VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office New Orleans, Louisiana

June 6, 2011
11-00238-184

ACRONYMS AND ABBREVIATIONS

COVERS	Control of Veterans Records System
NOD	Notices of Disagreement
OIG	Office of Inspector General
PTSD	Post-Traumatic Stress Disorder
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VACOLS	Veterans Appeals Control and Locator System
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, New Orleans, Louisiana

Why We Did This Review

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

What We Found

The New Orleans VARO correctly processed herbicide exposure-related claims. VARO performance was generally effective in the following areas: processing post-traumatic stress disorder disability claims correctly, establishing correct dates of claim in the electronic record, ensuring Systematic Analyses of Operations were timely and complete, and correcting errors identified by the Veterans Benefit Administration Systematic Technical Accuracy Review program staff.

However, VARO management lacked effective controls and accuracy in processing temporary 100 percent disability evaluations as well as traumatic brain injury claims. Overall, VARO staff did not accurately process 29 (27 percent) of the 108 disability claims that we reviewed. Controls over processing Notices of Disagreements for appealed claims, mail handling, and final competency determinations also were not fully effective.

What We Recommended

We recommended New Orleans VARO management review all remaining temporary 100 percent disability evaluations identified during our inspection to determine if reevaluations are required. VARO management also needs to implement controls to ensure staff establishes reminder notifications for the temporary 100 percent disability reevaluations and follow up as appropriate. We also recommended VARO management establish an additional level of review for traumatic brain injury rating decisions to ensure accurate benefit payments.

Further, VARO management needs to strengthen controls to ensure timely establishment of Notices of Disagreement in the Veterans Appeals Control and Locator System and proper mail handling procedures, as well as implement measures to ensure the accuracy of final competency determinations.

Agency Comments

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

(original signed by:)

BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

The Benefits Inspection Program is part of the Office of Inspector General's (OIG) efforts to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Division contributes to improved management of benefits processing activities and veterans' services by conducting onsite inspections at VA Regional Offices (VAROs). These independent inspections provide recurring oversight focused on disability compensation claims processing and performance of Veterans Service Center (VSC) operations. The objectives of the inspections are to:

- Evaluate how well VAROs are accomplishing their mission of providing veterans with access to high quality benefits and services.
- Determine if management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; and minimize the risk of fraud, waste, and other abuses.
- Identify and report systemic trends in VARO operations.

In addition to this standard coverage, inspections may examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

Scope of Inspection

In November 2010, the OIG conducted an inspection of the New Orleans VARO. The inspection focused on 5 protocol areas examining 10 operational activities. The five protocol areas were disability claims processing, data integrity, management controls, workload management, and eligibility determinations.

We reviewed 78 (12 percent) of 666 disability claims related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and herbicide exposure that the VARO completed from July through September 2010. In addition, we reviewed 30 (13 percent) of 226 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months, generally the longest period a temporary 100 percent disability evaluation may be assigned under VA policy without review.

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

RESULTS AND RECOMMENDATIONS

1. Disability Claims Processing

The OIG inspection team focused on disability claims processing related to temporary 100 percent disability evaluations, PTSD, TBI, and herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

Finding 1 VARO Staff Need to Improve Disability Claims Processing Accuracy

The New Orleans VARO needs to improve the control and accuracy of processing temporary 100 percent disability evaluations and TBI residual-related disability claims. VARO staff incorrectly processed 29 (27 percent) of the total 108 disability claims reviewed. We advised VARO management regarding the inaccuracies noted during our inspection and they initiated corrective measures to address them.

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

Table

Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Disability Evaluations	30	24	9	15
PTSD	30	2	0	2
TBI	18	3	1	2
Herbicide Exposure-Related Disabilities	30	0	0	0
Total	**108**	**29**	**10**	**19**

Source: OIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 24 (80 percent) of 30 temporary 100 percent disability evaluations we reviewed. Veterans Benefits Administration (VBA) policy requires a temporary 100 percent disability evaluation for a service-connected disability needing surgery or specific treatment. At the end of a mandated period of convalescence or the 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 evaluations.

