DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

VA Southern Nevada Healthcare System's Alleged Unnecessary Use of Outside Vendors to Purchase Prosthetics

On January 15, 2019, this report was revised to correct errors on pages i, ii, 5, 6 and 19. These corrections do not alter this report's findings or conclusions.

AUDIT | **REPORT #16-02247-165** | **JUNE 27, 2018**

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Executive Summary

Why the OIG Did This Audit

An anonymous complaint received in January 2016 alleged that the VA Southern Nevada Healthcare System's Prosthetics Laboratory was unnecessarily sending veterans to vendors to obtain prescribed compression garments and orthotic shoes. As a result, the VA Southern Nevada Healthcare System (the system) paid higher prices for these items. According to an analysis of National Prosthetics Patient Database (NPPD) data, the system spent about $702,000 on 6,825 prescribed compression garments and 4,939 prescribed orthotic shoes provided to veterans from October 2014 through May 2016. About 91 percent of the system's spending on prescribed compression garments and orthotic shoes, or $637,000, went to vendors during this 19-month period.

During the audit, purchasing employees reported to the audit team that they were incorrectly using the non-item Healthcare Common Procedure Coding System (HCPCS) code NR018 to close prosthetic consults prematurely. Accordingly, the audit team expanded the scope of its audit to include a review of the Prosthetics Laboratory's use of the NR018 code.

What the Audit Found

The audit team substantiated the allegation that the system's Prosthetics Laboratory unnecessarily sent veterans to vendors for prescribed compression garments and orthotic shoes from October 2014 through May 2016. Prosthetics Laboratory employees did not make sound decisions when they sent about 99 percent of veterans who required compression garments and about 75 percent of veterans who required orthotic shoes to vendors.

The high reliance on vendors was not justified given the Prosthetics Laboratory's personnel and inventory resources. The Prosthetics Laboratory's personnel managed small workloads from October 2014 through May 2016 because the bulk of the laboratory's prescribed compression garment and orthotic shoe workload was outsourced to vendors. The Prosthetics Laboratory personnel had the capacity to increase their workload to fit and issue most of the outsourced compression garments and orthotic shoes. From June 2016 through October 2016, the Orthotic Fitter's consult workload increased by 87[*] percent when the current Chief of Prosthetics took steps to reduce the reliance on vendors to fit and issue frequently prescribed compression

[*] This figure was corrected. Data points on pages ii, 5, 6, and 19 were also corrected.

garments and orthotic shoes, including dedicating employees to fit veterans with these items and providing additional training to Prosthetics Laboratory employees.[1]

Prosthetics Laboratory employees also did not consider the laboratory's on-hand inventory when outsourcing frequently prescribed compression garments to vendors. A physical inventory performed by the current Chief of Prosthetics in June 2016 showed that the Prosthetics Laboratory had nearly 300 compression garments on hand; however, Prosthetics Laboratory personnel rarely used this inventory. The audit team's analysis of NPPD data showed the Prosthetics Laboratory only issued two compression garments from its inventory in May 2016, but outsourced 278 compression garments to vendors during the same time.

The poor decision-making by Prosthetics Laboratory employees, underutilized laboratory personnel, and unused inventory went undetected because the former Chief of Prosthetics did not effectively monitor the Prosthetics Laboratory's operations. Subsequently, the laboratory did not maximize its resources to provide timely and cost-effective services to veterans for frequently prescribed compression garments and orthotic shoes. The former Chief of Prosthetics told the audit team he tracked employee workload using information from the Computerized Patient Record System, but he was unable to provide any documentation to support such reviews.

Due to the system's unnecessary reliance on vendors to provide frequently prescribed compression garments and orthotic shoes, veterans experienced significant delays—on average 46 days—in obtaining vendor-provided prescribed compression garments. Veterans also waited on average 24 days longer for vendor-provided orthotic shoes than they would have for orthotic shoes provided directly by the system's Prosthetics Laboratory. In addition, the system spent more to send veterans to vendors for these items.

The audit team determined the Prosthetics Laboratory had the capacity from October 2014 through May 2016 to fit and issue at least 70 percent of compression garments and 58 percent of orthotic shoes outsourced to vendors. Had the Prosthetics Laboratory leveraged its existing personnel and inventory resources to fit and issue compression garments and orthotic shoes in house rather than send veterans to vendors for these items, the system could have saved an estimated minimum of $242,000. This is a questioned cost because the Prosthetics Laboratory did not fully leverage its resources.

The audit team also found that prosthetic purchasing employees likely closed 9,514 prosthetic consults incorrectly from October 2014 through May 2016. Purchasing employees closed these consults using the non-item HCPCS code NR018 to indicate that the veteran did not follow through with the consult, but did not confirm whether veterans actually followed through with the consult and obtained the prescribed item.

[1] The current Chief of Prosthetics began working for the VA Southern Nevada Healthcare System on May 15, 2016.

Prosthetic purchasing employees told the audit team that the former Chief of Prosthetics instructed them to close consults using a non-item HCPCS code. The former Chief of Prosthetics told the audit team that sometime in 2015 he instructed purchasing employees to close pending consults because they were unable to effectively monitor the overwhelming number of pending consults. However, the former Chief of Prosthetics told the audit team that purchasing employees were only supposed to close consults when no further action was required on their part.

The audit team determined the former Chief of Prosthetics failed to perform his supervisory duties when he did not perform routine reviews of non-item HCPCS code use to ensure purchasing employees complied with Veterans Health Administration standards. The lack of supervisory oversight allowed the practice of inappropriately closing prosthetic consults with the NR018 code to go uncorrected. Because purchasing employees used the NR018 code so frequently, the system has little assurance that these employees performed the necessary follow-up actions to determine if veterans needed the prescribed orthotic or prosthetic device before they closed consults with the NR018 code. Without such assurances, the system risks delaying veterans' access to care and to prescribed prosthetic and orthotic items.

The audit team made the current Chief of Prosthetics aware of its findings following its site visit. The current Chief of Prosthetics reported taking the following actions:

- Dedicating employees to fit veterans with compression garments and orthotic shoes
- Providing additional training to Prosthetics Laboratory employees to reduce wait times and spending on compression garments and orthotic shoes by more efficiently using the laboratory's resources
- Providing further instruction and training to purchasing employees on managing prosthetic consults to discontinue the practice of incorrectly closing prosthetic consults

According to NPPD data from June 2016 through June 2017, the Prosthetics Laboratory's reliance on outside vendors for compression garments and orthotic shoes decreased significantly during this time, and in-house productivity increased. The Prosthetics Laboratory's use of non-item HCPCS codes also decreased.

What the OIG Recommended

The Veterans Integrated Service Network (VISN) 21 needs to address the lack of oversight over resource use at the system's Prosthetics Laboratory. The Acting VISN 21 Director should ensure the VA Southern Nevada Healthcare System Director develops and implements effective processes. NPPD workload reports can be used to monitor and ensure the Prosthetics Laboratory operates in a manner that maximizes its personnel and on-hand inventory to provide veterans with timely and cost-effective services for compression garments and orthotic shoes.

