VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office San Juan, Puerto Rico

July 12, 2013
13-00586-228

ACRONYMS AND ABBREVIATIONS

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

Report Highlights: Inspection of VA Regional Office San Juan, Puerto Rico

Why We Did This Review

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

What We Found

VARO staff did not accurately process 26 (59 percent) of 44 disability claims we reviewed. We sampled claims that we considered to be at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing lacks consistent compliance with VBA procedures and is increasing the risk of inaccurate and unnecessary benefits.

Specifically, 21 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate, generally because VARO staff did not establish suspense diaries in the electronic record as required. Management did not provide effective oversight of second-signature reviews and therefore staff incorrectly processed 5 of 14 traumatic brain injury (TBI) claims completed from July through September 2012.

Systematic Analyses of Operations were incomplete and untimely. VARO managers lacked adequate measures to ensure staff addressed all required elements of the annual analyses and submitted them by the due dates. Further, staff did not always address or document decisions regarding Gulf War veterans' entitlement to mental health treatment. VARO staff provided adequate outreach to homeless veterans in the VARO's area of jurisdiction.

What We Recommend

The VARO Director should implement a plan to ensure staff enter suspense diaries in the electronic record and review for accuracy the 132 temporary 100 percent disability evaluations that we provided at the end of this inspection. Management should develop and implement a plan to ensure effective second-signature reviews of TBI claims. The Director also needs to implement a plan to ensure staff completely and timely address all required elements of Systematic Analyses of Operations.

Agency Comments

The VARO Director generally concurred with our recommendations. The Director non-concurred in part with the recommendation to review 132 temporary 100 percent disability evaluations because VBA is tracking these evaluations at a national level. Management's actions are responsive and we will follow up as required on the VARO's progress in completing its review of the 132 disability evaluations. The VARO expects appropriate action to be completed in June 2013.

LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

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

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

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

Scope of Inspection

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

We reviewed 30 (19 percent) of 162 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months. This is generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to Veterans Benefits Administration (VBA) policy. We examined the available 14 of the total 16 TBI claims that VARO staff had completed during the period July through September 2012.

Other Information

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

RESULTS AND RECOMMENDATIONS

I. Disability Claims Processing

Claims Processing Accuracy

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

Finding 1

San Juan VARO Could Improve Disability Claims Processing Accuracy

The San Juan VARO did not consistently process temporary 100 percent disability evaluations and TBI cases accurately. Overall, VARO staff incorrectly processed 26 of the total 44 disability claims we sampled, resulting in 140 improper monthly payments to 7 veterans totaling $208,368 and ranging from November 2007 until January 2013.

We sampled claims related to specific conditions we considered at higher risk of processing errors. As a result, the errors identified do not represent the universe of disability claims processed at this VARO. As reported by VBA's Systematic Technical Accuracy Review program as of November 2012, the overall accuracy of the VARO's compensation rating-related decisions was 80.5 percent—9.5 percentage points below VBA's FY 2013 target of 90 percent.

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

Table 1

San Juan VARO Disability Claims Processing Accuracy

Type of Claim	Reviewed	Claims Inaccurately Processed		
		Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits	Total
Temporary 100 Percent Disability Evaluations	30	5	16	21
Traumatic Brain Injury Claims	14	2	3	5
Total	**44**	**7**	**19**	**26**

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

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 21 of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a service-connected disability following a veteran's surgery or when specific treatment is needed. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

For temporary 100 percent disability evaluations, including confirmed and continued evaluations where rating decisions do not change veterans' payment amounts, VSC staff must input suspense diaries in VBA's electronic system. We identified 14 instances where suspense diaries were not established as required. A suspense diary is a processing command that establishes a date when VARO staff must schedule a reexamination. As a suspense diary matures, the electronic system generates a reminder to alert VARO staff to schedule the reexamination.

Without effective management of these temporary 100 percent disability ratings, VBA is at risk of paying inaccurate financial benefits. Available medical evidence showed 5 of the 21 processing errors we identified affected veterans' benefits and resulted in 104 improper monthly payments totaling $198,593 from as early as November 2007 until the time of our inspection. Details on the most significant overpayment and underpayment follow.

