VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Systemic Issues Reported During Inspections at VA Regional Offices

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ACRONYMS AND ABBREVIATIONS

C C	Confirmed and Continued
C P	Compensation and Pension
COVERS	Control of Veterans Records System
IRIS	Inquiry Routing and Information System
NOD	Notice of Disagreement
OIG	Office of Inspector General
PII	Personally Identifiable Information
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: Systemic Issues Reported During Inspections at VA Regional Offices

Why We Did These Reviews

The Office of Inspector General established its Benefits Inspection Program in March 2009 as a major initiative to help ensure timely and accurate delivery of veterans' benefits and services. This report is a summary of systemic issues identified at 16 VAROs inspected from April 2009 to September 2010. We did not inspect all operational activities at each VARO.

What We Found

VARO management teams face multiple challenges in providing benefits and services to veterans. Challenges include providing additional oversight and training for personnel responsible for processing disability compensation claims related to temporary 100 percent disability evaluations, post-traumatic stress disorder, traumatic brain injury, herbicide-related disabilities, and Haas cases. We projected that VARO staff did not correctly process 23 percent of approximately 45,000 claims.

We also found weaknesses associated with processing Notices of Disagreements for appealed claims, correcting errors identified by VBA's Systematic Technical Accuracy Review Program, ensuring timely and complete Systematic Analyses of Operations, and processing claims-related mail. Additionally, VARO staff did not always safeguard veterans' personally identifiable information or make timely final competency decisions for beneficiaries unable to manage their affairs.

What We Recommend

As a result of the 16 inspections, we made 86 recommendations to improve VARO operations regarding the systemic issues addressed. VARO Directors concurred with all of the recommendations.

We further recommend the Acting Under Secretary for Benefits revise the policy on evaluating residuals of Traumatic Brain Injuries and provide training to medical examiners conducting traumatic brain injury medical examinations to ensure compliance with current examination requirements. We also recommend the Acting Under Secretary develop a clear and measurable standard for timely completion of competency determinations.

Agency Comments

The Acting Under Secretary for Benefits concurred with our recommendations. Management's planned actions are responsive and we will follow up as required on all actions.

(original signed by:)

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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 conducts onsite inspections at VA Regional Offices (VAROs). These inspections contribute to the improvement and management of benefits processing activities and veterans' services. The purpose of these independent inspections is to provide recurring oversight of VAROs by focusing on disability compensation claims processing and performance of Veterans Service Center (VSC) operations. The objectives of the inspections are to:

- Evaluate to what extent VAROs are accomplishing their mission of providing veterans with access to high quality benefits 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

From April 2009 through September 2010, we conducted inspections of the following 16 VAROs (listed in order of inspection):

- Nashville, TN
- Wilmington, DE
- Baltimore, MD
- San Juan, PR
- Anchorage, AK
- Roanoke, VA
- Togus, ME
- Philadelphia, PA
- Waco, TX
- Albuquerque, NM
- Muskogee, OK
- Denver, CO
- Cheyenne, WY
- Detroit, MI
- Jackson, MS
- Newark, NJ

Appendix A provides additional details on the scope of the inspections. Appendix B contains the Acting Under Secretary for Benefits' comments. Appendix C provides a summary of the inspection results for the 16 VAROs inspected and includes the criteria used to evaluate each operational activity. We did not always review the same operational activities at each VARO inspected.

RESULTS AND RECOMMENDATIONS

1. Disability Claims Processing

The OIG inspection team focused on disability claims processing related to temporary 100 percent disability evaluations, post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), herbicide exposure, and Haas cases. Haas[1] claims involve veterans who served in waters off Vietnam, never having set foot in Vietnam, and whether those veterans are entitled to the presumption of exposure to herbicide agents, including Agent Orange.

Finding 1 Veterans Benefits Administration Needs to Improve Disability Determination Accuracy

The Veterans Benefits Administration (VBA) needs to improve the accuracy of disability claims processing. Based on 16 VARO inspections, we projected that VARO staff incorrectly processed about 23 percent of an estimated 45,000 claims. Of these, about 8 percent affected veterans' benefits and approximately 15 percent had inaccuracies with the potential to affect veterans' benefits. Table 1 summarizes our projection of the errors affecting veterans' benefits, and those with the potential to affect benefits.

Table 1

Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed (Projected)*		
		Error Rate	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Disability Evaluations	277	82%	20%	62%
PTSD	470	8%	4%	4%
TBI	325	19%	11%	8%
Herbicide Exposure-Related Claims	453	8%	6%	1%
Haas	89	13%	2%	11%
Total	**1614**	**23%**	**8%**	**15%**

*Numbers for projected error rates do not equal due to rounding.

[1]Haas claims are affected by a U.S. Court of Appeals for Veterans Claims decision in *Haas v. Nicholson*. VA put a stay of adjudication on these claims; however, it lifted the stay in January 2009.

Temporary 100 Percent Disability Evaluations

In October 2009, we began inspecting temporary 100 percent disability evaluations. None of the 10 VAROs inspected followed VBA policy in processing these claims. VBA policy allows a temporary 100 percent evaluation for service-connected disabilities requiring surgery or specific treatment. At the end of a mandated period of convalescence or cessation of treatment, VARO staff must review the veteran's medical condition to determine if staff should continue the temporary evaluation.

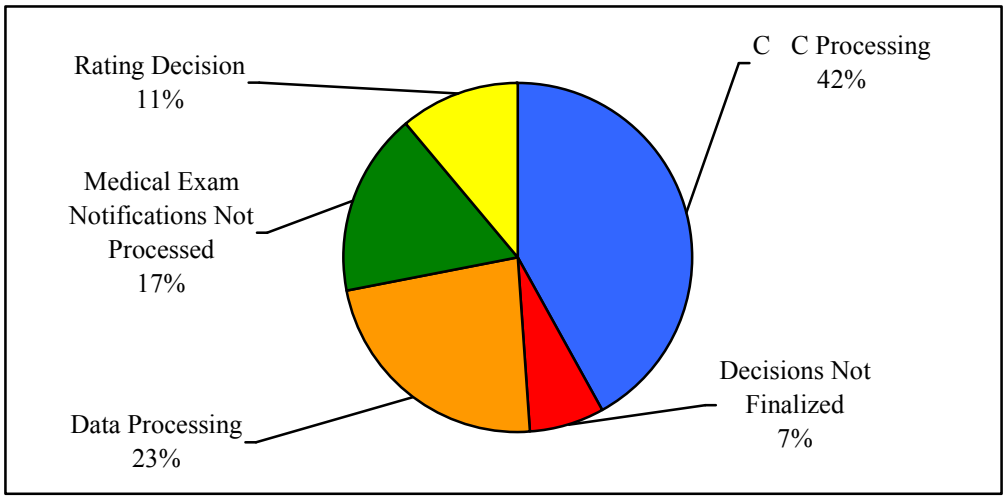
We projected that VARO staff did not adequately process temporary 100 percent evaluations for about 6,800 (82 percent) of approximately 8,300 veterans. This generally occurred because VARO management did not establish controls to ensure staff input reminder notifications (also known as diaries) for reexaminations into VBA's electronic record as required. As a result, veterans did not always receive accurate benefit payments.

Our *Audit of VBA's 100 Percent Disability Evaluations*, (Report No. 09-03359-71, January 2011), projected approximately $1.1 billion dollars in overpayments over the next 5 years if VBA does not implement controls to improve processes associated with 100 percent disability evaluations. Further, this report disclosed that VAROs are not correctly evaluating and monitoring 100 percent evaluations. As the Acting Under Secretary for Benefits provided comments to that report, we make no additional recommendations.

Figure 1 depicts projected error rates in temporary 100 percent disability claims processing.

Figure 1

Projected Errors Rates in Temporary 100 Percent Disability Claims



We estimated 42 percent of the errors involved confirmed and continued (C C) rating processing errors. A C C rating is one where the evidence does not necessitate changing the veteran's existing disability evaluation. For example, a veteran receives a temporary 100 percent evaluation for prostate cancer. Medical evidence from reexamination to determine if the evaluation should continue shows the veteran still receives treatment for this condition. Therefore, the RVSR confirms the veteran remains entitled to the temporary 100 percent evaluation and decides to continue the evaluation until the next required reexamination period, as established by diaries.

