VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Houston, Texas

June 24, 2013
13-00367-226

ACRONYMS AND ABBREVIATIONS

EP	End Product
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of VA Regional Office, Houston, Texas

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and 1 Veterans Service Center nationwide that process disability claims and provide a range of services to veterans. We evaluated the Houston VARO to see how well it accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 37 (62 percent) of 60 disability claims we reviewed. We sampled claims we consider to be at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing lacks consistent compliance with VBA procedures and is resulting in paying inaccurate and unnecessary financial benefits.

Specifically, 22 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate. This generally occurred because VARO management did not ensure staff took appropriate action to reduce benefits when required, and because staff did not follow up on requests for hearings where veterans could present additional evidence to show that temporary 100 percent evaluations were still warranted. Also, staff misinterpreted VBA policy and inaccurately processed 15 of 30 traumatic brain injury claims.

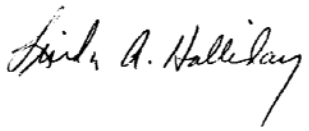
VARO managers did not ensure staff accurately completed Systematic Analyses of Operations or addressed Gulf War veterans' entitlement to mental health treatment. VARO staff provided adequate outreach to homeless veterans; however, we cannot fully assess the effectiveness of VBA's outreach activities because VBA needs a performance measure to assess its homeless veterans outreach program.

What We Recommend

The VARO Director should implement a plan to ensure staff comply with VBA policy to reduce temporary 100 percent disability evaluations and follow up on hearing requests associated with proposed reductions in benefits. Further, staff should review the 689 temporary 100 percent disability evaluations remaining from our inspection universe and take action to manage these evaluations appropriately. The Director needs to implement a plan to ensure effective training and accurate second-signature reviews of traumatic brain injury claims. The Director should also provide refresher training and ensure the Systematic Analyses of Operations checklist is amended to address all elements required by current VBA policy.

Agency Comments

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



LINDA A. HALLIDAY
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 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 oversight, inspections may examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

Scope of Inspection

In January 2013, we inspected the Houston VARO. The inspection focused on the following four protocol areas: disability claims processing, management controls, eligibility determinations, and public contact. Within these areas, we examined two high risk claims processing areas: temporary 100 percent disability evaluations and traumatic brain injury (TBI) claims. We also examined three operational activities: Systematic Analyses of Operations (SAOs), Gulf War veterans' entitlement to mental health treatment, and the homeless veterans outreach program.

We reviewed 30 (4 percent) of 719 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months. This is generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to Veterans Benefits Administration (VBA) policy. We also examined 30 (43 percent) of 70 disability claims related to TBI that VARO staff completed during the period July through September 2012.

Other Information

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

RESULTS AND RECOMMENDATIONS

I. Disability Claims Processing

Claims Processing Accuracy

The OIG Benefits Inspection team focused on accuracy in processing temporary 100 percent disability evaluations and TBI claims. We evaluated these claims processing issues and assessed their impact on veterans' benefits.

Finding 1 The Houston VARO Could Improve Disability Claims Processing Accuracy

The Houston VARO did not consistently process temporary 100 percent disability evaluations and TBI cases accurately. Overall, VARO staff incorrectly processed 37 of the total 60 disability claims we sampled, resulting in 233 improper monthly payments to 11 veterans totaling $397,919 ranging from January 2004 until December 2012.

We sampled claims related to specific conditions that we considered at higher risk of processing errors. As a result, the errors identified do not represent the universe of disability claims processed at this VARO. As reported by VBA's Systematic Technical Accuracy Review program as of December 2012, the overall accuracy of the VARO's compensation rating-related decisions was 87.4 percent—2.6 percentage points below VBA's target of 90 percent.

The following table reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Houston VARO.

Table 1

Houston VARO Disability Claims Processing Accuracy

Type of Claim	Reviewed	Claims Inaccurately Processed		
		Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits	Total
Temporary 100 Percent Disability Evaluations	30	10	12	22
Traumatic Brain Injury Claims	30	1	14	15
Total	**60**	**11**	**26**	**37**

Source: VA OIG analysis of VBA's temporary 100 percent disability evaluations paid at least 18 months or longer and TBI disability claims completed in the fourth quarter FY 2012

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 22 of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a service-connected disability following a veteran's 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 100 percent disability evaluation. For temporary 100 percent evaluations, VARO staff must input suspense diaries in VBA's electronic system. A suspense diary is a processing command that establishes a date when staff must schedule a medical reexamination. As a suspense diary matures, the electronic system generates a reminder notification to alert staff to schedule the medical reexaminations.

