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Office of Audits and Evaluations

VETERANS BENEFITS ADMINISTRATION

The Compensation Service Could Better Use Special-Focused Reviews to Improve Claims Processing

REVIEW | REPORT #21-01361-192 | AUGUST 9, 2022

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Executive Summary

The Veterans Benefits Administration (VBA) provides disability compensation for eligible veterans. Accurate and consistent decisions on related claims are vital to ensuring these veterans receive the benefits they deserve. The Compensation Service, which is part of VBA, has a quality assurance mission "to drive improvement in accuracy and consistency in the claims process of benefits delivered to veterans and their families."[1] Prior VA Office of Inspector General (OIG) reports have highlighted deficiencies in VBA quality assurance programs, including those that fall under the Compensation Service.[2] This review addresses an additional component of quality assurance not previous addressed: special-focused reviews.

Compensation Service staff conduct special-focused reviews on "topics of special interest" or claims-processing issues "where a need has been identified in the effort to improve quality as well as assess consistency and compliance based on current policy and procedures."[3] Topics may be identified by the Government Accountability Office (GAO), the OIG, or the Compensation Service. Examples of topics covered in special-focused reviews are disability claims related to amyotrophic lateral sclerosis (ALS), Blue Water Navy, and military sexual trauma.

Special-focused reviews are used to assess claims-processing accuracy and support VBA's overall quality assurance mission, which includes driving improvement in accuracy and consistency in the claims process. GAO provides standards and the overall framework for establishing and maintaining an effective internal control system for federal agencies.[4] Internal controls provide reasonable assurance that the objectives of an entity will be achieved. Federal agencies are required to establish internal control systems consistent with GAO's standards,[5] which include five components:

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[1] VBA Compensation Service Quality Assurance Mission Statement, accessed November 12, 2020, https://vbaw.vba.va.gov/bl/21/data/quality/qa_home.htm. (This is an internal VA website not publicly accessible.)

[2] VA OIG, *The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings*, Report No. 20-00049-122, May 18, 2021; *VA OIG, Site Visit Program Can Do More to Improve Nationwide Claims Processing*, Report No. 19-07062-230, August 18, 2020; VA OIG, *The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies*, Report No. 19-07059-169, July 22, 2020; VA OIG, *Deficiencies in the Quality Review Team Program*, Report No. 19-07054-174, July 22, 2020; VA OIG, *Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide*, Report No. 19-07062-255, September 29, 2020.

[3] VBA Compensation Service Quality Assurance's Special Focus Reviews description, accessed July 16, 2021, https://vbaw.vba.va.gov/bl/21/data/quality/consis/consis_focus.htm.(This is an internal VA website not publicly accessible.)

[4] Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014. See "Internal Controls" in appendix B for additional information.

[5] Federal Managers' Financial Integrity Act of 1982, as amended 31 U.S.C. § 3512 (c) and (d) (2021). The Comptroller General is required to issue standards for internal control in the federal government.

1. **Control Environment**: the foundation for an internal control system that provides the discipline and structure.
2. **Risk Assessment**: the assessment of risks facing the entity as it seeks to achieve its objectives.
3. **Control Activities:** the actions managers establish through policies and procedures to achieve objectives and respond to risks in the internal control system.
4. **Information and Communication:** the use of effective information and communication for an entity to achieve its objectives.
5. **Monitoring:** the assessment of performance over time and prompt resolution of findings from audits and other reviews.

The OIG conducted this review to evaluate VBA's design of the special-focused review process, including its standard operating procedure, and implementation of the reviews. The team assessed the process, in light of GAO's standards, to identify how VBA could enhance it to help improve quality and assess consistency and compliance.

What the Review Found

The OIG team assessed 10 special-focused reviews, including examining the final reports summarizing the results, that the Compensation Service special-focused review staff completed from January 2019 through April 2021. The team identified weaknesses in all five internal control components listed above. Although the Compensation Service has a special-focused review process, its standard operating procedure does not provide sufficient guidance to fully support claims-processing improvement. For example, the standard operating procedure does not specify that final reports must discuss the causes for errors. Therefore, although special-focused review staff assess some risks by identifying errors and trends, they do not analyze why claims processors made the errors. Without this "root cause" information, leaders are not well-positioned to remediate the risk of continued deficiencies.

The OIG team also found Compensation Service does not communicate all necessary information internally. Despite the requirement in the standard operating procedure for staff to provide error trends in final reports, this information was not always provided. Some regional office training managers reported that they did not receive error trends for their offices, which could have allowed for more targeted training. Further, the Compensation Service does not measure the effectiveness of actions taken in response to each special-focused review. Without effective control activities, communication, and monitoring, VBA lacks assurance that special-focused reviews are improving quality as intended.

In addition, the OIG team found some claims processors erroneously updated VBA's electronic Quality Management System to reflect corrections that were not made. This occurred because the system allows claims processors to close their own errors in the system and VBA has not established a sufficient error correction validation process. As a result, VBA leaders do not know whether all errors requiring correction were resolved. Until VBA enforces accountability, enhances the information system, and improves monitoring activities, claims will remain uncorrected—meaning veterans may not receive the benefits to which they are entitled.

What the OIG Recommended

The OIG made six recommendations to the under secretary for benefits.[6] The OIG recommended VBA update the special-focused review standard operating procedure to require analysis of why errors occurred. Further, the OIG recommended establishing controls to ensure special-focused review reports communicate both benefit entitlement and procedural errors, as well as all errors identified at both the national and regional office levels. In addition, the OIG recommended VBA implement a process to measure the effectiveness of actions taken in response to each special-focused review and determine whether a follow-up review is needed. Finally, the OIG recommended VBA reassess special-focused review errors marked as "corrected" to determine whether corrective actions were taken, assess whether an enhancement to the Quality Management System could help prevent claims processors from closing special-focused review errors without correction, and develop a process to ensure corrective actions are taken on all errors.

VA Comments and OIG Response

The principal deputy under secretary for benefits, signing for the Northeast District director who was performing the delegable duties of the under secretary for benefits, concurred with recommendations 1, 2, 3, 5, and 6; and provided responsive action plans. The principal deputy under secretary concurred in principle with recommendation 4, noting, "Each [special-focused review] is a standalone review with unique features resulting in need for a case-by-case determination if a follow-up review is needed. VBA will update the [standard operating procedure] to establish procedures to ensure follow-up reviews are completed when recommended in a [special-focused review] report."

[6] The recommendations addressed to the under secretary for benefits are directed to anyone in an acting status or performing the delegable duties of the position.

As proposed, the submitted action plan was responsive to the intent of the recommendation. The OIG will monitor VBA's implementation of planned actions and will close the recommendations when satisfied that sufficient progress has been made to address the recommendations and issues identified. The full text of the principal deputy under secretary's comments appears in appendix D.

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Contents

Abbreviations

ALS	amyotrophic lateral sclerosis
FY	fiscal year
OIG	Office of Inspector General
QMS	Quality Management System
VBA	Veterans Benefits Administration

Introduction

The Veterans Benefits Administration (VBA) provides disability compensation for eligible veterans. Accurate and consistent decisions on related claims is vital to ensuring these veterans receive the benefits they deserve. The Compensation Service, part of the Veterans Benefits Administration (VBA), has a quality assurance mission "to drive improvement in accuracy and consistency in the claims process of benefits delivered to veterans and their families."[7] Since 2020, the VA Office of Inspector General (OIG) has issued five reports highlighting deficiencies about various components of VBA quality assurance programs, including those administered by the Compensation Service.[8]

This report addresses a component of quality assurance that the prior OIG publications have not covered: special-focused reviews. The Compensation Service conducts these reviews on "topics of special interest" or claims-processing issues "where a need has been identified in the effort to improve quality as well as assess consistency and compliance based on current policy and procedures[.]"[9] Compensation Service quality assurance reported topics of special-focused reviews are often driven by external influences such as reports by the Government Accountability Office (GAO) and the OIG, or internally by the Compensation Service. Examples of topics include amyotrophic lateral sclerosis (ALS), Blue Water Navy, and military sexual trauma.[10]

Special-focused reviews are one of VBA's internal control measures to assess claims-processing accuracy and support the overall quality assurance mission, which includes driving improvement in accuracy and consistency in the claims process. Internal controls are processes established by federal agencies to provide reasonable assurance that the objectives of an entity will be achieved. GAO provides the standards and the overall framework for establishing and maintaining an

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[7] VBA Compensation Service Quality Assurance Mission Statement, accessed November 12, 2020, https://vbaw.vba.va.gov/bl/21/data/quality/qa_home.htm. (This is an internal VA website not publicly accessible.)

