VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Benefits Administration

Review of Alleged Removal of Workload Controls at the VA Regional Office in San Juan, Puerto Rico

May 24, 2017
15-05235-200

ACRONYMS

EP	End Product
FY	Fiscal Year
OIG	Office of Inspector General
VA	Department of Veterans Affairs
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Highlights: Review of Alleged Removal of Workload Controls at the VARO in San Juan, PR

Why We Did This Review

We conducted this review in response to an allegation received in August 2015 through the VA OIG Hotline. Allegedly, San Juan VA Regional Office (VARO) staff improperly removed a control identified as End Product 930 (EP 930) in the Veterans Benefits Administration's (VBA) workload management system; this workload had been a recurring weakness. The End Product system is VBA's primary electronic workload monitoring and management tool and claims coded as EP 930 required additional processing, which may not have been properly performed before the removal of the claims from the system.

What We Found

We substantiated the allegation that VARO claims processors improperly removed work products identified as EP 930s and processing of this workload was a challenge for VSC management. Improperly removing claims coded as EP 930 from the system had the effect of improperly terminating these veterans' claims without appropriate review and processing. We determined claims processors inaccurately removed six of the 30 cases we sampled. One of six errors delayed paying a veteran about $23,000 in benefits by more than three years; the remaining five errors had the potential to affect benefits.

Our analysis also confirmed that claims processing staff prematurely removed some of the 722 EP 930s, processed during an initiative in August and September 2015 to reduce this inventory. The removal actions exceeded the total number of cases processed during the prior 10 months. Twenty of the 30 claims we sampled were removed during this two-month period; four of the 20 cases contained errors. Because VSC management did not ensure staff followed plans to process this workload, the inventory continued to increase.

What We Recommended

We recommended that the San Juan VARO Director develop and implement a plan to review the 722 cases that claims processors removed from its inventory in August and September 2015 and monitor the effectiveness of current plans to manage the EP 930 workload.

Agency Comments

The VARO Director concurred with the recommendations and provided an acceptable plan for corrective actions. We will follow up on the implementation of these corrective actions.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Background

Veterans Benefits Administration (VBA) policy states the effectiveness of workflow management depends on the quality of information entered for each claim.[1] The End Product system is VA's primary electronic workload monitoring and management tool at its Veterans Service Centers (VSCs).[2] End Products are the work units VBA uses to properly control pending workloads and appropriately measure work credit through assigned codes specific to types of claims or actions required.[3]

Claims are tracked via its End Product system, and each claim is assigned an End Product code (EP Code); upon completion of its processing, a claim (i.e., End Product) is removed from the End Product system and the office is given credit for each End Product cleared (i.e., closed).[4] The EP Code is a designated three-digit modifier to identify specific issues or types of claims. For example, a claim can be designated as an EP 930. In the context of this report, an EP 930 code signifies a claim that was previously removed from the system but it was subsequently determined that the claim may have been prematurely cleared. EP 930s must be properly addressed and accurately processed before they can be removed from the system. (In this report, removing or clearing an EP 930 means that the claim is removed from the electronic record system, at which point it is deemed closed and not subject to further action). Accurate work measurement is essential to substantiate proper staffing requirements and in determining the production capacity at individual VSCs.[5] Claims processors incorrectly removing End Products from the electronic record resulted in inaccurate, incomplete, or in some instances, no decision on veterans' claims.

Criteria

VA Regional Office (VARO) managers must ensure staff review electronic systems when receiving correspondence[6] and ensure claims are promptly placed under End Product control. End Products should also remain pending until all required actions are completed.[7] When claims processing staff erroneously or prematurely remove End Products from VBA's inventory of claims, they are required to correct these errors using an End Product 930 (EP 930).[8]

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[1] Manual Reference: M21-4, Chapter 2, Subchapter II, Section 2.04(a), *Effective Workflow Management*
[2] *Id.* Appendix B, Section I (a), *Correct EP Use and Work Measurement*
[3] *Id.* Appendix B, Section III(a), *Work-Rate Standards*
[4] *Id.* Chapter 2, Subchapter II, Section 2.04(a), *Effective Workflow Management*
[5] *Id.* Appendix B, Section I (a), *Correct EP Use and Work Measurement*
[6] Manual Reference: M21-1, Part III, Subpart iii, Chapter 1, Section D.1.a, *Routine Review of eFolder Documents*
[7] Manual Reference: M21-4, Appendix B, Section 1 (b), *Establishing and Maintaining EP Control*
[8] *Id.* Section II, 930 – *Review, Referrals, Other*

The following are other examples of when VARO staff should use an EP 930:

- VA received additional evidence but it was not associated with the veteran's record before a claim decision was made.
- VARO staff did not address or missed issues related to a veteran's claim.
- VARO staff needed to correct errors identified by VBA's national or local quality review programs.

