Quality Monthly Call – June 2020

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Hello everybody.

This is Robert Johnson with quality assurance and welcome to the June compensation service quality call. Thank you for watching our presentation today. If you are a subject matter expert who would like to present a topic to your peers during a future quality call, I will share information with you at the end of today's presentation.

Here is today's agenda. We will discuss part three of the ALS series, a special quality review on homeless veterans, blue water navy cases, public use DBQs, some rating reminders, how to adjust awards on CUEs decisions, centralize printing , another reminder on the package manager and how it applies to DSR and RVSR and day reminder that the evaluation builder is not updated for fingers, laws that cross reference other laws in a couple of new updates to the M21-1.

Let's get started.

I’d like to introduce Jessica Flannery who has part three of the ALS comment site visit findings. Jessica?

Hello everyone. Thanks, Robert, for the introduction. I'm glad to be back on the call today to share some more of the errors we are finding with our site visits in relation to ALS claims processing. As you know if you have been following this call, two months ago we started a special four-part series discussing comment site visit findings regarding ALS claims processing. I think it's important to know that based on these ALS claims we have reviewed in conjunction with site visits, we are hovering around a 35% to 38% accuracy rate, and that's why we designed this four-part series, to give those of you who process ALS claims or quality review ALS claims quick information to boost the accuracy of the claims. If you have missed any of the four-part series, I strongly urge you to check it out in April and May 2020 compensation service recordings in TMS. Today we will cover part three which are simple but needed reminders in the series. Let's get started.

 Our first comment site visit finding is actually the highest error that we find when reviewing ALS claims and that is not using the proper legal basis or not properly citing the laws or regulations to grant ALS. The fact is that ALS can be established on the basis of presumption under 38 CFR 3.318, if manifested at any time after discharge or release from active military service. It's important to remember here that when you are granting ALS, granting service connection for the first time, you are granting it on a direct basis. You are granting it on a presumptive basis using 38 CFR 3.318 and that allows us to grant ALS if it manifests anytime after discharge.

 Our next comment site visit finding is granting complications of ALS on a direct or incurred basis. Again, the fact here is that for any complications of ALS or issues that arise secondary to the primary condition of ALS, service connection should be awarded for conditions that are approximately due to or the result of an SC condition under 38 CFR 3.310. Not on a direct basis or a presumptive basis. So again, complications or conditions that are secondary to the primary condition of ALS or derived from the primary condition should be granted on the basis of secondary under 3.310.

 For a best practice, it is important you spend time and quickly review your rating decision narrative, because this is where we see errors come up. We want to ensure the proper legal basis and proper laws and regulations are cited in the decision. Make sure your narrative references the basis of presumption for granting ALS initially, and for any secondary conditions, ensuring your narrative references a secondary basis rather than a direct or presumptive basis. And ensure that you are citing the proper laws and regulations using 38 CFR 3.318 or 3.310 and not 3.307 or 3.309. An example of this is below on the bottom of this slide. Service connection may be granted for specific diseases or conditions which are presumed to have been caused by service if manifested to a compensable degree following military discharge. Although not shown in service, service connection for ALS has been granted on the basis of presumption. And that is quoting 38 CFR 3.318. That is an example of what your narrative should look like if granting ALS on the presumptive basis. Now we will jump over to a quick practical exercise or quiz. The RVSR must ensure the legal basis and laws and regulations are applicable in the rating decision narrative. If granting service connection for ALS on the basis of presumption, which example best represents the correct narrative? A, service connection for ALS has been established as directly related to military service. 38 CFR 3.303 and 38 CFR 3.304. Or is B a better choice? Service connection may be granted for specific diseases or conditions which are presumed to have been caused by service if manifested to a compensable degree following military discharge. Although not shown in service, service connection for ALS has been granted on the basis of presumption citing 38 CFR 3.307 and 38 CFR 3.309. Or is C better? Service connection may be granted for specific diseases or conditions which are presumed to have been caused by service if manifested to a compensable degree following military discharge. Although not shown in service service connection for ALS has been back on the basis of presumption citing 38 CFR 3.318. If you chose C, you are correct. What we see most often in site visits's folks using what you see in A and B. Either incorrect language showing it was a direct basis or incorrect laws and regulations are cited even though it's granted on the correct basis. Make sure you are using the language and the correct or applicable regulation when making your decision.

