DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Insufficient Oversight for Issuing Prosthetic Supplies and Devices

AUDIT | REPORT #18-00972-38 | FEBRUARY 11, 2021

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Executive Summary

The VA Office of Inspector General (OIG) conducted this audit to assess the Veterans Health Administration's (VHA) oversight of the issuance of prosthetic supplies and devices to veterans. Prosthetics include any device that supports or replaces a body part or function, such as artificial limbs, wheelchairs, and pacemakers. They also include sensory aids, such as hearing aids, optical prescriptions, low vision and mobility aids, and speech and communication aids. To prescribe and request prosthetic supplies and devices for veterans, clinicians create and use orders known as Prosthetic and Sensory Aids Service (PSAS) consults.

The audit focused on three aspects of issuing supplies and devices:

- **Cloning closed consults.** If a veteran needs a replacement device within a certain period, the clinician does not need to prescribe it again. Instead, PSAS staff copy the original request, a process known as cloning, and issue the replacement.[1] The clone function is also used to correct errors, process recurring supply transactions, rentals, and device repairs.
- **Issuing duplicate supplies and devices to the same veteran.** Prosthetics may be issued more than once to the same veteran (e.g., shoes may be issued repeatedly because they incur regular wear and tear).
- **Issuing supplies following the death of a veteran.** Although the veteran no longer needs supplies, some supply transactions related to the veteran's care need to be recorded. For example, PSAS may process a transaction to retrieve equipment from a deceased veteran's home or pay outstanding invoices for items received while the veteran was alive.

According to a VA fact sheet, the VA PSAS is the world's largest provider of prosthetic devices and sensory aids.[2] PSAS also administers benefits related to clothing allowances, automobile adaptive equipment, and home improvement and structural alterations. The cost of PSAS services increased almost 18 percent from over $2.9 billion in fiscal year (FY) 2016 to nearly $3.5 billion in FY 2019.

[1] This is a process in which PSAS duplicates an entry in the Veterans Health Information Systems and Technology Architecture (VistA) PSAS suspense menu. This menu provides a method for any prosthetic service request or item request to be ordered electronically.

[2] VA Fact Sheet, "What to Expect from Your VA Prosthetic and Sensory Aids Service," January 2015.

What the Audit Found

The OIG found VHA has oversight weaknesses that led to PSAS staff improperly cloning consults. Consequently, VHA improperly issued an estimated $15.8 million in prosthetic supplies during (calendar year) 2017. In contrast, the audit team determined that VHA maintained adequate oversight to prevent duplicate supply issuance. Additionally, the OIG found that while 6 percent of transactions for supplies to deceased veterans were improper, the team did not identify evidence of fraud.

PSAS Oversight Weaknesses Led to Improperly Cloned Consults

PSAS issued prosthetic supplies to an estimated 8,400 veterans by improperly cloning consults during 2017. Based on its review of sampled cloned consults, the audit team estimated that 78,800 transactions were completed improperly nationwide, valued at an estimated $15.8 million.[3]

The OIG found cloning was improper because consults

- had been closed improperly,
- had gone at least 365 days without clinical review and approval, or
- were for nonprescribed supplies.

PSAS's business practice guidelines require purchasing employees to put consults in a pending status until consults can be properly closed.[4] However, the OIG found that the employees improperly closed consults instead and later cloned the consults to issue supplies through an estimated 47,800 transactions (61 percent). Four of 22 employees responsible for purchasing that the team interviewed stated they closed consults earlier than directed by the guidelines to comply with timeliness standards that give the appearance of a fulfilled consult.[5] Because PSAS improperly closed consults, VHA had less assurance about the number of days taken to fulfill a consult, and the open and pending consults could be understated, while the number of fulfilled

[3] The audit team's review for cloned consults consisted of 86 samples. Through its review, the audit team defined a sample as a set of bundled transactions for one veteran's cloned consult for one supply item. Therefore, a transaction represents an action taken on one veteran's cloned consult for a supply item. The estimated amount of over $15.8 million in improper transactions during 2017 included an estimated $6.1 million in prosthetic supplies through cloned consults that were more than 365 days old, and an estimated $9.8 million in improperly issued accessory and consumable supplies.

[4] PSAS, *Business Practice Guidelines for PSAS Consult Management*, May 2017; PSAS, *Business Practice Guidelines for Prosthetics Consult Management*, April 2010.

[5] Consults in pending status must be reviewed at least weekly by the PSAS chief, or designee, and the prosthetic employee responsible for completing the consult. Each time a pending consult is reviewed, PSAS staff document the action by placing a note on the consult including the action taken, the person contacted, and the date.

consults could be overstated. In addition, improperly closing consults could cause PSAS to lose sight of veterans' needs and allow the consult to go unfulfilled.

The audit team also identified an estimated 11,900 transactions (15 percent) in which the consults were cloned after the 365-day limit without the necessary clinical review and approval. When a consult is over 365 days old, clinicians are to determine whether the veteran needs to be reevaluated before reissuance, according to PSAS's business practice guidelines. The cloned consults that exceeded the 365-day threshold ranged from 1,845 to almost 4,800 days after the initial consult date. This resulted in VHA improperly issuing an estimated $6.1 million in prosthetic supplies through cloned consults that were more than 365 days old during 2017.

Additionally, PSAS improperly issued accessory and consumable supplies (e.g., air purifier filters and shoe inserts) not prescribed in the consult. This resulted in VHA improperly issuing an estimated $9.8 million worth of supplies through an estimated 19,100 transactions nationwide.

The practices of incorrectly closing prosthetic consults, cloning beyond 365 days after creation without clinical review and approval, and cloning to issue nonprescribed items went undetected because field or facility reviews of cloned consults were not conducted. A PSAS metrics storyboard allows leaders at PSAS facilities and VHA regional networks to monitor the activity of facilities' prosthetic staff, and the PSAS business practice guidelines necessitate a weekly review of cloned consults. However, despite the availability of this oversight tool, the audit team found no evidence that PSAS personnel reviewed cloned or pending consults at facilities. Without effective action to address the problem, the risk of improper issuance would total an estimated $79.2 million over a five-year period.

The audit team also assessed whether weaknesses identified in 2017 data were ongoing in FY 2019. The team reviewed a random sample of eight cloned consult transactions totaling about $13,252. Of the eight transactions, five (63 percent) had issues similar to those present in 2017.

PSAS Maintained Effective Oversight of Duplicate Supply Issuance

To check for duplicate supplies, the audit team reviewed a random sample of 385 transactions valued at about $136,700 for 2017. Of the 385, 379 were proper (98 percent), while only six (2 percent) valued at about $200 were improper. The OIG considered this an acceptable error rate.

Prosthetic Transactions Involving Deceased Veterans Were Generally Appropriate

The audit team reviewed 586 transactions associated with 365 deceased veterans for 2017. The review determined that 94 percent of the prosthetic transactions were proper. The remaining 6 percent were improper. The OIG did not find evidence of fraud with respect to these errors. Rather, the OIG believes they occurred because the Master Veteran Index record system had not

been updated with the veterans' dates of death. VHA previously relied on staff to establish dates of death but began populating the Master Veteran Index using Social Security Administration dates of death in November 2017, which was close to the end of the period reviewed.

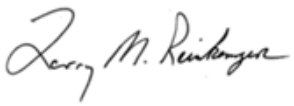
The Master Veteran Index is VA's authoritative source for veterans' personally identifiable information. It is managed by VHA's Data Quality Health Care Identity Management Program. The index links a patient's record to national databases for multiple VA healthcare facilities and other VA systems that support health care. In December 2019, the audit team reviewed FY 2019 data to determine if the weaknesses identified in 2017 data were ongoing. The OIG selected a sample of 10 deceased veterans' transactions totaling about $42,500 and determined that all 10 were proper.