- A Rating Veterans Service Representative (RVSR) correctly continued a temporary 100 percent disability evaluation of a veteran's service-connected prostate cancer and annotated the need for a routine future examination in June 2007; however, VSC staff did not input a suspense diary in the electronic system as required. Therefore, a reminder notification to schedule the reexamination did not generate. VA treatment reports showed the veterans' prostate cancer was no longer active and the temporary 100 percent disability evaluation was no longer supportable per VBA's policies. As a result, VA overpaid the veteran $174,186 over a period of 5 years and 2 months.
- An RVSR did not establish a veteran's entitlement to special monthly compensation based on multiple disabilities, as required. As a result, VA underpaid the veteran $11,028 over a period of 2 years and 10 months.

The remaining 16 of the total 21 errors had the potential to affect veterans' benefits. In most cases, we could not determine whether the evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to reevaluate each case. In cases where routine future medical reexaminations were not scheduled as required, claims processing delays ranged from approximately 1 year and 2 months to 7 years and 1 month. An average of approximately 3 years and 5 months

elapsed from the time staff should have scheduled these medical reexaminations through January 2013.

Summaries of the total 21 errors we identified follow.

- Fourteen errors occurred when staff did not establish suspense diaries in the electronic record, thereby removing the possibility that staff would receive reminder notifications to schedule medical reexaminations.

- Two errors occurred when staff did not timely take final actions to reduce veterans' benefits after notifying them of the intent to do so. On average, approximately 3.5 months elapsed from the time staff should have reduced the benefits until the date of our inspection. The delays ranged from 2 to 5 months.
- One error occurred when an RVSR did not grant entitlement to Dependents' Educational Assistance when evidence in the claim folder showed the veteran's disabilities were permanently and totally disabling, thereby warranting the additional benefit.
- One error occurred when an RVSR did not establish the correct effective date for an increased evaluation for a veterans' prostate cancer. Based on the medical evidence, the veteran warranted an earlier effective date.
- One error occurred when an RVSR did not establish a veteran's entitlement to special monthly compensation based on multiple disabilities, as required.
- One error occurred when staff requested a medical examination for a veterans' prostate cancer but did not establish a pending work product to ensure they followed up and reviewed the examination results. Consequently, staff did not review the examination results and were unaware that the cancer was in remission and that a temporary 100 percent disability evaluation was no longer supported by medical evidence. Without a pending work product, VARO staff may never have taken action to reduce the temporary 100 percent disability evaluation to a disability level commensurate with the medical condition.
- One error occurred when an RVSR incorrectly continued a temporary 100 percent evaluation of a veteran's prostate cancer although medical evidence showed no active disease or symptoms.

In November 2009, VBA provided refresher guidance to VARO staff about the need to input suspense diaries to the electronic record to ensure reminders to schedule medical reexaminations. However, VARO management had no oversight procedure in place to ensure staff established the suspense diaries as required. Temporary 100 percent disability evaluations could have continued uninterrupted over veterans' lifetimes if we

had not identified the need for VARO staff to take actions to schedule reexaminations.

National Audit Follow-Up

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

However, VBA did not provide each VARO with a list of temporary 100 percent disability evaluations for review until September 2011. VBA subsequently extended the national review deadline to December 31, 2011, and then June 30, 2012, and then again to December 31, 2012. We remain concerned about the lack of urgency VBA demonstrated when completing this review, which is critical to minimize the financial risks of making inaccurate benefits payments. To date, our national audit recommendation for VBA to review all temporary 100 percent disability evaluations remains open. We do not intend to close this recommendation with VBA until our inspection results show a significant decrease in the types of errors identified during our national audit.

During our 2012 inspection, we followed up on VBA's national review of its temporary 100 percent disability evaluation processing. We sampled 40 cases from the lists of cases needing corrective actions that VBA provided to the San Juan VARO for review. We determined VARO staff accurately reported actions, such as inputting suspense diaries or scheduling reexaminations, on all 40 cases we reviewed. However, in comparing VBA's national review lists with our data on temporary 100 percent disability evaluations, we found 12 cases involving prostate cancer or non-Hodgkin's lymphoma that VBA had not identified. We will continue monitoring this situation as VBA works to complete its national review.

