ADMINISTRATIVE SUMMARY OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL IN RESPONSE TO ALLEGATIONS REGARDING PATIENT WAIT TIMES

Orthotics & Prosthetics Laboratory at VA Medical Center in Temple, Texas March 8, 2016

1. Summary of Why the Investigation Was Initiated

On August 18, 2014, the Department of Veterans Affairs (VA) Office of Inspector General (OIG), South Central Field Office in Dallas, TX, was advised by a special agent in the Federal Bureau of Investigation in Waco, TX, that his office had received an allegation from a complainant regarding the Prosthetics and Sensory Aids Service (PSAS) at the VA Medical Center (VAMC) in Temple, TX. Based on this information, on September 23, 2014, VA OIG special agents interviewed the complainant.

The complainant stated that until recently, the PSAS Chief had purchasing agents overseeing the management of all PSAS consultations (consults), which would include artificial limbs. The complainant opined that purchasing agents are not qualified to manage consults for artificial limbs. The complainant alleged that the purchasing agents were mistakenly closing artificial limbs consults, which require an appointment, due to the pressure that they were under to abide by durable medical equipment (DME) consult performance measurements. He also alleged that the PSAS Assistant Chief determined that the purchasing agents did not need to send a letter to the veteran before closing the consult. Due to the pressure to meet consult performance measurements, it became a standard practice to close consults without first sending a letter to the veteran.

The complainant stated that once the consult was closed, there is no longer a record that showed patients did not receive the intended care. However, the consult is good for 1 year, which means that the patient can come in any time during that year. He opined that if a veteran were not aware of the consult, the veteran would never learn of the consult due to the cessation of notification letters. He said that referring physicians also do not have time to follow up on the consults they originate. Furthermore, referring physicians are supposed to inform the veteran of the consult, but many do not and assume that PSAS will send a letter.

In addition, the complainant stated that closing consults without sending a letter is a violation of the PSAS Business Practice Guidelines (BPG) for Prosthetics Consult Management and that it was being done to meet consult management performance measurements so that PSAS consult management reports would look better.

In support of his allegation, the complainant provided a Microsoft Excel file, which contained data related to 677 Orthotics & Prosthetics Laboratory closed consults for May and June 2014. He stated that the 677 consults were closed without the veterans being informed in writing. PSAS staff reportedly reviewed 435 of the 677 closed consults. The spreadsheet is divided by tabs for May 2014 (389 patient records) and June 2014 (288 patient records). According to the complainant, the spreadsheet is further divided into groups of consults for items that were fitted (meaning the veteran came in on his/her own); consults for items that

were still outstanding (meaning the veteran has not yet come in); and consults that were not reviewed. Of the 389 patient records for May 2014, PSAS staff reportedly identified 35 consults for items that were fitted; 112 consults for items that were still outstanding; and 242 consults that they did not review. Of the 288 patient records for June 2014, PSAS staff reportedly identified 65 consults for items that were fitted and 223 consults for items that were still outstanding.

The complainant further stated that as of September 17, 2014, PSAS was managing consults in accordance with the PSAS BPG for Prosthetics Consult Management. He told the VA OIG investigators that he was satisfied with the new procedures and believed that PSAS will properly manage Orthotics & Prosthetics Laboratory consults because qualified personnel will review every consult to determine if any consult should be handled by the Orthotics & Prosthetics Laboratory. Furthermore, PSAS will send a letter before closing consults.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** In addition to the complainant, VA OIG interviewed a combination of current and former PSAS purchasing agents and Orthotics & Prosthetics Laboratory employees, as well as the chief and assistant chief of PSAS.

- **Records Reviewed:** The complainant provided investigators consult data for May and June 2014, which was given to VA OIG, Office of Healthcare Inspections (OHI) in Dallas, TX, to conduct a review of notes/charts in the Computerized Patient Record System (CPRS)/Veterans Health Information Systems and Technology Architecture (VistA).

3. Summary of the Evidence Obtained From the Investigation

The investigation revealed that, prior to September 2014, PSAS purchasing agents managed all PSAS consults. Beginning in September 2014, PSAS Prosthetic representatives helped to manage all PSAS consults to ensure that no consults were being closed without appropriate actions.

Interviews Conducted

- A former PSAS purchasing agent at VAMC Temple stated that there was always confusing direction concerning the handling of the consults because there were a lot of changes. However, she never became backlogged on the consults she received because she stayed on top of them.

- A PSAS purchasing agent (PA1) at VAMC Temple stated that she has never been asked or pressured to close a consult without taking some kind of action. She was not aware of anyone closing consults without taking some kind of action.