 Now for one more quiz question. If the RVSR is granting loss of use of bilateral feet secondary to service-connected ALS, which example best represents the correct narrative? A, service connection for loss of use of bilateral feet have been established as directly related to military service. 38 CFR 3.303 and 38 CFR 3.304. B, service connection may be granted for specific diseases or conditions which are presumed to have been caused by service if manifested to a compensable degree following military discharge. Although not shown in service, service connection for loss of use of bilateral feet has been granted on the basis of presumption. 38 CFR 3.307 and 38 CFR 3.309. Or C, service connection for loss of use of bilateral feet has been established is related to service-connected disability of ALS and 38 CFR 3.310. Again if you chose C, you are correct. However we are often seeing responses or narratives that show what you see in A or B, so make sure if you are granting secondary service connection for conditions related to ALS, that you do so on a secondary basis under 38 CFR 3.310. And that wraps it up for this month comment site visit findings with ALS claims. Join us again next month for the last part of our ALS series where we will touch on special monthly compensation. Thank you for taking the time to do the right thing and improve the accuracy of these claims.

Next up we have David Hannigan.

 Jessica, thank you. The morning everyone. This is David Hannigan. I will be talking to you quickly about a topic that is very important but interesting at the same time. The correlation between homeless veterans and TBI claims. Based on some news reports we have seen, compensation service was interested to see based on claims we had reviewed in the past if we had seen any kind of correlation between homeless veterans and those claiming traumatic brain injury. So we went back and looked at FY19 and identified 25 homeless veterans claims that underwent a STAR assessment. Of those claims, 22 had claimed traumatic brain injury and a mental disability, predominantly posttraumatic stress disorder. The rating issue based accuracy for the claim was actually quite high at 90.6% with three critical errors found out of 219 total issues reviewed. Regarding the three benefit entitlement errors, two errors were cited on the same review for failure to grant service connection for radiculopathy of the bilateral lower extremities as secondary to the veteran's service connected spine condition in our 82 error category and cited for failure to request the VA exam and a medical opinion prior to the denial of service connection for PTSD based on military sexual trauma, a B 2 error. We saw six claims with non-benefit entitlement comment, noncritical errors such as missing a favorable finding for PTSD, an incorrect evaluation was noted in the rating decision narrative, a new claim needed to be placed under and product control, and failing to list the claimant's contentions when denying the claim. So this small subset of STAR cases, the accuracy was quite good . It came in at 98.6%, meaning you folks out in the regional offices are serving these at risk veterans well, and we appreciate that. This is mainly for your awareness, but we ask for a focus on this type of work, but keep up the awesome work. That's really it for my topic. Again short and brief, but important.

At this point, I'm going to turn it over to our STAR consultant, Vanessa Carr, who will talk about our blue water navy STAR . Vanessa?

 Thank you, David. Hello everyone. The compensation service quality assurance staff has assembled a small team of consultants assigned to review the quality of the blue water navy claims completed by the eight centralized stations. In March of 2020, the blue water navy quality assurance team completed a special focused review of 104 randomly selected cases from the blue water navy cases from the month of January. The blue water navy specific accuracy for these 104 cases was 96.4% for blue water navy. That indicated 16 issues of 452 issues which were reviewed. The overall issue based accuracy was 85.6% which indicated 65 errors of 452 issues which were critical errors. Upon the completion of this review, the team reviewed cases that were completed in the month of February. Beginning in the month of February, the monthly sample size is reduced to 80, a review of 80 cases, 10 from each of the centralized stations were selected for quality review. Keep in mind, this sample size is separate from the STAR sample and the blue water navy sample is not included in the regional office accuracy numbers. The report for blue water navy will have two areas of focus. Those two areas are blue water navy accuracy and issue based accuracy. The issue based accuracy is identical to the STAR quality review that involves assessment of questions one through eight on the national compensation quality review checklist. The blue water navy accuracy evaluates items such as if the verification memo were backlogged and [ Indiscernible ] approximately uploaded into [ Indiscernible ] and we analyze if the dates from the veterans personal record and logs coincide with the dates the ship was noted to be in the eligible waters. Another element of blue water navy accuracy is the effective date and those are assigned based on the blue water navy guidance is accurate. The February 2020 blue water navy accuracy report has been released to the eight centralized stations, and the blue water navy quality assurance team is met with each station to review and discuss their individual findings. The issue based accuracy for those claims that were completed in the month of February were 96.2% for BWN in specific accuracy and 85.3% for the overall issue based accuracy. A monthly review of cases will be completed until further notice. The report for the January -- the report for the January special focused review and blue water navy report can be found in the special focused review links on the quality assurance homepage located in the compensation service Internet home page. The January focused review is located in the FY2020 special focused review link. The February blue water navy quality report is located in the February 2020 blue water navy quality report link. As these monthly reports are completed, these reports will be uploaded to this location. That completes my report regarding blue water navy.

