Quality Monthly Call – August 2020

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Hello everybody. Thank you for watching our presentation today.

This is Robert Johnson, a senior quality assurance specialist with compensation service. Welcome to the August compensation service quality call. If you are a subject matter expert who wants to present a topic to your peers during a future quality call, I will share some information with you at the end of today's presentation.

Quality calls are centrally assigned in TMS to all claims processors. You will receive an email from TMS letting you know when the call material is placed on your to do list. The material has current information. So, it is best practice to view it as soon as possible. If you have not received an email from TMS regarding the July quality call, please reach out to your local training manager to have them add you to the list.

Here is today's agenda. We will give an update, adding rating decisions. We will have original subject matter expert show us how to avoid AMA IQR errors. We will close at the quality call by discussing request for applications, separation and separate pay events, ace examinations and something new. Automated hospitalization reports.

Let's get started. I have the first two topics.

Up first is an update on developing for 8940 with the board grants individual ability, or IU.

In the February quality call we were aware of cases where the board of veterans appeals also referred to as, the board grants IU and the issue was raised when there is no VA form 21 8940, which is a veterans application for increased compensation for his unemployability. We advised at that time that the manual should be reviewed to determine if specific clarification was necessary relative to board grants without a BVA report. The manual was updated on July 31. In 21-5, chapter 7 section G, topic one, block I we are directed to review the claims form to determine if the 8940 is already in evidence. If not, first developed for the 8940 before implementing the board's grant of IU. It continues by noting that the veteran may later fail to respond to the development efforts, and decision-makers should then implement the board’s decision to grant IU using the availability of record. So, this is new guidance from the key changes document to use moving forward.

My next topic is involving inputting applicable laws and regulations in our decisions based on the veterans’ appeals improvement and modernization act of 2017, or AMA.

Instead adding only the laws and regulations applicable to the decision made, there are some decision-makers that are adding extra lots as shown on the slide. To protect themselves from errors on missing applicable AMA laws and regulations. Adding only the laws and regulations that are applicable and relevant to the decision made is crucial, because a statement of the case is no longer provided to the claimant and his or her representative. They list only the pertinent laws and regulations, because that is very important in order to determine how to overcome a decision and obtain service connection for higher evaluation. Listing a block of laws and regulations which are not even applicable to the decision being made defeats the spirit of law. While compensation service quality assurance has released prior guidance that listing too many laws and regulations should not be cited as a critical error, we are monitoring these types of cases to determine if alternate guidance should be issued.

As a reminder decision-makers should continue to use the evaluation builder and text in VBMS-R, because most of the text in decision include the applicable laws and regulations. Always use the rating schedule with evaluation builder. Become familiar with part three and use the existing AMA materials.

The next presenter is Jennifer Monville who has great information . Jennifer?

Thank you, Robert. Again, welcome to the August 2020 quality call. My name is Jennifer Monville. I am with the Nashville regional office. The May 2020 call initially covered this topic, however since missing law, AMA errors continue to be a problem. We will continue to provide guidance as to how you can avoid these types of errors. We have identified a few issues within VBMS-R that may be contributing to the errors. We will cover them in more detail. Understanding why the applicable laws or regulations are now required might help with the rating and review process for decision-makers. The appeals modernization act changed many things, to include BVA notification requirements.

A list of the eight notification requirements can be found in the listed regulation. Specifically, this regulation requires that BVA provide the veteran with "A summary of the laws and regulations applicable to the claim ". This is generally done in the rating narrative specific to the issue being addressed. To assist decision-makers with this new mandate, VBMS-R, to include lottery fragments and the evaluation builder were meticulously updated to populate laws and regulations. These tools, as Robert said will generate the correct citation most of the time if they are used properly. The data has identified that there are many missing rating criteria regulation errors on C&C evaluations. While C&C evaluation errors are not the sole types of errors in this category, to represent a large number of the errors. Therefore, we will focus on how to avoid C&C evaluation errors. And, we have identified a reason that VBMS-R may not populate complete citations. For evaluation purposes, it is the evaluation builder that selects and assigns the rating criteria regulatory citations. If the user bypasses the evaluation builder, and instead selects the disability decision information or DDI manual entry selection, there is no guarantee that the correct evaluation criteria regulation will populate into the rating narrative.

