Chapter 3. National Quality Reviews

**Overview**

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| **In This Chapter** | This chapter contains the following topics and appendices: |

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| **Subchapter I. General** |
| 3.01 | Purpose  |
| **Subchapter II. Systematic Technical Accuracy Review (STAR) Methodology** |
| 3.02 | Quality Review Sampling |
| 3.03 | Quality Review Structure |
| 3.04 | Recording and Analysis of Review Results |
| 3.05 | Reporting the Correction of STAR Error Calls |
| 3.06 | Procedures for Clams Folder Transfer or Electronic Notification |
| 3.07 | Requests for Reconsideration |
| **Appendix A. STAR Rating Quality Review Checklist** |
| **Appendix B. STAR Authorization Review Checklist** |

Subchapter I. General

**3.01 Purpose**

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| **Introduction** | This topic describes the purpose of national quality reviews, including* methods to determine and improve quality
* Systematic Technical Accuracy Review (STAR), and
* quality review and the Veterans Service Center (VSC).
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| **a. Methods to Determine and Improve Quality** | Effective quality reviews and positive action to improve quality levels are required for all compensation claims. Methods used to determine quality levels and improve quality on an organized technical basis vary and are described in the following subchapter. The methods may consist of * regular supervision and training
* mandatory or optional reviews and spot checks
* controls of various kinds including cost controls or formal control procedures such as the Systematic Technical Accuracy Review (STAR) program, and
* special focused quality improvement reviews.
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| **b. STAR** | STAR is the Veterans Benefits Administration’s (VBA) national program for measuring compensation claims processing accuracy. STAR includes review of work in two areas * claims that usually require a rating decision, and
* claims that generally do not require a rating decision.

***Note***: STAR results are generated for all of VBA’s regional offices (ROs) and are included in both the station’s and the RO Director’s Performance Dashboards. |

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| **c. Quality Review and the VSC** | The quality review system is intended to assist managers in monitoring the level of service to claimants. This system requires that quality observations and reviews be performed on a continuing basis in all areas of Veterans Service Center (VSC) operations.***Note***: The quality review system does not require that evaluations encompass every work team within the VSC. |

Subchapter II. Systematic Technical Accuracy Review (STAR) Methodology

#### 3.02 Quality Review Sampling

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| **Introduction** | This topic describes the quality review sampling procedures, including* selection procedures
* annual sample sizes
* rating end product (EP) review, and
* authorization EP review.
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| **a. Selection Procedures** | Twice monthly, the Office of Performance Analysis and Integrity (PA&I) generates a list of end products (EPs) selected for STAR for delivery to Quality Assurance (QA). These EPs are randomly sampled from those completed during the previous two weeks.The total monthly sample for each RO includes both rating and authorization EPs, allowing assessment of all essential claim adjudication actions. |

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| **b. Annual Sample Sizes** | PA&I uses a statistical formula that considers both historical accuracy and workload values when determining valid sample sizes for rating and authorization EPs at each station.***Notes***:* Annual sample sizes are determined based on an average of two fiscal years’ worth of accuracy and workload data and are not subject to real-time adjustment.
* The annual sample is spread out over the course of the year so that there are enough EPs selected during each bi-monthly period for every RO to have a full sample at the end of the year.
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| **c. Rating EP Review** | Rating EPs are those associated with original and reopened claims, or claims for increased evaluation. They involve issues that are generally more complex and subject to greater scrutiny by stakeholders. Review of an EP is not limited to rating actions, but rather assesses the accuracy of all adjudicative actions leading up to the completion of that EP.Compensation rating EPs subject to national quality review are* 010 series – Original disability compensation, eight or more issues
* 020 series – Reopened disability compensation
* 070 – Appeals processing
* 110 series – Original disability compensation, seven or less issues
* 172 – Statement of the case/benefits
* 174 – Hearings conducted by Decision Review Officer (DRO)/decisions
* 310, 311, 312, 313, 315, 316, 317, 318, 319 – Routine future examinations
* 405, 409 – Fast Track System (Agent Orange claims)
* 681 – Agent Orange presumptives, and
* 687 – *Nehmer* Agent Orange.
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| **d. Authorization EP Review** | Authorization EPs are those that require development, review, and administrative decision or award action, but generally not a rating decision. However, if a rating decision is necessary to complete action on the EP, that decision will also be subject to review.Compensation authorization EPs subject to national quality review are* 130, 131, 132, 134, 136, 138, 139 – Dependency claims for living Veterans
* 290, 291, 292, 294, 296, 298 – Eligibility determinations, and
* 600, 601, 602, 603, 604, 605, 606, 609 – Predetermination notice.
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#### 3.03 Quality Review Structure

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| **Introduction** | This topic describes the quality review structure, including* STAR checklists
* general guidelines for quality reviews
* procedural deficiencies
* determining whether a case is correct or in error
* deselections
* reviewing all evidence associated with a claim
* clearly identifying and explaining errors
* appropriate citations
* cascade effect
* recording additional errors, and
* documentation of additional errors.
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| **a. STAR Checklists** | The STAR process requires a comprehensive review and analysis of all elements of processing associated with a specific claim or issue. STAR checklists are designed to facilitate consistent structured reviews.The Rating and Authorization checklists classify errors into three categories* Benefit Entitlement
* Decision Documentation/Notification, and
* Administrative.
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| **b. General Guidelines for Quality Reviews** | The general guideline is to record an error when an action taken violates current regulations or other directives and affects outcome, or has the potential to affect outcome.Examples of outcome-related deficiencies include, but are not limited to * errors that result in an overpayment or underpayment to a claimant
* procedural deficiencies that violate the claimant’s due process rights, and
* deficiencies which would result in a remand from the Board of Veterans Appeals (BVA) if not corrected.

***Note***: The deficiencies include all items listed under Benefit Entitlement on the STAR Checklist for rating and authorization.  |

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| **c. Procedural Deficiencies** | Procedural deficiencies generally do not raise to the level of benefit entitlement errors. These deficiencies are usually recorded as* decision documentation
* notification
* administrative (internal controls)
* examination and medical opinion request-related
* expedited favorable decision, and
* non-benefit entitlement errors when corrective action is needed.

***Notes***:* If an error is identified with an issue not related to the EP under review, that error is also recorded as a comment.
* Accuracy rates for decision documentation/notification comments are assessed monthly by STAR for quality improvement purposes. This information is useful in tracking station adherence to established procedural guidance.
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| **d. Determining Whether a Case Is Correct or in Error** | For each case reviewed, the case is considered either correct or in error (i.e., it is either entirely correct or it is wrong).***Important***: An answer of “NO” to any of the questions on the checklist relating to the processing of the issue (EP) action under review will result in the case being classified as “in error.”***Note***: The last section of the Rating and Authorization checklists contains an area for administrative questions that are not related to the accuracy of claims processing; an answer of “NO” for one of these questions will not indicate an error in the case. |

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| **e. Deselections** | In an effort to ensure a statistically valid sample, every effort will be made to perform a quality review on all cases identified on the QA staff’s call-up list. In rare instances, when a review may not be appropriate, QA staff will deselect the case if there is no other alternative. |

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| **f. Reviewing All Evidence Associated With a Claim** | Reviewers must be thorough in their review of each issue. It is not sufficient to simply review a decision and the letter of notification. All of the evidence associated with a claim must be reviewed to ensure that all issues (inferred as well as claimed) have been properly adjudicated.  |

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| **g. Clearly Identifying and Explaining Errors** | Sufficient narrative must be provided to clearly identify and explain the error cited. In most cases the explanation for the error(s) found should be sufficient to allow a reader to understand the problem area(s) without reviewing the claims folder. If the correct action was something other than the obvious converse of the erroneous action, then a statement indicating what the correct action would have been is required.  |

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| **h. Appropriate Citations** | Appropriate citation supporting an error call must be provided. In most cases, the reference should cite the appropriate statute or regulation, but it may also cite a* manual provision
* General Counsel (GC) precedent decision, or
* Court of Appeals for Veterans Claims (CAVC) precedent decision.

