DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS BENEFITS ADMINISTRATION

Deficiencies in the Quality Review Team Program

REVIEW | REPORT #19-07054-174 | JULY 22, 2020

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Executive Summary

The Veterans Benefits Administration's (VBA) Compensation Service oversees the delivery of disability compensation benefits for veterans. Within the Compensation Service, the quality assurance program helps ensure veterans receive the benefits they deserve in an accurate and timely manner. This review focused on the quality review team (QRT) program, a component of VBA's quality assurance program for veterans' disability compensation benefits. QRT specialists perform quality reviews on employees responsible for processing disability compensation claims.[1] This important function exists to ensure the accuracy with which VBA staff process compensation claims, identify any trends in errors committed by claims processors, provide training and mentoring on error trends, and review the performance of individual employees. Without accurate quality reviews, the risk increases that claims will be adjudicated with less accuracy and VBA will lack adequate information about staff performance levels or improvements needed.

The VA Office of Inspector General (OIG) conducted this review to determine whether QRT specialists conducted accurate quality reviews, regional office managers appropriately decided requests for reconsideration, and employees initiated timely action to correct identified claims-processing errors based on established standards. This review is one in a series of five VA OIG reports regarding VBA's quality assurance program.

What the Review Found

The OIG found that QRT specialists did not identify a significant number of claims-processing errors that should have been identified. Based on a statistical sample, the OIG estimated that 9,900 of the 28,400 quality reviews (35 percent) completed during the review period contained missed claims-processing errors that should have been identified. Quality reviews with identified errors are routed to another QRT specialist for peer review to help ensure the cited errors are appropriate. The OIG determined that the current peer review process was not adequate to identify errors missed during the initial quality review. In addition, performance reviews of QRT specialists did not promote competency, resulting in missed claims-processing errors.

Additionally, errors identified by QRT specialists were overturned by regional office managers in violation of VBA's procedures.[2] The OIG estimated that during the review period regional office managers inappropriately overturned errors identified by QRT specialists in 430 of 870

[1] QRT specialist refers to a "quality review specialist" on the quality review team at the regional office. The scope of this review covered the work of rating quality review specialists.

[2] Regional office managers responsible for reconsiderations include QRT supervisors, assistant veterans service center managers, and veterans service center managers; VA Manual 21-4, chap. 6, topic 5.h, "Reconsideration Requests on Employee Performance Reviews," January 16, 2018.

quality reviews (about 50 percent) where claims processors requested reconsideration. Reconsiderations are requested by employees when they disagree with a cited error. Errors affect employee quality for performance review purposes. The OIG found that VBA's current procedure regarding requests for reconsideration did not promote objectivity or contribute to accuracy of decisions. In addition, incorrectly overturned errors resulted in inaccurate performance quality for employees.

VBA's procedures direct that *QRT* supervisors manage the error correction process, while an *employee's* supervisor ensures corrections are completed in a timely manner.[3] However, the Office of Field Operations has not established adequate oversight or accountability to ensure the timeliness of error corrections.[4] The OIG estimated that during the review period 2,000 of 4,400 identified errors (45 percent) were not corrected in a timely manner and 810 of 4,400 identified errors (18 percent) were not corrected at all. In addition, there is no process to confirm that corrective action was taken on error corrections. To maximize the effectiveness of the QRT program, additional oversight, objectivity, and accountability should be established.

The deficiencies noted by the OIG resulted in the QRT program not achieving its stated mission of improving the accuracy and timeliness of compensation claims processing. If this continues, the quality of claims-processing decisions will not improve, and VBA employees will not be held accountable for the accuracy of their work.

What the OIG Recommended

The OIG recommended the under secretary for benefits assess the current peer review process and determine whether a more in-depth review should be required to ensure all claims-processing errors are identified, revise the QRT specialist performance review process to promote competency, revise the error reconsideration process to promote objectivity and adherence to current VBA procedures, and improve oversight of the error correction process.

[3] VA Manual 21-4, chap. 6, topic 3.a, "Responsibilities of the QRT Coach and/or Other QRT Supervisor," January 16, 2018.

[4] The Office of Field Operations oversees operations at VBA's regional offices and is responsible for ensuring that benefits and services delivered by VBA are provided in an effective and efficient manner.

Management Comments

The under secretary for benefits concurred with recommendations 1 through 5 and provided acceptable action plans for all recommendations. The OIG will monitor VBA's progress and follow up on the implementation of the recommendations until all proposed actions are completed.

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Assistant Inspector General
for Audits and Evaluations

Contents

Abbreviations

OIG	Office of Inspector General
QMS	Quality Management System
QRT	Quality Review Team
RVSR	rating veterans service representative
STAR	Systematic Technical Accuracy Review
VBA	Veterans Benefits Administration

Introduction

Accurate and prompt decisions on disability compensation claims are vital to achieving VA's vision of providing world-class benefits and services to veterans. The Veterans Benefits Administration (VBA) created the Quality Review Team (QRT) program to improve the accuracy and timeliness of compensation claims processing. Specifically, the program is responsible for evaluating the accuracy with which VBA staff process compensation claims, identifying any trends in errors committed by claims processors, providing training and mentoring on error trends, and reviewing the performance of individual employees. If the QRT program does not provide accurate reviews, the risk increases that claims will be processed with less accuracy and VBA will lack adequate information about staff performance levels or improvements needed.

The purpose of the VA Office of Inspector General's (OIG) review of the QRT program was to determine whether

- QRT specialists performed quality reviews in an accurate manner,
- Regional office managers made appropriate decisions regarding requests for reconsideration of identified claims-processing errors, and
- Employees initiated action to correct identified claims-processing errors in a timely fashion under established standards.[5]

VBA Entities and Staff Involved in the QRT Program

The two primary VBA entities involved in the operation and oversight of the QRT program are the Compensation Service and the Office of Field Operations as shown in figure 1. The QRT program is comprised of supervisors and QRT specialists.

[5] QRT specialist refers to a "quality review specialist" on the quality review team at the regional office. The scope of this review covered the work of rating quality review specialists. Regional office managers responsible for reconsiderations include QRT supervisors, assistant veterans service center managers, and veterans service center managers.