VBA policy requires a 65-day due process period when a veteran is notified of a proposed adverse action, such as a reduction of a temporary 100 percent evaluation. At the end of the due process period, immediate action should be taken as appropriate to reduce the evaluation and thereby minimize overpayments. If the veteran timely requests a hearing to present evidence in response to the proposal to reduce the benefits, final action on the reduction cannot take place until after the hearing is held.

Without effective management of these temporary 100 percent disability ratings, VBA is at risk of paying inaccurate financial benefits. Available medical evidence showed that 10 of the 22 processing errors we identified affected veterans' monthly benefits and resulted in 226 improper monthly payments totaling $396,638, ranging from January 2004 until December 2012. Nine errors involved overpayments totaling $388,091 and two errors involved underpayments totaling $8,547. One of the 10 errors contained both an overpayment and an underpayment. The remaining 12 of the total 22 errors had the potential to affect veterans' benefits. Details on the most significant overpayment and underpayment follow.

- A Rating Veterans Service Representative (RVSR) correctly granted service connection and a 100 percent disability evaluation following a veteran's liver transplant, and a routine future medical reexamination was requested. The medical reexamination was not completed until April 2012, more than 8 years later; however, there was no evidence in the veteran's file to indicate why this delay occurred. Medical evidence showed the veteran's residuals warranted a 30 percent disability evaluation, and the veteran was notified of the proposed reduction. As of December 2012, VSC staff had still not taken final action to reduce the veteran's temporary 100 percent disability evaluation. As a result, VA continued processing monthly benefits and overpaid the veteran $221,090 over a period of 8 years and 9 months.
- An RVSR assigned an incorrect effective date of January 4, 2011, for a temporary 100 percent disability evaluation for prostate cancer. Medical

evidence showed a recurrence of cancer on October 22, 2010. Therefore, an earlier effective date was warranted. As a result, the veteran was underpaid $5,277 over a period of 3 months.

VARO staff did not schedule medical reexaminations as required for some of the errors identified. In 11 cases, we found scheduling delays from approximately 2 months to 9 years and 1 month.

Summaries of the total 22 errors we identified follow.

- Six errors occurred when VSC staff did not timely schedule hearings for veterans to present evidence in response to proposals to reduce their benefits, or not taking immediate action following the hearings.
- Six errors occurred when VSC staff established controls to reduce veterans' benefits payments, but did not take final action to reduce the benefits. Delays ranging from approximately 3 months to 1 year and 6 months elapsed from the time staff should have taken final action to reduce benefits until December 2012.
- Two errors occurred when staff proposed to reduce veterans' benefits payments, but did not establish controls to manage the proposed reductions. Delays of approximately 1 year and 4 months and 2 years and 9 months elapsed from the time staff should have taken final action to reduce benefits until December 2012.
- Two errors occurred when RVSRs proposed to reduce veterans' temporary 100 percent evaluations when they were still undergoing treatment for their conditions.
- Two errors occurred when staff did not establish suspense diaries in the electronic record, thereby removing the possibility that staff would receive reminder notifications to schedule medical reexaminations.
- Two errors occurred when RVSRs assigned improper effective dates for benefits payments.
- One error occurred when an RVSR granted service connection for prostate cancer without evidence showing it was related to military service.
- One error occurred when staff established a suspense diary, but did not request a medical reexamination when required.

The most frequent processing inaccuracies in 14 of the 22 errors resulted from a lack of management oversight to ensure timely action on proposals to reduce veterans' temporary 100 percent disability evaluations. A January 2011 Compensation and Pension VBA Site Visit report also identified lack of management oversight in this area. Interviews with VSC

managers and staff revealed that delays in finalizing proposed reductions were due to an emphasis on processing higher priority compensation claims.

