DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS BENEFITS ADMINISTRATION

VBA Did Not Ensure Complex Appeals Were Decided by Appropriate Staff

REVIEW | REPORT #22-01814-36 | MARCH 9, 2023

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Executive Summary

The Veterans Benefits Administration (VBA) provides monthly compensation benefits to veterans for disabilities caused by diseases or injuries incurred or aggravated during active military service. When veterans disagree with VBA's decision, they may appeal it. Decision review operations centers (DROCs) are responsible for appeals processing, which consists of developing, deciding, and providing decision notices regarding the appealed issues. The DROCs are located in Seattle, Washington; St. Petersburg, Florida; and Washington, D.C. VBA's Office of Administrative Review (OAR) manages and operates the DROCs by establishing policies and procedures, and conducting quality control, training, and site visits.

Complex appeals can involve high priority and complex processing of claims related to amyotrophic lateral sclerosis (ALS), military sexual trauma (MST), and traumatic brain injury (TBI). Specialized processors designated to issue decisions on these complex appeals are rating veterans service representatives (RVSRs) and decision review officers (DROs). In this report, the term "rater" refers to both RVSRs and DROs, unless otherwise specified.

Raters must meet specific requirements and follow certain procedures to decide complex appeals. These requirements and procedures include

- designation in VBA's Workforce Information Tool (WIT) as a specialized claims processor,[1]
- completion of all mandatory training courses specific to complex appeals,[2] and
- second signature reviews of rating decisions that involve MST and TBI, until a rater has demonstrated an accuracy rate of 90 percent or greater based on a review of at least 10 cases.[3]

In March 2022, an anonymous source submitted a hotline allegation to the VA Office of Inspector General (OIG) that a DROC was not designating the appropriate staff to work complex appeals. The complainant stated there were no designated decision makers assigned to work these complex appeals, and staff had not completed any additional training that would provide proficiency to work these complex appeals.

[1] VA Manual M21-5, "Decision Review Operations Center (DROC) Structure," chap. 1, sec. A in *Appeals and Reviews*, January 5, 2022; November 12, 2021; and October 6, 2020.

[2] VA Manual M21-5, "National Training Program," chap. 2 in *Appeals and Reviews*, February 3, 2022; December 8, 2021; November 18, 2021; and October 1, 2021.

[3] DROs are exempt from the MST second signature requirement. VA Manual M21-1, "Codesheet Section," part v, sub. iv, chap. 1, sec. B in *Adjudication Procedures Manual*, November 12, 2020.

Previous OIG reports found that when raters were not fully trained, designated, or subjected to second signature reviews, disability claims associated with complex appeals were frequently inaccurately processed and leading to improper payments.[4] As an example, during this review, the OIG observed three inaccurate decisions of complex appeals completed by raters who did not meet requirements. As a result of one of the inaccurate decisions, a veteran was underpaid approximately $12,900 for an ALS evaluation. While the accuracy of the decisions was not in the scope of this review, and, as such, this review did not focus on the accuracy of each decision and does not represent VBA's overall claims processing accuracy rate, this example is presented to convey when raters do not meet requirements, inaccurate decisions can result which can lead to improper payments. This underscores the importance of ensuring raters meet requirements when deciding complex appeals.

The OIG conducted this review to assess the merits of the hotline allegation.

What the Review Found

Following the hotline allegation, the OIG substantiated that some raters from each DROC did not meet all requirements while issuing decisions on complex appeals. The review team looked at three distinct samples of appeals (referred to as complex appeals), consisting of ALS, MST, and TBI decisions that were completed by DROC raters during the review period of October 1, 2021, through February 28, 2022.

The OIG estimated 1,200 of 1,300 complex appeals (93 percent) were decided by DROC raters who had not been designated in the WIT to process complex appeals, had not completed all mandatory training, or did not receive the second signature reviews when required. In addition, the OIG estimated:

- 760 of 1,300 complex appeals were decided by DROC raters who were not designated in the WIT as a specialized processor,
- 780 of 1,300 complex appeals were decided by DROC raters who had not completed all mandated training courses concerning the appealed issue, and
- 820 of 820 complex appeals were decided by DROC raters without required second signatures.[5]

[4] VA OIG, *Systemic Issues Reported During Inspections at VA Regional Offices*, Report No. 11-00510-167, May 18, 2011; VA OIG, *Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma*, Report No. 17-05248-241, August 21, 2018; and VA OIG, *Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis*, Report No. 18-00031-05, November 20, 2018. The scopes of these reports were focused at the VA regional office level.

[5] Population is smaller for this finding as it consisted of only those samples that required second signatures at the time of the OIG review.

The OIG found that OAR did not monitor completed appeals to ensure they were decided by raters who met requirements. OAR did conduct DROC site visits, which consisted of reviews ensuring DROCs had the required percentage of raters designated to issue decisions on complex appeals and that those raters were associated with appropriate training cohorts.[6] However, prior to April 2022, the site visit reviews did not look at completed appeals to determine if the raters who issued decisions met the necessary requirements. Managers with OAR noted they did not monitor appeals this way because, prior to the OIG's findings, they were unaware complex appeals were being decided by raters who had not met requirements.

Some DROC managers and supervisors informed the OIG team that they assumed DROs met requirements and could issue decisions on any type of appeal. Also, some raters at the DROCs stated they did not know which raters were designated to issue decisions on complex appeals.

VBA employs a work routing system that distributes appeals to raters. This routing system has to be manually updated to match WIT designations to ensure appeals get assigned to the appropriate staff. DROC managers and an OAR manager noted that if WIT designations did not match VBA's work routing system, complex appeals could have been assigned to raters who were not designated to decide them. The OIG estimated 400 complex appeals were assigned by the work routing system to raters who were not designated in the WIT as a specialized claims processor.

Also, the St. Petersburg DROC piloted a web-based program called WaitWhile in January 2021 to route appeals involving informal conferences to DROs.[7] A St. Petersburg DROC supervisor noted the program routed work that could involve complex appeals to DROs regardless of whether the DRO met requirements. The supervisor noted she did not realize that only designated DROs could decide complex appeals prior to the OIG bringing it to her attention. VBA's deputy under secretary for policy and oversight acknowledged the St. Petersburg DROC was not aware of this flaw until the OIG called attention to it. To ensure cases get routed to appropriate DROs, updated procedures were provided by OAR that directed DROs to notify their supervisors when they get complex appeals if they do not meet requirements.

Finally, while the adjudication procedures manual noted TBI decisions required DROs to meet accuracy standards to provide single-signature decisions, the same guidance did not direct DROCs to maintain records on the DROs who met single-signature status. This led to DROCs not having documentation noting which raters met single-signature requirements for TBI appeals. The OIG's review brought it to the attention of OAR that records were not maintained showing which staff met single-signature status. In response, OAR updated the adjudication

[6] VA Manual M21-5, "Decision Review Operations Center (DROC) Structure;" VA Manual M21-5, "National Training Program," chap. 2 in *Appeals and Reviews,* February 3, 2022; December 8, 2021; November 18, 2021; and October 1, 2021.

[7] An informal conference is an option provided to appellants to have telephone contact with a VA senior reviewer to identify any errors of fact or law in a prior decision.

procedures manual to note DROCs were required to maintain these records.[8] Because OAR updated its guidance and planned to monitor compliance, the OIG did not make a recommendation for this issue.

What the OIG Recommended

The OIG made four recommendations to the under secretary for benefits, including VBA incorporating oversight to periodically ensure decisions issued for complex appeals are completed by DROC employees that met all requirements associated with them.[9] The OIG also recommended that VBA ensure DROCs identify which raters meet all the requirements to issue decisions on complex appeals, and to communicate to managers and staff which raters meet those requirements. VBA should also provide guidance to DROC supervisors on how to maintain system routing rules, and have OAR establish a procedure to periodically ensure WIT and workload designations at the DROCs are in alignment. Finally, VBA should ensure the St. Petersburg DROC monitors the effectiveness of its modified procedures to ensure only designated DROs are assigned informal conferences for complex appeals, and ensure complex appeal designation will be accounted for in future informal conference routing applications.

VA Comments and OIG Response

The senior advisor for policy, performing the delegable duties of the under secretary for benefits, concurred with the OIG's findings and recommendations. The senior advisor requested recommendations 1 and 4 be closed, based on actions taken by VBA. The senior advisor's comments and actions are responsive to recommendation 1, and the OIG considers this recommendation closed based on the updates to site visit protocols. VBA requested closure of recommendation 4 based on its updated site visit protocols as well. However, the OIG will close this recommendation after VBA has specifically monitored the effectiveness of the updated procedures at the St. Petersburg DROC site visit. The OIG will monitor implementation of all planned actions and will close the remaining recommendations when VBA provides sufficient evidence demonstrating progress addressing the intent of the recommendations and the issues identified.

The senior advisor also provided technical comments regarding the OIG's citing previous reports that found claims that were inaccurately processed leading to improper payments. VBA's comment stated

[8] VA Manual M21-5, "Decision Review Operations Center (DROC) Structure," chap. 1, sec. A in *Appeals and Reviews*, April 25, 2022.