***Note***: VBA letters may also be referenced.  |

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| **i. Cascade Effect** | Based on the logical progression of the review sheets, when an error is identified, generally all subsequent processing related to that issue will also be in error. This pattern of derived error is referred to as a ***cascade effect***.***Examples***:* If an issue was not addressed, it is most likely that the issue was not developed, not rated, or notification for the issue was not sent.
* If a claim was properly developed but not properly rated, then inherently, the notification would be incorrect.
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| **j. Recording Additional Errors** | Recording additional errors inherent in the initial deficiency would distort identification of the basic or critical errors of the case, while adding little or no insight into root causes of the error itself.STAR reviews are outcome oriented and not process oriented. Once an error concerning a specific issue associated with a claim (i.e., a “NO” answer for one of the processing questions) is detected and recorded, no additional errors related to that issue should be recorded. The review of the case must continue for any other issues subject to review and the first error found in processing each additional issue contained within the claim should be recorded. |

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| **k. Documentation of Additional Errors** | The additional errors found and documented will not change the outcome for the particular case – since any one critical error (a “NO” answer) makes the entire action incorrect.Documentation of additional critical errors, however, will provide valuable information about the nature of primary errors and a better definition of the extent of accuracy concerns for station or District Office review (i.e., of the cases in error, how many total critical errors were identified and in what categories?).  |

#### 3.04 Recording and Analysis of Review Results

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| **Introduction** | This topic describes procedures for recording and analysis of review results, including* availability of review results
* report categories
* Benefit Entitlement categories
* Decision Documentation/Notification categories
* issue-based and claim-based rating reviews
* claim-based accuracy, and
* issue-based accuracy.
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| **a. Availability of Review Results** | The results of national reviews are maintained in a consolidated database. All accuracy reports within the database include RO-specific and national results. * STAR accuracy reports are published via the VBA Intranet in twelve-month rolling cumulative, three-month rolling cumulative, quarterly, and monthly formats for both claim-based and issue-based errors.
* Distribution of error reports are provided in twelve-month rolling cumulative as well as monthly and quarterly formats.

The STAR reports are updated monthly.***Note***: Station performance ratings are generated during September using the most current available data. For STAR reports, the most current data available in September will be the twelve-month cumulative report for the period from October through September. This represents the performance year. |

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| **b. Report Categories** | STAR reports reflect claims processing accuracy in two separate review categories for rating and authorization reviews. These categories are Benefit Entitlement and Decision Documentation/Notification.  |

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| **c. Benefit Entitlement Categories** | Benefit Entitlement review categories include* addressing all issues
* Duty to Assist ([38 CFR 3.159](http://www.ecfr.gov/cgi-bin/text-idx?SID=12a7960923b93c3bc9b9b42aea2a61dd&mc=true&node=se38.1.3_1159&rgn=div8)) and other applicable regulations for complete development
* correct decisions
* correct evaluations
* correct effective dates, and
* correct payment rates.

***Note***: The Benefit Entitlement accuracy rate is the official measure of claims processing accuracy and is the result used for performance measurement purposes. |

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| **d. Decision Documentation/Notification Categories** | Decision Documentation/Notification categories include review of the decision and the notification sent to the claimant.***Note***:Accuracy of these categories is assessed and reported, but is not included for station quality performance. |

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| **e. Issue-Based and Claim-Based Rating Reviews** | Effective October 1, 2012, issue-based reviews are conducted in conjunction with the traditional rating claim-based reviews.An issue-based review and a claim-based review are conducted on every rating claim submitted for STAR.  |

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| **f. Claim-Based Accuracy** | Claim-based reviews assess accuracy based on the entirety of the claim. If one benefit entitlement element of the claim is incorrect, the claim is marked as incorrect. Claim-based accuracy is calculated as the percentage of cases considered correct out of the total number of cases reviewed. |

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| **g. Issue-Based Accuracy** | Issue-based accuracy is measured by individually evaluated medical conditions within a rating-related compensation claim.Each issue must go through the same claims process that represents a series of completed tasks, such as development, research, adjudication, and decision, that could result in a specific benefit for a Veteran or survivor. More importantly, issue-based accuracy provides the Department of Veterans Affairs (VA) the opportunity to precisely target those medical issues where adjudication is most error-prone and additional training is needed. Stations are provided with the total number of issues reviewed, and the total number of issues in error, on every issue-based review.***Note***: Issue-based accuracy is calculated as the percentage of issues considered correct based on the total number of issues reviewed for any review period.***Important***: Claim-based accuracy remains the official measure of claims processing accuracy. |

#### 3.05 Reporting the Correction of STAR Error Calls

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| **Introduction** | This topic describes procedures for reporting the correction of STAR error calls, including* action to take following a STAR error
* corrective actions and reporting
* time limit for corrective action
* indicating when re-adjudication is not appropriate, and
* management’s responsibility for corrective action.
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| **a. Action to Take Following a STAR Error** | STAR benefit entitlement errors constitute a finding of insufficient development or clear and unmistakable error which affected the outcome of the benefit made under the authority of the Director, Compensation Service. One of two actions must take place on a STAR error* the station must take corrective action (re-adjudication, feedback, or training as appropriate), or
* the station must request reconsideration of the error. (If Compensation Service withdraws the error, no further action is required. If the error call is upheld, the station must take corrective action.)
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| **b. Corrective Actions and Reporting** | Stations must provide notice (report) that corrective action has been taken for any rating or authorization STAR benefit-entitlement and decision-documentation error citations.* Stations are required to report corrective action on errors under the *Comments* categories on the rating checklist and *M* categories on the authorization checklist, including issue-based, development, decision, and payment errors not associated with the EP under review, unless the error citation specifies no corrective action is required.
* Comments for all other actions not associated with the EP under review also require corrective action.
* Stations are required to report corrective action on errors under grant, denial, and percentage disability determination for the EP under review categories.
* Stations are also required to report corrective action on missed issues for the EP under review.
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| **c. Time Limit for Corrective Action** | ROs will be provided a listing of all the rating and authorization errors cited. This listing will not include STAR comments or administrative error calls that do not require corrective action.***Important***: Within ***30 days*** of receipt of the list, the RO is required to report the corrective action taken for each rating and authorization. |

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| **d. Indicating When Re-Adjudication Is Not Appropriate** | In cases in which re-adjudication may be inappropriate, the RO must indicate why re-adjudication is not appropriate and describe other action taken, such as training or feedback. The RO may also indicate that reconsideration has been requested. The reconsideration request must be submitted prior to reporting this on the error list. If the reconsideration request is denied, the corrective action must be taken and appropriately reported. |

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| **e. Management’s Responsibility for Corrective Action** | Upon notice of a completed STAR review, station management must ensure that deficiencies noted are corrected.* For paper folders, station management must also ensure the STAR Checklist-Identifier and STAR Checklist are removed from the claims folder.
* Document in the claims folders any corrective actions taken.
* Maintain the STAR Checklist-Identifier and STAR Checklist separately and use them for training purposes.
* Review and address STAR errors and all problem quality areas in the next periodic Systematic Analyses of Operations (SAOs) covering the quality of rating and authorization actions.
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#### 3.06 Procedures for Claims Folder Transfer or Electronic Notification