Additionally, the station's workload management plan did not contain procedures for oversight of veterans' hearing requests associated with proposed benefit reductions. The VSC Manager was unaware of this lack of oversight and may have continued to overpay veterans receiving temporary 100 percent evaluations.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Houston, Texas* (Report No. 10-03770-125, March 21, 2011), we reported that inaccuracies in processing 24 of 27 temporary 100 percent disability evaluations occurred because VARO staff did not properly establish suspense diaries to ensure follow-up on these temporary evaluations. The Director of the Houston VARO agreed to provide refresher training and controls to ensure staff established suspense diaries as reminders to schedule the required medical reexaminations. Additionally, the Director concurred with our recommendation to review the 735 temporary 100 percent disability evaluations remaining from our sample universe and under the VARO's jurisdiction to determine if reevaluations were required and take appropriate action. The OIG closed this recommendation in December 2011, based on documentation showing this review of temporary 100 percent disability evaluations was completed, and training was conducted for the appropriate VSC employees in October 2011.

During this current inspection, we did not identify any cases after October 2011 where staff did not input suspense diaries in the electronic system to generate reminders to follow up on temporary 100 percent disability evaluations. As such, we made no further recommendation in this area.

Actions Taken in Response to Prior Audit Report

In response to a recommendation in our national report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the then-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. Our report stated, "If VBA does not take timely corrective action, they will overpay veterans a projected $1.1 billion over the next 5 years." The then-Acting Under Secretary for Benefits stated in response to our audit report that the target completion date for the national review would be September 30, 2011.

However, VBA did not provide each VARO with a list of temporary 100 percent disability evaluations for review until September 2011. VBA subsequently extended the national review deadline to December 31, 2011, then to June 30, 2012, and then again to December 31, 2012. In January 2013, the Houston VARO received indication the review was still ongoing with the completion deadline extended to January 18, 2013. We are

concerned about the lack of urgency in completing this review, which is critical to minimize the financial risks of making inaccurate benefits payments.

During our 2013 inspection, we followed up on VBA's national review of its temporary 100 percent disability evaluation processing. We sampled 40 cases from the lists of cases needing corrective actions that VBA provided to the Houston VARO for review. We determined VARO staff accurately reported taking actions in 37 of 40 cases we reviewed. In 2 of the 40 cases, staff stated they did not take action because the veterans were no longer receiving benefits payments. However, in both cases the veterans were actually still receiving benefits. Staff should have reviewed the available medical evidence to determine if follow-up medical examinations were necessary. In the remaining case, staff did not update the electronic record showing the veteran was entitled to a permanent 100 percent disability evaluation even though they reported doing so. Further, in comparing VBA's national review lists with the 30 temporary 100 percent disability evaluations we reviewed during our inspection, we found 1 case that VBA had not identified. We will continue monitoring this situation as VBA works to complete its national review.

TBI Claims

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

In response to a recommendation in our annual report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-167, May 18, 2011), VBA agreed to develop and implement a strategy for ensuring accurate TBI claims rating decisions. In May 2011, the Under Secretary for Benefits provided guidance to all VARO Directors to implement a policy requiring a second signature on each TBI case an RVSR evaluates until the RVSR demonstrates 90 percent accuracy in TBI claims processing. The policy indicates second-signature reviewers come from the same pool of staff as those used to conduct local station quality reviews.

VARO staff incorrectly processed 15 of 30 TBI claims we reviewed. One of the processing errors affected a veteran's benefits and resulted in seven improper monthly payments totaling $1,281. In this case, an RVSR incorrectly established separate evaluations for a veteran's TBI and post-traumatic stress disorder when the VA examiner stated it was not possible to differentiate which symptoms were attributable to each condition. In contrast, VBA policy requires staff to assign a single evaluation when a medical examiner states symptoms of TBI and a coexisting mental disorder

cannot be clearly separated. As a result of the processing error, VA overpaid the veteran over a period of 7 months, from May 2012 until December 2012.

The remaining 14 processing errors had the potential to affect veterans' benefits. Generally, these errors involved VSC staff not:

- Assigning a single evaluation for TBI and a coexisting mental disorder when symptoms could not be clearly separated. These errors did not affect veterans' monthly benefits, but may affect future evaluations.
- Returning inadequate VA medical examinations as required. Neither VARO staff nor we can ascertain all of the residual disabilities of TBI without an adequate or complete medical examination.