[9] 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.

> The summary referenced findings from "VA OIG, Systemic Issues Reported During Inspections at VA Regional Offices." This was a separate review and findings regarding regional offices, not the decision review operations centers (DROCs), and is an inaccurate comparison that provides an erroneous negative implication for the findings of this report for the DROCs. That report found a high error rate for regional offices which is not supported by this report, or the independent reviews conducted by OAR. It is an inaccurate depiction of the DROCs.

Although the OIG's previous reports cited in this reference were not specific to DROCs, it should be noted that in response to the high error rates detailed in these reports, VBA committed to developing and implementing strategies for ensuring the accuracy of complex TBI, ALS, and MST claims. These strategies included training, specialized groups of staff to process complex claims, and second signature requirements, which were applicable to DROCs as well. In response to VBA's comment, the OIG moved the reference to the reports and the related risks in the executive summary so not to imply a comparison. In addition, the report was updated to specify the previous reports focused on VA regional offices, as opposed to DROCs.

The second technical comment requested that the OIG revise or remove the section in the executive summary providing an example illustrating an inaccurate decision that resulted from a rater who did not meet requirements when deciding complex appeals. The request was based on the OIG noting quality was not within the scope of this review. The comment further noted that

> By citing a single example, OIG puts quality at issue by making a generalization which, to the lay reader, wrongly implies that the quality was both in question, and directly impacted by the findings. Doing so misrepresents that a single example reflects the whole and is outside the scope of this report. Furthermore, OAR reiterates its review of benefit entitlement accuracy as related to all cases OIG reviewed and determined the decision maker did not meet the processing requirements during this engagement, in which OAR found a 99% (158/160) benefit entitlement accuracy rate.

The OIG has now added language to clarify that the example cited in the report was to demonstrate that inaccurate decisions resulting in improper benefits can occur when raters who do not meet requirements decide complex appeals. As previously stated, the objective of this review was not to determine the accuracy of decisions. However, the OIG team observed three instances in which inaccurate decisions did affect veterans' benefits. These three cases were not documented as errors in OAR's review and determination that 99 percent were accurately decided. After the OIG team identified the three erroneous decisions to VBA, corrections were made by VBA to all three decisions. The OIG reaffirms the example cited in the executive summary and report.

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Contents

Abbreviations

ALS	amyotrophic lateral sclerosis
AMA	Appeals Modernization Act
DRO	decision review officer
DROC	Decision Review Operations Center
MST	military sexual trauma
OAR	Office of Administrative Review
OIG	Office of Inspector General
RVSR	rating veterans service representative
TBI	traumatic brain injury
VBA	Veterans Benefits Administration
VBMS	Veterans Benefits Management System
WIT	Workforce Information Tool

Introduction

The Veterans Benefits Administration's (VBA) compensation program provides tax-free monthly benefits to veterans for compensation due to the effects of disabilities caused by diseases or injuries incurred or aggravated during active military service. This compensation is awarded based on a review of, and a decision made on, the information provided in the veteran's application and other information that may be later requested. When a veteran disagrees with a VBA decision, they may appeal it. Decision review operations centers (DROC) are responsible for processing appeals, which consists of developing, deciding, and providing decision notices regarding the appealed issues. Complex appeals can involve high priority and complex claims processing related to amyotrophic lateral sclerosis (ALS), military sexual trauma (MST), and traumatic brain injury (TBI). VBA designates claims processors to decide these complex appeals. These claims processors receive additional training and may have to meet other requirements. In March 2022, an anonymous source submitted a hotline allegation to the VA Office of Inspector General (OIG) that a DROC was not designating the appropriate staff to work complex appeals. The complainant stated that there were no designated decision makers assigned, and staff had not completed any additional training to allow them to work these complex appeals. The OIG conducted this review to assess the merits of this allegation.

VBA Compensation Claim Process

VA pays monthly disability compensation to veterans with service-connected disabilities according to the severity of the disability. As shown in the development step in figure 1, after a veteran submits a claim to VA, veterans service representatives review the claim and assist the veteran in gathering evidence needed to evaluate it. Rating veterans service representatives analyze the evidence and make decisions on the claim. Then veterans service representatives implement the decision, notify the veteran, and authorize payment.

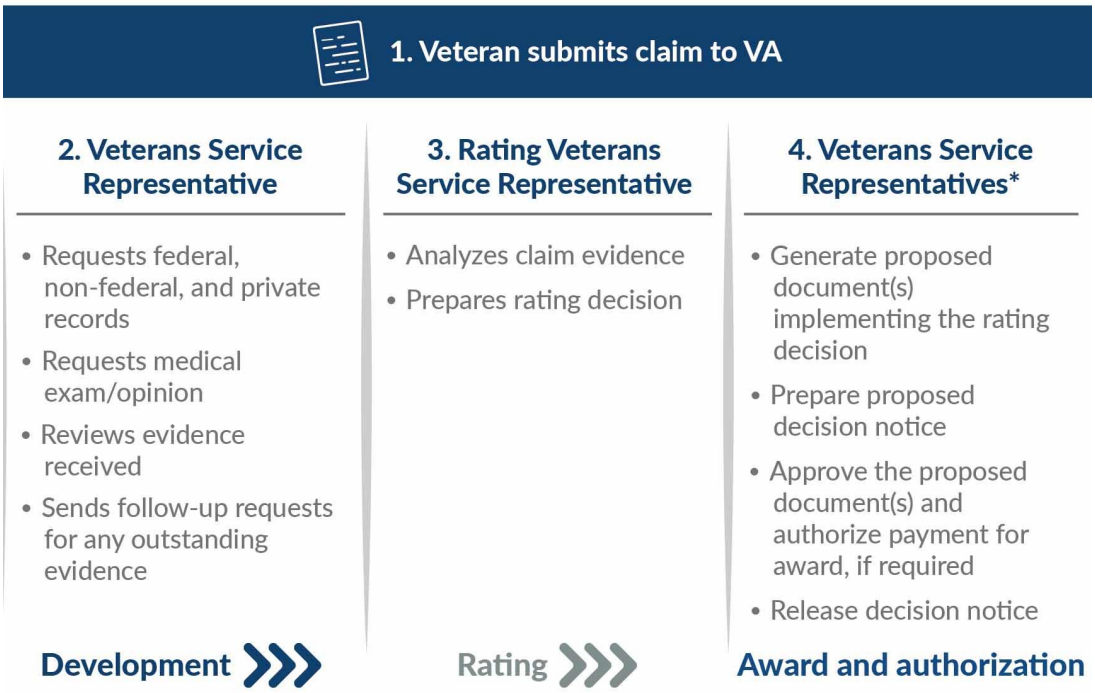

Figure 1. *VA benefits claims process.*

Source: VA OIG's analysis of VA Manual 21-1 and VBA training materials.

**Decisions cannot be generated (awarded) and authorized by the same veterans service representative.*

Veterans Appeals Improvement and Modernization Act of 2017

The Veterans Appeals Improvement and Modernization Act of 2017 (Appeals Modernization Act or AMA) was established by Public Law 115-55 to streamline and improve appeals processing and demonstrate a commitment to appeals reform.[10] The AMA allows veterans to choose from one of three new review options or "lanes" when they disagree with a decision—a higher-level review, supplemental claim, or a direct appeal to the Board of Veterans' Appeals.

- A **higher-level review** is a new review of the same evidence for an issue(s) that was previously decided by VA. In this option, a senior reviewer at a DROC will take a new look at a case and determine whether the decision can be changed based on a difference of opinion or an error.
- A **supplemental claim** is a new review of an issue VA previously decided based on submission of new and relevant evidence. These are worked by VBA's regional offices.
- A **direct appeal** allows a veteran to submit additional evidence. A veterans law judge at the Board of Veterans' Appeals will review the appeal. The Board of Veterans Appeals

[10] Veterans Appeals Improvement and Modernization Act of 2017 (Appeals Modernization Act [AMA]), Pub. L. No. 115-55, 131 Stat. 1105 (2017).

may remand cases to the DROCs for additional actions, such as requesting more information from the veteran or scheduling an examination.

Figure 2 provides an overview of veterans' review options under the AMA.