In addition, the OIG made a recommendation to VISN 22 because the system's former Chief of Prosthetics is now the Chief of Prosthetics at the VA San Diego Healthcare System. The OIG believes that the former Chief of Prosthetics' ineffective management of the VA Southern Nevada Healthcare System Prosthetics Laboratory's operations and resources may also put the VA San Diego Healthcare System's Prosthetic Service at similar risk. The OIG recommended that the Acting VISN 22 Director makes sure the VA San Diego Healthcare System Director takes similar steps to monitor the Prosthetic Service and maximize resources.

To address the inappropriate use of the NR018 code to prematurely close prosthetic consults, the OIG recommended the Acting VISN 21 Director ensure the VA Southern Nevada Healthcare System Director

- Develops and implements effective controls to ensure proper usage of all non-item HCPCS codes, and
- Examines incorrectly closed consults from October 2014 through May 2016 to ensure veterans received the prescribed prosthetic or orthotic item(s).

Management Comments

The Acting VISN 21 Director concurred with the OIG's report and recommendations. The Acting VISN 21 Director provided an acceptable action plan for Recommendation 1 to monitor and ensure the Prosthetics Laboratory maximizes its resources to provide timely and cost-effective services for compression garments and orthotic shoes. The Acting VISN 21 Director also provided an acceptable action plan for Recommendations 3 and 4 to ensure proper usage of all non-item HCPCS codes and that veterans received the prescribed prosthetic or orthotic item(s) when purchasing agents incorrectly closed prosthetic consults using the NR018 code. The OIG considers Recommendations 1, 3, and 4 closed.

The Acting VISN 22 Director concurred with the OIG's report and Recommendation 2 related to ensuring the VA San Diego Healthcare System's Prosthetics Laboratory maximizes its resources to provide timely and cost-effective services for compression garments and orthotic shoes. The Acting VISN 22 Director provided an acceptable action plan, and the OIG considers Recommendation 2 closed.

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Abbreviations

CPRS	Computerized Patient Record System
HCPCS	Healthcare Common Procedure Coding System
NPPD	National Prosthetics Patient Database
OIG	Office of Inspector General
PSAS	Prosthetic and Sensory Aid Service
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Objective

The OIG conducted this audit to assess an anonymous hotline complaint received in January 2016. The complaint alleged that the VA Southern Nevada Healthcare System's Prosthetics Laboratory unnecessarily sent veterans to vendors for prescribed compression garments and orthotic shoes, which resulted in the facility paying higher prices for these items. The audit team expanded the scope of the audit to include a review of the Prosthetics Laboratory's use of the NR018 non-item Healthcare Common Procedure Coding System (HCPCS) code from October 2014 through May 2016 because VA Southern Nevada Healthcare System employees reported to the audit team that purchasing employees were incorrectly using this code to close prosthetic consults.

VA Southern Nevada Healthcare System's Prosthetic and Orthotic Laboratory

The audit team's analysis of National Prosthetics Patient Database (NPPD) data found the VA Southern Nevada Healthcare System's Prosthetics Laboratory spends about $2.7 million annually to provide prosthetic and orthotic items to about 7,000 veterans. The Prosthetics Laboratory can design, fabricate, fit, and repair custom-made artificial limbs, braces, arch supports, and similar items prescribed to veterans. The Laboratory Supervisor reports to the Chief of Prosthetics, who is responsible for ensuring the laboratory operates efficiently and economically. As of October 2015, the Chief of Prosthetics reported to the assistant director, who reports to the Director of the VA Southern Nevada Healthcare System. Figure 1 details the Prosthetics Department structure.

Figure 1. *VA Southern Nevada Healthcare System Prosthetics Department Organizational Structure*
Source: OIG analysis of VA Southern Nevada Healthcare System's Prosthetic and Sensory Aids Service Organizational Chart fiscal year 2016

Compression Garments and Orthotic Shoes

A compression garment is a tightly fitted garment designed to increase blood flow in the lower extremities by applying varying degrees of pressure to a specific area. Compression garments treat conditions like varicose veins, the swelling of limbs, and circulation problems often associated with blood clots.

Orthotic shoes are specially designed shoes that provide support and pain relief to the feet, ankles, or legs and are often prescribed to individuals with diabetes, arthritis, or a hammertoe. According to the audit team's analysis of NPPD data, the VA Southern Nevada Healthcare System spent about $702,000 on compression garments and orthotic shoes prescribed to veterans from October 2014 through May 2016.

Consult Process for Prosthetic and Orthotic Items

Primary care or specialty care providers initiate prosthetic consults through VA's Computerized Patient Record System (CPRS). Prosthetics Laboratory personnel are responsible for evaluating the patient and identifying the appropriate item to be provided to the veteran. In cases where the medical facility cannot provide the prescribed prosthetic or orthotic device, purchasing employees place the prosthetic consult into a pending status until the item can be provided. The Veterans Health Administration's (VHA's) *Prosthetic and Sensory Aid Service's (PSAS)*

Business Practice Guidelines for Prosthetic Consult Management, dated April 2010, provided guidance to facilities on how to manage the prosthetic consult process.[2]

Health Care Common Coding Procedure System

The HCPCS is a standardized set of codes VA uses for billing items and services. The HCPCS is divided into two principal subsystems, referred to as Level I and Level II:

- Level I of the HCPCS is a uniform coding system consisting of descriptive terms and identifying codes, used primarily to identify medical services and procedures furnished by physicians and other health care professionals.
- Level II of the HCPCS is a standardized coding system used primarily to identify products, supplies, and services not included in Level I of the HCPCS, such as ambulance services, durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office.

VA developed non-item HCPCS codes to close consults when the prescribed prosthetic or orthotic item is no longer needed or when the veteran did not follow through with the vendor to obtain the prescribed item.

National Prosthetics Patient Database

VHA's NPPD captures data on veterans, their eligibility, and the type of prosthetic treatment they received at a facility. The database captures facility information on prosthetic costs, vendor sources, and purchasing employees.

[2] VHA updated its *PSAS Business Practice Guidelines for Prosthetics Consult Management,* dated April 2010, with the *PSAS Business Practice Guidelines for PSAS Consult Management* in May 2017. The OIG used VHA's April 2010 guidelines for prosthetics consult management because these guidelines were in effect during the scope of the audit. The key differences between VHA's April 2010 guidelines and the updated *PSAS Business Practice Guidelines for PSAS Consult Management* dated May 2017 are discussed in Appendix A: Background.

Results and Recommendations

Finding 1 Former Chief of Prosthetics' Lack of Leadership over the Prosthetics Laboratory Resulted in Care Delays and Increased Spending

The audit team substantiated the allegation that the VA Southern Nevada Healthcare System's Prosthetics Laboratory unnecessarily sent veterans to vendors for prescribed compression garments and orthotic shoes from October 2014 through May 2016. The audit team found that despite having the capacity to do so in house, the VA Southern Nevada Healthcare System's Prosthetics Laboratory relied heavily on vendors to provide veterans with frequently prescribed compression garments and orthotic shoes. The unnecessary reliance on vendors resulted in veterans experiencing significant delays—an average of at least 24 days—for either vendor-provided frequently prescribed compression garments or orthotic shoes. Leveraging its in-house capacity to provide frequently prescribed compression garments and orthotic shoes could have saved the VA Southern Nevada Healthcare System an estimated $242,000 from October 2014 through May 2016. As a result, the audit team determined the $242,000 that the VA Southern Nevada Healthcare System could have saved by providing compression garments and orthotic shoes in-house is a questioned cost.