Here is an example of what the user should select in VBMS-R. The legacy evaluation builder is bypassed, and instead the DDI manual entry is selected.

Then, the user selects confirmed and continued evaluation and saves changes. Bypassing the evaluation builder in this way will cause VBMS-R to regenerate the evaluation criteria text from the last rating that addressed that specific issue. So, if the prior rating decision did not include a numeric rating criteria citation, then the current generated text will not include any rating criteria citation. If the prior rating included an incorrect citation, such as 4.12 a during the time period in early 2019, when the evaluation builder wasn't including that in every evaluation, then the same incorrect rating criteria citation will populate into the current NATO reactive. Narrative.

This is an example of a decision where we are seeing no sustained improvement and bypasses the evaluation builder by using the DDI manual entry selection. Notice that the required rating evaluation criteria for epilepsy is missing. It is incumbent upon the decision-maker to proofread the rating narrative and either add the missing regulatory citation, or correct the regulatory citation if an incorrect citation is populated.

Now that we have identified one potential cause of incorrect or missing evaluation criteria regulation, how can you as a decision-maker easily avoid these types of errors? First, use the evaluation builder for C&C evaluations, remembering that the use of the evaluation builder is mandatory. Properly using VBMS-R selections, glossary fragments and the evaluation builder should generally ensure that the proper legal citations populate into the narrative text.

However, remember that the decision-maker is ultimately responsible for ensuring that any missing or improper legal citations are added or corrected. We know that when the evaluation builder suggested evaluation is less than the current evaluation, but reduction is not in order using the evaluation builder becomes problematic, because it wants to assign or proposed the lower evaluation. C&C, for no sustained improvement is the most common example. In these situations, abandon the initial evaluation builder input and output and reenter the information into the evaluation builder using the symptoms from the prior rating that were used to support the current evaluation. C&C the evaluation as no sustained improvement. This should maintain the proper C&C evaluation , and will populate the proper regulation, the proper next tire criteria and evaluation criteria regulations. Also, as Robert mentioned earlier, use eCFR to make sure the regulations are correct and complete. I have included a hyperlink to the eCFR. I encourage everyone to open it at the beginning of the day and refer to it frequently.

We also want to mention a few other helpful hints that might eliminate missing laws or regulations errors, but are not limited to C&C evaluations. Remember , if a specific legal theory discussed in a rating narrative, then the numerical citation from which that legal theory drives is also required in the rating. If you add your own pretext or use glossaries into the rating narrative, make sure that free text includes any pertinent legal citations. We noticed people will discuss and wait evidence in the rating narrative without including the pertinent legal citations. If you have graded your own free text glossaries, and a lot of us have over the years lease look at them to ensure that they are updated to include parenthetical regulatory citations where applicable. Most of the VBMS-R glossaries have been updated to include the regulatory citations. There are a lot of great premade VBMS-R glossaries. I suggest you take a look at that if you have not done so lately. Some examples of free text that is added to a rating narrative, but is missing the relative regulatory citation include, reasonable doubt. Remember, you're likely is not medical opinion language that is derived from these two regulations. Citing either of these regulations when discussing likely is not is always a best practice. Pyramiding, and the higher of two evaluations. These are examples of free text we see in rating narratives that are missing the regulatory citations. Remember that you are your own best defense against missing citation errors. Proofread your rating. Train your eyes to look for what might be missing from each rating narrative. Make sure that a law or regulation is included for each component or legal theory discussed in your rating narrative. If you are granting service connection, the numerical regulation used two grant is required. For example, 38 CFR 3.34 direct service connection. If you have an assigned effective date, all of the numerical regulations used to select that effective date are required. For example, 38 CFR 3.400 is the general effective date will. Or, 38 CFR 3.20 500, which guides supplemental claim dates. Or, 38 CFR 3.155, which covers intent to file. Sometimes, all three will be necessary. If you are granting based on the continuously pursued supplemental claim, for example 38 CFR 3.20 500 and 38 CFR 3.400 will be necessary. In addition to any other regulation you may use. Let's practice training our eyes to easily identify what legal citations might be missing or incorrect. Our first example is a legally sufficient rating when it comes to meeting the AMA requirements. Are grant includes the legal citation that supports the grant, 38 CFR 3.303 and 38 CFR 3.304. If the grant is properly done in VBMS-R, these citations auto populate. Our effective date selection includes the regulatory citation that dictated the effective date based on date of claim, 38 CFR 3.400. The effective date builder will populate 38 CFR 3.400, but will not correctly populate most other effective date citations, such as 38 CFR 3.20 500. You must remember to add them if they are applicable. Our evaluation criteria includes the proper regulatory citation that guides the evaluation of Tinnitus. If it is used it should automatically populate.