The inaccuracies occurred when VARO staff did not input suspense diaries for reexaminations in an electronic system as mandated by VBA policy. A diary is a processing command that establishes a date when VSC staff must schedule reexaminations. As diaries mature, the electronic system generates reminder notifications to alert VSC staff to schedule the mandatory reexaminations. When staff omit diaries, the temporary 100 percent disability evaluation will continue throughout a veteran's lifetime because nothing calls such cases into question again for reexamination.

Following are descriptions of the remaining error types for which we made projections.

- Data processing errors: Incorrectly using computer applications, such as canceling reexamination reminder notifications designed to manage workloads associated with temporary evaluations.
- Medical exam notifications not processed: Taking no action upon receiving a notification from the Benefits Delivery Network to schedule a medical examination. (VBA no longer uses the Benefits Delivery Network to generate these notifications.)
- Rating decision inaccuracies: Omitting diary dates in rating decisions for mandatory future medical examinations. When the date is omitted, VSC staff do not recognize the need to input a diary to prompt a future examination.
- Decisions not finalized: Proposing in rating decisions to reduce temporary 100 percent disability evaluations, but not taking final action to follow through with the reductions.

In November 2009, VBA's Compensation Pension (C P) Service published guidance reminding VAROs about proper system input for C C evaluation ratings. Based on our analysis, it does not appear VAROs are following this guidance. To assist VBA in monitoring VARO compliance with guidance for processing temporary 100 percent disability evaluations, including C C evaluations, we provided VBA our procedures for extracting data from VA systems on cases in existence for 18 months or more. VBA would benefit from using such data to monitor VARO compliance on an ongoing basis.

In his comments on a draft of this report, the Acting Under Secretary for Benefits stated the computer system did not properly maintain the future examination dates and VBA identified multiple computer system errors. We did not examine the sufficiency of this computer system and make no comment on the system errors VBA identified. However, the problems we found were due to employee errors in not entering suspense diaries in the system for confirmed and continued decisions. During our inspections, for numerous cases and at various locations, we showed VARO staff in the computer system that no histories existed of suspense diaries ever having been input.

The results of our inspection work reinforce the findings identified in the January 2011 *Audit of VBA's 100 Percent Disability Evaluations*. As such, we will continue to review temporary 100 percent disability evaluations during our annual inspection work to ensure that VBA implements a process to improve accuracy in this area.

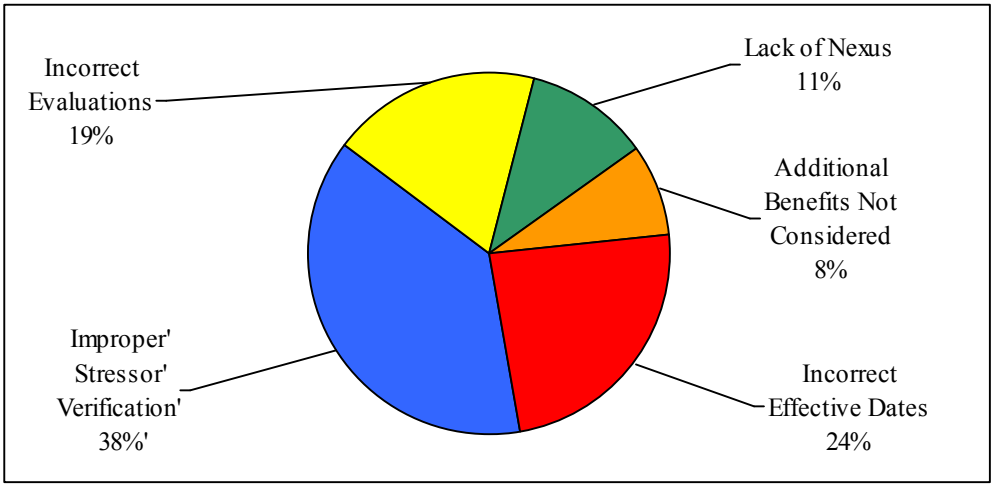
PTSD Claims

Of the 16 VAROs inspected, 8 (50 percent) did not follow VBA policy when processing PTSD claims. Service connection for PTSD requires credible evidence that a claimed in-service stressful event occurred, medical evidence diagnosing the condition, and a nexus (established by medical evidence) linking current symptoms and the in-service stressful event.

We projected VARO staff did not correctly process about 1,350 (8 percent) of approximately 16,000 PTSD claims completed from April 2009 through July 2010. This generally occurred because VARO staff lacked sufficient experience and training to process these claims accurately. Additionally, some VAROs were not conducting monthly quality assurance reviews. For these reasons, veterans did not always receive accurate benefits. The figure below provides projected error rates by the types of PTSD errors identified.

Figure 2

Projected Error Rates in PTSD Claims Processing



For example, we projected that of the PTSD claims incorrectly processed, about 38 percent involved improper verification of a related in-service stressful event. Stressor verification errors occurred when staff did not obtain sufficient evidence that the alleged stressful events actually occurred.

Further, inaccuracies related to incorrect effective dates occurred because RVSRs used the wrong dates to establish benefits, often resulting in inaccurate payments to veterans.

Following are descriptions of the remaining three types of PTSD errors.

- Incorrect evaluations: Assigning incorrect evaluations for veterans' mental status inconsistent with evidence in medical examination reports.
- Lack of nexus: Improperly granting service connection for PTSD without a medical opinion linking a current diagnosis of PTSD to a claimed, in-service stressful event.
- Additional benefits not considered: Not considering entitlements, such as Dependents' Educational Assistance.

Effective July 13, 2010, VA amended its rule for processing PTSD disability compensation claims. The new rule allows VARO staff to rely on a veteran's lay testimony alone to establish a stressor related to fear of hostile military or terrorist activity, provided the claimed stressor is consistent with the circumstances of service. Prior to the rule change, we identified a 13 percent error rate associated with PTSD claims processing. From the date of the rule change until September 2010, however, we identified a 5 percent error rate. Because of this noticeable improvement in PTSD claims processing, we made no recommendations for corrective actions in this area. We may modify our review of PTSD claims in future inspections until VAROs have sufficient time to implement fully the amended rule.

TBI Claims

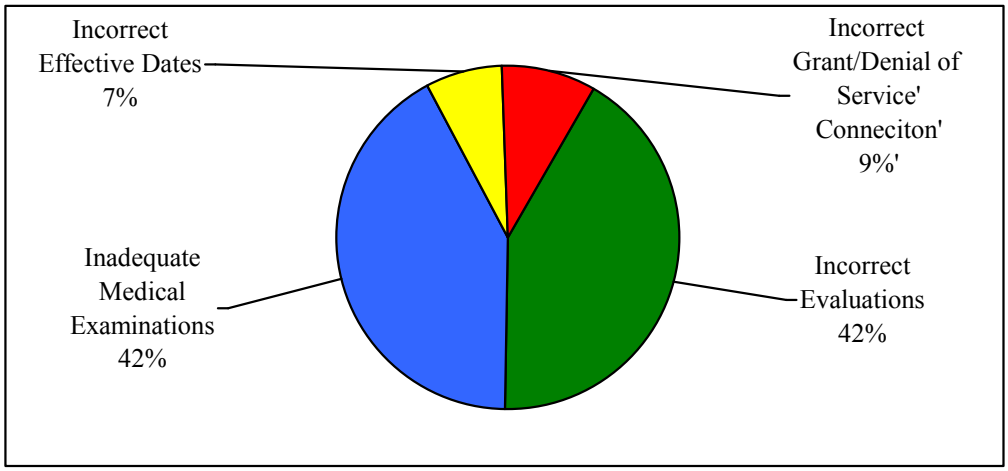
Of the 16 VAROs inspected, 12 (75 percent) did not follow VBA policy when processing claims for residuals of TBI. The Department of Defense and VBA commonly define a TBI as a traumatically induced structural injury or physiological disruption of brain function because of an external force. The major residual disabilities of a TBI fall into three main categories-physical, cognitive, and behavioral. VBA policies require staff to evaluate residual disabilities.