[8] The five VA OIG reports are (1) *The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings*, Report No. 20-00049-122, May 18, 2021; (2) *Site Visit Program Can Do More to Improve Nationwide Claims Processing*, Report No. 19-07062-230, August 18, 2020; (3) *The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies*, Report No. 19-07059-169, July 22, 2020; (4) *Deficiencies in the Quality Review Team Program*, Report No. 19-07054-174, July 22, 2020; and (5) *Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide*, Report No. 19-07062-255, September 29, 2020.

[9] VBA Compensation Service Quality Reports, accessed July 16, 2021, https://vbaw.vba.va.gov/bl/21/data/quality/consis/consis_focus.htm. (This is an internal VA website not publicly accessible.)

[10] Blue Water Navy Vietnam Veterans Act of 2019, Pub. L. No. 116-23, § 1116A (2019). This act expanded the presumption of herbicide exposure to veterans who served within 12 nautical miles of South Vietnam. Claims from these veterans are known as Blue Water Navy claims.

effective internal control system for federal agencies.[11] Federal agencies are required to establish internal control systems consistent with GAO's standards,[12] which include five components:

1. **Control Environment**: the foundation for an internal control system that provides the discipline and structure, which affects the overall quality of internal control.
2. **Risk Assessment**: the assessment of risks facing the entity as it seeks to achieve its objectives, which provides the basis for developing appropriate risk responses.
3. **Control Activities:** the actions management establishes through policies and procedures to achieve objectives and respond to risks in the internal control system, which includes the entity's information systems.
4. **Information and Communication:** the use of effective information and communication are vital for an entity to achieve its objectives; management needs access to relevant and reliable communication related to internal as well as external events.
5. **Monitoring:** the assessment of performance over time and prompt resolution of findings from audits and other reviews, which includes corrective actions.

The OIG team evaluated VBA's design of the special-focused review process, including its standard operating procedure, and implementation of the reviews. The team assessed the process, in light of GAO's standards, to identify how VBA could enhance the process to help improve quality and assess consistency and compliance. As seen in figure 1, GAO identifies 17 principles under the five components; the seven principles focused on in this review are in blue.[13]

[11] Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

[12] Federal Managers' Financial Integrity Act of 1982, as amended, 31 U.S.C. § 3512 (c) and (d) (2021). The Comptroller General is required to issue standards for internal control in the federal government.

[13] Since this review was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time.

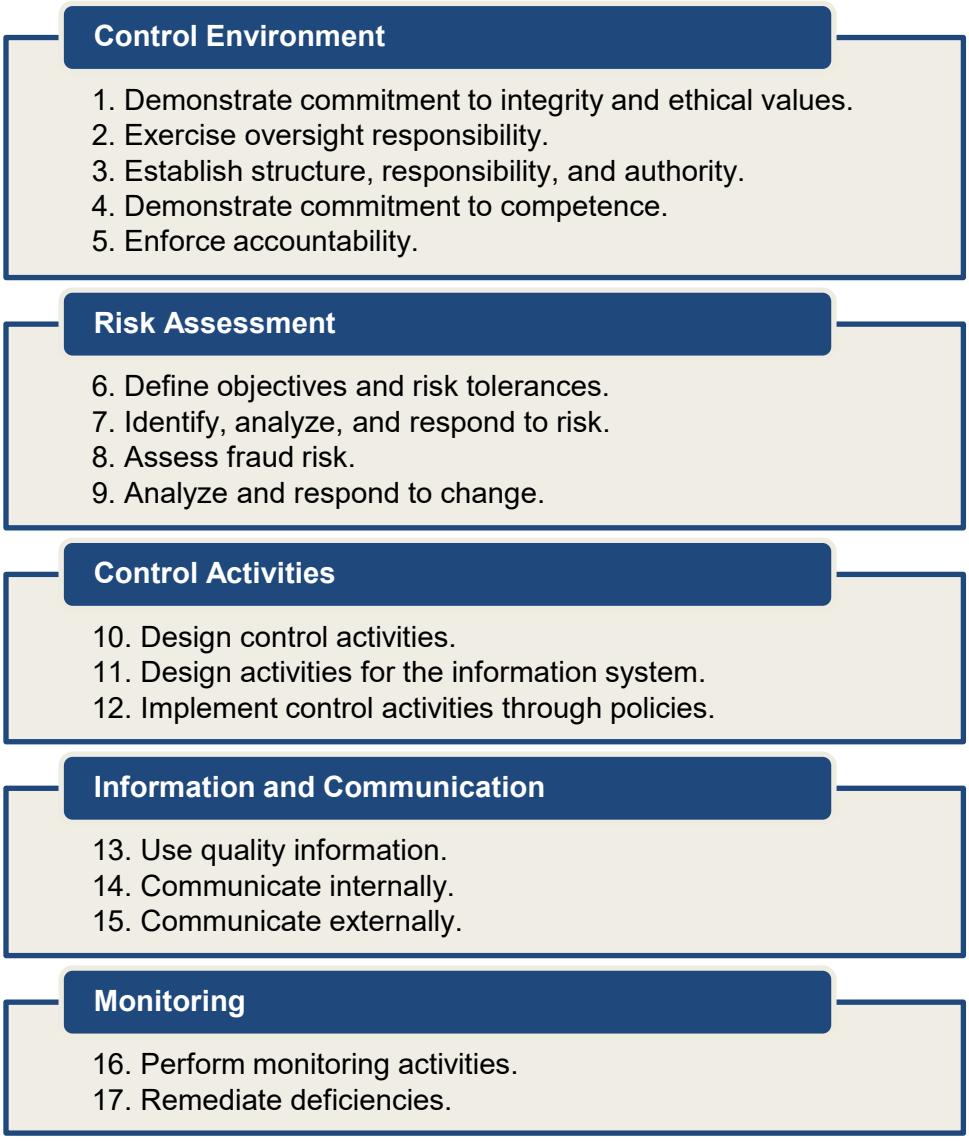


Figure 1. *Overview of internal control principles*

Source: OIG analysis. The principles listed are consistent with GAO Standards for Internal Control in the Federal Government.

Note: Principles 7, 10, 14, 16, and 17 are discussed in finding 1, and principles 5, 11, and 16 (again) are discussed in finding 2.

VBA Components Related to the Special-Focused Review Process

Both VBA's Compensation Service and the Office of Deputy Under Secretary for Field Operations (commonly referred to as the Office of Field Operations within VBA) support the special-focused review process. The Compensation Service's quality assurance office conducts the reviews, and the Office of Field Operations oversees corrective actions taken by regional office staff for errors identified as part of special-focused reviews. The Office of Field

Operations also evaluates management goals and objectives for VBA regional and district offices and helps develop achievable performance measures that ensure the quality and consistency of benefits delivery systems. The offices are included in VBA's organizational structure as shown in figure 2. The offices highlighted in blue conduct special-focused reviews.

