DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Better Oversight of Prosthetic Spending Needed to Reduce Unreasonable Prices Paid to Vendors

AUDIT | **REPORT #20-01802-234** | **SEPTEMBER 23, 2021**

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Executive Summary

To enable veterans to function at their highest level and maximize their independence, VA provides medically prescribed prosthetic and rehabilitative items and services to eligible recipients. Previous VA Office of Inspector General (OIG) audits identified weaknesses in the oversight of the prosthetics program by the Veterans Health Administration's (VHA) Prosthetic and Sensory Aids Service (PSAS) that led to overpayments to vendors and missed opportunities for cost savings.[1] The OIG conducted this audit to determine whether VHA provided effective oversight of spending on prosthetic and orthotic items provided to veterans by outside vendors. Such items—artificial limbs, shoes, shoe inserts, and compression garments—accounted for about $318.8 million, or about 9 percent of prosthetic spending in fiscal year 2019. The audit team sought to determine if VHA oversight ensured medical facilities paid reasonable prices when reimbursing vendors for these items.

VHA has not established pricing guidance for prosthetic and orthotic items it provides to veterans using outside vendors, so the team used available Medicare rates, established by the Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS), for prosthetic and orthotic items to assess the reasonableness of rates. According to Title 38 of the United States Code (U.S.C.), section 1703(i), VHA should, to the extent practicable, reimburse outside providers no more than established Medicare rates for medical services provided to veterans under any provision of Title 38.[2] Under section 1701, the term "medical services" includes wheelchairs, artificial limbs, trusses, and similar appliances, which are all items that PSAS is responsible for providing to veterans.[3] For purchased prosthetic and orthotic items without Medicare rates, the OIG identified rates to use as benchmarks for the reasonableness of prices VHA paid for these items across all medical facilities. These national benchmarks were based on a pricing methodology described in the Code of Federal Regulations (C.F.R.).[4] The OIG considers these national rates (referred to in this report as OIG benchmark rates) reasonable for reimbursement of prosthetic and orthotic items provided by vendors. In addition, the audit team briefed PSAS officials about its methodology at the start of and during

[1] The previous audit reports are listed in appendix A.

[2] 38 U.S.C. § 1703(i)(1).

[3] 38 U.S.C. § 1701(6)(F)(i); VHA Handbook 1173.1 *Eligibility,* November 2, 2000.

[4] 38 C.F.R. § 17.56. This regulation ceased to apply to items included in this audit on June 6, 2019; however, it still applies to some care furnished after this date. The audit team used a pricing methodology based on this regulation because PSAS lacks guidance on specific reimbursement rates for prosthetic and orthotic items purchased from vendors that do not have Medicare rates. The pricing methodology was supposed to be determined by the authorizing medical facility and represented the charge falling at the 75th percentile when the facility's billings for a procedure code were ranked from the highest to the lowest. Rather than ranking prices by facility, the team ranked prices nationally to be conservative. Appendixes B and C detail the team's methodology and sampling.

the audit. PSAS leaders agreed that the OIG's sampling and pricing methodologies were reasonable for the purpose of this audit.

What the OIG Found

VHA's oversight of prosthetic spending was ineffective, resulting in medical facilities sometimes reimbursing vendors at unreasonable rates. The audit team estimated that medical facilities spent about $10 million more than reasonable rates in the six-month period from October 2019 through March 2020. Furthermore, the team found that prosthetic spending data were unreliable—about 36,200 transactions in the National Prosthetics Patient Database (NPPD) from October 2019 through March 2020 contained at least one inaccurate data element, including the price paid.

Unreasonable rates, along with data inaccuracies, occurred because PSAS leaders did not assume their oversight role and take steps to

- assess the applicability of laws and regulations to prosthetic spending to ensure reasonable rates,
- review and update policies that designate oversight roles and responsibilities, or
- establish processes and procedures to monitor the accuracy of prosthetic spending data.

Facilities Sometimes Reimbursed Vendors at Rates That Exceeded Medicare and OIG's Benchmark

The audit team reviewed a random sample of 207 prosthetic transactions from October 2019 through March 2020 to determine if prices paid to vendors exceeded reasonable rates. Based on this review, the audit team estimated that about 41,300 of roughly 112,600 transactions during the review period exceeded reasonable rates.[5] The OIG determined VHA paid excessive prices because VA and VHA officials did not assess the applicability of 38 U.S.C. § 1703(i) to VHA's prosthetics program and did not provide other guidance to ensure that medical facilities reimburse vendors at consistent prices for prescribed prosthetic and orthotic items. Without guidance or a benchmark to measure price reasonableness, the audit team found purchasing agents simply reimbursed vendors at the billed amounts. Medical facilities paid vendors varying amounts for the same items, some of them unreasonable.

[5] See appendix C, table C.2.

VA and VHA Officials Did Not Assess the Applicability of Laws and Regulations to Prosthetics

When asked by the audit team, PSAS officials reported they did not know whether 38 U.S.C. § 1703(i) (use of Medicare rates) or the pricing methodology in Title 38 of the C.F.R. § 17.56 (for items without Medicare rates), applied to the prosthetics program.[6] They said it was not their responsibility to monitor laws and regulations and that they rely on the advice of VA's Office of Regulatory and Administrative Affairs or the Office of General Counsel to advise PSAS regarding the applicability of any new laws or regulations to the program. According to a PSAS regulatory specialist, neither of these offices notified PSAS officials of the applicability of 38 U.S.C. §1703(i) or that Medicare rates should be used when reimbursing vendors. The OIG recommended appropriate officials, including the VA Office of General Counsel, determine if the laws and regulations cited in this report apply to the reimbursement rates medical facilities should pay for prosthetic and orthotic items provided by vendors. If these laws and regulations apply, guidance should be issued requiring medical facilities to adhere to them; if not, guidance should be developed to ensure medical facilities purchase items at reasonable prices.

PSAS Did Not Update Policy That Designates Oversight of Prosthetic Spending

The audit team found the applicable handbook was outdated and inconsistent with the oversight responsibilities reported, and PSAS inadequately monitored prosthetic spending. The VHA handbook makes the executive director of PSAS responsible for developing policy to ensure the overall consistency of the prosthetics program and its budget.[7] However, the executive director reported that since 2010, Veterans Integrated Service Network (VISN) prosthetic representatives have, in fact, been responsible for overseeing operations.[8] The PSAS executive director reported that the handbook has not been updated to reflect practice because of pending actions to amend VA's regulations related to the provision of prosthetic and rehabilitative items and services. According to the chief counsel of the Office of General Counsel Health Care Law Group, pending regulations are slowing revisions to the handbook. However, the chief counsel stated that these regulations do not prevent issuing guidance to update oversight responsibilities. The OIG recommended the establishment of a formal oversight structure for the prosthetics program and processes and procedures to monitor prosthetic spending.