Based on analysis of available medical evidence, 9 of the 24 processing inaccuracies identified affected veterans' benefits—6 involved overpayments totaling $431,033 and 3 involved underpayments totaling $8,974. Examples of the most significant overpayment and underpayment follow:

- A claims file transferred to the New Orleans VARO, in May 2005, noted a veteran needed reexamination for prostate cancer; however, the examination was never scheduled. Our review of VA treatment records showed the prostate cancer was no longer active. As a result, an overpayment of $163,865 occurred over a period of 5 years and 2 months.
- A Rating Veterans Service Representative (RVSR) did not grant a veteran special monthly compensation for a residual disability associated with prostate cancer. As a result, VA underpaid the veteran a total of $4,108 over a period of 3 years and 8 months.

The remaining 15 of the 24 inaccuracies had the potential to affect veterans' benefits. In 13 cases, we could not determine if the evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to reevaluate each case. In the other two cases, VSC staff did not establish diaries for future reevaluations.

Delays in scheduling the examinations ranged from approximately 2 months to 5 years and 11 months. An average of 2 years and 9 months elapsed from the time staff should have scheduled the medical examinations until the date of our inspection—the date staff ultimately took corrective actions to obtain the necessary medical evidence.

For temporary 100 percent disability evaluations, including confirmed and continued evaluations where rating decisions do not change a veteran's payment amount, VSC staff must input suspense diaries in VBA's electronic system. A suspense diary is a processing command that establishes a date when VSC staff must schedule a reexamination. As the diary matures, the electronic system generates a reminder notification alerting VSC staff to schedule the reexamination.

The most frequent processing error noted in 11 (46 percent) of the 24 cases reviewed occurred when VSC staff did not establish suspense diaries needed to alert staff that VA reexaminations needed to be scheduled. The second most frequent processing error noted in 10 (42 percent) of the 24 cases

occurred when VSC staff did not follow up on established reminder notifications or proposed actions to reduce benefits.

These errors occurred because VARO management did not have a local policy in place to ensure VSC staff entered suspense diaries or controls in place to ensure staff took action on reminder notifications. Because adequate oversight measures were not in place, these temporary 100 percent disability evaluations could have continued uninterrupted over the course of the veterans' lifetimes. As such, veterans did not always receive correct benefit payments.

PTSD Claims

VARO staff incorrectly processed 2 (7 percent) of 30 PTSD claims. In both cases, RVSRs incorrectly granted service connection for PTSD without having required information from the examining physicians linking the PTSD diagnoses to the veterans' stressful in-service events. Given the infrequency of these types of errors, we concluded the VARO generally followed VBA policy when processing PTSD claims and we made no recommendations for improvement in this area.

TBI Claims

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

VARO staff incorrectly processed 3 (17 percent) of 18 TBI claims—1 of these claims processing inaccuracies affected a veteran's benefits. In this instance, the veteran received unwarranted benefits as the RVSR over-evaluated residual disabilities related to a TBI. As a result, an overpayment of approximately $7,102 occurred over a period of 1 year and 4 months.

The remaining two cases had the potential to affect veterans' benefits. RVSRs incorrectly evaluated TBI-related residual disabilities using inadequate medical examination reports. For example in one case, the medical examiner did not indicate as required whether the veteran's symptoms were associated with residuals of a TBI or a co-existing mental condition. Neither VARO staff nor we can ascertain all residual disabilities related to TBI without an adequate or complete medical examination.

VARO managers acknowledged that examination reports from the VA Medical Centers were not always adequate for evaluating disabilities. Prior to our inspection, VARO managers implemented measures to reinforce policy and improve the quality of medical examinations provided by VA Medical Center staff in New Orleans. For example, the VARO Quality Assurance Officer provided guidance to medical center staff regarding the specific information required in medical reports for the VARO to make

proper disability determinations. Additionally, prior to our inspection, VARO managers initiated regular meetings between VARO and VA Medical Center staff to address issues related to the quality and timeliness of VA medical examinations.