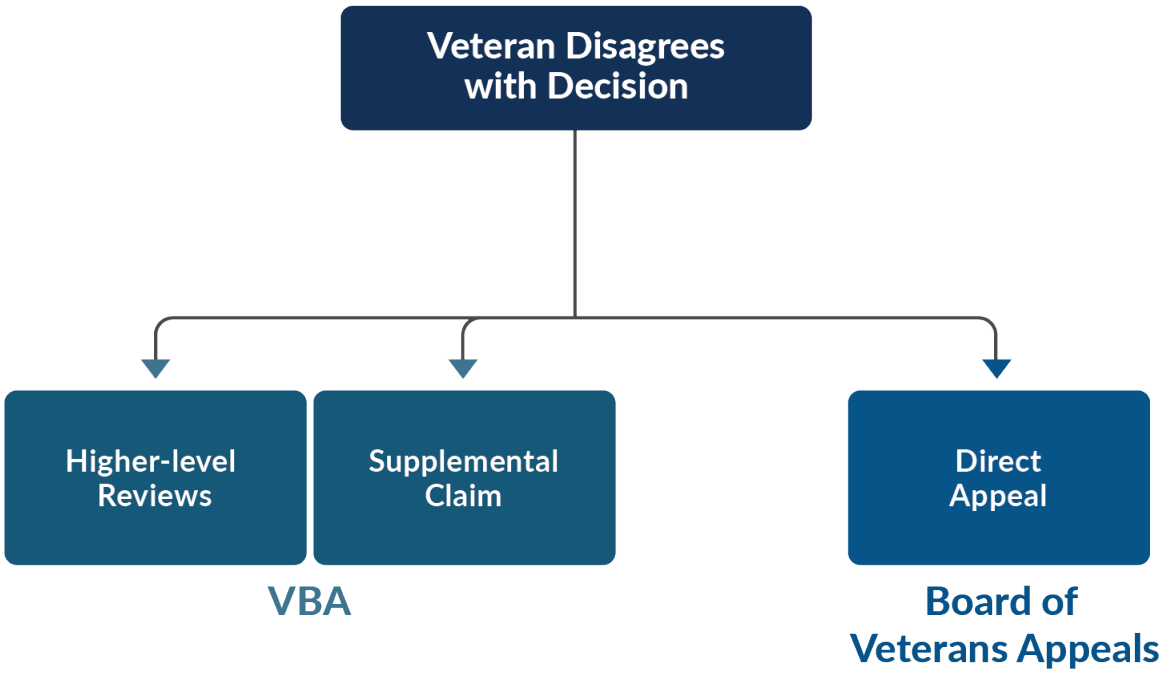

Figure 2. *Three lanes for veterans' appeals.*
Source: VA OIG analysis of Appeals Modernization Fact Sheet, https://www.benefits.va.gov/BENEFITS/factsheets/appeals/Appeals-FactSheet.pdf.

VBA consolidated AMA higher-level review processing into two DROCs in Seattle, Washington, and St. Petersburg, Florida. A third DROC in Washington, D.C. is responsible for processing legacy appeals.[11] The Office of Administrative Review (OAR) manages and operates the DROCs by establishing policies and procedures, providing quality control and training, and by conducting site visits. Figure 3 illustrates the organizational structure for OAR and the DROCs.

[11] A legacy appeal is a disagreement with a VA benefits decision made before February 19, 2019, the effective date of Public Law 115-55, the Veterans Appeals Improvement and Modernization Act of 2017.

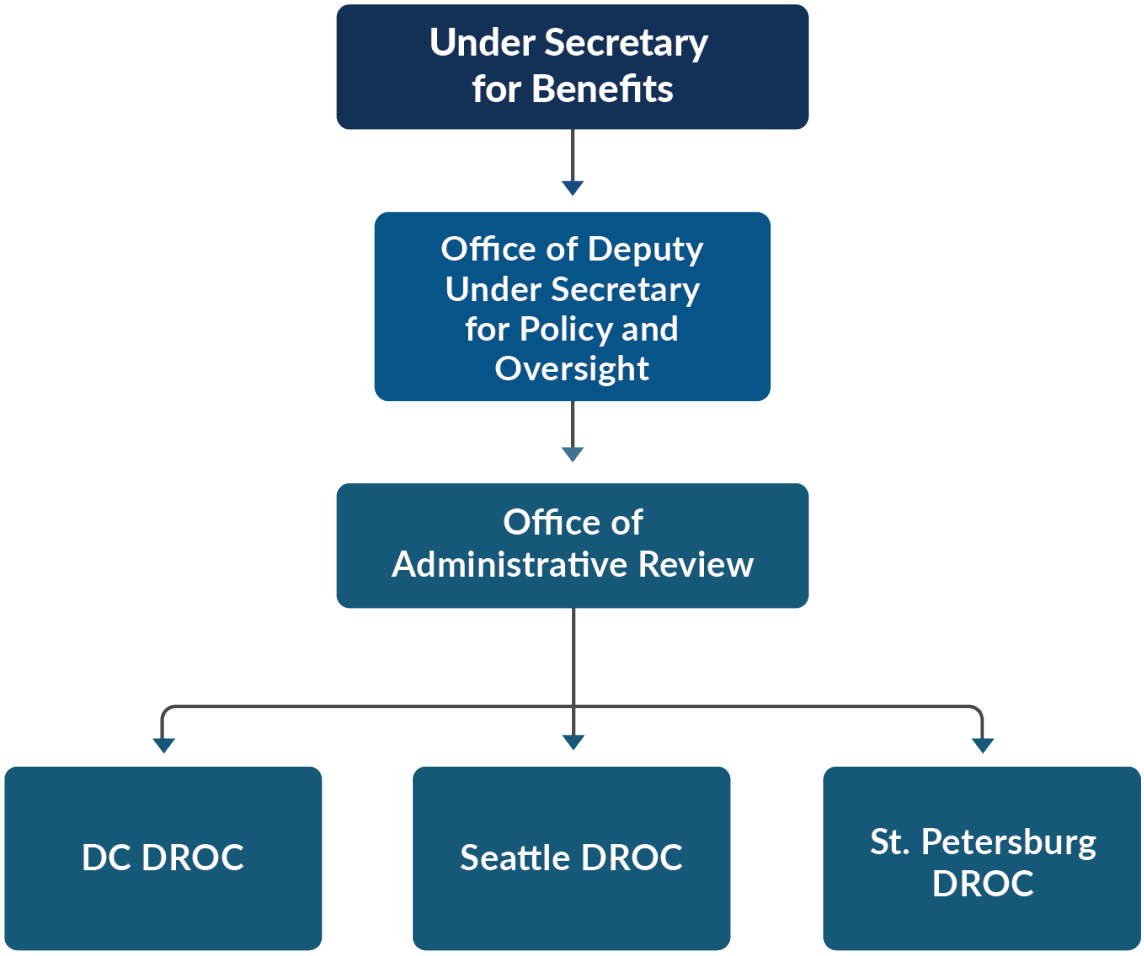

Figure 3. *Organization structure for OAR and the DROCs.*
Source: VA OIG analysis of VA organizational charts.

Complex Appeals

Each DROC is responsible for designating specialized groups of trained personnel to process high-priority complex appeals that involve conditions such as the following:[12]

- Amyotrophic lateral sclerosis (ALS), commonly known as Lou Gehrig's disease, is a neuromuscular disease that causes degeneration of nerve cells in the brain and spinal cord, resulting in muscle weakness, muscle atrophy, and spontaneous muscle activity.
- Military sexual trauma (MST) is a subset of personal trauma and refers to sexual harassment, sexual assault, or rape that occurs in a military setting.

[12] VA Manual M21-5, "Decision Review Operations Center (DROC) Structure," chap. 1, sec. A in *Appeals and Reviews*, January 5, 2022; November 12, 2021; and October 6, 2020.

- Traumatic brain injury (TBI) means the physical, cognitive and/or behavioral/emotional residual disability resulting from an event of external force causing an injury to the brain.

Requirements for Processing Complex Appeals

The specialized processors who can issue decisions on complex appeals are rating veterans service representatives (RVSRs) and decision review officers (DROs). An RVSR analyzes claims and prepares rating decisions. Rating decisions typically involve RVSRs evaluating disabilities and granting or denying entitlement to service connection for diseases and injuries. A DRO is a senior reviewer who is responsible for holding hearings and processing appeals. In this report, the term "rater" refers to both RVSRs and DROs, unless otherwise specified. Raters must meet specific requirements and follow certain procedures to process complex appeals.

Designations for Specialized Processors

VBA uses data in its Workforce Information Tool (WIT) to drive national workload distribution. For example, the WIT provides VBA leadership information on staff available to process claims. DROCs must designate specialized groups in the WIT to process these complex appeals. According to VBA policy, these designated raters should be the only individuals processing complex appeals at the DROCs.[13] If a rater is not correctly designated in the WIT, they may not receive the mandatory training for complex appeals.

Mandatory Training

Each complex appeal type has specific training requirements that include one-time mandatory courses and, in some instances, annual courses. A training curriculum ensures that DROC employees develop and acquire the technical skills to be competent in their positions, deliver excellent customer service, and improve the veteran experience. DROCs are required to assign specialized training to designated personnel; these employees must be the only individuals processing specialized appeals.[14] Based on WIT designation, DROC training managers add raters to training cohorts to ensure they get assigned the mandatory specialized training.[15] Cohorts make it possible to assign training, as well as track and report progress toward meeting training requirements. When an employee is placed in a training cohort for ALS, MST, and TBI, they should then automatically receive the annual training requirements for those subjects.

[13] VA Manual M21-5, "Decision Review Operations Center (DROC) Structure."

[14] VA Manual M21-5, "Decision Review Operations Center (DROC) Structure."

[15] VA Manual M21-5, "National Training Program," chap. 2 in *Appeals and Reviews*, February 3, 2022; December 8, 2021; November 18, 2021; and October 1, 2021.