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[6] While the requirements of 38 C.F.R. § 17.56 ceased to apply to most services on June 6, 2019, the audit team interviewed officials from PSAS to determine if they had taken steps to develop a fee schedule, as described in this regulation, for items without a Medicare rate.

[7] VHA Handbook 1173.1. This document refers to the chief consultant, PSAS Strategic Healthcare Group; however, according to the PSAS executive director, this is now the executive director position.

[8] VHA delivers health care through 18 regional VISNs, each led by a director who is responsible for the coordination and oversight of administrative and clinical activities at medical facilities in the specified area.

In December 2020, VA finalized the regulations related to the provision of prosthetic and rehabilitative items and services.[9] As a result, the assistant under secretary for health for patient care services issued a notice rescinding certain handbooks that assigned oversight responsibility of the prosthetics program to the PSAS executive director.[10] Rescinding outdated handbooks is the first step in addressing oversight responsibilities; however, action needs to be taken to establish roles and responsibilities for the prosthetics program. The OIG notes that during the period of review for prosthetic purchases—October 2019 through March 2020—the handbooks were still in effect.

PSAS Did Not Adequately Monitor Prosthetic Spending Data

The integrity of prosthetic spending data is key to helping managers readily discern whether medical facilities are reimbursing vendors at higher than reasonable rates for the same prosthetic and orthotic items. Despite the importance of this information, VISN prosthetic representatives did not regularly monitor NPPD spending data to make sure the data were accurate. The audit team found that data in the NPPD that are critical to monitoring prosthetic spending, such as prices paid, quantities purchased, and Healthcare Common Coding Procedure System codes used, were not always accurate. The team estimated that about 34,500 transactions contained an error related to incorrect codes or prices paid. The OIG recommended NPPD data limitations be addressed and controls and monitoring requirements enhanced to make sure facilities enter accurate prosthetic spending data that can provide VHA with a sound basis to compare what it should have paid with what it did pay.

Impact of Ineffective Oversight of Prosthetic Spending

Ineffective oversight of prosthetic spending puts VHA at risk of paying vendors higher than reasonable prices. The OIG estimates VHA could save up to $20 million per year by taking steps to assess laws and regulations and implementing guidance to make sure medical facilities reimburse vendors for prosthetic and orthotic items at reasonable prices.[11]

Management Comments and OIG Response

The deputy to the deputy under secretary for health, performing the delegable duties of the under secretary for health, concurred with the recommendations. The deputy provided corrective action

[9] Prosthetic and Rehabilitative Items and Services, 85 Fed. Reg. 84245, 84261 (December 28, 2020) (to be codified at 38 C.F.R. pt. 17).

[10] VHA Notice 2021-06, "Recission of VHA Prosthetics Policies," April 6, 2021. See appendix A for policy documents rescinded by this notice.

[11] The potential savings for one year are based on the OIG estimate that medical facilities paid vendors about $4.1 million more than established Medicare rates and about $5.9 million more than the OIG's benchmark rates nationally for the six months from October 2019 through March 2020. As noted in appendix D, the OIG summed and annualized these amounts to arrive at the potential savings of about $20 million for one year.

plans that are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and will close recommendations when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

The deputy also provided general and technical comments regarding the OIG's pricing methodology. Specifically, the deputy requested that the OIG remove report language that the audit team had shared with PSAS officials throughout the audit and that officials had agreed the OIG's pricing methodology was reasonable. According to the deputy, PSAS did not agree that the sampling and pricing methodologies were fair and consistently contested the applicability of both 38 C.F.R. § 17.56 and 38 U.S.C. § 1703. The deputy said, "PSAS does not believe that the methodology in 38 C.F.R. § 17.56 is the standard of 'reasonableness' that should be applied for pricing."

The OIG did not make these changes to the report as requested by the deputy. The audit team met with and briefed PSAS officials, including the executive director and a field operations manager, several times to give status updates on the audit. The team also had detailed discussions about how it conducted the audit and calculated the rates (Medicare rates and OIG-identified rates using the pricing methodology from 38 C.F.R. § 17.56) used to benchmark price reasonableness, as well as the transactions that exceeded these rates. PSAS officials agreed that the OIG's approach was reasonable for this audit. The OIG acknowledged in the report that PSAS officials were not aware whether laws and regulations on reimbursing outside providers applied to the prosthetics program. The report makes clear that the team did not consider the pricing methodology in 38 C.F.R. § 17.56 to be the legally required standard; rather, the team used this methodology to establish price reasonableness for items without Medicare rates because VHA lacked any other pricing guidance related to these items. Appendix E includes the full text of the deputy's comments, including the general and technical comments.

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Contents

Abbreviations

C.F.R.	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
FY	fiscal year
GAO	Government Accountability Office
HCPCS	Healthcare Common Procedure Coding System
NPPD	National Prosthetics Patient Database
OIG	Office of Inspector General
PSAS	Prosthetic and Sensory Aids Service
U.S.C.	United States Code
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

In fiscal year (FY) 2019, VA spent about $3.47 billion on prosthetic and rehabilitative items and services such as artificial limbs, orthopedic footwear, orthopedic braces and supports, eyeglasses, hearing aids, speech communication aids, cosmetic restorations, and home oxygen. Previous VA Office of Inspector General (OIG) audits identified weaknesses in oversight by the Veterans Health Administration's (VHA) Prosthetic and Sensory Aids Service (PSAS) leading to overpayments to vendors and missed opportunities for cost savings.[12]

The National Prosthetics Patient Database (NPPD) organizes the $3.47 billion spent on prosthetic and rehabilitative items into 27 groups, such as wheelchairs and accessories, oxygen and respiratory, home dialysis, and surgical implants. The OIG focused on spending in four groups:

- 200 – Artificial Legs
- 300 – Artificial Arms and Terminal Devices
- 400 – Orthosis/Orthotics
- 500 – Shoes/Orthotics

Total spending on prosthetic and orthotic items in these four groups amounted to about $318.8 million, or about 9 percent, of the FY 2019 total.[13] The OIG conducted this audit to determine if VHA provided effective oversight to ensure medical facilities paid reasonable prices, such as established Medicare rates, for prosthetic and orthotic items during the first half of FY 2020—from October 2019 through March 2020.[14]

Spending on Prosthetic and Orthotic Items

VA provides medically prescribed prosthetic and sensory aids, medical and assistive devices, and repair services for devices to eligible veterans to help them function at their highest level and maximize their independence. Before the COVID-19 pandemic, spending related to the overall prosthetics program steadily rose, with obligations from FY 2013 through FY 2019 increasing by an average of 8 percent annually. The number of veterans receiving prosthetic devices also increased during this time, by an average of 3 percent annually.