TBI Claims

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

In response to a recommendation in our annual report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-167, May 18, 2011), VBA agreed to develop and implement a strategy for ensuring accurate TBI claims rating decisions. In May 2011, VBA provided guidance to all VARO Directors to implement a policy

requiring a second-signature on each TBI case an RVSR evaluates until the RVSR demonstrates 90 percent accuracy in TBI claims processing. The policy indicates second signature reviewers come from the same pool of staff as those used to conduct local station quality reviews.

We determined that VARO staff incorrectly processed 5 of 14 TBI claims. Available medical evidence showed 2 of these errors affected veterans' benefits and resulted in 36 improper monthly payments totaling $9,775 from as early as February 2011 until the time of our inspection. Summaries of the two errors affecting veterans' benefits follow.

- An RVSR incorrectly evaluated a veteran's TBI residuals as 10 percent disabling based on a VA medical examination report noting subjective symptoms of memory, attention, concentration, and executive function impairments. However, the VA physician noted objective evidence of mild impairment based on testing, which supported a 40 percent evaluation. As a result, the veteran was underpaid approximately $5,467 over a period of 1 year and 11 months.
- An RVSR did not establish a veteran's entitlement to special monthly compensation based on evaluations of multiple disabilities as required by VBA policy. As a result, the veteran was underpaid approximately $4,308 over a period of 1 year and 1 month.

The remaining three processing errors had the potential to affect veterans' benefits.

- An RVSR incorrectly granted a veteran a separate evaluation for residuals of TBI when there was an existing co-morbid mental disorder for which an examiner could not delineate symptoms. In cases where medical examiners cannot delineate TBI and mental disorder symptoms, VBA policy requires that staff use those symptoms to establish a single disability evaluation.
- An RVSR prematurely denied a veteran service connection for residuals of TBI in the absence of a VA medical examination report to substantiate the denial. Nonetheless, the claim file included evidence of an in-service TBI and current symptomatology.
- An RVSR used an incomplete VA medical examination report to evaluate disabilities related to a TBI; specifically, the VA examiner did not delineate the TBI and post-traumatic stress symptoms as required. In this case, the RVSR used the same symptoms to assign evaluations for disabilities related to the TBI and post-traumatic stress disorder—a practice which is prohibited by VBA policy.

Generally, errors in TBI claims processing occurred because VARO management did not provide effective oversight of quality review

procedures. For example, VARO management did not track errors found during second-signature reviews to identify trends and areas for local training, as indicated by VBA policy. As a result, veterans may not always receive correct benefit decisions.

Follow Up to Prior VA OIG Inspection

Our prior report, *Inspection of the VA Regional Office, San Juan, Puerto Rico,* (Report No. 09-01996-41, December 4, 2009), stated 13 of the total 19 TBI claims reviewed had processing errors. The majority of the errors occurred because RVSRs used outdated TBI examination worksheets and therefore did not always fully assess all TBI residual disabilities. In response to our recommendations, the VARO Director reported rotating supervisors within the VSC and assigning a Decision Review Officer to the rating team to confront this challenge. The OIG closed this recommendation in August 2010. During our January 2013 inspection, we found no instances where staff used outdated TBI examination worksheets. Thus, the corrective actions put in place to address our 2009 inspection results were considered effective.

Recommendations

1. We recommend the San Juan VA Regional Office Director develop and implement a plan to ensure claims processing staff input suspense diaries to the electronic record as required.
2. We recommend the San Juan VA Regional Office Director develop and implement a plan to review for accuracy the 132 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.
3. We recommend the San Juan VA Regional Office Director develop and implement a plan to ensure effective second-signature reviews of traumatic brain injury claims decisions.

Management Comments

The VARO Director generally concurred with our recommendations. As part of its random compliance reviews, managers and quality review staff plan to revise an existing checklist to ensure staff properly enter suspense diaries in the electronic record. In July and August 2013, staff will receive training on processing claims in need of future examinations.

