

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Inspection of the VA Regional Office Los Angeles, California

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ACRONYMS AND ABBREVIATIONS

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

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Report Highlights: Inspection of the VA Regional Office, Los Angeles, California

Why We Did This Review

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

What We Found

Los Angeles VARO staff provided adequate outreach to homeless veterans and followed Veterans Benefits Administration's policy for correcting errors identified by Systematic Technical Accuracy Review staff.

The VARO lacked effective controls and accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations resulted when staff did not establish controls to schedule future medical reexaminations. Staff used insufficient medical examination reports to process traumatic brain injury claims. Further, errors in herbicide exposure-related disability claims occurred because staff incorrectly interpreted policy. VARO staff did not correctly process 54 (60 percent) of the 90 disability claims we sampled as part of our inspection. These results do not represent the overall accuracy of disability claims processing at this VARO.

VARO management did not ensure staff timely completed Systematic Analyses of Operations, properly processed search mail,

or accurately addressed Gulf War veterans' entitlement to mental health treatment. Further, inadequate monitoring of corrective actions on prematurely closed claims and lack of management controls over the processing of oldest pending claims resulted in significant delays.

What We Recommended

We recommended the VARO Director develop and implement a plan to ensure staff return insufficient medical examination reports for traumatic brain injury claims, as well as provide enhanced training on processing herbicide exposure-related claims. VARO management needs to ensure staff complete all elements of Systematic Analyses of Operations timely, provide oversight of search mail, and follow Veterans Benefits Administration policy on processing Gulf War veterans' entitlement to mental health treatment. The Director should develop and implement a plan to ensure management provides adequate oversight of prematurely closed claims and oldest pending claims.

Agency Comments

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

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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 2012, we conducted an inspection of the Los Angeles VARO. The inspection focused on six protocol areas examining nine operational activities. The six protocol areas were disability claims processing, management controls, workload management, eligibility determinations, public contact, and data integrity. Additionally, we conducted a special review of the VARO's ten oldest pending disability claims available for review at the time of our inspection. We did not review competency determinations because the Veterans Benefits Administration (VBA) has centralized all Western Area fiduciary activities at the Salt Lake City VARO.

We reviewed 60 (17 percent) of 358 disability claims related to traumatic brain injury (TBI) and herbicide exposure that VARO staff completed from July through September 2011. In addition, we reviewed 30 (6 percent) of 470 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months, generally the longest period a temporary 100 percent disability evaluation may be assigned under VA policy without review.

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

RESULTS AND RECOMMENDATIONS

1. Disability Claims Processing

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

The Los Angeles VARO has been conducting service center operations in a "Safe Mode" environment since approximately May 2011. Interviews with the Director and VSC leadership explained that while in Safe Mode, managers were not enforcing national and local quality and production standards. According to the Director, management took this action in order to allow employees to focus on improving claims processing accuracy versus productivity.

Finding 1 Los Angeles VARO Could Improve Disability Claims Processing Accuracy

The Los Angeles VARO lacked controls and accuracy in processing claims for temporary 100 percent disabilities, TBI, and herbicide exposure. VARO staff incorrectly processed 54 (60 percent) of 90 disability claims we reviewed and overpaid a total of \$925,126. VARO management agreed with our findings and initiated action to correct the inaccuracies identified.

Because we sampled claims related to specific conditions, these results do not represent the universe of disability claims processed at this VARO. At the time of our inspection, VBA's target for accuracy was 92 percent. As reported by VBA's Systematic Technical Accuracy Review (STAR) program, the overall accuracy of the Los Angeles VARO's compensation rating-related decisions was 77.5 percent—14.5 percentage points below the 92 percent VBA target.

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

Table 1

Los Angeles VARO Disability Claims Processing Results				
Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Disability Evaluations	30	29	12	17
Traumatic Brain Injury Claims	30	17	0	17
Herbicide Exposure-Related Claims	30	8	2	6
Total	90	54	14	40

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

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 29 (97 percent) of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a service-connected disability following surgery or when specific treatment is needed. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

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

Available medical evidence showed 12 of the 29 processing inaccuracies affected veterans' benefits—all involved overpayments totaling \$922,886. Details on the most significant overpayments follow.

- VARO staff did not schedule a follow-up medical examination to evaluate a veteran's prostate cancer. VA medical treatment records showed the veteran had completed treatment, warranting a reduction in benefits as of May 2000. As a result, VA continued processing monthly benefits and ultimately overpaid the veteran \$315,099 over a period of 11 years and 4 months.
- VARO staff did not take action on a follow-up medical examination to evaluate a veteran's cancer of the vocal cord. The examination showed the veteran had completed treatment, warranting a reduction in benefits as of September 2003. As a result, VA continued processing monthly

benefits and ultimately overpaid the veteran \$158,343 over a period of 9 years and 6 months.