This is an example of a legally sufficient rating. Train your eyes to look at the places the regulation should be located. And, do this for every issue in your proofread process.

Now, let's look at a rating narrative that is legally insufficient. To evaluate epilepsy, it is being C&C . The rating narrative is missing the regulatory citation for sustained improvement. 3.344 would need to be manually added to the rating narrative by the user. Additionally, the evaluation criteria regulation of 38 CFR 4.124 a is missing. The user must also manually add the regulation to the rating narrative. Hopefully these tricks and tips will assist decision-makers in assuring that all missing or incorrect regulatory citations are identified and corrected.

Thank you for your attention. I will now turn it over to Dustin, who will be discussing prescribed minimum evaluations for us.

Thank you Jennifer. Hello everyone. My name is Dustin Williams and, I am a program analyst for the procedures maintenance staff. Last month, we heard from Jessica of our program office staff on when a routine future examination is not appropriate. We thought it would be a nice tie in this month to further explore one of the variation she discussed. Namely prescribed scheduler minimum evaluations.

Prescribed scheduler minimum evaluation ratings are discussed in the listed regulations. Those provisions stipulate the BVA should not re-examine if it is a prescribed minimum. It is important to have a good working understanding of what we mean when we say, prescribed scheduler minimum evaluation ratings. Let's start with counterexamples and what the phrase does not mean. Prescribed scheduler minimum is not intended to refer to an evaluation at the schedule provides at the lowest specified numerical percentage associated with the given diagnostic code. Just because a disability schedule criteria don't proceed all the way down to a 0% evaluation doesn't mean the lowest evaluation listed is the prescribed minimum for that disability. Because, we have the option of using a different regulation to assign a zero evaluation for confirmed diagnosis that don't rise to meeting the regulation and that scheduler criteria. If we are evaluating cirrhosis of the liver, we can look at the rating schedule in 38 CFR 4.144 and see that the lowest explicitly discussed scheduler evaluation for that disability is at 10%. That doesn't mean that a more or less asymptomatic case of that condition would be guaranteed the scheduler 10% rating and could conceivably be assigned a non-rating. That is not prescribed scheduler minimum.

Instead, prescribed scheduler minimum evaluations actually refers to one where the schedule demand assignment of at least a certain evaluation once a condition manifests or exists in a certain way described. In other words, once the veterans disability meets the scheduler standard, there is a regulatory guarantee it will be signed and evaluation inferior to what is listed as a minimum. It probably sounds rudimentary, but homework of these types of evaluations will show that more often than not it uses the word minimum to qualify the rating value. These are commonly seen such disabilities as neurodegenerative orders like Parkinson's and multiple sclerosis. Certain anatomical losses, organ transplantations, and joint replacements are also included. Other examples are shown on the slide. So, you can see we have diagnostic code 8009, which is commonly used for brain vessel hemorrhage or strokes. Those are typically evaluated based on body systems specific residuals, that in the event there are none there is a guaranteed minimum evaluation of 10%. Also, we have diagnostic code 7019 four cardiac transplantation. Of course, the veteran could get in excess of a 30% base on their criteria. In the event that none are applicable, there is a prescribed scheduler minimum rating for 30% for that disability. And, with diagnostic code 7617, or hysterectomy with removal of uterus and both ovaries, there is a guaranteed prescribed scheduler minimum for that disability a 15%. We anticipate updating in 2021, the regulations with this publication. Keep in mind that prescribed scheduler minimum evaluations are only one component of the considerations that go into determining the need for future re-examination. It is worth reiterating that it is the agencies general policy to only re-examine when it is necessary to monitor for anticipated improvement, or to ensure the propriety of an assigned evaluation.