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| **Introduction** | This topic describes procedures for folder transfer or electronic notification, including* cases selected for STAR
* permanently transferred folders
* completing pending action
* shipment of paper folders, and
* outcome of STAR reviews.
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| **a. Cases Selected for STAR** | Cases selected for STAR will be reviewed electronically whenever possible. QA will request those folders not available in the Veterans Benefits Management System (VBMS) or Virtual VA from the station of jurisdiction (SOJ). The paper folders should be routed via United Parcel Service (UPS) to the QA office as quickly as possible.***Important***: When documents associated with the EP under review are not initially available in the electronic record, every effort must be made to scan and associate them in the Veteran’s electronic folder. |

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| **b. Permanently Transferred Folders** | When a claims folder has been permanently transferred to another station and the EP under review cannot be adequately reviewed electronically, the station must report that the folder is no longer under its jurisdiction due to permanent transfer. |

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| **c. Completing Pending Action** | Claims folders requested for QA may be reviewed for accuracy prior to transfer; however, any corrective action taken will not be considered during STAR. Any pending action, however, must be completed so the files can be transferred by the date shown on the notice. In addition, all drop file mail ***must*** be associated with the folder prior to transfer. |

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| **d. Shipment of Paper Folders** | All cases sent for STAR must have a ***single*** print of the Control of Veterans Records System (COVERS) Temporary Transfer Slip stapled to the outside of the left-hand flap of the paper claims folder. The document should show the name and number of the transferring station and indicate the receiving station as* *VACO (101/214BN) STAR Program* for rating, or
* *VACO (101/214BNA) STAR Program* for authorization.

All folders transferred for STAR review are to be sent by UPS and addressed as follows (rating ***and*** authorization reviews).Compensation Quality Assurance Staff (214BN)3322 West End AvenueSuite 730Nashville, TN 37203***Note***: When the volume of cases from an RO is sufficient to warrant shipment in a box, care must be taken to pack and ship the files in cartons that are in good condition and approved for the shipment of folders. Cartons must be packed firmly and reinforced with tape. Individual folders and multiple files in small bundles must be shipped in padded mailers or appropriately sized overnight or express mail cartons. |

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| **e. Outcome of STAR Reviews** | Stations will learn the outcome of* a STAR review on a paper folder EP by means of a hard-copy completed review checklist placed in the file prior to its return to the station, and
* STAR reviews completed electronically via regular “Notification of Completed PLCP Reviews” emails sent from the VAVBAWAS/CO/214B mailbox.
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#### 3.07 Requests for Reconsideration

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| **Introduction** | This section describes procedures for requests for reconsideration, including* formally addressing disagreements
* requesting reconsideration
* time limit for reconsideration requests
* memorandum for reconsideration requests, and
* additional reconsideration requests.
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| **a. Formally Addressing Disagreements** | It is anticipated that occasionally ROs may receive a review result with which they disagree or believe the explanation offered is unclear or inadequate. Any basic disagreement over the correctness of a call must be formally addressed. |

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| **b. Requesting Reconsideration** | If an RO believes an erroneous error call has been made, the case may be returned for a formal reconsideration by the QA Staff under the direction of the Quality Assurance Officer (QAO). To request reconsideration of an error, prepare a memorandum to the QA Office stating the basis for the request for reconsideration. |

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| **c. Time Limit for Reconsideration Requests** | Requests for reconsiderations must be submitted within ***30 days***. The 30-day period for rating and authorization will begin with the date the RO receives the file or is notified that an electronic review has been completed. QA Staff will establish an official grace period of 10 days for paper cases after the prescribed 30-day period, which begins when the station receives the paper folder from the QA Office.***Notes***:* The 10-day grace period takes into account mailing. This will be moot once all files are electronic.
* Exceptions to the 30-day period may be requested by contacting the QA Staff at VAVBAWAS/CO/214B.
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| **d. Memorandum for Reconsideration Requests** | The memorandum requesting reconsideration must include pertinent* supporting statutes
* regulations
* CAVC opinions
* GC Opinions
* manual, or
* other appropriate citations.

When a paper claims folder exists, it must be submitted with the memorandum for review. The RO will be provided a formal decision. When a reconsideration results in a withdrawal or change in the error status, the QA Staff will update the STAR database to reflect the decision. Results of reconsideration requests will be maintained and monitored to ensure the effectiveness and integrity of the review process. |

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| **e. Additional Reconsideration Requests** | Stations will have the right to seek additional reconsideration from Compensation Service on upheld benefit entitlement errors.* Requests must be made by the station’s Director to the Deputy Director for Operations, Compensation Service.
* Requests must be within 15 calendar days of when the station receives the file back after STAR reconsideration or when the RO receives notification that an electronic review has been completed and may be submitted via e-mail.

***Important***: Compensation Service reserves the right to alter this timeline at the end of the fiscal year reporting period to ensure timely final quality reports. If the Deputy Director disagrees with the action taken by the QA Staff, the error will be withdrawn. The folder will be returned to the QA Staff to amend the decision as directed, and feedback will be given to ensure that such errors are not cited in the future.***Reference***: For instructions regarding sending a claims folder to QA, please refer to section 3.06(d) of this chapter. |

#### Appendix A. STAR Rating Quality Review Checklist

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| **Introduction** | This appendix includes the * STAR Rating Quality Review Checklist
* instructions and guidelines for rating review, and
* rating review elements.
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| **a. STAR Rating Quality Review Checklist** | The following is a sample of the rating checklist. |