The VARO Director nonconcurred in part with recommendation 2. As we recommended, the VARO began a review of 132 temporary disability evaluations remaining from the OIG's inspection universe. However, the VARO discontinued this review after receiving revised guidance from the Southern Area Director on managing these types of disability claims. The revised guidance stated VBA would track temporary 100 percent disability evaluations at a national level and provided each VARO a list of claims to review. The San Juan VARO expects to complete its claims reviews for VBA by June 2013. A comparative review of VBA's national list and the

132 temporary disability evaluations remaining from the OIG's inspection universe was taking place to determine which cases still needed review.

VARO staff received training in May 2013 on second-signature requirements for traumatic brain injury claims. A Certified Decision Review Officer assigned to the Quality Review Team reviews all traumatic brain injury claims requiring second signature. Errors found during these second-signature reviews are tracked to identify training needs.

OIG Response

The Director's comments and actions are responsive to the recommendations. We will follow up regarding the VARO's progress in completing reviews of all 132 temporary 100 percent disability evaluations remaining from the OIG's inspection universe as part of the new VBA-directed national review effort.

II. Management Controls

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of SAOs. We also considered whether VSC staff used adequate data to support analyses and recommendations identified within each SAO. An SAO is a formal analysis of an organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish annual SAO schedules designating the staff required to complete the SAOs by specific dates. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 mandated SAOs annually.

Finding 2 **Oversight Is Needed To Ensure Timely and Complete Systematic Analyses of Operations**

Ten of the 11 mandated SAOs were incomplete (missing required elements) and/or untimely. This occurred because VARO management did not provide adequate oversight to ensure staff responsible for completing SAOs addressed all required elements or submitted the analyses by the due date. As a result, VARO management may not have adequately identified existing and potential problems for corrective action to improve VSC operations.

VARO management told us they recently instituted procedures for requesting extensions for SAO submissions in FY 2013. The new procedures require division chiefs to direct all extension requests to the Director's office for approval. We could not assess the effectiveness of this policy change because it occurred after we conducted our inspection.

Follow-Up to VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, San Juan, Puerto Rico* (Report No. 09-01996-41, December 4, 2009), we determined VARO staff did not timely or accurately complete 8 of the 11 SAOs available for review. VARO managers stated this occurred because of inadequate monitoring of employees responsible for completing the SAOs. In response to our recommendations, the Director reported providing training and close monitoring of SAO preparation activities to ensure complete, accurate, and timely submissions. The OIG closed this recommendation in August 2010; however, during our January 2013 inspection, we found VARO staff continued to struggle with providing complete and timely SAOs. Improvement in this area is not evident.

Recommendation

4. We recommend the San Juan VA Regional Office Director develop and implement a plan to ensure staff completely and timely address all required elements of Systematic Analyses of Operations.

Management Comments

The VARO Director concurred with our recommendation. In July 2013, VARO staff will receive additional training on completing SAOs. In addition, a standardized operating procedure will formalize the schedule, assignments, and clearly outline responsibilities for completing SAOs.

OIG Response

The Director's comments and actions are responsive to the recommendation. We are concerned that untimely and incomplete SAOs at the San Juan VARO continue to be an area of noncompliance since the OIG's December 2009 benefits inspection report and recommendations for improvement.

III. Eligibility Determinations

Entitlement to Medical Treatment for Mental Disorders

Gulf War veterans are eligible for medical treatment for any mental disorder they develop within 2 years of the date of separation from military service. According to VBA, whenever an RVSR denies a Gulf War veteran service connection for any 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 mental health care treatment when denying service connection for a mental disorder. This pop-up notification does not generate if a previous decision did not address entitlement to mental health services and a mental condition is not part of the current claim.

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

VARO staff did not properly address whether 7 of 30 Gulf War veterans were entitled to receive treatment for mental disorders, according to policy in effect as of December 17, 2012—the date we began our claims folder reviews. As a result, veterans may be unaware of their possible entitlement to treatment for mental disorders and may not get the care they need. Following are summaries of the seven errors observed.

- Three errors occurred when RVSRs correctly addressed the entitlement decisions but did not formally annotate them on the decision documents.
- Three errors occurred when RVSRs did not address veterans' entitlement to mental health treatment in the current disability decisions—in spite of pop-up notifications reminding them to do so.
- One error occurred when an RVSR did not address entitlement to mental health treatment on the current decision after a previous decision also did not address the issue.