The remaining 17 inaccuracies had the potential to affect veterans' benefits. Following are descriptions of these inaccuracies.

- In 12 cases, VSC staff did not schedule follow-up medical reexaminations needed to determine whether the veterans' temporary 100 percent evaluations should continue. We could not determine if the evaluations should have continued because the veteran's claims folders did not contain medical evidence needed to reevaluate each case.
- In one case, a Rating Veterans Service Representative (RVSR) incorrectly annotated the need for future reexamination of a veteran diagnosed with incurable chronic lymphocytic leukemia. In making this decision, the RVSR also did not consider entitlement to Dependents' Educational Assistance benefits as required by VBA policy.
- An RVSR correctly continued a 100 percent disability evaluation without requiring a future reexamination. In making this decision, the RVSR also did not consider entitlement to Dependents' Educational Assistance benefits as required by VBA policy.
- On a July 2005 decision document, Muskogee VARO staff proposed to reduce a veteran's temporary 100 percent disability evaluation because he did not report for a medical reexamination. In August 2005, the veteran contacted the Los Angeles VARO and provided his current address. The Los Angeles VARO received the veteran's claims folder on August 26, 2005, but did not request a medical reexamination or take action to reduce the veteran's 100 percent disability evaluation. Without a medical reexamination, neither VARO staff nor we can ascertain the current level of the veteran's disability.
- An RVSR prematurely granted service connection for a condition associated with prostate cancer. According to VBA policy, when medical evidence indicates a disability may be associated with a service-connected condition, VSC staff must obtain a medical opinion prior to establishing service connection. Neither VARO staff nor we can determine whether service connection is warranted in the absence of a medical opinion.
- In one case, a VA medical reexamination report was available for review in August 2011. However, by the time of our inspection, VSC staff had not taken action to review the medical reexamination report to determine whether the temporary 100 percent disability evaluation should continue.

For 13 of the 17 inaccuracies with the potential to affect veterans' benefits, an average of 3 years and 9 months elapsed from the time staff should have

scheduled medical reexaminations until the date of our inspection. The delays ranged from approximately 1 month to 13 years and 2 months.

Sixteen of the 29 inaccuracies resulted from staff not establishing suspense diaries when they processed rating decisions requiring temporary 100 percent disability reexaminations. Twelve of these inaccuracies involved confirmed and continued rating decisions. In November 2009, VBA provided guidance reminding VAROs about the need to add suspense diaries in the electronic record for confirmed and continued rating decisions. However, VARO management had no oversight procedure in place to ensure VSC staff established suspense diaries and timely scheduled reexaminations as required.

In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each evaluation had a future examination date entered in the electronic record. Then in September 2011, VBA provided each VARO with a list of temporary 100 percent disability evaluations for review. VBA directed each VARO to complete this review by the end of March 2012. As such, we made no specific recommendation for this VARO.

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.

VARO staff incorrectly processed 17 (57 percent) of 30 TBI claims—all had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- In 16 cases, RVSRs and Decision Review Officers (DROs) prematurely evaluated TBI residuals using insufficient medical examination reports. According to VBA policy, when a medical examination report does not address all required elements, VSC staff should return it to the clinic or health care facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without an adequate or complete medical examination.
- An RVSR incorrectly evaluated TBI residuals as 10 percent disabling. Medical evidence showed residuals warranting no more than a 0 percent disability evaluation, entitling the veteran to health care for the condition but not monetary compensation. Because of the veteran's multiple service-connected disabilities, this error did not affect the veteran's

monthly benefits but could affect future evaluations for additional benefits.

Generally, inaccuracies associated with TBI claims processing occurred because VARO staff did not return insufficient medical examination reports to the issuing clinics or health care facilities to ensure they addressed all required elements. Interviews with RVSRs and DROs revealed that despite recent training, VSC staff did not adhere to VBA policy and used their own interpretations of incomplete or inconclusive medical examination results to decide TBI claims. VSC management and staff explained that returning insufficient examination reports to VA medical facilities would delay claims processing. As a result of using insufficient medical examination reports, veterans may not have always received correct benefits.

**Herbicide
Exposure-Related
Claims**

VARO staff incorrectly processed 8 (27 percent) of 30 herbicide exposure-related claims we reviewed. Two of the eight processing inaccuracies affected veterans' benefits—one involved an underpayment totaling \$11,960, and one involved an overpayment totaling \$2,240. Details on the underpayment and the overpayment follow.

