VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Benefits Administration

Review of Alleged Manipulation of Quality Review Results at VA Regional Office San Diego, California

May 9, 2016
15-02376-239

ACRONYMS

ASPEN	Automated Standardized Performance Elements Nationwide
DRO	Decision Review Officers
OIG	Office of Inspector General
PTSD	Post Traumatic Stress Disorder
QRT	Quality Review Team
RVSR	Rating Veterans Service Representative
TBI	Traumatic Brain Injury
VA	Department of Veterans Affairs
VARO	VA Regional Office
VSC	Veterans Service Center

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Highlights: Review of Alleged Manipulation of Quality Review Results at VARO San Diego, CA

Why We Did This Review

On February 13, 2015, the Office of Inspector General received allegations that data integrity and mismanagement issues were occurring at the San Diego VA Regional Office (VARO). The complainant alleged VARO staff altered individual quality review results and hid claims from the quality review process by completing them during overtime hours. To support the allegations, the complainant provided 23 individual quality reviews completed by Quality Review Team (QRT) staff that VARO management had inappropriately overturned.

What We Found

We assessed the merits of the allegations and did not substantiate that VARO management inappropriately overturned, altered, or interfered with established procedures for reconsideration of individual quality review errors. We also did not substantiate the allegation that staff at the San Diego VARO worked some cases during overtime hours to avoid having the cases undergo individual quality reviews by QRT staff.

During the course of our review, we observed that VARO management did not provide adequate oversight to ensure staff followed its local policy to correct individual quality review errors within 5 days. Of the 50 errors sampled, 39 required corrective actions, such as revised decision documents, while the 11 remaining errors related to actions, such as improper development for evidence, and did not require revised decision documents.

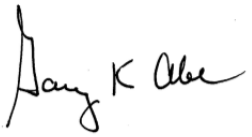
We also confirmed that VBA did not have a timeliness standard for staff to correct individual quality review errors at its 56 VAROs. Delays in correcting the individual quality review errors at the San Diego VARO resulted in improper benefits payments to some veterans.

What We Recommended

We recommended the San Diego VARO Director implement a plan to ensure staff comply with local policy to correct individual quality review errors, as well as take action to correct the backlog of individual quality review errors pending correction. Furthermore, we recommended the Under Secretary for Benefits establish a timeliness standard for VBA staff to correct individual quality review errors.

Management Comments

The Under Secretary for Benefits and VARO Director concurred with our findings and the corrective actions were responsive to the recommendations.



GARY K. ABE
Acting Assistant Inspector General for
Audits and Evaluations

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INTRODUCTION

Purpose of the Review

We performed this review in response to allegations made to the VA Office of Inspector General (OIG) Hotline in February 2015, with our onsite review work beginning in April 2015. This review assessed the merits of allegations that management at the San Diego VA Regional Office (VARO) altered errors reported by Quality Review Team (QRT) staff. The complainant indicated altered quality reviews resulted in mismanagement of government resources and affected the data integrity of quality reviews conducted at the VARO. In addition, the complainant alleged that subpar work was hidden during overtime because work completed during overtime was not subject to accuracy reviews.

Background

In 2012, VBA established QRTs in all 56 VAROs to provide timely, responsive quality assurance and training to its workforce. According to VBA, implementation of the QRT initiative reduced the lag-time in measuring accuracy from 4 months to 1 week—permitting timely corrective actions to prevent repeat errors.

As a means to assess the accuracy of claims processing actions and employee performance, QRT staff conduct individual quality reviews. Each VARO follows VBA's national guidance. Cases identified for individual quality reviews are selected using a random generator tool in ASPEN—VBA's workload tracking system. Results of the individual quality reviews are documented in ASPEN. Typically, QRT staff reviews five randomly selected cases per month for VARO staff who have a quality element associated with their performance standards. The standard used to identify quality review errors requires the error to be a clear violation or misapplication of VBA policies or procedures. VARO staff disagreeing with a quality error can dispute the error by following local procedures to have the error call reconsidered.

RESULTS AND RECOMMENDATIONS

Question 1 Did San Diego VARO Management Alter Accuracy Review Results Identified by the Quality Review Team?

We did not substantiate that VARO management and staff incorrectly overturned, altered, or interfered with established procedures for having individual quality review errors reconsidered.