Despite efforts to improve VA examinations, RVSRs continue to use inadequate medical examinations to evaluate TBI-related disabilities. VARO staff acknowledged they understood how to identify and return inadequate examination reports to request additional information. RVSRs indicated they did not always return inadequate examinations to the VA facility for correction due to pressure from management to heighten productivity. As a result, veterans did not always receive correct benefit payments.

Herbicide Exposure-Related Claims

In accordance with VBA policy, VARO staff correctly processed all 30 herbicide exposure-related disability claims we reviewed. We made no recommendations for improvement in this area.

Recommendations

1. We recommend the New Orleans VA Regional Office Director review the 196 temporary 100 percent disability evaluations identified but not included in our inspection sample to determine if reevaluations are required and take appropriate action.
2. We recommend the New Orleans VA Regional Office Director implement controls to ensure staff establish reminder notifications for temporary 100 percent disability reevaluations.
3. We recommend the New Orleans VA Regional Office Director implement controls to ensure staff take appropriate follow-up actions on reminder notifications for temporary 100 percent disability reevaluations.
4. We recommend the New Orleans VA Regional Office Director require traumatic brain injury claims undergo an additional level of review (two-signatures) to ensure adequate medical examinations and accurate rating evaluations prior to finalizing benefit payments decisions.

Management Comments

The VARO Director concurred with all recommendations for improving disability claims processing accuracy. The Director informed us VSC staff will review the 196 additional temporary 100 percent evaluations and take action on those that require reevaluation. Further, the VARO will follow VBA's national review plan and interim guidance to ensure the staff records future examination diaries in the electronic record.

In March 2011, the VSC began reviews of 15 cancelled 810 Work Items per month to ensure the staff is taking appropriate action on reminder notifications. In addition, the VSC's quality review team began reviewing routine future exam actions to ensure improvements in this area. Further, the Director indicated the VSC would require second signatures on TBI cases for

each RVSR until it demonstrates a 90 percent average quality for 10 TBI cases reviewed.

OIG Response

Management's comments and actions are responsive to our recommendations. We will monitor the implementation and effectiveness of VBA's national plan for the review of temporary 100 percent disability evaluations. In the VARO Director's response, she did not believe the recommendation to generate an award for each of these cases was necessary or appropriate. Though we discussed generating awards to address this issue, we made no recommendation to this effect.

2. Data Integrity

Effective Dates

We reviewed claims folders to determine if the VARO is following VBA policy to establish effective dates in the electronic record. Generally, an effective date indicates when entitlement to a specific benefit arose. VARO staff followed VBA policy and correctly established effective dates for all 108 disability claims we reviewed. As such, we made no recommendation for improvement in this area.

Dates of Claim

We analyzed claims folders to determine if the VARO is following VBA policy to establish dates of claim in the electronic records. VBA generally uses a date of claim to indicate when a document arrives at a VA facility. VBA relies on accurate dates of claim to establish and track key performance measures, including the average number of days to complete a claim. VARO staff established an incorrect date of claim in the electronic record for 1 (3 percent) of the 30 claims we reviewed. Generally, VARO staff followed VBA policy when establishing dates of claim, so we made no recommendation for improvement in this area.

Notices of Disagreement

We reviewed claims folders to determine if VARO staff timely recorded Notices of Disagreement (NODs) in the Veterans Appeals Control and Locator System (VACOLS). An NOD is a written communication from a claimant expressing dissatisfaction or disagreement with a benefits decision and a desire to contest the decision. An NOD is the first step in the appeals process.

VACOLS is a computer application that allows VARO staff to control and track veterans' appeals as well as to manage the pending appeals workload. VBA policy states staff must create a VACOLS record within 7 days of receiving an NOD. Accurate and timely recording of an NOD is required to ensure an appeal moves through the appellate process expeditiously.

Finding 2 Controls Over Recording Notices of Disagreement Need Strengthening

The Appeals Team did not have controls in place to ensure staff recorded NODs in VACOLS within VBA's 7-day standard. Management did not provide adequate oversight to ensure VARO staff timely entered NODs in VACOLS to meet the standard. Untimely recording of NODs in VACOLS affects data integrity and misrepresents VARO performance.