[12] Appendix A summarizes prior OIG audits.

[13] This amount represents costs associated with prosthetic and orthotic items issued from medical facilities' inventory and the Denver Logistics Center, as well as purchase card transactions from vendors.

[14] The audit team considered prosthetic and orthotic items included in NPPD groupings 200 through 500. These groupings include items such as artificial limbs, shoes, shoe inserts, and compression garments. Appendix B provides additional information on the scope and methodology.

Figure 1 shows obligations for all prosthetic spending and the number of veterans receiving prosthetic items from FY 2013 through FY 2019.

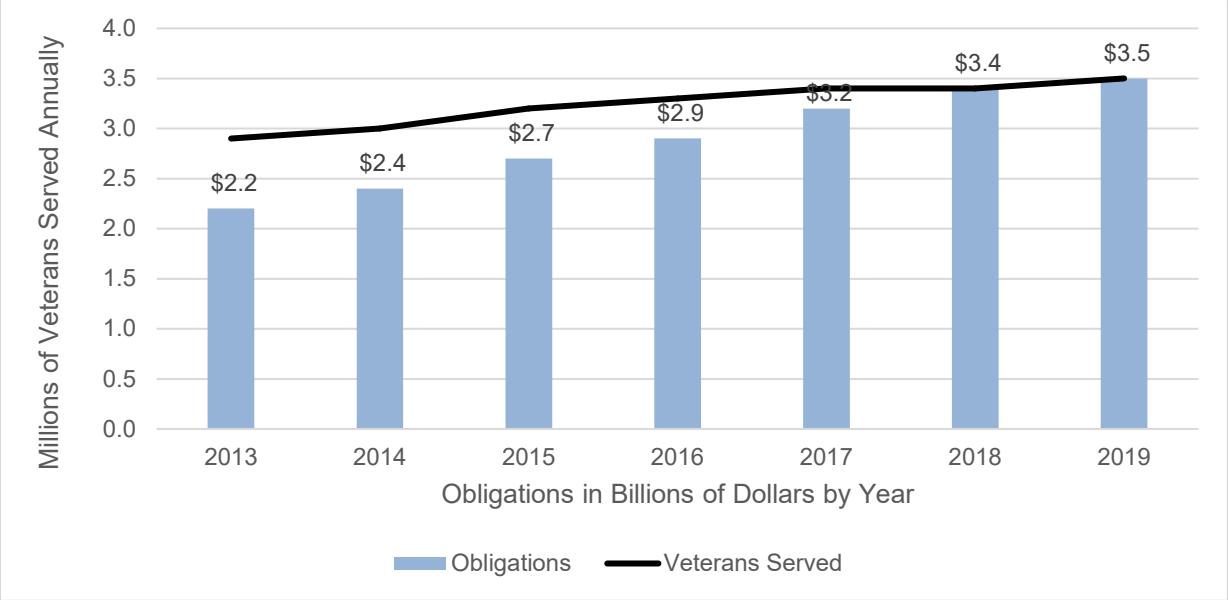

Figure 1. *Obligations for prosthetic spending and veterans receiving prosthetic items from FY 2013 through FY 2019.*
Source: VA OIG analysis of VA's annual budget submissions from FY 2015 through FY 2021. Actual obligations are reported in budget submissions two years after the end of the fiscal year. For example, FY 2019 actual obligations are reported in the FY 2021 budget submission.

It should be noted that FY 2020 was not representative of this steady rise in program spending because of the decline in the number of veterans who received care through VHA during the COVID-19 pandemic. In FY 2020, VA spent about $3.1 billion providing about 3.3 million veterans with prosthetic items.[15]

Governance Structure of the Prosthetic and Sensory Aids Service

At the medical facility level, orthotic and prosthetic personnel such as prosthetists, orthotists, orthotic fitters, and technicians are generally responsible for providing prosthetic items to veterans—from the point when a healthcare provider prescribes a prosthetic or orthotic item to when the item is delivered and, if necessary, fitted to the veteran. Orthotic and prosthetic personnel are also generally responsible for teaching veterans how to use the item and for replacing and repairing these items.

At the national level, PSAS is led by an executive director. According to the incumbent, the executive director reports to the executive director of the Rehabilitation and Prosthetics Service,

[15] OIG's analysis of VHA Pyramid Analytics data for prosthetic spending during FY 2020.

who reports to the under secretary for health. The executive director of PSAS is responsible for developing policy to ensure the overall consistency of the prosthetics program and its budget across Veterans Integrated Service Networks (VISNs) and medical facilities.[16] The PSAS executive director reported that PSAS relies on prosthetic representatives at the VISN level to implement national guidance and ensure local compliance.[17] However, the PSAS executive director does not have direct authority over VISN prosthetic representatives because they report to positions such as the chief medical officer, chief logistics officer, or deputy network director within the VISN, who reports to the assistant under secretary for health for operations, a separate reporting structure.

Figure 2 presents the governance structure of VHA's prosthetics program as of July 1, 2020.[18]

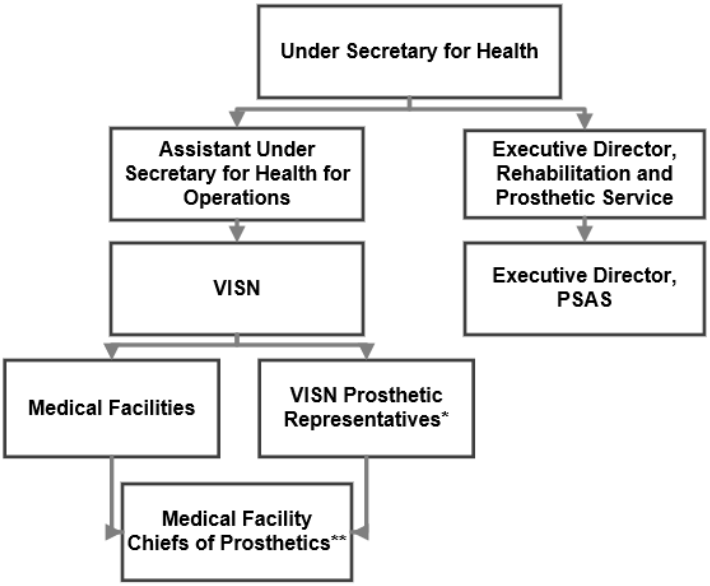

Figure 2. *PSAS reporting structure.*

Source: VA OIG analysis of VHA organizational chart, July 1, 2020; Rehabilitation and Prosthetics Service organizational chart, September 2016; results of the OIG's survey of VISN prosthetic representatives; and discussion with representatives from VHA's PSAS.