What We Did

On April 13, 2015, we conducted an unannounced review of the San Diego VARO to assess the merits of the allegations. We reviewed VBA's national policy and the VARO's local policies related to individual quality reviews. We interviewed VARO management and staff responsible for the oversight, implementation, and the day-to-day management of the VARO's Quality Review program. In addition, we reviewed 23 cases the complainant provided, which reportedly demonstrated that VARO management altered or inappropriately overturned individual quality review errors identified by QRT staff.

Criteria

The San Diego VARO policy to dispute individual quality review errors requires employee to discuss errors with the team supervisor. If the error cannot be resolved at that level, the policy indicates the employee should discuss the error with the quality reviewer who identified the error. If disputed errors cannot be resolved, the employee has 7 workdays to submit a written rebuttal of the error to a "Panel of Three" (Panel) to determine if the error should be overturned. The Panel comprises two Decision Review Officers (DROs) and an Assistant Veterans Service Center (VSC) manager.[1] Membership on the Panel rotates on a predetermined basis; DROs rotate quarterly, and the Assistant VSC manager position rotates monthly. According to the VARO policy, all three Panel members must agree on the error call; otherwise, the error is overturned. VARO employees have 5 days to correct individual quality review errors that are not disputed.

What We Found

Of the 23 individual quality review errors the complainant provided, we determined 19 of the decisions to overturn the accuracy errors were appropriate and in line with VBA and local procedures to dispute error calls. We declined to review one of the remaining four cases because of an ongoing review by OIG criminal investigators. Summaries of the three remaining errors follow.

- Two errors were benefit entitlement errors that required corrective actions; however, staff had not taken action to correct the errors.

[1] DROs are not part of VARO management. DROs have the authority to reverse disability determinations completely or in part.

  - In one case, a Rating Veterans Service Representative (RVSR) established service connection for sinusitis, without a required opinion linking the condition to military service. The quality reviewer determined the RVSR prematurely established compensation benefits for sinusitis. The Panel overturned the error, stating that the veteran had sinusitis in service and that the current examination indicated sinusitis was chronic. We disagreed with the Panel's decision to overturn the error. Absent evidence of chronicity, VBA policy requires a medical opinion linking the current disability, sinusitis, to a medical condition that existed while in military service some 15 years earlier. At the time of our review, VARO staff had not taken action to obtain the required medical opinion.
  - In the second case, a quality reviewer determined an RVSR used the same psychiatric symptom to evaluate a veteran's posttraumatic stress disorder (PTSD) and to assign a 10 percent evaluation for a residual disability associated with a traumatic brain injury (TBI). The Panel did not consider this an error because the original error occurred in a prior decision document. However, despite overturning the error, the Panel instructed the RVSR to evaluate PTSD and TBI as either a psychiatric or a neurological disorder, whichever resulted in a better assessment of the veteran's overall impairment. We disagreed with the Panel's decision to overturn the error. VBA policy prohibits VARO staff from using the same symptoms to assign multiple evaluations with different diagnostic codes. At the time of our review, VARO staff had not taken action to reevaluate the veteran's PTSD and TBI disabilities as instructed by the Panel.
- In the third case, we could not determine if the employee submitted a written request, as required by local policy, to have the error reconsidered. As such, we could not determine if the Panel's decision to overturn the error was accurate.

QRT staff, responsible for conducting individual quality reviews at the San Diego VARO, reported they did not attempt to overturn individual quality review errors or alter quality review results outside the established procedures to have cases reconsidered. In addition, current and former members of the Panel told us VARO management did not pressure or coerce them to change quality review results.

Conclusion

We did not substantiate that the Panel incorrectly overturned, altered, or interfered with established procedures for reconsideration of quality errors. Of the 22 cases that VARO staff allegedly overturned inappropriately, we determined 19 of the decisions were appropriate and in line with VBA and local procedures. For the remaining three cases, we disagreed with the Panel's decision to overturn two of the errors and could not make a determination in the third case. However, we did not find a systemic or organized attempt to overturn accuracy errors identified by QRT staff.

Question 2 Did VARO Staff Complete Some Claims During Overtime Hours To Avoid Individual Accuracy Reviews by Quality Review Team Staff?

We did not substantiate that VARO staff completed cases with accuracy issues during overtime hours to avoid individual quality reviews by QRT staff.