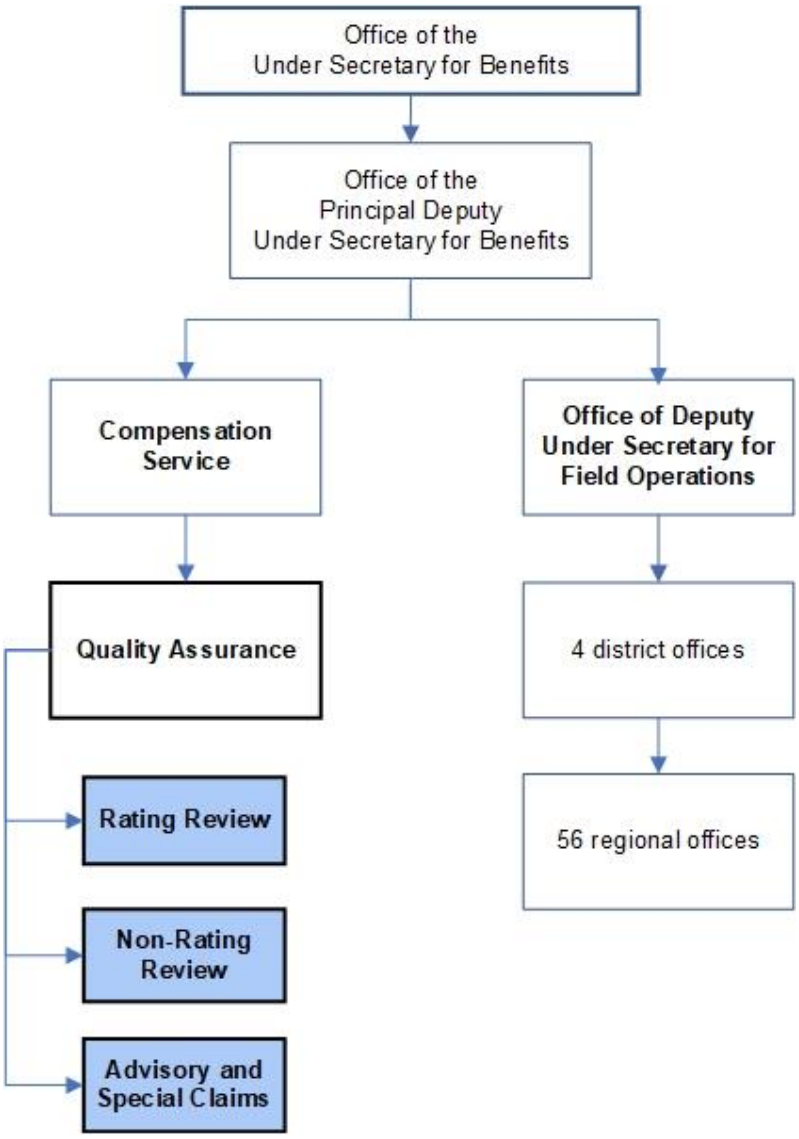


Figure 2. *Organization of VBA offices associated with special-focused reviews.*

Source: OIG interpretation of various VBA organization charts.

Note: Compensation Service's quality assurance also contains Program Operations staff; however, they do not directly participate in completing special-focused reviews.

Compensation Service

The Compensation Service uses multiple methods to determine quality levels and improve claims processing. These methods include training, national and local quality reviews, as well as special-focused reviews. Three teams under quality assurance participate in special-focused reviews: Rating Review, Non-Rating Review, and Advisory and Special Claims.

Office of Field Operations

The Office of Field Operations oversees VBA's district, regional, and other field offices to ensure they deliver benefits and services effectively and efficiently. It is also responsible for

- providing VBA benefits and services in a timely and objective manner with respect to speed, accuracy, and customer satisfaction;
- managing workload based on the availability of resources at each regional office; and
- evaluating the performance of regional and district offices.[14]

District Offices

Each district office is responsible for the effective management of VBA regional offices for an assigned geographical area. They monitor, track, and evaluate operations of the regional offices within their area of jurisdiction; provide oversight on implementation of new or revised programs, policies, initiatives, and applications; and regularly visit and meet with regional office leadership to ensure operations conform to all applicable laws, regulations, and established policies and procedures.

Regional Offices

Regional offices process claims for benefits. They also serve as a point of contact for veterans to obtain information about VA benefits, request assistance in filing a claim, receive information and evidence.

Overview of the Special-Focused Review Process

Compensation Service special-focused review staff developed a standard operating procedure for special-focused reviews.[15] Staff are expected to implement their special-focused reviews using the procedure's related guidelines. The Compensation Service has also developed quality review checklists for each special-focused review. These checklists are designed to facilitate

[14] VA, *Functional Organizational Manual*, ver. 6.0, organizational charts as of May 15, 2020, remaining data as of September 1, 2020.

[15] VBA, "Compensation Service Quality Assurance Staff Special-Focused Reviews Standard Operating Procedure (SOP)," October 2019.

consistently structured reviews for a specific topic. Quality assurance reviewers complete the checklist for each claim in the Quality Management System (QMS), which is the electronic system VBA uses to track claims quality metrics for analysis and training purposes.

When Compensation Service special-focused review staff complete a review, they publish the results to an internal website accessible to VBA staff. Table 1 describes the individuals serving within the quality assurance office whose roles and responsibilities relate to the special-focused review process.

Table 1. Quality Assurance Positions Responsible for Special-Focused Reviews

Position	Description
Compensation Service executive director	Determines when to conduct a special-focused review, considering areas in which quality improvement is needed for consistency and compliance with VBA procedures.
Quality assurance director	Provides final approval for a special-focused review when staff has identified a quality improvement need (in addition to any proposed by the executive director).
Quality assurance officer	Assigns the special-focused review based on subject matter expertise. Communicates progress to the quality assurance director.
Special-focused review supervisor	Manages the entire special-focused review process with all relevant staff and provides direction and guidance to draft the special-focused review final report.
Special-focused review lead analyst	Prepares for and conducts the review, analyzes data, and prepares a draft of the final report.
Special-focused review staff	Review cases and document results in QMS.

Source: VA OIG analysis of VBA positions responsible for special-focused reviews based on descriptions located in the special-focused review operating procedure, VBA Compensation Service workload management plan, and quality assurance interviews.

Note: Conducting special-focused reviews is an ancillary duty for Compensation Service quality assurance staff members, who are internally referred to as quality review specialists, consultants, or team members. For the purpose of this report, "special-focused review staff" refers to the quality assurance staff members who conducted the special-focused reviews.

Types of Errors

Special-focused review staff may cite two types of errors, as seen in table 2.

Table 2. Types of Errors

Error	VBA's definition	Example
Benefit entitlement	Incorrect or premature claims-processing actions that do not comply with regulations or other directives and affect or potentially affect the outcome of claims.	The claims processor made an adverse final determination without allowing the veteran the required 60 days to respond.
Procedural deficiencies	Incorrect or premature claims-processing actions that do not generally rise to the level of benefit entitlement errors but may also require corrective action.	The claims processor did not correctly request clarification of a medical opinion.

Source: VA OIG analysis of VBA's manual.[16]

[16] VA Manual 21-4, chap. 3, topic 3, block b, "BE Categories," November 19, 2019; VA Manual 21-4, chap. 3, topic 3, block d, "Procedural Deficiencies," November 19, 2019.

Results and Recommendations

Finding 1: The Compensation Service Needs to Enhance the Special-Focused Review Process to Improve Claims-Processing Quality

In FY 2020, VBA paid over $91 billion in disability compensation benefits to over five million recipients.[17] The Compensation Service's quality assurance staff is responsible for driving improvement in accuracy and consistency in the claims process of benefits delivered to veterans and their families. As such, it is responsible for designing control activities to achieve objectives; it conducts special-focused reviews to help improve quality and assess consistency and compliance. However, the OIG team identified weaknesses in the special-focused review process in four internal control areas: risk assessment, control activities, information and communication, and monitoring.

Although the Compensation Service has a special-focused review process, its standard operating procedure does not provide sufficient guidance to fully support claims-processing improvement. For example, the standard operating procedure does not specify that final reports must discuss the causes for errors. Therefore, although special-focused review staff assess some risks by identifying errors and trends, they do not analyze why claims processors made the errors. Without this "root cause" information, leaders are not well-positioned to remediate the risk of continued deficiencies.

Further, the Compensation Service does not communicate all necessary information internally. Despite the standard operating procedure requiring staff to provide error trends in final reports, the Compensation Service did not always include information on all errors. Some regional office training managers reported that they did not receive error trends for their office, which could have allowed for more targeted training. Finally, VBA does not measure the effectiveness of actions taken in response to each special-focused review. Without this monitoring component, VBA lacks assurance that special-focused reviews are improving quality as intended.

Until the Compensation Service improves its special-focused review process, it will continue to miss opportunities to ensure veterans receive accurate decisions and, ultimately, the benefits they deserve.

What the OIG Did

The OIG conducted this review to evaluate VBA's design of the special-focused review process, including its standard operating procedure, and implementation of the reviews. The OIG team

[17] "Quick Reference: Recipients, Payments and Disabilities," VBA, accessed May 6, 2022, https://www.benefits.va.gov/REPORTS/abr/docs/2020_compensation.pdf.

assessed 10 special-focused reviews, including examining the final reports summarizing the results, that the Compensation Service special-focused review staff completed from January 2019 through April 2021. This period covered 10 claims-processing reviews with nine topics (two involving military sexual trauma) as listed in table 3. For additional information regarding the topic of each special-focused review, see appendix A.