We projected that VARO staff did not adequately process about 800 (19 percent) of approximately 4,100 TBI claims completed from April 2009 through July 2010. This generally occurred because VARO staff lacked sufficient experience and training to process TBI claims accurately. Further, some VAROs did not perform adequate quality reviews of completed TBI claims. For these reasons, veterans did not always receive accurate benefits.

Figure 3 reflects projected error rates by the types of TBI errors identified.'

Figure 3

Projected Error Rates in TBI Claims Processing



We estimated 42 percent of TBI errors occurred because VARO staff used medical examinations that did not contain sufficient information to make accurate benefit decisions. VA medical examiners did not always use the most current examination formats when conducting medical examinations. As such, some examiners provided VARO staff with medical examination reports that did not contain the necessary information to properly render disability determinations. Some RVSRs did not always return inadequate medical examinations to the appropriate medical facilities for correction as required by VBA policy.

Additionally, 42 percent of TBI errors occurred because RVSRs incorrectly evaluated TBI-related residual disabilities. VBA policy requires a separate evaluation for any disability with a distinct diagnosis related to a TBI, such as migraine headaches or tinnitus. However, in these instances, RVSRs did not grant separate evaluations for distinct disabilities related to TBI. In other cases, RVSRs provided separate evaluations for symptoms without medical examiners providing distinct diagnoses.

Neither VARO staff nor we can correctly ascertain all of the residual disabilities of TBIs without adequate medical examinations. As a result, veterans might not always receive accurate benefit payments. Following are descriptions of the remaining types of TBI claims processing errors.

- Incorrect Grant/Denial of service connection: Incorrectly granting or denying entitlement to benefits.
- Incorrect effective dates: Using wrong dates to establish benefits, often resulting in inaccurate payments to veterans.

During interviews, several VARO managers specifically attributed these errors to the complex policies regarding the TBI evaluation process, which RVSRs found difficult to follow. VBA training materials acknowledge that symptoms of co-existing mental disorders and TBI residuals commonly overlap; it can be hard or impossible for a VA medical examiner to attribute the overlapping symptoms to one specific disability. For example, if a veteran reports for a medical examination with symptoms of memory loss, examiners find it difficult to determine if those symptoms are a result of a TBI or a mental condition such as PTSD.

Based on the percentage of inadequate TBI medical examinations provided to VAROs, it appears physicians also had difficulty with this issue. Following are examples of inadequate medical examinations found during our inspections:

- Physicians did not identify if symptoms were related to mental disorders or residuals of TBI.
- Physicians did not fully evaluate all residual disabilities related to TBI.
- Physicians did not always provide distinct diagnoses.

Because of the complex policies related to processing TBI claims and the high percentage of inadequate medical examinations, VBA would benefit from having more experienced staff perform an additional level of review of these claims prior to finalizing benefit determinations. As a means to ensure adequate medical evidence when veterans claim TBI related-residual disabilities with co-existing mental conditions, VBA would benefit from requiring staff to request a current mental medical examination concurrently with medical examinations for TBI residuals.

Herbicide Exposure-Related Disability Claims

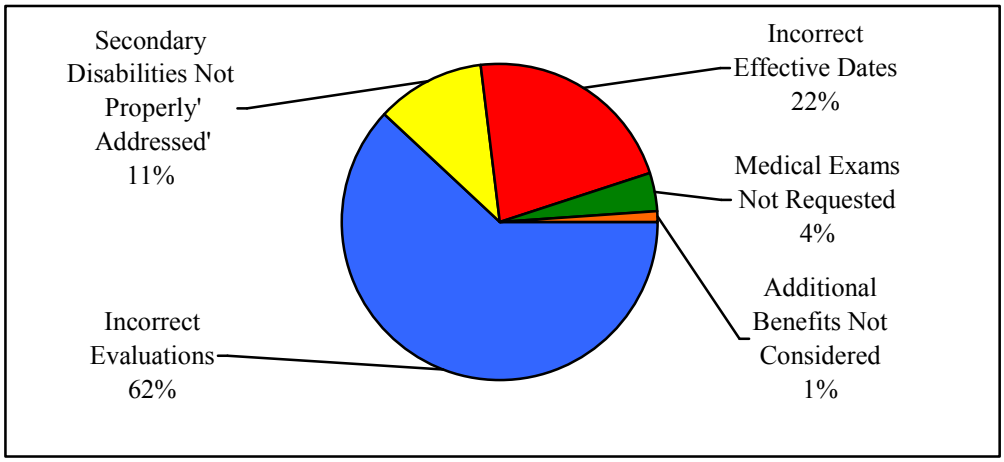
Of the 16 VAROs inspected, 7 (44 percent) did not follow VBA policy when processing herbicide exposure-related claims. VBA policy states for veterans claiming exposure to herbicide agents during active military service, certain disabilities should be service-connected, provided VBA has verification of the herbicide exposure and the disease manifested to a degree of 10 percent or more disabling at any time after discharge from service.

We projected that VARO staff did not adequately process about 800 (8 percent) of approximately 10,500 herbicide exposure-related disability claims completed from April 2009 through July 2010. These processing inaccuracies occurred because VARO staff lacked sufficient experience and training to process these types of claims accurately. Additionally, some VAROs did not perform adequate quality reviews of completed herbicide exposure-related claims. For these reasons, veterans did not always receive accurate benefits.

Figure 4 depicts projected error rates by type for herbicide exposure-related claims.

Figure 4

Projected Error Rates in Herbicide Exposure Claims Processing



The majority of inaccuracies occurred when VARO staff assigned incorrect evaluations for veterans' disabilities. For example, an RVSR incorrectly determined a veteran's service-connected diabetes was 40 percent disabling although medical evidence in the veteran's claims folder revealed the disability was 20 percent disabling. These incorrect evaluations involved both over/under payments to veterans.

Following are descriptions of the remaining types of herbicide exposure-related claims processing errors.

- Incorrect effective dates: Using wrong dates to establish benefits, often resulting in inaccurate payments to veterans.
- Improperly addressed secondary disabilities: Improperly granting or denying benefits for secondary conditions related to disabilities such as diabetes and prostate cancer. This might include making incorrect decisions regarding renal dysfunction caused by diabetes.
- Medical examinations not requested: Failing to request follow-up medical examinations to determine a veteran's current level of disability.
- Additional benefits not considered: Not considering additional benefits, such as allowances for adaptive automobile equipment.

Haas Claims

Of the six VAROs inspected for compliance with this issue, five (83 percent) did not follow VBA policy when processing these claims. Haas claims involve veterans who served in waters off Vietnam, never having set foot in Vietnam, and whether those veterans are entitled to the presumption of exposure to herbicide agents, including Agent Orange.

VA's interpretation of the 38 Code of Federal Regulations was that a service member had to have actually set foot on Vietnamese soil or served on craft in its rivers in order to be entitled to the presumption of exposure to herbicides. The Court of Appeals for Veterans Claims in *Haas vs. Nicholson* determined that Vietnam veterans who served in the waters off Vietnam and did not set foot in Vietnam were entitled to a presumption of exposure to herbicide agents, including Agent Orange.

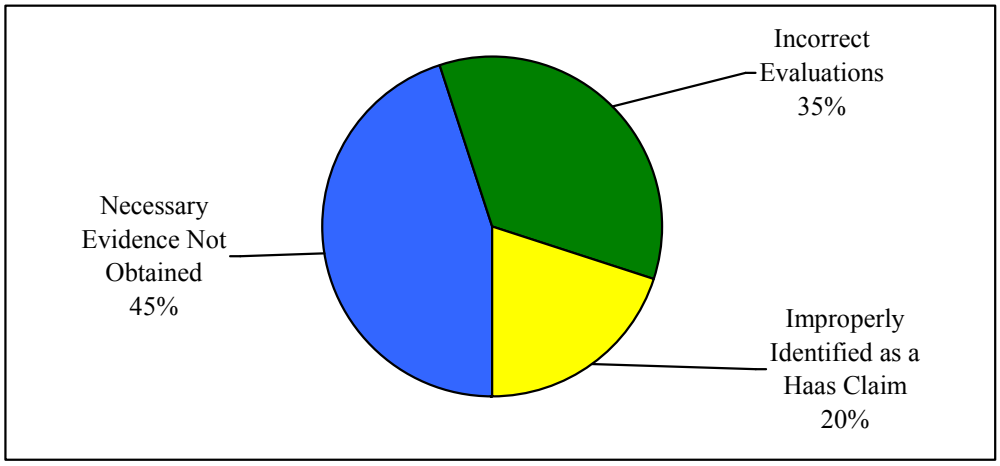
VA appealed this decision to the U.S. Court of Appeals for the Federal Circuit and put a stay of adjudication on Haas claims. VA lifted the stay in January 2009 after the Federal Circuit reversed the decision by the Court of Appeals for Veterans Claims and the Supreme Court denied petition to review the case.

