VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Newark, New Jersey

August 28, 2013
13-01625-273

ACRONYMS AND ABBREVIATIONS

HVOC	Homeless Veterans Outreach Coordinator
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of VA Regional Office Newark, NJ

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and 1 Veterans Service Center in Cheyenne, Wyoming, that process disability claims and provide a range of services to veterans. We evaluated the Newark VARO to see how well it accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 21 of 46 disability claims reviewed. We sampled claims that we considered at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing lacked consistent compliance with VBA procedures and is resulting in paying inaccurate and unnecessary financial benefits.

Specifically, 17 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate. Errors primarily occurred because VARO staff did not take actions to reduce these temporary evaluations as appropriate. Additionally, 4 of 16 traumatic brain injury claims were incorrectly processed because management did not ensure effective second-signature review of these claims.

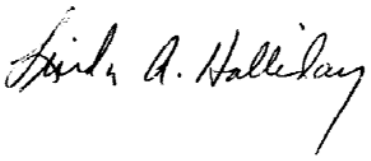
In general, VARO managers ensured Systematic Analyses of Operations were complete and timely and staff addressed Gulf War veterans' entitlement to mental health treatment as required. VARO staff did not provide adequate outreach to homeless veterans in the VARO's area of jurisdiction. Due to a lack of performance measures, we could not fully assess the effectiveness of the VARO's homeless veterans outreach efforts.

What We Recommend

The VARO Director should implement a plan to ensure staff follow up to reduce temporary 100 percent disability evaluations as appropriate. The Director should ensure staff review for accuracy the 149 temporary 100 percent disability evaluations we did not sample during our inspection. Management should develop and implement a plan to ensure second-signature review of traumatic brain injury claims. Further, management should ensure staff conduct outreach to homeless veterans in the VARO's area of jurisdiction as required.

Agency Comments

The Director concurred with our recommendations. Management's planned actions are responsive and we will follow up as required.



LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

TABLE OF CONTENTS

INTRODUCTION

Objective

The Benefits Inspection Program is part of the Office of Inspector General's (OIG) efforts to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Divisions contribute to improved management of benefits processing activities and veterans' services by conducting onsite inspections at VA Regional Offices (VAROs). These independent inspections provide recurring oversight focused on disability compensation claims processing and performance of Veterans Service Center (VSC) operations. The objectives of the inspections are to:

- Evaluate how well VAROs are accomplishing their mission of providing veterans with access to high-quality benefits and services.
- Determine whether management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; and minimize the risk of fraud, waste, and other abuses.
- Identify and report systemic trends in VARO operations.

In addition to this oversight, inspections may examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

Scope of Inspection

In March and April 2013, we inspected the Newark VARO and focused on the following four protocols—disability claims processing, management controls, eligibility determinations, and public contact. Within these protocols, we examined two high-risk claims processing areas of temporary 100 percent disability evaluations and traumatic brain injury (TBI) claims. In addition, we examined three other operational activities—Systematic Analyses of Operations (SAOs), Gulf War veterans' entitlement to mental health treatment, and the homeless veterans outreach program.

We reviewed 30 (17 percent) of 179 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months. This is generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to Veterans Benefits Administration (VBA) policy. We examined 16 of 20 TBI-related disability claims that VARO staff completed from October through December 2012. Three of the 20 claims files were unavailable for review due to the transition to automated claims processing. A fourth file had been lost.

Other Information

- Appendix A includes details on the VARO and the scope of our inspection.
- Appendix B outlines criteria we used to evaluate each operational activity and a summary of our inspection results.
- Appendix C provides the VARO Director's comments on this report.

RESULTS AND RECOMMENDATIONS

I. Disability Claims Processing

Claims Processing Accuracy

The OIG Benefits Inspection team focused on accuracy in processing temporary 100 percent disability evaluations and TBI claims. We evaluated these claims processing issues and assessed their impact on veterans' benefits.

Finding 1 Newark VARO Could Improve Disability Claims Processing Accuracy

The Newark VARO did not consistently process temporary 100 percent disability evaluations and TBI cases accurately. Overall, VARO staff incorrectly processed 21 of the total 46 disability claims we sampled. We identified 86 improper monthly payments to 11 veterans totaling $115,255 from January 2010 until April 2013.