What We Did

We interviewed VARO management and staff responsible for the oversight and implementation of VBA's quality review program. We also reviewed VBA policy regarding use of Automated Standardized Performance Elements Nationwide (ASPEN) generator to select random cases for quality review.

Criteria

QRT staff select cases for individual quality reviews via a random generator in ASPEN—VBA's workload tracking system. The results of the quality reviews are also recorded in ASPEN. Typically, QRT staff review five randomly selected cases per month, per employee—all employees have a quality element listed in their performance standards. In August 2014, VBA's Office of Field Operations directed QRT staff to include cases worked during overtime hours when selecting cases for individual quality reviews.

We confirmed that QRT staff followed VBA policy and used the random generator tool in VBA's workload tracking system when selecting cases for individual quality reviews, and that these selections included cases worked during overtime hours. Furthermore, VARO management and staff were familiar with VBA's August 2014 guidance that required QRT staff at VAROs to include claims processing work completed during overtime hours.

Conclusion

We did not substantiate the allegation that staff at San Diego VARO worked cases during overtime hours to avoid individual quality reviews by QRT staff. We determined QRT staff followed VBA policy and used the random generator tool, in VBA's workload tracking system, when selecting cases for individual quality reviews—including cases worked during overtime hours.

Question 3 Did VA Regional Office Management Ensure Staff Took Timely Action To Correct Accuracy Errors Identified by the Quality Review Team?

We examined accuracy errors identified by QRT staff and determined VARO management lacked adequate oversight to ensure staff complied with its local policy to correct individual quality review errors within 5 days.

What We Did

During our review of the allegations, we obtained several spreadsheets from QRT staff documenting individual quality review errors and observed that the date accuracy errors that were corrected were consistently missing from the spreadsheets. We obtained quality review results for the first two quarters of fiscal year 2015 and randomly sampled 50 of the total 1,016 accuracy errors that QRT staff identified. These 50 errors represented the claims of 30 veterans—some of the claims contained multiple errors so the total errors identified exceeded 30.

Criteria

VBA policy requires that each VARO, with minor local variations, follow VBA's national guidance for conducting individual quality reviews. VBA's national guidance does not identify a specific time in which VARO staff must correct errors identified by QRT staff. However, the San Diego VARO policy required staff to correct errors within 5 days.

What We Found

Of the 50 errors sampled, 39 required corrective actions such as revised decision documents—the 11 remaining errors related to actions such as improper development for evidence and did not require revised decision documents. On average, it took VARO staff 66 days to correct 26 errors, which exceeded the VARO's 5-day standard. For 13 of the 50 errors, VARO staff had not taken any actions to correct the errors.

VARO management assigned responsibility for tracking and monitoring accuracy errors identified by QRT staff to the QRT supervisor. The QRT supervisor maintained monthly spreadsheets to track details associated with accuracy errors, such as the type of error, the date the error was disputed, the date a disputed error was resolved, and the date an error was corrected. VARO management reported that conflicting workload priorities resulted in its lack of attention to ensure staff corrected individual quality review errors within 5 days. One VARO manager indicated that the lack of controls for correcting errors was a "loophole" in the VARO's quality review process. VARO management suggested that its staff were diverting resources intended for the correction of individual quality review errors in order to complete other workload with higher priority, such as cases awaiting a rating decision.

We disagree with the VARO's rationalization. Although other workload priorities may have affected correcting the errors, we determined this condition existed because VARO management did not adequately monitor staff to ensure they corrected errors within its 5-day timeliness standard.

Additionally, the VARO Director was unaware that staff did not correct the accuracy errors until we alerted him to this deficiency in April 2015.

We determined that delays in correcting individual quality review errors resulted in improper benefits payments to some veterans who had claims completed at the San Diego VARO. Examples of delayed corrections affecting benefits payments follow.

- In an October 17, 2014, rating decision, a RVSR established benefits for radiculopathy of the left lower extremity—a disease of the spinal nerve roots, resulting in pain, numbness or weakness. The effective date used to pay benefits was July 14, 2014. On October 31, 2014, a QRT staff member conducted a quality review of the case and determined the correct date to begin payments was July 14, 2013. However, the RVSR did not correct the error until May 11, 2015. Consequently, accurate benefits payments to a veteran were delayed by more than 6 months.
- In an October 27, 2014, rating decision, an RVSR assigned a 0 percent disability evaluation for a veteran's right shoulder strain. On November 3, 2014, during a quality review of the case, a QRT staff member determined the correct evaluation for the shoulder strain was 10 percent. However, the RVSR did not correct the error until April 21, 2015—more than 5 months later.