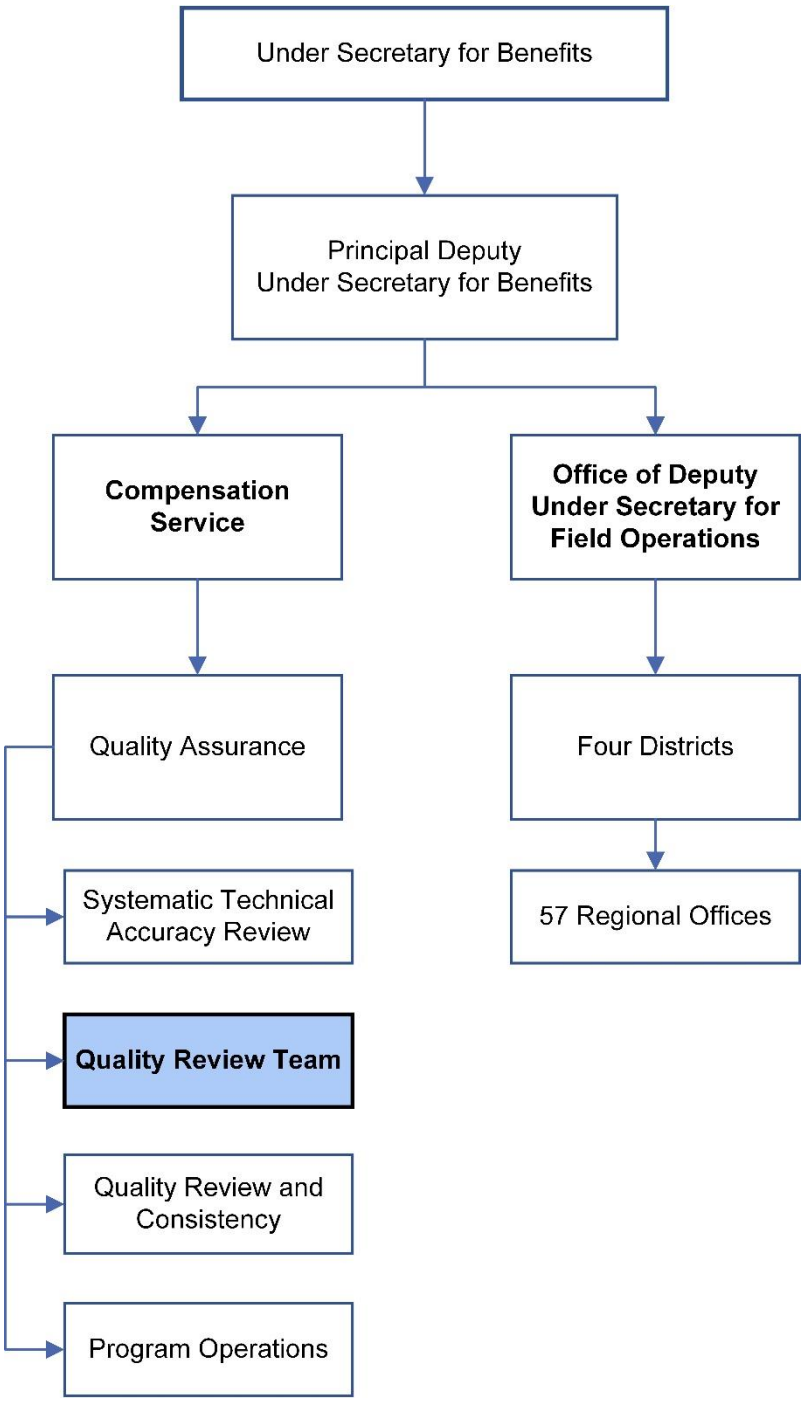

Figure 1. *Organization of VBA offices involved in the oversight and operation of the QRT program.*

Source: VA OIG analysis.

Compensation Service

The Compensation Service provides oversight of the delivery of disability compensation benefits to veterans. The QRT program is one component of VBA's multifaceted quality assurance program to ensure disability benefits are administered accurately. During the OIG review period, the quality assurance program consisted of four components:

1. **Systematic Technical Accuracy Review (STAR)**: VBA uses this program to measure the accuracy with which compensation claims are processed nationwide. Results from these evaluations determine the quality statistics VBA reports to the public and are used in trend analyses to identify training needs. The reviews affect regional office quality metrics but do not affect employees' individual performance assessments.
2. **QRT program**: Staff conduct quality reviews of regional office employees and perform error trend analyses to identify areas for training and mentoring. The purpose of the program is to enhance quality in every VBA facility that processes compensation claims. Per the Compensation Service executive director, quality results are not made available to the public.
3. **Quality Review and Consistency program**: This program assesses regional office variance in disability ratings for the most frequently rated disabilities, conducts studies to evaluate the consistency of rating veterans service representatives (RVSR) across regional offices, and provides guidance to QRTs.
4. **Program Operations** (the site visit program): Staff conduct site visits to review veterans service center operations, maintain the quality assurance manual, review and approve changes to controls for pending workload, and provide special assistance to regional offices and other stakeholders regarding compensation benefits.[6]

The QRT program differs from the other three components of the quality assurance program in staffing and supervision. The quality review teams are comprised of regional office personnel who are supervised by regional office management and fall under the jurisdiction of the Office of Field Operations. The other three components are staffed and supervised by the Compensation Service. Although both the STAR and QRT programs focus on claims-processing accuracy, they differ in the types of reviews they complete and how errors are categorized. QRT reviews examine the work of individual employees while STAR reviews evaluate completed claims, which may have been worked by multiple employees at various regional offices. Errors cited by STAR are broken into two categories: (1) benefit entitlement errors that affect outcome, and

[6] VBA restructured the quality assurance program in June 2019 with no significant impact to this report.

(2) procedural deficiencies that do not affect outcome. In contrast, errors identified under the QRT program are cited as critical errors whether outcome is affected or not.[7]

Office of Field Operations

The Office of Field Operations is responsible for ensuring that benefits and services delivered by VBA are provided in an effective and efficient manner. Specifically, with respect to the QRT program, this office is responsible for

- Developing achievable performance measures that ensure timeliness, quality, and consistency of benefits;
- Evaluating the performance of VBA regional offices; and
- Overseeing operations at VBA's regional offices, which includes ensuring that established policies and procedures regarding error corrections and requests for reconsideration are adhered to.

The QRT Program

VBA established the QRT program under the Compensation Service in March 2012 for the purpose of improving the quality and timeliness of claims processing. The program is comprised of dedicated QRT specialists located in every VBA facility that processes compensation claims, which includes regional offices, the appeals management office, integrated disability evaluation system sites, and consolidated processing sites. This OIG review focuses on the quality review teams established at the regional offices.

At the time of this OIG review, the QRT program had almost 900 dedicated QRT specialists located at VBA's claims-processing facilities. The number of QRT specialists assigned to each regional office is relative to the number of claims processors employed by that office: a 1:10 ratio is recommended for the number of *rating* QRT specialists to the number of RVSRs, and a 1:14 ratio is recommended for the number of *authorization* QRT specialists to the number of veterans service representatives. At a minimum, each regional office has at least one rating QRT specialist and one authorization QRT specialist.

Authorization QRT specialists review the work of veterans service representatives, which includes claims development, promulgation, and authorization of awards. *Rating* QRT specialists review the work of RVSRs and decision review officers who are responsible for making formal entitlement decisions. All QRT specialists complete reviews using the same process outlined in the flowcharts in figures 2, 3, and 4. Due to the potential impact on veterans' benefits, this review focused on the work of *rating* QRT specialists.

[7] VA Manual 21-4, chap. 6, topic 5.f, "Peer Review Disagreements," January 16, 2018.

QRT *specialists* are regional office employees who fall under the supervision of the regional office director. Employees selected as QRT specialists are expected to have an expert degree of knowledge of applicable compensation and pension regulations as well as detailed knowledge of federal laws pertaining to compensation and VA regulations. They must also demonstrate an ability to train others and communicate effectively, both orally and in writing.

Compensation Service personnel developed and maintain the policies and procedures used by the QRT program. A deputy director with the Office of Field Operations reported that individual performance standards for QRT specialists were initially created by the Compensation Service many years ago. These standards were updated in 2019 by the Office of Field Operations. The 2019 performance standards contain four critical elements for a QRT specialist to be considered fully successful during a fiscal year. The rating QRT specialist performance standard outlines the following:

- Element 1, quality of work: Specialists must achieve a 93 percent accuracy rate on completed initial reviews.
- Element 2, timeliness: Specialists may have no more than three documented instances of failure to complete a review within two business days of assignment.
- Element 3, required reviews: Specialists must complete an average of 10 weighted reviews/claims-processing actions per day. At the direction of national leadership, specialists may also complete claims processing, which counts towards this element.
- Element 4, training: Specialists must complete nationally mandated training by assigned deadlines with no more than one violation. In addition, they must prepare and conduct training, monitor progress, and provide mentoring to other employees with no more than two instances of noncompliance.

QRT *supervisors* are also regional office employees. They are responsible for the efficient operation of quality review teams and are charged with managing the error correction process, updating tracking systems for overturned errors, and performing error trend analyses to determine areas for training and mentoring of regional office employees. QRT supervisors are also responsible for ensuring that QRT specialists are meeting their performance standards.

Quality Review Process

QRT specialists are tasked with completing quality reviews on employee transactions (work actions). These reviews are not a review of the entire file; rather, the review is limited to the action(s) of the employee for whom the review is being completed. The review is conducted according to a standardized quality review checklist and all errors are cited as critical errors.

From March 2012 until July 2017, quality review teams were responsible for selecting and performing reviews on employees at their regional offices. In July 2017, the responsibility for

selecting employee reviews was shifted to VBA's Office of Performance Analysis and Integrity, located at VA central office. Employee work actions selected for review are uploaded to the Quality Management System (QMS) and distributed to QRT specialists.[8] In January 2018, the distribution of reviews was changed so that QRT specialists no longer performed reviews on employees at their own regional office.

Quality reviews completed by QRT specialists on RVSRs and veterans service representatives must be completed in QMS. Figure 2 outlines the process for completing quality reviews. This process begins with the assignment of the review in QMS to a QRT specialist and shows the steps that are required depending on whether an error is cited.