Table 3. Special-Focused Review Topics

Special-focused review	Publication month and year
Fugitive felon	January 2019
ALS	February 2019
Special monthly compensation housebound benefits	April 2019
End-product cancellation	October 2019
Posttraumatic stress disorder due to military sexual trauma	November 2019
Blue Water Navy	March 2020
Dependency	April 2020
End-product closures	June 2020
Posttraumatic stress disorder due to military sexual trauma (follow-up review)	March 2021
Accuracy of Claims Decisions Involving Conditions of the Spine	April 2021

Source: VBA's internal site for special-focused reviews.[18]

The team interviewed staff who performed special-focused reviews, managers from both the Compensation Service and the Office of Field Operations, and regional office claims-processing staff and managers. The team also assessed relevant documentation, as further explained in appendix B in the scope and methodology.

The following sections detail the determinations in support of the OIG's finding:

- Special-focused review staff did not determine why claims processors made errors.
- Final reports did not always include information about procedural errors.
- Final reports did not include a breakdown by regional office.
- The Compensation Service did not always follow up to assess whether special-focused reviews improved quality.

[18] VBA Compensation Service Quality Assurance's Special Focus Reviews, accessed July 16, 2021, https://vbaw.vba.va.gov/bl/21/data/quality/consis/consis_focus.htm. (This is an internal VA website not publicly accessible.)

Special-Focused Review Staff Did Not Determine Why Claims Processors Made Errors

As discussed above, managers should identify, analyze, and respond to risks; design controls to respond to risks; and remediate identified deficiencies.[19] Improving the design and implementation of special-focused reviews would assist Compensation Services in achieving these principals. This includes enhancing the standard operating procedure to require a more detailed analysis to determine the reasons why claims processors made errors.

Compensation Service special-focused review staff use a topic-specific checklist to meet the review objective and document the checklists in QMS for each claim reviewed. Once the claims review is complete, the team lead analyzes data to determine what error trends will be included in the final report. Although the Compensation Service quality assurance standard operating procedure states that case selection for the review should begin with the intent to pinpoint root causes and determine why errors are happening, it does not specify that final reports must discuss the causes.

To determine if special-focused review reports were analyzing why claims-processing errors occurred, the OIG team examined 10 special-focused review final reports. None of the reports included this analysis. Further, the quality assurance checklists for each of the special-focused reviews did not have a question asking for an assessment of why the error occurred. For example, for the errors identified in the report titled *Accuracy of Claims Decisions Involving Conditions of the Spine Special-Focused Review*, special-focused review staff noted a high percentage of errors were related to examinations and medical opinions.[20] However, the report did not determine or discuss why exam-related errors were made nor did it provide a recommendation to address these errors. Figure 3 shows the recommendations from the report relate only to where to post the final report (without an analysis of causes among its findings) and how those findings should be communicated.[21]

[19] GAO, *Standards for Internal Control in the Federal Government*.

[20] See appendix C for the full text of this special-focused review report.

[21] VA OIG report *Accuracy of Claims Decisions Involving Conditions of the Spine*, Report No. 18-05663-189, September 5, 2019. In the report, the OIG recommended the under secretary "[i]mplement a plan to conduct a focused analysis of claims processor compliance with the requirements set forth by recent court decisions regarding examiner opinions and formulate a plan to review and take corrective action on affected claims if deemed necessary based on the results of the review." In response, VBA conducted this special-focused review.

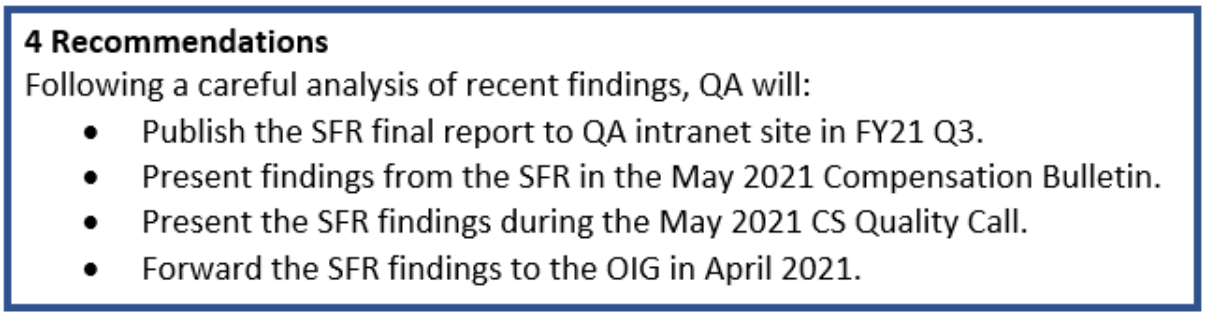


Figure 3. *Excerpt from the conditions of the spine special-focused review report.*

Source: Accuracy of Claims Decisions Involving Conditions of the Spine Special-Focused Review, VBA Memo dated April 21, 2021, posted to VBA's internal site.

The OIG team was unable to determine why the spine errors identified by special-focused review staff occurred and concluded that Compensation Service would need to complete additional work to determine why exam errors were made since this was not documented in the special-focused review checklist. The OIG team asked the Compensation Service quality assurance supervisors if staff conducting the special-focused reviews contact regional office employees to determine why errors occurred. The supervisors indicated this level of analysis is not required by the standard operating procedure. Also, contacting regional office employees would be time-consuming and would require coordination and approval from the Office of Field Operations. However, the Compensation Service quality assurance director stated that special-focused reviews were originally developed to analyze why claims-processing errors occurred. The director did acknowledge that it is difficult to identify why errors are made without having a discussion with claims processors.

Although the standard operating procedure does not specify that special-focused review staff must identify the root causes in the final report, the OIG team determined the lack of information hinders Compensation Service's ability to effectively address the identified deficiencies. The standard operating procedure only provides guidance that error trends—which may not include the cause for those errors, as explained above—are to be discussed in the final report. By communicating this more comprehensive information, VBA may help reduce continued errors.

Recommendation 1 is to update the special-focused review standard operating procedure to require an analysis of why errors occurred.

Final Reports Did Not Always Include Information about Procedural Errors

Managers should internally communicate the necessary quality information to achieve the agency's objectives.[22] The standard operating procedure requires special-focused review staff

[22] GAO, *Standards for Internal Control in the Federal Government*.

provide error trends in final reports; it does not exempt procedural errors. However, the team found staff did not always provide information about procedural errors in final reports. The OIG team analyzed data for all 10 special-focused reviews and found that quality assurance reviewers identified and internally documented both benefit entitlement errors and procedural deficiencies. However, only four of the 10 special-focused review final reports contained a discussion about procedural deficiencies. Example 1 describes a special-focused review report that did not contain a discussion of procedural deficiencies despite having this data available.

Example 1

For the Military Sexual Trauma Special-Focused Review Report in March 2021, quality analysts cited one or more errors on 117 of 242 claims. In the final report, the Compensation Service discussed the 34 benefit entitlement errors, resulting in a reported accuracy rate of 85.9 percent. However, despite having the information readily available, it did not report on the 103 procedural errors that may have affected veterans' claims.

While special-focused reviews did not place as much emphasis on procedural deficiencies as they do on benefit entitlement errors, procedural errors reflect a lack of compliance. Noncompliance can lead to improper or premature denials of claims and affect the accuracy of claims and the benefits veterans receive. In a prior report, the OIG identified an example demonstrating the importance of claims processors following VBA procedural requirements and how noncompliance with these procedures can lead to improper or premature denials of claims and affect benefits.[23] In this case, the special-focused review staff identified procedural errors and indicated they required correction. Correction of the error resulted in a grant of benefits to the veteran.

Example 2

Special-focused review staff reviewed a denied military sexual trauma claim as part of their special-focused review. A claims processor denied the claim, stating, "We are unable to identify any in service event or markers." Staff performing the special-focused review reported the claim as accurate. However, staff identified procedural deficiencies including that alternative evidence was not considered and potential behavioral markers were overlooked (the veteran received nonjudicial punishment in the same year as the claimed assault). Based on these facts, a claims processor should have requested an examination. The veteran reported the claim denial "triggered more suppressed memories." The veteran's personnel records, which were reviewed as part of the original claim, showed

[23] VA OIG, *Improvements Still Needed in Processing Military Sexual Trauma Claims*, Report No.20-00041-163, August 5, 2021.

> *evidence the veteran was punished for not reporting to their place of duty when the claimed assault was a forced sexual encounter by a superior. Regional office staff reviewed the records again and requested an examination based on the reported marker. The examiner provided a positive diagnosis and opinion. The veteran's claim for posttraumatic stress disorder due to military sexual trauma was later granted.*

Until Compensation Service provides information about procedural errors in final reports, to include identifying and analyzing them, it will not be well-positioned to take action to remediate these deficiencies. Therefore, the OIG's second recommendation is to establish controls to ensure special-focused review reports communicate both benefit entitlement and procedural errors.

