. As a result,

management may not have adequately identified existing and potential problems for corrective action to improve VSC operations.

VSC staff stated they followed VBA policy when preparing SAOs; however, for seven SAOs they did not address all required elements or complete related analyses. Management informed us that prior reviews of SAOs were more or less cursory in nature. The Assistant VSC Manager responsible for SAO preparation indicated the VSC had recently implemented a new SAO review process. We could not determine the effectiveness of this new process because the VSC completed the SAOs we reviewed prior to its implementation.

During our inspection, we identified weaknesses in VSC operations that staff may have recognized had they addressed all elements and completed SAOs as required. For example, VSC staff did not complete the required Quality of Files Activity SAO in FY 2011; as such, they did not analyze management of search mail and use of the Control of Veterans Records System (COVERS). Additionally, in the Claims Processing Timeliness SAO, staff did not conduct analysis of claims pending over 1 year. Had staff completed these analyses they may have identified weaknesses similar to those we observed regarding search mail, COVERS, and claims pending over 1 year.

Recommendation

5. We recommend the San Diego VA Regional Office Director develop and implement a plan to ensure staff address and analyze all required elements of Systematic Analyses of Operations.

Management Comments

The VARO Director concurred with our recommendation and provided us a copy of the VARO's SAO action plan and new FY 2012 SAO schedule for review. According to the plan, the VSC Manager will ensure that monthly reviews of SAOs occur to ensure compliance with SAO requirements. Further, management will conduct bi-annual reviews of all completed SAOs to ensure staff take appropriate action and comply with policy.

OIG Response

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

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

Finding 4 Improvement Needed for Timely Mail Processing

VARO staff did not always date-stamp mail the same day it arrived at the mailroom as required. This occurred because the responsible VARO managers were unaware of VBA's policy to date-stamp mail on the date of receipt. As a result, beneficiaries may not have received accurate benefits payments.

The VARO received 241 pieces of incoming mail on January 17, 2012; however, staff did not date-stamp this mail until January 18, 2012. We determined that 44 (18 percent) of 241 pieces of this incoming mail was claims-related; 26 dependency-related claims, 11 new compensation claims, and 7 appeals-related claims. Once we advised VARO managers of the incorrect mail date-stamping, staff took immediate action to correct the deficiency.

Claims-related mail that is not properly date-stamped can affect benefits payments. For example, if staff properly date-stamp claims-related mail received on January 31, the benefits would be payable on February 1. However, if staff improperly date-stamp this same mail a day late on February 1, the payment date would be March 1, and VSC staff would unintentionally underpay the beneficiary by 1 month.

One VARO mailroom manager was unaware of VBA's policy requiring staff to process mail within 4 to 6 hours of receipt. As such, they did not have measures in place to ensure staff processed mail as required. Mailroom staff agreed they did not process all mail on the same day they received it. They nonetheless advised us that all mail received at the end of each month was processed on the date of receipt. Because we did not observe end-of-month mail processing, we could not confirm this occurred.

Recommendation

6. We recommend the San Diego VA Regional Office Director develop and implement a plan to ensure staff process all claims-related mail within 4 to 6 hours of its receipt.

Management Comments

The VARO Director concurred with our recommendation and indicated all mailroom personnel received training on the proper procedures for processing claims-related mail in February 2012. Additionally, the Director provided us a copy of an April 2012 claims-related mail action plan. According to the plan, the Director assigned responsibility for providing oversight of mail processing to the Support Services Division Chief.

OIG Response

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

VSC Mail-Processing Procedures

We assessed mail-processing procedures within the VSC 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 control of workflow within the VSC.

VBA policy requires that VSC staff use COVERS to track claims folders and control 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 after staff place the mail in the claims folders. VBA policy allows VAROs to send claims folders to another VA facility for a limited length of time. VARO staff commonly refer to mail received for claims folders temporarily transferred out (TTO) to another VA facility as TTO mail.

Finding 5 Control of Mail Management Procedures Need Strengthening

VSC staff mishandled 19 (23 percent) of 81 pieces of mail according to policy. Of the 81 pieces of mail reviewed—9 pieces consisted of search mail, 42 pieces of TTO mail, and 30 pieces of drop mail. VSC staff correctly handled all drop mail we reviewed. However, inaccuracies occurred when VSC managers did not always monitor and ensure staff accurately processed search and TTO mail according to VBA policy. Consequently, beneficiaries may not receive accurate and timely benefits payments.