Signature Reviews

Rating decisions must contain the rater's digital signature.[16] The signature certifies that the rater reviewed the claims folder and all phases of the claims process leading to the decision were correctly handled. TBI and MST decisions require two signatures until an RVSR has demonstrated an accuracy rate of 90 percent or greater based on a review of at least 10 cases. DROs are exempt from the MST second signature requirement, but not the TBI requirement.[17] Decisions that require second signatures must be signed by a reviewer who has completed the required training.[18] Once an RVSR and DRO meet the accuracy standards, they can provide a single signature on TBI or MST decisions without a secondary review. The OIG team confirmed with VBA that a rater must complete all mandatory training on a topic before providing a second signature.

Prior OIG Reports

Complex appeals decided by DROC raters not meeting requirements could lead to inaccurate decisions for veterans' appeals, resulting in veterans being improperly denied benefits or receiving improper payments. Previous OIG reviews showed accuracy issues with these complex issues which resulted in recommendations for these requirements. At the time of these prior reports, the DROCs did not exist so the reviews were not a reflection of their work.

A report issued by the OIG in May 2011 determined that 12 VA regional offices did not adequately process TBI claims. It was also estimated that about 800 (19 percent) of approximately 4,100 TBI claims completed from April 2009 through July 2010 were not adequately processed.[19] As a result, veterans might not have received accurate benefit payments. The errors were found to be generally due to regional office staff lacking sufficient experience and training to accurately process TBI claims. In response to the report, the acting under secretary for benefits noted regional offices would require a second signature on TBI cases for each RVSR until the RVSR demonstrated a 90 percent quality score on these types of decisions.

In an August 2018 report, the OIG estimated VBA staff incorrectly processed approximately 1,300 (49 percent) of the 2,700 MST-related claims denied from April 1, 2017, through

[16] VA Manual M21-1, "Codesheet Section," part v, sub. iv, chap. 1, sec. B in *Adjudication Procedures Manual*, November 12, 2020.

[17] VA Manual M21-1, "Codesheet Section.

[18] VA Manual M21-1, "Traumatic Brain Injury (TBI)," part v, sub. iii, chap. 12, sec. B in *Adjudication Procedures Manual*, April 16, 2020; VA Manual M21-1, "Evidence Evaluation and Decisions for Postraumatic Stress Disorder (PTSD) Claims Based on Personal Trauma," part viii, sub. iv, chap. 1, sec. E in *Adjudication Procedures Manual*, July 29, 2021.

[19] VA OIG, *Systemic Issues Reported During Inspections at VA Regional Offices*, Report No. 11-00510-167, May 18, 2011.

September 1, 2017.[20] The report recommended that VBA specialize processing of MST claims, require second-level reviews, and update training on MST. In response to the report, VBA's under secretary for benefits noted VBA would institute a requirement for a 90 percent accuracy rate on at least 10 cases per employee, with all cases subject to a second-signature review until the accuracy rate is achieved. This specialized group of claim processors would earn single-signature authority once they reached the required accuracy rate. In addition, the under secretary noted VBA would mandate training for MST and issue guidance designating a specialized group of MST-trained RVSRs to process MST-related claims.

In a November 2018 report, the OIG projected that 430 (45 percent) of the 960 total ALS veterans' cases completed during a six-month period had erroneous decisions.[21] For those 430 cases, improper payments were made to about 230 veterans through September 2017, resulting in underpayments of approximately $750,000 and overpayments of approximately $649,000. In response to the report, VBA's under secretary for benefits noted VBA would designate specialized groups of ALS-trained raters at regional offices to process ALS-related claims.

[20] VA OIG, *Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma*, Report No. 17-05248-241, August 21, 2018.

[21] VA OIG, *Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis*, Report No. 18-00031-05, November 20, 2018.

Results and Recommendations

Finding: Complex Appeals Were Decided by Raters Who Did Not Meet All Requirements

Following the hotline allegation, the OIG substantiated that raters from each DROC issued decisions on complex appeals while not meeting all requirements. DROC raters issuing decisions on complex appeals without meeting requirements could lead to inaccurate decisions for veterans' appeals resulting in veterans being improperly denied benefits or receiving improper payments. OAR did not monitor completed appeals to ensure they were decided by raters who met requirements.

According to some DROC supervisors, this occurred because they assumed that DROs met requirements and could issue decisions on any type of appeals. In addition, some raters at the DROCs stated they were not aware which raters were designated to issue decisions on complex appeals, to include themselves. DROC managers and an OAR manager noted if WIT designations did not match VBA's system that routed appeals work to raters, it could have resulted in complex appeals being assigned to raters who were not designated to decide them. Further, the St. Petersburg DROC piloted a web-based program that routed appeals involving informal conferences to DROs even if the DRO did not meet requirements to process complex appeals.[22] Finally, a lack of guidance led to DROCs not having documentation noting which DROs could sign TBI appeals without having a secondary signature.

Detailed support for this finding is provided in the following sections:

- Complex appeals were decided by raters who did not have required qualifications.
- OAR did not ensure complex appeals were decided by raters who met requirements.
- Supervisors were not always aware or effectively communicating who could decide complex appeals.
- Veterans Benefits Management System (VBMS) routing rules did not ensure designated processors were assigned complex appeals.
- The St. Petersburg DROC used a program to assign appeals to raters regardless if requirements were met.
- OAR did not provide guidance to document raters approved for single signature.

[22] An informal conference is an option provided to appellants to have telephone contact with a VA senior reviewer to identify any errors of fact or law in a prior decision.

- Raters who did not meet requirements may have issued inaccurate decisions on complex appeals.

What the OIG Did

The OIG estimated that nearly 1,300 complex appeals were completed from October 1, 2021, through February 28, 2022, (the review period) by DROC raters. From this population, the OIG team reviewed all 13 ALS appeals and a statistically random sample of 80 MST and 80 TBI appeals. The MST samples were generated from an estimated population of 490 appeals, while the TBI samples were generated from an estimated population of 760 appeals.

The team interviewed VBA's deputy under secretary for policy and oversight, OAR managers and staff, and managers and staff assigned to the following DROCs: Washington, D.C.; Seattle, Washington; and St. Petersburg, Florida. Appendixes A and B provide additional details on the scope and methodology.

Complex Appeals Were Decided by Raters Who Did Not Have Required Qualifications

The OIG estimated 1,200 of 1,300 complex appeals (93 percent) were decided by DROC raters who had not been designated in the WIT to process complex appeals, had not completed all mandatory training, or did not receive the second signature reviews when required. The OIG estimated that 750 of 1,300 complex appeals (59 percent) were decided by raters who did not meet multiple requirements. The OIG also estimated that 440 complex appeals (35 percent) were decided by raters who did not meet any of the requirements.

In addition, the OIG estimated that

- 760 of 1,300 complex appeals were decided by DROC raters who were not designated in the WIT as a specialized processor,
- 780 of 1,300 complex appeals were decided by DROC raters who had not completed all mandated training courses concerning the appealed issue, and
- 820 of 820 complex appeals were decided by DROC raters without required second signatures.[23]

[23] The population is smaller for this finding as it consisted of only those samples that required second signatures at the time of the OIG review.

Mandatory Training

Raters designated in the WIT were required to complete multiple mandated training courses.[24] The OIG estimated 780 complex appeals were decided by raters who had not completed all the mandatory training at the time they issued decisions on those appeals. Of those, the team estimated 42 percent were decided by raters who had completed some, but not all, of the mandated training at the time they issued rating decisions on complex appeals. The other estimated 58 percent were decided by raters who had not completed any of the mandatory courses at the time they issued decisions on complex appeals.

Designations for Specialized Processors

If a rater is not designated in the WIT as a specialized processor, they might not receive the mandatory training required for complex appeals. In addition, failing to designate staff in the WIT does not ensure specialized raters will decide these appeals. The OIG estimated that 47 percent of complex appeals were decided by raters not designated in the WIT as specialized processors and had not completed all mandatory training for the complex appeals.

Signature Reviews

At the time of this review, the VBA adjudication procedures manual did not address maintaining documentation of staff who are approved to decide complex appeals without a second signature. The OIG team reached out to each DROC to obtain a list of staff who had this authority for MST and TBI decisions. DROC managers and management analysts informed the OIG they were unable to verify the dates that any DROs received single-signature authority. The team was informed of the following information about RVSRs:

- All Washington, D.C. RVSRs required a second signature on MST and TBI decisions.
- One Seattle RVSR out of 33 was authorized to sign MST decisions without a second signature; none were authorized to decide TBI decisions without a second signature.
- One St. Petersburg RVSR out of 78 was authorized to sign MST and TBI decisions without a second signature.

Of the 820 estimated complex appeals that were completed by raters without a required second signature, 580 were completed by raters unknown to have met requirements as the DROC did not maintain that information.

[24] VA Manual M21-5, "Decision Review Operations Center (DROC) Structure;" VA Manual M21-3, "Fiscal Year 2022 (FY22) Compensation Service National Training Curriculum (CSNTC) Overview," sec. A in *Training Program Manual*, February 25, 2022; October 1, 2021.