** VISN prosthetic representatives may report to VISN officials, such as the chief medical officer, chief logistics officer, or deputy network director.*

*** Medical facility chiefs of prosthetics may report to medical facility officials, such as the associate director, assistant director, or nurse executive, or they may report directly to a VISN prosthetic representative.*

[16] VHA Handbook 1173.1, *Eligibility,* November 2, 2000; VHA Directive 1048, *Prosthetic and Sensory Aids Service Specific Purpose Funding*, March 17, 2020. VHA Handbook 1173.1 refers to the chief consultant, PSAS Strategic Healthcare Group; however, according to the PSAS executive director, this is now the executive director position.

[17] VHA delivers health care through 18 VISNs, which are regional networks of medical facilities.

[18] While VHA's organization chart was updated July 1, 2020, the organizational and reporting structure of PSAS remained unchanged.

Provision of Prosthetic Appliances

VA prosthetic and orthotic laboratories should be the primary source for providing artificial limbs and orthotic items to veterans; however, medical facilities may pay for these items to be furnished by VA-authorized vendors. Whether items will be furnished by VA or by a VA-authorized vendor depends on factors such as VA capacity and availability, geographic availability, and cost. In some instances, vendors may have a contractual relationship with VISNs to provide items such as artificial limbs. These contracts generally include language that limits reimbursement of these items to Medicare rates, minus a discount. In the absence of a contract, however, prescribed prosthetic or orthotic items may be purchased from vendors on the open market. Open market purchases are to be used only after every effort has been made to locate the items on a contract.[19] Medical facility prosthetic purchasing agents are responsible for reimbursing vendors for prosthetic and orthotic items when they are at or below the micropurchase threshold of $10,000.[20]

Healthcare Common Procedure Coding System and Fee Schedule

The Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) maintains the Healthcare Common Procedure Coding System (HCPCS). The HCPCS provides standard codes describing items, such as durable medical equipment, prosthetics, orthotics, and medical services and procedures, prescribed by healthcare providers or provided during the delivery of care. Medicare and other insurers generally use the HCPCS codes to classify items and services for billing.

CMS publishes a fee schedule showing reimbursement rates for most HCPCS codes. This fee schedule—referred to as Medicare rates in this report—is updated quarterly. The fee schedule lists over 3,000 HCPCS codes and price ranges for each state and gives further detail by rural or nonrural area for each item. According to VHA Handbook 1173.1, issued in November 2000, VHA adopted this system as a national mechanism of common identification.[21]

When existing HCPCS codes do not adequately describe a prosthetic or orthotic item, CMS-established "Not Otherwise Classified" codes may be applicable. The audit team did not include items described with a Not Otherwise Classified code in its scope. The audit scope and methodology are further discussed in appendix B.

Figure 3 is an excerpt from the CMS fee schedule showing the ceiling, floor, and some individual state rates for a diabetic shoe for density insert (HCPCS code A5500) and a diabetic custom molded shoe (A5501) to illustrate how the prices for the two items can vary.

[19] VA Financial Policy, vol. 16, chap. 1B, "Government Purchase Card for Micro-Purchases," October 2019.
[20] VA Financial Policy, vol. 16, chap. 1B.
[21] VHA Handbook 1173.1.

Durable Medical Equipment,
Prosthetics, Orthotics, and Supplies
(DMEPOS)
January 2020 Fee Schedule

HCPCS	Ceiling	Floor	AL (NR)	AL (R)	AR (NR)	AR (R)	AZ (NR)	AZ (R)
A5500 - diabetic shoe for density insert	$ 88.64	$ 66.48	$ 73.87	$ -	$ 73.87	$ -	$ 73.87	$ -
A5501 - diabetic custom molded shoe	$ 265.88	$ 199.41	$ 221.57	$ -	$ 221.57	$ -	$ 221.57	$ -

Figure 3. *Excerpt from CMS fee schedule for HCPCS Codes A5500 and A5501.*
Source: VA OIG analysis of CMS fee schedule for January 2020.
Note: Prices listed are for Alabama (AL), Arkansas (AR), and Arizona (AZ). Prices for nonrural areas in a state are designated with NR; prices for rural areas in a state are designated with R. Dashes indicate that prices are not available for those areas.

Law and Regulation for the Reimbursement of Vendors for Prosthetic and Orthotic Items

VHA lacks pricing guidance to ensure VA medical facilities reimburse vendors who provide veterans with prosthetic and orthotic items at reasonable rates for the same or similar items. Absent this pricing guidance, the audit team used rates from the following law and regulation to determine if medical facilities reimbursed vendors at reasonable prices.

- **Title 38 of the United States Code (U.S.C.) § 1703(i)(1)**—Unless an exception in the statute applies, and to the extent practicable, the rate paid by VA to a vendor for medical services provided under any provision of this title may not exceed Medicare rates.[22] Further, 38 U.S.C. § 1701(6) defines medical services to include those pertaining to medical examination, treatment, and rehabilitation, as well as items such as wheelchairs, artificial limbs, trusses, and similar appliances. PSAS is responsible for providing these latter items to veterans.[23] The OIG interprets the requirements of 38 U.S.C. §1703(i) to be applicable to prosthetic and orthotic items included in this audit. Therefore, the audit team used Medicare rates, when available, as a benchmark for price reasonableness.
- **Title 38 of the Code of Federal Regulations (C.F.R.) § 17.56**—Because 38 U.S.C. §1703(i) does not specify what rates medical facilities should use to reimburse vendors for their services when Medicare rates are not available, the OIG identified

[22] The United States Code is the codification by subject matter of the general and permanent laws of the United States. It is divided by broad subjects into 54 titles. Title 38 of the United States Code provides laws related to veterans' benefits, which include hospital, nursing home, domiciliary, and medical care available to veterans.
[23] VHA Handbook 1173.1.

rates based on a pricing methodology described in this regulation to benchmark price reasonableness for these items (referred to in this report as OIG benchmark rates).[24] Though this regulation is generally not applicable to care furnished after June 6, 2019, the audit team looked to this regulation because (1) it established a pricing methodology for items without Medicare rates and (2) VHA's Office of Community Care uses this methodology to reimburse community providers when Medicare rates are not available for services provided. The OIG considers these rates a benchmark for price reasonableness when Medicare rates are not available for the reimbursement of prosthetic and orthotic items provided by vendors. The audit team briefed PSAS officials at the start of and during the audit, and they agreed that the methodology used by the OIG to identify a price benchmark for this audit was reasonable.