What the OIG Recommended

The OIG made four recommendations to improve oversight of the clone consult function. Specifically, the OIG recommended the under secretary for health ensure PSAS business practice guidelines include requirements for conducting and properly documenting reviews of cloned and pending consults, staff develop a process to verify that consults include accessory and consumable supplies for prosthetic items before issuance, establishes field consistency requirements for conducting program reviews and evaluations, and complies with existing policy for reviewing program assessments and evaluations and communicates the results to regional prosthetic representatives.[6]

Management Comments

The executive in charge, Office of the Under Secretary for Health, concurred with the recommendations and provided corrective action plans that are responsive to the intent of the recommendations. Appendix E includes the full text of the executive in charge's comments. The OIG will monitor the implementation of planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.



LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

[6] Recommendations directed to the under secretary for health were submitted to the executive in charge, who had the authority to perform the under secretary's functions and duties. Effective January 20, 2021, he was appointed to acting under secretary for health with the continued authority to perform the functions and duties of the under secretary.

Contents

Abbreviations

CPRS	Computerized Patient Record System
FY	fiscal year
MVI	Master Veteran Index
NPPD	National Prosthetic Patient Database
OIG	Office of Inspector General
PSAS	Prosthetic and Sensory Aids Service
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture

Introduction

According to a VA fact sheet, the VA Prosthetic and Sensory Aids Service (PSAS) is the world's largest and most comprehensive provider of prosthetic devices and sensory aids.[7] Prosthetic devices include not only artificial limbs, but any device that supports or replaces a body part or function, such as wheelchairs and pacemakers. Sensory aids include items such as hearing aids, optical prescriptions, low vision and mobility aids, and speech and communication aids. PSAS also administers certain benefits to veterans such as clothing allowances, automobile adaptive equipment, and home improvement and structural alterations.

In recent years, the cost of PSAS services has increased significantly, from over $2.9 billion in fiscal year (FY) 2016 to nearly $3.5 billion in FY 2019—a rise of almost 18 percent. The VA Office of Inspector General (OIG) conducted this audit to assess the Veterans Health Administration's (VHA) oversight of the issuance of prosthetic supplies and devices to veterans.

Prosthetic and Sensory Aids Service and Its Process for Issuing Supplies

PSAS is a national program that falls under VA's Rehabilitation and Prosthetic Services. It is responsible for administering policies and programs concerning medical rehabilitation, prosthetic, and sensory aid services. (Appendix A details the policies.) These services promote health, independence, and quality of life for veterans with disabilities. PSAS brings together clinical expertise, clinical and practice guidance, and specialized procurement resources to provide comprehensive rehabilitation, prosthetic, and orthotic services across the VHA healthcare facility system.

The issuance process begins with a consult. A consult is a request for clinical services created by a physician or other healthcare provider on behalf of a patient, seeking opinion, advice, or expertise regarding evaluation or management of a specific patient problem. In the case of prosthetic devices, VA clinicians create and use PSAS consults to prescribe and request prosthetic supplies for veterans. The consult must have a detailed description of the device or service required and an appropriate clinical justification for the request, at a minimum, to facilitate the issuance or procurement of the device or service.[8] Once PSAS receives a consult, the ideal course of action is to completely resolve and close it without ever having to put it in pending status.

[7] VA Fact Sheet, "What to Expect from Your VA Prosthetic and Sensory Aids Service," January 2015.
[8] PSAS, Business Practice Guidelines for PSAS Consult Management, May 2017.

A prosthetic consult is closed when one of the following has occurred:

- A purchase order has been created in the veteran's name for a PSAS item to be shipped to VA for the veteran to pick up or shipped to the veteran's home.
- A stock issue has been posted for a veteran for the required item(s)—meaning the item was issued from stock and assigned to the veteran's record—and the item has been picked up by the veteran or shipped to the veteran's home.
- An appointment has been made for a clinic.
- No further action can be taken, and the consult has been coded as "non-response."[9]

PSAS staff said closed prosthetic consults sometimes need to be reopened to correct errors, purchase and issue replacement supplies, or process recurring supply transactions, rentals, and device repairs. When this need arises, PSAS staff use a process called cloning. Cloning simply means copying the original request.[10] During the review period, cloning was permitted for up to one year from the date of the initial consult without clinical verification that the consult still applies. Cloning is allowed for the replacement of common or routine prosthetic items and for minor or routine repairs.

However, new guidance issued in January 2018 permits cloning for up to three years to replace recurring supplies or accessories without verification.[11] If a veteran or clinician submits a request for repair or replacement of a prosthetic supply within the permissible cloning time frame, PSAS staff clone the original consult and process the order. For example, supplies such as diabetic socks, which are prone to wear and tear and need replacement within a year, would not require a new consult. In this example, PSAS staff may clone the consult to issue the replacement socks. If, however, three years have passed, PSAS staff must first notify the PSAS chief, who must contact the clinician to verify that the veteran needs to be seen.[12]

Prosthetic supplies and devices that are issued to veterans are automatically recorded on the Record of Prosthetic Services, a VA form that is part of the Veterans Health Information

[9] PSAS, *Business Practice Guidelines for PSAS Consult Management*. Non-response codes allow PSAS staff to link and close a consult that would typically not be connected with the creation of a purchase order or a stock issue for a device or service. For example, the codes are used when an item is no longer needed, a duplicate PSAS request was made, the veteran died, or an item is not a PSAS item, among other reasons.

[10] This is a process in which PSAS duplicates an entry in the Veterans Health Information Systems and Technology Architecture (VistA) PSAS Suspense package.

[11] PSAS, *Business Practice Guidelines for Cloned Consults*, January 2018.

[12] PSAS*, Business Practice Guidelines for PSAS Consult Management; Business Practice Guidelines for Prosthetics Consult Management,* April 2010.

Systems and Technology Architecture (VistA), when purchases are obligated or items are issued from stock.[13] Any returned prosthetic items can be listed on the form.[14]

If the item was ordered or issued from VA's stock, PSAS staff must also link the prosthetic item to the consult in VistA.[15] Linking an item to a consult in VistA indicates the item was provided to the veteran and provides valuable data for VA about the various disabilities PSAS serves. Failure to link a supply or device to the veteran's record can increase the risk of unfulfilled consults, duplicate issuance of supplies, or misrepresentation of the funds spent nationally under the PSAS program. Figure 1 illustrates the PSAS prosthetic supply issuance cycle.