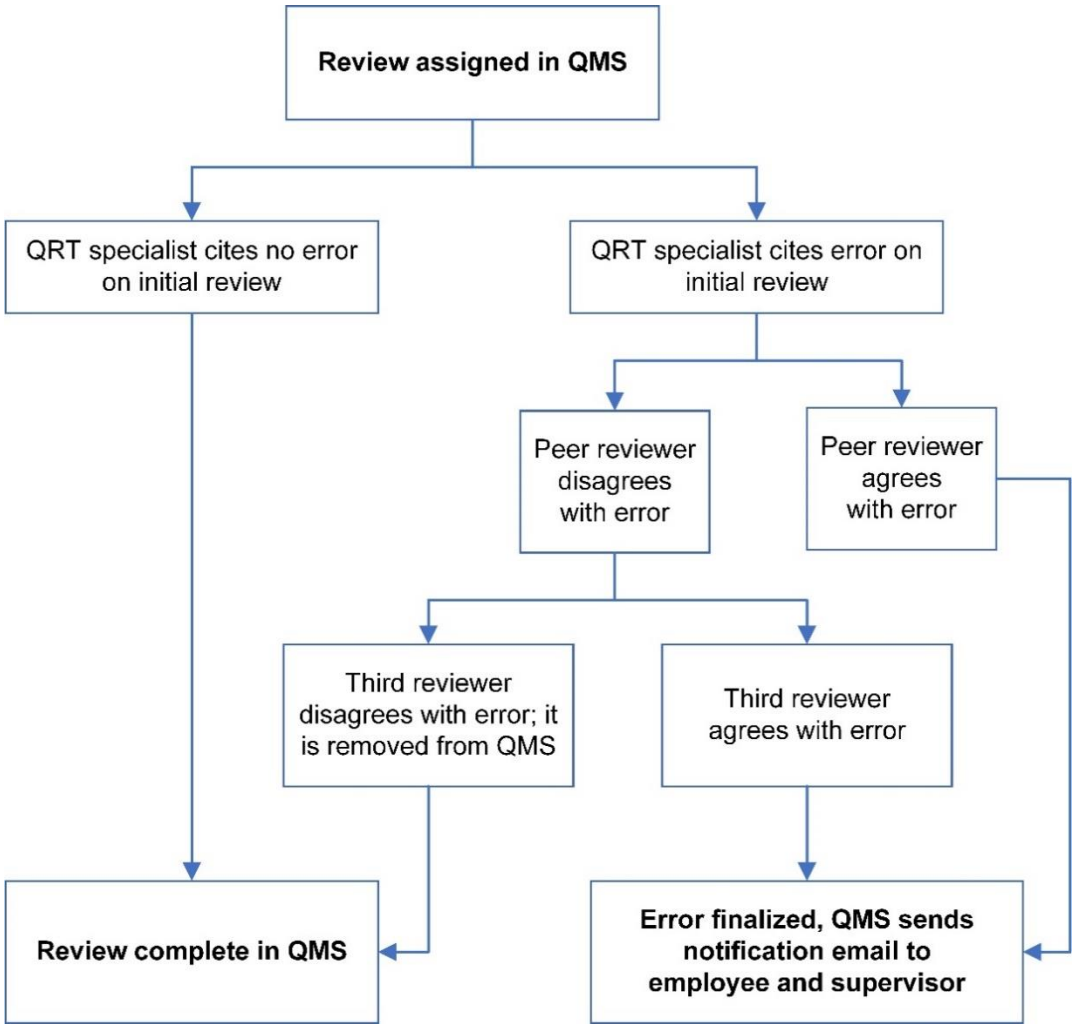

Figure 2. *Quality review process from assignment to notification.*

Source: OIG created based on QMS User Guide issued January 2018, and VA Manual M21-4, chapter 6.

[8] QMS is a claims quality management system that integrates multiple quality review processes into one system.

Figure 3 outlines the process from the time that an employee is notified of an error. It shows the steps that are followed depending on whether the employee agrees with the error.

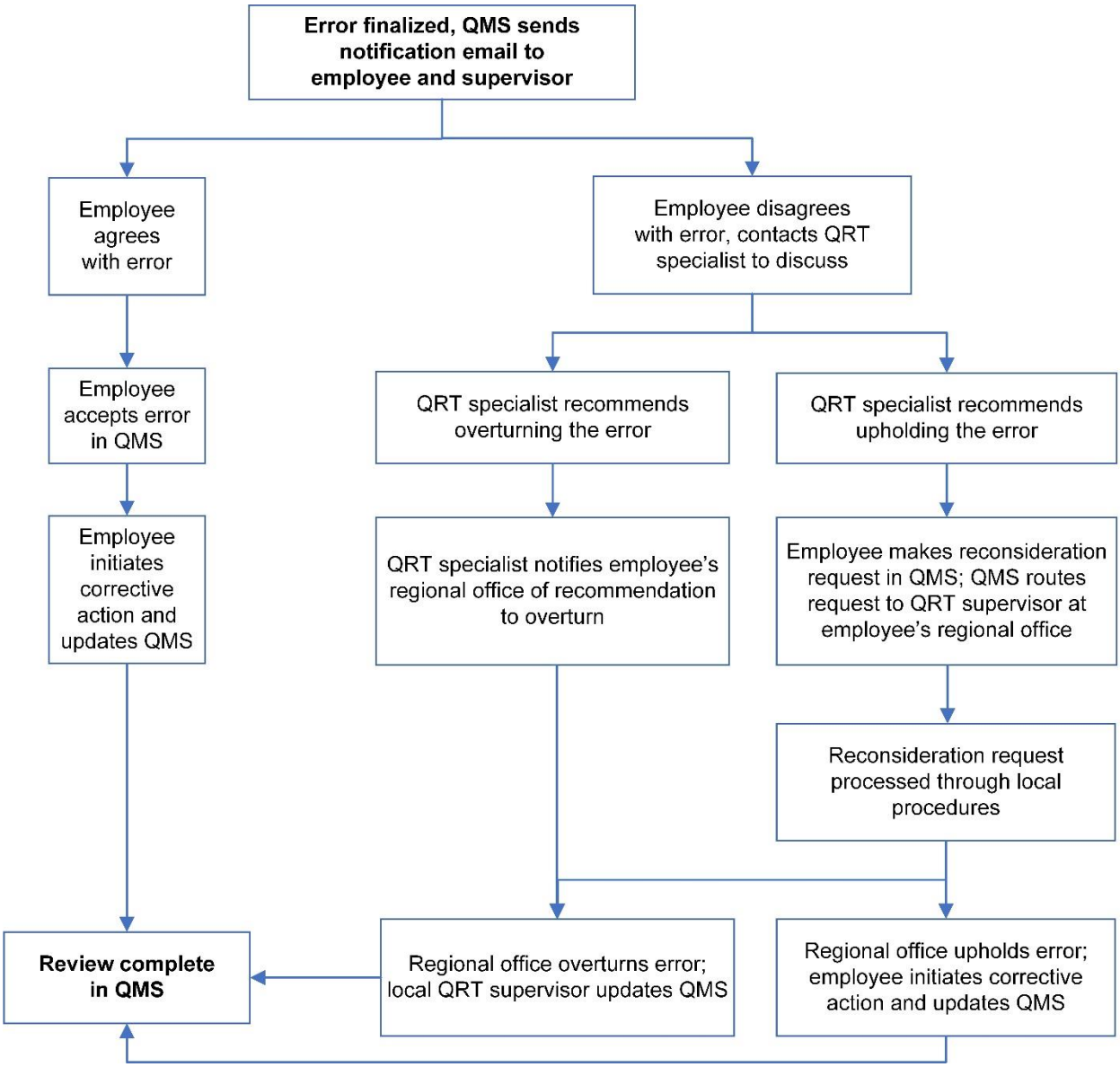

Figure 3. *Quality review process from notification to completion.*

Source: OIG created based on QMS User Guide issued January 2018, VA Manual M21-4, chapter 6, and QRT interviews conducted during regional office site visits.

Results and Recommendations

Finding: The QRT Program Lacks Adequate Oversight and Objectivity to Promote Claims-Processing Improvement

VBA did not establish adequate oversight of the QRT program. This led to deficiencies such as missed claims-processing errors and untimely corrections, which hindered the program's ability to achieve its mission of quality improvement. If these deficiencies continue, the quality of claims-processing decisions will not improve, and VBA employees will not be held accountable for the accuracy of their work.