The VARO exceeded VBA's 7-day standard for 9 (30 percent) of the 30 NODs we reviewed. It took staff an average of 46 days to record these nine NODs in VACOLS. According to the VARO's workload management plan, VARO mailroom staff properly delivered new NODs daily to the Appeals team. Upon receipt, management distributed the new NODs to team members to record in VACOLS. Management informed us, and we confirmed, they did not check to ensure staff recorded all NODs within VBA's 7-day standard.

Data integrity issues make it difficult for VARO and senior VBA leadership to accurately measure and monitor VARO performance. Further, VBA's National Call Centers rely upon accurate VACOLS information to provide quality customer service to veterans. Unnecessary delays in controlling NODs affect national performance measures for NOD inventory and timely completion of appeals.

Recommendation

5. We recommend the New Orleans VA Regional Office Director develop and implement a plan to provide adequate oversight to ensure staff timely enter Notices of Disagreement in the Veterans Appeals Control and Locator System.

Management Comments

The VARO Director concurred with the recommendation and indicated Appeals Team supervisors will review 10 randomly selected NODs to ensure compliance with VBA's 7-day standard. Management will use the results of these reviews to address training needs.

OIG Response

Management's comments and actions are responsive to the recommendation.

3. Management Controls

Systematic Technical Accuracy Review

We assessed management controls to determine if VARO management adhered to VBA policy regarding correction of errors identified by VBA's Systematic Technical Accuracy Review (STAR) staff. The STAR program is VBA's multifaceted quality assurance program to ensure that veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that VAROs take corrective action on errors

that STAR staff identify. In general, VARO staff followed VBA policy regarding the correction of STAR errors.

VARO staff did not correct 1 (4 percent) of 28 errors identified by VBA's STAR program staff from July through September 2010. In this case, VSC management erroneously reported to STAR staff that all corrective actions had been completed. We did not consider the error rate significant, so we made no recommendation for improvement in this area.

Systematic Analysis of Operations

We assessed if VARO management had controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). An SAO is a formal analysis of a VSC organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish an annual SAO schedule designating the staff required to complete the SAOs by specific dates.

Our analysis revealed 1 (8 percent) of the 12 mandated SAOs was not completed timely per the annual schedule. We did not consider the error rate significant, so we made no recommendation for improvement in this area.

4. Workload Management

Mailroom Operations

We assessed controls over mailroom operations to ensure VARO staff timely and accurately processed incoming mail. VBA policy states staff will open, date stamp, and route all mail to the appropriate locations within 4–6 hours of receipt at the VARO. The New Orleans VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. VARO mailroom staff processed, date stamped, and delivered all VSC mail to pick-up points on a daily basis as required; therefore, we made no recommendations for improvement in this area.

Triage Mail-Processing Procedures

We assessed the VSC Triage Team's mail processing procedures to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. VBA policy indicates that oversight to ensure staff use available plans and systems is the most important part of workload management. It also states that effective mail management is crucial to the success and control of workflow within the VSC.

VBA policy requires that staff use the Control of Veterans Records System (COVERS), an electronic tracking system, to track claims folders and search mail. VBA defines search mail as active claims-related mail waiting to be associated with a veteran's claim folder. Additionally, VBA policy states VSC staff will route and process mail requiring action according to established procedures. VBA defines action mail as forms and letters

received from outside the VSC. Conversely, non-priority drop mail should consist of documents requiring no action.

Finding 3 Control of Triage Mail Management Procedures Need Strengthening

The Triage Team did not always process and control search mail and non-priority drop mail according to VBA policy. This occurred because the Triage Team did not follow established procedures to process search mail as outlined in the station's workload management plan. Additionally, the plan did not contain sufficient oversight measures to ensure the Triage Team processed non-priority drop mail correctly. Consequently, RVSRs may not always have all available mail in the claims file when making disability determinations and claimants may not always receive prompt and accurate benefits.

For 12 (40 percent) of 30 pieces of search mail reviewed, staff did not properly use COVERS to ensure timely processing and adequate control of the mail. Following are examples of mail without a corresponding search in the electronic record.