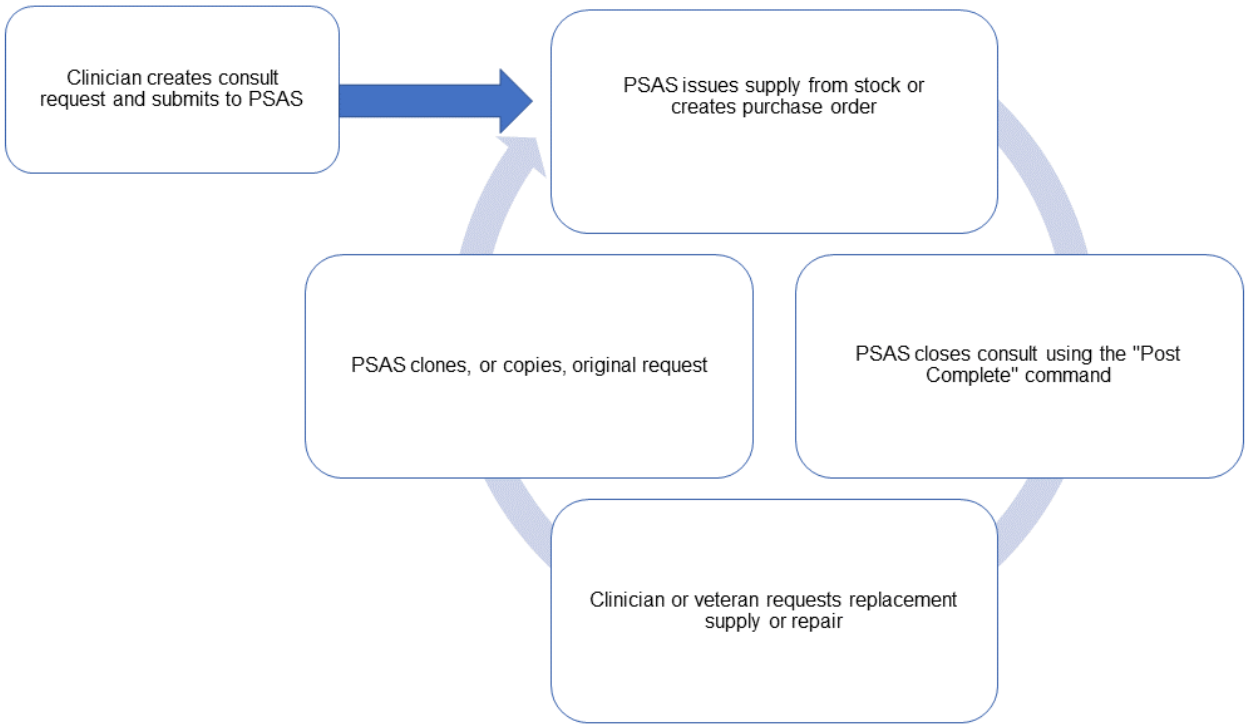


Figure 1. *Supply issuance cycle.*

Source: VA OIG analysis of PSAS business practice guidelines and VistA Guides.

Note: PSAS staff duplicates a record in the PSAS suspense menu of VistA.

If PSAS staff need to link and close a consult that would typically not be connected with creation of a purchase order or a stock issuance, they can use a non-response code.[16] For instance, if a

[13] VA Form 10-2319, "Record of Prosthetic Services"; *VistA Prosthetics Technical Manual*, October 2014.

[14] VA Form 10-2319.

[15] PSAS, *Business Practice Guidelines for PSAS Consult Management;* PSAS, *Business Practice Guidelines for Prosthetics Consult Management*.

[16] PSAS, *Business Practice Guidelines for Prosthetics Consult Management*. Non-response codes were called non-item codes in PSAS.

clinician created a duplicate consult and PSAS closed the original consult, PSAS should close the duplicate consult with a non-response code indicating "item ordered and linked to another consult."[17]

If a veteran is deceased and VA records accurately reflect that status, PSAS staff receive an alert that must be acknowledged upon accessing the veteran's record. PSAS staff may need to reconcile items in the deceased veteran's record that were issued before death. However, if staff determine no action is needed, PSAS should close any open or pending consults for the deceased veteran using the appropriate non-response code that indicates the veteran is deceased. Figure 2 shows the management process for deceased veteran consults.

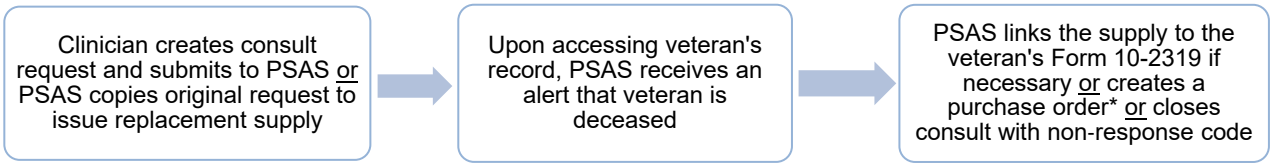


Figure 2. *Process for managing deceased veteran consults.*

Source: VA OIG analysis of PSAS business practice guidelines and VistA guides.

**This may be needed to reconcile items issued before death.*

Master Veteran Index

The Master Veteran Index (MVI) is the authoritative source within VA to maintain veterans' personally identifiable information.[18] The MVI contributes directly to the VistA and the Computerized Patient Record System (CPRS) deceased veteran alerts. It links a patient's record to multiple VA healthcare facilities' national databases and other VA systems that support health care. VHA began populating MVI with Social Security Administration death data in November 2017.[19]

After a veteran's date of death is entered into the MVI, both VistA and the CPRS display a deceased patient alert when users open a veteran's record. The alert displays the veteran's date of

[17] PSAS, *Business Practice Guidelines for PSAS Consult Management; Business Practice Guidelines for Prosthetics Consult Management*.

[18] VHA Directive 1906, *Data Quality Requirements for Health Care Identity Management and Master Veteran Index Functions,* April 29, 2013. The term "personally identifiable information," as defined in 2 C.F.R. § 200.79, refers to information that can be used to distinguish or trace an individual's identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual.

[19] The VHA Data Quality Health Care Identity Management Program is the business owner and data steward of personally identifiable data in the MVI.

death and prompts users with "yes" or "no" options to proceed with the transaction and continue accessing the veterans' records, as depicted in figure 3.

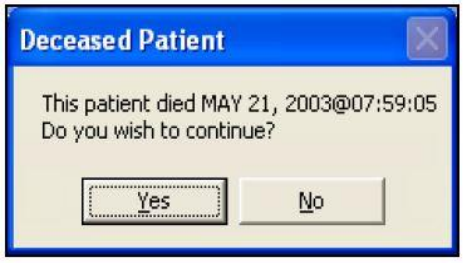


Figure 3. *Deceased patient alert.*

Source: Compensation and Pension Record Interchange User Manual.

PSAS relies on the alerts to determine if a veteran is deceased. If the alert does not display, it means there is no date of death in the MVI. Without a deceased patient alert, PSAS staff assume the veteran is alive and continue to order and issue supplies.

Results and Recommendations

Finding 1: PSAS Oversight Weaknesses Led to Improperly Cloned Consults

From January 1 through December 31, 2017, PSAS issued prosthetic supplies to an estimated 8,400 veterans by improperly cloning consults. This resulted in an estimated 78,800 transactions, valued at an estimated $15.8 million, completed improperly nationwide.[20] In December 2019, the audit team performed a limited review of fiscal year (FY) 2019 data and found ongoing weaknesses similar to those from 2017.

For an estimated 47,800 transactions (61 percent), PSAS purchasing employees closed consults before the date indicated by the PSAS business practice guidelines and then used the cloning feature to issue supplies to veterans. Instead, they should have placed the consults in a pending status in accordance with the guidelines.[21] Some PSAS purchasing employees told the audit team that they were told to close consults within five days to comply with verbal timeliness guidance from PSAS chiefs, which would give the appearance of a fulfilled consult. For an estimated 11,900 transactions (15 percent), consults were cloned after the 365-day limit without clinical review and approval. This occurred because the required cloned consult reviews were not being conducted. According to the guidelines, when a consult is over 365 days old, clinicians are to determine whether the veteran needs to be reevaluated before reissuing items.[22] PSAS staff also improperly issued accessory and consumable supplies not explicitly prescribed by the consult, such as air purifier filters and shoe inserts, through cloned consults for an estimated 19,100 transactions nationwide valued at an estimated $9.8 million.