We projected that VARO staff did not adequately process about 850 (13 percent) of approximately 6,400 Haas claims completed from April 2009 through September 2009. These processing inaccuracies occurred because VARO staff lacked sufficient experience and training to process these claims accurately.

Additionally, some VAROs were not conducting monthly quality assurance reviews that could have provided the oversight needed to identify and correct Haas claims processing errors. For these reasons, veterans did not always receive accurate benefits. Figure 5 depicts projected error rates by type of error in processing Haas claims.

Figure 5

Projected Error Rates in Haas Claims Processing



The majority of the inaccuracies occurred because Veterans Service Representatives (VSRs) did not develop necessary evidence to support rating decisions. The remaining errors consisted of incorrect evaluations and improper delays of claims by placing them under the Haas stay. In one

instance, the VARO received evidence one month after a veteran submitted his claim, enabling staff to decide the case immediately. However, VARO staff did not complete the claim for 6 months.

We discontinued our review of Haas claims because VA lifted the stay and VBA resumed processing these claims. Ultimately, completed Haas claims are included in our universe of herbicide claims for future inspections.

Previous Recommendations

To improve the accuracy of disability claims processing, we made 37 recommendations to VARO Directors, including the following:

- Review all temporary 100 percent disability evaluations under their jurisdictions to determine if reevaluations are required and take appropriate actions.
- Implement controls to ensure staff establish suspense diaries for temporary 100 percent disability reevaluations.
- Provide training to ensure RVSRs properly evaluate PTSD, TBI, and herbicide exposure-related disabilities, and Haas claims.
- Provide training to ensure RVSRs recognize inadequate TBI examinations.
- Improve oversight of the quality assurance process to ensure staff follow correct procedures for processing PTSD, TBI, and herbicide exposure-related disabilities, and Haas claims.

VARO Directors reported they have implemented corrective measures in response to all 37 recommendations related to claims processing. The following recommendation will address systemic issues related to processing disability claims for TBI-related residuals.

Recommendation

1.&We recommend the Acting Under Secretary for Benefits work collaboratively with the Under Secretary for Health to ensure that all clinicians performing traumatic brain injury compensation and pension examinations complete the new training for traumatic brain injury available in the VA Learning Management System under VA Item Number 7833, Compensation and Pension Evaluation Program Traumatic Brain Injury Examination.

2.&We recommend the Acting Under Secretary for Benefits develop and implement a strategy for ensuring the accuracy of decisions on traumatic brain injury claims, prior to finalizing benefit payments.

3.&We recommend the Acting Under Secretary for Benefits collaborate with the Veterans Health Administration to develop and implement a mechanism to ensure that when a veteran has a mental disability co-existing with a traumatic brain injury examination, medical examiners clearly state in their examination reports which emotional/behavioral signs and symptoms are related to which disability.

Management Comments

The Acting Under Secretary for Benefits concurred with our recommendations for improving areas related to the processing of traumatic brain injury claims. He informed us that VBA is working collaboratively with the Under Secretary for Health to ensure that clinicians performing TBI C P medical examinations complete new training modules on proper procedures for completing these types of exams. The Under Secretary for Benefits stated that VAROs will now require a second signature review on traumatic brain injury cases for each RVSR until the RVSR can demonstrate a 90 percent quality score on these types of decisions. Further, VBA will collaborate with the Veterans Health Administration's Disability Examination Management Office to ensure medical examiners clearly delineate between emotional/behavioral signs and symptoms relating to a traumatic brain injury and those relating to a co-existing mental condition.

OIG Response

Management's comments and actions are responsive to the recommendations. We will follow up on the implementation of these recommendations during future inspections.

2. Data Integrity

Notices of Disagreement

VAROs did not always establish Notices of Disagreement (NODs) within VBA's 7-day standard. An NOD is a written communication from a claimant expressing dissatisfaction or disagreement with a decision and desiring to contest the decision. It is the first step in the appeals process. The Veterans Appeals Control and Locator System (VACOLS) is an application that allows VARO staff to control and track veterans' appeals and manage the office's appeals workload. The effectiveness of VACOLS is dependent upon the quality of information entered.

Finding 2 Controls Over Notices of Disagreement Need Strengthening

We inspected controls over NOD processing at eight VAROs. Of those, 6 VAROs (75 percent) did not timely control NODs in VACOLS. VARO staff exceeded VBA's 7-day standard for 108 (37 percent) of 294 NODs reviewed. Staff took an average of 21 days to record the 108 disagreements into VACOLS. The VAROs nonetheless generally met VBA's pending timeliness goal of 145 days for NOD processing. The untimely recording of NODs in VACOLS occurred because of a lack of staff training and inadequate oversight of the appeals workload. Further, one VARO did not consider this work a priority and one VARO did not utilize available electronic databases to assist in timely NOD recording. Delays in recording NODs affect the integrity of VACOLS data and misrepresent performance.

Data integrity issues we identified make it difficult for VAROs and senior VBA leadership to accurately measure and monitor the performance of regional offices. Delays in recording NODs in VACOLS misrepresent VBA's NOD inventory and timeliness--both critical elements for consideration in workload decisions. Further, VBA's National Call Centers rely upon VACOLS information to provide accurate customer service to veterans regarding their appeals.

Previous Recommendations

To ensure timely establishment of NODs, we made six recommendations to VARO Directors, including the following:

- Develop and implement a plan to train Triage Team members on proper NODs identification.
- Develop and implement a plan to establish NODs in VACOLS within VBA's 7-day standard.

Regional Office Directors reported they have implemented improvements in response to these recommendations. We will follow up on these recommendations during future inspections.

3. Management Controls

Systematic Technical Accuracy Review

We assessed management controls to determine if the VAROs adhered to VBA policy regarding correction of errors identified by VBA's Systematic Technical Accuracy Review (STAR) staff. The STAR Program is VBA's multi-faceted quality assurance program to ensure veterans and other beneficiaries receive accurate and consistent C P benefits. VBA policy requires that VAROs take corrective actions on errors the STAR Program identifies. Management needs to strengthen oversight to ensure that VARO staff correct or appropriately address errors identified by VBA's STAR Program staff.

Finding 3 Errors Identified by STAR Program Not Always Corrected

Of the 16 VAROs inspected, seven (44 percent) did not follow VBA policy when correcting errors identified by VBA's STAR staff. VARO staff did not properly correct 33 (11 percent) of the 294 errors reviewed although VSC management erroneously reported to STAR staff that all corrective actions were completed. In all instances, VSC management did not provide oversight to ensure correction of the errors identified. Because VARO staff did not correct these errors, they lacked assurance that veterans and other beneficiaries received accurate and consistent benefits. For example, VBA underpaid two veterans a total of $21,476 due to uncorrected STAR errors.

In March 2010, the OIG provided testimony to Congress regarding VBA's quality assurance processes. We stated that most regional offices did not have formal procedures in place to ensure employees took corrective actions on errors identified by STAR staff.

Systematic Analysis of Operations

We assessed whether VARO management timely completed Systematic Analyses of Operations (SAOs). SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VBA policy requires VSCs perform SAOs annually, covering all aspects of claims processing, including quality, timeliness, and related factors.

Finding 4 Improved Oversight is Needed to Ensure Timely and Complete SAOs

Six (38 percent) of the 16 regional offices did not follow VBA policy to ensure SAOs were timely and complete. We determined a total of 53 (30 percent) of 175 SAOs were untimely and/or incomplete. This occurred because VARO management did not provide oversight to ensure SAOs addressed all necessary elements and operations of the VSC. By not completing SAOs as required by VBA policy, management may fail to identify existing or potential problems that could hamper effective delivery of benefits and services to veterans.