[24] This regulation required the general use of a VA fee schedule to reimburse healthcare professional services and all other medical services associated with non-VA outpatient care. The VA fee schedule amount was determined by the authorizing medical facility and represented the charge falling at the 75th percentile when the facility's billings for a procedure code were ranked from the highest to the lowest. Instead of ranking prices by facility to identify the charge falling at the 75th percentile, the audit team ranked prices nationally to create national benchmark rates for ease of calculation.

Results and Recommendations

Finding: VHA's Ineffective Oversight of Prosthetic and Orthotic Spending Resulted in Unreasonable Vendor Reimbursements and Unreliable Data

Although medical facilities generally reimbursed vendors for prosthetic and orthotic items at amounts that were below reasonable rates, they reimbursed an estimated 37 percent of transactions at unreasonable—that is, higher than reasonable—rates.[25] The excessive payments occurred because VHA did not provide effective oversight of prosthetic spending; specifically, PSAS leaders did not fulfill their oversight roles and responsibilities. Federal guidance directs leaders to exercise oversight responsibility and determine what laws and regulations are applicable.[26] PSAS officials, however, did not determine whether laws and regulations limited reimbursement of outside vendors to Medicare rates or if alternatively developed rates applied to the prosthetics program. The audit team found that when facilities paid more than reasonable rates, overages amounted to an estimated $10 million in just six months from October 2019 through March 2020.

Further, PSAS leaders did not establish processes and procedures to monitor the accuracy of spending data. The audit team estimated that about 36,200 transactions (about 32 percent) captured in the NPPD from October 2019 to March 2020 contained at least one incorrect HCPCS code or other inaccuracy that could hamper VHA managers' ability to monitor prosthetic spending effectively.

The finding builds on the following observations:

- Facilities reimbursed vendors at rates that exceeded Medicare and OIG's benchmark rates.
- Prosthetic and orthotic spending sometimes exceeded reasonable pricing because PSAS did not fulfill its oversight role.

What the OIG Did

To gain an understanding of prosthetic spending oversight responsibilities, the team interviewed the PSAS executive director; a regulation specialist from VHA's Office of Regulations, Appeals, and Policy; officials from the VA Office of General Counsel; and several VISN prosthetic representatives. The OIG conducted an electronic survey of all 18 VISN prosthetic

[25] The review team determined reasonable and unreasonable rates based on Medicare or OIG benchmarks.

[26] Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

representatives to gain an understanding of their roles and responsibilities with a 100 percent response rate. No site visits to medical facilities were conducted during this audit due to COVID-19 pandemic precautions.

The audit team obtained data from NPPD on prosthetic and orthotic items from the following groups:

- 200 – Artificial Legs
- 300 – Artificial Arms and Terminal Devices
- 400 – Orthosis/Orthotics
- 500 – Shoes/Orthotics

From these groups, the team excluded any item with a Not Otherwise Classified code of L2999, L3999, L5999, or L7499 and identified 421,688 vendor transactions valued at about $94.8 million from October 2019 through March 2020—the first half of FY 2020.[27] The team analyzed this universe to identify all transactions that appeared to exceed Medicare rates.[28] When Medicare rates were not available, the audit team developed a price benchmark for each prosthetic or orthotic item using the pricing methodology from 38 C.F.R. § 17.56. The team identified these rates by ordering the prices that medical facilities paid for each item from highest to lowest and selecting the price that represented the 75th percentile.[29]

Transactions that appeared to exceed reasonable rates numbered 112,632 and totaled about $34.2 million. From these transactions, the team selected a random sample of 207 transactions and requested supporting documentation from VHA medical facilities to confirm whether the selected transactions used higher than reasonable rates. Documentation included purchase orders and invoices to verify the accuracy of NPPD data as to quantities, HCPCS codes, and prices paid. The team's review of supporting documentation identified data inaccuracies such as incorrect prices and HCPCS codes. The team followed up with medical facility chiefs of prosthetics and VISN prosthetic representatives regarding these inaccuracies and made applicable adjustments to identify the actual number of transactions in the sample that exceeded rates established by the team. This number was then used to estimate the total number of transactions that exceeded reasonable rates from October 2019 through March 2020. (Data inaccuracies and their impact on the oversight of prosthetic spending are discussed later in the report.)

[27] Purchased items within these groups identified by the team included artificial limb components, compression garments, diabetic and orthotic shoes, shoe inserts, and braces. Appendix B presents additional details on the audit scope and methodology.

[28] The audit team used the highest available state rate, excluding Alaska and Hawaii, to perform the analysis.

[29] As previously detailed, the audit team used Medicare and OIG benchmark rates as a basis for consistency because PSAS lacks guidance on specific reimbursement rates for prosthetic and orthotic items purchased from vendors.

The audit team briefed PSAS officials, including the executive director and field operations manager, about its methodology throughout the audit. These briefings included status updates on the project, as well as detailed discussions about how the team conducted the audit and calculated the rates (Medicare rates and OIG-identified rates using the pricing methodology from 38 C.F.R. § 17.56) used to develop a price benchmark and the transactions that exceeded these rates. PSAS officials acknowledged that the OIG's approach was reasonable for this audit. Appendix B provides additional details on the audit scope and methodology. Appendix C provides details on the statistical sampling.

Facilities Reimbursed Vendors at Rates That Exceeded Medicare and OIG's Benchmark

The OIG estimated that 41,280 (or about 37 percent) of 112,632 prosthetic and orthotic transactions had prices that exceeded reasonable rates. These transactions were facility purchases of items such as shoes, shoe inserts, compression garments, and splints. Amounts exceeding reasonable rates ranged from as little as $2.46 (for below-knee prosthetic socks) to as much as $3,071 (for below-knee compression wraps). The OIG estimated that VHA could have saved about $10 million by limiting prices to Medicare rates or to no more than the OIG benchmark for the six-month review period from October 2019 to March 2020.

Items for Which Medicare Rates Were Available

The audit team estimated that VHA paid more than applicable Medicare rates on 15,241 of 112,632 transactions for prosthetic or orthotic items purchased during the review period. Based on this analysis, VHA could have saved as much as an estimated $4.1 million by using applicable Medicare rates over those six months.