 Up next, we have Tina Skelly.

 Thank you, Vanessa. And morning everyone. As most of you know, DBA has discontinued the use of public use DBQs and the links to the DBQs have been removed from the VA Internet and intranet sites. References to the public use DBQs have also been removed externally on VA.gov. I believe you are aware of the main reasons why they were removed, but quickly there were three main reasons. The first is that we have modernized and we need the forms to be more agile. VA does not have the ability to timely push required regulatory and court driven changes to the public DBQs as they are public forums which go through the OMB or office of management and budget paperwork reduction act for the approval process. It's especially true now with the [ Indiscernible ] revisions which have the effect of outdated forms being available publicly. The next reason is simply that we have increased our capacity to conduct C and P exams. Are contact examiners have expanded VA's ability to conduct exams in more places than traditional VA medical centers or OPC. The contract examiners can provide wider coverage especially in our rural areas and also in conducting exams in prisons, federal and state prison facilities. One of our contract vendors conducts these exams and 33 countries overseas where we have not previously had a presence. The last reason is likely the reason you are most familiar with and that is we are safeguarding against fraud. Over the last several years, we have seen a growing industry of individuals and large companies marketing the service of completing DBQs for veterans and some have provided valuable service to veterans, but others have resulted in VA making hundreds of referrals to the VA office of the Inspector General for OIG. We have referred both individuals and companies who are engaged in questionable and even fraudulent practices that include charging very high prices for completing DBQs or submitting DBQs with findings that are very different than the other evidence in the veteran's claims folder. VA OIG recently issued an audit report about the providers who are completing DBQs for veterans remotely and recommended VA revisit its practice of making public facing DBQs available. That weighed into the decision to discontinue these public DBQ forms. Several references to the public use DBQs have already been updated and the adjudication procedures manual including part three, subpart four, three, D, and ft which are about discontinuance of publicly available DBQs and the authenticity of DBQs. They were updated on May 27th, 2020, and also part three, subpart 2, 1C8E handling discontinued forms was updated May 11th, 2020. The remainder of the references will be updated by the end of this fiscal year. Should your offices receive any public use DBQs after they were discontinued, please treat them as you would any medical evidence that you receive as the VA cannot exclude evidence. Once all the evidence is received, graders will review the authenticity and weigh the evidence overall in part of the normal decision-making process for the updated manual guidance. DBA has no plans to discontinue the use of the internal DBQs for examinations conducted by VHA, examiners or contracted examiners. These are disability examinations are remaining in effect. Unlike the public DBQs that go through formal OMB public forums approval process, we can update the internal forms as needed, whether it be for a presidential court decision or as an update. That's all I have. Thank you for your time.

 Next up we have Andrew Gray who will talk about hospital adjustments and rating reminders. Andrew?