Unjustified Reliance on Vendors to Provide Compression Garments and Orthotic Shoes

Prosthetics Laboratory employees did not make sound decisions when they sent almost all veterans to vendors to obtain compression garments and orthotic shoes. The audit team found that the VA Southern Nevada Healthcare System outsourced 99 percent of frequently prescribed compression garments and about 75 percent of orthotic shoes from October 2014 through May 2016. VHA standards require facility Orthotic and Prosthetic Laboratories to provide veterans with orthotic devices and repairs in house to the fullest extent possible.[3] Table 1 details the proportion of compression garments and orthotic shoes the Prosthetics Laboratory outsourced from October 2014 through May 2016.

[3] VHA Handbook 1173.10, *Orthotic Devices and Repairs*, January 29, 2008.

Table 1: Comparison of Compression Garment and Orthotic Shoe Sourcing by the VA Southern Nevada Healthcare System (October 2014–May 2016)

Item	Oct. 2014 to May 2016	Percentage
Compression Garments		
Vendor	6,759	99%
In-House	66	1%
Total	6,825	100%
Orthotic Shoes		
Vendor	3,681	75%
In-House	1,258	25%
Total	4,939	100%

Source: OIG analysis of NPPD from October 2014 through May 2016

Laboratory Had Adequate Personnel and Inventory Resources

The high reliance on vendors to provide veterans with frequently prescribed compression garments and orthotic shoes was not justified, given the Prosthetics Laboratory's personnel and inventory resources. The laboratory's personnel managed only small daily workloads because the bulk of the laboratory's prescribed compression garment and orthotic shoe workload was outsourced to vendors. From October 2014 through May 2016, the former Laboratory Supervisor addressed only 132 consults per month on average —approximately eight consults per day.[4] Similarly, the Prosthetic Technician addressed an average of 298 consults—approximately 16 consults per day—and the Orthotic Fitter addressed an average of 530 consults during this same period—approximately 29 consults per day.

Prosthetics Laboratory personnel had the capacity to fit and issue most of the frequently prescribed compression garments and orthotic shoes outsourced to vendors. From June 2016 through October 2016, the same personnel increased their monthly consult workload by as much as 253 percent when the current Chief of Prosthetics took steps to reduce the reliance on vendors.[5] Table 2 compares the average monthly consult activity of Prosthetics Laboratory

[4] The former Laboratory Supervisor retired from VA on September 15, 2017.

[5] The current Chief of Prosthetics began working for the Southern Nevada Healthcare System on May 15, 2016.

personnel from October 2014 through May 2016 to the monthly consult activity from June 2016 through October 2016.[6]

Table 2: Average Monthly Consult Activity by Employee (October 2014–October 2016)

Employee	Oct. 2014–May 2016	June 2016–October 2016	Percent Increase
Former Laboratory Supervisor	132	467	253%
Prosthetic Technician	298	705	137%
Orthotic Fitter	530	989	87%

Source: OIG analysis of Corporate Data Warehouse data from October 2014 through October 2016

Adequate On-hand Inventory

Prosthetics Laboratory employees did not consider the laboratory's on-hand inventory when referring veterans to vendors for frequently prescribed compression garments. According to a physical inventory performed by the current Chief of Prosthetics, the Prosthetics Laboratory had nearly 300 compression garments on-hand as of June 2016.[7] This inventory was more than enough to meet the demand for frequently prescribed compression garments. The audit team's review of NPPD data found that the Prosthetics Laboratory only issued two compression garments from its inventory in May 2016, but outsourced 278 compression garments to vendors.

The audit team discussed the results of its assessment of the adequacy of the Prosthetics Laboratory's on-hand inventory and personnel resources with the current Chief of Prosthetics. The current Chief of Prosthetics agreed with the audit team that the VA Southern Nevada Healthcare System did not fully leverage its in-house resources to provide veterans with frequently prescribed compression garments and orthotic shoes prior to June 2016.

Former Chief of Prosthetics Did Not Ensure the Prosthetics Laboratory Was Operating Effectively

The former Chief of Prosthetics did not effectively monitor the Prosthetics Laboratory's operations to ensure the laboratory maximized its resources to provide timely and cost-effective

[6] OIG used October 2016 as an end date to be consistent with existing staffing levels from October 2014 through May 2016. Appendix B provides more details on OIG's scope and methodology.

[7] VHA Handbook 1173.10, dated January 29, 2008 requires that Orthotic and Prosthetic Laboratories maintain an inventory of the more frequently requested prefabricated orthotic appliances and soft goods for immediate issue to eligible beneficiaries.

services to veterans for frequently prescribed compression garments and orthotic shoes.[8] As a result, Prosthetics Laboratory employees' poor decision-making, unused inventory, and underutilized laboratory personnel went undetected.

The former Chief of Prosthetics told the audit team he tracked employee workload using information from CPRS; however, he was unable to provide documentation to support any such reviews. The former Chief of Prosthetics should also have used NPPD data to monitor the facility's reliance on vendors for frequently prescribed compression garments and orthotic shoes. A review of NPPD data, along with monitoring employee workload data from CPRS, would have positioned the former Chief of Prosthetics to take corrective action to maximize the laboratory's in-house capacity to provide frequently prescribed compression garments and orthotic shoes while minimizing its reliance on vendors. This failure by the former Chief of Prosthetics allowed Prosthetics Laboratory employees to outsource almost all compression garments and orthotic shoes. According to VA standards, the Chief of Prosthetics was fully responsible for the management and supervision of all phases of prosthetic operations, which includes managing resources such as supplies and personnel.[9] Furthermore, the Chief of Prosthetics is responsible for ensuring the Prosthetics Laboratory operates in an efficient and economical manner.[10]

Former Chief of Prosthetics Deflected Blame

The former Chief of Prosthetics also did not take individual responsibility for the inefficient operations of the Prosthetics Laboratory and deflected blame. He told the audit team that his office was located away from the Prosthetics Laboratory and that it was actually the former Laboratory Supervisor's responsibility to monitor the laboratory's operations. While the former Laboratory Supervisor may have been responsible for the Prosthetics Laboratory, he reported directly to the Chief of Prosthetics. As such, the Chief of Prosthetics had the ultimate responsibility for the management and supervision of the Prosthetics Laboratory and its resources.

Reliance on Vendors Not Regularly Monitored by VISN

The Veterans Integrated Service Network (VISN) 22 Prosthetic Representative did not monitor how much the VA Southern Nevada Healthcare System Prosthetics Laboratory's operations relied on vendors for frequently prescribed compression garments and shoes.[11] Reliance on

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[8] The former Chief of Prosthetics was a GS-13 in the Southern Nevada Healthcare System and left that health care system in February 2016. This individual is now employed as the Chief of Prosthetics at the San Diego Healthcare System as a GS-13 since February 2016.

[9] VA Handbook 5005/15 Part II, Appendix G34, dated March 17, 2006.

[10] VHA Handbook 1173.2, dated November 3, 2000, and VHA Handbook 1173.10, dated January 29, 2008.