RESULTS AND RECOMMENDATIONS

Finding VARO Staff Removed Controls and Prioritized Other Workload

Allegation

In August 2015, the OIG Hotline received a complaint alleging San Juan VARO claims processors improperly removed claims subject to a workload control identified as EP 930. The complainant reported that VSC management implemented a local initiative to reduce the VARO's high inventory of EP 930s by the end of FY 2015. Further, the complainant indicated processing EP 930s had been a recurring issue at the San Juan VARO.

Assessment

We substantiated the allegation that VARO claims processors improperly removed EP 930s. The End Product system is VA's primary electronic workload monitoring and management tool at VSCs. This occurred because VARO management prioritized other cases over the EP 930 workload and later identified a training issue related to these End Products. As a result, claims processors inaccurately removed six of the 30 EP 930s we sampled from the 1,004 cases pending as of July 31, 2015.

We also substantiated that managing and processing the EP 930 workload had been a challenge for VSC management. We confirmed that claims processing staff processed and removed 722 EP 930s in August and September 2015, which exceeded the total number of cases processed during the prior 10 months. This resulted in the premature removal of some of these cases from the VARO's inventory by closing or canceling the End Product without taking the required actions. Claims processors removed 20 of the 30 claims we sampled during this period and four of the 20 cases contained errors, which required correction and thus should not have been removed from the electronic record system (i.e., closed). Because of other workload priorities, the EP 930 inventory continued to increase.

Removal of Workload Controls

We determined claims processors inaccurately removed six of the 30 EP 930s we sampled from the 1,004 cases pending as of July 31, 2015. This occurred because VARO managers did not monitor or provide adequate oversight of the EP 930 workload. VARO management concurred with all but one of these errors. Summaries of the six errors follow.

- In the case that affected benefits, a manager prematurely removed a claim with an EP 930 code prior to resolving an issue relating to a veteran's duplicate records. VARO claims processors never provided the veteran with a decision on a claim for post-traumatic stress disorder, despite a medical opinion that related the post-traumatic stress disorder to combat. Consequently, VA did not pay the veteran about $23,000 in benefits and

delayed processing the claim by more than three years. Claims processors took corrective action and paid the veteran his benefits once we alerted them of this error. The VSC manager concurred with our assessment in this case.

- For the five errors that had the potential[9] to affect veterans' benefits, VARO claims processors established EP 930s because the VARO received additional evidence related to claims that had already been decided. In certain situations, VBA decision makers may be required to reconsider these claims and review newly submitted evidence.[10] However, managers and claims processors removed some EP 930s without reviewing or considering the additional evidence. The assistant VSC manager agreed with our assessments in four of the five cases. Details of the case with which the assistant VSC manager disagreed follow:
  - In October 2014, a Rating Veterans Service Representative decided a veteran's claim but omitted medical evidence received in September 2014. This evidence was not associated with the claims folder when the Rating Veterans Service Representative decided the claim. The assistant VSC manager disagreed that staff removed the EP 930 prematurely because a Decision Review Officer subsequently considered the new evidence as part of the veteran's appeal. However, VBA policy requires claims processors to use an EP 930 to correct errors such as deciding claims without all the evidence.[11] Additionally, the Decision Review Officer corrected the previous error using an EP 170, which is reserved for appealed claims.[12] The VARO received additional work credit even though prohibited by VBA policy.[13] It took the Appeals Team staff about one year and four months to reconsider the previously omitted evidence, delaying an accurate decision and misrepresenting the type of claim the VARO processed.

These conditions existed because VSC managers directed resources away from these cases due to other workload priorities and later identified a training issue related to establishing EP 930s. In some instances claims processors prematurely removed electronic controls needed to manage this workload, such as when they could not determine why the EP 930 had been initially established. In these instances, they simply removed the claims from the electronic record system, thus closing them inappropriately.