Final Reports Did Not Include a Breakdown by Regional Office

The OIG team determined none of the special-focused review final reports during the review period provided specific errors or trends by regional office. A supervisory program analyst with the Office of Field Operations told the OIG team that special-focused review results are based on national findings but should include a regional office breakdown of information, and this breakdown would be beneficial as error trends may not pertain to all regional offices. This lack of communication may result in regional office staff continuing to make similar errors, which can affect the accuracy of claims decisions involving veterans' benefits.

By not providing targeted regional office feedback, the Compensation Service missed an opportunity to improve claims-processing accuracy and consistency. Some regional office training managers reported that they did not receive error trends for their office, which could have allowed for more targeted training. That information could also help provide the Office of Field Operations personnel a greater understanding of why errors occurred at offices they oversee.

Recommendation 3 is to establish controls to ensure special-focused review reports communicate all errors identified at both the national and regional office levels.

The Compensation Service Did Not Always Follow Up to Assess Whether Special-Focused Reviews Improved Quality

Managers should establish and monitor personnel's compliance with VBA procedures and evaluate the results.[24] An initial special-focused review can be used to establish a quality baseline from which an action plan can be developed to address and remediate deficiencies

[24] GAO, *Standards for Internal Control in the Federal Government.*

found. After the deficiencies are addressed, a partial or full follow-up process can assess the effectiveness of actions taken by VBA to help determine if quality has improved.

The Compensation Service special-focused review standard operating procedure does not provide guidance on how quality assurance will measure the effectiveness of special-focused review report recommendations. A Compensation Service quality assurance supervisor indicated that a follow-up process had not been established and without a follow-up plan, the Compensation Service cannot determine if improvements have been demonstrated. A Compensation Service quality assurance manager said there is not an established threshold to determine whether a follow-up review is warranted, and another indicated the need for a follow-up review is determined on a case-by-case basis.

Despite the lack of follow-up guidance offered by the standard operating procedure, the Compensation Service special-focused review staff recommended a follow-up review be completed in five of the 10 special-focused reviews. However, only two follow-up reviews had been completed at the time of the OIG's review, as shown in table 4. Based on responses from Compensation Service quality assurance managers, the OIG team concluded that planned follow-up special-focused reviews were not completed due to competing projects, priorities, and staffing.

Table 4. Special-Focused Review Follow-up Status as of April 30, 2022

VBA recommended follow-up review	Follow-up completed
Fugitive felon	No
Special monthly compensation (housebound benefits)	Yes
End-product cancellations	No
Posttraumatic stress disorder due to military sexual trauma (2019)	Yes
End-product closures	No

Source: OIG team summary of special-focused review reports with a recommendation of a follow-up review.

The OIG's fourth recommendation is to implement a process to measure the effectiveness of actions taken in response to each special-focused review and determine whether a follow-up review is needed.

Finding 1 Conclusion

Although Compensation Service special-focused review staff conducted special-focused reviews to improve quality and assess compliance with VBA procedures, they did not determine why claims processors made the errors. Further, final reports did not always include procedural errors and breakdown by regional office. By not communicating critical information to responsible

parties, the Compensation Service hindered leaders' ability to effectively address deficiencies. Finally, the Compensation Service did not always monitor whether special-focused reviews had the intended result of ensuring consistency and compliance with VBA's procedures. Therefore, without effective control activities, communication, and monitoring, VBA lacks assurance that special-focused reviews are improving quality as intended and may be missing opportunities to enhance the process. By making improvements to the process, the Compensation Service can make special-focused reviews more meaningful and leverage the results to improve claims-processing quality for veterans.

Recommendations 1–4

The OIG made the following recommendations to the under secretary for benefits:[25]

1. Update the special-focused review standard operating procedure to require analysis of why errors occurred.
2. Establish controls to ensure special-focused review reports communicate both benefit entitlement and procedural errors.
3. Establish controls to ensure special-focused review reports communicate all errors identified at both the national and regional office levels.
4. Implement a process to measure the effectiveness of actions taken in response to each special-focused review and determine whether a follow-up review is needed.

VA Management Comments

The principal deputy under secretary for benefits, signing for the Northeast District director who was performing the delegable duties of the under secretary for benefits, concurred with recommendations 1, 2, and 3, and provided action plans to address each recommendation. The principal deputy under secretary concurred in principle with recommendation 4, noting, "Each [special-focused review] is a standalone review with unique features resulting in need for a case-by-case determination if a follow-up review is needed. VBA will update the [standard operating procedure] to establish procedures to ensure follow-up reviews are completed when recommended in a [special-focused review] report." As proposed, the submitted plan for corrective action was responsive. Appendix D includes the full text of the principal deputy under

[25] The recommendations addressed to the under secretary for benefits are directed to anyone in an acting status or performing the delegable duties of the position.

secretary's comments. A summary of VBA's responses to the recommendations follow, all of which have a target completion date of July 31, 2022:

- **Recommendation 1.** VBA will update the special-focused review standard operating procedure to require an analysis of why errors occurred.
- **Recommendation 2.** VBA will update the standard operating procedure to ensure that procedural errors are identified, analyzed, and included in final reports.
- **Recommendation 3.** VBA will update the standard operating procedure to ensure special-focused review reports communicate all errors at the national and regional office levels.
- **Recommendation 4.** VBA will update the standard operating procedure to include a process to measure the effectiveness of actions taken in response to each special-focused review, as well as ensure follow-up reviews are completed when recommended in a report.

OIG Response

The action plans provided were responsive to address recommendations 1, 2, and 3. Although VBA concurred only in principle with recommendation 4, the action plan was responsive to address the intent of the recommendation. The OIG will monitor VBA's implementation of planned actions and will close the recommendations when satisfied that sufficient progress has been made to address the recommendations and the issues identified.

Finding 2: VBA Does Not Effectively Monitor Error Corrections to Ensure They Are Completed

While conducting special-focused reviews, Compensation Service special-focused review staff often find errors in claims processing that must be corrected. However, the OIG team determined some claims processors erroneously updated QMS to reflect corrections that were not taken and there is not a sufficient error correction validation process. As a result, VBA leaders do not know whether all errors requiring correction were resolved. Until VBA enforces accountability, designs activities for the information system, and improves monitoring activities, claims will remain uncorrected—meaning veterans may not receive the benefits to which they are entitled. The OIG team identified weaknesses in the special-focused review process in three internal control areas: control environment, control activity, and monitoring.

What the OIG Did

The OIG team analyzed the errors cited in special-focused reviews published between January 2019 and April 2021. For the seven special-focused reviews completed in QMS, the team reviewed the veterans' electronic claims records for the 179 claims with one or more benefit entitlement errors cited by special-focused review staff.[26] As the fugitive felon, ALS, and special monthly compensation housebound benefits special-focused reviews were conducted prior to the use of QMS to document these reviews, the team did not review the error correction completion status for these reviews. The team also reviewed the Compensation Service special-focused review standard operating procedure and VBA's manual guidance for error corrections. The team interviewed staff who performed special-focused reviews, managers from both the Compensation Service and the Office of Field Operations, and regional office claims-processing staff and managers.

VBA Did Not Hold Staff Accountable for Correcting Errors or Effectively Monitor the Correction Process

The OIG team identified that about 26 percent of claims reviewed (47 of 179) were erroneously marked as corrected in QMS.[27] VBA was notified of the uncorrected errors, and they agreed with one or more of the OIG findings in nearly 94 percent of the claims (44 of 47). Example 3 demonstrates the potential consequences to veterans when claims processors improperly indicate errors have been corrected.

[26] There were 180 claims with benefit entitlement errors cited by special-focused review staff during the seven special-focused reviews. The OIG team did not review one claim because the risk of revealing personally identifiable information was high due to the public prominence of the individual involved.

[27] The errors remained uncorrected as of July 22, 2021.

Example 3

Special-focused review staff identified two errors in a claim during the Blue Water Navy special-focused review. Disability compensation benefits should have been granted effective a year earlier, and clarification of the VA examination was needed. Staff documented the errors in QMS, and the responsible claims processor indicated that the claim had been corrected in QMS. However, the OIG team's review of the claim record showed that neither of the errors were corrected. As a result, the veteran did not receive over $14,000 in retroactive disability benefits and the examination clarification had not been addressed. As of August 1, 2022, these errors still had not been corrected.