We sampled claims related to specific conditions we considered at higher risk of processing errors. As a result, the errors identified do not represent the universe of disability claims processed at this VARO. As reported by VBA's Systematic Technical Accuracy Review (STAR) program as of February 2013, the overall accuracy of the VARO's compensation rating-related decisions was 84.1 percent—5.9 percentage points below VBA's FY 2013 target of 90 percent. The STAR program information was not reviewed during the scope of this inspection.

The following table reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Newark VARO.

Table 1

Newark VARO Disability Claims Processing Accuracy

Type of Claim	Number of Claims Reviewed	Claims Inaccurately Processed		
		Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits	Total Errors
Temporary 100 Percent Disability Evaluations	30	10	7	17
Traumatic Brain Injury Claims	16	1	3	4
Total	**46**	**11**	**10**	**21**

Source: VA OIG analysis of VBA's temporary 100 percent disability evaluations paid at least 18 months or longer and TBI disability claims completed in the first quarter FY 2013

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 17 of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a service-connected disability following a veteran's surgery or when specific treatment is needed. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

Without effective management of these temporary ratings, VBA is at risk of paying inaccurate financial benefits. Available medical evidence showed 10 of the 17 processing errors affected veterans' benefits and resulted in 84 improper monthly payments to 10 veterans totaling $106,297 from as early as January 2010 until April 2013. Details on the most significant overpayment and underpayment follow.

- A Rating Veterans Service Representative (RVSR) did not take final action to reduce benefits after notifying the veteran of the intent to do so. As a result, VA continued processing monthly benefits and ultimately overpaid the veteran a total of $24,333 over a period of 11 months.
- An RVSR did not establish a veteran's entitlement to special monthly compensation based on multiple disabilities and loss of use of a creative organ, as required. As a result, VA underpaid the veteran a total of $16,280 over a period of 3 years and 3 months.

The ten errors affecting benefits occurred when staff did not take final action to reduce benefits after notifying veterans of the intent to do so. VARO managers did not have oversight in place to ensure staff reduced compensation payments to veterans in a timely manner after advising them of the intent to do so. Management also did not ensure staff complied with a local policy requiring them to closely monitor and take appropriate follow-up actions on benefits reduction cases. Managers stated staff did not complete actions to reduce benefits because the VARO diverted efforts to support other national production goals. On average, 4 months elapsed from the time staff should have reduced benefits until April 2013. The delays ranged from 28 days to 1 year.

For the remaining seven errors, we concluded these errors have the potential to affect veterans' benefits. In most cases, we could not determine whether the evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to evaluate each case. Specifically:

- Four errors occurred when staff did not establish suspense diaries in the electronic record as required. A suspense diary is a processing command that establishes a date when VSC staff must schedule a medical reexamination. As a suspense diary matures, the electronic system

generates a reminder notification for VSC staff to schedule the medical reexamination. Because staff did not enter the suspense diaries in the electronic record, automated notifications to alert staff to schedule medical reexaminations did not generate. Reexaminations are needed to support decisions on whether to continue temporary 100 percent disability evaluations.

- One error occurred when an RVSR did not establish entitlement to special monthly compensation for a medical condition related to prostate cancer.
- One error occurred when an RVSR prematurely proposed reducing a veteran's benefits before the mandated treatment period had expired.
- One error occurred when staff did not schedule a required medical examination for a veteran's prostate cancer after receiving a reminder notification to do so.

Actions Taken in Response to Prior Audit Report

In response to a recommendation in our national report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, dated January 24, 2011), the then-Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each had a future examination date entered in the electronic record. Our report stated, "If VBA does not take timely corrective action, they will overpay veterans a projected $1.1 billion over the next 5 years." The then-Acting Under Secretary for Benefits stated in response to our audit report that the target completion date for the national review would be September 30, 2011.

However, VBA did not provide each VARO with a list of temporary 100 percent disability evaluations for review until September 2011. VBA subsequently extended the national review deadline to December 31, 2011, then to June 30, 2012, and then again to December 31, 2012. Based on the numerous delays and our continued findings, we are concerned about the lack of urgency in completing the national review, which is critical to minimize the financial risk of making inaccurate benefits payments.