[9] Errors that have the potential to affect benefits are those that either had no immediate effect on benefits or had insufficient evidence to determine the effect to benefits.
[10] 38 CFR 3.156(b), *New and material evidence*
[11] Manual Reference: M21-4, Appendix B, Section II, *930 – Review, Referrals, Other*
[12] *Id. 170 – Appeal Control*
[13] *Id. Review, Referrals, Other*

The VSC manager stated the VARO struggled with this inventory despite several plans to address the weaknesses with EP 930s. VARO managers also reported the following factors affected the accuracy and inventory of the pending EP 930 workload at the San Juan VARO:

- Management and claims processors did not always follow the workload plans.
- Prior plans lacked effective oversight thereby enabling all claims processing staff to establish EP 930s in the electronic record.
- From February through October 2015, the VSC reassigned the intake analyst who screened incoming mail, to other VBA workload priorities.
- Directing resources to complete other national priorities affected the VARO's ability to process EP 930s.
- Management also stated that claims processors removed EP 930s from the electronic record without taking any action when they were unable to determine why these claims were established.

Management of EP 930 Workload

Our analysis of claims files, data, local policies, and interviews with VARO staff substantiated that managing and processing the EP 930 workload had been a challenge for VSC management. VSC management did not ensure staff followed plans to process this workload, and as a result, the inventory continued to increase. We confirmed that claims processing staff processed and removed 722 EP 930s during a two-month period to reduce this inventory—exceeding the total number of cases processed during the prior 10 months. Four of the six errors we identified were included in these 722 cases.

We determined VBA's Office of Field Operations, the Southeast District Director, and the San Juan VSC Manager, had ongoing concerns related to the management of EP 930 inventories, but did not take appropriate action to prevent the problems. The timeline below provides a summary of those concerns.

- In July 2014, VBA's Office of Field Operations directed all VAROs to review and take appropriate actions on their EP 930 inventories as part of a plan to reduce this part of VBA's pending claims. However, VAROs were not required to report the results of their reviews or the actions they took based on their reviews.
- In June 2015, VBA's Southeast District requested the San Juan VARO Director provide an action plan within one week to address its pending inventory of EP 930s. In response to the Southeast District Director's concerns, the San Juan VSC Manager sent an action plan for reducing the backlog of EP 930s stating that the VSC manager and assistant manager

will continuously monitor the age and number of pending EP 930s to ensure that they are being completed timely.

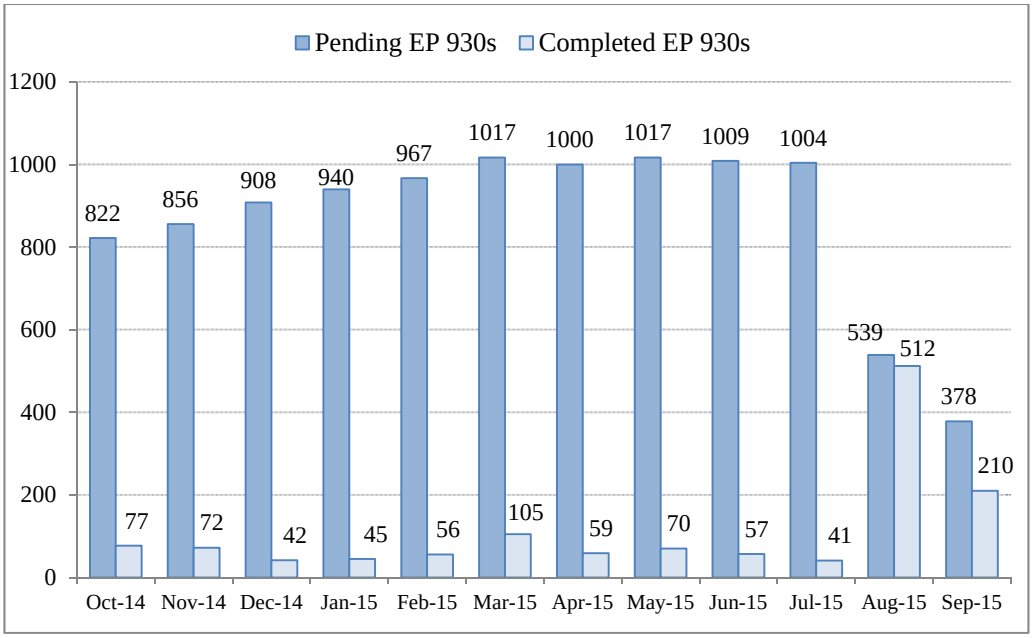
- Also in June 2015, the VSC manager issued a memo to all staff containing specific instructions for controlling EP 930s. The memo reported VSC weaknesses in establishing EP 930s, such as using incorrect dates of claims and the lack of notes in the electronic records necessary to explain why EP 930s were established.
- In August 2015, the VSC manager reminded all staff of the updated processing procedures for EP 930s and warned that failure to follow procedures would result in supervisory intervention.
- In December 2015, the VSC manager implemented another plan to reduce the EP 930 workload; however, these changes occurred after our review so we were unable to assess the effectiveness of that plan.