In July 2020, the OIG issued two reports regarding VBA's quality assurance program and recommended that "VBA establish adequate policies, procedures, and monitoring to ensure corrections are completed timely and accurately" as well as "improve oversight procedures for monitoring the timeliness of error corrections."[28] After the reports were issued, the Compensation Service quality assurance team reviewed QMS and found over 10,000 local and national quality errors (to include special-focused reviews) still pending correction dating back to early FY 2017. Based on a discussion with a Compensation Service senior quality assurance specialist, the OIG team determined that these included cases in which (1) no action had been taken or (2) action had been taken but QMS was not updated.

In response to the unresolved error corrections and OIG recommendations, the Compensation Service developed an error correction monitoring tool using QMS data. During the development of the monitoring tool, Compensation Service personnel reported they spoke with numerous regional office managers and realized there was no standardized process to identify outstanding errors still needing correction. QMS includes a checkbox for claims processors to indicate they have accepted and corrected an error; the tool tracks data from these checkboxes. Following training on and implementation of this monitoring tool, VBA reported it was able to reduce the number of pending corrections shown in QMS from over 10,000 to just under 2,000 by July 2021.

Although the OIG recognizes VBA's efforts to improve compliance with error corrections, the OIG team found that the data in the monitoring tool is unreliable; some employees, despite not making the corrections, updated QMS to reflect corrections were made. Although supervisors are required to ensure claims processors took corrective actions to resolve errors, due to the system design of QMS, claims processors can close out errors without supervisory approval. The system does not have a mechanism to route errors with a status of "complete" to supervisors for

[28] VA OIG, *The Systemic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies*, Report No. 19-07059-169, July 22, 2020; VA OIG, *Deficiencies in the Quality Review Team Program*, Report No. 19-07054-174, July 22, 2020.

validation. Further, the special-focused review standard operating procedure does not include a process to validate whether regional office employees corrected errors.

While VBA reported that the QMS monitoring tool has improved completion and timeliness of pending corrections, a senior quality assurance specialist acknowledged that VBA could not know whether the actions taken on error corrections were accurate without a validation process. The analyst reported several reasons why no specific process existed, including

- national quality review staff were not regularly completing validation of error corrections due to other duties, and
- validation of error corrections was up to the discretion of regional office managers, but there was no requirement for them to ensure error corrections were accurate.

Although this report focuses on actions at the Compensation Service and regional offices, the OIG team noted the Office of Field Operations and the district offices share responsibility for ensuring operations conform to all applicable laws, regulations, and established policies and procedures. Compensation Service staff informed the OIG team that they do not have responsibility over employees to ensure that special-focused review report findings, recommendations, or guidance are followed by regional office employees—this responsibility falls to the Office of Field Operations and the district offices. A quality assurance supervisor stated the Office of Field Operations is responsible for ensuring the corrective action occurs, while a supervisory program analyst at the Office of Field Operations stated regional office managers are generally accountable for error corrections.

Until staff are held accountable, VBA will continue to lack assurance that errors were corrected as intended. Recommendation 5 is for VBA to reassess special-focused review errors marked as "corrected" to determine whether corrective actions were taken. The OIG's sixth recommendation is to assess whether an enhancement to QMS could mitigate the risk of claims processors closing special-focused review errors without correction and develop a process to ensure corrective actions are taken on all errors going forward.

Finding 2 Conclusion

Some VBA claims processors erroneously indicated errors were corrected in QMS without making necessary corrections. Without accurate error correction data, VBA leaders cannot confirm whether errors are being corrected and are not well-informed to make strategic decisions to improve the special-focused review process. Until VBA enforces accountability, enhances the information system, and improves monitoring activities, it will continue to lack assurance that claims processors are making necessary corrections, and veterans may not receive the benefits they deserve.

Recommendations 5 and 6

The OIG made the following recommendations to the under secretary for benefits:

5. Reassess special-focused review errors marked as "corrected" to determine whether corrective actions were taken.
6. Assess whether an enhancement to the Quality Management System could mitigate the risk of claims processors closing special-focused review errors without correction and develop a process to ensure corrective actions are taken on all errors.

VA Management Comments

The principal deputy under secretary for benefits, signing for the Northeast District director who was performing the delegable duties of the under secretary for benefits, concurred with recommendations 5 and 6 and provided action plans to address each recommendation. Appendix D includes the full text of the principal deputy under secretary's comments. A summary of VBA's responses to the recommendations follow:

- **Recommendation 5.** With a target completion date of October 31, 2022, VBA will develop a plan to reassess special-focused review errors that were marked as "corrected" to determine whether corrective actions were taken.
- **Recommendation 6.** With a target completion date of December 31, 2022, VBA will develop a process to ensure corrective actions are taken on all special-focused review errors. This will include an assessment of whether an enhancement to the Quality Management System is required.

OIG Response

The action plans provided were responsive to each recommendation. The OIG will monitor VBA's implementation of planned actions and will close the recommendations when satisfied that sufficient progress has been made to address the intent of the recommendations and the issues identified.

Appendix A: VBA Special-Focused Reviews during the Review Period

This review focused on VBA's special-focused reviews published during the period from January 2019 through April 2021, as listed below.

Table A.1. Special-Focused Review Topics

Topic	Publication date	Topic justification
Fugitive felon	January 2019	Initiated by Compensation Service quality assurance to better determine accuracy and ensure compliance with current guidance and policies relating to the processing of fugitive felon claims.
ALS	February 2019	Initiated in response to an OIG recommendation to monitor these claims to ensure staff proficiency and that veterans with ALS receive notice regarding any possible additional special monthly compensation benefits.
Special monthly compensation housebound benefits	April 2019	Initiated in response to an OIG recommendation to conduct periodic reviews of high-risk cases in which special monthly compensation housebound benefits are being paid.
End-product cancellation	October 2019	Initiated by Compensation Service quality assurance to confirm compliance with proper usage of the current end-product system.
Posttraumatic stress disorder due to military sexual trauma	November 2019	Initiated in response to an OIG recommendation that a special-focused review be completed and an OIG finding that nearly half of denied military sexual trauma -related claims were not properly processed due to failure to follow VBA policy.
Blue Water Navy	March 2020	Initiated by Compensation Service quality assurance following implementation of the Blue Water Navy Vietnam Veterans Act of 2019.

Topic	Publication date	Topic justification
Dependency	April 2020	Initiated by Compensation Service quality assurance to determine the accuracy of dependency decisions and concerns regarding potential missed dependency claims, errors in adding or removing dependents, and improper effective dates.
End-product closures	June 2020	Initiated by Compensation Service quality assurance to confirm compliance and proper usage of the current end-product system.
Posttraumatic stress disorder due to military sexual trauma	March 2021	Initiated by Compensation Service quality assurance to annually review denials of service connection for posttraumatic stress disorder and other mental conditions due to military sexual trauma.
Accuracy of claims decisions involving conditions of the spine	April 2021	Initiated based on VBA response to OIG report recommendation that a special-focused review be completed for claims involving the spine to ensure compliance with the requirements set forth by recent court decisions involving examiner opinions.

Source: VBA Compensation Service quality assurance special-focused reviews description, accessed July 16, 2021, https://vbaw.vba.va.gov/bl/21/data/quality/consis/consis_focus.htm. (This is an internal VA website not publicly accessible.)

Source: OIG summary of multiple VBA documents and reports.

Appendix B: Scope and Methodology

Scope

The OIG team conducted its work from February 2021 through June 2022. The review focused on evaluating the design and implementation of VBA's special-focused reviews published during the period from January 2019 through April 2021.

Methodology

To accomplish the review objective, the team identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines for special-focused reviews. The OIG team requested and obtained information from the regional offices in Houston, Texas; San Diego, California; St. Louis, Missouri; and Winston-Salem, North Carolina. The team interviewed and obtained information on work processes associated with errors identified during special-focused reviews from managers and staff at the four regional offices as well as VBA's central office, including the Compensation Service and the Office of Field Operations.

The OIG team assessed the actions VBA took to design and implement special-focused reviews. The team reviewed errors from seven special-focused reviews that Compensation Service special-focused review staff entered into QMS. These reviews were the End-Product Cancellation, Posttraumatic Stress Disorder due to Military Sexual Trauma (2019), Blue Water Navy, Dependency, End-Product Closures, Posttraumatic Stress Disorder due to Military Sexual Trauma (2021), and Accuracy of Claims Decisions Involving Conditions of the Spine.