None of the estimated 820 appeals completed by raters who were not approved to single sign complex appeals received valid second signatures. The 820 appeals either did not receive any second signature review, or the second signer was not fully trained on the subject of the complex appeal.

OAR Did Not Ensure Complex Appeals Were Decided by Raters Who Met Requirements

OAR conducted annual site visits at each DROC to assess performance, identify best practices, and identify areas of improvement. However, prior to April 2022, OAR site visits did not monitor completed appeals to determine if the raters who issued decisions met the necessary requirements. Instead, the site visits focused on ensuring DROCs had the required 10 to 25 percent of raters designated to issue decisions on complex appeals and that those raters were associated with the appropriate training cohorts.[25] OAR managers noted prior to this report's findings, they were unaware complex appeals were being decided by raters who had not met requirements.

VBA's deputy under secretary for policy and oversight informed the OIG team he would recommend OAR update site visits to conduct reviews similar to the OIG's and would have DROCs periodically certify requirements are met. OAR's chief, management and program analyst for internal controls and compliance, noted that going forward site visits would review completed decisions to ensure they were done by raters who met single-signature status. In addition, the OAR chief stated that more recent site visits have begun to look at completed appeals to ensure decisions were made by raters who were designated to process complex appeals.

The OIG's first recommendation addresses the need for VBA to incorporate oversight to review completed complex appeals and ensure DROC employees met requirements when issuing decisions.

Supervisors Were Not Always Aware or Effectively Communicating Who Could Decide Complex Appeals

Some DROC managers and supervisors informed the OIG team prior to its review that they assumed DROs met requirements and could issue decisions on any type of appeal. The Seattle and D.C. DROC managers noted that when DROs became part of their DROCs, it was assumed they all met single-signature requirements for complex appeals. The St. Petersburg DROC

[25] VA Manual M21-5, "Decision Review Operations Center (DROC) Structure;" VA Manual M21-5, "National Training Program".

manager stated DROs may have been under the impression they could issue decisions on any appeal, as they were considered "the best" decision makers.

A total of 16 raters and supervisors at each DROC informed the OIG team they were not made aware of which raters with their office were designated to issue decisions on complex appeals. If neither the rater nor supervisor are aware of which raters were designated to process complex appeals, the appeals could be assigned to raters who do not meet requirements. Division managers at the DROCs stated they assumed frontline supervisors made raters aware that they were designated to process complex appeals. Frontline supervisors stated they assumed raters were already aware which raters could issue decisions on complex appeals. Overall, 11 raters informed the OIG team they were not familiar with the WIT database. Further, nine raters did not know which raters were designated to issue decisions on complex appeals.

Based on interviews with supervisors and RVSRs at the DROCs, the OIG found that they were generally unaware of which RVSRs could provide single signatures for complex appeals that warranted them. Specifically:

- A supervisor at the St. Petersburg DROC did not know which RVSRs could single sign complex appeals.
- A supervisor at the Seattle DROC thought multiple RVSRs could single sign complex appeals, despite that office noting only one RVSR met that standard.
- Raters from each DROC thought they met single-signature status for complex appeals; however, they were not shown to be on the DROC's list of single signers provided to the review team.

In addition, RVSRs incorrectly assumed other RVSRs could provide single-signature decisions on complex appeals, despite their DROC only listing one or zero RVSRs total as being eligible to provide single-signature decisions.

The OIG's second recommendation addresses the need for VBA to ensure DROCs identify which raters meet all the requirements to issue decisions on complex appeals, and to communicate to managers and staff which raters meet those requirements.

VBMS Routing Rules Did Not Ensure Designated Processors Were Assigned Complex Appeals

VA processes claims in the VBMS.[26] DROCs use VBMS routing rules to automatically assign appeals to raters. Routing rules and WIT designations should match each other; for example, if a rater is designated in the WIT to process complex appeals, then VBMS routing rules should

[26] VBMS is a web-based program used to process claims.

reflect this to ensure only designated raters get assigned complex appeals. However, VBMS does not communicate directly with the WIT, therefore each DROC is responsible for updating and maintaining both VBMS routing rules and WIT designations.

DROC managers and OAR's chief, management and program analyst for internal controls and compliance, noted if the routing rules and WIT did not match, this could lead to undesignated raters getting assigned complex appeals they did not meet requirements to decide. The OIG estimated the VBMS system assigned 400 complex appeals to raters who were not designated in the WIT as a specialized claims processor.

OAR conducts site visits to review DROCs' workflow and workload management. However, the chief noted OAR did not have access to each DROC's routing rules for VBMS and was looking to get access. By the end of April 2022, each DROC had conducted an internal review to ensure VBMS routing rules aligned with designated specialized processors who met all training requirements. DROC managers approved recommendations from these reviews that each DROC conduct periodic internal reviews to ensure routing rules align with designated processors. However, a St. Petersburg DROC management analyst informed the OIG team that the DROC missed the May 5, 2022, deadline to conduct an additional review. In July 2022 the director of the St. Petersburg DROC noted the additional reviews had been completed.

A supervisor at the St. Petersburg DROC noted she did not fully understand how to maintain VBMS routing rules. An OAR site visit of the St. Petersburg DROC found that the office's routing rules were not efficient because the station's VBMS subject matter expert left the DROC. When supervisors do not know how to update routing rules, they cannot ensure the system will assign complex appeals to raters who are designated to process them.

The OIG's third recommendation addresses the need for VBA to provide guidance to managers on how to maintain VBMS routing rules and to have OAR establish a procedure for periodically ensuring WIT and workload designations at the DROCs align.

St. Petersburg DROC Used a Program to Assign Appeals to Raters Regardless of Whether Requirements Were Met

In October 2020, the St. Petersburg regional office's Public Contact Team began using a web-based platform called WaitWhile to schedule appointments for discussing benefits and services with veterans, service members, and their dependents. Despite WaitWhile initially being used for public contact appointments, the St. Petersburg DROC piloted the program in January 2021 to route appeals involving informal conferences to DROs.[27] The program was to automate the process to promptly notify veterans of scheduled conferences. The assistant director

[27] An informal conference is an option provided to appellants to have telephone contact with a VA senior reviewer to identify any errors of fact or law in a prior decision.

for the St. Petersburg DROC stated the pilot program was initially proposed and implemented by the St. Petersburg office in coordination with OAR. During the OIG's review a supervisor at the St. Petersburg DROC noted she learned that only designated DROs could decide complex appeals and informed the OIG the WaitWhile program will automatically assign appeals to available DROs, regardless of whether they met requirements.

VBA's deputy under secretary for policy and oversight acknowledged the St. Petersburg DROC was not aware of this flaw until the OIG brought it to their attention. After bringing it to VBA's attention, OAR provided the OIG with updated procedures to ensure appeals get routed to appropriate DROs. The modified procedures directed DROs who are not designated to process complex appeals to notify their supervisors if they get appeals sent to them from WaitWhile. The deputy under secretary also noted OAR is in the process of procuring a system to replace WaitWhile that will have the capability to assign a special issue designation to appeals.

The OIG's fourth recommendation is to ensure the St. Petersburg DROC monitors the effectiveness of its modified procedures so only designated DROs are assigned informal conferences for complex appeals, and account for complex appeal designation in future informal conference routing applications.

OAR Did Not Provide Guidance to Document Raters Approved for Single Signature

None of the DROCs maintained documentation listing which DROs could single sign TBI appeals. This occurred because OAR did not initially provide guidance directing DROCs to maintain records on the raters who met single-signature status. Further, the prior deputy director of OAR informed the OIG team that there was no consistent method across all DROCs to ensure staff issuing decisions met single-signature requirements. DROC supervisors confirmed the process for maintaining records of raters who met single-signature status was not structured. OAR managers noted the majority of employees who joined the DROCs were already VBA employees. In addition, OAR managers stated that although the employees may have been approved for single signature at their prior workstations, the documentation may not have been provided to the DROC.

After the OIG team made OAR aware of this issue, it updated guidance to note DROCs are required to keep a memorandum of record confirming completion of the MST and TBI requirements and designation of single-signature authority for raters.[28] OAR managers informed the team they would enforce this policy with their site visits going forward. Following the OIG's review, OAR updated their site visit protocols to ensure DROCs maintain records identifying

[28] VA Manual M21-5, "Decision Review Operations Center (DROC) Structure," chap. 1, sec. A in *Appeals and Reviews*, April 25, 2022.

staff who met requirements to process complex appeals. Because OAR updated its guidance and planned to monitor compliance, the OIG did not make a recommendation.

Raters Who Did Not Meet Requirements May Have Issued Inaccurate Decisions on Complex Appeals

As discussed, OIG reports previously found accuracy issues when complex decisions were decided by raters who did not receive specialized training, secondary reviews, or special designations. Those reports did not focus on the work of DROCs, while this report did focus on determining whether DROC staff who made decisions on ALS, MST, and TBI appeals met training, signature, and designation requirements. As such, this review did not focus on the accuracy of each decision and does not represent VBA's overall claims processing accuracy rate. However, the training, signature and designation requirements are intended to promote the accuracy of decisions. When raters made decisions without meeting requirements, VBA lacked assurance that decisions would be accurate.