- An RVSR incorrectly evaluated diabetes mellitus with nephropathy as 10 percent disabling. The medical evidence showed the veteran met the criteria for an evaluation of 20 percent for the diabetes, and a separate evaluation of 60 percent for the nephropathy. As a result, VA underpaid the veteran \$11,960 over a period of 1 year and 5 months. We discussed this underpayment with VARO officials who agreed to take corrective action.
- An RVSR used an incorrect effective date to establish service connection for an herbicide exposure-related disability and entitlement to an additional special monthly benefit based on evaluations of multiple disabilities. As a result, VA continued processing monthly benefits and ultimately overpaid the veteran \$2,240 over a period of 7 months.

The remaining six inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- In three cases, RVSRs correctly granted service connection for post-cardiac surgery scars. However, the decision documents did not provide the veterans with the criteria to receive the next higher evaluation for the scars, as required. These inaccuracies did not affect the veterans' monthly benefits but could affect future evaluations for additional benefits.
- An RVSR incorrectly granted a 100 percent evaluation for Parkinson's disease. VBA policy requires a separate evaluation for any disability directly affected by Parkinson's disease. The RVSR should have

separately evaluated the multiple complications related to this disease. In the same decision document, the RVSR also incorrectly granted special monthly compensation based on the veteran needing assistance dressing and bathing. According to VBA policy, if the medical evidence shows a need for daily assistance and the rating criteria does not adequately compensate the veteran for the disability, the VARO must obtain an advisory opinion from headquarters.

- An RVSR did not grant service connection for a post-cardiac surgery scar diagnosed by a VA examination. This rating did not affect the veteran's monthly benefits but may affect future evaluations for additional benefits.
- An RVSR prematurely granted service connection for hypertension worsened by service-connected diabetes. According to VBA policy, when medical evidence indicates a disability may be associated with a service-connected condition, VSC staff must obtain a medical opinion prior to establishing service connection. Neither VARO staff nor we can determine whether service connection is warranted in the absence of this medical opinion.

Generally, inaccuracies associated with herbicide exposure-related claims processing resulted from VSC staff incorrectly interpreting VBA policy. Interviews with DROs and RVSRs revealed they received guidance from the VARO's Rating Quality Review staff that conflicted with herbicide-related regulations and policies. Additionally, prior to our inspection, VSC staff completed an additional level of review of five of the eight inaccuracies without identifying any errors. As a result of misinterpreting VBA policy, VSC staff did not properly evaluate herbicide exposure-related disabilities.

Recommendations

1. We recommend the Los Angeles VA Regional Office Director develop and implement a plan to ensure Veteran Service Center staff return insufficient medical examination reports to health care facilities to obtain the evidence needed to support traumatic brain injury claims.
2. We recommend the Los Angeles VA Regional Office Director develop and implement a plan to ensure Veteran Service Center staff correctly apply Veterans Benefits Administration policy for proper processing of herbicide exposure-related disabilities.

Management Comments

The VARO Director concurred with our recommendations. In response to recommendation 1, the Director stated the Quality Review Team conducted formal training on April 12, 2012, on sufficiency of examinations for TBI. The Quality Review Team supervisor will track all TBI errors and will coordinate with the VARO Training Manager for additional training based on a trend analysis. In response to recommendation 2, the Director indicated that in tracking errors identified through both local and STAR quality

reviews, the Quality Review Team looks for evidence of conflicts with VBA policy in processing herbicide-exposure related claims.

OIG Response Management's actions are responsive to the recommendations. We will follow up as required on all actions.

2. Management Controls

**Systematic
Technical
Accuracy Review**

We assessed whether VARO management adhered to VBA policy regarding correction of errors identified by VBA's STAR staff. The STAR program is VBA's multifaceted quality assurance program to ensure veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that VARO staff take corrective action on errors identified by STAR.

Los Angeles VARO staff adhered to VBA policy by taking corrective action on all 22 errors identified by VBA's STAR program from July through September 2011. Therefore, we made no recommendation for improvement in this area.

**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.

Finding 2 Oversight Needed To Ensure Timely and Complete SAOs

Ten (91 percent) of 11 SAOs were not completed timely per the annual schedule, were incomplete (missing required elements), or were both untimely and incomplete. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 SAOs annually. VARO management did not provide adequate oversight to ensure VSC staff completed the SAOs in accordance with VBA policy. As a result, VARO management may not have adequately identified existing and potential problems for corrective actions to improve VSC operations.