 Thank you, Tina. Hello everyone. I am Andrew Gray and today I would like to discuss two rating reminders from our hospital adjustment review. Statutory housebound and [ Indiscernible ]. After completing a temporary 100% rating for paragraph 29, in cases where the veteran also has an additional 60% combined evaluation, statutory housebound was not granted, we will flag a validation issue when you first go to the document tab. When this validation issue arises, the user should select the read text. When the user selects the red text it brings up a brown warning box that explains that the veteran may be eligible for benefits. The user should select the yellow text to review. When selected, the review for SMC for statutory housebound appears and provides the rating period in which the system believes the eligibility criteria has been met. In most cases, the benefit for statutory housebound is warranted and the user should select the yes radio button and then select save. Once this occurs, the user will be returned to the issue management tab and the tab will automatically populate the contingent for SMC housebound for them to complete. The second rating reminder I would like to discuss is the need to address competency. According to M21-1 part three, subpart 48 A2A competency must be addressed in cases where mental condition is initially evaluated is totally disabling her when the total evaluation is continued in a rated decision. This includes assigning a temporary total evaluation for a mental condition under 4.29. In cases where a veteran is determined to be competent, the same block from the previous live instructs them to include the VA company glossary selection within the rating for these cases. The text generated by that selection is italicized below. It is important to note that when granting paragraph 29 benefits and staging the ratings to reduce benefits once the hospitalization period ends, VBMS are does not prompt employees to consider competency. It's extremely important for them to remember the competency must be addressed in these cases.

Next up we have Erin Hawkins.