During this review, the OIG team observed inaccurate decisions of complex appeals completed by raters who did not meet requirements. The following example is provided to illustrate an inaccurate decision that affects a veteran's benefits can occur when a rater who does not meet requirements decides a complex appeal.

Example

On October 20, 2021, a veteran received a rating decision regarding the service-connected evaluation of his ALS. The veteran submitted a request for a higher-level review of this rating, which was received on November 9, 2021. On November 17, 2021, a DRO issued an incorrect evaluation. The DRO, who was not designated in the WIT to rate ALS appeals, had not completed any of the mandatory training courses on ALS. The OIG team reviewed the case and found the veteran was entitled to a higher evaluation at an earlier effective date. As a result of the improper decision, there was an underpayment of approximately $12,900.

Conclusion

The OIG team substantiated a hotline allegation that some DROC raters did not meet all requirements before issuing decisions on complex appeals. This occurred for several reasons, including the following:

- OAR did not effectively monitor completed appeals.
- DROC supervisors assumed that DROs could issue decisions on any type of appeal.
- Raters and supervisors lacked awareness of who could process complex appeals.

- VBA's electronic systems did not support the accurate routing of complex appeals only to raters who were assigned to work them.

Until VBA takes steps to ensure raters who issue decisions on complex appeals meet requirements, veterans will remain at risk of being improperly denied benefits or receiving improper payments.

Recommendations 1–4

The OIG made the following recommendations to the under secretary for benefits:[29]

1. Incorporate oversight to periodically ensure decisions issued for complex appeals were completed by DROC employees that met all requirements associated with them.
2. Ensure DROCs identify which raters meet all the requirements to issue decisions on complex appeals, and to communicate to managers and staff which raters meet those requirements.
3. Provide guidance to DROC supervisors on how to maintain VBMS routing rules, and have OAR establish a procedure to periodically ensure WIT and workload designations at the DROCs are in alignment.
4. Ensure the St. Petersburg DROC monitors the effectiveness of its modified procedures that only designated DROs are assigned informal conferences for complex appeals, and ensure complex appeal designation will be accounted for in future informal conference routing applications.

VA Management Comments

VBA's senior advisor for policy, performing the delegable duties of the under secretary for benefits, concurred with all of the OIG's recommendations and provided technical comments.

To address recommendation 1, VBA reported updating its procedures manual to incorporate a review of specialized processing cases in the site visit protocol. The revised site visit protocol was noted as now aligning with the review process the OIG conducted as part of this review. OAR disseminated this change to the DROCs on December 1, 2022. OAR conducts site visits to the DROCs annually and will make appropriate recommendations for correction if not compliant with the guidelines and will track corrective implementation actions through completion, as applicable. As such, VA requested closure of this recommendation.

[29] 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.

To address recommendation 2, VBA noted on April 25, 2022, that OAR updated its procedures manual to clearly outline the requirements for adjudicators to decide specialized processing cases in accordance with the OIG's findings and recommendations. OAR noted it updated this section to provide guidance to DROC staff regarding training, signature requirements, and required documentation for MST, TBI, and ALS claims processing. In June 2022, OAR noted it received confirmation from all DROCs that the appropriate employees were identified and designated to complete specialized claims, to include ALS, MST, and TBI as outlined in the manual provisions. OAR reported it is currently validating these certifications from the DROCs, and that these designations will consistently be audited during OAR's annual site visits of the DROCs through the National Training Curriculum and the WIT. Finally, OAR noted it will make appropriate recommendations for correction if the DROCs are not compliant with the guidelines and will track corrective implementation actions through completion, as applicable. The target completion date is March 31, 2023.

To address recommendation 3, VBA reported OAR will provide guidance and training to DROC supervisors during fiscal year 2023. VBA further noted OAR will request routine certification from the DROCs regarding the accuracy of routing rules, WIT, and workload designations. On November 23, 2022, OAR reported it updated the site visit protocol to review specialized processing cases to align with the review process the OIG conducted as part of this review. During the annual site visit to each DROC, OAR noted it will ensure that the DROCs are adhering to the required procedures. OAR further reported it will make appropriate recommendations for corrective action if they are not compliant and will track corrective implementation actions through completion, as applicable. The target completion date is September 29, 2023.

To address recommendation 4, VBA noted that on June 7, 2022, the St. Petersburg DROC updated its procedures regarding informal conference scheduling for specialized claims and confirmed the procedures were provided to all claims processors. This update included guidance on ensuring complex appeal designation is accounted for in informal conference routing applications. On November 23, 2022, OAR updated its site visit protocol to include oversight of specialized processing cases to align with the process the OIG conducted as part of this review. During site visits, OAR noted it will ensure that all DROCs are adhering to the required procedures and that only specialized processors are conducting informal conferences for ALS, TBI, and MST claims. OAR reported it will make appropriate recommendations for correction and track corrective implementation actions through completion, as applicable. Therefore, VBA requested closure of this recommendation.

VBA provided two technical comments. The first comment concerned the report's statement that "Previous OIG reports found that when raters were not fully trained, designated, or subjected to second signature reviews, disability claims associated with complex appeals were frequently inaccurately processed and leading to improper payments." VBA noted that the OIG had

conducted a separate review and findings regarding regional offices, not the decision review operations centers (DROCs), and is an inaccurate comparison that provides an erroneously negative implication for the findings of this report for the DROCs. That report found a high error rate for regional offices which is not supported by this report, or the independent reviews conducted by OAR. It is an inaccurate depiction of the DROCs.

The second technical comment concerned the report's statement that

> However, in the course of this review, the OIG did find inaccurate decisions based on a review of a small judgmental sample of complex appeals completed by raters who did not meet requirements. For example, as a result of the inaccurate decisions, a veteran was underpaid approximately $12,900 for an ALS evaluation.

VBA requested this section of the OIG report be removed or revised to provide adequate context. As the OIG noted quality was not within the scope of this review, VBA requested quality not be put at issue in the executive summary. By citing a single example, VBA felt that the OIG put quality at issue by making a generalization which, to the lay reader, wrongly implies that the quality was both in question, and directly affected by the findings. Doing so misrepresents that a single example reflects the whole and is outside the scope of this report. Furthermore, OAR noted its review of benefit entitlement accuracy as related to all cases the OIG reviewed and determined the decision maker did not meet the processing requirements during this engagement, in which OAR found a 99 percent (158 out of 160 cases) benefit entitlement accuracy rate.

Appendix C provides the full text of VA management comments.

OIG Response

VBA's senior advisor for policy, performing the delegable duties of the under secretary for benefits, provided acceptable action plans for all recommendations. The OIG considers recommendation 1 closed based on OAR's updates to site visit protocols. VBA requested closure of recommendation 4 based on its updated site visit protocols as well. However, the OIG will close this recommendation after VBA has specifically monitored the effectiveness of the updated procedures at the St. Petersburg DROC site visit. The OIG will monitor implementation of all planned actions and will close the remaining recommendations when VBA provides sufficient evidence demonstrating progress addressing the intent of the recommendations and the issues identified.

Regarding VBA's first technical comment, although the OIG's discussion of previous reports was not specific to DROCs, it should be noted that in response to the high error rates detailed in these reports, VBA committed to developing and implementing strategies for ensuring the accuracy of complex TBI, ALS, and MST claims. These strategies included training, specialized groups of staff to process claims, and second signature requirements, to ensure those issues would be accurately processed throughout all of VA, whether it be a VA regional office or

DROC facility. In response to VBA's comment, the OIG moved the reference to the reports and the related risks in the executive summary so as not to imply a comparison. In addition, the report was updated to specify the previous reports did not focus on the accuracy of DROC decisions.

In response to VBA's second comment, the example cited in the report was to demonstrate that inaccurate decisions resulting in improper benefits can occur when raters who do not meet requirements decide complex appeals. This underscores the importance of ensuring raters meet requirements when deciding complex appeals. As previously stated, the OIG did not review the accuracy of decisions and therefore cannot validate OAR's 99 percent accuracy rate contention. However, the OIG team did observe three instances in which inaccurate decisions did affect veterans' benefits. These three cases were not documented as errors in OAR's review. After the OIG team identified the three erroneous decisions to VBA, corrections were made by VBA staff to all three decisions. The OIG reaffirms the example cited in the executive summary and report. However, the OIG moved the example in the report so as to not be misread as a finding.

Appendix A: Scope and Methodology

Scope

The OIG conducted its review work from March 2022 through November 2022. The review team assessed appeals completed by the DROCs from October 1, 2021, through February 28, 2022. The team reviewed three data samples for ALS, MST, and TBI to ensure raters who issued decisions were designated in the WIT and met training and signature requirements.