Management did not always use adequate data to support its analyses for the 11 required SAOs. At the time of our inspection, seven (64 percent) were incomplete, one (9 percent) was untimely, and two (18 percent) were both untimely and incomplete. One of the SAOs that the VARO did not

accurately complete involved mail handling. The Quality of Files Activities SAO identified a significant increase in search mail that had not been associated with veterans' claims folders. However, the SAO did not provide a time frame for completion of the recommendation. Although VSC managers stated they refer to VBA policy when completing SAOs, they were unaware that recommendations required a time frame for completion of proposed actions. If the VARO had implemented recommendations in a timely manner, they may have prevented the errors we found related to mail handling procedures.

Recommendation 3. We recommend the Los Angeles VA Regional Office Director develop and implement a plan to ensure staff complete Systematic Analyses of Operations timely and address all required elements.

Management Comments The VARO Director concurred with our recommendation. The Director stated VARO staff uses a reports control system to ensure all internal reports are completed and submitted. In addition to approving extensions under extenuating circumstances, the VARO Director may return SAOs when they lack required elements or accurate analyses. In June 2011, the Director provided training to all VSC managers and supervisors on SAO preparation and recently reminded them of all required elements of SAOs.

OIG Response Management's actions are responsive to the recommendation. We will follow up as required on all actions.

3. Workload Management

Mailroom Operations We assessed controls over VARO mailroom operations to ensure staff timely and accurately processed incoming mail. VBA policy states staff will open, date-stamp, and route all mail to the appropriate locations within 4 to 6 hours of receipt at the VARO. The Los Angeles VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. Mailroom staff were timely and accurate in processing, date-stamping, and delivering VSC mail to the Triage Team control point daily. As a result, we determined mailroom staff were following VBA policy and made no recommendation for improvement in this area.

Triage Mail Management Procedures We assessed the VSC's Triage Team mail-management 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 control of workflow within the VSC.

**Search and Drop
Mail**

VBA policy requires that VARO staff use the Control of Veterans Records System, an electronic tracking system, to track claims folders and control search mail. VBA defines search mail as active, claims-related mail waiting to be associated with veterans' claims folders. Conversely, drop mail requires no processing action upon receipt.

Staff did not properly control 2 (7 percent) of 30 pieces of drop mail reviewed. At the time of our inspection, approximately 1,950 pieces of drop mail were awaiting association with the related claims folders. The most significant drop mail error occurred when the VARO received medical evidence regarding a veteran's competency to handle his or her affairs on January 6, 2012. VSC staff incorrectly placed it in the drop mail holding area instead of associating it with the veteran's claims folder. If not for our review in January 2012, VSC staff may not have determined the veteran's competency to handle his or her affairs, potentially putting the veteran's benefits at risk. Because we did not consider the frequency of inaccuracies to be significant in drop mail, we made no recommendation for improvement in this area.

**Finding 3 Oversight Needed To Ensure Proper Control and
Processing of Search Mail**

VSC Triage Team staff did not properly control 15 (50 percent) of 30 pieces of search mail reviewed. Inaccuracies related to search mail occurred because VARO guidance contained inadequate provisions for supervisory oversight of search mail holding areas. As a result, VSC staff may not have all available evidence to make decisions, and beneficiaries may not receive accurate and timely benefits payments.

The most significant error occurred when the VARO received a new claim for benefits from a veteran on September 7, 2011, and staff incorrectly placed it in the search mail holding area. Because the file was located in the VARO's file holding area, staff should have associated the mail with the file, as required by VBA policy. By the time of our inspection in January 2012, the VARO had established the claim in the electronic system but had not taken action to associate this piece of mail with the veteran's file.

VSC managers stated they do not consistently review search mail holding areas to ensure compliance with search-mail management procedures. Interviews with VSC managers revealed they were not aware of all policies regarding search mail. Additionally, the Quality of Files Activities SAO was incomplete and did not adequately assess search mail management as intended. If VARO staff had provided a complete analysis of search mail in this SAO, they may have identified search mail not properly controlled in the Control of Veterans Records System. Untimely association of mail with

veterans' claims folders can cause delays in processing benefits claims and potentially result in inaccurate rating decisions.

Recommendation 4. We recommend the Los Angeles VA Regional Office Director amend the Workload Management Plan to include adequate provisions to ensure oversight of search mail.

Management Comments The VARO Director concurred with our recommendation. The Director indicated VSC management updated its Workload Management Plan to ensure proper control and oversight of search mail. The Director also stated VSC staff will clear out search mail holding areas and the VSC supervisor will review a Control of Veterans Records System report on a weekly basis to ensure search mail is timely associated with the appropriate claims folders.

