VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Waco, Texas

July 30, 2013
13-00368-244

ACRONYMS AND ABBREVIATIONS

C&C	Confirmed and Continued
D1BC	Day 1 Brokering Center
DRO	Decision Review Officer
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
TBI	Traumatic Brain Injury
TMS	Talent Management System
TPSS	Training and Performance Support System
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center
WMP	Workload Management Plan

Report Highlights: Inspection of the VA Regional Office, Waco, Texas

Why We Did This Review

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

What We Found

Overall, VARO staff did not accurately process 24 (40 percent) of 60 disability claims we reviewed. We sampled claims we consider 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, 15 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate, generally because VARO staff did not establish controls to request future medical reexaminations. Errors in processing 9 of 30 traumatic brain injury claims occurred primarily due to ineffective training and inexperienced staff rating these complex claims.

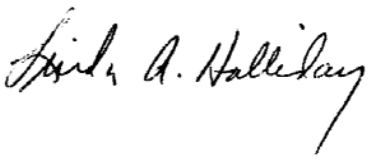
Systematic Analyses of Operations were incomplete, generally because the work performed did not include recommendations. The VARO's performance was generally effective in addressing Gulf War veterans' entitlement to mental health treatment. Waco VARO staff provided adequate outreach to homeless veterans; however, VBA needs a measure to assess its outreach program.

What We Recommend

We recommend the VARO Director develop and implement a plan to review all remaining temporary 100 percent disability evaluations identified during our inspection and take appropriate action. The Director should provide refresher training on processing traumatic brain injury claims and monitor the effectiveness of the training. Actions should be taken to ensure staff comply with VBA's policy requiring second-level review of traumatic brain injury claims decisions by more experienced decision makers. The Director should ensure staff includes recommendations for addressing problems identified through Systematic Analyses of Operations.

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 Divisions contribute 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 Waco 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 825 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 examined 30 (16 percent) of 182 disability claims related to TBI that VARO staff completed from 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 their impact on veterans' benefits.

Finding 1 The Waco VARO Could Improve Disability Claims Processing Accuracy

The Waco VARO did not consistently process temporary 100 percent disability evaluations and TBI cases accurately. Overall, VARO staff incorrectly processed 24 of the total 60 disability claims we sampled, resulting in 88 improper monthly payments to 4 veterans totaling $161,689 from January 2009 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 or the overall accuracy rate at this VARO. As reported by VBA's Systematic Technical Accuracy Review program as of November 2012, the overall accuracy of the VARO's compensation rating-related decisions was 84 percent—6 percentage points below VBA's target of 90 percent. This program information was not reviewed during the scope of this inspection.

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

Table 1

Waco 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	4	11	15
Traumatic Brain Injury Claims	30	0	9	9
Total	**60**	**4**	**20**	**24**

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 15 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 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.

Four of the 15 processing errors involved C&C rating decisions where VSC staff did not input suspense diaries as required. The reasons for the remaining errors varied; we did not identify a common trend or pattern related to processing temporary 100 percent disability evaluations.

In response to a recommendation in our national report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), VBA updated the electronic system to automatically establish diaries for C&C rating decisions when a future medical reexamination is required. VBA confirmed the update was successful in June 2011. After the update, we have not identified any errors involving C&C rating decisions. This update appears to be working; therefore, we made no recommendation for improvement in this area.

Without effective management of these temporary 100 percent disability ratings, VBA is at increased risk of paying inaccurate financial benefits. Available medical evidence showed that 4 of the 15 processing errors we identified affected veterans' benefits. The errors resulted in 88 improper monthly payments totaling $161,689 from January 2009 until December 2012. Details on the most significant overpayment and underpayment follow.

- A Rating Veterans Service Representative (RVSR) incorrectly continued a temporary 100 percent evaluation of a veteran's non-Hodgkin's lymphoma. VA treatment records showed the veteran had completed medical treatment and the condition was in remission, warranting a reduction in benefits as of September 1, 2009. VA continued processing monthly benefits and ultimately overpaid the veteran $81,969 over a period of 3 years and 3 months.
- An RVSR did not grant a veteran entitlement to a special monthly benefit based on the loss of use of a procreative organ, as required by VBA

policy. As a result, VA underpaid the veteran $198 over a period of 2 months.