Methodology

To accomplish the objective, the OIG completed these actions:

- Reviewed applicable laws, policies, and procedures related to WIT designations, training requirements, and signature requirements for ALS, MST, and TBI.
- Assessed three population samples, consisting of
    - All 13 ALS completed appeals;
    - Statistical sample of 80 MST completed appeals; and
    - Statistical sample of 80 TBI completed appeals.
- Interviewed and obtained information from VBA's deputy under secretary for policy and oversight, managers and staff from OAR, and personnel in the following DROCs: Seattle, Washington; St. Petersburg, Florida; and Washington, District of Columbia.

Fraud Assessment

The review team assessed the risk that fraud and noncompliance with provisions of laws and regulations, significant within the context of the review objectives, could occur during this review. The team exercised due diligence in staying alert to fraud indicators by:

- Identifying laws, regulations, and procedures related to the subject matter to help detect noncompliance or misconduct,
- Completing the Fraud Indicators and Assessment Checklist, and
- Requesting relevant OIG hotline complaints for reports of fraud in the area under review.

The OIG identified no instances of fraud or potential fraud during this review.

Data Reliability

The review team used data from VBA and computer-processed data from VBA's corporate database. To test for reliability, the team's goal was to determine if data were missing from key fields, included 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. The team compared veterans' names, file numbers, dates of claims, and special issues. They also used information from electronic claims folders to review completed dates from the data received in the 173 completed appeals. Testing of the data disclosed that the data were sufficiently reliable based on the review objectives. Comparison of the data with information from the electronic claims folders disclosed no 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 B: Statistical Sampling Methodology

Approach

To accomplish the objective of determining whether DROC staff who made decisions on ALS, MST, and TBI appeals met training, signature, and WIT designation requirements, the team reviewed veterans' records from three datasets:

1. All completed appeals with the ALS special issue[30]
2. A statistical sample of completed appeals with the MST special issue
3. A statistical sample of completed appeals with the TBI special issue

The appeals associated with all datasets were completed by a DROC from October 1, 2021, through February 28, 2022. The team reviewed all ALS samples and used statistical sampling for the MST and TBI datasets to quantify the extent to which DROC raters decided who were not designated in the WIT, had not completed all mandatory training, and had not met single-signature authority.

Population

The review population for the first dataset included 16 completed appeals. For the purposes of this review, the review team excluded three samples because ALS was neither claimed nor decided in the appeal. After excluding samples that the OIG determined to be outside the scope of the review, the population for the first dataset was 13.

The review population for the second dataset included 518 completed appeals. For the purposes of this review, the team excluded four samples because MST was not an issue decided on the completed appeal. After excluding samples that the OIG determined to be outside the scope of the review, the estimated population for dataset two was 493.

The review population for the third dataset included 826 completed appeals. For the purposes of this review, the team excluded seven samples because the decision was not completed by a DROC or TBI was not an issue decided on the completed appeal. After excluding samples that the OIG determined to be outside the scope of the review, the estimated population for dataset three was 760.

[30] Special issues are claim-specific indicators and can represent a certain claim type, disability, disease, or other special notation that is only relevant to a particular claim. Special issues must be identified and inputted when applicable. Special issues can be used to route work by the National Work Queue and in local routing rules.

Sampling Design

The first dataset consisted of all 13 samples. For dataset two and three, the team coordinated with an OIG statistician to review a statistical sample of 80 samples each. There was a total of 173 in-scope samples reviewed. The statistical samples are based on a 90 percent confidence level with the following design precisions and expected error rates:

- **MST.** Design precision of 10 percent and an expected error rate of 49 percent.
- **TBI.** Design precision of 9 percent and an expected error rate of 55 percent.

Weights

Samples were weighted to represent the population from which they were drawn, and the weights were used in the estimate calculations. For example, the team calculated the error rate estimates by first summing the sampling weights for all sample records that contained the given error, then dividing that value by the sum of the weights for all sample records.

Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margin of error and confidence interval show the precision of the estimate. If the OIG repeated this audit with multiple sets of samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time.

The OIG statistician employed statistical analysis software to calculate estimates, margins of error, and confidence intervals that account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistical concerns of the sample review. While precision improves with larger samples, the rate of improvement decreases significantly as more records are added to the sample review.

Figure B.1 shows the effect of progressively larger sample sizes on the margin of error.

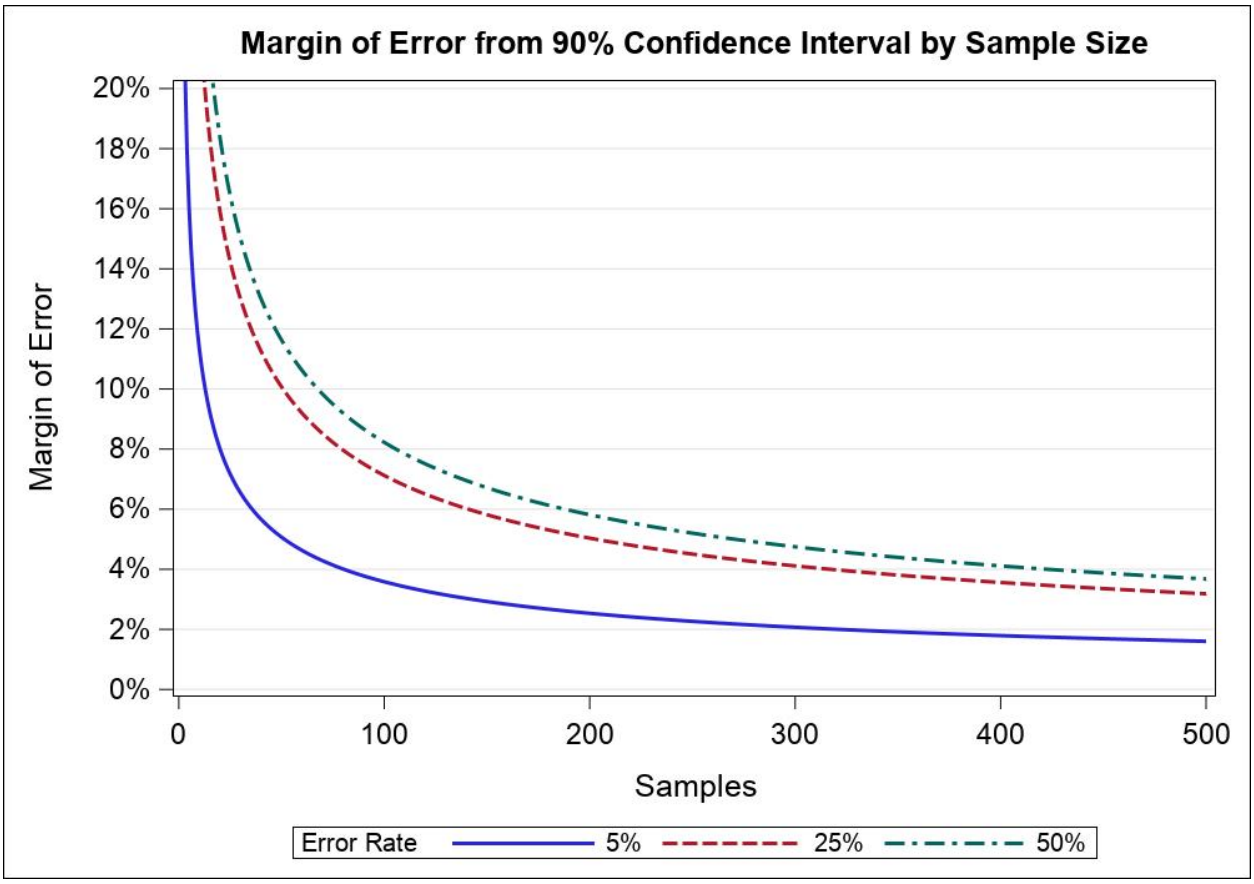

Figure B.1. *Effect of sample size on margin of error.*

Source: VA OIG statistician's analysis

Projections

The following tables detail the review team's analysis and projected results for complex appeals completed during the review period

Table B.1. Statistical Projections Summary for Estimated Universes of Completed Complex Appeals

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Complex appeals completed during the review period*	1,266	44	1,222	1,310	173
MST appeals completed during the review period	493	21	472	513**	80

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
TBI appeals completed during the review period	760	39	721	799	80
Completed complex appeals warranting single signature authority	822	50	772	871**	90

Source: VA OIG statistician's projection of estimated population based on the team's findings.
** All of the estimated universe of complex appeals completed during the review period warranted WIT designation and specialized training.*
*** Projections and confidence intervals may not total precisely due to rounding.*

Table B.2. Statistical Projections Summary for Estimated Universe of Complex Appeals Decided by DROC Raters Not Meeting Requirements

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Complex appeals decided by DROC raters without designation in the WIT, completed mandatory training, or second signature reviews (percent)	1,171 (93)	55 (3)	1,116 (90)	1,226 (95*)	157
Complex appeals decided by DROC raters who did not meet multiple requirements (percent)	752 (59)	80 (6)	672 (53)	833* (65)	100
Complex appeals decided by DROC raters who did not meet any requirements (percent)	444 (35)	70 (5)	374 (30)	514 (40)	54

Source: VA OIG statistician's projection of estimated population based on the team's findings.
** Projections and confidence intervals may not total precisely due to rounding.*

Table B.3. Statistical Projections Summary for Estimated Universe of Completed Appeals by DROC Raters Who Were Not Designated in the WIT

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Complex appeals decided by DROC raters not designated in the WIT	761	81	680	842	104
Percentage of complex appeals decided by raters not designated in the WIT and had not completed all mandatory training	47	6	41	54*	83
VBMS System assigned complex appeal to rater not designated in the WIT	402	75	327	477	52

Source: VA OIG statistician's projection of estimated population based on the team's findings.
** Projections and confidence intervals may not total precisely due to rounding.*

Table B.4. Statistical Projections Summary for Estimated Universe of Complex Appeals Decided by DROC Raters Not Meeting Training Requirements

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Complex appeals decided by DROC raters not meeting specialized training	777	82	695	859	110
Percentage of the estimated 777 complex appeals that were decided by DROC raters who had not completed some mandated training	42	5	37	47	57
Percentage of the estimated 777 complex appeals that were decided by DROC raters who had not completed any of the mandatory training	58	5	53	63	53

Source: VA OIG statistician's projection of estimated population based on the team's findings.