To the extent practicable, 38 U.S.C. §1703(i) requires VA to reimburse outside vendors no more than established Medicare rates for medical services. According to 38 U.S.C. § 1701(6)(F)(i), medical services include the provision of wheelchairs, artificial limbs, trusses, and similar appliances. The language of the statute categorizes artificial limbs and similar appliances as medical services. Based on this language, the OIG interprets this law to apply to the prosthetics program, specifically to medical facilities' reimbursement of community vendors for veterans' prosthetic and orthotic items. However, the audit team found medical facilities did not always limit vendor reimbursement to the applicable Medicare rate.

Example 1

The Medicare rate for A5513—multiple density insert for diabetics only—is $44.96 for each insert provided or $89.92 for a pair. The team found a facility paid a vendor $240 for a pair of inserts or about $150 more than the established Medicare rate.

Federal guidance directs leaders to identify applicable laws and regulations.[30] The audit team, however, found the executive director of PSAS did not assess 38 U.S.C. §1703(i) to determine if this statute limited vendor reimbursement to Medicare rates or some other benchmark. Based on the language of the statute that includes artificial limbs and similar appliances as medical services and the OIG's interpretation of the requirements of 38 U.S.C. §1703(i), the OIG believes PSAS deviated from this law. The team interviewed seven VISN prosthetic representatives who reported that Medicare rates were appropriate; however, all seven representatives reported they were unaware of any guidance or documentation requiring the use of Medicare rates.

Items with No Medicare Rates Measured against OIG Benchmark

VHA paid more than OIG benchmark rates for about 26,039 of 112,632 transactions for prosthetic or orthotic items that had no Medicare rate from October 2019 to March 2020. During this six-month period, VHA could have saved as much as an estimated $5.9 million if it had developed and applied benchmark rates for these items.

The law that limits reimbursement to Medicare rates (38 U.S.C. §1703(i)) does not indicate what rates VA should use when Medicare rates are not available for medical services provided to veterans. VA formerly required the general use of the VA fee schedule to reimburse healthcare professional services and all other medical services associated with non-VA outpatient care.[31] Though this requirement ceased to apply to most services on June 6, 2019, the audit team used the associated pricing methodology that had been laid out in the C.F.R. as the basis to develop benchmark rates to measure price reasonableness for this audit. As discussed earlier in the report, the audit team briefed PSAS officials about its pricing methodology throughout the course of the audit. PSAS officials agreed the methodology used to identify price benchmarks was reasonable for the purpose of this audit.

Absent a pricing benchmark for items without Medicare rates, the audit team found some prosthetic purchasing agents were simply paying vendors what they charged. The team applied the OIG's pricing benchmark and determined that VHA paid inconsistent and higher than reasonable prices for similar items. Figure 4 illustrates the broad range of unit prices and the mean prices that some medical facilities in the VA Southeast Network (VISN 7) paid vendors for a below-knee compression stocking (HCPCS code A6530), compared with the $23.58 benchmark rate.[32]

[30] GAO, *Standards for Internal Control in the Federal Government*.

[31] 38 C.F.R. § 17.56. A medical facility's VA fee schedule amount is determined by ranking all the facility's billings for the same procedure code and selecting the amount that falls at the 75th percentile as a maximum.

[32] The mean price represents the average price paid by facilities from October 2019 through March 2020.

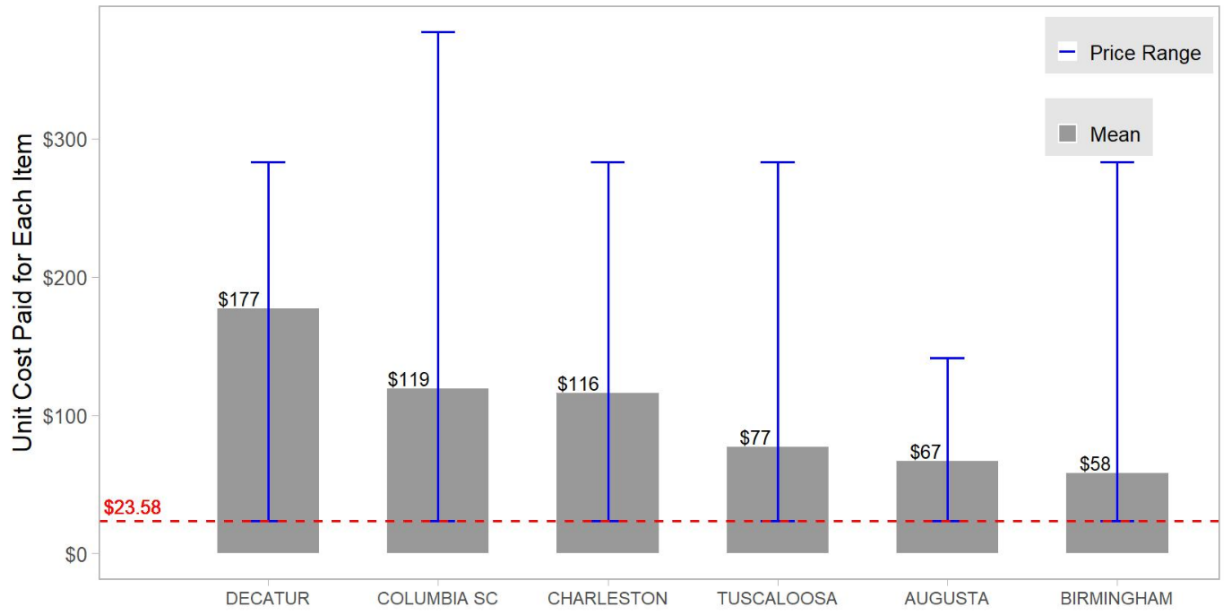

Figure 4. *Range of unit prices paid by some facilities in the VA Southeast Network (VISN 7) to vendors for a below-knee compression stocking compared with the mean.*

Source: VA OIG analysis of NPPD data from October 2019 through March 2020.

Prosthetic and Orthotic Spending Exceeded Reasonable Pricing Because PSAS Did Not Assume Its Oversight Role

The executive director of PSAS did not entirely fulfill the position's oversight role, which includes recommending policies and ensuring the efficient and economic operation of the prosthetics program.[33] Further, the executive director of PSAS did not establish goals and objectives for the program and ensure compliance with relevant laws and regulations.[34] Although leaders of PSAS—the policy office for the $3.47 billion prosthetics program—issued handbooks and directives on other matters, the audit team found the executive director did not issue policies establishing controls and monitoring activities related to prosthetic spending, such as establishing prosthetic payment rates to ensure medical facilities reimburse vendors at reasonable prices. As a result, no control was in place to prevent medical facilities from paying vendors more than the OIG deems reasonable or to increase accuracy through ongoing monitoring.