Thank you so much for listening. I will turn things over to Kat Calvitti.

Thank you, Dustin. Good morning. My name is Kat Calvitti . I am an operations analyst with the program operations staff and I will be discussing request for application site visit findings.

Compensation service reviewed 90 request for application EP for hundreds for processing accuracy in conjunction with site visit this year. Of the 90 reviewed, 50 were processed correctly for 57.8% accuracy. The error identified the appropriate prescribed form was received and request for application letter was erroneously sent to the veteran. The request for application letter would be attached to VA form 21-526 easy and it was sent to the veteran when the review letter was required. Also, there was no evidence in the e-folder to warrant the request for application.

Claims processors are minded to carefully review the evidence and forms submitted in VBMS-R to determine whether the request for benefits was submitted on the correct form in accordance with the manual. If the appropriate prescribed form was submitted, lace it under control using the appropriate system. If the claim was not submitted on the appropriate prescribed form, establish EP 400 with the date of claim as the date the evidence was received and generate the applicable RFA letter.

If any issues were previously decided or denied and the claimant was not submitted on VA form 20-0995 or 20-0996, send the veteran the request for the AMA review letter. This must be established in shared to prevent the RFA letter with the attached VA form from being auto generated. It must be sent to the veteran using package manager. The claims processor must update the subject line to indicate it is an AMA RFA letter and the source documents that initiated the claims should be labeled in the subject line is an incorrect AMA application. It is important to review package manager to ensure the letter was sent.

That is all I have for this site visit findings. Up next is Erin Hawkins who will discuss separation and severance pay evidence.

Thank you, I appreciate that. Good morning everyone. My name is Erin Hawkins. I am with national quality assurance and I will be addressing separation and severance pay. This is not representative of any recent changes to our laws and regulations. It serves as general reminders to our promulgators.

38 CFR 3.700 is the regulation that prohibits the VA from paying compensation to veterans who received CERT and separation benefits. By separation benefits, it breaks down into things like separation pay, readjustment pay, severance pay.

If the entire category of benefits a veteran may receive from the military at separation. It is very important that we screen the file for evidence of separation pay benefits, because failure to do so constitutes an improper payment, because the veteran way may see benefits that he or she is not eligible to receive. The impact of not catching separation benefits and adjusting the veterans award appropriately upfront can result in rework. And, when it comes to separation benefits, rework is a lot more difficult, time intensive and resource intensive later, down the road when we catch it. We have to issue due process and go through additional steps down the road, versus catching it upfront and adjusting with the initial award. Also, it can cause potential hardship to the veteran. When we award compensation benefits, we provide the veteran notification of monthly benefits that we are going to pay. The veteran may adjust his or her lifestyle or budget accordingly in anticipation of that monthly benefit that we provided in writing that he or she will receive. Later down the road, when VA catches the separation benefit and issues due process, we are going to be changing the veteran's life by either reducing or removing the complete monthly benefit for a while, as we recoup the benefits. This could lead to hardship on the part of the veteran, and we need to do everything we can to avoid that. Also, VA collects data about improper payments and we report this information to certain stakeholders, including Congress. We most definitely want to paint the VA in as good a light as possible by eliminating improper payments.

I have two manual references on the screen. The top one gives us some indicators in the file. It talks about, when reviewing the file what type of evidence is present that we can review for and extract to see if there is separation pay. This includes standard thing such as to 14 or 215. Can also include letters from the service department, for the Navy or Coast Guard Air Force provides VA written notification of the separation benefits. It can include reviewing referrals for the corporate record on the military tab to see if there is evidence separation pay. Another big one is the actual application for benefits. Often the veteran will disclose to us that he or she received benefits. This reference also talks about STD codes, which I will talk about when I get into some examples. This is the reference that provides a link and a breakdown of those SPD and what they mean. As a reminder, once we have a positive indicator of separation pay benefits, we are obligated to confirm the amount. This bottom reference walks as through the steps on confirming the benefits.