 Thank you, Andrew. And morning everybody. My name again is Erin Hawkins and I'm a consultant on the advisory and special review team here in quality assurance in Nashville. Today I will be addressing VBMS-A user tips for correcting clear and unmistakable errors. On March 2020 compensation service quality call it discussed recent manual updates in regards to correcting the record for scenarios and we had an excellent walk through the gate visual aid demonstrations for how raters can interact with VBMS-R to correct the record for ratings. Today's focus is a complementary to that with the emphasis on the VS are actions needed for these decisions. One of the major changes that came out in the manual was a requirement that the code sheet be modified so it appears how it should have been had no error been made. This change impacts promulgation via SARS and the steps required in VBMS-A to prevent an overpayment from being created as well as ensure we continue to pay the veteran correctly if there is a modification to a running award. So here we see at typical interaction of a rating deficient narrative, the code sheet and a screenshot. This is an example of the decision in which a CUE was found for evaluation in the left elbow on it was reduced effective July 9th, 2017. On the code sheet for that particular issue, the only evaluation we see now is the corrected one of 10%. Whatever the decision was correcting if it was 20%, 30%, a 40% previously, it's no longer affected on the code sheet because it's updated to reflect how it should have looked if no mistake was made. The combined evaluation is a result of the CUE decision shows a great reduction on July 9th, 2017. So previously the veteran was rated at 40% and now as a result of the corrective action we see the veteran has a rate going down to 30%. Since the code sheet is the driver to VBMS-A to generate the rates, when the user clicks generate award, the award will now reflect the rate reduction. Down below, highlighted in red, on July 9th, 2017, we see the corresponding rate reduction. This is where promulgate her's have to step in and take action to prevent the rate reduction. And the manual section that gives us direction on how to do this is found in eliminating an overpayment resulting from correction of an administrative error. It gives us direction to go to the other adjustment tab and to utilize the at cross rate feature. I have a screenshot here in the right showing in the BSA where to access that. For our example, my first box on the left shows what the award looked like before the CUE decision. I added July 9th, 2017 line to have a line by line perfect comparison to show the previous rate and the new rate. The middle box shows if the user just generated the award, here is what the award would show. If you know, there is a rate reduction on July 9th which continues down until April first, 2019, and the veteran is now paid less than what he was previously paid. Users must calculate manually the difference between the old rate and the new rate and those are the inputs you will use in the ad to grocery feature. It's very similar to do the retired pay adjustment, except in this instance we increase the veteran's award and supplement the rate in order to restore them to the rate they were previously paid before the CUE decision was finalized. In the bottom of the screen I have the input for the and sweet feature and it takes the calculation comparing the new rate to the old rate and supplementing it for the veteran's monthly benefits. So if done correctly, and if the CUE decision was the only thing being worked, we should not see an overpayment. As a warning we should not see any sort of retroactive pay. The inputs for add to gross rate have to be calculated accurately because if we add too much we end up paying the veteran more than what was previously paid, so take action to note the net effect and there should be no debt and no retro if all we do is fix the CUE. And on the bottom, we see this little asterisk on each of the award lines for the add to gross rate feature, and every single rate should match with the veteran's previous payments if done correctly. A reminder for reductions to running awards. If the CUE decision results in a reduction to the running award, the running award is the veteran's is the current payment they get every single month, the CUE reduces that and the beneficiary must continue to receive his or her current rate of payment until the first day of the third month following final notice. There's been a propensity I have seen to reduce the veteran date last paid and that is not accurate. You need to continue to pay the veteran at the prior rate for an additional 60 days. Here is an example. A veteran is evaluated at 70% effective January first, 2020 with a payment effective date of February first, 2020. A CUE is discovered and due process is issued. Rating decision dated May 29th, 2020, finalizes the CUE decision, and the veteran's combined rating is corrected to reflect 50% effective January 6, 2020. In this instant we have a veteran that was previously 70% and getting paid at the 70% rate but now we are reducing and the veteran has 50%. Action being taken on June 3rd, 2020 two promulgate the rating. The award must be adjusted which is the add to gross rate feature must be used to continue pay at the 70% rate from February first, 2020 and also up until September first, 2020 which was the first day following 60 days after notice a final decision. However, sometimes the add to gross rate feature cannot be used. Some CUE rating decisions result in eliminating periods of entitlement fully. For these cases, the add to gross rate feature cannot be used to prevent an overpayment because VBMS-A won't allow new award payment lines during periods of non-entitlement to benefits. For example, a veteran's original claim for PTSD was granted a 50% effective September 23rd, 2016 with a payment effective date of October first, 2016. A CUE is discovered in the effective date and due process is issued and now we will correct the effective date from September 2016 all the way to October 6, 2017. That is an entire year we previously paid, and we previously said there was entitlement to benefits. When the final CUE decision is made, the add to gross rate feature cannot be used to force VBMS-A to pay at the prior rate because it was before the veteran became entitled to benefits. In these instances, the tool we can use it VBMS-A to prevent overpayment is to use the prior screen. Here is a screenshot of VBMS-A where priors is located. A lot of users have not interacted much with the screen and we don't typically use priors. The only time it is traditionally used lately is when we process audit error worksheets for added system payments. When we have periods of non-entitlement in the past, the priors screen much be used in order to prevent the overpayment. Here is a screenshot of how the priors screen looks for my case scenario. Again, the veteran was granted 50% effective September 23rd, 2016, with a payment effective date of October first, 2016. A CUE was discovered, and we need to correct the effective date to not pay until November first, 2017. What we are going to do is we will edit to October first, 2016 and the December first 2016 line to change the award net 20. Priors makes you put entries on the disability level and the reason code, so you must select something. Those are not inputs that impact the overpayment. The only part that will correct the overpayment is changing the award net to 0. If done correctly, it will look like this now. So the system will read all the prior lines for the new date of entitlement we will now have paid 0 dollars. This is what allows VBMS-A when it generates the new award to read and say we never paid prior to the new date and it prevents the overpayment. And again, priors should only be used for period of non-entitlement. If there is still entitlement we should use the add to gross rate feature. When we terminate entitlement to benefits, this is our workaround for reducing overpayment. However, since VBMS-A does not recognize award payment lines during periods of non-entitlement, it can be problematic if we have a CUE decision that results in eliminating entitlement to benefits completely. In this instance, authorization activity cannot manipulate the award to ensure both the overpayment is prevented and the veteran continues to receive payment until the first day following 60 days after notice of final decision. For example, a veteran is only rated for as much as 30%. A CUE is discovered, and we sever condition and rating decision dated March second, 2020. Since the veteran has no entitlement to benefits, VBMS-A will not generate any award payment lines in order to continue to pay at the 30% rate until the first day of the third month following notice of final decision or June first. There is nothing BSR or authorization can do to pay correctly in this instance because VBMS-A recognize this veteran is not entitled to benefits, so we cannot force a pay line into the system. We can manipulate priors to eliminate the overpayment, but we cannot guarantee or manipulate the system to pay for the additional 60 days. In those instances we have an email address on the screen which is who should be contacted for assistance and guidance. If we connected VBMS-A to eliminate the overpayment and pay correctly because of a CUE, please contact this team and I'm sure they will get prompt assistance to you. Thank you very much.

 But that I would like to introduce Devin Johnston.