- On August 9, 2010, the VARO received original service treatment records in conjunction with a veteran's July 27, 2010, compensation claim. By the time of our inspection, approximately four months after receiving the service treatment records, VARO staff had not identified and marked these documents search mail. Because these essential documents were not on search, the risk increased that RVSRs would make disability determinations without considering all evidence submitted by the veterans.
- On October 29, 2010, the VARO received medical evidence from a veteran to support his pending claim. The electronic record indicated this medical evidence was the last piece of mail needed before moving the claim forward to the next processing stage. Because VARO staff did not place the mail on search, a 33-day delay occurred in processing this veteran's claim.

Additionally, during our inspection we observed a backlog of approximately 2,600 pieces of mail marked as non-priority drop mail. However, our sample review showed that 10 (17 percent) of 60 pieces of this non-priority drop mail did require action. Following are examples of action mail found in non-priority mail bins.

- VARO staff did not record two new benefits claims in the electronic record. The VARO staff was not aware of these claims until we identified them during our inspection.

- Two pieces of mail for pending claims contained date stamps with earlier dates of claim than shown in the electronic record. For both claims, veterans may have been entitled to benefits at earlier dates.
- One piece of mail was a veteran's statement describing stressful in-service events to support a claim for PTSD. Because this evidence was not associated with the file, the RVSR prematurely denied the claim.

VSC management acknowledged weaknesses associated with mail processing. The workload management plan required management and Triage staff to conduct monthly reviews of search mail. Interviews with staff confirmed that neither Triage Team staff nor management was adhering to the Regional Office's workload management procedures. Additionally, the VSC workload management plan did not contain sufficient measures for management oversight of non-priority drop mail.

Recommendations

6. We recommend the New Orleans VA Regional Office Director amend the workload management plan to include oversight measures for properly classifying action and non-priority drop mail.
7. We recommend the New Orleans VA Regional Office Director develop an oversight mechanism to ensure staff accurately process search and drop mail.

Management Comments

The VARO Director concurred with our recommendations for improving Triage mail management processes. The Director indicated the VSC updated the Workload Management Plan to require that Triage Team supervisors review pull, priority, and non-priority mail on a monthly basis. Further, supervisors are required to review search mail locations bi-weekly to determine the appropriate actions needed for search mail pending for more than 15 days.

OIG Response

Management's comments and actions are responsive to the recommendations.

5. Eligibility Determinations

Competency Determinations

We reviewed competency determinations completed by the VSC Decision Team to ensure staff completed them accurately and timely. Delays in making these determinations ultimately affect the Fiduciary Unit's ability to be timely in appointing fiduciaries.

VA must consider beneficiary competency in every case involving a mental health condition that is totally disabling or when evidence raises questions as to a beneficiary's mental capacity to manage his or her affairs. The Fiduciary Unit supports implementation of incompetency determinations by

appointing a fiduciary, who is a third party that assists in managing funds for an incompetent beneficiary.

VBA policy requires staff to obtain clear and convincing medical evidence that a beneficiary is incapable of managing his or her affairs prior to making a final competency decision. The policy allows the beneficiary a 65-day due process period to submit the evidence showing an ability to manage funds and other personal affairs. At the end of the due process period, VARO staff must take immediate action to determine if the beneficiary is competent.

In the absence of a definition of "immediate," we allowed 14 calendar days after the due process period to determine if VARO staff timely completed a competency decision. We considered this a reasonable period to control, prioritize, and finalize these types of cases.

Finding 4 VARO Staff Need to Improve the Accuracy of Competency Determinations

VARO staff did not always make accurate competency determinations. Two (11 percent) of the 18 competency determinations we reviewed contained processing inaccuracies. These inaccuracies occurred due to a lack of training regarding the type of medical evidence necessary to deem a beneficiary incompetent to manage VA funds. As a result, veterans were determined to be incompetent and denied the ability to manage their funds independently even though such decisions may have been unwarranted.

In one case, VARO fiduciary staff acted upon an incorrect determination and appointed a fiduciary to manage a veteran's monthly benefit payment. The fiduciary received the veteran's benefit payments of $2,922 over a period of approximately 3 months. In the second case, the VARO did not appoint a fiduciary; however, the veteran was only able to access funds under the supervision of the Fiduciary Unit. In both cases, we did not find evidence of misused funds. VARO management agreed with our assessment that the decisions in both cases were premature and initiated corrective actions to obtain the required medical evidence to determine if the veterans were incompetent.