The remaining 11 of the total 15 errors had the potential to affect veterans' benefits. VARO staff did not schedule medical reexaminations as required for some of the errors we identified. In nine cases, we found scheduling delays from approximately 7 months to 7 years and 3 months.

Summaries of the total 15 errors we identified follow.

- Six errors occurred when staff did not establish suspense diaries, thereby removing the possibility that staff would receive reminder notifications to schedule medical reexaminations. Four of these errors involved C&C rating decisions; however, they occurred prior to the June 2011 update to the electronic record.
- Two errors occurred when RVSRs improperly continued veterans' temporary 100 percent evaluations although medical evidence showed improvement and required reductions of benefits payments.
- Two errors occurred when RVSRs did not grant entitlement to Dependents' Educational Assistance when evidence in the claims folders showed the veterans' disabilities were permanently and totally disabling, thereby warranting the additional benefits.
- One error occurred when an RVSR granted a temporary 100 percent evaluation for lung cancer, but did not schedule an immediate examination.
- One error occurred when an RVSR did not establish entitlement to special monthly compensation for a medical condition secondary to service-connected prostate cancer.
- One error occurred when an RVSR established an increased evaluation for a veteran's prostate cancer with an incorrect effective date.
- One error occurred when staff established controls to reduce a veteran's benefit payments, but did not take final action to reduce the benefits. A delay of approximately 173 days elapsed from the time staff should have taken final action to reduce benefits until November 2012.
- One error occurred when staff proposed to reduce a veteran's benefit payments, but did not establish control to manage the proposed reduction. A delay of approximately 46 days elapsed from the time staff should have taken final action to reduce benefits until November 2012.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Waco, TX* (Report No. 09-03848-130, dated April 16, 2010), we stated errors in processing temporary 100 percent evaluations generally occurred because VARO staff did not input suspense diaries in the electronic system to provide reminder notifications to schedule medical reexaminations. In addition,

errors occurred when staff did not schedule needed examinations after receiving reminder notifications to do so.

The Director of the Waco VARO concurred with our recommendation to implement a plan that ensures staff schedule future medical reexaminations for temporary 100 percent disability evaluations. Effective March 2010, the VARO implemented a plan requiring staff to print copies of computer screens identifying the future examination dates and file these documents in the claims folders as proof that future dates were populated in the electronic record. Also, Senior Veterans Service Representatives were required to review all C&C ratings to ensure staff input suspense diaries in the electronic system as required. The OIG closed this recommendation in September 2010. While managers stated they put this policy in effect, they did not implement oversight procedures to ensure staff followed it. Of the four processing errors involving C&C rating decisions, we found only two errors occurred after the March 2010 plan was implemented.

The Director of the Waco VARO also concurred with our recommendation to conduct a review of all temporary 100 percent disability evaluations under his jurisdiction to determine whether reevaluations were required and take appropriate action. The OIG closed this recommendation in September 2010, after VARO managers indicated they had completed reviews of the temporary 100 percent evaluations that we did not include in our inspection.

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, dated January 24, 2011), the then-Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each evaluation 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. Based on the numerous delays and our continued findings, we are concerned about the lack of urgency in completing this review, which is critical to minimize the financial risk of making inaccurate benefits payments.

During our January 2013 inspection, we followed up on VBA's national review of its temporary 100 percent disability evaluation processing. We examined 40 (7 percent) of 578 temporary 100 percent disability evaluations on VBA's SharePoint lists of cases for review. We determined VARO staff

accurately took actions, such as inputting suspense diaries or scheduling reexaminations, on all 40 cases we reviewed. However, in comparing VBA's national review list with our data on temporary 100 percent disability evaluations, we found five cases 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, dated May 18, 2011), VBA agreed to develop and implement a strategy for ensuring the accuracy of TBI claims decisions. In May 2011, VBA 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 9 of 30 TBI claims—all 9 claims had the potential to affect veterans' benefits. Following are descriptions of these errors.