Of those six VAROs that had untimely and/or incomplete SAOs, five had the lowest performance in other operational activities inspected, such as claims processing, mail handling, and data integrity. At five VAROs, vacancies in senior management positions contributed to delays in completing SAOs and implementing corrective actions. Additionally, one of those five offices considered SAOs to be of little or no value toward improving VARO performance.

Conversely, five other VAROs that ensured SAOs were timely and complete were the most compliant in other operational activities we inspected. Based on this analysis, we see a correlation between VAROs producing complete and timely SAOs and VSC compliance with other VBA policies. VBA would benefit from conducting a further analysis of VARO performance in comparison to timely completion of SAOs.

Management Vacancies

We recognize a number of factors can affect VARO performance. However, based on our reviews, vacancies in senior management positions seemed to have a negative impact on VARO operations. Of the top five compliant VAROs, senior management remained relatively unchanged. Conversely, four of the five least compliant VAROs had prolonged vacancies in key VARO leadership positions, including the VARO Director and the Veterans Service Center Manager positions. We believe prolonged vacancies in these positions were a contributing factor to the high level of noncompliant activities.

Of the activities inspected, the following VAROs were the lowest performing, San Juan, Waco, Albuquerque, Anchorage, and Baltimore. With the exception of the Waco, these VAROs had Director or VSCM positions vacant or filled with temporary staff for periods of 5 months, or greater.

Table 2 shows the most compliant and least compliant VAROs and the corresponding vacancies.

Table 2

Comparison of Management Vacancies to Inspection Compliance

VARO	Inspection Compliance Rate*	SAO Compliance	Vacant or Temporarily-Filled Position	Longest Period of Vacancy
Five most compliant VAROs				
Jackson	70%	Y	None	None
Denver	67%	Y	None	None
Cheyenne	63%	Y	None	None
Muskogee	60%	Y	None	None
Roanoke	57%	Y	None	None
Five least compliant VAROs				
San Juan	33%	N	Director	5 months
Waco	25%	N	None	None
Albuquerque	22%	N	Director VSCM	8 months
Anchorage	7%	N	VSCM	8 months
Baltimore	7%	N	VSCM	6 months

*As reported in Appendix D

The Director of the Salt Lake City VARO is responsible for overseeing operations at the Anchorage VARO. During the 8-month absence of the Anchorage Veterans Service Center Manager, that office did not have any senior leadership physically in place to manage and oversee operations. Further, the St. Petersburg VARO Director provided oversight of the San Juan VARO during the period that its Director position was vacant.

We believe, based on our reviews, VBA would benefit from conducting further analysis on improving the timely selection and replacement of key VARO leadership positions.

Previous Recommendations

To improve oversight related to the correction of errors identified by STAR staff and the completion of SAOs, we made 13 recommendations to VARO Directors, including the following:

- Develop a plan to ensure VSC management takes corrective action to address errors identified by STAR Program staff.
- Develop and implement a mechanism to ensure the VSC management team performs complete analyses of VSC operations within the prescribed time and takes appropriate corrective actions to address identified problems.

Regional Office Directors reported they have implemented improvements in response to these recommendations. We will make no recommendations regarding SAOs and management vacancies at this time and we will continue to monitor these during future inspections.

4. Workload Management and Information Security

VARO Mail Processing Procedures

We assessed controls over VARO mailroom operations to ensure staff timely and accurately processed incoming mail. Further, we assessed the VSC's Triage Team procedures to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. We determined that controls over VARO mailroom operations and Triage Team mail processing procedures need strengthening.

Finding 5 Controls over VARO Mail Processing Need Strengthening

Of the 16 VAROs inspected, 12 (75 percent) did not always control and process mail according to VBA policy. This occurred because VARO management and staff were generally unaware of policy requirements, including date stamping, governing mail processing at VA facilities. Further, VARO workload management plans contained unclear procedures or first-line supervisors did not always follow guidance delineated in these plans. Consequently, beneficiaries may not have received accurate or timely benefit payments.

At three (19 percent) of the VAROs inspected, mailroom staff did not always process all incoming mail daily, including not date stamping all mail the same day it arrived in the VA facility as required by VBA policy. Typically, the mail delivery date determines the date VBA will pay benefits to veterans or beneficiaries.

Generally, a benefit payment date is the first of the month following the date stamped on the incoming claim. For example, if mailroom staff properly date stamp claims-related mail received on January 31, the benefits would be payable on February 1. However, if mailroom staff improperly date stamp this same mail on February 1, the payment date would be March 1, and VARO staff would unintentionally underpay the beneficiary by 1 month. Neither VARO employees nor we could identify specific veterans' claims affected by this incorrect process.

Triage Mail Processing Procedures

At 10 (63 percent) of the 16 VAROs, staff untimely controlled and improperly managed claims-related mail. Triage Teams are responsible for reviewing, controlling, and processing or routing all incoming mail received from the VARO mailroom. Triage Teams did not always control incoming mail within 7 days of receipt or use the Control of Veterans Records System (COVERS) to electronically track search mail as VBA policy requires. Search mail is active claims-related mail waiting to be associated with a veteran's claims folder. Following is a summation of our review of individual pieces of mail and the associated mail handling weaknesses we identified.

- Staff did not control 25 (21 percent) of 120 pieces of incoming mail in the electronic system within 7 days of receipt, as required.
- Staff did not properly use COVERS to ensure timely processing and control of 57 (24 percent) of 240 pieces of search mail.

Untimely association of search mail with veterans' claims folders can cause delays in processing disability claims. Because VARO staff did not properly use COVERS to control search mail, RVSRs did not always consider all available evidence when making disability determinations.

We issued a Management Advisory to the Veterans Health Administration's Under Secretary for Health requesting action to develop procedures for ensuring prompt return of veterans' claims folders. We issued this advisory because at one VARO, we found 1,462 pieces of search mail, 476 (33 percent) of which were waiting to be associated with claims folders temporarily located at a VA Medical Center. Untimely return of claims folders following completion of examinations has resulted in claims processing delays because VARO staff could not associate claims-related mail with the appropriate folders.

The Director of the Eastern Colorado Health Care System implemented Standard Operating Procedures that provided guidance for employees to return claims folders to the VARO upon completion of medical examinations. Further, the Director instructed staff to use COVERS to track the location of claims folder and return them to the VARO once physicians complete medical examinations.

Destruction and Safeguarding of Documents

In September 2009, we issued *Audit of VA Regional Office Claim-Related Mail Processing*, (Report No. 08-01759-234), which disclosed that VARO mailrooms needed improvements in the handling, processing, and protection of claims-related documents. In addition, staff had inappropriately placed some claims-related documents in shred bins. In response to this report, VBA issued policy stating that under no circumstances will claims or guardianship files, loose mail, or material of any kind that has

claimant/veteran Personally Identifiable Identification (PII) be stored in desk drawers, credenzas, personal two-drawer lockable cabinets, or other personal storage containers.

Finding 6 Veterans' Personally Identifiable Information Not Always Safeguarded

We inspected controls over the safeguarding of PII at nine VAROs and found those nine did not always safeguard veterans' PII. During those inspections, we found 78 instances (42 percent) of improper safeguarding of veterans' sensitive information. VBA policy requires supervisors to perform routine inspections of workstations; however, some VAROs were not performing these inspections as directed. As a result, VAROs did not always properly safeguard veterans' PII.

Although we found no evidence of improper document destruction, we did find evidence of improper storage of documents and other materials containing PII. Examples of unsecured items were training materials, original claims documentation including service treatment records, and administrative-type reports, all with veterans' identifiable information. In addition, we discovered claims documentation improperly marked for shredding and an unauthorized paper-shredding machine.

In September 2009, we submitted a Management Advisory to the Under Secretary for Benefits recommending VBA issue to all VAROs immediate guidance on safeguarding the handling and storage of Deoxyribonucleic Acid (DNA) specimens labeled with PII. We issued this advisory because at one VARO we found within a common area in the VSC an unmarked shipping box containing 14 DNA specimen packages, one laboratory glass vial, and 23 dental x-rays, all containing veterans' names and Social Security numbers (Initially, this material was associated with the veterans' service treatment records and improperly removed by VARO staff). VBA issued guidance to VAROs indicating that staff should shred or incinerate this type of material. We discontinued our review of this topic because the majority of the material found was relatively low-risk such as unredacted training materials.