OIG Response Management's actions are responsive to the recommendation. We will follow up as required on all actions.

4. Eligibility Determinations

Entitlement to Medical Care and Treatment for Mental Disorders Gulf War veterans are eligible for medical treatment for any mental disorders they develop within 2 years of the date of separation from military service. According to VBA, whenever an RVSR denies a Gulf War veteran service connection for a mental disorder, the RVSR must consider whether the veteran is entitled to receive mental health treatment.

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

Finding 4 Gulf War Veterans Not Receiving Accurate Entitlement Decisions for Mental Health Treatment

In all eight cases we reviewed, VARO staff did not properly address whether Gulf War veterans were entitled to receive treatment for mental disorders. These inaccuracies occurred because VSC staff lacked understanding of VBA policy and overlooked electronic reminder notifications to consider entitlement to mental health treatment. As a result, veterans may be unaware of their possible entitlement to treatment for mental disorders and may not get the care they need.

Interviews with VSC staff confirmed they did not always follow VBA policy to consider entitlement to mental health treatment when denying Gulf War veterans service connection for mental health disorders. In December 2011, VARO staff conducted training on mental health treatment for Gulf War

veterans and implemented a mandatory review of all completed decision documents. VSC staff stated despite recent training and the required review of completed decision documents, they still did not have clear understanding of VBA policy and did not take action on reminder notifications.

Recommendation 5. We recommend the Los Angeles VA Regional Office Director develop and implement a plan to ensure staff follow current Veterans Benefits Administration policy regarding Gulf War veterans' entitlement to mental health treatment when denying service connection for mental disorders.

Management Comments The VARO Director concurred with our recommendation. The Director stated VARO staff use numerous quality check-sheets throughout claims processing. VSC staff have updated the check-sheet for reviews of rating decisions to include a check for Gulf War veterans' entitlement to mental health treatment.

OIG Response Management's actions are responsive to the recommendation. We will follow up as required on all actions.

5. Public Contact

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.

Outreach to Homeless Veterans

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

The Los Angeles VARO has a full-time Homeless Veterans Outreach Coordinator. Our review confirmed that the coordinator provided effective homeless veterans outreach and contact with local homeless service providers as required by VBA policy. Therefore, we made no recommendation for improvement in this area.

6. Data Integrity

Special Review of End Product 930

VBA uses End Product (EP) codes as identifiers to monitor workload and productivity of its regional offices. Generally, VAROs establish an EP 930 in the electronic system when VSC staff prematurely closed any pending claim or correct an error in a previously closed case. VBA does not monitor these types of claims in its national performance measure.

When establishing an EP 930 for the above reasons, VAROs must use the same date of claim as the one that VARO staff incorrectly closed. VBA relies on accurate dates of claim as the effective dates for awarding benefits.

According to VBA policy, management should use suspense dates to monitor pending workload for receipt or non-receipt of information requested from a veteran, beneficiary, or other sources for a claim. VAROs must update or take action on the suspense dates as appropriate to ensure timely action. We reviewed 30 claims to determine if the Los Angeles VARO correctly established EP 930s and processed them according to VBA policy.

Finding 5 Oversight Needed On Corrective Actions For Prematurely Closed Claims

We conducted this review in response to an OIG hotline alleging Los Angeles VARO staff were cancelling pending claims and establishing EP 930s. We did not find evidence to substantiate this allegation. However, VSC staff did not always properly process prematurely closed claims. In response to a recommendation from a March 2011 Compensation Service Site Visit, VSC management incorporated a review process for prematurely closed claims in the workload management plan. VARO management did not provide adequate oversight to ensure VSC staff followed the new process. As a result, veterans may not receive timely decisions on their claims.

VARO staff incorrectly processed 23 (77 percent) of 30 EP 930 claims reviewed. Twenty errors had expired suspense dates, and three were incorrectly established because VSC staff had not completed processing the current claims. VARO staff must take action on expired suspense dates, as appropriate. Additionally, VARO staff incorrectly established the dates of claim in 11 of the 23 cases. Incorrect dates recorded in the electronic record affect data integrity and make it difficult for VARO leadership to determine accurate office performance.

We provided our observations on these 23 claims to VSC managers and supervisory staff tasked with managing this workload. These officials confirmed that they were not following requirements of the workload

management plan regarding these types of claims. VSC management stated that due to competing priorities, they had not monitored this workload since August 2011.