[11] The VA Southern Nevada Healthcare System was part of VISN 22. In October 2015, the healthcare system was organized under VISN 21.

vendors and the soundness of doing so was also not part of the performance elements used to rate the performance of the former Chief of Prosthetics. The former Chief of Prosthetics' performance plan—set at the time by the VISN 22 Prosthetic Representative—included performance elements such as budget and project management, which focused on effectively managing the laboratory's annual budget and adhering to nationally established guidelines and goals. According to the VISN 21 Associate Quality Management Officer, VISN 21 does not have a permanent Prosthetic Representative. The Acting VISN 21 Director should ensure the VA Southern Nevada Healthcare System Director establishes effective processes such as using NPPD workload data reports to monitor and ensure the Prosthetics Laboratory maximizes its resources to provide veterans with timely and cost-effective fitting services for compression garments and orthotic shoes.

Former Chief of Prosthetics' Ineffective Management Places VA San Diego Healthcare System at Risk

The former Chief of Prosthetics left the VA Southern Nevada Healthcare System in February 2016 and is employed as the Chief of Prosthetic Services by the VA San Diego Healthcare System. The former Chief of Prosthetics received an outstanding performance rating for fiscal year 2017. The former Chief of Prosthetics' performance plan for fiscal year 2017 included business acumen as a performance element, which focused on resource management and creating value within the prosthetics department. The audit team believes that this employee's ineffective management of the VA Southern Nevada Healthcare System Prosthetics Laboratory's operations and resources may also place the VA San Diego Healthcare System's Prosthetics Service at similar risk. The OIG recommended that the Acting VISN 22 Director ensure the VA San Diego Healthcare System Director takes steps such as using NPPD workload data reports to monitor and ensure the Prosthetics Service maximizes its resources to provide veterans with timely and cost-effective fitting services for compression garments and orthotic shoes.

Veterans Waited Longer for Vendor-Provided Compression Garments and Shoes

As result of the VA Southern Nevada Healthcare System's reliance on vendors, veterans experienced delays in obtaining their prescribed compression garments and orthotic shoes from October 2014 through May 2016. Because the Prosthetics Laboratory maintained an inventory of the most commonly issued compression garments, veterans could have received their prescribed compression garment on the same day of their appointment. Instead, for the most commonly issued compression garments, it generally took on average 46 days longer to close compression garment consults sent to vendors. In addition, the audit team also found it took the Prosthetics Laboratory about 24 days longer to close orthotic shoe consults that were sent to vendors as compared to when the Prosthetics Laboratory issued the shoes directly to the veteran. These delays placed veterans at increased risk for circulation problems often treated with compression

garments, and for continued pain in their feet, ankles, or legs, which is typically associated with arthritis or hammertoe and treated with orthotic shoes.

Reliance on Vendors Resulted in Unnecessary Spending

The VA Southern Nevada Healthcare System spent more for compression garments and orthotic shoes fitted and purchased through vendors than it would have cost the Prosthetics Laboratory to fit and issue these items in-house. For example, in fiscal year 2015 the VA Southern Nevada Healthcare System could purchase off-the-shelf compression garments on average for $8.11 per item. By comparison, similar compression garments veterans obtained from vendors cost the facility an average of $60.63 per item. For the same period, the facility paid vendors on average about $74.75 for a pair of orthotic shoes. In contrast, a pair of orthotic shoes provided in-house by the VA Southern Nevada Healthcare System cost on average $51.02.

The VA Southern Nevada Healthcare System spent about $637,000 from October 2014 through May 2016 by sending veterans to vendors for frequently prescribed compression garments and orthotic shoes. The audit team determined the Prosthetics Laboratory had the capacity to provide at least 70 percent of compression garments and 58 percent of orthotic shoes to veterans in-house using its existing personnel and resources.[12] The audit team determined the VA Southern Nevada Healthcare System could have saved at least an estimated $242,000, had it leveraged its existing laboratory personnel and inventory resources to provide compression garments and orthotic shoes in-house.

Current Chief of Prosthetics Reported Reforms with Immediate Impact

The current Chief of Prosthetics told the audit team in February 2017 that she took actions to better utilize the Prosthetics Laboratory's resources and decrease the VA Southern Nevada Healthcare System's reliance on vendors to fit and provide veterans with compression garments and orthotic shoes. Reforms included dedicating employees to fit veterans with compression garments and orthotic shoes, providing additional training to Prosthetics Laboratory employees, and hiring two additional orthotic fitters. To assess the extent to which these reforms affected the Prosthetics Laboratory's operations, the audit team compared the VA Southern Nevada Healthcare System's outsourcing of compression garments and orthotic shoes to vendors before and after the arrival of the current Chief of Prosthetics in May 2016.

According to NPPD data, the VA Southern Nevada Healthcare System's reliance on vendors significantly decreased and in-house productivity increased. For example, prior to June 2016, the VA Southern Nevada Healthcare System relied on vendors to provide 6,759 of 6,825

[12] To estimate the Prosthetics Laboratory's capacity to provide compression garments and orthotic shoes in-house from October 2014 through May 2016 the OIG calculated an average of the laboratory's in-house issuance of compression garments and orthotic shoes using NPPD data from June 2016 through October 2016. Appendix B provides more details on OIG's scope and methodology.

compression garments (99 percent). After June 2016, the VA Southern Nevada Healthcare System's reliance on vendors to provide compression garments decreased to 731 of 5,333 (14 percent), and in-house use increased to 4,602 of 5,333 (86 percent). Table 3 compares the VA Southern Nevada Healthcare System's reliance on vendors to provide compression garments and orthotic shoes before and after June 2016.

Table 3: VA Southern Nevada Healthcare System's Reliance on Vendors to Provide Compression Garments and Orthotic Shoes Before and After June 2016 (October 2014–June 2017)

Item	Before June 2016 (Oct. 2014–May 2016)	After June 1, 2016 (June 2016–2017)
Compression Garments		
Vendor	6,759	731
In-House	66	4,602
Total	6,825	5,333
Orthotic Shoes		
Vendor	3,681	798
In-House	1,258	1,770
Total	4,939	2,568

Source: OIG analysis of NPPD from October 2014 through June 2017

Current Reliance on Vendors Comparable to Other VISN 21 Medical Centers

The VA Southern Nevada Healthcare System's reliance on vendors—after the current Chief of Prosthetics reported implementing reforms—is also comparable to that of the other medical centers in VISN 21. Table 4 details this comparison from June 2016 through June 2017.

Table 4: Comparison of Percent of Compression Garments and Orthotic Shoes Provided In-House and Outsourced to Vendors by Facilities within VISN 21 (June 2016–June 2017)

Item	VA Southern Nevada Healthcare System	Sierra Nevada Healthcare System	Palo Alto Healthcare System	San Francisco VA
Compression Garments				
In-House	86%	75%	61%	64%
Vendor	14%	25%	39%	36%
Orthotic Shoes				
In-House	69%	53%	45%	97%
Vendor	31%	47%	55%	3%

Source: OIG analysis of NPPD from June 2016 through June 2017

While the reforms made by the current Chief of Prosthetics are promising, the Acting VISN 21 Director needs to take steps to ensure that the Director of the VA Southern Nevada Healthcare System develops and implements effective processes to effectively monitor and ensure that the Prosthetics Laboratory is operated in an efficient and economical manner. Specifically, the Director of the VA Southern Nevada Healthcare System needs to make sure that the Chief of Prosthetics maximizes the Prosthetics Laboratory's personnel and on-hand inventory to provide veterans with timely and cost-efficient access to compression garments and orthotic shoes.