Drop Mail

VSC staff correctly processed all 30 pieces of drop mail we reviewed. VSC managers stated they were able to maintain a low inventory of drop mail because they used temporary employees to process drop mail on a daily basis.

Search Mail

VSC staff did not properly use VBA's COVERS application to process and control 2 (22 percent) of 9 pieces of search mail pending at the time of our inspection. Following are descriptions of the mail discrepancies observed.

- On November 17, 2011, VSC staff received medical reports for a veteran's pending claim. Staff forwarded the mail to a mail control point but did not place it on search in COVERS. At the time of our inspection, staff had delayed associating the medical evidence with the veteran's claims folder for 55 days.
- On November 21, 2011, VSC staff received a request from a veteran regarding the status of a pending claim and placed the mail on search in COVERS. However, staff deleted the electronic search mail notice and

the mail was not associated with the claims folder, resulting in a 51-day delay in responding to the veteran.

TTO Mail

Staff mishandled 17 (40 percent) of 42 pieces of TTO mail we reviewed. Staff did not associate TTO mail with claims folders returned to the VARO from temporary locations. On average, TTO mail remained unassociated with veterans' claims folders for approximately 60 days.

Mishandling of search and TTO mail occurred because VSC managers did not always monitor mail processing to ensure staff complied with local policy. VSC staff confirmed they did not always conduct weekly search mail reconciliations or use COVERS reports to monitor search mail as required. Although VSC managers reported they routinely conducted COVERS compliance checks, the results of their November and December 2011 checks reflected a 65 percent compliance rate. VSC management confirmed weaknesses associated with mail processing controls. For example, managers indicated that local mail processing procedures were outdated, did not reflect how staff should process mail, and did not include guidance for monitoring search and TTO mail to ensure compliance.

Additionally, we determined VSC staff did not complete a mandatory SAO for the Quality of Files Activity in FY 2011. Had staff completed this SAO, analyses of VSC mail processing may have identified the weaknesses we found with search and TTO mail.

Recommendations

7. We recommend the San Diego VA Regional Office Director develop and implement a plan to ensure supervisors monitor search and temporary transfer mail processing.
8. We recommend the San Diego VA Regional Office Director revise local directives to reflect current mail processing procedures.

Management Comments

The VARO Director concurred with our recommendations. VSC management provided us with a copy of the February 2012 Covers Compliance and Mail Processing Standard Operating Procedure. According to this plan, staff are provided specific instructions regarding the proper use of COVERS and the current mail processing procedures. Further, the Triage Team supervisor is responsible for providing oversight to ensure staff comply with the Standard Operating Procedure.

OIG Response

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

4. Eligibility Determinations

Entitlement to Medical Treatment for Mental Disorders

Gulf War veterans are eligible for medical treatment for any mental disorder developed within 2 years of the date of separation from military service. According to VBA, whenever an RVSR denies a Gulf War veteran service connection for any mental disorder, the RVSR must consider whether the veteran is entitled to receive mental health treatment.

In February 2011, VBA updated its Rating Board Automation 2000, a computer application designed to assist RVSRs in preparing disability decisions. The application provides a pop-up notification, known as a tip master, to remind staff to consider a Gulf War veteran's entitlement to health care treatment when denying service connection for a mental disorder.

Finding 6 Gulf War Veterans Are Not Always Receiving Entitlement Decisions for Mental Health Treatment

VSC staff did not address whether 16 (53 percent) of 30 Gulf War veterans were entitled to receive treatment for mental disorders. RVSRs found it easy to overlook this entitlement decision despite an understanding of VBA policy. As a result, staff did not accurately inform veterans of entitlement to treatment for mental disorders.

Although RVSRs and Decision Review Officers we interviewed were able to explain the correct process for addressing Gulf War veterans' mental health care entitlement, they stated it was easy to overlook the entitlement even with pop-up notifications reminding them to do so. RVSRs did not receive any refresher training in FY 2011 emphasizing the need to consider entitlement to mental health treatment for Gulf War veterans.

In 8 (50 percent) of 16 cases we reviewed, pop-up notifications reminded RVSRs to consider Gulf War veterans' mental health entitlement. For the remaining eight cases, the system did not generate the pop-up notifications. The majority of staff and management we interviewed felt the pop-up notification was not effective as it was easy to ignore.