The OIG team estimated that about 35 percent of the quality reviews completed during the review period did not identify all claims-processing errors and about 50 percent of errors identified by QRT specialists where claims processors requested reconsideration were inappropriately overturned. It was also estimated that 45 percent of quality reviews with errors not refuted by the employee (accepted) were not corrected within required time frames, while 18 percent of quality reviews with accepted errors were not corrected at all.[9] The OIG team determined that deficiencies existed in the QRT program because VBA did not establish adequate oversight and objectivity.

What the OIG Did

This review is one in a series of five VA OIG reports regarding VBA's quality assurance program and covered about 28,400 quality reviews completed by QRT specialists from July 1 through September 30, 2018. The OIG team chose this time period to ensure employees had sufficient time to complete corrections on errors that were identified by QRT specialists. The OIG team reviewed a statistical sample of 180 quality reviews to assess compliance with VBA's policies, procedures, and standardized checklist. The team used VBA's electronic systems, including QMS and the Veterans Benefits Management System, to review the sampled quality reviews and relevant documentation.[10] The team discussed the quality reviews with VBA officials and included their comments in the report as appropriate.

To accomplish the objectives of this review, the OIG team also

- Examined regulatory requirements, documentation, and actions applicable to the QRT program;

[9] The review population included RVSR individual quality reviews.

[10] Veterans Benefits Management System is a web-based, electronic claims-processing system.

- Interviewed management and staff at VBA's central office who had responsibilities related to the QRT program; and
- Conducted site visits to the regional offices in Phoenix, Arizona; Portland, Oregon; St. Louis, Missouri; and Detroit, Michigan.

The finding addresses how

- QRT specialists missed claims-processing errors that should have been identified,
- Errors identified by QRT specialists were inappropriately overturned by regional office managers, and
- Corrective actions on errors identified by QRT specialists were not initiated timely or at all by employees.

QRT Specialists Missed Claims-Processing Errors That Should Have Been Identified

The OIG team determined that in 63 of the 180 quality reviews, QRT specialists did not identify all claims-processing errors. Based on these statistical sample results, the team estimated that about 9,900 of 28,400 quality reviews (35 percent) completed during the review period contained missed claims-processing errors. QRT specialists are responsible for completing quality reviews using a standardized checklist. The checklist assesses different actions taken by the RVSR during the rating process and is intended to promote consistency and uniformity.[11] When QRT specialists do not identify all claims-processing errors during reviews, veterans may receive incorrect benefit payments and employees may receive inaccurate performance reviews.

Example 1 details how a QRT specialist missed claims-processing errors that should have been identified. This example represents the most significant monetary impact among the quality reviews the OIG team reviewed.

Example 1

A QRT specialist identified deficiencies in the processing of a veteran's claim. However, the OIG team found an additional deficiency that neither the QRT specialist nor the peer reviewer identified. Medical evidence was sufficient to continue the veteran's 100 percent evaluation for lymphoma for an additional two years, but the claims processor failed to grant the continued evaluation. Because this deficiency was not found during the quality review, no corrective

[11] RVSRs decide whether to award or deny benefits and assign rating percentages. A rating percentage is a multiple of 10 percent that indicates the severity of the disability and how much it diminishes the veteran's health and ability to function.

action was taken by the regional office. At the time of the OIG's review, the deficiency had yet to be corrected and the veteran was owed over $70,000 in retroactive payments.

The Peer Review Process Is Inadequate to Identify Missed Claims-Processing Errors

The OIG team determined that VBA's current peer review process is not adequate to identify errors missed by QRT specialists during initial quality reviews. When a QRT specialist identifies an error, QMS automatically initiates a peer review by another specialist. The QRT program chief for the Compensation Service stated the second specialist may or may not be located at the same regional office as the initial reviewer. In instances where a QRT specialist does not identify an error, there is no peer review process and the review is considered complete.

Current VBA procedure directs that peer reviews are a "quick-touch review" to ensure that all cited errors are appropriate and to identify any obvious error(s) not cited by the initial reviewer.[12] The QRT program chief for the Compensation Service confirmed that peer reviews were designed as a check to ensure that errors cited during the initial quality review were accurate. Peer reviews were not designed to be as in-depth as initial quality reviews, which look at all associated actions that were taken or should have been taken by the employee under review.

The 63 quality reviews with missed claims-processing errors were analyzed to determine whether reviews that had undergone a peer review had a lower missed-error rate. The OIG team reviewed 120 quality reviews where a peer review was completed and found 42 with missed claims-processing errors. The team also reviewed 60 quality reviews where a peer review was not completed and found 21 with missed claims-processing errors. Based on these findings, the missed error rate is about 35 percent whether a peer review is competed or not.

The current peer review process is not adequate to identify errors missed during the initial quality review. If the peer review process is not modified to be a more in-depth review and expanded to include non-error quality reviews, errors will continue to be missed, resulting in inaccurate employee and regional office performance information, unidentified error trends, and incorrect benefit payments to veterans.

Recommendation 1 addresses the need for VBA to assess the current peer review process and determine whether a more in-depth review should be required to ensure claims-processing errors are identified.

Recommendation 2 addresses the need for VBA to establish a process to peer review a sample of quality reviews with no errors identified to ensure initial reviewers did not miss any claims-processing errors.

[12] VA Manual 21-4, chap. 6, topic 5.e, "Peer Reviews," January 16, 2018.

The Performance Review Process for QRT Specialists Does Not Promote Competency

Work quality is one element of QRT specialists' performance standards. To determine whether this performance element is being met, an average of five actions completed by each QRT specialist are randomly selected per month. QRT specialists are responsible for performing reviews on each other and either agreeing or disagreeing with the action under review. If the QRT specialist disagrees with the action taken by the QRT specialist under review, the performance review is routed through QMS to a QRT supervisor for peer review. The QRT program chief for the Compensation Service reported that the QRT performance review process includes no location restrictions; therefore, performance reviews can be completed by a QRT specialist at the same regional office as the QRT specialist under review. This was confirmed during VA regional office site visits where the QRT supervisors stated that they had been assigned peer reviews in QMS for QRT specialists at their regional offices.

Figure 4 below shows the QRT performance process from the time the QRT specialist completes the action selected for review to completion of the performance review.