During this 2013 inspection, we followed up on VBA's national review of its temporary 100 percent disability evaluation processing. We sampled 40 cases from the lists of cases needing corrective actions that VBA provided to the Newark VARO for review. We determined VARO staff accurately reported taking actions, such as inputting suspense diaries or scheduling reexaminations, on all 40 cases.

However, in comparing VBA's national review lists with our data on temporary 100 percent disability evaluations, we found seven cases involving prostate cancer or non-Hodgkin's lymphoma that VBA had not identified. We could not determine why VBA did not identify these cases; however, we will monitor this situation as VBA works to complete its

national review. This review is important because 17 of the 30 temporary evaluations we reviewed contained processing errors. We provided VARO officials with 149 claims remaining from our inspection universe to assist with its review of these temporary evaluations.

Follow-Up to Prior VA OIG Inspection

Our prior report, *Inspection of the VA Regional Office, Newark, NJ* (Report No. 10-03055-259, dated September 29, 2010), stated 24 of the total 30 temporary 100 percent disability evaluations we reviewed had processing errors. The most frequent processing error occurred when staff did not establish suspense diaries in the electronic record for confirmed and continued evaluations; thereby removing the possibility that staff would receive reminder notifications to schedule medical reexaminations. In response to our recommendations, the Director agreed to review the 129 temporary 100 percent disability evaluations remaining from our inspection universe. The Director also agreed to ensure staff enter suspense diaries in the electronic record by conducting random reviews of temporary 100 percent disability evaluations. The OIG closed this recommendation in November 2010.

During our April 2013 inspection, we did not identify any errors where staff did not enter suspense diaries in the electronic record for confirmed and continued temporary 100 percent disability evaluations. We concluded the corrective actions taken by VARO staff adequately addressed recommendations made in our 2010 inspection. As such, we made no further recommendation for improvement in this area.

TBI Claims

The Department of Defense and VBA commonly define a TBI as a traumatically induced structural injury or a physiological disruption of brain function caused by an external force. The major residual disabilities of TBI fall into three main categories—physical, cognitive, and behavioral. VBA policy requires staff to evaluate these residual disabilities.

In response to a recommendation in our annual report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-167, dated May 18, 2011), VBA agreed to develop and implement a strategy for ensuring the accuracy of TBI claims decisions. In June 2011, the Under Secretary for Benefits provided guidance to VARO Directors to implement a policy requiring a second signature on each TBI case an RVSR evaluates until the RVSR demonstrates 90 percent accuracy in TBI claims processing. The policy indicates second-signature reviewers come from the same pool of staff as those used to conduct local station quality reviews. In July 2012 as part of its organizational transformation, VARO management additionally assigned responsibility for TBI disability claims processing to the Special Operations team. In this model, experienced RVSRs are assigned to rate complex cases such as TBI claims.

VARO staff incorrectly processed 4 of 16 TBI claims completed from October through December 2012. One of the processing errors affected the veteran's benefits—the remaining three errors had the potential to affect benefits. Descriptions of the four cases with errors follow.

- An RVSR did not assign the correct level of special monthly compensation for a seriously disabled veteran with a traumatic brain injury. In this case, the level of special monthly compensation was not consistent with the type of aid and attendance needed by this veteran to assist with the activities of daily living. As such, the veteran was underpaid approximately $8,958 over a period of 2 months.
- An RVSR used an insufficient medical examination report to establish compensation benefits for migraine headaches associated with an in-service TBI. VBA policy requires VA examiners to use a specific template on the initial examination report to fully assess and identify all disabilities related to a TBI. In this case, the veteran did not receive the comprehensive examination, but instead received an examination to assess headaches. Without the medical evidence expected from a comprehensive examination, neither VARO staff nor we can ascertain all of the residual disabilities of a TBI.
- An RVSR did not establish compensation benefits for migraine headaches associated with a veteran's TBI despite medical evidence obtained from a VA examination that linked the migraines to the in-service TBI.
- An RVSR established compensation benefits for a TBI even though the medical examination reports did not provide a diagnosis to support granting the benefits.