 Thank you, Erin. Good morning. I'm here today to provide reminders for the centralized printing requirements. When you create a package to mail to a claimant, it is imperative all requirements are complied with in order to successfully print and mail the letters. For additional information and training, please see the manual section cited here on training materials provided in the learning catalog. Attaching colorful pamphlets or forms with color images results in a letter package failing at the printer. This causes an unnecessary delay and significant work which is reworked to fix it to get it to print. If you must include something that does not meet these requirements, there are steps you need to take to make sure your documents meet these requirements before adding them to the package manager. How to fix them, you use Adobe. Adobe is what you need to open the document in and use the right hand side where it says go to organize pages. In order to rotate any landscape pages and in short they are now in portrait. Once you are in organize pages, you would click where it shows select landscape pages, and Adobe will locate and highlight all the landscape pages within the document. All you need to do is one simple click to rotate all of them from landscape into portrait and then save that document. That helps at least resolve any pages that are not in portrait. How do I fix it if I do have colorful images? I need to print that PDF in order to remove the color. You remove the color by ensuring that you use all of these specifications shown. When you go to print the document, you have to make sure you check the box that says to print in grayscale and black and white. You need to make sure to select print oversize pages to shrink. We want to make sure all of them fit within the appropriate measurements. You also want to make sure that portrait orientation only is selected, and then you go ahead and print your entire document. That would be what you would want to upload and attach in package manager. This may also be a solution for fillable PDF's if you have no other version of that form available. However, whenever the attachment already exists as an option in package manager, you should use that version of the form as they have been designed to meet the requirements. Thank you.

 I will now turn it over to Robert.

 Thanks, Devin. So Bonnie and I have a couple of Q-tips today.

Q-tips are brief reminders that keep our work accurate and consistent. They can apply to pre-or post the SR's, decision-makers, quality review teams, etc. So any kind of processor. If you have a tip, please send it to David and his email address is on the slide.

I have today's first Q-tip.

We received great feedback from last month's package manager topic and George and Erin presented it. The audio recording, slides and bulletin have lots of good information, so check it out if you have not yet. Subpart two, chapter 1, section B, topic 4, Block B tells us that the package manager will be used for outgoing mail. In subpart five, chapter 2, section B, topic one, Block M, it says claims processors are required to review the package manager to ensure documents were transmitted for centralized printing and mailing. So basically claims processors should review the package manager to confirm letters were successfully sent before adjudicating and promulgating claims. Here are a couple of examples that shows how these apply to BSR's and RVSR's. The first example shows before marking the claim ready for decision that VSRs should review the package manager to make sure that 5103 was sent. The other example shows before taking final action to reduce or sever, the RVSR should review the package manager to make sure the action letter was sent. If you review TMS 441-5957 on using the package manager.

Up next is Bonnie with our Q-tip 2.

 Hello. I have a second Q-tip today. It is about the workaround for finger evaluations. This is a little reminder that we are looking at some of the errors cited from failure to include AMA compliant regulations and we notice a trend in this category as well as in the evaluation category. It was presented originally in the June compilation service quality call and also in the manual. Since the evaluation order doesn't come up with the right evaluation for fingers, we need to do that outside of the evaluation builder. There is a workaround in the manual and the references are here in our bulletin today. I wanted to give a little reminder about that as we did see trends of people forgetting to use it or when using it, including the proper laws. So just a reminder about that. That's all there is to the second Q-tip.

 I do have the next topic as well which is citing laws and rating decision specifically when laws cross-reference other laws or regulations.