The team used VBA's electronic systems, including the Veterans Benefits Management System and QMS, to review the sampled veterans' electronic claim records and relevant quality review documentation required to assess whether VBA took actions to complete cited error corrections. The team also reviewed relevant documentation required to assess whether VBA designed and conducted the special-focused reviews in accordance with agency procedures. This included review of

- VBA's special-focused review guidance,
- the published report for each special-focused review,
- details on errors identified during the reviews, and
- relevant documentation in veteran's electronic claim records to assess whether claims processors corrected the errors.

Internal Controls

Oversight and accountability are intertwined and span several federal internal control principles. The OIG team assessed the internal controls of VBA's Compensation Service significant to the review objective. This included an assessment of the requirements for each of the five internal control components to include control environment, risk assessment, control activities, information and communication, and monitoring.[29] In addition, the team reviewed the requirements for the 17 principles of internal controls as associated with the objective. The team identified the following five components and seven principles as significant to the objective.[30] The team identified internal control weaknesses in all five components during this review and proposed recommendations to address the control deficiencies detailed in table B.2.

Table B.1. OIG Analysis of Internal Control Components and Principles Identified as Significant

Component	Principle and applicable attribute(s)	Deficiency identified by this report
Control environment	5. Enforce accountability *Attribute: enforcement of accountability*	VBA did not establish an effective validation method for error corrections.
Risk assessment	7. Identify, analyze, and respond to risks *Attributes: analysis of and response to risks*	The standard operating procedure did not require a complete analysis to determine why claims processors made errors.
Control activities	10. Design control activities *Attributes: response to objectives and risks and design of appropriate types of control activities*	Compensation Service did not design the standard operating procedure to include reporting and error trending of all error information to drive claim quality improvement.
	11. Design activities for the information system *Attribute: design of the entity's information system*	VBA's QMS does not restrict regional office claims processors from updating cited errors without completing corrective action.
Information and communication	14. Communicate internally *Attribute: communication throughout the entity*	(1) The standard operating procedure did not require communication of complete results to reduce continued errors. (2) Claims-processing deficiencies identified during special-focused reviews are often not reported. (3) Regional office details of errors were not included in final reports.

[29] GAO, *Standards for Internal Control in the Federal Government*.

[30] Since the review was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this review.

Component	Principle and applicable attribute(s)	Deficiency identified by this report
Monitoring	16. Perform monitoring activities *Attributes: establishment of a baseline, internal control system monitoring, evaluation of results*	(1) The standard operating procedure did not require a follow-up process to assess whether special-focused reviews improved quality. (2) VBA does not have assurance that special-focused review errors are being corrected and are accurate.
	17. Evaluate issues and remediate deficiencies *Attributes: reporting and evaluation of issues, corrective actions*	The standard operating procedure did not require a complete analysis of cited errors to target identified deficiencies.

Source: OIG analysis. The principles listed are consistent with GAO Standards for Internal Control in the Federal Government.

Fraud Assessment

The OIG team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the review objectives, could occur during this review. The team exercised due diligence in staying alert to any fraud indicators and did not identify any instances of fraud or potential fraud during this review.

Data Reliability

The OIG team used VBA's computer-processed data from its special-focused reviews in the form of post-review data workbooks for each review:

- **Fugitive felon** consisted of 246 cases involving automated and nonautomated adjustments during calendar year 2017.
- **ALS** consisted of 200 cases involving ALS entitlement decided during FY 2018.
- **Special monthly compensation housebound benefits** consisted of 50 cases that involved special monthly compensation (housebound) entitlement decided during FY 2018.
- **End-product cancellations** consisted of 261 cases involving both rating and non-rating end-products that were canceled after pending for more than 60 days during FY 2018 and in FY 2019 through March 31, 2019.
- **Posttraumatic stress disorder due to military sexual trauma (FY 2019) consisted** of 207 cases involving denied military sexual trauma claims finalized during May and June 2019.

- **Blue Water Navy** consisted of a total of 104 cases with 452 issues related to Blue Water Navy service as the primary disability, secondary disability, or ancillary benefits. No date range of claims reviewed was provided.
- **Dependency** consisted of a sample of 243 cases completed from October 1, 2017, through June 30, 2019, that consisted of both rating and non-rating end-products.
- **End-product closures** consisted of 263 cases involving both rating and non-rating end-products that were cleared (without rating action) under 30 days during FY 2019 (October 1, 2018, through September 30, 2019).
- **Posttraumatic stress disorder due to military sexual trauma (FY 2020)** consisted of 242 randomly selected cases with decisions made between July 2019 and September 2020.
- **Accuracy of claims decisions involving conditions of the spine** consisted of 203 randomly selected decisions made between October 1, 2019, and September 30, 2020.

To test for reliability, the team determined whether any data were missing from key fields, included any calculation errors, or were outside the time frame requested. The team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, the team compared veterans' names, file numbers, dates of claims, and end-product closed dates as provided in the data received to the Veterans Benefits Management System records reviewed.

Testing of the data sets disclosed that they were sufficiently reliable for the review objectives. Comparison of the data with information contained in the Veterans Benefits Management System records reviewed did not disclose any problems with data reliability.

Government Standards

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

Appendix C: Accuracy of Claims Decisions Involving Conditions of the Spine Special-Focused Review

Department of Veterans Affairs Memorandum

Date: April 21, 2021

From: Executive Director, Compensation Service (21C)

Subj: Accuracy of Claims Decisions Involving Conditions of the Spine Special Focused Review (SFR)

1. On September 5, 2019, the Office of the Inspector General (OIG) completed a review of decisions involving conditions of the spine and subsequently recommended that the Under Secretary for Benefits (USB) conduct a focused analysis to assess the accuracy of claims processors focusing on seeking clarification on examinations.
2. The Compensation Service (CS) Quality Assurance (QA) Staff conducted an SFR on decisions involving the spine from February to March 2021. The review sample consisted of 203 randomly selected cases with decisions made between October 1, 2019 to September 30, 2020. To be reviewed, a decision must have been made on a spine diagnostic code, 38 CFR §4.71a (5235 through 5243) on a Rating Bundle End Products 010, 110, 020 and 310.
3. The findings of this SFR are attached.

The OIG removed point of contact information prior to publication.

(Original signed by)

Beth Murphy
Executive Director
Compensation Service

Background

On September 5, 2019, VA's Office of Inspector General (OIG) issued a report titled "Accuracy of Claims Decisions Involving Conditions of the Spine". In this report, the OIG estimated the Veterans Benefits Administration (VBA) incorrectly processed more than half of the claims, involving the spine, decided in the first six months of 2018. The OIG review was based on a review of claims decided from January 1 to June 30, 2018. The OIG noted most errors involved inadequate exams, improper evaluations and missed secondary conditions. The OIG found errors resulted from inadequate processes and minimal guidance. Two specific reasons for errors involved the Court decisions of Mitchell v. Shinseki, Aug 23, 2011, 25 Vet.App. 32 and Sharp v. Shulkin, Sep 6, 2017, 29 Vet.App. 26 (2017). After the OIG report was issued, VBA made several changes to improve quality.

The February 2019 Quality Call (TMS # VA 4492181) addressed Mitchell Opinions in the post-Sharp World.

On February 25, 2019, revised Back (Thoracolumbar Spine) and Neck (Cervical Spine) Disability Benefit Questionnaires (DBQs) were released to VHA Facilities and VBA Contract Vendors.

The March 2019 Quality Call (TMS # VA 4499115) addressed Mitchell/Sharp – Sufficiency & Partial Rating Decisions.

The April 2019 Quality Call (TMS # VA 4501061) addressed Sharp-Compliant Mitchell Rationale Examples.

Training was conducted in 2019 for decision-makers ((TMS # 4489948 "The References, Episode One: Mitchell Opinions in the Post-Sharp World", which was part of the National Training Curriculum. This training was also provided to both Veterans Health Administration (VHA) examiners and contract examination providers.

On May 21, 2020, M21-1 III.iv.4.A.1.j clarified guidance on handling an examiner's statement that speculation is required.

On May 27, 2020, M21-1 III.iv.3.D.4.g a note was added regarding examiner's review of a claims folder in musculoskeletal claims involving functional loss.

On June 17, 2020, revised Back (Thoracolumbar Spine) and Neck (Cervical Spine) DBQs were released to VHA Facilities and VBA Contract Vendors.