Inventory Reduction Initiative

We determined the inventory of EP 930s generally increased during FY 2015. We found claims processing staff processed and removed 722 EP 930s during August and September 2015, which was more than the prior 10 months combined. Claims processors removed 20 of the 30 claims we sampled during this two-month period and four of the 20 cases contained errors. These four errors occurred when claims processors removed EP 930s but did not consider evidence submitted with previous decisions.

Figure 1 shows the VARO's gradual increase in EP 930 inventory during FY 2015 until the reduction initiative began in August 2015.

Figure 1. San Juan FY 2015 EP 930 Pending and Completed Workload



Source: OIG analysis of VBA's Veterans Service Network Operations Reports

Conclusion

We substantiated that San Juan VARO managers and claims processors improperly removed six of the 30 EP 930s we reviewed. One of six errors delayed paying a veteran about $23,000 in benefits by more than three years and the remaining five errors had the potential to affect benefits. We also substantiated that the management and processing of this workload had been a historical challenge for VARO management.

In August and September 2015, claims processing staff removed 722 cases from its inventory, which exceeded the total number of cases processed during the prior 10 months. Claims processors removed 20 of the 30 claims we sampled during this two-month period—of the 20 cases removed, four contained errors. We concluded VARO supervisors prioritized other workload over EP 930s and claims processors prematurely removed claims subject to the electronic controls needed to manage this workload.

Recommendations

1. We recommended the San Juan VA Regional Office Director develop and implement a plan to review the 722 End Product 930s that staff removed from its inventory in August and September 2015.
2. We recommended the San Juan VA Regional Office Director monitor the effectiveness of current plans to manage the End Product 930 workload.

Management Comments

The San Juan VARO Director concurred with the recommendations and provided acceptable action plans. For Recommendation 1, the VARO Director provided a three-level review plan for the 722 EP 930s with a target completion date in August 2017. For Recommendation 2, the VARO Director restricted staff who could establish EP 930s to specific personnel, approved by the VSC manager and/or the Assistant Director. VSC management provides weekly briefings on the progress of processing EP 930s to the VARO Director and/or Assistant Director.

The VARO Director disagreed with terminology in the report and provided an alternative. Specifically, on the Highlights page of this report, the director disagreed with the phrase "We substantiated the allegation that VARO claims processors improperly removed work products identified as EP 930s." The director indicated the phrase implied VARO staff intentionally removed EP 930s without action or review.

OIG Response

The San Juan VARO Director's comments and actions are responsive to the recommendations. We will continue to follow up as required. Regarding the terminology used in the report, we offered no conclusion or attestation as to the intent of VARO employees. The examples and conclusions in this report showed VARO staff improperly removed claims designated as EP 930 from the electronic record system in six of the 30 cases reviewed. In these six cases, VARO staff did not take required actions such as considering additional evidence and reconsidering claims based on the new evidence.

Appendix A Scope and Methodology

Scope

We conducted our work from January 2016 to February 2017. We reviewed a random sample of 30 from the 1,004 EP 930 cases (less than 1 percent), pending at the San Juan VARO as of July 31, 2015, which corresponded to the time frame of data submitted with the original allegation.

Methodology

We visited the San Juan VARO in February 2016 to assess the merits of the allegations. We obtained and analyzed internal reviews, policies, reports, and training records relevant to the allegations. We also interviewed VARO managers and claims processing staff responsible for the EP 930 workload. Further, we reviewed and analyzed 30 pending EP 930 cases to determine whether staff took appropriate actions prior to closing the workload controls. Lastly, we analyzed monthly summary data of the San Juan VARO's EP 930s for FY 2015 to evaluate the ongoing concerns with this workload.

Data Reliability

We used computer-processed data from the Veterans Service Network Operations Reports to test the reliability of that data. We determined whether any data were missing from key fields or were outside the time frame requested. We assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Further, we confirmed that San Juan VARO staff processed all of the cases. Our comparison of the key fields of the data submitted to the OIG Hotline with information contained in the veterans' electronic records we sampled did not disclose any obvious problems with data reliability supporting the review objective.

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*.