Closing consults earlier than directed by the guidelines places veterans at risk of not receiving needed care in a timely manner. In addition, improperly issuing supplies against closed consults that should have remained in pending status resulted in inflated reporting of the timeliness of veterans' access to care through the PSAS program.

[20] The audit team's review for cloned consults consisted of 86 samples. Through its review, the audit team defined a sample as a set of bundled transactions for one veteran's cloned consult for one supply item. Therefore, a transaction represents an action taken on one veteran's cloned consult for a supply item. This means that a veteran could have many transactions.

[21] PSAS, *Business Practice Guidelines for PSAS Consult Management.* Consults are placed in pending status when more information is needed on the consult or a vendor, and while waiting for veterans or clinics to take action, such as picking up a stock item. Consults in pending status must be reviewed at least weekly by the PSAS chief, or designee, and the PSAS employee responsible for the consult. Each time a pending consult is reviewed, the reviewer is required to document the review or follow-up action that occurred in the form of a comment on the consult.

[22] PSAS, *Business Practice Guidelines for PSAS Consult Management; Business Practice Guidelines for Prosthetics Consult Management*.

What the OIG Did

The audit team used (calendar year) 2017 National Prosthetic Patient Database (NPPD) data to identify and review transactions processed as either cloned consults or duplicate issued supplies. The team reviewed a sample of 168 cloned consult transactions valued at about $96,000, which were selected from a population of 203,036 cloned consult transactions nationwide valued at an estimated $103.6 million. The audit team also reviewed a sample of 385 duplicate transactions valued at about $136,700, which were selected from a population of 351,456 duplicate transactions nationwide valued at about $376.6 million.

To assess whether the conditions identified during the original scope of review persisted in FY 2019, the audit team also reviewed a sample of eight cloned consult transactions valued at $13,252 from a total population of 197,172 cloned consult transactions valued at about $64.8 million.

Appendix B provides additional details on the audit's scope and methodology; appendix C details the statistical sampling methodology.

PSAS Cloned Improperly Closed Consults

The OIG found that for an estimated 47,800 transactions (61 percent), PSAS purchasing employees closed consults and later cloned them to issue supplies to veterans, instead of placing the consults in pending status in accordance with the guidelines.[23] While it is accepted practice to close consults and subsequently clone them, these cloned transactions were improper because the initial consults were closed earlier than directed by the business practice guidelines.

According to the *Business Practice Guidelines for Consult Management*, a PSAS member may clone a closed consult when one of the following has occurred:

- A purchase order has been created in a veteran's name for the item to be shipped.
- A purchase order has been created in a veteran's name for a PSAS item to be shipped to VA for veteran pickup or shipped to the veteran's home.
- VA's on-hand inventory has been posted for a veteran for the required item(s), and the item has been picked up by the veteran or shipped to the veteran's home.
- An appointment has been made for a clinic.
- No further action can be taken, and the consult is coded as "non-response."[24]

[23] PSAS, *Business Practice Guidelines for PSAS Consult Management; Business Practice Guidelines for Prosthetics Consult Management*.

[24] PSAS, *Business Practice Guidelines for PSAS Consult Management.* Staff might close a consult with a non-response code when a veteran could not keep an appointment, the item requested is not a PSAS item, the veteran is deceased, etc.

If a consult does not meet the guidelines, PSAS staff should leave it in pending status until it can be properly closed.[25] Closing a consult earlier than directed by the guidelines and later cloning it to issue supplies to veterans results in skewed performance metrics. Specifically, the number of days taken to fulfill a consult and the open and pending consults will be understated, while the number of fulfilled consults will be overstated. Example 1 demonstrates the effect of closing a consult earlier than directed by the guidelines.

Example 1

A veteran received a consult for orthopedic shoes on March 17, 2017. The consult was improperly closed on March 22, 2017, five days after the consult date, when a PSAS staff member forwarded the consult to the shoe clinic. The consult was cloned on March 28, 2017, 11 days after the initial consult date, to schedule an appointment for the veteran to be seen in the shoe clinic. The veteran received the shoes, and the cloned consult was closed on June 29, 2017, 93 days after it was cloned. Because the original consult was improperly closed and then cloned, it would appear to VHA that it only took five days to fulfill the consult even though it took 98 days from the initial consult date to provide the shoes to the veteran.

Four of the 22 PSAS purchasing employees interviewed by the audit team (18 percent) reported being told by PSAS chiefs to close consults within five days, but the team did not find any written guidance that supported the verbal direction. Closing consults gave the appearance of fulfilling a consult earlier than the consult was actually fulfilled. Because PSAS improperly closed consults, VHA had less assurance that veterans received supplies in a timely manner. In addition, improperly closing consults could cause PSAS to lose sight of veterans' needs and allow the consult to go unfulfilled.

PSAS Improperly Cloned Consults 365 Days or More After Creation

VHA did not have adequate controls in place to prevent PSAS staff from improperly cloning consults over 365 days past the initial consult date. The OIG projected that an estimated 11,900 transactions (15 percent) had consults cloned after the 365-day limit without clinical review and approval. According to the business practice guidelines, when a consult is over 365 days old, clinicians are to determine whether the veteran needs to be reevaluated before reissuing the item or supply.[26] Within the sample, cloned consults that exceeded the 365-day threshold ranged from 1,845 days to almost 4,800 days after the initial consult date. As a result of

[25] PSAS, *Business Practice Guidelines for PSAS Consult Management; Business Practice Guidelines for Prosthetics Consult Management*.

[26] PSAS, *Business Practice Guidelines for PSAS Consult Management*; *Business Practice Guidelines for Prosthetics Consult Management*.

inadequate controls, VHA improperly issued an estimated $6.1 million in prosthetic supplies through cloned consults that were more than 365 days old during 2017.

PSAS Improperly Issued Nonprescribed Items

VHA did not ensure that only supplies prescribed through consults were issued in accordance with the business practice guidelines.[27] The audit team found that in some cases, if a veteran requested prosthetic or associated accessory or consumable supplies not specifically prescribed by a consult, some PSAS staff simply issued the supplies by cloning the consult. The audit team estimated that PSAS improperly used cloned consults to issue accessory and consumable supplies like air purifier filters and shoe inserts through an estimated 19,100 transactions valued at an estimated $9.8 million nationwide. Example 2 describes this scenario.

Example 2

A veteran's consult was for shoe inserts to be issued from stock. The purchasing agent issued the inserts on June 19, 2017. The PSAS chief stated that the veteran returned, stating that he needed custom inserts instead of the standard inserts he received. Without seeking guidance from the clinician and without getting a new consult, the purchasing agent cloned the consult on October 19, 2017, to create a purchase order to a vendor for the customization and issuance of the custom inserts. The custom inserts cost $18.97.

Issuing supplies not specifically prescribed by the consult results in overspending of the prosthetics budget and questioned costs. Questioned costs are transactions that are not supported by adequate documentation and could result in improper payments.

Facility Oversight of Cloning Practices Was Lacking

The practices of incorrectly closing prosthetic consults, cloning beyond 365 days, and cloning to issue nonprescribed items went undetected because no reviews of cloned consults were conducted. The business practice guidelines necessitate weekly reviews, but were vague as to responsibilities and standards. According to the guidelines, a reviewer should conduct a weekly review of cloned consults and add a comment to consults, detailing any review or follow-up action that occurred.[28] However, before January 2018, the PSAS guidance did not indicate who was responsible for conducting weekly reviews of cloned and pending consults. In January 2018, PSAS guidance assigned the responsibility to the PSAS chief or a designee.[29] Nevertheless, the

[27] PSAS, *Business Practice Guidelines for Prosthetics Consult Management*.