Interviews with the VSC Manager and staff revealed they inappropriately used their own interpretations to decide TBI claims. Staff misinterpreted VA policy because they felt they had the authority to separately evaluate TBI and coexisting mental disorders, even when VA examiners stated it was not possible to differentiate which symptoms were attributable to each condition. Seven of the incorrect decisions we identified were approved by second-level reviewers. Three of these seven incorrect decisions were used to determine that some RVSRs were proficient in deciding TBI claims and no longer required their work to be reviewed. As a result of inadequate second-level reviews, veterans may not have always received correct benefits.

Follow Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Houston, Texas* (Report No. 10-03770-125, March 21, 2011), we reported 22 of 30 TBI processing errors occurred because staff incorrectly interpreted VBA policy. The Director of the Houston VARO concurred with our recommendation to conduct refresher training and implement a plan to improve the quality review process for TBI claims. OIG closed this recommendation in December 2011, after VARO officials provided a VSC memo outlining the required review process and stated appropriate employees received training on processing TBI claims. Although training occurred in November 2010 and December 2011, VSC staff continued to incorrectly interpret VBA policy.

Recommendations

1. We recommend the Houston VA Regional Office Director implement a plan to ensure staff timely follow Veterans Benefits Administration policy to reduce temporary 100 percent disability evaluations when required.
2. We recommend the Houston VA Regional Office Director develop and implement a plan to follow up on hearing requests associated with proposed reductions.
3. We recommend the Houston VA Regional Office Director conduct a review of the 689 temporary 100 percent disability evaluations remaining from the data we used to perform the inspection and take appropriate action.
4. We recommend the Houston VA Regional Office Director implement a plan to assess the effectiveness of training and provide refresher training on the proper processing of traumatic brain injury claims.
5. We recommend the Houston VA Regional Office Director develop and implement a plan to ensure accurate second-signature reviews of traumatic brain injury claims.

Management Response

The VARO Director concurred with our recommendations. The Houston VARO runs a weekly report to identify cases requiring medical examinations. These cases are assigned to RVSRs for review and appropriate action. In addition, the Houston VARO began providing training on processing 100 percent temporary disability evaluations in March 2013. The expected completion date for this required training is August 1, 2013.

The Director indicated the Houston VARO recently prepared a second hearing room to conduct local hearings, including pre-determination hearings. A hearing will be scheduled within 30 days of a request. All journey-level RVSRs will receive training on conducting hearings during July 2013.

The Houston VARO began reviewing the temporary 100 percent disability evaluations remaining from the OIG's list of cases used during its site visit in January 2013. The Houston VARO expects to complete all reviews by September 30, 2013. Further, all Decision Review Officers (DROs) and RVSRs working on TBI claims will receive TBI training in April 2013, with an expected completion date for this training in September 2013.

OIG Response

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

II. Management Controls

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). 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 annual SAO schedules 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 SAOs annually.

Finding 2 Oversight Needed To Ensure Complete SAOs

Ten of the 11 mandated SAOs were incomplete (missing required elements), untimely, or both incomplete and untimely. In addition, 2 of the 11 SAOs used insufficient data for analysis. VSC management did not provide adequate oversight to ensure staff accomplished the SAOs in accordance with VBA policy. Management also did not have an effective mechanism in place to ensure the SAOs were complete. As a result, management may not have adequately identified existing and potential problems for corrective action to improve VSC operations.

Management did not ensure SAOs were complete, as required. During an interview, the Assistant Director stated he had been tasked with oversight of all SAOs for the entire VARO. He revealed SAOs were incomplete because he had not effectively communicated expectations to VSC management and staff to ensure all required elements were addressed. We also found VARO staff used outdated VBA policy and focused on the timeliness instead of comprehensiveness of the SAOs. As a result, some of the SAOs did not contain all of the currently required elements.

For example, the Appeals SAO did not include all required elements. This SAO did not include review of hearings requested by veterans in response to proposals to reduce their benefits. If a veteran requests a hearing to present additional evidence to show a temporary 100 percent disability evaluation is still required, or to show that an evaluation higher than a proposed reduced evaluation is warranted, VARO staff should timely schedule the hearing and take appropriate action. VBA policy requires a hearing request to be scheduled immediately, if possible within 30 days of the request. In addition, the Houston VARO workload management plan requires appropriate actions to be taken within 15 days after the hearings are transcribed.