We also confirmed that VBA does not have a timeliness standard for staff at its 56 VAROs to correct errors identified by QRT staff. Conversely, VBA does have a 30-day timeliness standard that VARO staff must follow when correcting accuracy errors identified by its national Systematic Technical Accuracy Review staff.

VARO Interim Action

On April 21, 2015, the acting VSC manager at the San Diego VARO advised supervisors of their responsibility to ensure staff took timely action to correct quality review errors. On April 27, 2015, management issued a VSC memo 21-15-11, titled *Corrective Actions*, to all VSC staff, requiring staff to correct errors within 3 days. On April 28, 2015, VARO management updated its workload management plan designating staff responsible to ensure staff corrected quality review errors according to the VARO's updated policy.

Conclusion

We determined that San Diego VARO management did not provide adequate oversight to ensure staff followed its local policy to correct accuracy errors within 5 days. Of the 50 errors sampled, 39 required corrective actions such as revised decision documents—the 11 remaining errors related to actions such as improper development for evidence and did not require corrections. On average, it took VARO staff 66 days to correct 26 errors, exceeding the VARO's 5-day standard. For 13 of the 50 errors, VARO staff had not taken any actions to correct the errors.

VARO management attributed the delays in correcting the errors to conflicting priorities. However, we determined management did not adequately monitor staff to ensure they corrected errors within the VARO's 5-day standard. In addition, these delays resulted in improper benefits payments to some veterans. We also confirmed that VBA does not have a timeliness standard for staff at its 56 VAROs to correct errors identified by QRT staff. Once we alerted San Diego VARO management that staff did not always correct individual quality review errors as required, management initiated corrective actions to strengthen controls over the QRT quality review process.

Recommendations

1. We recommended that the San Diego VA Regional Office Director develop and implement a plan that provides management oversight to ensure staff comply with local policy to correct individual quality review errors.

2. We recommended that the San Diego VA Regional Office Director develop and implement a plan to ensure staff work through the remaining backlog of individual quality review errors pending correction.

3. We recommended that the Under Secretary for Benefits establish a timeliness standard in which claims processing staff at VA Regional Offices are expected to correct errors identified by Quality Review Team staff.

Management Comments

The Director concurred with our findings, and recommendations. The Director indicated that the station updated its Corrective Actions policy in January 2016 and that corrective actions would be prioritized and monitored. The Director also provided evidence that VARO staff corrected the backlog of individual quality review errors identified in this report. In addition, the Under Secretary for Benefits concurred with our recommendation to implement a timeliness standard for VBA staff to correct individual quality review errors. As of March 9, 2016, employees have 5 business days to correct errors.

OIG Response

The actions taken by the Director and the Under Secretary are responsive to the recommendation. The evidence provided was sufficient to close the recommendations.

Appendix A Scope and Methodology

Data Reliability

We obtained the quality review data used in this report from Quality Review Team staff at the San Diego VARO. To achieve the results for our review, we relied extensively on reports obtained from Quality Review Team staff at the San Diego VARO. The data represented quality review errors requiring correction by VARO claims processing staff. The data were maintained on stand-alone schedules recorded by various VARO QRT staff outside of any VA computer system.

We did not establish the completeness of these data due to system limitations with ASPEN. Specifically, there was no single report in ASPEN that would allow us to identify all errors requiring correction by VARO claims processing staff for the period of our review. Therefore, we could not provide assurance that the data were complete for the period of our review.

To assess the accuracy of data, we reviewed the data to determine whether any data were missing from key fields or were outside the period indicated in this report. We also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. We also compared the veterans' records identified for individual quality reviews, against VBA's claims processing systems to ensure the accuracy of the veterans' personally identifiable and claims information were accurate.

The accuracy errors annotated on the spreadsheets the VARO provided required corrective actions; however, not all errors listed in ASPEN require correction. For example, administrative errors such as overdeveloping or delays in development actions do not require corrective actions.

We validated that 28 of the 30 veteran claim numbers sampled existed in both VBA's corporate database and in ASPEN. We could not identify one of the claim numbers in VBA's corporate database or in ASPEN and concluded this was most likely due to a typographical error by the VARO staff member who entered the number on the spreadsheet. In the second case, we located the claim number in VBA's corporate record, but could not locate the ASPEN entry. The employee who made the error was promoted to management so the employee's name and associated error could not be located in ASPEN. We believe the conclusions and recommendations in this report are valid.