Conclusion

The audit team substantiated the allegation that the VA Southern Nevada Healthcare System's Prosthetics Laboratory unnecessarily sent veterans to vendors for compression garments and orthotic shoes. Prosthetics Laboratory personnel sent veterans to vendors for frequently prescribed compression garments and shoes without taking into consideration the laboratory's capacity to fit and issue these items in-house. Laboratory personnel's poor decision-making went uncorrected because the former Chief of Prosthetics did not provide effective oversight to ensure the laboratory was operating in an efficient and economical manner. The Acting VISN 21 Director needs to make sure that the Director of the VA Southern Nevada Healthcare System develops and implements effective processes to monitor and maintain the current Chief of Prosthetics' reforms. Without doing so, the healthcare system risks veterans experiencing unnecessary delays for compression garments and orthotic shoes. The VA Southern Nevada Healthcare System will also be at continued risk of spending too much on items and services it can readily provide in-house at a lower cost.

Recommendations 1–2

1. The Acting Veterans Integrated Service Network 21 Director ensures the Director of the VA Southern Nevada Healthcare System develops and implements effective processes such as using National Prosthetics Patient Database workload data reports to monitor and ensure the Prosthetics Laboratory operates in a manner that maximizes its personnel and on-hand inventory to provide veterans with timely and cost-effective fitting services for compression garments and orthotic shoes.

2. The Acting Veterans Integrated Service Network 22 Director ensures the VA San Diego Healthcare System Director takes steps such as using National Prosthetics Patient Database workload data reports to monitor and ensure the Prosthetic Service operates in a manner that maximizes its resources to provide veterans with timely and cost-effective fitting services compression garments and orthotic shoes.

Management Comments

The Acting VISN 21 Director concurred with Recommendation 1. To address this recommendation, the Acting VISN 21 Director reported that the Chief of Prosthetics and the Administrative Officer for Prosthetics run NPPD reports on a daily basis to monitor the issuance of compression garments and orthotic shoes, as well as other compliance monitors for the Prosthetics Laboratory. The Acting VISN 21 Director also reported that the Chief of Prosthetics reports contract compliance monitors to the VA Southern Nevada Healthcare Systems' Administrative Executive Council on a quarterly basis.

The Acting VISN 22 Director concurred with Recommendation 2. To address this recommendation, the Acting VISN 22 Director reported that the VISN 22 Prosthetics Manager analyzed data from NPPD for workload and the provision of compression garments and orthotic shoes for all VISN 22 sites using a number of measures such as Encounters per Unique and Purchase Order to Stock Issue. The Acting VISN 22 Director reported that the analysis performed demonstrated that the VA San Diego Healthcare System is operating within the expected range for the measures based on the average of all VISN facilities.

OIG Response

The Acting VISN 21 Director's corrective actions to address Recommendation 1 are responsive, and the OIG considers this recommendation closed. Appendix D contains the full text of the Acting VISN 21 Director's comments.

The Acting VISN 22 Director's corrective actions to address Recommendation 2 are responsive, and the OIG considers this recommendation closed. Appendix E contains the full text of the Acting VISN 22 Director's comments.

Finding 2 Purchasing Employees Incorrectly Closed Prosthetic Consults Which Placed Veterans at Risk of Delayed Care

Prosthetic purchasing employees at the VA Southern Nevada Healthcare System likely closed about 9,514 consults incorrectly using the non-item HCPCS code NR018—indicating the veteran did not follow through—for non-stock prosthetic and orthotic items ordered from a vendor from October 2014 through May 2016. Purchasing employees have a responsibility to perform follow-up actions to ensure the veteran received the prescribed item. If they confirmed the veteran did not follow through with the consult, then purchasing employees should have closed the consult with the NR018 code. However, purchasing employees closed these consults prior to confirming the veterans followed through with consults and obtained the prescribed items. Purchasing employees' practice of prematurely closing prosthetic consults placed veterans at risk of not receiving needed care, such as prescribed prosthetic and orthotic items, in a timely manner.

Prosthetic Purchasing Employees Frequently Used the NR018 Code to Close Consults

VHA standards require prosthetic purchasing employees to close prosthetic consults with the appropriate non-item HCPCS code, specific to the closing reason, after they determine the veteran did not receive the prescribed prosthetic or orthotic item.[13] The former Chief of Prosthetics told the audit team that the use of the NR018 code to close out prosthetic consults should only apply to a limited number of consults. The audit team, however, found purchasing employees used the code frequently. Incorrectly using the NR018 code to prematurely close consults places veterans at risk of not receiving needed care in a timely manner, such as prescribed prosthetic and orthotic items, because closed consults are no longer subject to routine monitoring and follow-up actions by purchasing employees. Table 5 details how frequently VA Southern Nevada Healthcare System purchasing employees used the NR018 code to close out prosthetic consults when compared to other non-item HCPCS codes from October 2014 through May 2016.

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

**Table 5: Frequency of Use of NR018 Code
October 2014 through May 2016**

Non-Item HCPCS Code	Closed Consults	Percent of Total
NR018	9,514	63%
All other non-item HCPCS codes	5,482	37%
Total Consults Closed Using non-item HCPCS Codes	14,996	100%

Source: OIG analysis of closed prosthetic consults from NPPD data

Prosthetic Purchasing Employees Incorrectly Closed Consults Using the NR018 Code

Instead of reviewing pending consults at least weekly and documenting the actions taken to follow up on the status of each consult, purchasing employees simply closed pending consults with the NR018 code and relied on vendors to determine when a veteran received the prescribed prosthetic or orthotic device.[14] Purchasing employees told the audit team that they used vendors' quotes as evidence that veterans received the prescribed prosthetic or orthotic device, and they would then clone the previously closed consult when vendors submitted their quotes to the VA Southern Nevada Healthcare System.[15] Consult cloning reopened the original closed consult and allowed purchasing employees to issue a purchase order to the vendor and close the consult with the HCPCS code that corresponded with the services or items provided.

According to the audit team's analysis of NPPD data, purchasing employees at the VA Southern Nevada Healthcare System cloned about 4,984 of 9,514 consults (52 percent) that were closed with the NR018 code from October 2014 through May 2016. From a review of a random sample of 50 cloned consults, the audit team found that none of the sampled consults included documentation of purchasing employees confirming the veteran did not follow through with the request, thereby violating VHA's *PSAS Business Practice Guidelines for Prosthetics Consult Management*. Purchasing employees told the audit team that they used the NR018 code to close consults because they were instructed to do so by the former Chief of Prosthetics. The former Chief of Prosthetics told the audit team that at some point in 2015 he instructed purchasing employees to close pending consults using a non-item HCPCS code only when no further action was required on their part, because they were unable to monitor the overwhelming number of pending consults.