We discussed a lack of oversight of veterans' hearing requests as one cause for inaccuracies in processing temporary 100 percent disability evaluations. If VARO managers had ensured completeness of the related SAO, they would be in a better position to take corrective actions, thus minimizing the financial risks of making inaccurate benefits payments.

Follow up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Houston, Texas* (Report No. 10-03770-125, March 21, 2011), we reported 2 of 12 SAOs were incomplete because management did not provide adequate oversight to ensure staff completed SAOs in accordance with VBA policy. The Director of the Houston VARO agreed to develop and implement a plan to ensure staff complete SAOs timely and address all required elements. The OIG closed this recommendation in December 2011 based on documentation showing VARO staff created a checklist to monitor the completion of SAOs. However, we found during our inspection that VSC staff were using outdated VBA policy and a checklist that was incomplete because it did not address all required elements.

Recommendation

6. We recommend the Houston VA Regional Office Director ensure Veterans Service Center management amends the Systematic Analyses of Operations checklist to address all elements currently required by Veterans Benefits Administration policy and provide refresher training.

Management Comments

The VARO Director concurred with our recommendation. The Houston VARO amended the SAO checklist to ensure all required elements are addressed. The Veterans Service Center was provided with a template to ensure reporting consistent with the policy, while providing an organized means for reviewing operations to identify existing or potential problems and proposing corrective actions. On February 21, 2013, both Houston VARO Assistant Directors provided SAO training to all management analysts, supervisors, and managers in the station.

OIG Response

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

III. Eligibility Determinations

Entitlement to Medical Treatment for Mental Disorders

Gulf War veterans are eligible for medical treatment for any mental disorder they develop within 2 years of the date of separation from military service. According to VBA policy in effect prior to December 21, 2012, whenever an RVSR denied a Gulf War veteran service connection for any mental disorder, the RVSR had to consider whether the veteran was entitled to receive mental health treatment. This policy required RVSRs to deny entitlement when no evidence of a mental disorder developed within 2 years of separation from military service.

In February 2011, VBA updated its Rating Board Automation 2000, a computer application designed to assist RVSRs in preparing disability ratings. The application provides a pop-up notification known as a tip master to remind staff to consider Gulf War veterans' entitlement to mental health treatment when denying service connection for a mental disorder. This pop-up notification does not generate if a previous decision did not address entitlement to mental health services and a mental condition is not part of the current claim.

Finding 3 Gulf War Veterans Did Not Always Receive Entitlement Decisions for Mental Health Treatment

VSC staff did not properly address whether 19 (63 percent) of 30 Gulf War veterans were entitled to receive treatment for mental disorders. These inaccuracies occurred because VSC management did not have a mechanism to monitor and ensure effectiveness of training in this area. Staff overlooked reminder notifications to consider entitlement to mental health treatment. As a result, veterans may be unaware of their entitlement to treatment for mental disorders and may not get the care they need.

VARO staff did not consistently address whether Gulf War veterans were entitled to mental health treatment as required when denying service connection for mental disorders. They also did not always correctly annotate the electronic record when correctly denying this entitlement in the rating decision document. Interviews and a review of the VARO's training records showed RVSRs did not receive formal refresher training in this area, and some lacked sufficient understanding of VBA's policy. In 9 of 19 errors, RVSRs overlooked the pop-up notification reminding them to consider entitlement to mental health treatment. The majority of the staff and management we interviewed said the pop-up notification was not effective and easy to ignore.

In December 2012, VBA modified its policy to state that RVSRs no longer have to address Gulf War veterans' entitlement to mental health care in all cases. RVSRs must consider this entitlement when a veteran's mental health benefit can be granted based on diagnosis of a mental disorder within 2 years

of separation from military service. Because this policy modification became effective in December 2012, during our inspection, we cannot determine the effect it will have on processing these claims. Therefore, we make no recommendation for improvement.

IV. 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 services. 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 20 VAROs that VA determined to serve the largest veteran populations. VBA guidance, last updated in September 2002, directs that coordinators at the remaining 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 nearby homeless service providers, local government, and advocacy groups to provide information on VA benefits and services.