Table B.5. Statistical Projections Summary for Estimated Universe of Complex Appeals Decided by DROC Raters Without Required Second Signatures

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Complex appeals decided by DROC raters without required second signatures	822	50	772	871*	90
Complex appeals decided by DROC raters unknown to have met single signature requirements, without receiving second signatures	581	49	532	631*	62

Source: VA OIG statistician's projection of estimated population based on the team's findings.
** Projections and confidence intervals may not total precisely due to rounding.*

Appendix C: VA Management Comments

Department of Veterans Affairs Memorandum

Date: January 9, 2023

From: Senior Advisor for Policy, Performing the Delegable Duties of the Under Secretary for Benefits (20)

Subj: OIG Draft Report -- VBA Did Not Ensure Complex Appeals Were Decided by Appropriate Staff [Project No. 2022-01814-AE-0078]

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

1. Attached is VBA's response to the OIG Draft Report: VBA Did Not Ensure Complex Appeals Were Decided by Appropriate Staff.

The OIG removed point of contact information prior to publication.

(Original signed by)
Joshua Jacobs

Attachments

Attachment

Veterans Benefits Administration (VBA)
Comments on OIG Draft Report:
VBA Did Not Ensure Complex Appeals Were Decided by Appropriate Staff.

The Veterans Benefits Administration (VBA) concurs with OIG's draft report findings and provides the following general comment:

VBA appreciates the opportunity to collaborate with the OIG regarding the review on internal controls for complex appeals, and for identifying opportunities to improve VBA's Office of Administrative Review (OAR) internal controls in this area. Upon receipt of the sampling used by OIG, OAR investigated the potential impact to Veterans identified. Of those cases identified by OIG as having been completed by staff who were not properly trained, OAR found a 99% (158/160) benefit entitlement accuracy rate. Although quality of the claims decisions was outside the scope of the OIG review, it reported that historically, weak internal controls has led to higher error rates. A thorough review by OAR did not find that failure to follow proper guidelines identified in this review led to an increase in errors in benefit entitlement or improper payments to Veterans. Rather, as noted, the 99% benefit entitlement rate found is consistent with OAR's public facing Directors Performance Plan goal of 93%. Even with the high quality found on the cases, OAR took measures to improve and strengthen its internal controls and oversight ensuring qualified personnel were properly identified to process complex cases as provided in OIG's recommendations.

We thank OIG for partnering with OAR and for considering the actions VBA has taken to ensure internal controls for these complex and sensitive cases are in place and are met.

VBA provides the following technical comments:

Page ii, Paragraph 3, Sentence 1:

"Previous OIG reports found that when raters were not fully trained, designated, or subjected to second signature reviews, disability claims associated with complex appeals were frequently inaccurately processed and leading to improper payments"

VBA Comment: The summary referenced findings from "VA OIG, Systemic Issues Reported During Inspections at VA Regional Offices." This was a separate review and findings regarding regional offices, not the decision review operations centers (DROCs), and is an inaccurate comparison that provides an erroneous negative implication for the findings of this report for the DROCs. That report found a high error rate for regional offices which is not supported by this report, or the independent reviews conducted by OAR. It is an inaccurate depiction of the DROCs.

Page ii, Paragraph 3, Sentence 4-5:

"However, in the course of this review, the OIG did find inaccurate decisions based on a review of a small judgmental sample of complex appeals completed by raters who did not meet requirements. For example, as a result of the inaccurate decisions, a veteran was underpaid approximately $12,900 for an ALS evaluation."

VBA Comment: We respectfully request this section of the OIG report be revised to provide adequate context or removed. OIG noted quality was not within the scope of this review, and we request quality not be put at issue in the executive summary. By citing a single example, OIG puts quality at issue by making a generalization which, to the lay reader, wrongly implies that the quality was both in question, and directly impacted by the findings. Doing so misrepresents that a single example reflects the whole and is outside the scope of this report. Furthermore, OAR reiterates its review of benefit entitlement accuracy as

related to all cases OIG reviewed and determined the decision maker did not meet the processing requirements during this engagement, in which OAR found a 99% (158/160) benefit entitlement accuracy rate (Attachment C).

VBA submits the following comments in response to the recommendations in the OIG draft report:

Recommendation 1: Incorporate oversight to periodically ensure decisions issued for complex appeals were completed by DROC employees that met all requirements associated with them.

VBA response: Concur. On November 23, 2022, OAR updated its M21-5, Appeals and Reviews to incorporate a review of specialized processing cases in the site visit protocol (Attachment E). The revised site visit protocol now aligns with the review process the OIG conducted as part of this review (Attachment F). OAR disseminated this change to the DROCs on December 1, 2022. OAR conducts site visits to the DROCs annually and will make appropriate recommendations for correction if not compliant with the guidelines and will track corrective implementation actions through completion, as applicable. As such, VA requests closure of this recommendation.

Recommendation 2: Ensure DROCs identify which raters meet all the requirements to issue decisions on complex appeals, and to communicate to managers and staff which raters meet those requirements.

VBA Response: Concur. On April 25, 2022, OAR updated its M21-5, Appeals and Reviews to clearly outline the requirements for adjudicators to decide specialized processing cases in accordance with OIG's findings and recommendations (Attachment G). OAR updated this section to provide guidance to DROC staff regarding training, signature requirements and required documentation for Military Sexual Trauma (MST), Traumatic Brain Injury (TBI) and Amyotrophic Lateral Sclerosis (ALS) claims processing. In June 2022, OAR received confirmation from all DROCs that the appropriate employees were identified and designated to complete specialized claims, to include ALS, MST and TBI as outlined in the manual provisions (Attachment H). OAR is currently validating these certifications from the DROCs. These designations will consistently be audited during OAR's annual site visits of the DROCs through the National Training Curriculum and the Workforce Information Tool (WIT) (Attachments D and F). OAR will make appropriate recommendations for correction if the DROCs are not compliant with the guidelines and will track corrective implementation actions through completion, as applicable.

Target Completion: March 31, 2023

Recommendation 3: Provide guidance to DROC supervisors on how to maintain VBMS routing rules, and have OAR establish a procedure to periodically ensure WIT and workload designations at the DROCs are in alignment.

VBA Response: Concur. OAR will provide guidance and training to DROC supervisors during fiscal year 2023. OAR will request routine certification from the DROCs regarding the accuracy of routing rules, WIT, and workload designations. On November 23, 2022, the Office of Administrative Review updated the M21-5, Appeals and Reviews site visit protocol to review specialized processing cases to align with the review process the OIG conducted as part of this review (Attachment E). During the annual site visit to each DROC, OAR will ensure that the DROCs are adhering to the required procedures. OAR will make appropriate recommendations for corrective action if they are not compliant and will track corrective implementation actions through completion, as applicable.

Target completion date: September 29, 2023.

Recommendation 4: Ensure the St. Petersburg DROC monitors the effectiveness of its modified procedures that only designated DROs are assigned informal conferences for complex appeals and

ensure complex appeal designation will be accounted for in future informal conference routing applications.

VBA Response: Concur. On June 7, 2022, St. Petersburg DROC updated its procedures regarding informal conference scheduling for specialized claims and confirmed the procedures were provided to all claims processors (Attachments A and I). This update included guidance on ensuring complex appeal designation is accounted for in informal conference routing applications. On November 23, 2022, OAR updated M21-5, Appeals and Reviews site visit protocol to include oversight of specialized processing cases to align with the process the OIG conducted as part of this review (Attachment J). During site visits, OAR will ensure that all DROCs are adhering to the required procedures and that only specialized processors are conducting informal conferences for ALS, TBI, and MST claims. OAR will make appropriate recommendations for correction and track corrective implementation actions through completion, as applicable. Therefore, VA requests closure of this recommendation.

OIG Note: The attachments were not included in this report. Copies may be obtained from the OIG Information Release Office.

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

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