- An employee who works with a PSAS purchasing agent at VAMC Waco told us that it was part of his duties and responsibilities to review the purchasing agent's consults to ensure that they are acted upon within a 5-day window, as well as following up on his

own consults and working to ensure they are completed within a 5-day window. The employee was not aware of consults being closed without contacting the patient by letter. He had no knowledge of any consults being closed without acting upon them in a timely and appropriate manner. When a letter is sent to a patient, a note is entered to reflect that a letter has been sent. The employee was never pressured in any way to change or manipulate consults, or hide consults, or close consults without taking appropriate action on them.

- PA2 at VAMC Temple said that every purchasing agent is responsible for specific consults, which are based on the last two digits of a patient's Social Security number. The employee said that she has closed a consult, but only because the patient had been given or received the item listed in the consult. She has not closed a consult without a reason to close it.

- Another former PSAS purchasing agent at VAMC Temple said that if a consult item had to be ordered for walk-in patients, the item was ordered and then mailed to the patient. For consults when the patient did not come to the PSAS within the 5 days, the consult item was ordered and then the consult was closed. She never sent letters to patients but was unaware if the letters were being mailed by the PSAS staff at the VAMC Waco. She also said she was never directed not to send letters.

- PA3 at VAMC Temple stated that he has never been asked or pressured to close a consult without taking some kind of action and has never closed a consult without action. Regarding managing consults, he receives hundreds of consults a day to work. He keeps the consult open for as long as it takes to complete the task so he can close the consult. He said that the goal is to close a consult within 5 days of receipt.

- A PSAS employee at the Orthotics & Prosthetics Laboratory at VAMC Temple said that, prior to April 2014, the PSAS had problems sending letters to veterans regarding closing their consults. The letters either did not go out or were sent to the wrong veterans. As a result, PSAS management decided that, in order to address the problem, PSAS employees at VAMC Waco would be responsible for sending the letters. The employee said that, in April 2014, she was informed by PSAS management that PSAS was no longer required to send out letters. The employee was aware of the PSAS BPG for Prosthetics Consult Management and interpreted it as requiring notification of consults to veterans (that is, letters); however, the supervisors' interpretation was that PSAS did not have to notify the veterans of consults. The employee noted that beginning in or around July 2014, PSAS resumed sending letters to veterans as notification of their consults. The employee created a Microsoft Excel file, which contained data related to 677 closed consults for May and June of 2014. She believed that the Microsoft Excel file documented consults for items that veterans should have been notified to pick up before closing the consult; however, the letters were not being sent to veterans.

- A PSAS Prosthetics representative at VAMC Temple stated that when she works a consult, she knows the consult is good for 1 year. The veterans are instructed to "walk in" to prosthetics, without an appointment, between 8 a.m. and 4 p.m., to pick up their item. At that point, the consult is changed from "open" to "pending." After 60 days, she

reviews the consult; if the item has been picked up, she notes that and closes the consult; if not, she sends a letter to the veteran, reminding the veteran of the item that should be picked up. When she sends the letter, she notates the item was not picked up, that a letter was sent, and then she closes the consult. The employee was not aware of any push by management to close consults due to the backlog of consults. She knows the service has been short staffed for some time and the backlog began to grow. Management made some changes to take pressure off the purchasing agents.

- PA4 at VAMC Temple did not recall ever being instructed not to send out letters to patients. The employee said purchasing agents have 5 days to take action on a consult and noted that once consults reach 5 days, purchasing agents are pressured to do something with the consults. He opined that there was pressure to get the consults completed within the 5-day time frame and take care of patients. The employee said that, as a result of some closed consults, there was a conflict between the Orthotics & Prosthetics Laboratory and the purchasing agents. He also said that when the purchasing agents closed a consult, it basically disappeared from the system and the Orthotics & Prosthetics Laboratory then would not see the consult. As a result, the Orthotics & Prosthetics Laboratory would receive calls from patients regarding their consults.

- PA5 at VAMC Temple said that the PSAS attempted to manage consults within 5 days of receipt. She explained that if a consult reached day 5, it would turn red in the system and that most consults were usually managed in about 3 days. The employee said that if for some reason a consult approached the 5-day mark, she would put it in pending status with a comment. She never received any instructions to close consults early because of the 5-day limit. She never received instructions not to send letters out to patients. She does not close consults unless there is a legitimate reason to close the consult and she enters the appropriate reason.