Recommendation

9. We recommend the San Diego VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives correctly address Gulf War veterans' entitlement to mental health treatment.

Management Comments

The VARO Director concurred with our recommendation. In January 2012, RVSRs received training regarding the proper procedures for considering entitlement to mental health treatment related to Gulf War Veterans.

OIG Response

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

5. Public Contact

Outreach to Homeless Veterans

In November 2009, VA developed a 5-year plan to end homelessness among veterans by assisting every eligible homeless veteran willing to accept service. VBA generally defines "homeless" as lacking a fixed, regular, and adequate nighttime residence.

Congress mandated that at least one full-time employee oversee and coordinate homeless veterans programs at each of the 20 VAROs that VA determined to have the largest veteran populations. VBA guidance, last updated in September 2002, directed that the coordinators at the remaining 37 VAROs be familiar with requirements for improving the effectiveness of VARO outreach to homeless veterans. These requirements include developing and updating a directory of local homeless shelters and service providers. Additionally, the coordinators should attend regular meetings with local homeless service providers, community governments, and advocacy groups to provide information on VA benefits and services.

The VSC provided a list of eight homeless shelters and service providers in the local area. Although we made multiple attempts to contact each facility, we were only able to contact three and each confirmed they had received information on VA benefits and services.

We also determined VARO and Veterans Health Administration homeless coordinators worked collaboratively by participating in community service events specific to homeless veterans in counties under the VAROs jurisdiction. Because the VARO provides information on VA benefits and services to homeless shelters and service providers as required, we made no recommendation for improvement in this area.

6. Special Review of Disability Claims Processing Timeliness

According to congressional delegations, veterans in California were experiencing lengthy processing delays related to their request for VA benefits. VBA policy requires that VSC management review all claims pending for more than 1 year. If VSC managers cannot personally review each claim, as an alternative they must review a monthly report prepared by staff assigned this review responsibility.

Finding 7 Oversight Needed To Ensure Timely Processing of Claims Over 365 Days Old

VARO staff did not always follow local and VBA policy on processing claims older than 1 year. Processing delays occurred when VARO managers did not effectively manage their aging workloads as required. As a result, VARO staff unnecessarily delayed processing some veterans' claims.

Five (50 percent) of 10 claims we reviewed contained avoidable processing delays. The claims had been pending an average of 843 days and ranged from 777 to 957 days old. A review of the claims folders showed VSC staff took an average of 61 days to enter these claims into the electronic record and another 56 days to begin processing. Following are descriptions of delays we observed.

- VARO staff did not take action on a veteran's request to reopen a previously denied claim when the claims folder was located at the Board of Veterans Appeals and unavailable for review. The COVERS history showed Board of Veterans Appeals staff returned the veteran's claims folder to the San Diego VARO on three separate occasions; however, VARO staff took no actions to process the claim. At the time of our inspection, the veteran's claim had been pending for 957 days.
- VARO staff received a claim from a veteran in October 2009 and requested service treatment records covering the period of 2004 through 2006; however, staff did not follow up on the requests for these records until July 2011—more than 18 months later. By the time of our inspection, the veteran's claim had been pending for 826 days.

In January 2011, VSC managers provided staff with specific instructions on how to expedite processing of claims pending for more than 365 days. However, management did not enforce compliance because most staff had been assigned responsibility to process claims related to a national initiative and were unavailable to review the older cases. VSC managers agreed staff did not process the older claims in FY 2011 as required and attributed the aging inventory, in part, to the shift in workload priorities. VSC managers advised us after our inspection that they had refocused resources to process the older claims because they had completed work on the priority national initiative.

For comparison, in FY 2011 when the VARO was involved in work on the national initiative, staff completed 2,828 disability claims that were 365 days old or more—averaging approximately 236 claims per month. In contrast, during the first 4 months of FY 2012, after finishing work on the national initiative, staff completed 2,999 claims over a year old—averaging approximately 750 old claims per month. Although the VSC has shown

significant improvement in reducing the backlog of the oldest claims, additional oversight is necessary given the avoidable delays we observed during our inspection.