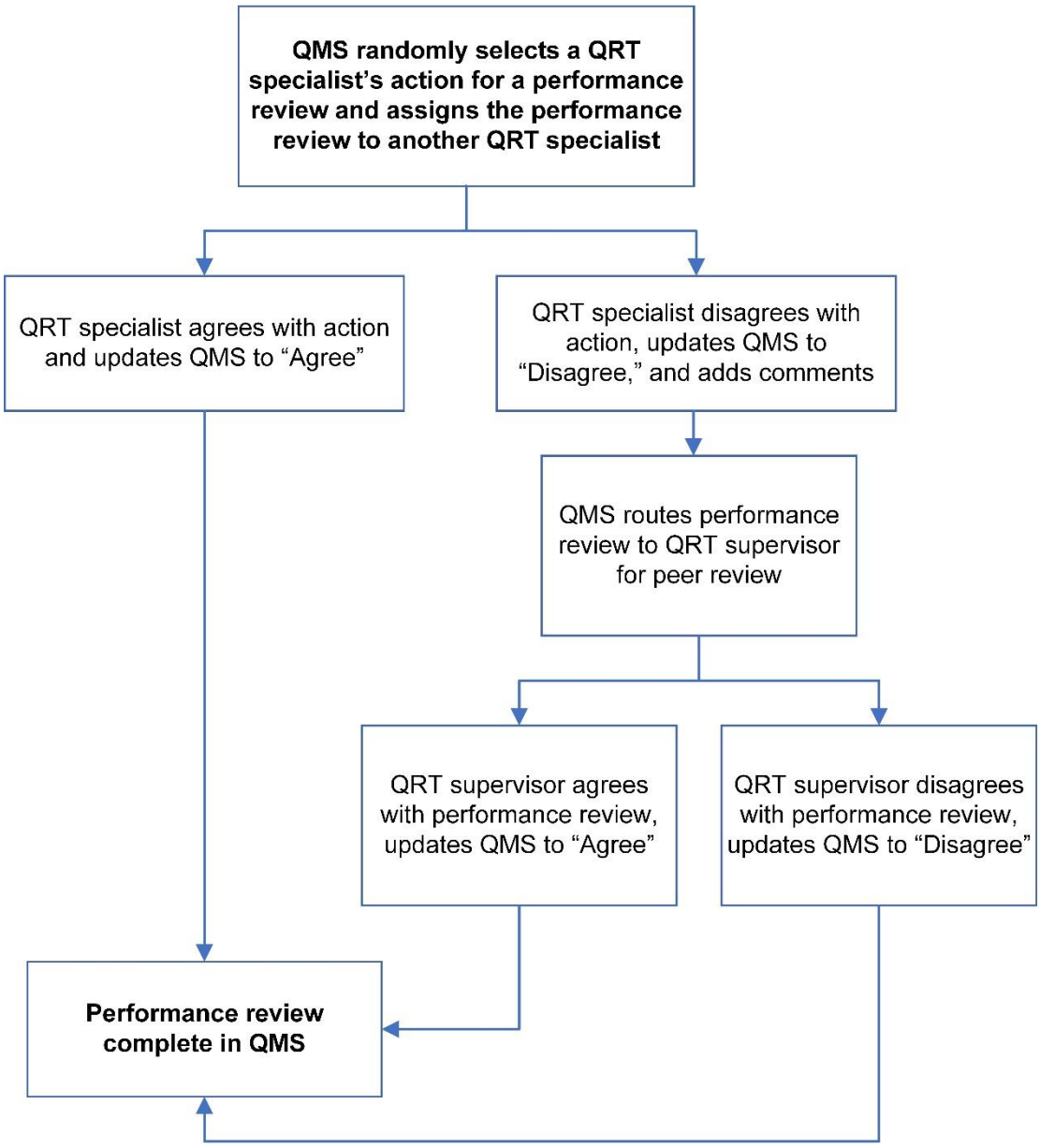

Figure 4. *QRT specialists' performance process.*

Source: OIG created based on VA Manual M21-4, chapter 6, topic 6 and QMS Review Routing Rules (October 2018).

QMS data from July 1 through September 30, 2018, show a national average performance quality of 99 percent for QRT specialists. However, the OIG team found a missed error rate of 35 percent. When asked about this discrepancy, the QRT program chief for the Compensation Service explained that performance reviews for QRT specialists are currently "claim based," meaning a quality review is considered either correct or incorrect. The program chief suggested that QRT specialists might not be identifying colleagues' performance errors as a way of protecting one another.

Performance reviews are intended to ensure that QRT specialists have the necessary competency to perform accurate quality reviews. If QRT specialist performance reviews are not completed accurately and objectively, feedback cannot be used to identify areas needing improvement. If QRT specialists' competency does not improve, claims-processing errors will continue to be missed.

Recommendation 3 addresses the need for VBA to revise the current QRT specialist performance review process to include more objectivity to ensure constructive feedback is provided to promote competency.

Errors Identified by QRT Specialists Were Inappropriately Overturned by Regional Office Managers

If an employee disagrees with an error cited by a QRT specialist, they have the option to request reconsideration. This option can be exercised on any error cited by a QRT specialist (see figure 3). From July 1 to September 30, 2018, employees requested reconsideration on approximately 23 percent of errors cited. The OIG team reviewed a statistical sample of 60 quality reviews in which QRT specialists identified an error, the employee requested reconsideration of the error within QMS, and the error was overturned by regional office managers. The OIG team determined that regional office managers inappropriately overturned errors in 30 of the 60 reviews. Based on these results, the team estimated that regional office managers inappropriately overturned errors identified by QRT specialists in 430 of 870 quality reviews (about 50 percent) where claims processors requested reconsideration.[13]

Example 2 provides details on a quality review where the QRT supervisor inappropriately overturned identified errors. The supervisor stated that the errors were overturned because they were not clear and unmistakable errors.[14] The OIG disagreed, as the errors identified were a violation of statutory and regulatory provisions noted on the standardized checklist. VBA concurred with OIG's finding that the errors were inappropriately overturned.

Example 2

A claims processor incorrectly continued a 40 percent evaluation for the veteran's back condition when medical evidence showed improvement in the condition warranting a proposed reduction to 10 percent disabling. Additionally, the claims processor incorrectly indicated that the veteran required reexamination for a neck condition, even though the condition did not show improvement. A QRT specialist cited these two errors, and a peer reviewer agreed. After being notified of the errors, the claims processor requested

[13] All projected numbers have been rounded in this report.

[14] 38 C.F.R. § 3.105.

reconsideration of both errors, which were overturned by the QRT supervisor. The OIG team determined that it was incorrect to overturn the errors. As a result, the veteran was incorrectly evaluated for his back condition and will be subjected to a needless reexamination.

Lack of Objectivity and Oversight Led to Inappropriate Overturning of Errors

The quality review process was modified in January 2018 so that QRT specialists are not assigned to conduct quality reviews on employees at their own regional office. However, the reconsideration request process continues to assign responsibility for overturning an error to the employee's regional office.

When a QRT specialist does a quality review and identifies an error, the specialist documents it in QMS. The system automatically emails the employee and the employee's supervisor to notify them of the error. The employee has five business days to either accept the error and initiate corrective action or request reconsideration of the error.

If the employee disagrees with an error identified by a QRT specialist, the employee should contact the specialist to discuss the error. If the QRT specialist does not overturn the error after discussion, the employee can initiate a request for reconsideration in QMS. QMS will automatically route the request for reconsideration to the QRT supervisor at the employee's regional office for local processing.

VBA procedure states the only basis for overturning an error is that the cited error was incorrect.[15] All of the inappropriately overturned errors identified by the OIG team were done in violation of VBA's procedures, as the errors cited by the QRT specialists were valid. The OIG identified three errors that were overturned by QRT supervisors but still corrected by the employees. In all three instances, the QRT supervisor indicated in QMS that corrective action was required. In two instances, the QRT supervisor acknowledged the identified error was valid but overturned it because the employee's work had been reviewed and approved by a second employee. In the third instance, the error was overturned because the same error on the claim had been identified on a review of an employee at another station but not corrected.

VBA Has Identified Similar Issues with Reconsideration Requests

Another component of the Compensation Service's quality assurance program, Program Operations, conducts site visits to review regional office operations. In fiscal year 2019, Program Operations staff identified issues with reconsideration requests at two regional offices. In an internal report issued in May 2019, Program Operations staff directed a regional office to

[15] VA Manual 21-4, chap. 6, topic 5.h, "Reconsideration Requests on Employee Performance Reviews," January 16, 2018.

discontinue the practice of overturning legitimate errors for "training" reasons. In a second internal report issued in July 2019, Program Operations staff noted that the regional office had a local memorandum of understanding in place that stated QRT supervisors were responsible for providing decisions on reconsideration requests within five business days. As of April 3, 2019, QMS data showed this regional office had 59 reconsideration requests pending review, to include one pending since November 30, 2018. Program Operations staff directed the regional office to develop a plan to ensure reconsideration reviews are completed in a timely manner and errors are overturned only in accordance with VBA's procedures.

The QRT program chief for the Compensation Service acknowledged that inappropriately overturned errors have been identified during site visits but denied having any additional information regarding errors being overturned inappropriately. The deputy under secretary for field operations reported that his staff does not conduct oversight of the reconsideration process and acknowledged that allowing regional offices to overturn errors on their own employees is an independence issue.

VBA's current procedure regarding requests for reconsideration does not promote objectivity or accuracy. If the current reconsideration process is not revised, identified errors may not be corrected, employee performance evaluations may not be based on accurate data, and error trends may not be identified.[16]

Recommendation 4 addresses the need for VBA to revise the error reconsideration process to ensure objectivity and adherence to current VBA procedures.

Corrective Actions on Errors Identified by QRT Specialists Were Not Initiated Timely or at All

When a QRT specialist identifies an error during a quality review and the employee accepts the error, that employee is required to correct it and update the review status in QMS to "corrected." VBA's procedures specify that employees have five business days following notification of the error to initiate corrective action on any accepted errors.[17]

To determine if claims processors took corrective action within the required timeframe, the OIG team reviewed 60 quality reviews where claims processors accepted the errors that QRT specialists identified. Twenty-seven of these quality reviews did not have corrective action taken within five business days, while 11 quality reviews had no corrective action taken. From these statistical sample results, the OIG team estimated that 2,000 of 4,400 quality reviews with

[16] National RVSR performance plan: For an RVSR with 25 or more months in the position, the accuracy rate during the evaluation period must equal or exceed 96 percent (cumulative) to be fully successful.