[33] VHA Handbook 1173.1; VHA Handbook 1173.2, *Furnishing Prosthetic Appliances and Services*, November 3, 2000.

[34] GAO, *Standards for Internal Control in the Federal Government*; OMB Circular A-123, "Management's Responsibility for Enterprise Risk Management and Internal Control," July 15, 2016.

Specifically, PSAS leaders did not

- assess the applicability of laws and regulations to prosthetic spending to ensure reasonable rates;
- update policy that designates oversight roles and responsibilities; or
- establish processes and procedures to monitor the accuracy of prosthetic spending data.

VA and VHA Officials Did Not Assess the Applicability of Laws and Regulations That Establish Proper Prosthetic Payment Rates

To comply with applicable federal guidance, a federal entity "determines which laws and regulations apply to the entity."[35] PSAS officials, however, reported they were unaware whether laws and regulations related to the reimbursement of outside vendors for medical services (38 U.S.C. §1703(i)'s requirement to generally limit reimbursement to Medicare rates) applied to the prosthetics program. Additionally, a regulatory specialist from PSAS said that monitoring laws' and regulations' applicability to VHA's prosthetics program is the responsibility of VHA's Office of Regulatory and Administrative Affairs or the Office of General Counsel, and the program's regulatory specialist said neither office had ever indicated Medicare rates should be used. The same regulatory specialist acknowledged PSAS officials had not taken steps to determine whether they should develop a fee schedule for items without a Medicare rate, even though other VHA offices had done so. For example, VHA's Office of Community Care uses a VA fee schedule as part of the community care contracts to reimburse providers when these medical services do not have established Medicare rates.

To understand the perspective of the legal and regulatory specialists, the audit team spoke with a staff attorney in VA's Office of General Counsel. The attorney confirmed that PSAS officials had not sought and the office had not rendered an opinion on the law's applicability or the need to limit reimbursements to Medicare rates. Additionally, the team was referred to a regulation specialist from VHA's Office of Regulations, Appeals, and Policy who reported that the pricing requirements of 38 U.S.C. § 1703(i) and whether they relate to VHA medical facilities' use of outside vendors to provide veterans with their prescribed prosthetic and orthotic items were not discussed with PSAS.

The OIG appreciates that PSAS leaders may lack the legal expertise to fully assess the applicability of laws and regulations such as 38 U.S.C. §1703(i) to the prosthetics program; however, the OIG concludes that PSAS leaders do have a responsibility to monitor laws and regulations and at least confer with those in the Office of Regulatory and Administrative Affairs or the Office of General Counsel to determine if they apply to the prosthetics program. While

[35] GAO, *Standards for Internal Control in the Federal Government*.

VA has not determined whether Medicare rates are an appropriate standard for setting prices related to prosthetic and orthotic items provided by vendors, the audit team found evidence that establishes the use of Medicare rates as a basis to reimburse vendors and supports the OIG's conclusion that Medicare rates are reasonable.

VA Regulations Support the Use of Medicare Rates

VA has issued several regulations related to the reimbursement of certain medical services provided to veterans and some veterans' families by non-VA providers. These services include emergency treatment for certain veterans with service-connected disabilities, as well as hospital care and medical services for some veteran family members. In all instances, VA used Medicare rates as a basis to establish reimbursement for the services provided.[36] These regulations are consistent with VHA's current and past practices that use Medicare rates as a basis to reimburse non-VA providers for services provided to veterans and support the OIG's conclusion that Medicare rates are a reasonable basis for medical facilities to reimburse vendors.

VHA Formerly Applied Medicare Rates in Contracts with Vendors

In August 2014, the deputy chief patient care services officer for Rehabilitation and Prosthetic Services announced the availability of a template VHA should use to establish contracts with vendors providing artificial limbs. The template language specifies that prices for the fabrication and repair of prosthetic limbs "shall not exceed" the Medicare fee schedule. This contract template, however, does not address all prosthetic and orthotic items. Additionally, since not all VISNs have artificial limb contracts, not all have implemented the template. According to the OIG's survey, six VISN prosthetic representatives reported their VISN did not have artificial limb contracts with local vendors.

Absent pricing guidance related to the reimbursement of outside vendors who provide veterans with prosthetic and orthotic items, PSAS should identify rates to benchmark prices paid to vendors to make sure medical facilities do not overpay for the same or similar items. Therefore, the PSAS executive director should coordinate with the appropriate officials to determine if laws and regulations that establish reimbursement rates, such as Medicare, apply when VHA pays vendors to furnish veterans with prosthetic and orthotic items. If these laws and regulations do not apply, the executive director should issue guidance to ensure medical facilities are paying vendors reasonable and consistent prices for the same or similar items.

[36] See appendix A for a list of regulations and a general description of their pricing methodologies.

VHA Issued Pricing Guidance for Some Items with No Medicare Rates

In August 2020, the executive director of VHA Procurement issued a memo to the PSAS executive director providing reimbursement guidance for items with Not Otherwise Classified codes.[37] Not Otherwise Classified codes are used to categorize prosthetic and orthotic items that do not have HCPCS codes and do not have associated Medicare rates. The guidance allows holders of prosthetic purchase cards to reimburse vendors at 150 percent of the manufacturer's price, as long as the total price does not exceed the micropurchase limit of $10,000. PSAS officials told the audit team the memo may apply to other items without Medicare rates; however, they were not sure how to interpret the language and referred the audit team to VHA's Procurement and Logistics Office.[38] An assistant director for procurement operations said the memo could apply to setting prices for some items the audit team reviewed—for example, orthotic shoes (L3221), which do not have a Medicare rate. The audit team did not assess the applicability of the memo to items without Medicare rates or the reasonableness of the 150 percent markup but noted that VHA issued pricing guidance that may apply to some items included in this audit.

PSAS Official Did Not Update Policy That Designates Oversight of Prosthetic Spending

Federal guidance states that managers should update policies as necessary for continued relevance and should assign responsibility and delegate authority to achieve the entity's objectives.[39] The PSAS executive director reported that VISN prosthetic representatives have been responsible for oversight and authority over the field since 2010; however, the PSAS executive director has not issued policy that clearly defined the span and scope of VISN prosthetic representatives' responsibilities and authorities. The only policy in effect related to oversight is a 20-year-old handbook that makes the PSAS executive director responsible for developing policy and the overall field consistency of the prosthetics program—without defining overall field consistency.[40] Without updated policy, VISN prosthetic representatives' approach to oversight of prosthetic spending varied.