Previous Recommendations

To improve controls over processing mail and safeguarding veterans' PII, we made 24 recommendations to VARO Directors, including the following:

- Develop and implement a plan to ensure all mail is properly controlled and processed within the Triage Team.
- Develop and implement a plan to ensure VSC staff are timely and correctly recording incoming mail in the electronic record and promptly retrieving search mail to enable accurate benefits decisions.

- Develop and implement a plan to ensure staff process and date stamp all incoming mail the same day it arrives in the VARO mailroom.
- Develop and implement a plan to ensure supervisors and records management officers consistently perform thorough reviews of workstations and common areas to ensure safeguarding of veterans' PII.

Regional Office Directors reported they have implemented improvements in response to these recommendations. We will follow up on these recommendations during future inspections.

5. Eligibility Determinations

Competency Determinations

Controls over the processing of competency determinations need strengthening. VA must consider the competency of beneficiaries in every case involving a mental health condition that is totally disabling or when evidence raises a question as to a beneficiary's mental capacity to manage his or her financial affairs, including VA benefits. We reviewed competency determinations at 7 of the 16 VAROs and identified several areas for improvement. We did not examine eligibility determinations at all VAROs because VBA has centralized fiduciary activities in their Western Area at the Salt Lake City VARO.

Finding 7 Controls over Competency Determinations Need Strengthening

We determined staff at seven VAROs unnecessarily delayed making final competency decisions in 54 (34 percent) of 159 cases completed from April 2009 to March 2010. These delays ranged from approximately 17 to 530 days. The delays occurred because VARO workload management plans did not make competency determinations a priority or include measures for oversight of this work. As a result, incompetent beneficiaries received their benefits directly without fiduciaries in place to manage their financial resources. While the beneficiaries were entitled to these payments, fiduciary stewardship may have been needed to ensure effective funds management and the welfare of the beneficiaries.

VBA policy requires staff to prepare a rating decision proposing a finding of incompetency after receiving clear and convincing medical evidence the beneficiary is incapable of managing his or her affairs. Prior to making a final decision, policy allows a 65-day due process period for the beneficiary to submit evidence showing he or she is capable of independently handling funds and managing his or her affairs. At the end of the due process period, VARO staff must immediately take final action to determine if the beneficiary is incompetent.

In the absence of VBA providing a clear definition of "immediate," we allowed 14 calendar days after the due process period to determine if staff were timely completing competency decisions. We considered 14 calendar days a reasonable period to take final action on competency determinations if staff used available computer applications to track these claims.

Our inspections revealed VARO managers have different interpretations of "immediate." Following are varying perspectives and definitions of "immediate" provided by managers at six of the seven VAROs inspected.

- One Director stated the term was unrealistic.
- One Director stated the definition changes with the station's workload.
- Four VSC Managers stated the term meant 3 to 30 days.

Such responses indicate the term "immediate" is not clear or consistent, leaving the interpretation of this standard to the discretion of VARO leadership. However, regardless of the differing definitions, three of the VAROs did not process competency determinations within their own definition or our 14-day standard. In addition, managers at one VARO were unaware of the requirement to complete these decisions "immediately" until we informed them of the policy.

The risk of incompetent beneficiaries receiving benefit payments without fiduciaries assigned to manage those funds increases if staff do not complete competency determinations promptly. As a result, in August 2010, we issued a Management Advisory to VBA's Director of C P Service recommending VBA establish a clear standard for timely completion of final competency determinations. In October 2010, the Director of C P Service responded to our Management Advisory, disagreeing with our recommendation and informing us "immediate" is sufficient as a clear standard.

The Director also informed us that the C P Site Visit team (a VBA internal quality control program) would modify their protocols to include a review of competency determinations to ensure VARO staff take immediate action to process them. However, the Director did not indicate how the C P Site Visit team would measure "immediate" completion of these determinations. We still believe VBA needs to create a measurable standard to reduce the risk of incompetent beneficiaries receiving monthly benefits without fiduciaries in place to manage those funds.

In addition to the inaccuracies related to processing delays, we identified 10 instances where VARO staff did not follow VBA policy when determining if beneficiaries were competent to handle VA funds. In five cases, VARO staff incorrectly determined beneficiaries were incompetent

without adequate medical evidence demonstrating they could not manage their affairs. In four cases, VAROs determined the beneficiaries were incompetent without providing the mandatory 65-day due process period for the beneficiaries to provide evidence to the contrary. Such practices resulted in $97,763 provided to fiduciaries that VSC staff prematurely or erroneously appointed. The remaining case involved an RVSR who did not properly assess a veteran's competency despite medical evidence indicating the veteran had difficulty managing his affairs.

Previous Recommendations

To improve the accuracy and timeliness of eligibility determinations, we made six recommendations to VARO Directors, including the following:

- Provide training to ensure RVSRs follow VBA policy when making competency determinations.
- Develop and implement a plan to increase oversight to ensure immediate completion of final competency determinations.

Regional Office Directors reported they have implemented improvements in response to these recommendations. We will follow up on these recommendations during future inspections.

Recommendation

4.&We recommend the Acting Under Secretary for Benefits develop a clear and measurable standard for timely completion of competency determinations.

Management Comments

The Acting Under Secretary for Benefits concurred with our recommendation and stated a 21-day standard will be sufficient time to complete competency determinations. Further, VBA will issue written guidance on this and notify field offices during weekly Office of Field Operations conference calls and monthly Veterans Service Center Managers' bulletins.

OIG Response

The Acting Under Secretary for Benefits' comments and actions are responsive to the recommendation. We will follow up on the implementation of this recommendation during future inspections.

Appendix A Scope of the Inspections

Scope

This report is a summary of systemic issues identified during 16 VARO inspections performed between April 2009 and July 2010. This summary report focused on 11 operational activities in 5 protocol areas, as outlined below.

Table 3

Protocols and Operational Activities Inspected

Protocol	Operational Activity
Claims Processing Issues	• Temporary 100 Percent Disability Evaluations • Post-Traumatic Stress Disorder • Traumatic Brain Injury • Herbicide Exposure-related disabilities • Haas
Data Integrity	• Notices of Disagreement
Management Controls	• Systematic Technical Accuracy Review • Systematic Analysis of Operations
Workload Management and Information Security	• Mail Handling Procedures • Destruction and Safeguarding of Documents
Eligibility Determinations	• Competency Determinations

Methodology

We designed the five protocols based on a risk analysis of previous OIG national audits and Combined Assessment Reviews, VBA's C P Site Visit reports, Government Accountability Office reports, and information provided by the Senate and House Veterans Affairs Committees. We review the protocols annually to identify new high-risk areas and make adjustments as necessary. Generally, we determined a VARO was non-compliant in an inspection area if the error rate was 10 percent or greater.

The Claims Processing protocol encompassed a review of 1,614 (16 percent) of 10,304 claims requiring rating decisions, completed from October 2008 through March 2010. Of those, 1,337 (83 percent) were related to PTSD, TBI, herbicide exposure, and Haas cases that VAROs completed. The remaining 277 (17 percent) involved rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months, generally the longest period under VBA policy such evaluations can be assigned without review. We reviewed these temporary 100 percent disability evaluations at 10 VAROs from October 2009 through July 2010.

The Data Integrity protocol involved reviewing 294 NODs to ensure timely reporting in VACOLS. The Management Controls protocol entailed determining whether VARO staff followed policy regarding correction of 294 errors identified by VBA STAR staff. Additionally, we determined if VARO management ensured 175 SAOs were timely and complete.

The Workload Management and Information Security protocol encompassed a review of 120 individual pieces of newly received mail to determine if VARO staff timely placed it under electronic control. In addition, we reviewed 240 individual pieces of mail to determine if VARO staff properly used COVERS to track and control the mail. We observed VARO mailroom operations with regard to receipt and initial date stamping of incoming mail. We conducted inspections of 186 employee workstations and unassigned areas to ensure VAROs properly safeguarded veterans' PII.

The Eligibility Determinations protocol entailed reviewing 159 competency determinations to ensure VARO staff avoided unnecessary delays in completing final decisions. Additionally, this review addressed the potential risk of mishandling VA benefits.