[17] VA Manual 21-4, chap. 6, topic 5.g, "Corrective Action Time Limits for IQRs," January 16, 2018.

accepted errors (45 percent) were not corrected timely and 810 of 4,400 quality reviews with accepted errors (18 percent) were not corrected at all.

Table 1 summarizes the OIG estimates regarding untimely correction of QRT-identified errors accepted by claims processors.

Table 1. Days Taken to Initiate Untimely Corrections

Days	Number of errors	Percentage
6–10 days[18]	370	8
11–30 days	740	17
30+ days	890	20
Total	**2,000**	**45**

Source: OIG analysis of estimated corrections.

Example 3 provides details on a quality review where the processing error was not corrected. When contacted, the QRT supervisor reported that the RVSR had accepted the error but left employment with VA prior to initiating correction. This quality review is another example of the significant monetary impact that errors may cause.

Example 3

> *The claims processor assigned an incorrect date of payment related to the evaluation of the veteran's bilateral nerve conditions. The employee was notified of the error on September 25, 2018, and accepted the error on October 16, 2018. However, the employee did not take corrective action. At the time of the OIG's review, the deficiency had yet to be corrected and the veteran is owed nearly $67,000 in retroactive payments over a period of almost 12 years.*

As illustrated by example 3, it is vital for VBA to establish a process to improve procedures for monitoring and tracking the timeliness of error corrections to help ensure that veterans receive the benefits to which they are entitled.

Inadequate Oversight Led to Untimely Error Corrections

VBA's procedures direct that the QRT supervisor at each regional office is responsible for managing the error correction process.[19] Information obtained from interviews with the Office of

[18] The estimate for six to 10 days has a higher relative margin of error than the other percentages, but it is included here to show that most of the untimely error corrections are over 10 days.

[19] VA Manual 21-4, chap. 6, topic 3.a, "Responsibilities of the QRT Coach and/or Other QRT Supervisor," January 16, 2018.

Field Operations and regional office personnel indicates that an employee's direct supervisor is primarily responsible for ensuring that corrections are completed timely. Two out of four QRT supervisors interviewed during site visits stated that they either provide reports to or work with an employee's direct supervisor regarding overdue corrections. Timely error correction is an element of RVSR national performance standards. One factor for employees not completing corrections may be that they are required to obtain a certain number of work credits per pay period; however, they do not receive work credit for correcting their own errors. In addition, two QRT supervisors interviewed during site visits reported there is no process to confirm that corrective action was taken on errors.

The organizational alignment of the QRT program complicates oversight of the error correction process. The QRT program is organized under the Compensation Service; however, the regional office employees and supervisors who are responsible for managing and correcting errors are under the Office of Field Operations. Therefore, the Compensation Service does not have the authority to ensure that errors are corrected timely. The authority lies with the Office of Field Operations, which is responsible for correcting deficiencies to ensure timeliness and quality of benefits.

VBA's Program Operations staff identified issues with the timeliness of correcting errors at six regional offices during fiscal year 2019. The regional offices under review were directed to address the backlog of errors requiring correction and develop processes to ensure corrections are addressed timely according to VBA's procedures. The QRT program chief for the Compensation Service denied any additional monitoring of corrections outside of the Program Operations staff. The deputy under secretary for field operations stated that timely error correction is a responsibility of regional office management and that additional accountability should be established at that level.

The Office of Field Operations has not established adequate oversight or accountability to ensure timeliness of error corrections. To maximize the effectiveness of the QRT program, additional oversight and accountability should be added to ensure timely corrections. If the current oversight is not revised, veterans may receive incorrect benefits and employees may not be held accountable for their work.

Recommendation 5 addresses the need for VBA to improve its oversight procedures for monitoring the timeliness of error corrections.

Conclusion

The OIG team found multiple factors preventing VBA's QRT program from meeting its defined mission of improving the accuracy and timeliness of compensation claims processing. QRT specialists are not being held accountable for the quality of their work. The peer review process does not ensure all claims-processing errors are identified. A lack of objectivity in the request for reconsideration process has resulted in claims-processing errors being inappropriately overturned

by regional office managers. In addition, a lack of program oversight has resulted in untimely corrective actions on errors identified by quality review staff. Unless VBA makes changes, resources will continue to be used without improving the accuracy of decisions.

Recommendations 1–5

The OIG recommends that the under secretary for benefits complete the following actions:

1. Assess the current peer review process and determine whether a more in-depth review should be required to ensure claims-processing errors are identified.
2. Establish a process where a sampling of non-error quality reviews undergo peer review to ensure claims-processing errors are identified.
3. Revise the QRT specialist performance review process to include more objectivity to ensure constructive feedback is provided to promote competency.
4. Revise the error reconsideration process to ensure objectivity and adherence to current VBA procedures.
5. Improve oversight procedures for monitoring the timeliness of error corrections.

Management Comments

To address recommendation 1, VBA will review the current error review process and determine whether modifications are necessary.

To address recommendation 2, VBA noted, since October 2019, the Compensation Service quality assurance staff reviews a sample of non-error quality reviews during quality assurance site visits. VBA further stated, as of May 11, 2020, quality assurance staff has reviewed 224 quality reviews, including those with no errors identified, and found an accuracy rate of 91.1 percent. VBA requested closure of this recommendation.

To address recommendation 3, VBA reviewed the QRT performance review process and determined most reviews are routed to a different regional office than where the QRT specialist works. VBA requested closure of this recommendation.

To address recommendation 4, VBA is developing a plan to randomize the error reconsideration process to be handled by a regional office other than where the employee works. This will require updating routing rules within the Quality Management System. VBA noted changing functionality within the Quality Management System will require prioritization and information technology funding to complete.

To address recommendation 5, the Compensation Service will partner with the Office of Field Operations and district offices to review existing policies, procedures, and processes related to error corrections to identify any areas for clarification or improvement. VBA will also develop and implement a plan to address the monitoring of error corrections.

OIG Response

The under secretary for benefits concurred with recommendations 1 through 5 and provided acceptable action plans for all recommendations. The OIG will monitor VBA's progress and follow up on the implementation of the recommendations until all proposed actions are completed.

Regarding recommendation 1, the OIG recognizes VBA has established a multilayered peer review process for quality reviews where QRT specialists identify errors. However, current VBA procedure directs that these reviews are a "quick-touch review" to ensure that all cited errors are appropriate and to identify any obvious error(s) not cited by the initial reviewer. The OIG notes the intent of this recommendation is for VBA to reassess the current peer review process to determine whether a more in-depth review should be required to ensure all claims-processing errors are identified.

Regarding recommendation 2, VBA stated that quality assurance staff now reviews a sample of non-error cases. These reviews began October 1, 2019, during the period of this OIG review. VBA requested closure of this recommendation based on a reported 91.1 percent accuracy rate for 224 individual quality reviews completed by quality assurance staff. VBA stated the 224 individual quality reviews included non-error cases; however, VBA did not specify how many. Additionally, VBA only provided summary data for the 224 individual quality reviews. Therefore, the OIG will assess closure of this recommendation upon receipt of additional details on the 224 individual quality reviews.

Regarding Recommendation 3, VBA noted it was a best practice for peer reviews to be conducted at a different regional office than where the QRT specialist works. VBA requested closure of this recommendation, stating that most peer reviews were in fact taking place at a different regional office, except for some regional offices that have special missions where subject matter expertise is required. The OIG determined additional information was needed regarding what changes will be made with the feedback provided to QRT specialists as part of the performance review process. Therefore, the OIG will assess closure of this recommendation upon receipt of this information.

Regarding recommendations 4 and 5, VBA provided acceptable action plans. The OIG will monitor VBA's progress and follow up on the implementation of the recommendations until all proposed actions are completed.

In VBA's response to this report, the under secretary for benefits noted the OIG's review did not assess the entirety of the QRT program because the scope of the review only focused on quality reviews for RVSRs.

The OIG chose to focus on the part of the process with the greatest risk to veterans' benefits. RVSRs are responsible for deciding entitlement to service connection and assigning disability evaluations and effective dates, all of which affect compensation benefits paid to veterans. It is

the responsibility of the RVSR to ensure all required development has been satisfied before rendering a decision on a veteran's claim. Therefore, the quality review on an RVSR by the rating QRT specialist includes a review of the claim's development by veterans service representatives.