- In four cases, RVSRs improperly evaluated residuals of TBI. These errors did not affect the veterans' ongoing monthly benefits, but have the potential to affect future benefits in the event of additional compensable disabilities.
- In three cases, RVSRs used inadequate VA medical examination reports to evaluate the veterans' disabilities. The RVSRs did not return these insufficient examination reports to the issuing clinics or health care facilities as required. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without adequate or complete medical evidence.
- In two cases, RVSRs improperly evaluated TBIs separately from coexisting mental conditions. For these cases, the RVSRs were required to assign a single evaluation for each veteran's overall impaired functioning due to both medical conditions.

Generally, errors associated with TBI claims processing resulted from inexperienced staff who had difficulty rating complex TBI claims. VSC management and staff indicated there were several RVSRs who lacked experience in processing these claims. Additionally, staff stated it was

difficult to become proficient in deciding complicated TBI cases because these types of claims were not common. Further, five of the nine TBI processing errors did not receive a second signature review by more experienced decision makers as required by VBA policy. VSC managers and staff said RVSRs may have forgotten the requirement for an additional level of review, particularly if they had not recently rated TBI claims. As a result, veterans may not always receive correct benefit decisions.

Follow-Up to Prior VA OIG Inspection

Our previous report, *Inspection of the VA Regional Office, Waco, TX* (Report No. 09-03848-130, dated April 16, 2010), stated eight of the total claims reviewed had processing errors. These errors generally occurred because RVSRs needed further training on processing complex TBI claims. The Director of the Waco VARO concurred with our recommendation to develop and implement refresher training to ensure staff maintained their rating skills.

On September 14, 2010, the OIG closed this recommendation after learning that the VARO provided the TBI refresher training to RVSRs and Decision Review Officers in February 2010. The VARO also held TBI training in April 2011 and May 2012. However, we continued to identify TBI processing errors as a result of our January 2013 inspection. Further, VSC staff were still unaware of some of the more complex policies for rating TBI claims. Some staff felt the TBI training they received did not prepare them to process these types of cases, indicating that the training was ineffective.

Recommendations

1. We recommend the Waco VA Regional Office Director conduct a review of the 795 temporary 100 percent disability evaluations remaining from the data we used to perform the inspection and take appropriate action.
2. We recommend the Waco VA Regional Office Director provide refresher training on processing traumatic brain injury claims and develop and implement a plan to monitor the effectiveness of the training.
3. We recommend the Waco VA Regional Office Director develop and implement a plan to ensure staff comply with Veterans Benefits Administration policy requiring second signature review of each traumatic brain injury claim processed.

Management Comments

The Director concurred with our recommendations and staff completed a review of all 795 temporary 100 percent disability evaluations remaining from data we used to perform our inspection. Corrective actions included requesting future reexaminations, continuing existing 100 percent disability evaluations, and granting ancillary benefits as appropriate. VARO staff completed TBI training in April and May 2013. Additionally, supervisors and staff received follow-up guidance regarding VBA's policy on second-

signature reviews of TBI claims. Management will utilize a tracking log to monitor the quality of completed TBI claims.

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 VARO Oversight is Needed To Ensure Complete SAOs

Eight of the 11 SAOs were incomplete (missing required elements). Five of the eight did not contain recommendations for addressing identified problems. VBA policy states when problems are identified, management should include recommendations in the SAO to remedy the problem or to implement process improvements. In addition, management should be specific in terms of what is expected and when staff will accomplish the recommendations. However, VARO management did not include recommendations in its SAOs. VARO management could have more effectively measured VSC performance had it included recommendations for corrective actions.

Waco VARO managers believed that because they took corrective action to address the problems identified, no recommendations were required. VSC managers stated they received inconsistent guidance from previous VARO management regarding whether or not recommendations were required in the SAOs.

An example of an SAO that did not include recommendations was Claims Processing Timeliness. This SAO noted claims processing timeliness was negatively affected by a time-sensitive national project and a large number of trainees. Management offered no recommendations or corrective action in the SAO. Recommendations to mitigate the impact of competing work priorities and trainees could have helped the VARO measure or ensure improvement of its claims processing timeliness.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Waco, TX* (Report No. 09-03848-130, dated April 16, 2010), we stated incomplete SAOs resulted from staff following outdated guidance. Also, a lengthy review process caused SAOs to be untimely. The OIG closed this recommendation on September 14, 2010, after the VARO put controls in place to shorten the review process of SAOs and designated a VSC

Management Analyst to review SAOs for accuracy. Although our current inspection showed SAOs to be timely, we determined they continued to be incomplete because VARO management did not require inclusion of recommendations for identified problems.