Appendix B Management Comments

Department of Veterans Affairs Memorandum

Date: March 31, 2017

From: Director, VA Regional Office San Juan Regional Office

Subj: OIG Draft Report – Alleged Removal of Workload Controls, VA Regional Office, San Juan, PR

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

1. Attached is the San Juan's Regional Office response to the OIG Draft Report: Alleged Removal of Workload Controls, VA Regional Office, San Juan, PR.

2. Questions may be referred to the Director's Office, at (787) 772-7302.

(Original signed by)

Wendy Torres

Attachment

Attachment

Veterans Benefits Administration (VBA)
Comments on Office of Inspector General (OIG) Draft Report Inspection of the VA Regional Office, San Juan Regional Office

The following comments are submitted in response to the recommendations in the OIG draft report:

Regional Office Comments:

In the section titled "What We Found," we do not agree with the phrase "We substantiated the allegation that VARO claims processors improperly removed work products identified as EP 930s". The phrase implies that employees of the VARO intentionally removed EP 930s without action or review. We request the paragraph to read as follows: We substantiated the allegation that VARO claims processors improperly removed work products identified as EP 930s due to a training issue and processing of this workload was a challenge for VSC management due to other claims priorities.

Recommendation 1: We recommended the San Juan VA Regional Office Director develop and implement a plan to review the 722 End Product 930s that staff removed from its inventory in August and September 2015.

VBA Response: Concur. Please see the attached plan which outlines the RO's plan to review the 722 EP 930s identified by OIG. Target Completion Date: August 11, 2017.

Recommendation 2: We recommended the San Juan VA Regional Office Director monitor the effectiveness of current plans to manage the End Product 930 workload.

VBA Response: Concur. The San Juan Regional Office restricts establishment of EP 930s to specific personnel with approval of the Veterans Service Center management and/or the Assistant Director. Veterans Service Center management briefs the Director and/or Assistant Director weekly on the progress of processing EP 930s.

For accessibility, the format of the original documents in this appendix has been modified to fit in this document.

Strategic Plan for reviewing all EP 930s processed
In August and September 2015

March 31, 2017

Project Managers:
The project managers for the execution of this plan are: Jannice Toledo, AVSCM, Jose A. Martinez, Quality Review Team Coach, and Enid Perez, Appeals Team Coach

Background:
In February 2016, OIG conducted a review of EP 930s processed by the San Juan Regional Office in August and September 2015. As a result of this review the OIG recommended that the RO develop and implement a plan to review the 722 EP 930s processed during that timeframe.

Procedures:
Due to the complexity, magnitude, and importance of this analysis, we developed a plan that establishes several levels of review.

a) **First Level Review** – First review was completed in February 2017 by the Quality Review Team (QRT) Coach, QRT Assistant Coach, and VSC-2 Assistant Coach. The purpose of this review was to perform a preliminary analysis of the 722 EP 930s in order to identify areas that need immediate attention, overall error trends, and obtain a general assessment of the current EP 930 workload plan's effectiveness.

The following findings were identified as a result of this initial review:

- Additional training is necessary to clarify when to cancel and clear an end product. Trainings were conducted in July 2, 2016 and September 22, 2016. Additional training is scheduled to be conducted from May 2 through May 5, 2017.
- When cancelling an EP most employees utilized the preprogrammed labels in SHARE which to do not provide the specific reason for cancellation. The use of the "other" label in SHARE provides a space for an explanation, and/or making notes in the system.
- In many instances the issue/claim that necessitated the need for EP 930 to be established was addressed under another EP and the EPC 930 was left pending unnecessarily.
- EP 930s were being established even though claimant specifically requested an appeal or reconsideration.
- Based on the above findings, the establishment of 930 EPs has been delegated to specific personnel.

b) **Second Level Review** - This review will be conducted by Quality Review Specialists in the QRT to ensure a comprehensive and detailed review of each individual case processed in August and September of 2015. A tracker containing the details of each one of the 722 cases will be updated with information about each case.

This level of review is expected to be completed by July 7, 2017.

c) Third Level – This review will be conducted by VSCM, AVSCM and Assistant Director. This level will ensure that all corrective actions have been completed. This level of review is expected to be completed by August 11, 2017.

Throughout this review, we will evaluate the effectiveness of our current EP 930 plan in May and July 2017 and implement any necessary strategies to ensure the EP 930 workload is effectively managed and processed.

Appendix C 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 Kristine Abramo Christopher Beltz Robert Campbell Suzanne Love Mary Shapiro

Appendix D Report Distribution

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