Generally, errors in processing TBI claims occurred because VARO managers did not have oversight procedures in place to ensure staff complied with VBA's second-signature review policy or the local policy requiring TBI claims to be processed by the Special Operations team. Of the 16 TBI claims completed from October through December 2012, 15 did not undergo second-signature review. Additionally, the specialized team did not process 5 of the 16 TBI claims we reviewed. Had oversight measures been in place, second-signature reviewers may have realized staff misinterpreted VBA policy when processing three of the four TBI errors we identified and taken actions to correct the errors.

RVSRs we interviewed stated they were unaware of VBA's second-signature review requirements for TBI disability claims, but were aware of the local policy requiring the Special Operations team to process these claims. Some RVSRs stated they were unaware of the local policy directing the Special Operations team to process TBI claims. Other RVSRs were aware of the local policy, but simply chose not to forward the claims as required.

VARO managers stated, and we confirmed, that staff did receive information on VBA's second-signature review policy. Managers agreed oversight procedures were lacking to ensure TBI claims received second-signature review for accuracy and were processed by the Special Operations team. Because of errors in processing TBI claims, veterans may not have received accurate benefits.

Follow-Up to Prior VA OIG Inspection

Our previous report, *Inspection of the VA Regional Office, Newark, NJ* (Report No. 10-03055-259, dated September 29, 2010), stated 11 of the 30 TBI claims reviewed had processing TBI errors. The majority of the errors occurred because RVSRs did not interpret VBA policy correctly and failed to assign separate non-compensable evaluations for TBI-related disabilities. In response to our recommendation, the VARO Director agreed to ensure staff received refresher training on evaluating TBI disability claims. The OIG closed this recommendation in November 2010.

However, during our 2013 inspection, three of the four errors we identified also involved staff misinterpreting VBA policy when processing TBI claims. Because the errors identified in our 2010 and 2013 inspections were similar, we determined improvement in this area was still needed.

Recommendations

1. We recommend the Newark VA Regional Office Director develop and implement a plan to ensure claims processing staff take timely actions to finalize reductions in benefits.
2. We recommend the Newark VA Regional Office Director develop and implement a plan to review the 149 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.
3. We recommend the Newark VA Regional Office Director develop and implement a plan to ensure effective second-signature reviews of traumatic brain injury claims decisions.

Management Comments

The VARO Director generally concurred with our recommendations. The Director assigned responsibility for oversight and case management to improve timeliness in cases involving benefit reduction actions to VARO managers.

The Director agreed to review the 149 temporary 100 percent disability evaluations remaining from the OIGs inspection universe. However, the Director indicated the majority of the 149 cases on the OIG's list were duplicates of cases on the list of 926 provided by the Eastern Area Office in early 2013. The Director expects to have the remaining cases from the Eastern Area Office and the OIG reviewed by the end of calendar year 2013.

The VSC manager reminded all staff about second-signature requirements for TBI claims. Management will randomly sample five completed TBI claims on a monthly basis to ensure compliance with the second-signature policy.

OIG Response The Director's comments and actions are responsive to the recommendations.

II. Management Controls

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of SAOs. We also considered whether VSC staff used adequate data to support analyses and recommendations identified within each SAO. An SAO is a formal analysis of an organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish annual SAO schedules designating the staff required to complete the SAOs by specific dates. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 mandated SAOs annually.

Generally, VARO management ensured SAOs were submitted by the required due date, contained thorough analyses, used appropriate data, and made recommendations for improvements where appropriate. Of the 11 mandated SAOs, staff delayed submitting the Quality of Development Activity SAO by 86 days. Because management ensured most SAOs were submitted by the required due date, we made no recommendation for improvement in this area.

Follow-Up to VA OIG Inspection

Our previous report, *Inspection of the VA Regional Office, Newark, NJ* (Report No. 10-03055-259, dated September 29, 2010), stated five of the mandatory SAOs were submitted untimely, incomplete, or both. In response to our recommendations, the VARO Director agreed to implement measures to ensure SAOs were thoroughly completed and submitted by the required due dates. In September 2010, the OIG closed this recommendation.

Because we found no systemic problems with SAOs during our April 2013 inspection, we concluded the VARO's corrective actions in response to our 2010 recommendations had been adequate.