Scope Limitation

To achieve the results for Question 3, we relied extensively on reports obtained from Quality Review Team staff at the San Diego VARO. The data represented quality review errors requiring correction by VARO claims processing staff. The data were maintained on stand-alone monthly schedules recorded by various VARO QRT staff outside of any VA computer system as a tool to monitor claims processing error corrections. According to VARO staff, they update the schedules with quality review errors requiring correction by

VARO claims processing staff as they have time. We did not establish the completeness of these data due to system limitations with ASPEN. Specifically, there was no single report in ASPEN that would allow us to identify all errors requiring correction by VARO claims processing staff for the period of our review. Therefore, we could not provide assurance that the data were complete for the period of our review.

Government Standards

We conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*. The procedures and mechanisms used to gather information could not ensure that the information was sufficiently reliable and complete for use in meeting all the inspection objectives. However, we believe the conclusions and recommendations in this report are valid.

Appendix B Management Comments – Director of VARO San Diego

Department of Veterans Affairs

Memorandum

Date: March 1, 2016

From: Director, San Diego VA Regional Office (344)

Subj: Draft Report: *Alleged Mismanagement and Employee Integrity Issues at the San Diego VARO*

Thru:: Director, Pacific District Office (20F4)

To Assistant Inspector General for Audits and Evaluations (52)

1. The San Diego VARO's comments are attached to the OIG Draft Report: *Alleged Mismanagement and Employee Integrity Issues at the San Diego VARO.*
2. Questions may be referred to Gary D. Chesterton, Assistant Director, at (619) 400-5400 or via email at dir.vbasdc@va.gov.

(original signed by:)

PATRICK C. PRIEB

Attachment

Attachment

Draft Report: Alleged Mismanagement and Employee Integrity Issues at the San Diego VARO

Recommendation 1:	**We recommended that the San Diego VA Regional Office Director develop and implement a plan that provides management oversight to ensure staff comply with local policy to correct individual quality review errors.**
OIG Comment:	Please ensure your response contains documentation to verify the completion of the stated actions below.
VA Response:	Concur. On January 13, 2016, the Corrective Actions policy was updated. A copy of the updated Corrective Actions policy is embedded below. Corrective actions are sent out daily from the VSC front office staff as part of the daily workload assignment. These are given the highest priority and monitored until completion.
Supporting Documentation:	*(Policy (21-16-12))
Status:	We request closure of this recommendation based on the evidence provided above.
Recommendation 2:	**We recommended that the San Diego VA Regional Office Director develop and implement a plan to ensure staff work through the remaining backlog of individual quality review errors pending correction.**
OIG Comment:	Please ensure your response contains documentation to verify the completion of the stated actions below.
VA Response:	Concur. Every individual quality review pending correction identified in the original audit has been completed. The original backlog of pending quality review corrections identified by OIG are listed on the attached spreadsheet.
Supporting Documentation:	*Final OIG Oct-Mar - IQR Rollup.xlsx
Status:	We request closure of this recommendation based on the evidence provided above.

**OIG Note: Due to the size of the supporting documents indicated herein, it is not included in this report. To obtain these documents, contact the OIG Information Officer.*

Appendix C Management Comments – Under Secretary for Benefits

Department of Veterans Affairs

Memorandum

Date: March 14, 2016

From: Acting Under Secretary for Benefits (20)

Subj: OIG Draft Report—Review of Alleged Mismanagement and Employee Integrity Issues at VA Regional Office, San Diego, California—VAIQ 7679022

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

1. Attached is VBA's response to recommendation 3 in the OIG Draft Report: Review of Alleged Mismanagement and Employee Integrity Issues at VA Regional Office, San Diego, California.
2. Questions may be referred to Ruma Mitchum, Program Analyst, at 632-8987.

(original signed by:)

DANNY G.I. PUMMILL

Attachment

Attachment A

***6*.06(h). Corrective Action Time Limits for IQRs**	The employee has 5 business days to correct any errors after being notified of an error or appeal the error as outlined in 6.06(i) of this section.

Appendix D OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Nora Stokes, Director Casey Crump Suzanne Love Michelle Santos-Rodriguez

Appendix E Report Distribution

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