Recommendation

8. We recommend the New Orleans VA Regional Office Director ensure Rating Veterans Service Representatives receive refresher training on evaluating evidence required to make accurate competency determinations.

Management Comments

The VARO Director concurred with our recommendation and informed us that on December 16, 2010, all Decision Review Officers and RVSRs received refresher training on the evidence required to make accurate competency determinations.

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

Finding 5 Controls Over Competency Determinations Need Strengthening

VARO staff unnecessarily delayed making final decisions in 3 (17 percent) of the 18 incompetency determinations VARO staff completed from July through September 2010. The delays ranged from 21 to 75 days, with an average completion time of 47 days. The delays occurred because the VSC workload management plan did not contain procedures emphasizing immediate completion of claims involving competency determinations. The risk of incompetent beneficiaries receiving benefit payments without fiduciaries increases when the staff does not complete the competency determinations immediately.

Using our interpretation of "immediate" (14 calendar days after the due process period expires), the most significant delay occurred when VARO staff did not make a final incompetency decision for approximately 75 days. During this period, the veteran received approximately $19,823 in disability payments. While the veteran was entitled to these payments, fiduciary stewardship was not in place to ensure effective funds management and the welfare of the veteran.

VARO managers stated they were aware of the VBA policy to process competency determinations immediately. One manager defined immediate as the day after the due process period expires, while another manager defined immediate as 30 days after the expiration of the due process period. However, the station's workload management plan indicated that RVSRs process incompetency determinations as a priority once the age of a case reached 125 days or more. Because the plan did not emphasize the importance of completing these determinations immediately, incompetent beneficiaries received payments for extended periods without a fiduciary.

Until recently, VBA did not have a clear, measurable definition of "immediate" and this timeframe varied from office-to-office. In response to our summary report for FY 2010, *Systemic Issues Reported During Inspections at VA Regional Offices*, (Report Number 11-00510-167, May 18, 2011), the Acting Under Secretary for Benefits defined "immediate" as 21 days following the expiration of the due process period. VBA plans to implement this new policy nationwide in June 2011. The VARO processed 14 of 16 determinations in 21 days.

Appendix A VARO Profile and Scope of Inspection

Organization

The New Orleans VARO is responsible for delivering nonmedical VA benefits and services to veterans and their families in Louisiana. The VARO fulfills these responsibilities by administering compensation and pension benefits, vocational rehabilitation and employment assistance, and outreach activities.

Resources

As of September 2010, the New Orleans VARO had a staffing level of 180 full time employees. Of these, the VSC had 149 employees (83 percent) assigned.

Workload

As of October 2010, the VARO reported 7,173 pending compensation claims. The average time to complete these claims during October 2010 was 165.7 days—approximately 9 days better than the national target of 175 days. As reported by STAR, the accuracy of compensation rating-related issues was 78.6 percent, which is below the 90 percent target set by VBA.

Scope

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

Our review included 78 (12 percent) of 666 disability claims related to PTSD, TBI, and herbicide exposure that the VARO completed from July to September 2010. For temporary 100 percent disability evaluations, we selected 30 (13 percent) of 226 existing claims from VBA's Corporate Database. We provided the VARO with the 196 claims remaining from the universe of 226 to assist in implementing our first report recommendation. The 226 claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months.

We reviewed 28 errors identified by VBA's STAR program during the period from July through September 2010. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR's assessments include a review of work associated with claims requiring rating decisions. The STAR staff reviews original claims, reopened claims, and claims for increased evaluation. Further, they review appellate issues that involve a myriad of veterans' disabilities claims.

Our process differs from STAR as we review specific types of disability claims such as PTSD, TBI, and herbicide exposure that require rating decisions. In addition, we review rating decisions and awards processing

involving temporary 100 percent disability evaluations. We selected dates of claim for those claims pending processing at the VARO. Additionally, we selected NODs that were pending processing between 31-60 days at the VARO during the time of our inspection. Further, we reviewed mail management by selecting mail in various processing stages within the VARO mailroom and the VSC.