I have on the screen three examples from IDD to 14, a separation pay benefit. Example one is a standard case where we have separation pay and a dollar figure is printed. It is right there in black and white. But, in example 2 we don't have a dollar figure. Instead, in the remarks section it says the soldier is authorized special separation benefits. But, it indicates the amount is not available. The same thing in example 3. And it is more indicative of a more recently discharged veteran. We will see this often. Member authorized separation pay, final entitlement amount to be determined by DFAS upon final pay resolution. While example 2 and three do not have a dollar figure, it gives us a positive indicator of separation benefits. We have to treat it as such. At this point, we would need to proceed with verification of those figures.

Sometimes, the remarks box doesn't have an indicator of separation pay. Here is the example of the bottom half where the remarks box just says good conduct medal. There is no written narrative about separation pay. But, inbox 28, which is the narrative reason for separation, that is where we see the indication of separation pay. In that box we see for early release program, SSB. Additionally, there is a separation code in Bob's 26. If you research with the separation code meant from the link provided in the above reference, it shows as an early release program, SSB. You have to use different pieces on the DD 214 to extract evidence separation pay.

Here is another example. In this case, the remarks box again was empty and there was no indication of separation pay. And, box 28 shows an indication, for shaping-dash VSP and the separation code corroborates evidence of the separation pay. If I looked up that code it would show me, for shaping VSP. VSP is a type of separation pay that we potentially need to recoup.

When we don't have dollar figures, but we have indicators we must proceed with verification. Is considered a positive indicator and verification steps are required. However, if there is an indication of separation arson--or severance pay, we are going to use the unverified amount. If we don't have an amount, we will use a generic figure of $99,999. We are going to use those amounts to put into the separation pay adjustment and proceed with promulgating the rating decision. We will establish an EP 290 proceed with verification through ask DFAS to verify the amount. We will control that under an EP 290 proceed with processing the rating decision.

A few reminders, reviewed application for benefits. Look at the 5 to 6. Not always, but very often the veteran will tell us that he or she received a separation benefit. At that point it is a positive indicator and we should proceed with verification. Review the file for DDD 214 and 215. They can update or revise content and update and include additional information regarding separation benefits. If the claim is that promulgation, and we don't have 214 of record because, we verified service using means that did not include getting a 214, best practice would be to get the personal records, or do VIS check for separation pay. I would like to remind the field that the DD 214 and 215 is typically located as a standalone document in the file, or embedded in the personal records they can also be found in the dental records, especially on older veterans files.

Additionally, I have seen a lot of records where we do VIS check. We upload the report, but it doesn't include the tab we need to look for separation pay. Often, we will upload the VIS and we will see the military history or profile. The actual tab in VIS that shows as the separation pay is a deep dive / Coast Guard payments tap. You can see it where I have highlighted it in red. There are codes. You will see pop-ups and it will tell you what type of separation pay it was and help you to determine if we need to recoup it, or not.

Thank you very much everyone. I would like to pass it to Kelly Kennedy.

Thank you, and my name is Kelly Kennedy. I am a senior quality review specialist with the quality review staff. I am going to talk today about ace exams.

As we are all aware, COVID 19 presents unique challenges to processing veterans claims. The use of ace has been strongly encouraged as a strategy to continue serving veterans in need of compensation and pension exams during the pandemic. However, we want to remind claims processors that the requirements for sufficient and complete examination have not changed. The medical disability exams quality staff, orstaff has seen numerous instances in which the ace process has been improperly utilized.

Some examples of such misuse include the use of prior information to populate a new DBQ request without evidence in the claims folder, or without documented contact with the veteran. Use a very old self-reported blood pressure readings, and use of outdated information and lack of communication with the veteran to complete prostate cancer DBQ's. The MDE quality staff is providing error trend feedback to vendor examiners on examinations.

Quality assurance would like to remind claims processors that it is imperative to return examinations that are insufficient or incomplete from VA rating purposes. Here are a few reminders regarding ACE exams. As with traditional in-person exams, ACE exams must be a thorough, accurate, and please evaluation of the current level of disability. Claims folder review is always required for ACE examinations. In many instances, a telephone conversation with the veteran may be necessary to obtain additional information to supplement the evidentiary record. Only new or interval medical evidence should be used by the examiners to complete the DBQs using ACE. If relevant information is missing and/or cannot be obtained, that ACE process cannot be used to complete the DBQ. So, if any of these things have been done, that is an improper use of ACE procedure, and the exam is insufficient.