In late December 2012, VBA modified its policy to state that RVSRs no longer have to address Gulf War veterans' entitlement to mental health care in all cases. RVSRs have to address this entitlement when the veteran's mental health benefit can be granted based on diagnosis of a mental disorder within 2 years of separation from military service. Because this policy modification became effective after we concluded our review of claims folders for the San Juan VARO inspection, we cannot determine whether the change might have affected the number of errors we identified. Therefore, we make no recommendation for improvement.

IV. Public Contact

Outreach to Homeless Veterans

In November 2009, VA developed a 5-year plan to end homelessness among veterans by assisting every eligible homeless veteran willing to accept service. VBA generally defines "homeless" as lacking a fixed, regular, and adequate nighttime residence.

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

We determined the San Juan VARO and VA Medical Center homeless veterans coordinators worked collaboratively by participating in community outreach events specific to homeless veterans in counties under the VARO's jurisdiction. Because the VARO provided information on VA benefits and services to homeless shelters and service providers as required, we make no recommendation for improvement in this area; however, VBA needs a performance measurement to fully assess the effectiveness of its homeless veterans outreach efforts.

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of December 2012, the San Juan VARO had a staffing level of 134.6 full-time employees. Of this total, the VSC had 110.6 employees assigned.

Workload

The San Juan VARO reported 5,097 pending compensation claims in December 2012. The average time to complete claims was 240.4 days-9.6 days less than the national target of 250.

Scope

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

Our review included 30 (19 percent) of 162 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of November 13, 2012. We provided VARO management with 132 claims remaining from our universe of 162 for its review. As a follow up to our national audit, we sampled 40 temporary 100 percent disability evaluations from the SharePoint list VBA provided to the VARO as part of its national review. We also reviewed 14 of the available 16 TBI-related disability claims VARO staff completed from July through September 2012. Two of the TBI claims folders had on going claims and were unavailable for our review—one of the folders had been transferred to a VA medical facility and the other to a brokering facility.

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

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

veterans outreach program by reviewing its directory of homeless shelters and service providers and determining whether staff regularly attended meetings and provided information on VA benefits and services.

Data Reliability

We used computer-processed data from the Veterans Service Network's Operations Reports and Awards. To test for reliability, we reviewed the data to determine whether any data were missing from key fields, 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 among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, VARO numbers, dates of claim, and decision dates as provided in the data received with information contained in the claims folders we reviewed.

Our testing of the data disclosed that they were sufficiently reliable to meet our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders at the San Juan VARO did not disclose any problems with data reliability.

Inspection Standards

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

Appendix B Inspection Summary

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

Table 2. San Juan VARO Inspection Summary

Five Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. Temporary 100 Percent Disability Evaluations	**Determine whether VARO staff properly processed temporary 100 percent disability evaluations.** (38 Code of Federal Regulations (CFR) 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1 MR Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for disabilities related to in-service TBI.** (FL 08-34 and 08-36) (Training Letter 09-01)		X
Management Controls			
3. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)		X
Eligibility Determinations			
4. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War veterans' claims, considering entitlement to medical treatment for mental illness.** (38 USC 1702) (M21-1MR Part IX, Subpart ii, Chapter 2)(M21-1MR Part III, Subpart v, Chapter 7) (FL 08-15) (38 CFR 3.384) (38 CFR 3.2)		X
Public Contact			
5. Homeless Veterans Outreach Program	**Determine whether VARO staff provided effective outreach services.** (Public Law 107-05) (VBA Letter 20-02-34) (VBA Circular 27-91-4) (FL 10-11) (M21-1, Part VII, Chapter 6)	X	

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

Appendix C VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: May 28, 2013

From: Director, VA Regional Office San Juan, Puerto Rico

Subj: Inspection of the VA Regional Office, San Juan, Puerto Rico

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

1. The San Juan VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, San Juan, Puerto Rico.*

2. Please refer questions to Al Zabala, VSCM, at 787-772-7396, or Tonia Robinson-King, AVSCM, at 787-772-7664.

(original signed by:)

MARLAN P. WALDROP
Director

Attachment

Attachment

Recommendation 1: We recommend the San Juan VA Regional Office Director develop and implement a plan to ensure claims processing staff input suspense diaries to the electronic record as required.