The OIG acknowledges that the work of authorization QRT specialists was not within the scope of this review.[20] However, the processes for peer review, QRT specialist performance review, error reconsiderations, and oversight of error correction apply to quality reviews completed on both veterans service representatives and RVSRs. Therefore, the OIG's findings and recommendations apply to the entire QRT program.

[20] Authorization QRT specialists review the work of veterans service representatives, which includes claim development, promulgation, and authorization of awards.

Appendix A: Scope and Methodology

Scope

The OIG conducted its work from March 2019 through April 2020. The review population included all RVSR individual quality reviews completed by QRT specialists from July 2018 through September 2018. The OIG team chose this time period to ensure VBA staff had sufficient time to complete the correction process for errors that were identified by QRT specialists. The data originated in QMS and were stored on and pulled from VBA's Electronic Data Warehouse by VBA's Performance Analysis and Integrity staff.

Methodology

To accomplish the review objectives, the OIG team identified and reviewed applicable regulatory requirements, documentation, and actions related to VBA's QRT program. The team interviewed and obtained information related to VBA's QRT program from management and staff at regional offices in Phoenix, Arizona; Portland, Oregon; Detroit, Michigan; and St. Louis, Missouri. The team also interviewed and obtained information from VBA officials in Washington, DC.

In coordination with OIG statisticians, the OIG team reviewed a stratified random sample of 180 quality reviews separated into three different strata. The team discussed the findings with VBA officials and included their comments where appropriate.

Appendix B provides more details on the statistical sampling methodology.

Fraud Assessment

The OIG team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this review. The OIG team exercised due diligence in staying alert to any fraud indicators:

- Completed Fraud Indicators and Assessment Checklist
- Reviewed the OIG's Hotline for reports of fraud in the review area
- Solicited the OIG's Office of Investigations for indicators

The OIG did not identify any instances of fraud during this review.

Data Reliability

The OIG team used computer-processed data from QMS that was stored on and pulled from the Electronic Data Warehouse by VBA's Performance Analysis and Integrity staff. To test for reliability, the team determined whether any data were missing from key fields or were outside

the time frame requested. The team also assessed whether the data contained obvious duplication of records, had alphabetic or numeric characters in incorrect fields, or contained illogical relationships among data elements. Furthermore, the team compared veterans' benefits claim identification numbers, end-product codes, dates of claim, and regional office numbers to information contained in the 180 Veterans Benefits Management System electronic claims folders that were reviewed.

Testing of the data disclosed that they were sufficiently reliable for the review objectives. Comparison of the data with information contained in the veterans' electronic claims folders 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 B: Statistical Sampling Methodology

Approach

To accomplish the objective, the OIG team reviewed a statistical sample of quality reviews completed by QRT specialists for the period July 2018 through September 2018 (review period). The OIG team used statistical sampling to quantify the extent of reviews where QRT specialists missed errors, QRT errors were inappropriately overturned, and QRT errors were not corrected timely.

Population

The review population included 30,097 RVSR individual quality reviews pulled and reviewed by QRT specialists during the review period. After excluding quality reviews determined to be outside the scope of review, the OIG team estimated the population to be 28,400 RVSR individual quality reviews.[21]

Sampling Design

The OIG team selected a statistical sample of 180 quality reviews from the population for the review period. The team selected a stratified random sample of 60 sample quality reviews from each of three strata:

- Stratum 1 consisted of all RVSR individual quality reviews where no errors were cited by a QRT specialist. The OIG team sampled 60 quality reviews from this stratum to determine if the reviews with no peer review were accurate.
- Stratum 2 consisted of RVSR individual quality reviews where an error was cited by a QRT specialist and the RVSR did not request reconsideration. The OIG team sampled 60 quality reviews from this stratum to determine if the reviews with peer review were accurate and corrections were initiated timely or at all.
- Stratum 3 consisted of RVSR individual quality reviews where an error was cited by a QRT specialist, the RVSR requested reconsideration, and the error was overturned. The OIG team sampled 60 quality reviews from this stratum to determine whether the reviews with peer review were accurate and whether errors were overturned appropriately.

[21] The OIG team identified quality reviews that were out of scope and excluded from statistical projections. For example, a QRT specialist cited an error on a pending decision and the decision was regenerated prior to completion. Therefore, the rating decision containing the error was no longer available for review by the OIG team.

Weights

The OIG team calculated estimates in this report using weighted sample data. Samples were weighted to represent the population from which they were drawn. The OIG team used the weights to compute estimates.

Projections and Margins of Error

The point estimate (i.e., estimated error) is an estimate of the population parameter obtained by sampling. The margin of error and confidence interval associated with each point estimate is a measure of the precision of the point estimate that accounts for the sampling methodology used. If the OIG repeated this audit with multiple 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 the weighted population estimates and associated sampling errors. This software uses replication methodology to calculate margins of error and confidence intervals that correctly 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 sample review. While precision improves with larger samples, the rate of improvement does not significantly change 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.

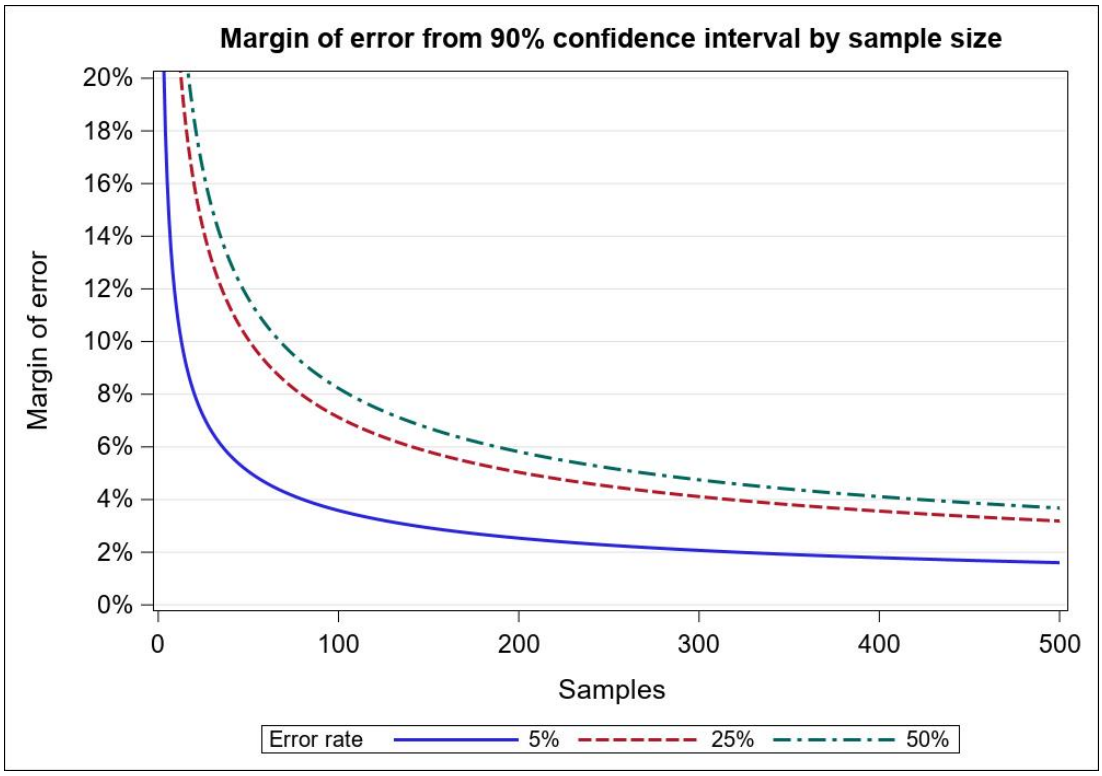

Figure B.1. *Effect of sample size on margin of error.*

Source: VA OIG statistician's analysis.

Projections

Tables B.1 through B.4 detail the OIG team's analysis and projected results.

Table B.1. Missed Errors (Combined No Error Called; Error Called without Reconsideration Request; and Error Called, Reconsideration Submitted, and Error Overturned Strata)

Estimate name	Estimate numbers	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Sample count with attribute	Sample size
Projected total reviews with missed error(s) in the universe	9,929	2,435	7,494	12,364	63	180
Projected reviews with missed error with peer review	1,917	490	1,427	2,407	42	120
Projected reviews with missed error without peer review	8,071	2,386	5,685	10,458	21	60
Total universe	28,368	974	27,394	29,342	-	180
Projected reviews with missed error(s) percentage	35	9	27	44	63	180
Projected reviews with missed error(s) with peer review percentage	36	9	27	45	42	120

Estimate name	Estimate numbers	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Sample count with attribute	Sample size
Projected reviews with missed error(s) without peer review percentage	35	10	25	45	21	60

Source: VA OIG analysis.