III. Eligibility Determinations

Entitlement to Medical Treatment for Mental Disorders

Gulf War veterans are eligible for medical treatment for any mental disorder they develop within 2 years of the date of separation from military service. According to VBA, whenever an RVSR denies a Gulf War veteran service connection for any mental disorder, the RVSR must consider whether the veteran is entitled to receive mental health treatment. However, the RVSR should address entitlement to mental health care in the decision when the entitlement can be granted.

In February 2011, VBA updated its Rating Board Automation 2000, a computer application designed to assist RVSRs in preparing disability ratings. The application provides a pop-up notification, known as a tip master, to remind staff to consider a Gulf War veterans' entitlement to mental health care treatment when denying service connection for a mental disorder. This pop-up notification does not generate if a previous decision did not address entitlement to mental health services and a mental condition is not part of the current claim.

VSC staff did not properly address whether 2 of 30 Gulf War veterans were entitled to receive treatment for mental disorders. In both cases, RVSRs did not address entitlement to treatment for mental disorders despite pop-up notifications reminding them to do so. In these cases, mental disorder diagnoses occurred within 2 years of discharge from military service.

Given that we found a low frequency of errors, we determined the VARO was generally compliant with VBA's policy for processing entitlement decisions for mental health care. As such, we made no recommendation for improvement in this area.

IV. Public Contact

Outreach to Homeless Veterans

In November 2009, VA developed a 5-year plan to end homelessness among veterans by assisting every eligible homeless veteran willing to accept services. VBA generally defines "homeless" as lacking a fixed, regular, and adequate nighttime residence.

Congress mandated that at least 1 full-time employee oversee and coordinate homeless veterans programs at each of the 20 VAROs that VA determined to have the largest veteran populations. VBA guidance, last updated in September 2002, directed that coordinators at the remaining VAROs be familiar with requirements for improving the effectiveness of VARO outreach to homeless veterans. These requirements include developing and regularly updating a resource directory of local homeless shelters and service providers. Additionally, the coordinators should attend regular meetings with homeless service providers, community government, and advocacy groups to provide information on VA benefits and services.

Finding 2 Oversight of Homeless Outreach Program Needs Improvement

The Newark VARO has a full-time Homeless Veterans Outreach Coordinator (HVOC). The VARO's HVOC did not regularly contact and provide information to homeless shelters and service providers within their jurisdiction, nor was the resource directory updated. This occurred because VARO management did not provide effective oversight or have mechanisms in place to assess outreach efforts. As a result, VARO management had no assurance that homeless shelters and service providers were aware of available VA benefits and services.

VARO management provided us a resource directory of homeless shelters and service providers located in New Jersey, excluding the seven counties under the Philadelphia VARO's jurisdiction. Staff stated, and we confirmed, that the directory provided was outdated and not used to perform homeless veterans outreach.

We confirmed the HVOC maintained a collaborative partnership with homeless coordinators at the VA Medical Center; however, contact with homeless shelters and service providers was limited to selected facilities. Further, VARO managers were unaware that staff had not contacted the majority of the homeless shelters and service providers within the VARO's jurisdiction and had not updated their homeless resource directory as required. Although the HVOC provided supervisors monthly handwritten calendars of outreach activities, the calendars lacked details, such as the names, locations, or contact numbers of the facilities visited.

Had managers provided adequate oversight of the VARO's outreach efforts, they may have determined that homeless shelters and service providers

within the VARO's jurisdiction were not being contacted or receiving information on VA benefits and services available to homeless veterans. Additionally, VBA needs performance measures for its Homeless Veterans Outreach Program. Without such measures, we cannot fully assess the effectiveness of the VARO's outreach activities.

Recommendation

4. We recommend the Newark VA Regional Office Director develop and implement a plan to ensure staff update the resource directory and regularly contact and provide outreach to homeless shelters and service providers within the VA Regional Office's jurisdiction.

Management Comments

The VARO Director concurred with our recommendations. The Director requires managers to meet quarterly to assess the VARO's outreach efforts. In May 2013, staff updated the resource directory and initiated contact with 26 of the 95 homeless shelters under the VARO's jurisdiction. In July 2013, VARO staff initiated an annual mailing of informational materials to homeless shelters to assist in outreach to homeless veterans.

OIG Response

The Director's comments and actions are responsive to the recommendations.