Recommendation 6. We recommend the Los Angeles VA Regional Office Director develop and implement controls to ensure staff follow up-to-date Veterans Benefits Administration policy and the local workload management plan regarding the processing of End Product 930s.

Management Comments The VARO Director concurred with our recommendation. The Director indicated VSC has a long-standing policy regarding processing EP 930s. Because of our findings, VSC management reissued the memorandum to all staff on April 11, 2012, and supervisors held meetings to remind employees of the policy for properly establishing and processing EP 930s.

OIG Response Management's actions are responsive to the recommendation. We will follow up as required on all actions.

7. Special Review of Claims Processing Timeliness

According to congressional delegations, veterans in California were experiencing lengthy processing delays related to their requests for VA benefits. VBA policy requires that division managers conduct a monthly review of all claims pending more than one year. If it is not feasible for division managers to personally review the claims, as an alternative, the managers must review a monthly report prepared by staff designated the review responsibility.

As of November 2011, the Los Angeles VARO had 22,228 total pending disability claims that averaged 246.2 days—66.2 days longer than the national target of 180 days. We reviewed the 10 oldest disability claims pending at the time of our inspection. These 10 claims had been pending from 905 to 2,867 days.

Finding 6 Oversight Needed To Ensure Timely Claims Processing

VARO staff delayed processing 8 (80 percent) of the 10 claims we reviewed. Processing delays occurred because VSC management did not always monitor claims pending longer than one year, as required by VBA policy. As a result, veterans did not receive timely benefits payments.

One significant delay occurred when a veteran filed an original claim on July 1, 2008, and VSC staff did not establish the claim until December 15, 2010, despite the veteran contacting VBA on multiple occasions. In the same case, staff requested additional evidence from the veteran on January 27, 2011, but took no additional action on the claim until

October 6, 2011. By the time of our review, the claim had been pending for 1,286 days.

Additionally, 8 (80 percent) of the 10 claims had past due suspense dates. In the most egregious case, VARO staff failed to follow up timely on a 978-day-old claim that required action on October 30, 2011. In this case, the veteran had an appeal pending and the claims folder was located at the Board of Veterans Appeals. The veteran submitted a new claim on May 5, 2009, that required a review of the service treatment records. In order to ensure timely processing, VSC staff should have requested the Board of Veterans Appeals temporarily return the claim folder to the VARO, as required by VBA policy. Additionally, the suspense date on this case had expired and VSC managers had not reviewed the claim in accordance with VBA policy.

Recommendation 7. We recommend the Los Angeles VA Regional Office Director develop and implement a plan to improve management oversight of all claims pending for more than 1 year in accordance with Veterans Benefits Administration policy.

Management Comments The VARO Director concurred with our recommendation. The Director stated the VSC updated its Workload Management Plan to specifically address claims over 1 year old. VSC supervisors provide lists of the oldest claims to staff and closely monitor to ensure timely processing. The Director indicated VARO Los Angeles is currently sending cases to another VARO for development of evidence and rating decisions, which should help the VARO's timeliness.

OIG Response Management's actions are responsive to the recommendation. We will follow up as required on all actions.

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of October 2011, the Los Angeles VARO had a staffing level of 234 full-time employees. Of this total, the VSC had 176 employees (75 percent) assigned.

Workload

As of November 2011, the VARO reported about 22,000 pending compensation claims. The average time to complete claims was 288.4 days—58.4 days more than the national target of 230.

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 60 (17 percent) of 358 disability claims related to TBI and herbicide exposure that the VARO completed from July through September 2011. For temporary 100 percent disability evaluations, we selected 30 (6 percent) of 470 existing claims from VBA's Corporate Database. We provided VARO management with 440 claims remaining from our universe of 470 for further review. These claims represented all instances in which VARO staff granted temporary 100 percent disability evaluations for at least 18 months as of November 2011.

We reviewed the 11 mandatory SAOs completed in FY 2011 and 2012. We reviewed 22 inaccuracies identified by VBA's STAR program during July through September 2011. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR measurements include a review of work associated with claims that require rating decisions. STAR staff review original claims, reopened claims, and claims for increased evaluation. Further, they review appellate issues that involve a myriad of veterans' disability claims. Our process differs from STAR as we review specific types of disability claims related to TBI and herbicide exposure that require rating decisions. In addition, we review rating decisions and awards involving temporary 100 percent disability evaluations.

For our review, we selected mail in various processing stages in the VSC. We reviewed eight completed claims processed for Gulf War veterans during July through September 2011 to determine whether VSC staff addressed

their entitlement to mental health treatment in their rating decision documents as required. We also assessed the effectiveness of the VARO's homeless veterans outreach program. Further, we selected for review 30 (5 percent) of 546 existing EP 930s and 10 of the oldest claims pending at the time of our inspection.