Recommendation

4. We recommend the Waco VA Regional Office Director develop and implement a plan to ensure staff follow Veterans Benefits Administration policy on including recommendations for identified problems in their Systematic Analyses of Operations.

Management Comments

The Director concurred with our recommendation and developed a cover sheet for each SAO that includes an area for additional recommendations.

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, whenever an RVSR denied a Gulf War veteran service connection for any mental disorder, the RVSR had to also consider whether the veteran was entitled to receive mental health treatment. This policy required RVSRs to deny entitlement when there was no medical evidence of a mental disorder that developed within 2 years of separation from military service even when the benefit had not been claimed by the veteran.

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 only have to consider this entitlement when a veteran's mental health benefit can be granted based on diagnosis of a mental disorder that developed within 2 years of separation from military service.

We determined staff did not properly address whether 2 of 30 Gulf War veterans were entitled to receive treatment for mental disorders. We also determined the VARO was generally following VBA's amended policy, thus we made no recommendation for improvement in this area.

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 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 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 local homeless service providers, local government, and advocacy groups to provide information on VA benefits and services.

The Waco VARO has a full-time Homeless Veterans Outreach Coordinator. Interviews with a local homeless shelter representative, North Texas VA Medical Center staff, and a local Veterans' Service Officer confirmed the Coordinator was proactive in providing outreach services to homeless veterans. We also received a list of homeless outreach activities the Coordinator had attended. Because we determined the Homeless Veterans Outreach Coordinator provided outreach services to homeless veterans as required, we made no recommendation for improvement in this area. However, VBA needs a measurement to assess the effectiveness of its homeless veterans outreach efforts.

Appendix A VARO Profile and Scope of Inspection

Organization

The Waco VARO administers a variety of services and benefits, including compensation and pension benefits; vocational rehabilitation and employment assistance; benefits counseling; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of October 2012, the Waco VARO reported a staffing level of 803 full-time employees. As of January 2012, of this total, the VSC had 714 employees assigned.

Workload

As of November 2012, the Waco VARO reported 48,753 pending compensation claims. The average time to complete claims was 451.1 days—201.1 days more than the national target of 250.

Scope

VBA has 56 VAROs, and 1 VSC in Cheyenne, Wyoming, that process disability claims and provide a range of services to veterans. We evaluated the Waco VARO to see how well it accomplishes this mission.

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. Prior to conducting our onsite inspection, we coordinated with VA OIG criminal investigators to provide a briefing designed to alert VARO staff to the indicators of fraud claims processing.

Our review included 30 (4 percent) of 825 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 26, 2012. We provided VARO management with 795 claims remaining from our universe of 825 for its review. As follow-up to our January 2011 audit, we sampled 40 temporary 100 percent disability evaluations from the SharePoint list VBA provided to the VARO as part of its national review. We also reviewed 30 (16 percent) of 182 TBI-related disability claims 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 the VAROs to adjust specific veterans' benefits. Processing any adjustments per this review is clearly a VBA program 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 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 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 inspection of the Waco VARO did not disclose any problems with data reliability.

While this report references VBA's Systematic Technical Accuracy Review data, the overall accuracy of the VARO's compensation rating-related decisions was 84 percent—6 percentage points below VBA's FY 2013 target of 90 percent. This data was not reviewed as part of this inspection.

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 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. Waco 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	**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) (M27-1, 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: June 19, 2013

From: Director, VA Regional Office Waco, Texas

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

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

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

2. Please refer questions to Pandi Van Houten, Veterans Service Center Manager, at (254) 299-9110.

(Original signed)

JOHN S. LIMPOSE
Director
Waco VA Regional Office (349)

Attachment

RECOMMENDATIONS AND RESPONSES:

1. We recommend the Waco VA Regional Office Director conduct a review of the 795 temporary 100 percent disability evaluations remaining from the data we used to perform the inspection and take appropriate action.