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| Claim Number  | Reviewer:  |
| End Product  | EP Cleared By:  |
| Review Type:  | Review Date:  |
| DOC  | Disp Date:  |
| Compensation:  | Pension:  | Both:  | N/A:  |
| New:  | Reopened:  | Increase:  | N/A:  |
| Rating Redesign:  | Hybrid Rating:  | Traditional Rating:  |
| SOC:  | SSOC:  | N/A:  |
| AMC:  | DES:  | FNOD:  |
| Name:  | Discharge Date:  |
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|  | YES | NO | N/A |
| BENEFIT ENTITLEMENT |  |  |  |
| Address All Issues |  |  |  |
| A1) Were all claimed issues addressed? |  |  |  |
| 🞏 A1a. Ancillary Benefit (SAD, SHA, DEA, Paragraphs 28-30, etc.) | 🞏 A1b. Competency | 🞏 A1c. IU |
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| 🞏 A1d. Pension | 🞏 A1e. SMC or SMP – A/A | 🞏 A1f. SMC or SMP - HB |
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| 🞏 A1g. SMC – other | 🞏 A1h. Service Connection | 🞏 A1i. Secondary service connection |
|  |  |  |
| 🞏 A1j. Increased evaluation | 🞏 A1k. Earlier effective date | 🞏 A1l. Other |
| A2) Were all unclaimed subordinate and/or ancillary issues addressed? |  |  |  |
| 🞏A2a. 38 CFR 3.324 (multiple non-compensable SC disabilities) | 🞏 A2b. Competency | 🞏 A2c. DEA |
|  |  |  |
| 🞏 A2d. Hypertension | 🞏 A2e. IU | 🞏 A2f. Medical care under 38 USC 1702 |
|  |  |  |
| 🞏 A2g. Pension (including extraschedular under 3.321b) | 🞏 A2h. SMC or SMP – A/A | 🞏 A2i. SMC or SMP – HB |
|  |  |  |
| 🞏 A2j. SMC – other | 🞏 A2k. Other |  |
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| Proper Development |  |  |  |
| B1) Was 38 USC §5103 pre-decision “notice” provided and adequate? |  |  |  |
| 🞏B1a. New and Material Verbiage | 🞏 B1b. Pension or SMP development incomplete | 🞏 B1c. Special issue development incomplete |
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| 🞏 B1r. VCAA not sent | 🞏 B1s. “What the Evidence Must Show” attachment missing or incorrect | 🞏 B1t. Other |
| B2) Does the record show VCAA compliant development to obtain all indicated evidence (including a VA exam, if required) prior to deciding the claim? |  |  |  |
| 🞏B2a. Admin denial insufficient – rating decision needed | 🞏 B2b. Advisory opinion needed from Comp or Pension Service | 🞏 B2c. Appeals issue |
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| 🞏 B2d. Complete income information not obtained | 🞏 B2e. Dependency verification deficiency | 🞏 B2f. Insufficient VA examination/medical opinion |
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| 🞏 B2g. IU development deficiency (i.e., 8940 needed before grant; employment history needed, etc.) | 🞏 B2h. Non-VA treatment records development deficiency | 🞏 B2i. SBP verification deficiency |
|  |  |  |
| 🞏 B2j. Service personnel records needed | 🞏 B2k. Service treatment records needed | 🞏 B2l. Social Security records development deficiency |
|  |  |  |
| 🞏 B2m. Special issue development incomplete |  |  |
|  |  |  |
| 🞏 B2bb. VA exam was needed | 🞏 B2cc. VA medical opinion was needed | 🞏 B2dd. VA treatment records not obtained |
|  |  |  |
| 🞏 B2ee. VCAA reply period not expired before denial | 🞏 B2ff. Other |  |
|  |  |  |  |
| Grant or Deny |  |  |  |
| C1) Was the grant or denial of all issues correct? |  |  |  |
| 🞏 C1a. Accrued benefits (warranted or not warranted) | 🞏 C1b. Hearing loss not shown under 38 CFR 3.385 | 🞏 C1c. Service connection not warranted for symptom or lab finding (i.e., pain, proteinuria, etc.) |
|  |  |  |
| 🞏 C1d. Service connection not warranted (general) | 🞏 C1e. Service connection warranted (general) | 🞏 C1f. Other |
| C2) Was the percentage evaluation assigned correct (including combined eval.)? |  |  |  |
| 🞏 C2a. Convalescence (warranted or not warranted) | 🞏 C2b. Misapplication of 38 CFR 4.86, Exceptional Patterns of Hearing Impairment | 🞏 C2c. Misapplication of bilateral factor |
|  |  |  |
| 🞏 C2d. Pyramiding (same symptomatology used for multiple disabilities) | 🞏 C2e. Reduction (warranted, not warranted, or done prematurely or too late) | 🞏 C2f. Separate evaluations warranted for one SC disability (i.e., knee LOM and instability) |
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| 🞏 C2g. Over-evaluation (general) | 🞏 C2h. Under-evaluation (general) | 🞏 C2i. Other |
|  |  |  |  |
| Award Actions  |  |  |  |
| D1) Are all effective dates affecting payment correct? |  |  |  |
| 🞏 D1a. Day after discharge (effective date incorrectly granted from day following RAD; or not granting from day following RAD when entitlement was shown) | 🞏 D1b. Dependency adjustment | 🞏 D1c. Diabetes complication – incorrect effective date |
|  |  |  |
| 🞏 D1d. Increased disability – incorrect effective date based on increase factually shown or not shown from that date | 🞏 D1e. IU – criteria met or not met from an earlier date | 🞏 D1f. Informal date of claim – missed or misapplied |
|  |  |  |
| 🞏 D1g. Liberalizing legislation misapplied | 🞏 D1h. Pension (granted administratively or by rating decision) | 🞏 D1i. SMC or SMP change |
|  |  |  |
| 🞏 D1j. Incorrect effective date for all other situations (general) | 🞏 D1k. Nehmer guidelines not followed, earlier effective date warranted | 🞏 D1l. Nehmer guidelines not followed, later effective date warranted |
|  |  |  |
| 🞏 D1m. Other |  |  |
| D2) Were all payment rates correct? |  |  |  |
| 🞏 D2a. CRDP or other MRP adjustment | 🞏 D2b. CRSC adjustment | 🞏 D2c. Dependency adjustment |
|  |  |  |
| 🞏 D2d. Month of Death payment (paid when not entitled; or not paid when entitled) | 🞏 D2e. Pension calculation incorrect | 🞏 D2f. Severance, Readjustment, or Separation Pay adjustment |
|  |  |  |
| 🞏 D2g. SMC coding incorrect | 🞏 D2h. Other |  |
| DECISION DOCUMENTATION/NOTIFICATION |  |  |  |
| Decision Documentation |  |  |  |
| E1) Was all **pertinent** evidence discussed? |  |  |  |
| E2) Was the basis of each decision identified and each denial explained? |  |  |  |
| E3) Was the rating narrative of acceptable length, without irrelevant or superfluous text or potions copied and pasted directly from CAPRI? |  |  |  |
|  |  |  |  |
| Decision Notification |  |  |  |
| F1) Was notification sent? |  |  |  |
| F2) Was the notification correct? |  |  |  |
| F3) Were appeal rights included? |  |  |  |
| F4) Was the Power of Attorney indicated, correct, and notification properly documented? |  |  |  |
|  |  |  |  |
| ADMINISTRATIVE |  |  |  |
| Appropriate Signatures (Internal Controls) |  |  |  |
| G1) Was appropriate second signature documented? |  |  |  |
| G2) Were third signatures appropriately documented when required? |  |  |  |
| G3) Was the end product selected for review over-developed? |  |  |  |
| G4) Did unnecessary development delay a decision on any claim associated with the EP under review? |  |  |  |
| Examination & Medical Opinion Requests |  |  |  |
| H1) If a VA examination was requested, was that examination necessary and if an opinion was requested was the opinion an appropriate medical (not legal) question? |  |  |  |
| H2) Examination Requests – Were correct worksheets requested? |  |  |  |
| H3) Examination Requests – Were issues (disabilities claimed) clearly identified? |  |  |  |
| H4) Examination Requests – When necessary or requested by VAMC was the claims folder provided by the regional office? |  |  |  |
| H5) Medical Opinion Requests – If a medical opinion was requested, were pertinent issues clearly identified and appropriate question(s) clearly asked? |  |  |  |
| H6) Medical Opinion Requests – Was the claim folder made available to the medical center by the regional office? |  |  |  |
| Expedited Favorable Decision |  |  |  |
| I) When evidence was sufficient to grant partial benefits, were those benefits granted promptly, while developing other issues? |  |  |  |
| Comments | YES |  |
| J1a) Issue Errors not associated with end product under review |  |  |
| J1b) Development Errors not associated with end product under review |  |
| J1c) Decision Errors not associated with end product under review |  |
| J1d) Payment Errors not associated with end product under review |  |
| J1e) Comments for all other actions not associated with end product under review? |  |
| J2) Disability Determination – end product under review |  |
| J3) Notification – end product under review |  |
| Special Issue Identification |  |
| FORMER POW |  |  |
| RADIATION CLAIM |  |
| GULF WAR CLAIM |  |
| AGENT ORANGE CLAIM |  |
| PTSD CLAIM |  |
| TBI CLAIM |  |
| BVA REMAND |  |  |
| BROKERED CASE |  | **Regional Office:** | **Resource Center:** |
|  | None selected | None selected |
| MST |  |   |
| BDD or QUICK START PROCESSING |  |
| PLCP |  |
| DBQ – VA provider |  |
| DBQ – private provider |  |
| Total number of issues reviewed(includes missed issues and missed inferred issues) |  |
| Number of issues with BE errors |  |