Reliability of Data During our inspection, we used computer-processed data from VETSNET Operations Reports and VETSNET Awards. To test the reliability of the data, we reviewed it to determine whether any data was missing from key fields, contained data outside of the time frame requested, included any calculation errors, contained obvious duplication of records, contained alphabetic or numeric characters in incorrect fields, or contained illogical relationships of date element to another. Further, we compared veterans' names, file numbers, social security numbers, station numbers, dates of claim, and decision dates provided in the data received to information contained in the 128 claims folders we reviewed.

Our testing of the data disclosed that it was sufficiently reliable for our inspection objectives. Our comparison of the data provided to information contained in the veterans' claims folders at VARO Los Angeles did not disclose any problems with data reliability.

Compliance with Inspection Standards We conducted this inspection in accordance with the *Quality Standards for Inspection and Evaluation*. We planned and performed the review to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our review objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our review objectives.

Appendix B VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: April 18, 2012
From: Director, VA Regional Office Los Angeles, CA
Subj: Inspection of the VA Regional Office, Los Angeles, CA
To: Assistant Inspector General for Audits and Evaluations (52)

1. Attached are the Los Angeles Regional Office's (RO) comments on the OIG Draft Report: Inspection of the VA Regional Office, Los Angeles, California. The RO concurs with the findings and recommendations in the areas of claims processing, management controls, workload management, eligibility determinations, and data integrity. The RO will ensure that implementation plans are fully engaged and are also coupled with the RO's ongoing efforts in improving overall claims processing accuracy.
2. We appreciate the audit team members' professionalism, insights, and their analyses throughout the audit.
3. Questions may be referred to me, at (310) 235-7696.

(original signed by:)

Dennis Kuewa

Director

Attachment

Los Angeles Regional Office
Response to Office of Inspector General, Benefits Inspection Division

Recommendation 1: We recommend the Los Angeles VA Regional Office Director develop and implement a plan to ensure Veteran Service Center staff return insufficient medical examination reports to health care facilities to obtain the evidence needed to support traumatic brain injury claims.

RO response: Concur

The RO Director has required additional training for all RVSRs and DROs specifically addressing sufficiency of examinations for traumatic brain injury ratings (TBI). The Quality Review Team (QRT) conducted formal training on April 12, 2012. In addition, all rating decisions involving TBI requires each decision to be reviewed and second-signed for adequacy prior to promulgation.

The QRT supervisor will track all TBI errors to identify any trends and will coordinate with the RO Training Manager for any additional training based on trend analyses.

The Los Angeles Regional Office recommends closure of this item.

Recommendation 2: We recommend the Los Angeles VA Regional Office Director develop and implement a plan to ensure Veteran Service Center staff correctly apply Veterans Benefits Administration policy for proper processing of herbicide exposure-related disabilities.

RO Response: Concur

The RO Director has substantiated compliance with VBA policy and procedures regarding the processing of herbicide exposure-related disability claims after being briefed on this issue by the QRT supervisor and staff. Since the QRT tracks all errors found on local quality reviews and STAR reviews, they will continue to look for evidence where the processing of herbicide exposure-related disabilities conflicts with VBA policy and procedures.

The Los Angeles Regional Office recommends closure of this item.

Recommendation 3: We recommend the Los Angeles VA Regional Office Director develop and implement a plan to ensure staff complete Systematic Analyses of Operations timely and address all required elements.

RO Response: Concur

The RO Director's staff uses a reports control system to ensure that all internal reviews and reports, including Systematic Analyses of Operations (SAOs), are completed and submitted as required. All extensions require the RO Director's approval. The RO Director typically approves requests for extensions under extenuating circumstances; however, the RO Director may also return SAOs for re-submission when determined that they lack any required elements or offer flawed analyses. This was the case in 2011, when the RO Director returned a majority

of SAOs for insufficiency or flawed analysis. Because of this trend, the RO Director provided training in June 2011 to all managers and supervisors in the VSC on the preparation of SAOs to include content, proper analysis, and M21-4 Chapter 5 requirements. VSC Management staff has been reminded of all required elements of SAOs.

The Los Angeles Regional Office recommends closure of this item.

Recommendation 4: We recommend the Los Angeles VA Regional Office Director amend the Workload Management Plan to include adequate provisions to ensure oversight of search mail.