Reliability of Computer-Processed Data

We assessed the reliability of VBA electronic data by comparing selected data elements to documentation in the claims folders (such as veterans' names, dates of birth, and Social Security Numbers). We concluded that the data used to accomplish the objectives was sufficiently reliable.

Compliance with Quality Standards for Inspection

Our assessment of internal controls focused on those controls relating to our inspection objectives. We conducted our review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspections.* These standards require that we plan and perform the inspections to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions.

Appendix B Acting Under Secretary for Benefits Comments

Department of Veterans Affairs

Memorandum

Date: April 26, 2011

From: Acting Under Secretary for Benefits (20)

Subj: Systemic Issues Reported During Inspections at VA Regional Offices

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

1. Attached is VBA's response to the OIG's Draft Report: Systemic Issues Reported During Inspections at VA Regional Offices.

2. Questions may be referred to Catherine Milano, Program Analyst, at 202-461-9216.

(original signed by:)

Michael Walcoff

Attachment

Veterans Benefits Administration (VBA)

Comments on OIG Draft Report

Systemic Issues Reported During Inspections at VA Regional Offices

The Veterans Benefits Administration provides the following comments:

In the "Report Highlights" and in Finding 1, OIG discusses VBA's challenges in processing disability compensation claims related to temporary 100 percent disability evaluations as found through VA Regional Office (VARO) inspections and the January 2011, *Audit of VBA's 100 Percent Disability Evaluations*. The OIG draft attributes the cause of the errors identified to RO staff not correctly processing evaluations. However, during the January 2011 audit, the OIG noted a significant number of cases identified in which RO staff did correctly establish future exam dates in the disability review process, but the computer system did not properly maintain the future exam dates. VBA identified multiple computer system errors, rather than employee error, that accounted for a high percentage of the tracking or monitoring errors noted by the OIG. These systemic errors and VBA's efforts to complete necessary software corrections were acknowledged by OIG in the January 2011 audit report. They should also be included in this report.

VBA makes every effort to ensure that Veterans are paid correctly and disability evaluations are assigned appropriately at all levels. We continue to identify system enhancements as the most effective protocol for making certain that future examinations are entered in the electronic record for all temporary 100 percent evaluations.

Page 3, third paragraph:

VBA Comment: VBA is addressing the errors identified in the January 2011 *Audit of VBA's 100 Percent Disability Evaluations*, and we suggest the following verbiage be added after the third paragraph:

"VBA responded to this report and agreed to address the errors identified with temporary 100 percent evaluations. We noted in the report a significant number of cases in which RO staff did correctly establish future exam dates in the disability review process, but the computer system did not properly maintain the future exam dates. VBA identified multiple computer system errors, rather than employee error, that accounted for the high percentage of the tracking or monitoring errors. System enhancements are being identified by VBA as the most appropriate method of establishing future examinations for these cases. In the interim, regional office employees will be provided with instructions that would ensure future diaries are established and maintained from this point forward."

Page 6, fourth paragraph:

VBA Comment: The OIG noted improvement in Post Traumatic Stress Disorder (PTSD) claims processing since the rule change effective July 2010, and we suggest replacing this paragraph with the following verbiage:

"Prior to the rule change, we identified a 13 percent error rate associated with PTSD claims processing. From the date of the rule change until September 2010, however, we identified a 5 percent error rate. Because of this noticeable improvement in PTSD claims processing, we made no recommendations for improvement in this area. We may modify our review of PTSD claims in future inspections until VAROs have sufficient time to fully implement the amended rule."

The following comments are submitted in response to the recommendations in the OIG Draft Report:

Recommendation 1: We recommend the Acting Under Secretary for Benefits work collaboratively with the Under Secretary for Health to ensure that all clinicians performing traumatic brain injury compensation and pension examinations complete the new training for traumatic brain injury available in the VA Learning Management System under VA Item Number 7833, Compensation and Pension Evaluation Program Traumatic Brain Injury Examination.

VBA Response: Concur. VBA is collaborating with the Veterans Health Administration (VHA) to address this recommendation. VHA is ensuring that all compensation and pension (C P) examination providers have completed the training on traumatic brain injury (TBI) examinations that is published in the Learning Management System. This initiative is approximately 70 percent complete, and all clinicians performing TBI medical examinations will have completed this training no later than June 30, 2011.

Target Completion Date: June 30, 2011

Recommendation 2: We recommend the Acting Under Secretary for Benefits develop and implement a strategy for ensuring the accuracy of decisions on traumatic brain injury claims, prior to finalizing benefit payments.

VBA Response: Concur. VBA agrees to develop and implement a strategy for ensuring the accuracy of traumatic brain injury decisions. Regional offices will require a second signature on traumatic brain injury cases for each Rating Veterans Service Representative (RVSR) until the RVSR demonstrates a 90 percent quality average on a minimum of 10 TBI cases. Once an RVSR has reached a 90 percent 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.

Target Completion Date: September 30, 2011

Recommendation 3: We recommend the Acting Under Secretary for Benefits collaborate with the Veterans Health Administration to develop and implement a mechanism to ensure that when a veteran has a mental disability co-existing with a traumatic brain injury examination, medical examiners clearly state in their examination reports which emotional/behavioral signs and symptoms are related to which disability.

VBA Response: Concur. VBA will collaborate with the VHA's Disability Examination Management Office (DEMO) to ensure that medical examiners clearly state which emotional/behavioral signs and symptoms are related to which disability when there are co-existing mental disabilities. DEMO will send an information letter to all C P facilities to instruct providers to follow the current Traumatic Brain Injury (TBI) Examination worksheet, and to be certain that attempts are made to differentiate whether neuropsychiatric or behavioral signs and symptoms are related to the TBI diagnosis or another diagnosis. If they cannot make the differentiation, they must make a statement that they are unable to differentiate the source of the neuropsychiatric or behavioral signs or symptoms.

Target Completion Date: June 30, 2011

Recommendation 4: We recommend the Acting Under Secretary for Benefits develop a clear and measurable standard for timely completion of competency determinations.

VBA Response: Concur. VBA has reviewed this cadre of work and determined that a 21-day standard would be sufficient for timely completion of competency determinations. This will be measured from the date of expiration of due process to the date of completion. Guidance will be issued in a fast letter. Notice will also be provided to the field offices through the weekly Office of Field Operations conference call and the monthly Veterans Service Center Managers' bulletin.

Target Completion Date: June 30, 2011

Appendix C Statistical Sampling Methodology

Population

The population consisted of about 45,000 completed disability claims for temporary 100 percent disability evaluations, PTSD, TBI, herbicide exposure, and Haas across all 57 VAROs during the timeframe for our reviews.

Sampling Design

The sample is representative of the population from which it was drawn. We used probability-sampling methods that gave all veterans records a chance of selection. We inspected 16 VAROs during a fifteen-month timeframe. We reviewed the VAROs in random order so that these 16 first inspected form stage one of a representative two-stage random sample of all 57 VAROs. Within each VARO, we sampled claims in each of the five categories included in our review using simple random sampling techniques.

Weights

We weighted each sample benefits claim based on the probability of selection at each stage of sampling. The weights affected projections we ultimately made based on the sample results. We used the weights to project error rates, which would not equal error rates computed based on the raw number of records sampled.

Projections and Margins of Error

All sample projections shown in the body of this report are also included in Tables 4, 5, and 6 below along with their associated margins of error. We computed the margins of error and confidence intervals based on a 90 percent confidence interval. This means that 90 percent of all possible samples we could have selected under the same essential conditions would have produced a projection within the upper and lower limits of the 90 percent confidence interval.