FOR EACH “NO” ANSWER RECORDED, PROVIDE A *BRIEF* NARRATIVE SUMMARY OF THE ERROR AND STATUTORY, REGULATORY, OR MANUAL REFERENCES ON THE ATTACHED NARRATIVE SUMMARY SHEET.

|  |  |
| --- | --- |
| **b. Instructions and Guidelines for Rating Review** | These instructions and guidelines have been developed to promote consistency and uniformity in the review of cases selected for the STAR program. Use these instructions/guidelines in conjunction with the STAR Rating Checklist. For the purpose of measuring technical accuracy under the STAR program, a case is considered either “accurate” or “in error,” for the claims based review. The claims based review is separate and distinct from the issue based review, in which only the specific reviewed issue will be considered either “accurate” or “in error.” At the current time, a case will be considered “accurate” when all of the questions for each element indicated on the Benefit Entitlement Section of the STAR Rating Checklist are answered “YES” or “N/A.” The elements are: A) Address all Issues, B) Proper Development, C) Grant or Denial, and D) Award actions. A case will be considered “in error” if the answer to any question for any element is “NO.” For each case reviewed, a STAR Checklist must be completed and all questions answered. A “YES” response indicates that the activity associated with the question was completed accurately. A “NO” response indicates that the activity associated with the question was “in error.” Indicate “N/A” if the question is not applicable to the case under review, or if a “NO” response was previously recorded for the only issue subject to review. A narrative summary is required with statutory, regulatory, judicial, or manual references for any “error” or “NO” answer recorded.The general guideline is that an error will be recorded when an action is taken that violates current regulations or established policies. Examples of outcome-related deficiencies include, but are not limited to, errors that result in an overpayment or underpayment to a claimant and deficiencies that would result in a remand from the BVA if not corrected. Procedural deficiencies are not recorded as benefit entitlement errors. These deficiencies are recorded as decision documentation/notification or administrative comments and either corrective action must be taken upon these deficiencies or a timely Request for Reconsideration must be submitted. A judgment or a difference of opinion reflecting a possible better practice or solution will not be recorded as a comment. If an error is identified with an issue not related to the end product under review, that error is also recorded as a comment in the *Comments* sections.  |

|  |  |
| --- | --- |
| **c. Rating Review Elements** | The following is a list of explanations of the elements of the STAR Rating Quality Review Checklist. |