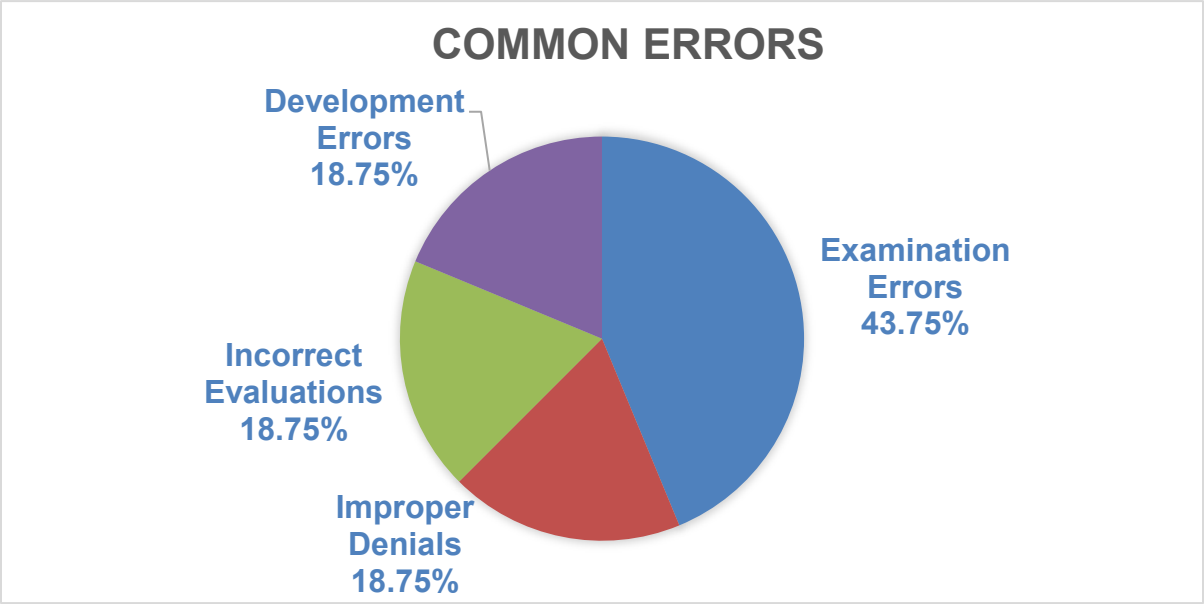
In February and March 2021, Compensation Service (CS) Quality Assurance (QA) Staff conducted a Special-Focused Review (SFR) involving the accuracy of decisions of the spine, expecting that the changes above may have improved quality.

Findings

Accuracy Overview

Claim files were reviewed for benefit entitlement (BE) errors. BE errors are defined as errors having an impact or potential impact on the outcome of a claim. Out of 203 cases reviewed, 14 cases contained BE errors. That is, 93.10% of the cases reviewed were not found to contain a BE error. Although, there were 16 BE errors in total as two cases had multiple BE errors. The most common errors found relate to the examinations and/or medical opinions provided being insufficient/inadequate. There were seven of these errors in total. A complete breakdown of BE error by category is listed below:

BE Error Category	Number of Errors	Percentage of Errors	Percentage in Error
Examination Errors	7	43.75%	3.45%
Improper Denial Errors	3	18.75%	1.48%
Evaluation Errors	3	18.75%	1.48%
Development Errors	3	18.75%	1.48%
Total Errors	16	100.00%	7.88%



Accuracy Details

A further breakdown of the noted 16 errors shows multiple reasons for errors falling in the four noted broad categories of examinations, improper denials, evaluations and development. More details are shown in the following table.

BE Error Breakdown		
Examination Errors		Number of Errors
	Correia Requirements Insufficient	2
	Sharp/Mitchell Requirements Insufficient	2
	VA Examination Addendum Not Requested	2
	Insufficient Medical Opinion	1
Total Examination Errors		**7**
Improper Denial Errors		
	Improper Denial of Spine Complications	2
	Improper Denial of Spine	1
Total Improper Denial Errors		**3**
Evaluation Errors		
	Improper Evaluation of Spine Complications	2
	Improper Evaluation of Spine	1
Total Evaluation Errors		**3**
Development Errors		
	Medical Records Not Requested	1
	Medical Opinion Not Requested	1
	Claimed Condition Not Addressed	1
Total Development Errors		**3**

Conclusion

The OIG conducted a review of claims involving the spine on claims worked approximately three years ago. The OIG review was conducted on 300 claims and the OIG found 171 errors, more than half of the claim the OIG found in error. VBA was responsive to the OIG findings and made multiple improvements. Among these improvements were additional training, adjudication manual updates and revised DBQs. It was envisioned by being responsive and making these improvements quality would improve. A review conducted now confirms these improvements did improve quality. The review conducted on claims processed between September 1, 2019 and October 1, 2020, shows 93.10% of the files reviewed were found to be without BE error(s).

Recommendations

Following a careful analysis of recent findings, QA will:

- Publish the SFR final report to QA intranet site in FY21 Q3.
- Present findings from the SFR in the May 2021 Compensation Bulletin.
- Present the SFR findings during the May 2021 CS Quality Call.
- Forward the SFR findings to the OIG in April 2021.

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Appendix D: VA Management Comments

Department of Veterans Affairs Memorandum

Date: July 15, 2022

From: Under Secretary for Benefits (20)

Subj: OIG Draft Report – The Compensation Service Could Better Used Special-Focused Reviews to Improve Claims Processing [Project No. 2021-01361-AE-0061] VIEWS 07799526

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

1. Attached is VBA's response to the OIG Draft Report: The Compensation Service Could Better Used Special-Focused Reviews to Improve Claims Processing

The OIG removed point of contact information prior to publication.

(Original signed by)

Mike J. Frueh, PDUBS
for Thomas J. Murphy
Director, Northeast District
Performing the Delegable Duties of the
Under Secretary for Benefits

Attachment

Attachment

Veterans Benefits Administration (VBA)
Comments on OIG Draft Report
The Compensation Service Could Better Used Special-Focused Reviews to Improve Claims Processing

The Veterans Benefits Administration (VBA) concurs with OIG's findings and provides the following comments in response to the recommendations in the OIG draft report:

Recommendation 1: Update the special-focused review standard operating procedure to require analysis of why errors occurred.

VBA Response: Concur. VBA will update the special-focused review (SFR) standard operating procedure (SOP) to require analysis of why errors occurred.

Target Completion Date: July 31, 2022

Recommendation 2: Establish controls to ensure special-focused review reports communicate both benefit entitlement and procedural errors.

VBA Response: Concur. VBA will update the SFR SOP to establish controls to ensure SFR reports communicate both benefit entitlement and procedural errors. The update will ensure that procedural errors are identified and analyzed in final reports.

Target Completion Date: July 31, 2022

Recommendation 3: Establish controls to ensure special-focused review reports communicate all errors identified at both the national and regional office levels.

VBA Response: Concur. VBA will update the SFR SOP to establish controls to ensure SFR reports communicate all errors identified at both the national and regional office levels.

Target Completion Date: July 31, 2022

Recommendation 4: Implement a process to measure the effectiveness of actions taken in response to each special-focused review and determine whether a follow-up review is needed.

VBA Response: Concur in principle. VBA will update the SFR SOP to include a process to measure the effectiveness of actions taken in response to each SFR. SFRs are conducted based on requests and information from multiple sources that includes but is not limited to the Office of Inspector General, Government Accountability Office, internally identified error trends and other internal request. Each SFR is a standalone review with unique features resulting in need for a case-by-case determination if a follow-up review is needed. VBA will update the SOP to establish procedures to ensure follow-up reviews are completed when recommended in a SFR report.

Target Completion Date: July 31, 2022

Recommendation 5: Reassess special-focused review errors marked as "corrected" to determine whether corrective actions were taken.

VBA Response: Concur. VBA will develop a plan to reassess SFR errors that were marked as "corrected" to determine whether corrective actions were taken. VBA anticipates completing the plan by October 31, 2022

Target Completion Date: October 31, 2022

Recommendation 6: Assess whether an enhancement to the Quality Management System could mitigate the risk of claims processors closing special-focused review errors without correction and develop a process to ensure corrective actions are taken on all errors.

VBA Response: Concur. VBA will develop a process to ensure corrective actions are taken on all errors. During development, VBA will assess whether an enhancement to Quality Management System (QMS) is required. VBA expects to develop a process and document our assessment of whether an enhancement to QMS is warranted by December 31, 2022.

Target Completion Date: December 31, 2022

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

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