 This is a topic we have received questions on for a while. I know it is old news, but AMA requires inclusion of applicable laws and regulations and decisions. It is good because VBMS does this for us most of the time when we select the correct language and does a good job. There are sometimes that it doesn't include everything that is needed and we have to add something. We know from a quality review perspective, failure to include the applicable laws, the absolutely necessary ones are on the checklist and a class nine error on the RVSR review checklist. The question pending is how should the listing of applicable laws or regulations that cross-reference other laws and regulations be handled for IQR? If we are reviewing a decision and it includes a law or regulation that cites another law or regulation within its text, is that sufficient for quality review purposes are not? And is it sufficient for meeting legal requirement for AMA guidelines? Our answer here which is also something we agree with policy and procedures as well as AML, so good information that everyone should be on the same page about, the decision-maker includes applicable law or regulation the cross-references and other applicable law or regulation but the second was not included in the decision, we don't want to cite a critical error in those cases. Instead we will cite a noncritical error such as a comment requiring correction. There is a little bit of a difference between what meets the legal requirement and what rises to a critical error. That's what we need to think about here. Basically if we don't include that law specifically, but it is feasible one could find it by looking up the law that was cited, that should not rise to a critical error against the employee. However, should the veteran still receive all laws related? Yes. That's why we cite a corrective comment. This is consistent with FAQs put out by policy and procedures on this topic that says the veteran should be provided with both. We are just giving a little bit more information regarding the IQR process year. This does rescind what we provided during our May 19th compensating quality call bulletin and we will update that as well. Once again, all applicable laws and regulations should be cited but it's not a critical error if you can get to the law based on the ones cited in the decision. This is also sent [ Indiscernible ] and posted to chatter. Let's just do two examples. These specifically speak to an issue that comes up. If we use ITF to Gran effective date and the decision-maker sites 3.155 but not 3.400, we can cite a noncritical error because 3.155 does cross reference 3.400 within its text. Another note about noncritical errors is we keep them in the same category so we can properly look at the data. We won't cite the critical error box. The second example is the same thing, we use ITF to grant an effective date but only site 3.400. A critical error is cited because both 3.403 .155 are applicable and should be sent to the reference and there's no reference to 3.155 within the 3.400 text. I know it seems a little bit of a small difference, but we want to look at the loss cited, and if you see one that is also needed in the text of the regulation, then you can cite a corrective comment rather than a critical error. We want to try to look at that difference, and this is best for the veteran because they get the medication they need and also for employees because we give them the benefit of the doubt if something is questionable. So hopefully that helps.

 I will next pass it on to Matthew Hof. Thank you.

 Thanks, Bonnie. This is Matt and I am the manual editor on the procedures maintenance staff and I want to go over two manual changes we have recently made. In M21-1 part three subpart three, chapter 1, section B we made an update dealing with the erroneous development response period. We wanted to clearly identify a claims processors authority to proceed with claims work if a request to the veteran or the claimant is made in error. This comes in the form of a new block 2 topic G which indicates we can nullify the response period if it wasn't supposed to be given to the claimant in the first place. When we do that and proceed with the claim, we need to make the claimant aware that the period was nullified in the rating decision or the decision notice. We are not going to be giving you standard language to use in the scenario, because there could be a wide variety of scenarios that could result in us moving forward with the claim so we allow the authorization to come up with the language in that scenario. We also provided two clear examples of when we want to use that authority. The first one is with the 21-686C which is the September 2018 version or later which provides the claimant with all the information they need and tells what they need to give us in relation to their claims. We don't need to go back to the claimant if there is missing information. That was a common one we saw based on the study of common errors. That's why that was added. The other one was sending additional section [ Indiscernible ] notice that wasn't necessary because the other one was active. And the reason behind this update is to get claims moving again when you recognize that and there was an error made with the request. The other update that we made was in part three, subpart one, chapter 1, section E dealing with document translation with the Pittsburgh RO. Two changes to make the process smoother. When we send that translation request to Pittsburgh, it needs to contain the document names and the corresponding date so the RO can find the documents easier and get to work on the translation. And once it is done they will close out the tract item which will help get that claim back to where it needs to go. That does it for me.

 I'm going to pass it back to Robert.

 Thank you, Matt. At this time I like to share with you how you can be a presenter on the future quality call and how you can submit topics and when the next recording of the quality call will be posted into TMS.

 We know their demands on production workload but we are extending opportunities for regional office subject matter experts to present quality call topics. We really believe that peers speaking to peers is a great way to share information, so if you are interested in presenting a topic, please discuss with your local management and if it is okay, have your management send us your name and topic to the internal QRS email address shown on this slide.

 If you have any suggestions for topics for upcoming quality calls, use the same email address and be sure to copy your local management on the email. In fact, today's presentation on VBMS-A CUE tips was a suggestion from the field, so we were glad we were able to have Erin present that information to everyone.

The next quality call is scheduled to be recorded in July.

 As always, we know your time is valuable, so thanks for listening today. We look forward to having you join us next month, so take care and goodbye.

[ Event concluded ]