Appendix A VARO Profile, Scope, and Methodology of Inspection

Organization

The Newark VARO administers a variety of services and benefits, including compensation and pension benefits; vocational rehabilitation and employment assistance; specially adapted housing grants; benefits counseling; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of March 2013, the Newark VARO reported a staffing level of 107 full-time employees. Of this total, the VSC had 82 employees assigned.

Workload

As of February 2013, the VARO reported 4,005 pending compensation claims. The average time to complete claims was 252.2 days—2.2 days more than the national target of 250.

Scope

VBA has 56 VAROs and 1 VSC in Cheyenne, Wyoming, that process disability claims and provide a range of services to veterans. We evaluated the Newark VARO to see how well it accomplishes this mission.

We reviewed selected management, claims processing, and administrative activities to evaluate compliance with VBA policies regarding benefits delivery and nonmedical services provided to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders.

Our review included 30 (17 percent) of 179 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of February 11, 2013. We provided VARO management with 149 claims remaining from our universe of 179 for its review. As follow-up to our prior inspection, we also sampled 40 temporary 100 percent disability evaluations from the SharePoint lists VBA provided to the VARO as part of its national review. We also reviewed 16 of the total 20 TBI disability claims folders that VARO staff completed from October through December 2012. Four of the total 20 TBI claims were unavailable for review.

Where we identify potential procedural inaccuracies, we provide this information to help the VARO understand the procedural improvements it can make for enhanced stewardship of financial benefits. We do not provide this information to require the VARO to adjust specific veterans' benefits. Processing any adjustments per this review is clearly a VBA program management decision.

We assessed the 11 mandatory SAOs the VARO completed in FY 2012 and FY 2013. We examined 30 completed claims processed for Gulf War veterans from October through December 2012 to determine whether VSC

staff had addressed entitlement to mental health treatment in the rating decision documents as required. Further, we assessed the effectiveness of the VARO's Homeless Veterans Outreach Program by reviewing its directory of homeless shelters and service providers and determining whether staff regularly attended meetings and provided information on VA benefits and services.

Data Reliability

We used computer-processed data from the Veterans Service Network's Operations Reports and Awards. To test for reliability, we reviewed the data to determine whether any data were missing from key fields, included any calculation errors, or were outside the time frame requested. We also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, VARO numbers, dates of claim, and decision dates as provided in the data received with information contained in the claims folders we reviewed.

Our testing of the data disclosed that they were sufficiently reliable to meet our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders reviewed in conjunction with our VARO inspection did not disclose any problems with data reliability.

This report references VBA's STAR data which places the overall accuracy of the VARO's compensation rating-related decisions at 84.1 percent, 5.9 percentage points below VBA's FY 2013 target of 90 percent. We did not test the reliability of this data.

Inspection Standards

We conducted this inspection in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.* We planned and performed the inspection to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our inspection objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our inspection objectives.

Appendix B Inspection Summary

Table 2 reflects the operational activities inspected, applicable criteria, and whether or not we had reasonable assurance of VARO compliance.

Table 2. Newark VARO Inspection Summary

Five Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Disability Claims Processing			
1. Temporary 100 Percent Disability Evaluations	**Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations.** (38 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) M21-1 MR Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for all disabilities related to in-service TBI.** (FL 08-34 and 08-36) (Training Letter 09-01)		X
Management Controls			
3. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)	X	
Eligibility Determinations			
4. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War veterans' claims, considering entitlement to medical treatment for mental illness.** (38 USC 1702) (M21-1MR Part IX, Subpart ii, Chapter 2) (M21-1MR Part III, Subpart v, Chapter 7) (FL 08-15) (38 CFR 3.384) (38 CFR 3.2)	X	
Public Contact			
5. Homeless Veterans Outreach Program	**Determine whether VARO staff provided effective outreach services.** (Public Law 107-95) (VBA Letter 20-02-34) (VBA Circular 27-91-4) (FL 10-11) (M21-1, Part VII, Chapter 6) (M27-1, Part II, Chapter 2)		X

Source: VA OIG
CFR=Code of Federal Regulations, FL=Fast Letter, M=Manual, MR=Manual Rewrite

Appendix C VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: August 2, 2013

From: Director, VA Regional Office Newark, New Jersey

Subj: Inspection of the VA Regional Office, Newark, New Jersey

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

1. The Newark VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Newark, NJ.*

2. Please refer questions to Director Michael Blazis at (973) 297-3348.

(original signed by:)

MICHAEL BLAZIS
Director

Attachment

IG Inspection Response

While we generally concur with the findings and recommendations in the report, there is an area that we feel needs to be clarified.