The Houston VARO has a full-time Homeless Veterans Outreach Coordinator. Our review confirmed that the coordinator was familiar with requirements for improving the effectiveness of VARO outreach to homeless veterans. The coordinator had established collaborative partnerships with local homeless outreach facilities to provide information on VA benefits and services. As such, we made no recommendation for improvement in this area. However, without established performance measures we cannot fully assess the effectiveness of VBA's outreach efforts. VBA needs a measurement to assess the effectiveness of its homeless veterans outreach efforts.

Appendix A VARO Profile and Scope of Inspection

Organization

The Houston VARO administers a variety of services and benefits, including compensation and pension 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 2013, the Houston VARO had a staffing level of 592 full-time employees. Of this total, the VSC had 388 employees assigned.

Workload

As of December 31, 2012, the Houston VARO reported 38,083 pending compensation claims. The average time to complete claims was 350.2 days—100.2 days more than the national target of 250.

Scope

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

Our review included 30 (4 percent) of 719 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of October 29, 2012. We provided VARO management with 689 claims remaining from our universe of 719 for its review and management of these temporary 100 percent disabilities. As follow-up to our prior inspection, we sampled 40 temporary 100 percent disability evaluations from the SharePoint list VBA provided to the VARO as part of its national review. We reviewed 30 (43 percent) of 70 disability claims related to TBI that the VARO completed from July through September 2012.

Where we identify potential procedural inaccuracies, we provide this information to help the VARO understand the procedural improvements it can make for enhanced stewardship of financial benefits. We do not provide this information to require VAROs to adjust specific veterans' benefits. Processing any adjustments affecting entitlement and benefits per this review is clearly a VBA management decision.

We assessed the 11 mandatory SAOs the VARO completed in FY 2012. We examined 30 completed claims processed for Gulf War veterans from July through September 2012 to determine whether VSC staff had addressed entitlement to mental health treatment in the rating decision documents as required. Further, we assessed the effectiveness of the VARO's homeless veterans outreach program.

Data Reliability

We used computer-processed data from the Veterans Service Network's Operations Reports and Awards. To test for reliability, we reviewed the data to determine whether any data were missing from key fields, included any calculation errors, or were outside the time frame requested. We also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, VARO numbers, dates of claim, and decision dates as provided in the data received with information contained in the 90 claims folders we reviewed for temporary 100 percent evaluations, TBI and Gulf War veterans' entitlement to mental health treatment claims.

Our testing of the data disclosed that they were sufficiently reliable for our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders reviewed as part of our Houston VARO inspection did not disclose any problems with data reliability.

Inspection Standards

We conducted this inspection 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 inspection to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our inspection objectives. We believe that the evidence obtained and those instances where our review of claims found no evidence provides a reasonable basis for our findings and conclusions based on our inspection objectives.

Appendix B Inspection Summary

Table 2 reflects the operational activities inspected, applicable criteria, and whether or not we had reasonable assurance of VARO compliance.

Table 2. Houston VARO Inspection Summary

Five Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Disability Claims Processing			
1. Temporary 100 Percent Disability Evaluations	**Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations.** (38 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1 MR 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.** (FL 08-34 and 08-36) (Training Letter 09-01)		X
Management Controls			
3. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)		X
Eligibility Determinations			
4. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War veterans' claims, considering 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) (FL 08-15) (38 CFR 3.384) (38 CFR 3.2)		X
Public Contact			
5. Homeless Veterans Outreach Program	**Determine whether VARO staff provided effective outreach services.** (Public Law 107-05) (VBA Letter 20-02-34) (VBA Circular 27-91-4) (FL 10-11) (M21-1, Part VII, Chapter 6) (M-27-1, Part II, Chapter 2)	X	

Source: VA OIG
CFR=Code of Federal Regulations, FL=Fast Letter, M=Manual, MR=Manual Rewrite

Appendix C VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: May 22, 2013

From: Director, VA Regional Office Houston, Texas

Subj: Inspection of the VA Regional Office, Houston, Texas

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

1. The Houston VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Houston, Texas.*

2. Please refer questions to Wendy Torres, Assistant Director, Houston VA Regional Office at (713) 383-1719.

(original signed by:)

Pritz Navaratnasingam
Director,
Houston VA Regional Office

Attachment:
Houston RO updates to OIG recommendations

Benefits inspection of the Houston Regional Office

I. Disability Claims Processing

Recommendation 1: We recommend the Houston VA Regional Office Director implement a plan to ensure staff timely follows Veterans Benefits Administration policy to reduce temporary 100 percent disability evaluations when required.