Table B.2. Inappropriately Overturned Errors (Error Called, Reconsideration Submitted, and Error Overturned Stratum)

Estimate name	Estimate numbers	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Sample count with attribute	Sample size
Projected total reviews with inappropriately overturned error(s) in the universe	433	97	336	530	30	60
Total universe	866	52	814	917	-	60
Projected reviews with inappropriately overturned error(s) percentage	50	11	39	61	30	60

Source: VA OIG analysis.

Table B.3. Timeliness of Corrections (Error Called without Reconsideration Request Stratum)

Estimate name	Estimate numbers	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Sample count with attribute	Sample size
Projected total reviews with untimely corrections (6-10 days) in the universe	370	266	104	636	5	60
Projected total reviews with untimely corrections (11-30 days) in the universe	740	361	379	1,102	10	60
Projected total reviews with untimely corrections (30+ days) in the universe	888	390	499	1,278	12	60
Total universe	4,441	390	4,051	4,830	-	60
Projected total reviews with untimely corrections (6-10 days) in the universe percentage	8	6	2	14	5	60
Projected total reviews with untimely corrections (11-30 days) in the universe percentage	17	8	9	25	10	60

Estimate name	Estimate numbers	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Sample count with attribute	Sample size
Projected total reviews with untimely corrections (30+ days) in the universe percentage	20	9	11	29	12	60
Projected total reviews with untimely corrections	1,998	506	1,492	2,504	27	60
Projected reviews with untimely corrections percentage	45	11	34	56	27	60

Source: VA OIG analysis.

Table B.4. Corrections Not Completed (Error Called without Reconsideration Request Stratum)

Estimate name	Estimate numbers	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Sample count with attribute	Sample size
Projected total reviews with no correction of error(s) called in the universe	814	376	438	1,190	11	60
Total universe	4,441	390	4,051	4,830	-	60
Projected reviews no correction of error(s) called percentage	18	8	10	27	11	60

Source: VA OIG analysis.

Appendix C: Management Comments

Department of Veterans Affairs Memorandum

Date: June 11, 2020

From: Under Secretary for Benefits (20)

Subj: OIG Draft Report – Deficiencies in VBA's Quality Review Team Program [Project No. 2019-07054-DN-0253] – VIEWS 02796106

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

1. Attached is VBA's response to the OIG Draft Report: Deficiencies in VBA's Quality Review Team Program.

The OIG removed point of contact information prior to publication.

(Original signed by)

Paul R. Lawrence, Ph.D.

Attachments

Attachment

Veterans Benefits Administration (VBA)
Comments on the OIG Draft Report:
Deficiencies in VBA's Quality Review Team Program

VBA concurs with the findings in OIG's draft report and provides the following comments:

In 2013, VBA established quality reviews teams (QRTs) at local regional offices (ROs), designed to more timely assess quality and provide immediate feedback to individual employees. Local QRTs are a complement to the longstanding national Systematic Technical Accuracy Review (STAR) Program. STAR looks at a statistically valid sample of completed claims to assess end-to-end accuracy of the claims process. STAR accuracy scores are reported externally to stakeholders to track quality of claims processing monthly and over time.

Local QRTs review the actions taken by an individual employee during a transaction in the claims process. QRT staff conduct individual quality reviews (IQRs) which measure the critical element of quality for individual employee performance. Quality Review Specialists (QRS) conduct either authorization quality reviews for Veteran Service Representatives (VSRs) or rating quality reviews for Rating VSRs (RVSRs) and these quality reviews are also subject to inspection by peers.

In July 2017, VBA's Compensation Service deployed the Quality Management System (QMS) to improve the quality assurance (QA) process by providing a central location for tracking all quality reviews. QMS replaced an antiquated system of standalone databases, manual lists, and SharePoint repositories. QMS captures all reviews at both the national and local levels, including STAR, IQRs, and targeted special focus reviews. QMS provides the following QA process improvements:

- Increased objectivity as QMS allows both random selection of work and routing of IQRs to regional offices other than where the employee is assigned,
- Enhanced error trend analysis with numerous reports available to QRTs, training managers, and RO management,
- Targeted training for employees, and
- Decrease in variance in the quality review process based on the trend analysis.

It should be noted that the scope of this report focused only on quality reviews for RVSRs, omitting most RO employees, VSRs who are involved in claims processing; therefore, it did not assess the entirety of the QRT program.

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

Recommendation 1: Assess the current peer review process and determine whether a more in-depth review should be required to ensure claims-processing errors are identified.

VBA Response: Concur. The quality reviews conducted by a Rating Quality Review Specialist (RQRS) are also subject to a random quality review, and any error cited on an RQRS is subject to a peer review by another RQRS. If the peer review results in a disagreement with the error called, the error review is sent to a third RQRS for a final decision. VBA will review the current multi-layer error review process and determine whether modifications are necessary. VBA expects to complete this assessment by the end of October 2020.

Target Completion Date: October 31, 2020.

Recommendation 2: Establish a process where a sampling of non-error quality reviews undergo peer review to ensure claims-processing errors are identified.

VBA Response: Concur. VBA is committed to continuous process improvement and ensuring accuracy of claims processing. Since October 1, 2019, the Compensation Service QA staff reviews a sample of no-error IQRs during QA site visits. As of May 11, 2020, the QA staff has reviewed 224 IQRs, including no-error IQRs, with an accuracy rate of 91.1%.

VBA requests closure of this recommendation.

Recommendation 3: Revise the QRT specialist performance review process to include more objectivity to ensure constructive feedback is provided to promote competency.

VBA Response: Concur. VBA acknowledges that a best practice to enhance objectivity and reduce bias of reviews on individual RVSRs is to route the quality review to a different RO than where the RVSR works. The QRT performance review process involves peer review of errors called by an RQRS, and VBA agrees that it is likewise a best practice for the peer review of an error to be conducted at a different RO than where the RQRS works. During the pendency of this audit, VBA reviewed the random QMS routing of error reviews for RQRS and validated that most of these reviews are in fact routed to a different RO. The exception is that some ROs have special missions, so error reviews on those special mission cases remain in-house because of the subject matter expertise required to conduct the review. These special missions include the Integrated Disability Evaluation System (IDES), appeals, and certain exposure-related cases. The attached QMS report titled “IQRs for QRT” provides documentation that significantly more IQRs for QRT staff are routed to other ROs except for those IQRs that need to remain in-house at an RO.

VBA requests closure of this recommendation.

Recommendation 4: Revise the error reconsideration process to ensure objectivity and adherence to current VBA procedures.

VBA Response: Concur. VBA has intended to randomize the error reconsideration process to be handed at an RO other than where the employee works and is actively pursuing a plan to update routing rules in QMS. Changing QMS functionality to accomplish this will require prioritization and information technology (IT) funding to complete. Due to existing IT priorities, VBA cannot project an expected completion date at this time.

Target Completion Date: TBD.

Recommendation 5: Improve oversight procedures for monitoring the timeliness of error corrections.

VBA Response: Concur. During the past two fiscal years, Compensation Service and the Office of Field Operations (OFO) worked collaboratively to do a significant catch up of pending error corrections. VBA includes error correction timeliness monitoring as part of QA site visit reviews. If an RO is not meeting the timeliness requirement, QA cites an action item and then follows up with the RO until they meet the requirement. Additionally, the QA staff provides recurring reminders to the QRTs and RO management of the timeliness requirement.

Compensation Service will partner with OFO and the District Offices to review existing policies, procedures, and processes related to error corrections to identify any areas for clarification or improvement. VBA will develop and implement a plan to address the monitoring of error corrections. As part of this plan, OFO will continue to monitor compliance by utilizing QMS data on cited errors and ensure ROs take appropriate action in a timely manner. OFO will require all ROs to submit their Quality

Systematic Analysis of Operations (SAO) for fiscal year 2020 for OFO review through its District Office. VBA expects to develop this plan and complete the SAO review by October 31, 2020.

Target Completion Date: October 31, 2020.

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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