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

[15] VHA's *PSAS Business Practice Guidelines for Prosthetics Consult Management*, April 2010, provided examples of when it was appropriate to clone a prosthetic consult. For example, a purchasing employee could clone a closed prosthetic consult if a veteran, vendor, or clinician resubmitted previously requested information.

Based on the results of its sample analysis, the audit team estimates that at least 95 percent of the 4,984 cloned consults were incorrectly closed using the NR018 code, and it is very likely that all 4,984 cloned consults were incorrectly closed. The following example illustrates the risks associated with the incorrect use of an NR018 code to close a prosthetic consult.

Example

A purchasing employee closed a consult for below-knee and above-knee prostheses in December 2014 with no documentation to support the use of the NR018 code. Because the purchasing employee did not perform any follow-up actions, the facility did not know until several months later that the veteran had encountered an issue trying to obtain the prescribed items. In February 2015, the veteran contacted the facility and said the vendor was waiting for approval from VA to provide the items. This contact prompted the facility to clone the consult and coordinate with the vendor to ensure delivery of the items to the veteran. A purchasing employee subsequently closed the cloned consult in March 2015, about three months after it was closed with the NR018 code. If the veteran had not contacted the facility, it would not have been aware of the delayed approval, placing the veteran at risk of experiencing even greater delays.

While closing and subsequently cloning a prosthetic consult is not prohibited, the process assumes employees closed the original consult correctly. Incorrectly closing a prosthetic consult and relying on vendors to provide quotes as evidence that the veteran received the prescribed item unnecessarily places the facility at risk. Facilities must be able to assess whether veterans received prescribed prosthetic or orthotic items from vendors. Because purchasing employees misused the NR018 code so frequently, the VA Southern Nevada Healthcare System has little assurance that purchasing employees performed the required follow-up actions to determine if veterans still needed the prescribed orthotic or prosthetic device before closing the remaining 4,530 consults with the NR018 code. Without such assurances, the VA Southern Nevada Healthcare System risks delaying veterans' access to prescribed prosthetic and orthotic items and care.

Former Chief of Prosthetics Did Not Ensure Compliance with VHA's Business Practice Guidelines

The practice of incorrectly closing prosthetic consults using the NR018 code went undetected because the former Chief of Prosthetics did not effectively monitor purchasing employees' compliance with VHA standards when they used non-item HCPCS codes to close a consult.[16] The audit team found minutes from an April 2011 VISN 22 Prosthetic Service Line Council

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

meeting, approved by the VISN 22 Prosthetic Representative, that recommended all Chiefs of Prosthetics conduct routine reviews of the usage of non-item HCPCS codes. The former Chief of Prosthetics told the audit team that he conducted reviews to ensure appropriate use of the codes, but he was unable to provide supporting documentation.

The Chief of Prosthetics is fully responsible for the management and supervision of all phases of prosthetic operations, which includes exercising oversight to ensure compliance with applicable laws, regulations, and relevant government guidance.[17] While there was no specific VHA requirement at the time to review purchasing employees' use of non-item HCPCS codes, the development and implementation of routine reviews, as recommended by VISN 22, would have established an oversight mechanism with the capacity to identify the purchasing employees' practice of incorrectly closing prosthetic consults using the NR018 code. VHA's updated *PSAS Business Practice Guidelines for PSAS Consult Management*, dated May 2017, established a requirement that the Chief of Prosthetics routinely monitors non-item HCPCS code usage. As such, the Acting VISN 21 Director should ensure the VA Southern Nevada Healthcare System Director develops and implements effective processes to perform routine reviews over the use of all non-item HCPCS codes.

New Prosthetics Chief's Reforms Show Promise

The current Chief of Prosthetics told the audit team that she instructed purchasing employees to discontinue the practice of incorrectly closing prosthetic consults using the NR018 code. The Chief of Prosthetics also said that she provided purchasing employees with further instructions and training on how to manage prosthetic consults and use HCPCS codes in accordance with VHA standards.[18] According to the audit team's analysis of NPPD data, purchasing employees only used the NR018 code 123 times from July 2016 through May 2017, compared to approximately 6,100 times from June 2015 through May 2016.

The reforms made by the current Chief of Prosthetics are promising. However, the Chief of Prosthetics needs to continue to monitor the usage of the NR018 code and provide ongoing instruction and training to purchasing employees to ensure their compliance with the updated VHA standards. The Acting VISN 21 Director should ensure that the director of the VA Southern Nevada Healthcare System develops and implements effective processes to monitor the usage of the NR018 code to ensure proper usage of non-item HCPCS codes when closing prosthetic and orthotic consults.

[17] VA Handbook 5005/15 Part II, Appendix G34, March 17, 2006.

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

Conclusion

The audit team determined prosthetic purchasing employees incorrectly closed some prosthetic consults from October 2014 through May 2016. These practices went undetected because the former Chief of Prosthetics did not ensure purchasing employees were compliant with VHA's prosthetics consult management and close-out processes and procedures. While reforms made by the current Chief of Prosthetics indicate that the misuse of the NR018 code is diminishing, management has a responsibility to exercise oversight to ensure compliance with VA guidance and policies. Without developing and implementing effective oversight processes to ensure purchasing employees comply with established guidelines and perform the required follow-up actions, veterans are at continued risk of not receiving prescribed prosthetic and orthotic items in a timely manner.

Recommendations 3–4

3. The Acting Veterans Integrated Service Network 21 Director ensures the VA Southern Nevada Healthcare System Director develops and implements effective processes to monitor purchasing employees' usage of all non-item Healthcare Common Procedure Coding System codes to ensure the proper utilization of these codes.
4. The Acting Veterans Integrated Service Network 21 Director ensures the VA Southern Nevada Healthcare System Director develops and implements a process to examine the 4,530 consults closed, but not cloned, by purchasing employees using the NR018 code from October 2014 through May 2016 and take necessary action to ensure veterans received their prescribed prosthetic or orthotic item(s).

Management Comments

The Acting VISN 21 Director concurred with Recommendation 3 and provided an acceptable action plan. To address this recommendation, the Acting VISN 21 Director reported that the Chief of Prosthetics and Administrative Officer for Prosthetics runs reports from NPPD on a daily basis to monitor the use of the NR018 code. The Acting VISN 21 Director also reported that the Chief of Prosthetics reports contract compliance monitors, which include NR018 code usage, to the VA Southern Nevada Healthcare Systems' Administrative Executive Council on a quarterly basis.

The Acting VISN 21 Director also concurred with Recommendation 4 and provided an acceptable action plan. To address this recommendation, the Acting VISN 21 Director reported that the Chief of Prosthetics reviewed the 4,530 consults that were closed but not cloned and notified the provider to reexamine the veteran to determine if veterans still needed the prescribed items. In cases where there was still a medical need for the item, new consults for the items were created.

OIG Response

The Acting VISN 21 Director's corrective actions to address Recommendations 3 and 4 are responsive and the OIG considers these recommendations closed. Appendix D contains the full text of the Acting VISN 21 Director's comments.

Appendix A: Background

VA Southern Nevada Healthcare System

The VA Southern Nevada Healthcare System reported providing inpatient and outpatient health care services to about 57,000 veterans. In addition to its main facility located in North Las Vegas, Nevada, the VA Southern Nevada Healthcare System operates seven outpatient clinics and community-based outpatient clinics across its catchment area. The healthcare system's catchment area includes Nevada's Clark, Nye, and Lincoln counties.