[28] PSAS, *Business Practice Guidelines for PSAS Consult Management*; *Business Practice Guidelines for Prosthetics Consult Management*.

[29] PSAS*, Business Practice Guidelines for Cloned Consults*.

new guidance omitted what the review should cover and prescribed no standards to ensure thorough reviews were conducted. The audit team found no evidence that reviews were being conducted by the chiefs of prosthetics or delegates for the eight facilities visited. In addition, despite the oversight tools available to PSAS leaders at facilities and Veterans Integrated Service Networks (VISNs) to monitor cloning practices, the lack of clarity in the PSAS governance structure contributed to PSAS's improper cloning practices.

PSAS Oversight Tools

According to VHA personnel, the Prosthetics Clinical Management Report Center compiles various data reports that are used to influence the development of national policy, manage the prosthetic-specific budget, and monitor key performance indicators, as well as provide data sets and analyses for customers and key stakeholders. Within the center, the PSAS Metrics Story Board provides leaders with key performance metrics that measure access to care and timeliness by tracking fulfilled consults, unfulfilled consults, and open or pending consults. As part of these metrics, PSAS personnel can see open and pending consults that are less than 90 days old. PSAS personnel can also view consults by request type, such as a clone, and see how long these consults have been open. The PSAS Metrics Story Board is a tool for PSAS facility and VISN leaders to monitor the activity of their facility's prosthetics staff. Despite the availability of the oversight tool, the audit team found no evidence that any PSAS personnel at facilities reviewed cloned or pending consults.

VHA PSAS Governance Structure

The lack of clarity of the PSAS governance structure contributed to PSAS's improper cloning practices. The chief consultant was responsible for ensuring field consistency across facility prosthetic programs and for maintaining a system of prosthetic program review and evaluations.[30] According to PSAS, the chief consultant role is now assumed by the PSAS executive director.

The audit team's interview with the then deputy chief patient care services officer for rehabilitation and prosthetic services established that at the time of the audit, the oversight responsibilities of that position were informally transferred to the VISN prosthetic representatives. The then deputy chief said ultimate responsibility for field guidance and oversight lies with field leaders and VISN prosthetic representatives. However, this change in responsibility is not reflected in guidance. Further, the audit team interviewed five of the 23 VISN prosthetic representatives, and only two said they were responsible for providing guidance to the field. The remaining three said they provided guidance as consultants and had no

[30] VHA Handbook 1173.1, *Eligibility*, November 2000.

oversight authority. Regardless of named responsible officials, the audit team found no evidence of program evaluations or facility reviews conducted by national or VISN prosthetic leaders.

By not communicating and enforcing the field guidance responsibilities to field leaders and prosthetic representatives, and by not conducting required program reviews and evaluations, the deputy chief patient care services officer for rehabilitation and prosthetic services did not create and maintain oversight that ensured field consistency.

PSAS Maintained Effective Oversight of Duplicate Supply Issuance

The audit team defined duplicate supply issuance as prosthetic supplies that are issued more than once to the same veteran, such as shoes that incurred regular wear and tear and were issued repeatedly. From a population of 351,456 duplicate prosthetic supply issuance transactions in 2017, the OIG reviewed a random sample of 385 transactions valued at about $136,700. Of the 385 duplicate supply issuance transactions, 379 were proper (98 percent), while only six valued at about $200 were improper (2 percent), an error rate the OIG considered acceptable. The population of 351,456 duplicate prosthetic supply issuance transactions totaled about $376.6 million during 2017.

Testing of Fiscal Year 2019 Data Showed Continued Issues

In December 2019, the OIG performed a review of FY 2019 data to determine if the weaknesses identified in 2017 data were ongoing. The OIG reviewed a random sample of eight cloned consult transactions totaling $13,252. Of the eight samples, five had similar issues to those identified in 2017 in that consults were cloned because PSAS improperly closed them. Because five of eight transactions were improper (63 percent), the OIG concluded that the cloning of improperly closed consults continues.

Finding 1 Conclusion

The OIG concluded that PSAS improperly purchased and issued prosthetic supplies estimated at $15.8 million through cloned consults in 2017. The responsibility to oversee reviews of cloned consults was not assigned to the facility PSAS chiefs or a designee until the issuance of PSAS's *Business Practice Guidelines for Cloned Consults* in January 2018. The development and implementation of thorough reviews would have detected PSAS staff's practice of incorrectly closing prosthetic consults and cloning them. However, the new guidance still does not specifically indicate how cloned consults should be reviewed locally to ensure a thorough, consistent nationwide review. The inadequate oversight process increases the risk of improper purchase and issuance of supplies and devices to veterans. If VHA does not take action to address the problem, the OIG estimates that the risk of improper issuance would total an estimated $79.2 million over a five-year period (appendix D).

Recommendations 1–4

The OIG made four recommendations to the under secretary for health to improve oversight of the clone consult function:[31]

1. Ensure Prosthetic and Sensory Aids Service business practice guidelines include specific requirements for conducting and properly documenting reviews of cloned and pending consults.
2. Ensure Prosthetic and Sensory Aids Service staff develop a process to verify that consults include accessory and consumable supplies for prosthetic items prior to issuance.
3. Ensure Prosthetic and Sensory Aids Service establishes field consistency requirements for conducting program reviews and evaluations.
4. Ensure the executive director of the Prosthetic and Sensory Aids Service complies with existing policy for reviewing program assessments and evaluations and communicates review and evaluation results to the regional prosthetic representatives.

Management Comments

The executive in charge, Office of the Under Secretary for Health, concurred with recommendations 1 through 4. To address recommendation 1, the executive in charge reported VHA will review current guidelines and identify areas of opportunity to ensure cloned and pending consults are being reviewed and properly documented, and update and communicate the guidelines. For recommendation 2, VHA's comments state that PSAS and other relevant personnel will identify opportunities for improvement on prosthetic consult service requests to support accessory and consumables included with durable medical equipment. As to recommendation 3, PSAS will standardize and communicate expectations for conducting and documenting program reviews. Finally, the executive in charge reported that for recommendation 4, PSAS will review existing policy and procedures to identify system modifications to enhance program assessments and communication processes. The full comments are included in appendix E.

OIG Response

The executive in charge's corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and will close the

[31] Recommendations directed to the under secretary for health were submitted to the executive in charge, who had the authority to perform the under secretary's functions and duties. Effective January 20, 2021, he was appointed to acting under secretary for health with the continued authority to perform the functions and duties of the under secretary.

recommendations when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

Finding 2: Prosthetic Transactions Involving Deceased Veterans Were Generally Appropriate

The audit team reviewed a statistical sample from 2017 of 586 prosthetic transactions involving 365 deceased veterans. The review determined that 94 percent of the transactions were proper, such as a transaction to retrieve equipment from a deceased veteran's home or payment of outstanding invoices. Although the remaining 6 percent were improper, the audit team did not find evidence of fraud with respect to these errors. Rather, the audit team believes they occurred because the Master Veteran Index (MVI) record system had not been updated with the veterans' dates of death.

Before November 2017, VHA relied on staff to establish dates of death before they updated the MVI, using evidence that included clinical summaries signed by hospital medical officers and coroners' reports of the veteran deaths. In November 2017, VHA's Data Quality Health Care Identity Management team began using the Social Security Administration's Weekly Death Master File for date-of-death updates to the MVI. The Health Care Identity Management team coordinator stated that the team conducts data reliability testing on the Social Security Administration's Weekly Death Master File to ensure VHA is not inaccurately listing veterans as deceased before importing the file. The Health Care Identity Management team coordinator also said that once uploaded, the MVI triggers the termination of veterans' benefits and cancellation of all future appointments.