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| --- | --- |
|  |  |
| BENEFIT ENTITLEMENT |  |
| ADDRESS ALL ISSUES | The STAR Rating review is, generally, focused on end products associated with original and reopened claims and appellate issues. Other issues such as dependency, income, net worth, withholdings/recoupments, incompetency, etc., when applicable to a case selected under STAR, will be reviewed as part of that end product. |
| A1) Were all claimed issues addressed? | A “claimed issue” is any benefit specifically mentioned by the applicant or his/her representative or any benefit that is reasonably raised by the evidence of record. Since a claim may be received through any means of communication, each document in the file must be checked to ensure that all issues have been addressed. |
| A2) Were all unclaimed subordinate and/or ancillary issues addressed? | A “subordinate issue” is derived from the consideration or outcome of related issues and often shares the same fact pattern. The Veterans Court in *McGrath v. Brown* has stated that “An issue may not be ignored or rejected merely because the Veteran did not expressly raise the appropriate legal provision for the benefit sought.” A list of some, but not all, subordinate issues is included in M21-1, III.iv.6.B.1.d. A list of some, but not all, ancillary issues are enumerated in M21-1, III.iv.6.B.1.c |
|  |  |
| PROPER DEVELOPMENT |  |
| B1) Was 38 USC §5103 pre-decision “notice” provided and adequate? | 38 CFR 3.159(b)(1) states, in part, that upon receipt of a substantially complete application, VA is required to notify the claimant and the claimant's representative, if any, of any information, and any medical or lay evidence, not previously provided that is necessary to substantiate the claim. As part of that notice, VA is required to indicate which portion of that information and evidence, if any, is to be provided by the claimant and which portion, if any, VA will attempt to obtain on behalf of the claimant. |
| B2) Does the record show development to obtain all indicated evidence (including a VA exam, if required) prior to deciding the claim? | 38 CFR 3.159(c)(2) states, in part, that VA must make reasonable efforts to help a claimant in obtaining the evidence necessary to substantiate a claim. Therefore, all indicated and necessary development must be completed before deciding a claim unless a grant is warranted based on the evidence of record.If a VA examination report was the basis for a rating decision, was that report adequate and sufficient for rating purposes? Was there already sufficient medical evidence of record to rate the claim? (See 38 CFR 3.326(b) & (c)). While requesting an examination is generally a judgment area with considerable latitude, that judgment must be exercised within a reasonable range. The record must contain evidence that fully supports the disability determination and not lack any evidence that would prompt a remand from the Board of Veterans Appeals. Requests for medical opinions on legal issues such as “is a condition service-connected” constitute error. |
|  |  |
| GRANT OR DENY |  |
| C1) Was the grant or denial of all issues correct? | Does the evidence of record support the decision according to applicable law regulation and policy? Any error called in this element must be the equivalent of a clear and unmistakable error. An error includes failure to allow benefits based upon application of the doctrine of reasonable doubt when a case is in equipoise (38 CFR 3.102). A judgment variance such as “difference of opinion” or “better rating practice” will not be considered an error or noted in a comment as QA does not make best practice suggestions at this time.Deficiencies invisible to the claimant such as award reason codes or entitlement codes should not be called. Such deficiencies should be noted in the *Remarks* section of the form. |
| C2) Was the percentage evaluation assigned correct (including combined eval.)? | Generally, an error in this category may only be called when supported by evaluation tools, such as the Evaluation Builder. If the Evaluation Builder was not used by the decision maker, then an error may still be called if the evaluation is not supported by the evaluation tool or is not in compliance with the Rating Schedule. The only possible judgment variance is when the evidence of symptomatology is divided between two evaluation criteria and the disability picture is not clear enough to conclusively apply 38 CFR 4.7. |
|  |  |
| AWARD ACTIONS |  |
| D1) Are all effective dates affecting payment correct? | Question D1 is self-explanatory. |
| D2) Were payment rates correct? | If applicable to the case being reviewed, issues such as dependency, income, withholdings and recoupments, hospitalization, etc., must be considered when deciding whether the payment rates are correct. |
|  |  |
| DECISION DOCUMENTATION/NOTIFICATION |  |
| DECISION DOCUMENTATION | Simply summarizing evidence and stating a conclusion does not constitute “reasons and bases.” In *Gabrielson v. Brown*, 7 Vet. App 36 (1994), the court stated: “fulfillment of the reasons and bases mandate requires the decision maker to set forth the precise basis for its decision, to analyze the credibility and probative value of all material evidence submitted by and on behalf of a claimant in support of the claim, and to provide a statement of its reasons and bases for rejecting any such evidence.” Failure to do this on an issue is an error. |
| E1) Was all **pertinent** evidence discussed? | Question E1 is self-explanatory. |
| E2) Was the basis of each decision identified and each denial explained? | Question E2 is self-explanatory. |
| E3) Was the rating narrative of acceptable length, without irrelevant or superfluous text or potions copied and pasted directly from CAPRI? | Question E3 is self-explanatory. |
|  |  |
| DECISION NOTIFICATION | This element includes Predetermination and Contemporaneous Notification, when applicable (38 CFR 3.103). |
| F1) Was notification sent? | Question F1 is self-explanatory. |
| F2) Was the notification correct? | It is essential that correspondence to claimants be viewed, to the extent possible, from the claimant’s perspective. Notification must:- Be factually correct,- Address all issues,- Be as direct and concise as possible,- Be logically laid out so thought sequences are not broken, and- Be free from apparent contradictory  statements.  |
| F3) Were appeal rights included? | Notice of procedural and appellate rights is required following every decision. This may be furnished by attachment of VA Form 4107 or equivalent language in the body of the notification.  |
| F4) Was the Power of Attorney indicated, correct, and notification properly documented? | The master record should be updated to include designation of the claimant’s representative so that computer-generated notices are furnished to both.  |
|  |  |
| ADMINISTRATIVE |  |
| APPROPRIATE SIGNATURE(Internal Controls) | The appropriate signature has been added for internal control purposes only. It is a means of checks and balances to eliminate potential fraud situations. |
| G1) Was appropriate second signature documented? | Question G1 is self-explanatory. |
| G2) Were third signatures appropriately documented when required? | Question G2 is self-explanatory. |
| G3) Was the end product selected for review over-developed? | Question G3 self-explanatory and is used only for data gathering purposes. |
| G4) Did unnecessary development delay a decision on any claim associated with the EP under review? | Question G4 is self-explanatory and used only for data gathering purposes. |
|  |  |
| EXAMINATION & MEDICAL OPINION REQUESTS  | A medical opinion may be required to reconcile diagnoses, determine the relationship between conditions, determine etiology or nexus to service-incurred disease or injury, or determine whether and to what extent service-connected disability has aggravated a nonservice-connected condition. Before requesting an opinion, review the claim and supporting evidence to ensure that minimum evidentiary requirements have been met. Always provide the claims folder for the examiner to review. Guidelines are provided in M21-1, I.1.C.3 and III.iv.3. |
| H1) If a VA examination was requested was that examination necessary and if an opinion was requested was the opinion an appropriate medical (not legal) question? | Question H1 is self-explanatory. It is not cascading to select “YES” for G3 and “NO” for H1. |
| H2) Examination Requests – Were correct worksheets requested? | The appropriate exam worksheet is to be selected for each specific claimed condition identified in the General Remarks section, including appropriate use of General Medical exam. [NOTE: If a general medical exam was requested the request must be supported by the remarks or other information in the exam request (for example, recently discharged Veteran)]. |
| H3) Examination Requests – Were issues (disabilities claimed) clearly identified? | The specific condition (or conditions) is (are) to be identified in the General Remarks section for each exam requested. Identify the evidence to be reviewed by tabbing it in the claims folder; however, advise the examiner that the review is not limited to this evidence. In the request, indicate the source (provider or facility) of the evidence, the subject matter and the approximate dates covered. |
| H4) Examination Requests – When necessary or requested by VAMC was the claims folder provided by the regional office? | Question H4 is self-explanatory. The reviewer should also select “YES” if the claims folder was available in electronic format and the examiner stated that it was reviewed. |
| H5) Medical Opinion Requests – If a medical opinion was requested, were pertinent issues clearly identified and appropriate question(s) clearly asked? | Clearly state the nature of the opinion requested. Also, explain why the opinion is needed, if this would clarify the request.  |
| H6) Medical Opinion Requests – Was the claim folder made available to the medical center by the regional office? | Question H6 is self-explanatory. The reviewer should also select “YES” if the claims folder was available in electronic format and the examiner stated that it was reviewed. |
|  |  |
| EXPEDITED FAVORABLE DECISION |  |
| I) When evidence was sufficient to grant partial benefits, were those benefits granted promptly, while developing other issues? | Make an intermediate rating decision if the record contains sufficient evidence to grant any benefit, including service connection at a noncompensable level. Grant service connection for a disability with a noncompensable evaluation, if supported by the evidence, even though the issue of service connection or compensation for other disabilities or the issue of a higher evaluation must be deferred. |
| COMMENTS | Identified in this section are discrepancies that would have otherwise been considered as errors had the end product in question been under review. Comments do not count as errors under the end product under review.  |
| J1) Errors not associated with end product subject to review? | The same principles that are outlined in A1 through D2 apply. |
| J2) Disability Determination | The same principles that are outlined in C1 and C2 apply. |
| J3) Notification | The same principles that are outlined in E1 through F4 apply. |
| SPECIAL ISSUE IDENTIFICATION | Identifies special issue cases that require special consideration or processing. |
| FORMER POW | Self-explanatory. |
| RADIATION CLAIM | Self-explanatory. |
| GULF WAR CLAIM | Self-explanatory. |
| AGENT ORANGE CLAIM | Self-explanatory. |
| PTSD CLAIM | Self-explanatory. |
| TBI CLAIM | Self-explanatory. |
| BVA REMAND | Identifies a case that has been remanded by BVA. |
| BROKERED CASE | In some instances cases may be processed by a regional office that does not have jurisdiction of a case, such as brokered cases. Identifying a case under this section will give the proper office credit for the case under review. |
| TIGER TEAM CASE | Identifies cases that are processed by the Tiger Team. |
| PLCP | Identifies cases that are processed in an electronic environment |
| DBQ – VA provider | If the claimant submits a DBQ completed by a VA provider, then select this field and then identify the VA facility that completed the DBQ. This does not include DBQs completed by a VA provider at the request of a RO or AMC. |
| DBQ – private provider | If the claimant submits a DBQ completed by a private provider, then select this field |
| Total number of issues reviewed(includes missed issues and missed inferred issues) | Enumerate the number of issues reviewed as part of the STAR process, to include the Award document if such a document was required to promulgate the rating decision (e.g., no award document is required when the rating decision confirms and continues the evaluation of the SC disability; therefore even if the RO generates an award document, it would not be counted). |
| Number of issues with BE errors | Self-explanatory. |

#### Appendix B. STAR Authorization Quality Review Checklist

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| --- | --- |
| **Introduction** | This appendix includes the * STAR Authorization Quality Review Checklist
* instructions and guidelines for authorization review, and
* authorization review elements.
 |

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| --- | --- |
| **Change Date** | August 13, 2015 |

|  |  |
| --- | --- |
| **a. STAR Authorization Quality Review Checklist** | The following is a sample of the authorization checklist. |

|  |  |
| --- | --- |
| Regional Office Number \_\_\_\_\_\_\_\_\_\_\_\_ | Claim Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| End Product \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Veteran’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