The VA Southern Nevada Healthcare System was realigned under the VA Sierra Pacific Network (VISN 21) in October 2015. VISN 21 includes seven major healthcare systems based in Fresno, California; Palo Alto, California; Mather, California; San Francisco, California; Honolulu, Hawaii; Las Vegas, Nevada; and Reno, Nevada. Before this realignment, the VA Southern Nevada Healthcare System was aligned under VISN 22, the Desert Pacific Healthcare Network.

Closing Consults

VHA's April 2010 *PSAS Business Practice Guidelines for Prosthetics Consult Management* required prosthetic purchasing employees to place prosthetic consults into a pending status until the consult was completed and closed. This document also provided examples of circumstances when a purchasing employee could close a prosthetic consult. For example, a purchasing employee could close a consult once it was determined that the veteran picked up or received the item, or a veteran was admitted to a hospital as an inpatient for 60 calendar days or longer. Purchasing employees could also use non-item HCPCS codes to close a prosthetic consult in certain instances, such as once they confirmed the veteran did not pick up the item or it was no longer needed.

Cloning Consults

Cloning prosthetic consults is a process used to reopen closed consults. VHA's prosthetics consult guidelines provided examples of when it was appropriate to clone a prosthetic consult.[19] For example, a purchasing employee could clone a closed prosthetic consult if a veteran, vendor, or clinician resubmitted previously requested information. A purchasing employee could also clone a closed prosthetic consult if the consult was less than a year old and if the prosthetic or orthotic item issued to the veteran required repair or replacement. Prosthetic consults closed for more than 12 months could also be cloned. However, before cloning a consult the Chief of

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

Prosthetics was required to contact the appropriate clinician to determine whether the veteran needed to be reevaluated.

Updated PSAS Business Practice Guidelines for Prosthetics Consult Management

VHA's updated *PSAS Business Practice Guidelines for PSAS Consult Management*, dated May 2017, details additional procedures that facilities should follow to manage the consult process for prosthetic or orthotic items, sensory aids, and related services. The updated guidelines eliminated the NR001 non-item HCPCS code (Veteran/Clinician did not follow through with request) and replaced it with

- NR018—Veteran did not follow through with PSAS request, and
- NR019—Clinician did not follow through with PSAS request.

The updated guidelines also required Chiefs of Prosthetics to routinely monitor non-item HCPCS code usage and develop corrective action plans as necessary to ensure employees are using these codes in accordance with the business practice guidelines.

Appendix B: Scope and Methodology

Scope

The OIG team conducted its audit from June 2016 through April 2018. The audit scope included a review of the VA Southern Nevada Healthcare System Prosthetics Laboratory's use of outside vendors to provide compression garments and orthotic shoes from October 2014 through June 2017. The audit team also reviewed the Prosthetics Laboratory's use of the NR018 code to close prosthetic consults from October 2014 through May 2017.

Methodology

To gain an understanding of how non-item HCPCS codes are used to close prosthetic consults and the use of outside vendors to fulfill these consults, the audit team reviewed applicable PSAS and VHA policies, procedures, and directives. The audit team conducted a site visit in June 2016 to the VA Southern Nevada Healthcare System's main facility in North Las Vegas, Nevada. The team interviewed facility officials and an official from VISN 21 who were knowledgeable about the Prosthetics Laboratory's use of outside vendors to provide compression garments and orthotic shoes, the prosthetic consult fulfillment process, and the use of non-item HCPCS codes. The audit team also interviewed Prosthetics Laboratory employees to learn more about their daily responsibilities and workload.

To assess the extent to which the VA Southern Nevada Healthcare System's purchasing employees accurately used the non-item HCPCS code NR018 to close out prosthetics consults, the audit team used NPPD data from October 2014 through May 2016. To identify cloned consults, the team first identified the consult number associated with the consults closed using the NR018 code. It then queried NPPD data to identify any duplicate consult numbers, which resulted in a population of 4,984 cloned consults. The audit team randomly selected 50 cloned consults to review from its NPPD data query. To assess the extent to which these sampled consults were closed correctly with the NR018 code, the audit team reviewed consult information captured in CPRS provided by the current VA Southern Nevada Healthcare System's Chief of Prosthetics.

Table 6 details the audit team's estimates related to the incorrect use of the NR018 code to close prosthetic consults.

Table 6: Incorrect use of NR018 code

Category	Estimate	Margin of Error	90% Confidence Interval Lower Limit	90% Confidence Interval Upper Limit
Percentage of Cloned Consults Closed Incorrectly Using NR018	100%	4.6%	95.4%	100%

Source: OIG analysis of a random sample of cloned prosthetic consults closed using the NR018 code from October 2014 through May 2016

Questioned Cost Calculation

To calculate the $242,000 in questioned cost, the audit team estimated the VA Southern Nevada Healthcare System Prosthetics Laboratory's capacity to provide compression garments and orthotic shoes in house from October 2014 through May 2016. To determine the laboratory's potential capacity from October 2014 to May 2016, the audit team averaged NPPD data for a five-month period of the laboratory's in-house provision of compression garments and orthotic shoes. The audit team used June 2016 through October 2016 as a basis for the average because it represented a timeframe after the current Chief of Prosthetics started and implemented reforms to increase the laboratory's use of existing resources. In addition, this timeframe included Prosthetics Laboratory personnel levels that were consistent with the laboratory's personnel levels from October 2014 through May 2016. The audit team believes its estimate is reasonable that the VA Southern Nevada Healthcare System Prosthetics Laboratory had the capacity to provide at least 70 percent of compression garments and 58 percent of orthotic shoes outsourced to vendors in-house from October 2014 through May 2016.

Fraud Assessment

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

- Soliciting the OIG's Office of Investigations to determine if there were any ongoing cases involving the outsourcing of compression garments and orthotic shoes at the VA Southern Nevada Healthcare System, and
- Analyzing NPPD data to identify trends in the VA Southern Nevada Healthcare System's usage of certain vendors when outsourcing compression garments and orthotic shoes.

The OIG identified some instances of potential fraud during this audit and referred these instances to the OIG Office of Investigations.

Data Reliability

The audit team used computer-processed data from NPPD to identify the total number of compression garments and orthotic shoes the VA Southern Nevada Healthcare System outsourced to vendors. The team used this data to estimate the financial impact of using vendors to provide veterans with compression garments and orthotic shoes. The audit team also used NPPD data to identify the total number of prosthetic consults closed using the NR018 code. To assess the reliability of NPPD data, the audit team compared a sample of NPPD transactions to supporting source documentation, such as prosthetic consult entries in CPRS and hard copy vendor invoices. The audit team concluded that NPPD data on prosthetic and orthotic item purchases made by the VA Southern Nevada Healthcare System was appropriate and sufficient for this audit.

The audit team also used Corporate Data Warehouse consult activity data to assess the workload of the VA Southern Nevada Healthcare System's former Prosthetics Laboratory Supervisor, Prosthetic Technician, and Orthotic Fitter. To assess the reliability of the consult activity data, the audit team compared a sample of consult activity to supporting source documentation, such as prosthetic consult entries in CPRS. The audit team concluded that the Corporate Data Warehouse consult activity data was appropriate and sufficient for this audit.