Table 4: Projections and Margins of Error for Sample Results

Claim Type	Error Type	Projection	Margin of Error for 90% Confidence Interval	90% Confidence Interval		Sample Size for Error Type	Sample Size for Claim Type
				Lower Limit	Upper Limit		
Temporary 100 Percent Disability Evaluations	Number in Error	6,768	466	6,302	7,235	215	277
	Error Rate	81.7	4.3	77.4	85.9	215	
	Impact	19.8	4.9	14.9	24.7	52	
	Potential Impact	61.9	6.2	55.7	68.1	163	
PTSD	Number in Error	1,353	478	876	1,831	46	470
	Error Rate	8.4	2.9	5.6	11.3	46	
	Impact	4.5	1.6	2.9	6.1	26	
	Potential Impact	3.9	2.0	1.9	5.9	20	
TBI	Number in Error	788	169	619	957	79	325
	Error Rate	19.2	4.1	15.1	23.3	79	
	Impact	11.1	3.9	7.1	15.0	26	
	Potential Impact	8.1	1.8	6.3	9.9	53	
Herbicide Exposure-Related Claims	Number in Error	798	250	548	1,049	44	453
	Error Rate	7.6	2.3	5.3	9.9	44	
	Impact	6.2	2.0	4.2	8.2	34	
	Potential Impact	1.4	1.1	0.3	2.6	10	
Haas	Number in Error	847	383	465	1,230	21	89
	Error Rate	13.2	5.9	7.3	19.1	21	
	Impact	2.1	1.7	0.3	3.8	5	
	Potential Impact	11.1	6.1	5.0	17.3	16	
Total	Number in Error	10,555	1,746	8,809	12,301	405	1,614
	Error Rate	23.3	3.8	19.4	27.1	405	
	Impact	7.9	2.4	4.4	9.2	143	
	Potential Impact	15.3	3.3	12.1	18.6	262	

Table 5: Projections and Margins of Error for Sample Results

Claim Type	Pie Chart Section	Projection	Margin of Error for 90% Confidence Interval	90% Confidence Interval		Sample Size for Error Type	Sample Size for Claim Type
				Lower Limit	Upper Limit		
Temporary 100 Percent Disability Evaluations	C C Processing Errors	42.2	6.8	35.4	49.0	87	277
	Data Processing Errors	22.8	5.5	17.3	28.3	47	
	Rating Decision	10.5	3.8	6.8	14.3	25	
	Medical Exam Notifications not Processed	17.4	5.2	12.2	22.5	39	
	Failure to Follow-up on Reductions	7.1	3.8	3.4	10.9	17	
PTSD	Incorrect Effective Date	23.6	17.2	6.3	40.8	7	470
	Stressor Verification	38.4	16.7	21.8	55.1	13	
	Incorrect Evaluations	19.4	11.2	8.3	30.5	13	
	Additional Benefits not Considered	7.5	6.8	0.7	14.3	7	
	Lack of Nexus	11.1	7.5	3.6	18.5	6	
TBI	Incorrect effective date	7.4	8.4	0.0*	15.7	2	325
	Improperly Identifying Residual Disability	41.9	13.0	28.9	54.8	29	
	Inadequate Medical Examinations	41.9	10.3	31.7	52.2	41	
	Incorrect Evaluations	8.9	6.8	2.1	15.7	7	
Herbicide Exposure-Related Claims	Additional Benefits Not Considered	1.3	2.3	0.0*	3.6	1	453
	Incorrect Effective Date	22.2	13.8	8.4	36.0	10	
	Incorrect Evaluation	62.3	13.2	49.1	75.6	25	
	Medical Examinations not Requested	3.9	4.1	0.0*	8.0	3	
	Secondary Disability not Properly Considered	10.3	8.5	1.8	18.7	5	
Haas	Improperly Identified as Hass Claim	19.9	15.1	4.8	34.9	6	89
	Incorrect Evaluations	34.9	30.3	4.7	65.2	6	
	Necessary Evidence not Obtained	45.2	29.8	15.4	75.0	9	

*Lower limit of confidence interval equals sample finding.

Table 6: Projections and Margins of Error for Sample Results

Claim Type	Net Overpayment Estimate	Margin of Error for 90% Confidence Interval	90% Confidence Interval		Sample Size for Error Type	Sample Size for Claim Type
			Lower Limit	Upper Limit		
Temporary 100 Percent Disability Evaluations	$81,497,821	$29,316,988	$52,180,832	$110,814,809	215	277

Appendix D VARO Inspection Results

VARO	Operational Activities Inspected	Compliance With Number of Activities Inspected
Nashville	PTSD, TBI, Diabetes, Haas, Date of Claim, COVERS, SAO, STAR, Date Stamp Accountability, Claims Processing Improvement, Mail Handling, Destruction of Documents, Inquiry Routing and Information System (IRIS), Congressional Inquiries, and Fiduciary.	5 of 15 (33 percent)
Wilmington	PTSD, TBI, Diabetes, Haas, Date of Claim, COVERS, SAO, STAR, Date Stamp Accountability, Claims Processing Improvement, Mail Handling, Destruction of Documents, IRIS, Congressional Inquiries, and Fiduciary.	7 of 15 (47 percent)
Baltimore	PTSD, TBI, Diabetes, Haas, Date of Claim, COVERS, SAO, STAR, Date Stamp Accountability, Claims Processing Improvement, Mail Handling, Destruction of Documents, IRIS, Congressional Inquiries, and Fiduciary.	1 of 15 (7 percent)
San Juan	PTSD, TBI, Diabetes, Haas, Date of Claim, COVERS, SAO, STAR, Date Stamp Accountability, Claims Processing Improvement, Mail Handling, Destruction of Documents, IRIS, Congressional Inquiries, and Fiduciary.	5 of 15 (33 percent)
Anchorage	PTSD, TBI, Diabetes, Haas, Date of Claim, COVERS, SAO, STAR, Date Stamp Accountability, Claims Processing Improvement, Mail Handling, Destruction of Documents, IRIS, and Congressional Inquiries.	1 of 14 (7 percent)
Roanoke	PTSD, TBI, Diabetes, Haas, Date of Claim, COVERS, SAO, STAR, Date Stamp Accountability, Claims Processing Improvement, Mail Handling, Destruction of Documents, IRIS, and Congressional Inquiries.	8 of 14 (57 percent)
Togus	100 Percent Disability Evaluations, PTSD, TBI, Diabetes, Date of Claim, SAO, STAR, Date Stamp Accountability, Mail Handling, Destruction of Documents, and Incompetency Determinations.	4 of 11 (36 percent)
Philadelphia	100 Percent Disability Evaluations, PTSD, TBI, Diabetes, Date of Claim, SAO, STAR, Date Stamp Accountability, Mail Handling, Destruction of Documents, and Incompetency Determinations.	6 of 11 (55 percent)
Waco	100 Percent Disability Evaluations, PTSD, TBI, Diabetes, Date of Claim, NODs, SAO, STAR, Date Stamp Accountability, Mail Handling, Destruction of Documents, and Incompetency Determinations.	3 of 12 (25 percent)
Albuquerque	100 Percent Disability Evaluations, PTSD, TBI, Diabetes, Date of Claim, NODs, SAO, STAR, and Mail Handling.	2 of 9 (22 percent)
Muskogee	100 Percent Disability Evaluations, PTSD, TBI, Diabetes, Date of Claim, NODs, SAO, STAR, Mail Handling, and Incompetency Determinations.	6 of 10 (60 percent)
Denver	100 Percent Disability Evaluations, PTSD, TBI, Diabetes, Date of Claim, NODs, SAO, STAR, and Mail Handling.	6 of 9 (67 percent)
Cheyenne	100 Percent Disability Evaluations, PTSD, TBI, Diabetes, Date of Claim, NODs, STAR, and Mail Handling.	5 of 8 (63 percent)
Detroit	100 Percent Disability Evaluations, PTSD, TBI, Diabetes, Date of Claim, NODs, SAO, STAR, Mail Handling, and Incompetency Determinations.	5 of 10 (50 percent)
Jackson	100 Percent Disability Evaluations, PTSD, TBI, Diabetes, Date of Claim, NODs, SAO, STAR, Mail Handling, and Incompetency Determinations.	7 of 10 (70 percent)
Newark	100 Percent Disability Evaluations, PTSD, TBI, Diabetes, Date of Claim, NODs, SAO, STAR, Mail Handling, and Incompetency Determinations.	4 of 10 (40 percent)

Appendix E OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments&	Brent Arronte, Director Kristine Abramo Daphne Brantley Brett Byrd Robert Campbell Madeline Cantu Danny Clay Kelly Crawford Ramon Figueroa Lee Giesbrecht Kerri Leggiero-Yglesias Nora Stokes Lisa Van Haeren Mark Ward

Appendix F Report Distribution

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