- A former PSAS purchasing agent at VAMC Temple said there once was a concern over "dropped consults." Occasionally, maybe about 5 to 10 times a month, a Primary Care consult would be managed by the clerk. The former employee explained that once the clerk received the consult for an item, the clerk would check the stock inventory, pull the item, and issue it to the patient. Once the item was issued to the patient and the clerk had notated it in the system, the consult was closed. As a result, the former employee would never see the consult. He was unaware of consults being closed prior to patients receiving the consult items. He had never been instructed by anyone to close consults prior to patients receiving the consult items.

- A PSAS Prosthetics representative with supervisory responsibilities at VAMC Waco said he uses the Prosthetics Matrix when he reviews consults to make sure consults are being routed correctly so the Orthotics & Prosthetics Laboratory at VAMC Temple can follow up. He only gets involved with the consults when they reach the 5-day time limit. If a consult is unresolved on day 5, a letter is sent to the veteran advising him/her that he/she needs to come in and pick up the consult item. The consult is then placed in a pending status for either 45 business days or 60 calendar days. While the consult is in the pending status, the consult is waiting for the veteran to come in to pick up the item.

- PA6 at VAMC Waco said that until approximately September 2014, he and another PSAS purchasing agent at VAMC Waco were responsible for all Orthotics & Prosthetics Laboratory consults and they had difficulty handling the workload. While there, they were instructed to wait 3 days before sending the veteran a letter to pick up the consult item and then close the consult. The employee believed that PSAS management did not want consults to get beyond the 5-day requirement. The reason most consults go beyond the 5-day requirement is that the particular employee assigned to the consult is out on leave or out of the office. As a result, purchasing agents are required to catch up. Around April 2014, the employee was instructed by the PSAS Chief to close consults without sending letters.

- PA7 at VAMC Waco stated that, recently, a PSAS Prosthetics representative at VAMC Temple began overseeing the consults assigned to help manage the Orthotics & Prosthetics Laboratory consults. From approximately April to September 2014, there were only two purchasing agents managing Orthotics & Prosthetics Laboratory consults. They were instructed to wait 3 days, send a letter to the veteran, and close the consult. The staff could then make an entry that the item had not been picked up. The employee noted a matrix was developed to try and assist purchasing agents with managing consults. From approximately May to September 2014, per instruction of the PSAS Chief, there were no letters being sent out and consults were being closed with the notation that the consult item needed to be picked up in Prosthetics, and consult is good for 1 year. Sometime in September 2014, letters started to be sent out again to veterans with consults.

- The service chief at VAMC Temple said VHA Directive 1173, *Prosthetics and Sensory Aids Service*, governs PSAS. She said the PSAS BPG for Prosthetics Consult Management were recommendations regarding how PSAS consults should be handled. She said the PSAS BPG for Prosthetics Consult Management should be followed to the letter and has been followed correctly since early 2014. Prior to 2014, the previous Prosthetics Chief modified the PSAS BPG for Prosthetics Consult Management, and as a result, it was not being followed exactly. She said the PSAS BPG for Prosthetics Consult Management was written by the VA Central Office to properly manage the consults and only VA Central Office was responsible for updates and revisions.

  She said PSAS purchasing agents and Prosthetics representatives work together to manage PSAS consults. Purchasing agents process the consults and Prosthetics representatives review the consults to ensure the purchasing agents are following the PSAS BPG for Prosthetics Consult Management.

  PSAS consults are never closed immediately. There are a large number of issues regarding the Orthotics & Prosthetics Laboratory because patients do not understand they have to come in to the Orthotics & Prosthetics Laboratory. In those instances, a reminder letter is mailed to the patient explaining that the provider has ordered an item for them and to please come in within the next 30 days to pick it up. The letter also explains that if they do not come in to pick up the item, the consult is good for 1 year. These consults are closed 45 to 60 days after the letters are mailed.

Purchasing agents have made errors when sending letters to patients regarding picking up items because patients actually needed appointments rather than just picking up the items. The Orthotics & Prosthetics Laboratory would sometimes complain because patients would show up at the lab even though there were no appointments for them.

She was not aware of any PSAS consults that were intentionally closed without appropriate review. She said if this happened, it would have been due to error by the purchasing agent. She also said PSAS consults have been closed without calling the veteran or sending the veteran a letter but attributed it to employee error due to high turnover and new employees; it was not intentional. It has always been permissible to send the patient a letter and it is not a requirement to call the patient. PSAS consults have never been closed to eliminate a backlog.

- A PSAS supervisor at VAMC Temple stated he ensures that PSAS employees abide by the PSAS BPG for Prosthetics Consult Management. PSAS uses the PSAS BPG for Prosthetics Consult Management because PSAS does not use the same software as other services and is therefore exempt from the directives that govern consult scheduling for regular clinical appointments. VHA Directive 1173, *Prosthetics and Sensory Aids Service*, is the governing directive for PSAS. According to the supervisor, the PSAS BPG for Prosthetics Consult Management, dated April 2010, was written and is maintained by VA Central Office. The PSAS BPG for Prosthetics Consult Management is for use by all PSAS employees nationwide throughout VA and it is maintained on the PSAS internal Web site for review and use, as a standard practice.