RO Response: Concur

The Workload Management Plan has been updated to ensure proper control and oversight of search mail on station. File Clerks are to attach all mail daily and when a file cannot be located, regardless of the COVERS location, the mail is to be placed on search in the COVERS application. A COVERS screen shot is attached to the mail, which shows the date it was placed on search. Search mail is then filed in search mail bins based on digits. File Clerks attach search mail when COVER'ing files throughout the VSC daily and search mail bins are "scrubbed" weekly to ensure search mail is timely associated with the folder(s). The Triage Coach runs the Search Mail Pending Report in COVERS weekly to ensure mail on search does not exceed 30 days.

The Los Angeles Regional Office recommends closure of this item.

Recommendation 5: We recommend the Los Angeles VA Regional Office Director develop and implement a plan to ensure staff follow current Veterans Benefits Administration policy regarding Gulf War veterans' entitlement to mental health treatment when denying service connection for mental disorders.

RO Response: Concur

Since the Los Angeles RO had already implemented numerous quality "Checkpoints" throughout the claims process, the check-sheet for daily peer-to-peer reviews of rating decisions has been updated to include a check for entitlement to 1702 healthcare benefit for wartime and GWOT Veterans.

The Los Angeles Regional Office recommends closure of this item.

Recommendation 6: We recommend the Los Angeles VA Regional Office Director develop and implement controls to ensure staff follow up-to-date Veterans Benefits Administration policy and the local workload management plan regarding the processing of End Product 930s.

RO Response: Concur

The Los Angeles Veterans Service Center (VSC) has had a long-standing written policy in place regarding the proper processing of EP 930s; however, due to the OIG findings this memorandum was reissued to all VSC employees on April 11, 2012. In addition, all VSC supervisors met with

their respective teams and reminded employees of the policy for properly establishing and processing EP 930s.

The Los Angeles Regional Office recommends closure of this item.

Recommendation 7: We recommend the Los Angeles VA Regional Office Director develop and implement a plan to improve management oversight of all claims pending for more than 1 year in accordance with Veterans Benefits Administration policy.

RO Response: Concur

The VSC workload management plan has been updated to specifically target the over 1 year old claims inventory. Each team is expected to identify the oldest cases in specific cycle times and process them as priorities. Weekly WIPP lists are assigned and closely monitored by team supervisors as well as VSC management. In addition, the Los Angeles Regional Office is currently participating in brokering of initial development and cases marked Ready-For-Decision which is projected to assist with timeliness.

The Los Angeles Regional Office recommends closure of this item.

Appendix C Inspection Summary

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

Table 2. Los Angeles VARO Inspection Summary			
Nine Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. Temporary 100 Percent Disability Evaluations	Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations. (38 Code of Federal Regulations (CFR) 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (Manual (M)21-1 Manual Rewrite (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 service connection for all residual disabilities related to in-service TBI. (Fast Letter (FL) 08-34 and 08-36, Training Letter 09-01)		X
3. Herbicide Exposure-Related Claims	Determine whether VARO staff properly processed claims for service connection for herbicide exposure-related disabilities. (38 CFR 3.309) (FL 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)		X
Management Controls			
4. Systematic Technical Accuracy Review	Determine whether VARO staff properly corrected STAR errors in accordance with VBA policy. (M21-4, Chapter 3, Subchapter II, 3.03)	X	
5. Systematic Analysis of Operations	Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs. (M21-4, Chapter 5)		X
Workload Management			
6. Mail-Handling Procedures	Determine whether VARO staff properly followed VBA mail-handling procedures. (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)		X
Eligibility Determinations			
7. Gulf War Veterans Entitlement to Mental Health Treatment	Determine whether VARO staff properly processed Gulf War Veterans' 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) (Fast Letter 08-15) (38 CFR 3.384) (38 CFR 3.2)		X
Public Contact			
8. VBA's Homeless Veterans Program	Determine whether VARO staff provided effective outreach services. (Public Law 107-95) (VBA Letter 20-02-34) (Fast Letter 10-11) (VBA Circular 27-91-4) (M21-1, Part VII, Chapter 6)	X	
Data Integrity			
9. EP 930 Review	Determine whether VARO staff correctly established EP 930s and processed them according to VBA policy. (M21-4, Appendix C) (Training Letter 09-04) (M21-4, Chapter 2)		X

Source: VA OIG

CFR=Code of Federal Regulations, FL=Fast Letter, M=Manual, MR=Manual Re-write

Appendix D **OIG 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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Acknowledgments	Dawn Provost, Director Bridget Bertino Orlan Braman Michelle Elliott Lee Giesbrecht Ambreen Husain Rachel Stroup Dana Sullivan
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