Background: Upon review of the 100 percent disability evaluations, 14 instances where suspense diaries were not established were discovered. A diary must be established when a reexamination is scheduled. When the diary matures, the electronic system generates a reminder to alert the RO staff to schedule the reexamination.

Response: Concur

Training on the proper procedure for reviewing and authorizing awards where a future review examination is indicated is scheduled for July 2013with a make-up date in August 2013. Compliance with future examination procedures will be incorporated into random spot checks conducted by the Veterans Service Center Coaches and Assistant Coaches and by the Quality Review Team staff. The Coaches/Asst. Coaches were already using a checklist to ensure COVERS and MAP-D compliance. This checklist will be revised to include review of the proper use of suspense diaries in the electronic record.

Recommendation 2: We recommend **t**he San Juan VA Regional Office Director develop and implement a plan to review for accuracy the 132 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

Background: Forty cases were sampled during the OIG inspection. Twelve cases involving prostate cancer or non-Hodgkin's lymphoma had not been identified by VBA.

Response: Non-Concur in part with comments

The Regional Office had started the review of the 132 temporary 100 disability percent disability evaluations remaining from the OIG inspection universe in order to take appropriate action, however, this review was not completed because revised national guidance on this topic was received on January 28, 2013. The national guidance indicated the 100% disability evaluations would be tracked at the national level.

Upon receipt of the national listing provided by Compensation Service, the IPC Coach reviews the temporary 100 percent disability evaluation cases and if action is deemed necessary, the cases are carried to the RVSRs assigned to the Express Lane for the necessary rating action. The Regional Office has completed all cases noted under our jurisdiction presently based on the national list.

Presently a comparative review of the 132 case list and the national list is taking place to determine which cases still need review. This review as well as the appropriate action is expected to be complete no later than end of month June 2013.

Recommendation 3: The San Juan VA Regional Office Director develop and implement a plan to ensure effective second signature reviews of traumatic bring injury claims decisions.

Background: Generally errors in TBI claims processing occurred because VARO management did not provide effective oversight of quality review procedures. Errors were not tracked to identify trends and areas for local training.

Response: Concur

A Certified Decision Review Officer assigned to the Quality Review Team reviews all claims, to include TBI claims, requiring second signature. Errors found are explained to the RVSR and are tracked in order to identify trends that require training. TBI training was completed in May 2013 for all employees.

Recommendation 4: We recommend **t**he San Juan VA Regional Office Director develop and implement a plan to ensure staff completely and timely address all required elements of Systmatic Analyses of Operations.

Background: VARO staff continue to struggle with providing complete and timely SAOs.

Response: Concur

The Director's office is currently preparing an SAO SOP that will be shared with the entire RO leadership team during training scheduled for July 2013. Although there is a process in place regarding the SAO schedule, assignments, etc., this SOP will formalize the SAO schedule and assignements and clearly outline responsibilities. The Director and the Management Analyst are currently responsible for ensuring Regional Office SAO compliance. The SOP will include specific deadlines and the responsible party at every level of the Regional Office.

Also during the July 2013 training, M21-4 Chapter 5 and the OIG's SAO Notification of Errors will be covered. The training will utilze previous incomplete SAOs, as well as provide examples of proper SAOs. Additionally, all VSC managers will be provided with copies of the updated M21-4 Chapter 5 as guidance to assist with completion of their assigned SAOs. Feedback will be provided to each person on the SAO they prepared in an effort to improve quality and completeness.

The VSCM and AVSCM will continue to review the list of SAOs assigned to the VSC management staff and revise the assignments as needed. Coaches and Assistant Coaches will continue to complete their assigned SAOs and turn them into the VSC Management Analyst for review. The VSC Management Analyst will refer them to the AVSCM and the VSCM before the SAO is finally submitted to the Director's Office for review. Within the Director's Office, the MA reviews, then refers, to the Director and the Assistant Director. A stantard cover sheet for feedback will continue to be utilized.

Appendix D Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Nora Stokes, Director Daphne Brantley Robert Campbell Madeline Cantu Ramon Figueroa Kyle Flannery Lee Giesbrecht Lisa Van Haeren Nelvy Viguera-Butler

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