|  |
| --- |
| Authorization Checklist |

|  |  |  |  |
| --- | --- | --- | --- |
|   | YES | NO | N/A |
| BENEFIT ENTITLEMENT |  |  |  |
| Address All Issues |  |  |  |
| A1) Were all claimed issues addressed? |  |  |  |
| A2) Were all inferred issues addressed? |  |  |  |
|  |  |  |  |
| Proper Development or Procedural Issues |  |  |  |
| B1) Was a development letter sent, addressing duty to notify (if applicable) and evidence requirements, for the claimed issues? |  |  |  |
| B2) Does the record show complete development, properly documented prior to final action on the claim (i.e., complete letters, VA Form 27-0820, Report of Contact, etc.)? |  |  |  |
| B3) Was the proper procedural process accomplished? |  |  |  |
|  |  |  |  |
| Income Issues |  |  |  |
| C1) Was Net Worth determination correct? |  |  |  |
| C2) Was total family income counted properly and/or in the correct reporting period? |  |  |  |
| C3) Were all deductions, including unreimbursed medical expenses, calculated correctly? |  |  |  |
|   |  |  |  |
| Dependency Issues |  |  |  |
| D1) Was a dependent spouse correctly established or removed? (38 CFR 3.50) |  |  |  |
| D2) Were dependent children correctly established or removed? (38 CFR 3.57 and 3.667) |  |  |  |
| D3) Were dependent parents correctly established or removed? (38 CFR 3.59) |  |  |  |
| D4) Was a surviving spouse correctly established or removed? (38 CFR 3.50(b)) |  |  |  |
| D5) Were surviving children correctly established or removed? (38 CFR 3.57) |  |  |  |
|  |  |  |  |
| Accrued Benefits Issues |  |  |  |
| F1) Was the proper claimant paid? |  |  |  |
| F2) Was the correct amount paid? |  |  |  |
|  |  |  |  |
| Adjustments (Hospital, Incarceration, Active Duty, or Drill Pay) |  |  |  |
| G1) Were required adjustments accomplished and correct? |  |  |  |
| G2) Was restoration of benefits correct? |  |  |  |
|  |  |  |  |
| Payment & Effective Dates  |  |  |  |
| H) Are all payment dates and rates correct? |  |  |  |
|  |  |  |  |
| DUE PROCESS/ADMIN DECISIONS/NOTIFICATION |  |  |  |
| Due Process Issues |  |  |  |
| I1) Was a predetermination notice sent? |  |  |  |
| I2) Was the predetermination notice fully informative? |  |  |  |
| I3) Was claimant given 60 days before the due process period expired? |  |  |  |
|  |  |  |  |
| Administrative Decisions |  |  |  |
| J1) Admin – Grant or Denial – Was all applicable evidence discussed?  |  |  |  |
| J2) Admin Grant or Denial – Was the basis of each decision explained?  |  |  |  |
| J3) Were required formal apportionment decisions completed and correct (apportionment, deemed valid marriage, character of discharge, etc.)? |  |  |  |
|  |  |  |  |
| Notification |  |  |  |
| K1) Was notification sent and documented in the file? |  |  |  |
| K2) Was the notification correct? |  |  |  |
| K3) Were appeal rights included? |  |  |  |
| K4) Was Power of Attorney indicated, correct and notification properly documented? |  |  |  |
|  |  |  |  |
| ADMINISTRATIVE |  |  |  |
| Appropriate Signature (Internal Control) |  |  |  |
| L1) Was the appropriate second signature documented? |  |  |  |
| L2) Were third signatures appropriately documented when required? |  |  |  |
|  |  |  |  |
| Comments | YES |  |
| M1a) Errors not associated with end product under review |  |  |
| M1b) Development Errors not associated with end product under review |  |
| M1c) Decision Errors not associated with end product under review |  |
| M1d) Payment Errors not associated with end product under review |  |
| M1e) Comment for all other actions not associated with end product under review |  |
| M1f) Notification Errors not associated with end product under review |  |
| M2) Notification Errors - end product under review |  |
| Special Case Identification |  |
| N1) Brokered Case |  | **Regional Office:** | **Resource****Office:**  |
|  | None selected | None selected |
| N2) Pension Management Center Case |  |  |
| N3) PLCP |  |

FOR EACH “NO” ANSWER RECORDED, PROVIDE A *BRIEF* NARRATIVE SUMMARY OF THE ERROR AND STATUTORY, REGULATORY, JUDICIAL OR MANUAL REFERENCES ON THE REVERSE OF ATTACHED NARRATIVE SUMMARY SHEET. NOTE: DATE OF CLAIM ERRORS DO NOT REQUIRE CITATIONS ON THE STAR CHECKLIST.

|  |  |
| --- | --- |
| **b. Instructions and Guidelines for Authorization Review** | These instructions and guidelines have been developed to promote consistency and uniformity in the review of cases selected for the STAR program. Use these instructions/guidelines in conjunction with the STAR Authorization Checklist.For the purpose of measuring technical accuracy under the STAR program, a case is considered either “accurate” or “in error.” A case will be considered “accurate” when all of the questions for each element indicated on the Benefit Entitlement Section of the STAR Authorization Checklist are answered “YES” or “N/A.” The elements are: A) Address All Issues, B) Proper Development or Procedural Issues, C) Income Issues, D) Dependency Issues, E) Burial Issues, F) Accrued Benefits Issues, G) Adjustments (Hospitalization, Incarceration, Active Duty, or Drill Pay), H) Payment & Effective Dates. A case will be considered “in error” if the answer to any question for any element is “NO.” For each case reviewed, a STAR Checklist must be completed and all questions answered. A “YES” response indicates that the activity associated with the question was completed accurately. A “NO” response indicates that the activity associated with the question was “in error.” Indicate “N/A” if the question is not applicable to the case under review or if a “NO” response was previously recorded for the only issue subject to review. A narrative summary is required with statutory, regulatory, judicial, or manual references for any “error” or “NO” answer recorded. ***Note***: Date of claim errors will no longer include citations on the STAR Checklist.The general guideline is that an error will be recorded when an action is taken that violates current regulations or established policies. Examples of outcome-related deficiencies include, but are not limited to, errors that result in an overpayment or underpayment to a claimant. Procedural deficiencies are not recorded as errors. These deficiencies are recorded as comments. However, if the procedural deficiency is severe in nature, it will be recorded as an error. A judgment or a difference of opinion reflecting a possible better practice or solution is recorded as a comment rather than an error. If an error is identified with an issue not related to the end product under review, that error is also recorded as a comment. |

|  |  |
| --- | --- |
| **c. Authorization Review Elements** | The following is a list of explanations of the elements of the STAR Authorization Quality Review Checklist. |