Government Standards

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1	Funds unnecessarily expended to send veterans to vendors to obtain compression garments and orthotic shoes, which could have been better utilized by the VA Southern Nevada Healthcare System		$242,000[20]
	Total		**$242,000**

[20] The questioned cost of $242,000 represents the amount the VA Southern Nevada Healthcare System could have saved if the Prosthetics Laboratory used its existing resources to fit and issue compression garments and orthotic shoes to veterans in-house, rather than outsourcing these items to vendors from October 2014 through May 2016. To estimate the Prosthetics Laboratory's capacity to provide compression garments and orthotic shoes in-house from October 2014 through May 2016, the OIG calculated an average of the laboratory's in-house issuance of compression garments and orthotic shoes using NPPD data from June 2016 through October 2016. The OIG believes that this estimate is reasonable as it reflects the personnel levels that existed during the OIG's period of review. Appendix B provides more details on OIG's scope and methodology.

Appendix D: Management Comments—Veterans Integrated Service Network 21

Date: April 16, 2018

From: Acting VISN 21 Network Director (10N21)

Subj: Draft Report: Audit of the VA Southern Nevada Healthcare System's Alleged Unnecessary Use of Outside Vendors to Purchase Prosthetics (Project Number 2016-02247-R1-0121)

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

1. This is in response to the Office of Inspector General (OIG) Draft Report: Audit of the VA Southern Nevada Healthcare System's Alleged Unnecessary Use of Outside Vendors to Purchase Prosthetics to obtain prescribed compression garments and orthotic shoes, which resulted in the facility paying higher prices for these items. Additionally, the OIG expanded the scope of the audit to include a review of the Prosthetics use of the non-item Healthcare Common Procedure Coding System NR018 code because VA Southern Nevada Healthcare System employees reported that purchasing employees were incorrectly using this code to close prosthetic consults.

RECOMMENDATION 1: The Veterans Integrated Service Network 21 Director ensures the Director of the VA Southern Nevada Healthcare System develops and implements effective processes such as using National Prosthetics Patient Database workload data reports to monitor and ensure the Prosthetics Laboratory operates in a manner that maximizes its personnel and on-hand inventory to provide veterans with timely and cost-effective fitting services for compression garments and orthotic shoes.

CONCUR: VA Southern Nevada Healthcare System concurs with the recommendation and has taken steps to continue to monitor the compression stockings and orthotic shoes (see attached). During fiscal year 2017 only 45 orders for compression stockings and 76 orders for orthotic shoes were sent to outside vendors. These were either due to travel issues, complexity of stockings or in the case of shoes other devices being attached. During fiscal year 2018 through March only 11 compression stockings and 25 orthotic shoe orders have been sent to outside vendors. These have also been for travel issues, complexity of stockings or in the case of shoes other devices being attached. The Chief of Prosthetics and Administrative Officer for Prosthetics run the NPPD daily monitoring not only the above but all compliance monitors for Prosthetic's to stay on top of all issues. The Chief of Prosthetic's also reports contract compliance monitors to the Administrative Executive Council (AEC) quarterly.

RECOMMENDATION 3: The Veterans Integrated Service Network 21 Director ensures the VA Southern Nevada Healthcare System Director develops and implements effective processes to monitor purchasing employees' usage of all non-item Healthcare Common Procedure Coding System codes to ensure the proper utilization of these codes.

CONCUR: VA Southern Nevada Healthcare System concurs with recommendation and has taken steps to continue to monitor the NPPD data daily, weekly, monthly and to report to the Administrative Executive Council (AEC) quarterly. During fiscal year 2017 the NR018 was used 14 times and during fiscal year 2018 through March has not posted at all. The Chief of Prosthetics and Administrative Officer for Prosthetics run the NPPD daily monitoring not only the above but all compliance monitors for Prosthetic's to stay on top of all issues.

RECOMMENDATION 4: The Veterans Integrated Service Network 21 Director ensures the VA Southern Nevada Healthcare System Director develops and implements a process to examine the 4,530 consults

closed, but not cloned, by purchasing employees using the NR018 code from October 2014 through May 2016 and take necessary action to ensure veterans received their prescribed prosthetic or orthotic item(s).

CONCUR: VA Southern Nevada Healthcare System concurs with recommendation, during the two-year period the OIG was working with the current Chief of Prosthetics the 4,530 consults were reviewed and where appropriate the provider notified to reexamine the veteran for medical need. In the cases where there was still a medical need, new consults were entered as the one- year period the consult is available had passed.

Based on the processes that have been implemented, I recommend this review be closed.

3. If you have any questions or concerns, please contact Deborah Bolda, Chief of Prosthetics Service at 702-791-9000, extension 15293.

(*Original signed by*)

Lisa M. Howard

Note: Additional documentation to support information in the response was provided to the OIG; however, due to the length of these documents the OIG did not include these documents in this report.

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

Appendix E: Management Comments—Veterans Integrated Service Network 22

Date: April 27, 2018 (received May 1, 2018)

From: Acting Director, Desert Pacific Healthcare Network\VISN 22 (10N22)

Subj: Draft Report: Audit of the VA Southern Nevada Healthcare System's Alleged Unnecessary Use of Outside Vendors to Purchase Prosthetics (Project Number 2016-02247-R1-0121)

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

This is in response to VAOIG Draft Report – Unnecessary Use of Outside Vendors Prosthetics – Las Vegas (Project # 2016-02247-R1-0121). The Acting Network Director (10N22) concurs with the report and VISN 22- specific recommendation and provides the corrective action outlined below.

RECOMMENDATION 2: The Veterans Integrated Service Network 22 Director ensures the VA San Diego Healthcare System Director takes steps such as using National Prosthetics Patient Database workload data reports to monitor and ensure the Prosthetic Service operates in a manner that maximizes its resources to provide veterans with timely and cost-effective fitting services compression garments and orthotic shoes.

CONCUR: VISN 22 concurs with the recommendation. The VISN 22 Prosthetics Manager has analyzed data from the National Prosthetics Patient Database for workload and the provision of compression garments and orthotic shoes for all VISN 22 sites using a number of measures including Encounters per Unique; Purchase Order to Stock Issue; and Purchase Order to Unique. The analyses demonstrate that VA San Diego is operating within the expected range for these measures based upon the average of all VISN facilities.

Similarly, the use of NR018 Non-response/Non-Item Healthcare Common Procedure Coding System code to close consults was reviewed for VA San Diego and for all VISN 22 sites. VA San Diego is currently exceeding the National Prosthetics Program FY 18 performance goal for fulfillment of consults at 92.39% alleviating concerns over use of NR018. Plans are underway to utilize and monitor the NPPD and other measures across the VISN to drive improvement, and to monitor effective and efficient operations.

Based on the data review and processes that are being implemented, I recommend this recommendation be closed.

If you have any concerns, please contact Randy Quinton, Deputy Network Director, at 562-826-5963.

(*Original signed by*)

Robert M. Smith, MD,

Acting Director

VA Desert Pacific Healthcare Network

Note: Additional documentation to support information in the response was provided to the OIG; however, due to the length of these documents the OIG did not include these documents in this report.

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

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