DBQs completed to the traditional in-person process and through that ACE process have the same goal and are held to the same quality criteria. Raters should not make decisions based on DBQs for which all the information required to diagnose, confirm treatment, etc. is not available or was not attained via the ACE process. Or, exams that are otherwise inaccurate or incomplete. Finally, we have some references where you can find more information on categories of exams for which the ACE process is prohibited . Requirements for claims folder reviews for ACE exams and identifying relevant evidence for examiner reviews. Requirements for ACE examination reports and insufficient examination reports.

That wraps up this topic. I will now turn it over to Paul Shute.

Good morning. I am excited to announce the new automated hospitalization reporting process.

Veterans that receive disability compensation and pension benefits who are hospitalized within the VA healthcare system are entitled to additional benefits or award adjustments based on their hospitalization. When the veterans hospitalization occurs within the VA health care system, it is the responsibility of VA to proactively identify those veterans and review records to make the appropriate adjudicated determination. Historically, the process that was undertaken in order to identify hospitalized veterans were as labor-intensive and lacked the internal controls to ensure all veterans cases were reviewed in a timely manner. It often resulted in improper payments for the veteran.

As part of the modern claims processing program, BVA has started to utilize computer medical data to improve business processes across the organization. One example of this is that development and implementation of the automated hospitalization reporting process, which uses hospitalization data derived from the veterans health administration's corporate data warehouse.

These new automated reports run in the background without any user intervention, and result in the automatic establishment of an and product that is routed by national work to your stations. On the left-hand side of the screen you will see the five categories or reports that we were accustomed to under the historical hospitalization recording process. On the right-hand side of the screen, you will see a more granular view of these reports that identify the specific benefit entitlement program impacted. For example, in the PNC related reports, you can see reports specific to improved pension. This additional level of granularity will allow the user to better understand what actions are required of them once the case is received in their you. This also assist from a data analytics standpoint to make sure we are able to properly identify timeliness and accuracy specific to each report.

One important distinction between the new automated hospitalization reporting process and the legacy process is we are now capturing this population of work under the end product 330 series. As I mentioned earlier, we have created unique claim labels to identify each of the various reports. When those claims are established, the contention will be identified as hospitalization review with a contention classification of administrative review. And, within the VBMS-R claim notes, the facility where the veteran was hospitalized will be included in the claim note. That is an important, helpful indicator to elude the adjudicator which records they will need to review in the pre-application.

Currently, the convalescence report and contract nursing home reports are out of scope or automation. Those reports will continue to require manual generation within CAPRI.

There is a variety of regulations that are impacted. They are outlined on the screen in front of you. We have also implemented changes to the M 21 to identify the new and products and claim attributes.

I would now like to turn it over to Robert Johnson for some closing remarks.

Thank you very much, Paul. At this time, I would like to share how you can be a presenter on the future quality call, how you can submit topic suggestions, as well as when the next recording of the Quality Call will be posted into TMS.

Like Jennifer Monville, you two too can be presenter on a quality call. We believe that peers speaking to peers is a great way to share information. If you are interested, please discuss it with your coach. If it is okay, please have your coach send us your name and topic to the internal QRS address.

If you have suggestions for topics for upcoming quality calls, use the same email address, and be sure to copy your local management on the email. Remember that the quality call bulletins themselves, are always located on the STAR intranet homepage. It has a very neat search function, if you are looking for information but you don't know what bulletin you are looking for, you can insert words or phrases into the search box, and it will search all of the quality bulletins and pull up the results for you. Bulletins, slides and audio recordings are in TMS and the VBA learning catalog. Remember that all claims processors will receive an email showing the quality call material is on your to do list.

This is the final quality call for this fiscal year. You will not receive an email from TMS in September. The calls will resume in FY 21.

As always, we know your time is valuable. Thank you for listening today. We look forward to having you join us in October. Thank you everybody and goodbye.

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