We completed our review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspections.* We planned and performed the review to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our review objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our review objectives.

Appendix B VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: May 12, 2011

From: Director, VA Regional Office New Orleans, Louisiana

Subj: Inspection of the VA Regional Office, New Orleans, Louisiana

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

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

2. Questions may be referred to Mr. Steve Kelly, Veterans Service Center Manager, at (504) 619-4560.

(original signed by:)

Debbie Biagioli
Acting Director

Attachment

New Orleans (321)

March 14, 2011

OIG Recommendations:

Recommendation 1: *We recommend the New Orleans VA Regional Office Director review the 196 temporary 100 percent disability evaluations identified but not included in our inspection sample to determine if reevaluations are required and take appropriate action.*

New Orleans RO Response: Concur

We concur with the recommendation. We began reviewing the list in December 2010. The list contained 196 cases to be reviewed. All but seven of the cases on the list that was provided have been reviewed.

Five of the seven cases that have not been reviewed are Nehmer cases that are currently located at an offsite location. These folders will be reviewed upon completion of the Nehmer Review Project as they are returned to our office. One folder was requested again from the St. Louis RMC in December 2010; however, that request was cancelled. The folder was requested again on March 3, 2011. This folder will be reviewed as soon as it is received. The final case is in the process of being rebuilt and upon completion will be reviewed. The Triage Coach and Rating Coach are controlling the completion of these reviews and will have these cases reviewed as soon as they are available.

Action has been taken on the folders, which required reevaluations.

Recommendation 2: *We recommend the New Orleans VA Regional Office Director implement controls to ensure staff establish reminder notifications for temporary 100 percent disability reevaluations.*

New Orleans RO Response: Concur

We agree that the electronic system should automatically populate future exam dates. However, we do not believe the recommendation to generate an award for each of these cases is necessary or appropriate. In response to OIG Report, "Audit of 100 Percent Evaluations," dated January 24, 2011, VBA developed a national plan to review 100 percent evaluation cases which was accepted by OIG. Therefore, the Regional Office will follow the national review plan.

On May 11, 2011, Compensation and Pension Service provided interim guidance to the Field that provided the four basic scenarios where Future Exam Diary control is either being cancelled unexpectedly or not being set at all during the VETSNET Award generation process. This interim guidance will be utilized where appropriate.

Recommendation 3: *We recommend the New Orleans VA Regional Office Director implement controls to ensure staff take appropriate follow-up actions on reminder notifications for temporary 100 percent disability reevaluations.*

New Orleans RO Response: Concur

We concur with the recommendation. The VSC will complete a review of fifteen cancelled 810 Work Items per month to ensure appropriate action is taken on the 810 Action Item. The reviews will begin in March 2011 and the findings will be saved on a shared drive for review. In addition, the quality team will add review of routine future exam actions to the quality checklist and this issue will become a part of the local quality review process. Any errors that are found will be reviewed and discussed with employees and trending data will be shared with the supervisor for training and follow-up action as needed.

Recommendation 4: *We recommend the New Orleans VA Regional Office Director require traumatic brain injury claims undergo an additional level of review (two-signatures) to ensure adequate medical examinations and accurate rating evaluations prior to finalizing benefit payments decisions.*

New Orleans RO Response: Concur In Part

We concur in part with the recommendation. The VSC will require a second signature on TBI cases for each RVSR until the RVSR demonstrates a 90% quality average on a minimum of 10 TBI cases. Once an RVSR has reached a 90% quality score average for a rolling 10 TBI cases, he or she will be awarded single signature authority for future TBI cases. Data obtained during this period of required second signatures will be used to identify training needs and to create any needed training sessions.