On page 2 of the report it is noted, "The Newark VARO did not consistently process temporary 100 percent disability evaluations and TBI cases accurately". It should be accentuated that the majority of the errors called were attributed to processing *timeliness* and not processing errors. All but two of the cases reviewed by the OIG were already in various stages of the review process.

In the course of the OIG team's visit, the Newark Regional Office was in the process of reviewing a list of 926 100% disability claims. The list was provided in late January 2013 by Eastern Area. Due to the size of the list and current staffing levels, the review and necessary adjustments were not completed at the time of the OIG review. We expect that the entire list will be reviewed and all necessary action(s) taken prior to the end of the 2013 calendar year.

Recommendation 1: We recommend the Newark VA Regional Office Director develop and implement a plan to ensure claims processing staff take timely actions to finalize reductions in benefits.

RO Newark Response: Concur

The Newark Regional Office recognizes the need to improve the timeliness of claims involving potential benefit reductions. To that end, all 600 end products (EPs) will be case managed by the Non-Rating Coach along with oversight by the Assistant Veterans Service Center Manager (AVSCM) and Veterans Service Center Manager (VSCM). The Coach will provide bi-weekly status updates and attend meetings with the VSCM and AVSCM concerning claims requiring reductions.

Recommendation 2: We recommend the Newark VA Regional Office Director develop and implement a plan to review the 149 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

RO Newark Response: Concur

As noted above, the Newark Regional Office has been engaged in the review of 926 100% disability claims since the beginning of the 2013 calendar year. The overwhelming majority of the claims identified on the IG list of 149 temporary 100% disability evaluations were on the list of 926. The Core Two Coach, (with oversight from the AVSCM) has been assigned the task of finalizing the review of the 926 cases, as well as any of the 149 that were not already on the list, by the end of the 2013 calendar year. Status updated will be provided to the VSCM monthly.

Recommendation 3: We recommend the Newark VA Regional Office Director develop and implement a plan to ensure effective second-signature reviews of traumatic brain injury claims decisions.

RO Newark Response: Concur

The Veterans Service Center Manager reiterated the existing second signature policy to all Veterans Service Center (VSC) employees. Furthermore, management will conduct a random sample of five completed TBI claims each month to ensure that the existing second signature policy is being observed.

Recommendation 4: We recommend the Newark VA Regional Office Director develop and implement a plan to ensure staff update the resource directory and regularly contact and provide outreach to homeless shelters and service providers within the VA Regional Office's jurisdiction.

RO Newark Response: Concur

The Public Contact Coach and Veterans Service Representative (individual performing the duties of the Homeless Veterans Outreach Coordinator) updated the resource directory of homeless shelters on May 7, 2013. Furthermore, contact was made with 26 of the 95 homeless shelters under the Newark RO's jurisdiction. The remaining shelters will be visited within the next 6 months. In conjunction with our in-person visits to the shelters, a contact/information letter was composed and will be mailed, at least once a year, to all the shelters under the Newark RO's jurisdiction. The initial mass mailing was completed in July 2013. The AVSCM and VSCM will meet with the Public Contact Coach quarterly to monitor our outreach efforts.

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Nora Stokes, Director Danny Clay Kelly Crawford Lee Giesbrecht Ambreen Husain Kerri Leggiero-Yglesias Suzanne Murray Lisa Van Haeren Nelvy Viguera Butler Mark Ward

Appendix E Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
Office of General Counsel
Veterans Benefits Administration Eastern Area Director
VA Regional Office Newark Director

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Jeffrey Chiesa, Robert Menendez
U.S. House of Representatives: Robert E. Andrews, Rodney Frelinghuysen, Scott Garrett, Rush Holt, Leonard Lance, Frank LoBiondo, Frank Pallone Jr., Bill Pascrell Jr., Donald M. Payne, Jon Runyan, Albio Sires, Chris Smith

This report is available on our Web site at **www.va.gov/oig**.