  Around March 2014, he discovered the PSAS BPG for Prosthetics Consult Management being used by the PSAS at VAMC Temple had been altered by the previous PSAS Chief. Between March and April 2014, he ensured that all PSAS staff at VAMC Temple were trained to use only the approved PSAS BPG for Prosthetics Consult Management, which is posted on the PSAS SharePoint portal. He said that the current PSAS Chief was aware that the former chief had revised the PSAS BPG for Prosthetics Consult Management. He opined that the former chief should have never revised the PSAS BPG for Prosthetics Consult Management because he did not have the authority to do so.

  The supervisor described the standard practice of sending letters to veterans to notify them of their PSAS consults. In order to close a consult, a PSAS clerk must enter either an item or an "NR" code; NR codes are related to HCPCS (Healthcare Common Procedure Coding System) code, which are Medicare reimbursement codes. Any time a consult is closed, it must be properly documented. PSAS uses its own specific software, which is separate from, but communicates with, CPRS and VistA. The application is known as the "handbag" because the icon looks like a hospital handbag, which is where the Orthotic Work Logs (OWLs) are created, purchase orders are created, and where data are obtained.

  There may have been consults closed without contacting the veteran, by calling or sending a letter, but according to the PSAS BPG for Prosthetics Consult Management, any time there is an action on a PSAS consult, the ward or clinic that entered the consult is notified by CPRS or VistA. There is no requirement to call the veteran each time; a

letter is sufficient notification. The supervisor has never allowed his employees to simply close consults to eliminate any backlog. Moreover, consults are also scrubbed quarterly to make sure none were missed and they are being closed timely and appropriately. Closed consults are still traceable and reviewable and they are good for 1 year even when closed.

Records Reviewed

On November 5, 2014, OIG investigation staff provided the Microsoft Excel file to VA OIG Office of Healthcare Inspections (OHI) to conduct a review of notes/charts in CPRS and/or VistA, in an effort to determine whether PSAS consults were closed improperly without notification to the veteran. OIG investigation staff requested a review of all consults listed in the Microsoft Excel file for any indication that the consults were improperly closed, any record of a letter related to the consult being sent to the veteran, or any questionable notes associated with the consults in the system.

On January 30, 2015, OHI provided OIG investigators with the results of their review. OHI reviewed the first 70 consults and a randomized sample of 50 consults for each month (May and June 2014). If the patient selected from the randomized sample had more than one consult, then OHI reviewed all of the consults for that patient. OHI determined the following:

- Some patients talked to their Primary Care provider about the consult for the item, on the same day as the consult, but did not pick it up.
- Some consults were not appropriate.
- Some referrals for conditions did not concur with the need and the patient did not pick up the item.
- Some patients picked up the item at a later date and it was documented as such.
- Some items were ordered and mailed to the patient (which could be why the patient did not show up to get the evaluation for size needed for some orders).
- The PSAS documented when the patient showed up and noted it as a walk in for evaluation/sizing of what the provider requested.
- OHI did not find any refusals to provide items when the patient showed up.
- OHI did not find that patients suffered harm and/or death as a result of any closed consults.

OHI noted the PSAS would not send a letter unless PSAS had evaluated the patient and needed to order the consult item. PSAS would then send a letter letting the patient know the consult item was ready for pickup/fitting. Otherwise, PSAS would not send a letter. If the consult were discontinued, the Primary Care provider would be responsible for discussion with the patient.

4. Conclusion

The allegation was not substantiated. The investigation did not reveal the intentional inappropriate closing of consults. The investigation did not reveal that consults were closed for the purpose of manipulating consult management performance measurements. The investigation revealed that, from approximately April to September 2014, PSAS consults were closed with no letters mailed to veterans. Two PSAS employees stated that the PSAS Chief gave the instruction not to send letters; however, the chief said that if letters were not sent, it was the result of employee error. Neither the PSAS BPG for Prosthetics Consult Management or VHA Directive 1173, *Prosthetics and Sensory Aids Service*, requires that a letter be mailed. The VA OIG Office of Healthcare Inspections did not find any refusals to provide items when the patient showed up or evidence that patients suffered harm and/or death as a result of consults that were closed.

The OIG referred the Memorandum for Record to VA's Office of Accountability Review on November 16, 2015.

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