Recommendation 5: *We recommend the New Orleans VA Regional Office Director develop and implement a plan to provide adequate oversight to ensure staff timely enter Notices of Disagreement in the Veterans Appeals Control and Locator System.*

New Orleans RO Response: Concur

We concur with the recommendation. As a result of findings from the C&P Site Visit in March 2010, the VSC implemented changes to the mail processing procedures of Notice of Disagreements (NODs). In June 2010, the VSC began having a Senior VSR review incoming mail daily and deliver all NODs to the Appeals Coach. The NODs are entered into the Veterans Appeals Control and Locator System the day they are received on the Appeals Team.

The VSC saw an improvement in the NOD control time since the changes were implemented in June 2010. The NOD control time was at 28 days in June 2010 and had decreased to 4 days in November 2010. The November 2010 data was the last data available due to data collection problems within the Office of Performance Analysis & Integrity (OPA&I). To ensure continued compliance with the 7-day timeframe for control of NODs, the Appeals Team supervisors will conduct a review of 10 randomly selected NODs monthly. Results of these reviews will be used to address training needs and to facilitate follow-up action as needed.

Recommendation 6: *We recommend the New Orleans VA Regional Office Director amend the workload management plan to include oversight measures for properly classifying action and non-priority drop mail.*

New Orleans RO Response: Concur

We concur with the recommendation. The VSC has updated our Workload Management Plan to show that the Triage Team supervisor will review mail placed under control by Claims Assistants for properly classified action on pull, priority and non-priority mail on a monthly basis.

Recommendation 7: *We recommend the New Orleans VA Regional Office Director develop an oversight mechanism to ensure staff accurately process search and drop mail.*

New Orleans RO Response: Concur

We concur with the recommendation. All incoming mail is reviewed by the Claims Assistants on the Triage Team. Mail that is received for folders that are stored in the file banks is associated with the corresponding claim folder. If the folder cannot be located the mail is placed on search in COVERS.

All claims files are COVERED when they are received and prior to working the claim. If a search request is in COVERS, the person with the file will get the search mail from Triage. Triage personnel will delete search mail from COVERS.

The VSC has updated our Workload Management Plan to show that mail that is located in the SEARCH bin for over 15 days will be reviewed by a Triage supervisor bi-weekly to determine if the location has changed or if a request was sent.

Recommendation 8: *We recommend the New Orleans VA Regional Office Director ensure Rating Veterans Service Representatives receive refresher training on evaluating evidence required to make accurate competency determinations.*

New Orleans RO Response: Concur

We concur with the recommendation. All DROs and RVSRs received refresher training on the evaluation evidence required to make accurate competency determination on December 16, 2010. In addition, these employees are scheduled for refresher training on this topic in June 2011.

Appendix C Inspection Summary

10 Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. 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) (M21-1MR Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Post-Traumatic Stress Disorder	**Determine whether VARO staff properly processed claims for PTSD.** (38 CFR 3.304(f))	X	
3. Traumatic Brain Injury	**Determine whether claims for service connection for all residual disabilities related to in-service TBI were properly processed.** (Fast Letters 08-34 and 08-36, Training Letter 09-01)		X
4. Herbicide Exposure-Related Claims	**Determine whether VARO staff properly processed claims for service connection for herbicide exposure (Agent Orange).** (38 CFR 3.309) (Fast Letter 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)	X	
Data Integrity			
5. Date of Claim	**Determine whether VARO staff properly recorded correct dates of claim in the electronic records.** (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)	X	
6. Notice of Disagreement	**Determine whether VARO staff properly entered NODs into VACOLS.** (M21-1MR Part I, Chapter 5)		X
Management Controls			
7. Systematic Technical Accuracy Review	**Determine whether VARO staff properly corrected STAR errors in accordance with VBA policy**. (M21-4, Chapter 3, Subchapter II, 3.03)	X	
8. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)	X	
Workload Management			
9. Mail Handling Procedures	**Determine whether VARO staff properly followed VBA mail handling procedures**. (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)		X
Eligibility Determinations			
10. Competency Determinations	**Determine whether VAROs properly assessed beneficiaries' mental capacity to handle VA benefit payments**. (M21-1MR Part III, Subpart v, Chapter 9, Section A) (M21-1MR Part III. Subpart v, Chapter 9, Section B) (Fast Letter 09-08)		X

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

Appendix D OIG Contact and Staff Acknowledgments

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