Recommendation

10. We recommend the San Diego VA Regional Office Director develop and implement a plan to provide oversight of the aging claims workload and ensure staff process the claims as timely as possible to avoid additional delays.

Management Comments

The VARO Director concurred with our recommendation and revised the Workload Management Plan in April 2012. According to the revised plan, VSC management is required to review reports weekly related to claims pending in excess of 365 days. Further, Veterans Service Representatives will process these claims daily as assigned.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

The San Diego VARO administers a variety of services and benefits, including compensation benefits; vocational rehabilitation and employment assistance; specially adapted housing grants; benefits counseling; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of January 2012, the San Diego VARO had a staffing level of 543.9 full-time equivalent employees. Of this number, the VSC had 303.5 employees assigned.

Workload

As of January 2012, the VARO reported approximately 16,500 pending compensation claims. The average time to complete claims was 262.7 days—32.7 days beyond the national target of 230 days.

Scope

We reviewed selected management, 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 49 (16 percent) of 313 disability claims related to TBI and herbicide exposure that the VARO completed from July through September 2011. For temporary 100 percent disability evaluations, we selected 30 (7 percent) of 415 existing claims from VBA's Corporate Database. We provided VARO officials with 385 claims remaining from our universe of 415 for their review. These 415 claims represented all instances where VARO staff had granted temporary 100 percent disability evaluations for at least 18 months or longer as of November 3, 2011.

We reviewed all 13 files containing errors identified by VBA's STAR program from July through September 2011. 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' disability claims.

Our process differs from that of STAR as we review specific types of disability claims, such as those related to TBI and herbicide exposure that require rating decisions. We reviewed rating decisions and awards processing involving temporary 100 percent disability evaluations. Additionally, we reviewed the 11 mandatory SAOs completed in FY 2011.

We reviewed selected mail in various processing stages in the VARO mailroom and VSC. We reviewed 30 claims completely processed for Gulf War veterans from July through September 2011 to determine whether VSC

staff addressed entitlement to mental health treatment in the rating decision documents as required. We also reviewed the effectiveness of the VARO's homeless veterans outreach program as well as management of the aging disability claims workload.

Compliance with Inspection Standards

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 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 10, 2012

From: Director, San Diego VA Regional Office (377/00)

Subj: Inspection of the VA Regional Office, San Diego, California

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

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

2. Questions may be referred to Patrick Zondervan, Veterans Service Center Manager, at (619) 400-5598.

(original signed by:)

JOANN CHAMBERS

Director

Attachment

San Diego VA Regional Office Response

OIG Recommendation 1: We recommend the San Diego VA Regional Office Director conduct a second review to ensure that staff accurately reports to the Western Area office corrective actions taken on all temporary 100 percent disability evaluations subject to review.

RO Response: Concur.

On January 17, 2012, the Veterans Service Center initiated a second review of all temporary 100 percent disability evaluations on the list received from the Western Area Office. The final review was completed on April 2, 2012. Recommend this item be closed as it has been completed.

As result of the OIG *Audit of 100 Percent Disability Evaluations conducted on January 24, 2011,* the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each had a future examination date entered in the electronic record. The vulnerability identified in the area of 100% disability evaluations subject to future review is a known challenge and is being addressed through diary end products established upon rating promulgation.

Note: VARO San Diego has identified concerns regarding the limited sample size reviewed during the course of the visit.

OIG Recommendation 2: We recommend the San Diego VA Regional Office Director develop and implement a plan to ensure staff returns insufficient medical examination reports to health care facilities to obtain the evidence needed to support decisions on traumatic brain injury claims.

RO Response: Concur.

An action plan was created and implemented for insufficient medical examinations. Recommend this item be closed as it has been completed.

OIG Recommendation 3: We recommend the San Diego VA Regional Office Director develop and implement a plan to ensure staff receive training on establishing effective dates and addressing complications of herbicide exposure-related disabilities.

RO Response: Concur.

Training for establishing effective dates was provided for RVSRs and was completed on March 16, 2012. (TMS # 1209928) Training for addressing complications of herbicide exposure-related disabilities will be scheduled. An action plan was created and all training is anticipated to be complete by May 11, 2012.

OIG Recommendation 4: We recommend the San Diego VA Regional Office Director develop and implement a plan to ensure action is taken to correct errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program.

RO Response: Concur.