In December 2019, the audit team performed a review of FY 2019 data to determine if the weaknesses identified in 2017 data were ongoing. The audit team reviewed a random sample of 10 deceased veterans with a combined count of 10 transactions totaling about $42,500. Of the 10 transactions, the audit team found that all were proper. The proper transactions included payments of outstanding invoices, such as vendor invoices for implants for veterans when they were alive. As a result, the OIG did not make any recommendations regarding prosthetic transactions involving deceased veterans.

What the OIG Did

From January 1 through December 31, 2017, VHA PSAS created 11,324 prosthetic supply transactions nationwide involving deceased veterans. From this population, the audit team reviewed a random sample of 586 transactions associated with 365 deceased veterans for 2017. The team used supporting documentation from VistA to determine if the transactions were proper. To understand PSAS's guidelines for issuing prosthetic supplies and devices, the audit team interviewed officials from VHA's PSAS national program office and VISN prosthetic representatives, as well as chiefs, supervisors, and staff from eight VA medical facilities' PSAS programs.

To determine whether the conditions identified during the 2017 data review persisted in FY 2019, the audit team identified a population of deceased veterans and corresponding transactions for FY 2019. The population consisted of 1,572 prosthetic transactions totaling about $1.1 million, representing 791 deceased veterans. From this population, the team reviewed a random sample of 10 transactions representing 10 veterans totaling about $42,500.

VHA PSAS Generally Prevented Issuance of Supplies and Devices to Deceased Veterans

The audit team determined PSAS correctly processed 94 percent of prosthetic supply issuance transactions involving deceased veterans. PSAS staff stated any improper transactions the audit team identified occurred because they were unaware the veterans were deceased. This occurred because, before November 2017, VHA relied on staff to establish dates of death before they updated the MVI, using evidence that included clinical summaries signed by hospital medical officers and coroners' reports of the veteran deaths. When VHA does not update veterans' dates of death in the MVI, VistA and CPRS do not display death alerts prompting system users that a veteran is deceased before allowing access to that veteran's records.

Once the date of death is established in the MVI, VistA and CPRS display an alert as a control to notify users that a veteran is deceased before allowing access to the veteran's record. PSAS staff reported during interviews that they learn of veterans' deaths through the alerts. When PSAS staff are prompted with a death alert, they should apply a non-response code to close all open and pending consults for the veteran.[32]

VHA Made Improvements Updating Death Information in the MVI

In November 2017, VHA's Data Quality Health Care Identity Management team began using the Social Security Administration's Weekly Death Master File for date-of-death updates to the MVI.[33] As of August 2019, the Data Quality Health Care Identity Management team coordinator explained that his team was still using the Social Security Administration's file for date-of-death updates to the MVI. He further explained that it may take from two to four weeks for a date-of-death update to be established in the MVI because his team first conducts data reliability testing to ensure VHA is not inaccurately listing veterans as deceased. The team coordinator further explained that entering dates of death into the MVI triggers the termination of veterans' benefits and cancellation of all future appointments.

[32] PSAS, *Business Practice Guidelines for PSAS Consult Management*; PSAS, *Business Practice Guidelines for Prosthetics Consult Management.*

[33] In September 2016, the Social Security Administration and the Veterans Benefits Administration modified an information exchange agreement to authorize the Veterans Benefits Administration to disclose the Social Security Administration's full Weekly Death Master File, including states' death data, to VHA.

Testing of FY 2019 Data Showed Appropriate Transactions for Deceased Veterans

In December 2019, the audit team performed a review of FY 2019 data to determine if the weaknesses found in 2017 data were ongoing. The audit team reviewed a random sample of 10 transactions for deceased veterans, totaling about $42,500. Of the 10 transactions, the audit team found all 10 were for the proper issuance of prosthetic supplies.

Finding 2 Conclusion

Due to improvements updating death information in the MVI, and because the 2019 deceased veteran sample data did not identify improper prosthetic supply issuance to deceased veterans, the OIG made no recommendations for this finding.

Appendix A: Background

Prosthetic devices and sensory aids include artificial limbs and bracing, wheeled mobility and seating systems, sensory-neural aids (for example, hearing aids and eyeglasses), cognitive prosthetic devices, items specific to women's health, surgical implants and devices surgically placed in the veteran, home respiratory care, and recreational and sports equipment.

VHA Handbook 1173.1 establishes uniform and consistent national policies and procedures for providing prosthetic and sensory aids and services to veterans.[34] However, this handbook was scheduled for recertification in July 2005. During the scope of the audit, PSAS used its April 2010 *Business Practice Guidelines for Prosthetics Consult Management* and May 2017 *Business Practice Guidelines for PSAS Consult Management* to govern the purchase and issuance of prosthetic supplies and devices.

According to *Business Practice Guidelines for PSAS Consult Management,* a PSAS consult is considered an administrative consult and is the method for VA clinicians to prescribe or request a PSAS appliance or service for an individual veteran. Consults submitted to PSAS must contain a detailed description of the device or service required and an appropriate clinical justification for the request, at a minimum, to facilitate the issuance or procurement of the device or service.

According to PSAS staff, closed consults can be reopened by using the cloned consult function. For repair and replacement supplies, PSAS's *Business Practice Guidelines for Prosthetics Consult Management* states that consults can only be cloned without verification when the consult is less than one year old, unless the clinician indicates otherwise on the consult. The *Business Practice Guidelines for PSAS Consult Management* instructs users to continue to follow previous guidelines until new and separate guidelines for cloned consults are approved.

PSAS's *Business Practice Guidelines for Prosthetics Consult Management* further states that the individual who clones the consult is required to enter a comment as to why the consult is being cloned. It also states that consults one or more years old can be cloned if approved by the prosthetics chief. If a consult is older than one year, PSAS staff must notify the prosthetics chief, who must contact the appropriate clinician to verify whether the veteran needs to be seen by a clinician before the repair or replacement can be provided. Furthermore, the prosthetics guidelines state that cloned consults are to be thoroughly reviewed, and weekly follow-up is expected; however, it did not define personnel responsible for this review or follow-up.

The mission of PSAS is to provide comprehensive support to optimize the health and independence of the veteran. Figure A.1 details the organizational structure of PSAS.

[34] VHA Handbook 1173.1.

Figure A.1. *PSAS organizational structure.*

Source: Office of the Deputy Under Secretary for Health for Policy and Services (10P).

Appendix B: Scope and Methodology

Scope

The audit team conducted its work from February 2018 through November 2020. The population consisted of 565,816 prosthetic supply issuance transactions totaling about $484.8 million during 2017. The scope of the audit included an examination of data, documentation, and information related to prosthetic supplies and devices issued to veterans between January and December 2017.[35] The audit team reviewed FY 2019 data for the cloned consult and death match attributes to determine if the weaknesses identified in 2017 data were ongoing.[36] The population for the cloned consults consisted of 197,172 transactions totaling about $64.8 million. The death match population consisted of 1,572 transactions from 791 deceased veterans totaling about $1.1 million.

Methodology

The audit team examined relevant criteria, including PSAS guidance and VHA directives and handbooks. The team interviewed key staff from the VHA's PSAS; VISN prosthetic representatives; and VA medical facility staff, including individuals from the Decedent Affairs Program, about their roles and responsibilities and the process of updating veterans' dates of death in VistA. The team also interviewed a key representative from VHA's Data Quality Health Care Identity Management team about date-of-death updates to the MVI using the Social Security Administration's Weekly Death Master File.