|  |  |
| --- | --- |
|  |  |
| BENEFIT ENTITLEMENT |  |
|  |  |
| ADDRESS ALL ISSUES | The reviewer must insure that all issues associated with the claim under review have been considered. |
|  |  |
| A1) Were all claimed issues addressed? | A “claimed issue” is any benefit specifically mentioned by the applicant or his/her representative. Since a claim may be received through any means of communication, each document in the hard copy file and/or electronic file must be checked to ensure that all issues have been addressed. |
| A2) Were all inferred issues addressed? | An “inferred issue” is not defined by regulation. An “inferred issue” is often derived from the consideration or outcome of a “claimed issue.” The Veterans Court has stated that “An issue may not be ignored or rejected merely because the Veteran did not expressly raise the appropriate legal provision for the benefit sought.” |
|  |  |
| PROPER DEVELOPMENT |  |
| B1) Was a development letter sent, addressing duty to notify (if applicable), and evidence requirements, for the claimed issues? | 38 CFR 3.159 states that upon receipt of a substantially complete application, VA is required to notify the claimant and the claimant's representative, if any, of any information, and any medical or lay evidence, not previously provided that is necessary to substantiate the claim. As part of that notice, VA is required to indicate which portion of that information and evidence, if any, is to be provided by the claimant and which portion, if any, VA will attempt to obtain on behalf of the claimant. |
| B2) Does the record show development, properly documented prior to final action on the claim (i.e., complete letters, VA Form 27-0820, Report of Contact, etc.)? | Have reasonable efforts been made to obtain the necessary evidence after the claim was established in order to complete the claim. |
| B3) Was the proper procedural process accomplished? | Procedural errors are considered errors with regard to manual direction but not specified by regulations and rising to the level of benefit entitlement error. |
|  |  |
| INCOME ISSUES |  |
| C1) Was Net Worth determination correct? | Net worth is a factor in determining eligibility for dependency of parents. |
| C2) Was total family income counted properly and/or in the correct reporting period?  | Income of family members can affect the monthly benefit rate. The number of family members can affect the maximum allowable income limit. Monthly income is determinative to establish dependency of parents. |
| C3) Were all deductions, including unreimbursed medical expenses, calculated correctly?  | Self-explanatory. |
|  |  |
| DEPENDENCY ISSUES | Establishment of qualifying dependents can affect the benefit rate payable. Two issues must be resolved: relationship and dependency. Dependency may be assumed or may require development. Dependency is secondary to the primary resolution of relationship. |
| D1) Was a dependent spouse correctly established or removed? (38 CFR 3.50) | 38 CFR 3.50 is the basic rule. Further definitions and development requirements are contained in 38 CFR 3.50 through 3.60 and 3.200 through 3.216. The scope of this and other dependency questions includes preparation of a justifiable Administrative Decision when required. |
| D2) Were dependent children correctly established or removed? (38 CFR 3.57 and 3.667) | The issues of date of birth, relationship, and, in some cases, custody must be properly resolved. Development for school attendance may be required. |
| D3) Were dependent parents correctly established or removed? (38 CFR 3.59) | 38 CFR 3.59 is the basic rule. Relationship and dependency must be properly established. |
| D4) Was a surviving spouse correctly established or removed? (38 CFR 3.50(b)) | 38 CFR 3.50(b) is the basic rule. |
| D5) Were surviving children correctly established or removed? (38 CFR 3.57) | 38 CFR 3.57 is the basic rule. |
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| E1) Was the proper claimant paid? | In addition to the obvious wording of this question, a “NO” response is warranted if the proper claimant was not identified or the proper claimant was erroneously denied payment. |
| E2) Were transportation charges applied correctly? | 38 CFR 3.1606 is the basic rule. |
| E3) Was the Burial/Plot/Headstone payment correct (or properly denied)? | The basic rules are contained in 38 CFR 3.1600 through 3.1612. |
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| ACCRUED BENEFITS ISSUES | The basic rules are contained in 38 CFR 3.1000 through 3.1009. Again, denials are equally applicable. |
| F1) Was the proper claimant paid? | Payment may be based on relationship or made as reimbursement. |
| F2) Was the correct amount paid? | Payment as reimbursement requires development of expense items. Payment based on relationship requires application of specific time limits. |
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| ADJUSTMENTS (HOSPITALIZATION, INCARCERATION, ACTIVE DUTY, OR DRILL PAY)  | The basic rules are contained in 38 CFR 3.551 through 3.559 for hospitalization, 3.665 and 3.666 for incarceration, and 3.654 for active duty and drill pay.  |
| G1) Were required adjustments accomplished and correct? | The benefit payable and type of VA care are critical for proper application of these rules; concurrent receipt of benefits is also a factor. The existence of dependents can affect the necessity for reduction or suspension in hospitalization cases. Periods of active duty may affect drill pay adjustments. |
| G2) Was restoration of benefits correct? | The type of benefit and medical discharge can affect restoration.  |
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| PAYMENTS & EFFECTIVE DATES | A clear error in this element results in an overpayment or underpayment of benefits. |
| H) Are all payment dates and rates correct? | Upon examination of the generated award the following basic rules are contained in 38 CFR 3.31, 3.114, 3.400-404, & 3.500-504. |
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| DUE PROCESS/ADMIN DECISIONS/NOTIFICATION |  |
| DUE PROCESS ISSUES | The basic rule concerning notice is contained in 38 CFR 3.103. Within that regulation, at 3.103(b)(2), are provisions for due process associated with adverse actions. Additional instructions for implementation are found in M21-1, Part I, Chapter 2. Strict adherence to these procedures is necessary both from the customer’s perspective and the Government’s. |
| I1) Was a predetermination notice sent? | This notice is based upon a proposed, rather than final, action. Contemporaneous notice is not included. |
| I2) Was the predetermination notice fully informative? | ***All*** of the elements specified in M21-1, I.2.B.2 must be included in this notice. |
| I3) Was the claimant given 60 days to respond before the due process period expired? | Control is maintained under end product 600. A 60-day waiting period is required unless the claimant agrees to the proposed action, states that all evidence has been provided, or the reduction is deemed unnecessary prior to expiration of due process. |
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| ADMINISTRATIVE DECISIONS |  |
| DENIALS |  |
| J1) Admin – Grant or Denial – Was all applicable evidence discussed? | Question J1 is self-explanatory. |
| J2) Admin – Grant or Denial – Was the basis of each decision explained? | Question J2 is self-explanatory. |
| J3) Were required formal admin decisions completed and correct (apportionment, deemed valid marriage, character of discharge, etc.)? | 38 CFR 3.450 through 3.461 contains the basic rules for apportionment decisions. The specific requirement for a formal apportionment decision, for both favorable and unfavorable decisions, is found in M21-1, III.v.3 and III.v.8.B.  |
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| NOTIFICATION | 38 CFR 3.103 contains the basic rule. Claimants and their representatives are entitled to timely notice of any decision made by VA. This rule applies to both awards and disallowances. |
| K1) Was notification sent and documented in the file? | Notification may be placed in claims folder or in the electronic record(s). The appeal period does not begin until the claimant and representative are notified of the decision. |
| K2) Was the notification correct? | Correspondence is VA’s primary communication medium. Information must be complete and accurate. |
| K3) Were appeal rights included? | Notice of procedural and appellate rights is required following every decision. |
| K4) Was Power of Attorney indicated, correct, and notification properly documented? | The Corporate record should be updated to include designation of the claimant’s representative so computer-generated notices are furnished to both.  |
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| ADMINISTRATIVE |  |
| APPROPRIATE SIGNATURE (INTERNAL CONTROL) | The appropriate signature has been added for internal control purposes only. It is a means of checks and balances to eliminate potential fraud situations.  |
| L1) Was the appropriate second signature documented? | This question typically relates to an administrative decision. |
| L2) Were three signatures appropriately documented when required? | This question typically relates to an administrative decision |
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| COMMENTS | Identified in this section are discrepancies that would have otherwise been considered errors had the end product in question been under review. Comments do not count as errors under the end product under review.  |
| M1a) Errors not associated with end product under review? | Use for errors that are not related to EP under review and do not fall under M1b-M1f. |
| M1b) Development Errors not associated with end product under review | Self-explanatory. |
| M1c) Decision Errors not associated with end product under review | Self-explanatory. |
| M1d) Payment Errors not associate with end product under review | Self-explanatory. |
| M1e) Comment for all other actions not associated with end product under review | Use for comments for both EPs under review and/or EPs not currently under review. |
| M1f) Notification Errors not associated with end product under review | Use for letter issues that are not part of the EP under review and corrective action is required. |
| M2) Notification Errors – end product under review |  |
| SPECIAL CASE IDENTIFICATION | In some instances, cases may be processed by a regional office that does not have jurisdiction of a case, such as brokered cases. Identifying a case under this section will give the proper office credit for the case under review. |
| N1) Brokered Case? | The regional office that processed the brokered case must be selected in this field. |
| N2) Pension Management Center Case? | The proper Pension Management Center must be identified in this field. |
| N3) PLCP | Select if the EP under review was paperless.  |