The workload management plan was revised to include detailed steps taken by the Quality Review Team Coach to verify that STAR corrections are completed as required. The WMP was submitted to the Western Area office on March 30, 2012. Recommend this item be closed as it has been completed.

OIG Recommendation 5: We recommend the San Diego VA Regional Office Director develop and implement a plan to ensure staff address and analyze all required elements of Systematic Analyses of Operations.

RO Response: Concur.

All deficiencies identified in the SAO's completed in FY11 have been corrected as of March 2012. A new SAO schedule is in place for FY 2012, which includes all required elements, and SAO's per M21-4. A copy of the SAO schedule for FY12 was provided. Recommend this item be closed as it has been completed.

OIG Recommendation 6: We recommend the San Diego VA Regional Office Director develop and implement a plan to ensure staff process all claims-related mail within 4 to 6 hours of its receipt

RO Response: Concur.

An action plan was developed and implemented. All SSD mailroom personnel were trained on the proper procedures in February 2012. Recommend this item be closed as it has been completed.

OIG Recommendation 7: We recommend the San Diego VA Regional Office Director develop and implement a plan to ensure supervisors monitor search and temporary transfer mail processing.

RO Response: Concur.

The VSC has updated the COVERs and Mail Processing Standard Operating Procedures on February 26, 2012 and provided training to all employees. Recommend this item be closed as it has been completed.

OIG Recommendation 8: We recommend the San Diego VA Regional Office Director revise local directives to reflect current mail processing procedures.

RO Response: Concur.

The VSC has updated the COVERs and Mail Processing Standard Operating Procedures on February 26, 2012 to reflect the current mail processing procedures. Recommend this item be closed as it has been completed.

OIG Recommendation 9: We recommend the San Diego VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives correctly address Gulf War veterans' entitlement to mental health treatment.

RO Response: Concur.

Training for Gulf War Veterans' entitlement to mental health treatment was provided for all RVSR's on station on January 29, 2012 (TMS# 2787976). Recommend this item be closed as it has been completed.

OIG Recommendation 10: We recommend the San Diego VA Regional Office Director develop and implement a plan to provide oversight of the aging claims workload and ensure staff process the claims as timely as possible to avoid additional delays.

RO Response: Concur.

The workload management plan was revised to include recurring reports of claims pending in excess of 365 that must be reviewed by the management staff weekly. The WMP was submitted to the WA office on March 30, 2012. Recommend this item be closed as it has been completed.

Appendix C Inspection Summary

Table 2. San Diego VARO 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 VARO staff properly processed claims for disabilities related to in-service TBI.** (Fast Letters 08-34 and 08-36, Training Letter 09-01)		X
3. 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
Management Controls			
4. 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
5. 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			
6. 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			
7. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War Veterans' entitlement to medical treatment for mental illness.** (38 United States Code 1702) (M21-1MR Part IX, Subpart ii, Chapter 2) (M21-1MR Part III, Subpart v, Chapter 7) (Fast Letter 08-15) (38 CFR 3.384)		X
Public Contact			
8. Homeless Veterans Outreach Program	**Determine whether VARO staff provided effective outreach services.** (Public Law 107-05) (M21-1MR Part III Subpart ii, Chapter 1, Section B) (M21-1MR Part III Subpart iii, Chapter 2, Section I) (VBA Letter 20-02-34) (C&P Service Bulletins, January 2010 and April 2010)	X	
Special Review			
9. Disability Claims Processing Timeliness	**Determine whether VARO staff effectively manages the aging claims workload.** (M21-1MR Part I, Chapter 1, Section C.5) (M21-1MR Part I. Chapter 5, Section F.29.C) (M21-1MR Part III Subpart iii, Chapter 2, Section I. 58 and 59) (M21-1MR Part III Subpart iv, Chapter 2, Section B) (M21-1 MR Part IV, Subpart ii, Chapter 2, Section B.4.d) (Fast Letter 10-49) (Training Letters 07-02 and 10-05)		X

Source: VA OIG
C&P=Compensation and Pension, CFR=Code of Federal Regulations, M=Manual, MR=Manual Rewrite

Appendix D Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Brent Arronte, Director Daphne Brantley Brett Byrd Nelvy Viguera Butler Robert Campbell Madeline Cantu Ramon Figueroa Lee Giesbrecht Nora Stokes Lisa Van Haeren Mark Ward

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