The audit team requested veterans' prosthetic records, consults, purchase orders, and vendor invoices to determine if PSAS issued prosthetic supplies properly. The requested documents were provided by individuals from the VA medical facilities. The team also accessed the Compensation and Pension Record Interchange to verify veterans' dates of death.

National Prosthetic Patient Database

To identify the number of veterans to which VHA issued prosthetic supply items, the audit team used NPPD and Corporate Data Warehouse data from January through December 2017. The team also obtained a data extract from the NPPD that identified a universe of 565,816 prosthetic supply issuance transactions. Appendix C provides details on the statistically sampled population.

[35] The population of prosthetic supply issuance transactions included supplies issued to deceased veterans, supplies issued through cloned consults, and duplicate prosthetic supplies (those issued more than once to the same veteran).

[36] Death match attribute is defined as prosthetic items for veterans deceased for 30 or more days.

Site Visits

The audit team visited eight statistically selected VA medical facilities associated with the initial sample testing and conducted virtual audit work on 10 additional facilities after expanding the scope to review additional transactions for deceased veterans. The San Antonio VA medical facility was statistically selected twice, for a total of 17 VA medical facilities. During the site visits, the audit team interviewed staff responsible for overseeing and managing the PSAS program, including prosthetic representatives, chiefs of prosthetics, supervisors, and purchasing agents. The interviews provided information on how PSAS issues prosthetic supplies to veterans. Table B.1 displays the eight medical facilities visited in person, and table B.2 displays the 10 medical facilities where the team conducted audit work remotely.

Table B.1. VA Medical Facilities Visited

VISN	VA medical facilities	Location
2	New York Harbor Healthcare System	New York, New York
6	Charles George VA Medical Center	Asheville, North Carolina
7	Columbia VA Health Care System	Columbia, South Carolina
10	Richard L. Roudebush VA Medical Center	Indianapolis, Indiana
10	Aleda E. Lutz VA Medical Center	Saginaw, Michigan
10	Dayton VA Medical Center	Dayton, Ohio
17	South Texas Veterans Health Care System	San Antonio, Texas
23	VA Black Hills Health Care System	Fort Meade, South Dakota

Source: VA OIG statistician.

Table B.2. Additional Medical Facilities

VISN	VA medical facilities	Location
5	Washington DC VA Medical Center	Washington, District of Columbia
7	Birmingham VA Medical Center	Birmingham, Alabama
8	North Florida/South Georgia Veterans Health System	Gainesville, Florida
8	Miami VA Healthcare System	Miami, Florida
8	San Juan VA Medical Center	San Juan, Puerto Rico
17	Michael E. DeBakey VA Medical Center	Houston, Texas
17	South Texas Veterans Health Care System	San Antonio, Texas
21	San Francisco VA Health Care System	San Francisco, California
22	VA Greater Los Angeles Healthcare System	Los Angeles, California
22	VA San Diego Healthcare System	San Diego, California

Source: VA OIG statistician.

Fraud Assessment

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

- soliciting the OIG's Office of Investigations for indicators,
- developing a fraud indicator checklist,
- analyzing NPPD data to identify trends at the statistically selected medical facilities to determine prosthetic supplies issued to veterans,
- asking managers and staff if they were aware of fraud under the program, and
- reviewing documentation for issuance of prosthetic supplies.

The OIG identified three potential instances of fraud regarding prosthetic supplies issuance during the course of this audit and referred them to the OIG Hotline Division.

Data Reliability

The OIG used computer-processed data from VHA's Corporate Data Warehouse to sample a total of 536 supplies across 17 VA medical facilities. In addition to reasonableness tests performed by OIG data analysts, the audit team performed accuracy and completeness tests and compared NPPD data to documentation from VistA and CPRS. The OIG gained a general understanding of system controls for purchasing and issuing prosthetic supplies to veterans. The OIG assessed the reliability of NPPD data by comparing them to data on printed documents such as consults, purchase orders, and veterans' records. The OIG found no significant discrepancies and concluded the computer-processed data were sufficiently reliable to support the audit objective, conclusions, and recommendations.

Government Standards

The OIG conducted this audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for its findings and conclusions based on the audit objectives. The OIG believes that the evidence obtained provides a reasonable basis for its findings and conclusions based on the audit objectives.

Appendix C: Statistical Sampling Methodology

To accomplish the audit objective, the OIG reviewed a statistical random sample of prosthetic supply item transactions created from January 1 through December 31, 2017.

Population

The population of transactions for prosthetic supply issuance from January 1 through December 31, 2017, was 565,816 and valued at about $484.8 million. The population represented the three attributes the OIG tested. Table C.1 identifies each attribute, its definition, the transaction count, and the amount.

Table C.1. Prosthetic Transaction Population

Attribute	Definition	Transaction count	Amount
Cloned consults	Created to issue supply items through cloned consults and consults over 365 days	203,036	$103,602,981
Duplicates	Issued duplicate and multiple prosthetic items more than once to the same veteran	351,456	$376,608,361
Death match	Created more than 30 days after veterans' reported dates of death	11,324	$4,580,573
	Total	**565,816**	**$484,791,914**

Source: VA OIG statistician's stratified population. Data were obtained from VHA's NPPD and Corporate Data Warehouse, and from the Social Security Administration's Weekly Death Master File.
Note: Numbers in the amount column are rounded.

Sampling Design

The sampling design for the selection of prosthetic supply item transactions for the three tested attributes was organized by VA medical facility. Table C.2 identifies each facility by location, the number of randomly selected samples, and the number of prosthetic supply item transactions associated with the samples for the cloned consult attribute.

Table C.2. Cloned Consult Attribute Samples by Facility

Facility location	Samples	Transactions
Asheville	10	19
Fort Meade	10	12
Columbia	10	14
Dayton	10	10
Indianapolis	10	16
New York	16	56
Saginaw	10	11
San Antonio	10	30
Total	**86**	**168**

Source: VA OIG statistician.

Table C.3 identifies each facility by location, the number of randomly selected samples, and the number of prosthetic supply item transactions associated with the samples for the duplicates attribute.

Table C.3. Duplicates Attribute Samples by Facility

Facility location	Samples	Transactions
Asheville	10	38
Fort Meade	15	51
Columbia	10	43
Dayton	10	35
Indianapolis	10	59
New York	10	45
Saginaw	10	30
San Antonio	10	84
Total	**85**	**385**

Source: VA OIG statistician.

Table C.4 identifies each facility by location, the number of randomly selected samples, and the number of prosthetic supply item transactions associated with the samples for the death match attribute.

Table C.4. Death Match Attribute Samples by Facility

Facility location	Samples	Transactions
Asheville	10	10
Birmingham	30	61
Fort Meade	5	5
Columbia	10	10
Dayton	10	10
Indianapolis	10	10
Gainesville	30	48
Los Angeles	30	79
Houston	30	39
Miami	30	46
New York	10	13
Saginaw	10	10
San Diego	30	39
San Francisco	30	65
San Juan	30	51
San Antonio	30	42
Washington, DC	30	48
Total	**365**	**586**

Source: VA OIG statistician.

Weights

The OIG statistician calculated the population estimates in this report using weighted sample data. The statistician computed sampling weights by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

The margins of error and confidence intervals are indicators of the precision of the estimates. If the OIG repeated this audit with multiple samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time. For example,

90 percent of all samples would give an estimate of the true universe of veterans' cases with improperly cloned closed consults between 6,129 and 10,633, with a point estimate of 8,381.

Tables C.5 through C.7 present the projections, including the estimates, margins of error, lower 90 percent values, and upper 90 percent values. The OIG used estimates throughout the report.