Director Response: Concur

The Houston Regional Office runs the End Product (EP) 810 data from the Veterans Operations Report (VOR) weekly, along with checking for any new EP 684s that have been generated by Compensation Service. The EP 810 report is then filtered by the following Message Descriptions: 631A Future Physical Examination and 631R Review Need for Reevaluation. These cases are assigned to the Rating VSRs for review and appropriate action. Proper controlling EP is then established, and pre-determination proposals are generated as necessary.

Two RVSRS are dedicated to the task of reviewing all pre-determinations notices and reducing the temporary 100 percent disability evaluation when required. Once the final decision is done, it is implemented within two business days of completion. One VSR is assigned to review all past and current dues on EP 600 and refer them for final decision to the RVSRs.

In addition, the Houston RO began providing Training Performance Support System (TPSS) training on hospitalization and 100 percent temporary disability evaluations in March. The expected completion date for this training (100% compliance) is August 1, 2013.

Recommendation 2: We recommend the Houston VA Regional Office Director develop and implement a plan to follow up on hearing requests associated with proposed reductions.

Director Response: Concur

The Houston RO recently prepared a second hearing room to conduct local hearings, to include pre determination hearings. We will conduct training on hearings for all journey-level RVSRS during July, 2013. This will allow for more space and resources to conduct these hearings. The hearings will be scheduled within 30 days of the request. The assignment of a VSR to review all EP 600 past due and coming dues will assist with increased control over those cases where hearings have been requested.

Recommendation 3: We recommend the Houston VA Regional Office Director conduct a review of the 689 temporary 100 percent disability evaluations remaining from the data we used to perform the inspection and take appropriate action.

Director Response: Concur

On January 17, 2013, the Houston RO began the review of the remaining temporary 100 percent disability evaluations from the OIG list of cases used during their visit. Corrective actions are

being taken when necessary during the review process. The Houston RO expects to complete all reviews by September 30, 2013.

Recommendation 4: We recommend the Houston VA Regional Office Director implement a plan to assess the effectiveness of training and provide refresher training on the proper processing of traumatic brain injury claims.

Director Response: Concur

The Houston RO began providing traumatic brain injury (TBI) TPSS training (22 hours) to all DROs and RVSRs working TBI claims (special operation team and appeals, 38 employees), this also includes all Rating Quality Review Specialist (RQRS), in April 2013. Expected completion date for this training (100 percent compliance) is September 30, 2013.

Recommendation 5: We recommend the Houston VA Regional Office Director develop and implement a plan to ensure accurate second-signature reviews of traumatic brain injury claims.

VBA implemented a policy requiring two signatures on rating decisions involving TBI until sufficient accuracy is proven on the part of the RVSR. The Quality Review Team currently conducts reviews of cases completed by the Special Operations Team and Appeals Team prior to implementation. Once each employee has achieved 90% accuracy on these cases they are released to single signature. Quality Reviews are then completed by a random selection of these cases to ensure sustained accuracy.

II. Management Controls

***Recommendation 6*:** We recommend the Houston VA Regional Office Director ensure Veterans Service Center management amends the Systematic Analyses of Operations checklist to address all elements currently required by Veterans Benefits Administration policy and provide refresher training.

Director Response: Concur

The Houston RO has amended the Systematic Analyses of Operations (SAO) checklist to ensure all elements required IAW M21-4, Chapter 5 are addressed. The Veterans Service Center was provided with a template to ensure their reporting is consistent with the policy while providing an organized means for reviewing operations to identify existing or potential problems and proposing corrective actions. The SAO schedule was also reviewed and reissued to the VSC with new due dates that would provide sufficient time to research, analyze, identify potential areas for improvement and make sound recommendations. On February 21, 2013, both Houston RO Assistant Directors provided SAO training to all management analysts, supervisors and managers in the station. The training addressed the preliminary findings provided by the OIG team in their exit briefing.

III. Eligibility Determinations

No recommendations made.

IV. Public Contact

No recommendations made.

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.
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