Response: Concur. The Waco VARO has completed the review of all 795 temporary 100 percent disability evaluations and appropriate action has been taken. The review found that appropriate actions included preparing a record purpose rating to update corporate; granting entitlement to Chapter 35; or requesting a review examination, which resulted in a proposed reduction, a confirmed and continued (C&C) rating decision with a Chapter 35 grant, or a C&C rating decision with a future examination. Mandatory training from Central Office was provided to all Rating Veterans Service Representatives (RVSRs) and Decision Review Officers (DROs) through the Talent Management System (TMS) to address procedures on 100 percent disability evaluations. These cases are currently assigned to the Express lane.

2. We recommend the Waco VA Regional Office Director provide refresher training on processing traumatic brain injury claims and develop and implement a plan to monitor the effectiveness of the training.

Response: Concur. The Waco VARO completed the traumatic brain injury (TBI) Training and Performance Support System (TPSS) module (22 hours) in April and May 2013. All RVSRs and DROs assigned to the Special Operations, Appeals and Quality Review Teams completed this training. Additionally, a select number of RVSRs and DROs were identified in the Day 1 Brokering Center (D1BC) to process TBI cases and those individuals also completed the training. The Rating Quality Review Specialists received this training also so that they could properly perform quality reviews on TBI cases.

3. We recommend the Waco VA Regional Office Director develop and implement a plan to ensure staff comply with the Veterans Benefits Administration policy requiring second-signature review of each traumatic brain injury claim processed.

Response: Concur. The Veterans Service Center (VSC) management team provided guidance to the division in June 2011. Follow-up guidance was sent to the employees and supervisors in January 2013, reminding employees of the processing requirements. Per notice of the Office of Inspector General (OIG) recommendation received on May 31, 2011, the Waco VARO followed the guidance for single signature authority. A tracking log is maintained solely to monitor the rolling 10 cases and 90 percent accuracy for RVSRs. Once the decision maker has attained 90 percent accuracy, they are released to single signature for TBI claims. Based on the current organizational model, TBI claims are assigned to the Special Operations lane.

Additionally, all recommendations noted above are topics of discussion and review on VSC quarterly briefings to the Director.

4. We recommend that the Waco VA Regional Office Director develop and implement a plan to ensure staff follow Veterans Benefits Administration policy in including recommendations for identified problems in their Systematic Analyses of Operations.

Response: Concur. The Waco VARO performs Systematic Analyses of Operations (SAOs) on all areas in accordance with M21-4, Chapter 5.06 on an annual basis, with the exception of the area of Fiduciary, which is no longer under Waco VARO jurisdiction. SAOs on Claims Process Timeliness; Quality of Compensation, Pension and Ancillary Actions (Rating); Quality of Compensation, Pension, and Ancillary Actions (Authorization); and Quality of File Activities are prepared semi-annually. Problems are often identified and dispatched *as they arise* by attentive management of the operations. Subsequently, the problems identified in SAOs were shown to be addressed as corrective actions taken rather than recommendations for future action. When problems or significant opportunities for improvement are identified by an SAO, the report includes recommended actions to remedy the problem or implement processing improvements. A new cover sheet implemented by the Director is now in place for the concurrence process to include an area for additional recommendations.

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 Ed Akitomo Brett Byrd Ambreen Husain Jeff Myers David Piña Nelvy Viguera Butler Diane Wilson

Appendix E Report Distribution

VA Distribution

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Non-VA Distribution

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Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: John Cornyn, Ted Cruz
U.S. House of Representatives: Joe Barton, Kevin Brady, Michael Burgess, John Carter, Joaquin Castro, K. Michael Conaway, Henry Cuellar, John Culberson, Lloyd Doggett, Blake Farenthold, Bill Flores, Pete Gallego, Louie Gohmert, Kay Granger, Al Green, Gene Green, Ralph M. Hall, Jeb Hensarling, Rubén Hinojosa, Sheila Jackson Lee, Eddie Bernice Johnson, Sam Johnson, Kenny Marchant, Michael T. McCaul, Randy Neugebauer, Pete Olson, Beto O'Rourke, Ted Poe, Pete Sessions, Lamar Smith, Steve Stockman, Mac Thornberry, Marc Veasey, Filemon Vela, Randy Weber, Roger Williams

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