Table C.5. Summary of Estimated Projected Populations for Prosthetic Transactions through Cloned Consults and Consults 365 Days or Older

Error type	Point estimate	Margin of error	90% Confidence interval lower limit	90% Confidence interval upper limit	Number of errors	Sample size
Improper issuance through cloned consults	19,109	10,699	8,410	29,808	8	79
Improper issuance through consults 365 days or older	11,943 (15%)	8,270 (18%)	3,673 (0%)	20,213 (33%)	5	6
Transaction processing errors through cloned consults	47,773 (61%)	16,111 (9%)	31,663 (52%)	63,884 (70%)	20	85
Total	**78,826**	**21,184**	**57,641**	**100,010**	**33**	

Source: VA OIG statistical analysis of sample results projected over the audit universe.
Note: Numbers in the point estimate column are rounded. Numbers in the columns for margin of error, lower limit, and upper limit do not add to the totals shown; they are based on statistical formulas because they represent a measure of uncertainty for the point estimates.

Table C.6. Summary of Estimated Projected Amount of Improper Issuance through Cloned Consults and Consults 365 Days or Older

Error type	Point estimate	Margin of error	90% Confidence interval lower limit	90% Confidence interval upper limit
Improper issuance through cloned consults	$9,750,869	$5,459,420	$4,291,449	$15,210,289
Improper issuance through consults 365 days or older	$6,094,293	$4,219,964	$1,874,329	$10,314,257
Total	**$15,845,162**	**$7,019,200**	**$8,825,962**	**$22,864,361**

Source: VA OIG statistical analysis of sample results projected over the audit universe.
Note: Numbers in the columns for margin of error, lower limit, and upper limit do not add to the totals shown; they are based on statistical formulas because they represent a measure of uncertainty for the point estimates.

Table C.7. Summary of Estimated Veteran Population

Error type	Point estimate	Margin of error	90% Confidence interval lower limit	90% Confidence interval upper limit	Number of errors	Sample size
Improper issuance through cloned and expired consults	8,381	2,252	6,129	10,633	33	85

Source: VA OIG statistical analysis of sample results projected over the audit universe.

Appendix D: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendations	Explanation of benefits	Better use of funds	Questioned costs
1–4	Value of prosthetic supplies and devices issued to veterans through improperly cloned consults in the estimated amount of $15.8 million in 2017. This includes an estimated $6.1 million in prosthetic supplies and devices through cloned consults that were more than 365 days old and an estimated $9.8 million in improperly issued accessory and consumable supplies. The estimated $15.8 million would amount to an estimated $79.2 million over a five-year period.	N/A	$79.2 million*
	Total	**N/A**	**$79.2 million**

** Numbers in this table are rounded.*

Appendix E: Management Comments

Department of Veterans Affairs Memorandum

Date: December 15, 2020

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: OIG Draft Report: Insufficient Oversight for Issuing Prosthetic Supplies and Devices (OIG 2018-00972-R3-0035) (VIEWS 04023251)

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

1. Thank you for the opportunity to review the subject draft report.

2. I concur with the draft report and provide the attached action plan in response to recommendations 1-4.

3. Prosthetic and Sensory Aids Service (PSAS) is the largest and most comprehensive provider of prosthetic devices and sensory aids. Fifty-five percent of Veterans enrolled in health care in the Veterans Health Administration receive Prosthetic services. In fiscal year (FY) 2019, VA obligated $3.5 billion to provide 22 million devices to 3.5 million Veterans.

4. PSAS developed several business practice guidelines which directly support the consult management reduction efforts. As a result, in FY 2019 and 2020, there was an 84% reduction of durable medical equipment awaiting fulfillment. Additionally, PSAS conducted in-depth quality reviews for all requests, which enhanced timeliness with procurement actions. PSAS also improved the device delivery approach with the adoption of mail-out for medical devices and drive-thru fittings and pick up services. This approach led to a reduction in the need for hospital visits.

The OIG removed point of contact information prior to publication.

(Original signed by)

Richard A. Stone, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Draft Report Action Plan

Insufficient Oversight for Issuing Prosthetic Supplies and Devices

(OIG 2018-00972-R3-0035)

Recommendation 1. Ensure Prosthetic and Sensory Aids Service business practice guidelines include specific requirements for conducting and properly documenting reviews of cloned and pending consults.

VHA Comments: Concur.

The Office of Prosthetic and Sensory Aids Service (PSAS) agrees that the enhancement of business practice guidelines will provide greater clarity and operating procedures. To accomplish this, PSAS will:

1. Review current Business Practice Guidelines and identify areas of opportunity to ensure cloned and pending consults are being reviewed and properly documented.
2. Make necessary updates to the current Business Practice Guidelines to ensure compliance with OIG recommendation.
3. Communicate updated changes to Veterans Integrated Service Networks and Facility Prosthetic Leadership and reiterate expectations.

To demonstrate full implementation, VHA will provide the following documentation:

- Updated Business Practice Guidelines.
- Communication documents provided to the field which outline the updated processes.

Status: In process Target Completion Date: September 2021

Recommendation 2. Ensure Prosthetic and Sensory Aids Service staff develop a process to verify that consults include accessory and consumable supplies for prosthetic items prior to issuance.

VHA Comments: Concur.

The Office of Prosthetic and Sensory Aids Service (PSAS) agrees that the enhancement of business practice guidelines will provide greater clarity and improved operating procedures. To accomplish this, PSAS will partner with Clinical Access Coordinators, PSAS Data Management Council, and Veterans Integrated Service Networks and Facility PSAS leadership to identify opportunities for improvement on prosthetic consult service requests to support accessory and consumables included with durable medical equipment.

To demonstrate full implementation, VHA will provide the following documentation:

- Updated Business Practice Guidelines which include opportunities to consider a potential inclusion of accessory and consumable supplies as deemed appropriate for that facility.

Status: In process Target Completion Date: September 2021

Recommendation 3. Ensure Prosthetic and Sensory Aids Service establishes field consistency requirements for conducting program reviews and evaluations.

VHA Comments: Concur.

The Office of Prosthetic and Sensory Aids Service (PSAS) agrees that establishing consistent requirements for conducting program reviews and evaluations will ensure a standardized process. PSAS will:

1. Partner with Veterans Integrated Service Networks Prosthetic leadership and improve standardized procedures for program review and evaluations.
2. Communicate via Prosthetic Leadership Board and respective PSAS Governance Council the expectations for conducting and documenting program reviews.

To demonstrate full implementation, VHA will provide the following documentation:

- Guidance documentation that establishes the expectations for conducting program reviews.

Status: In process Target Completion Date: November 2021

Recommendation 4. Ensure the Executive Director, Prosthetic and Sensory Aids Service complies with existing policy for reviewing program assessments and evaluations and communicates review and evaluation results to the regional prosthetic representatives.

VHA Comments: Concur.

The Office of Prosthetic and Sensory Aids Service (PSAS) agrees that establishing consistent requirements for conducting program reviews and evaluations will ensure a standardized process. PSAS will review existing policy and procedures to identify protentional system modifications to enhance program assessments and communication processes.

To demonstrate full implementation, VHA will provide the following documentation:

- Guidance documentation that establishes the expectations for communicating program review assessments.

Status: In process Target Completion Date: November 2021

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Audit Team	Cherie Palmer, Director Ada Campbell Jennifer Leonard Trevor Rogers Michael Schiltz LaTasha Smith Grisbell Soto Jasmine Young
Other Contributors	Daniel Blodgett Kim Cragg Daniel Morris Michael Soybel Nelvy Viguera Butler

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