Consequently, the audit team identified inconsistencies in program oversight authority and requirements among VISN prosthetic representatives. According to the OIG's survey, 12 of

[37] VHA procurement executive director memo, "Not Otherwise Classified Prosthetic Items Purchased by Prosthetics Purchase Cardholders," August 4, 2020.

[38] The memo refers to "Not Otherwise Classified (NOC) prosthetic items and L-coded items that do not have [a] Centers for Medicare & Medicaid bundled fee schedule."

[39] GAO, *Standards for Internal Control in the Federal Government*.

[40] VHA Handbook 1173.1.

18 (67 percent) representatives reported having no supervisory responsibility or authority over facility chiefs of prosthetics. One of these representatives explained this role was to be a liaison or consultant between the chiefs of prosthetics and PSAS, while another representative reported lacking authority at the facility level. As for requirements, eight of 18 VISN prosthetic representatives responded to the OIG's survey that their performance plans either did not include or were unclear about requirements to ensure consistency of the prosthetics programs within their VISNs. Ten of 18 VISN prosthetic representatives (56 percent) reported monitoring facilities prosthetic spending to ensure prices paid to vendors do not exceed established Medicare rates. The team did not verify what actions these representatives took to monitor facility spending.

The PSAS executive director reported that the handbook has not yet been updated because of a pending regulation. In October 2017, VA published a proposal to reorganize and update its regulations related to prosthetic and rehabilitative items and define the types of items and services available to eligible veterans.[41] The chief counsel in the Office of General Counsel Health Care Law Group, while acknowledging the delays due to pending regulations, said those delays would not prevent PSAS from issuing guidance to clarify and update oversight responsibilities for the prosthetics program.

The PSAS executive director's lack of action to update policy defining the oversight roles and responsibilities for the prosthetics program resulted in inconsistencies in how oversight is conducted. The PSAS executive director should take steps to establish a formal oversight structure that defines the roles and responsibilities of those charged with providing oversight of the prosthetics program. Unless oversight roles are documented and communicated to the field clearly, medical facilities will be less likely to reimburse vendors at reasonable rates.

VHA Rescinded Some Prosthetic Handbooks

On December 28, 2020, VA published a final rule that amended regulations related to eligibility and other criteria for the provision of prosthetic and rehabilitative items and services authorized as medical services under 38 U.S.C. § 1701(6)(F) and 38 U.S.C. § 1710(a).[42] Because of these regulations, the assistant under secretary for health for patient care services issued a notice in April 2021 to rescind certain handbooks that included language assigning oversight responsibility for the prosthetics program to the PSAS executive director.[43] Though VHA rescinded some handbooks in April 2021, these handbooks—including VHA

[41] Prosthetic and Rehabilitative Items and Services, 82 Fed. Reg. 48018, 48030 (October 16, 2017) (to be codified at 38 C.F.R. Part 17).

[42] 85 Fed. Reg.84245, 84261.

[43] VHA Notice 2021-06, "Recission of VHA Prosthetics Policies," April 6, 2021. See appendix A for policy documents rescinded by this notice.

Handbook 1173.1—were still in effect during the scope of the audit, which covered prosthetic purchases made during the review period from October 2019 through March 2020.

While rescinding outdated handbooks is the first step in addressing oversight responsibilities, the PSAS executive director reported that no other directives have been issued. The PSAS executive director therefore needs to take action to establish the roles and responsibilities of the prosthetics program.

PSAS Did Not Adequately Monitor Prosthetic Spending Data

Federal government managers are expected to design their information systems to meet their agency's objectives and provide complete, accurate, and valid data by implementing control activities through policies.[44] The NPPD is intended to be used by prosthetic representatives, national and regional prosthetics program managers, and other prosthetics employees to provide financial and clinical oversight of the prosthetics program. Monitoring the NPPD can assist in reducing costs at local, regional, and national levels and improve efficiency if carried out as intended—for example, comparing costs system-wide, validating data, determining where coding errors occur, and identifying areas to develop training. Accordingly, data in the NPPD must be accurate for financial and clinical oversight of the prosthetics program—for example, detecting when medical facilities reimburse vendors at unreasonable rates for the same items. VISN prosthetic representatives are responsible for ensuring proper data entry into the NPPD for billing and accountability purposes.[45] The audit team found, however, that spending data in the NPPD related to HCPCS codes, prices, and quantities purchased were not accurate for an estimated one-third of the transactions.[46] Without accurate data in these fields, VHA does not know whether it overpaid for prosthetic and orthotic items.

Two of the most common data errors identified by the audit team were incorrect HCPCS codes and inaccurate prices. The team estimated that 34,489 transactions (about 31 percent) contained an incorrect HCPCS code or an incorrect price paid for the items provided. For example, the audit team found a transaction for which the recorded price in NPPD was $444 compared with the actual price paid of about $1,470.

The team also found that quantities recorded in NPPD lacked meaning because the system did not make clear their unit of measure. Medical facilities issue prosthetic and orthotic items in various units—each, pair, or months (if the items are rented). NPPD, however, lacks descriptors that distinguish what the data in each field represent. For example, the Medicare price for

[44] GAO, *Standards for Internal Control in the Federal Government*.

[45] VHA Directive 1081, *Procurement Process for Individual Prosthetic Appliances and Sensory Aids Devices Above the Micro-Purchase Threshold*, March 25, 2014.

[46] The audit team took steps, such as obtaining vendor invoices and coordinating with medical facility chiefs of prosthetics, to validate the accuracy of prices paid, HCPCS codes, and quantities. When inaccuracies arose, the audit team updated the information to make sure the OIG's estimates were based on accurate information.

molded removable inserts (HCPCS code L3010) is about $176 for each insert or $352 for a pair. For one transaction the team found the NPPD-recorded price was about $346 for a quantity of one. Without an indication of whether the quantity represented one insert or one pair of inserts, the data appeared to show an overpayment for one insert. However, the audit team reviewed supporting documentation and determined the payment was for a pair of inserts. Therefore, the rate paid ($346) was less than the Medicare rate ($352).

Ensuring Prosthetic Representatives Regularly Monitor NPPD Would Help Pinpoint Irregularities

Most VISN prosthetic representatives who responded to the OIG's survey reported taking at least some action to ensure the accuracy of NPPD data. Of the eighteen respondents,

- 14 reported reviewing the accuracy of HCPCS codes;
- 12 reported reviewing the accuracy of prices paid;
- 8 reported reviewing the accuracy of quantities; and
- 2 reported taking no action to review the accuracy of NPPD data.

While most VISN prosthetic representatives reported monitoring some data fields in NPPD for accuracy, PSAS needs to ensure these data fields are monitored regularly. For example, establishing a price benchmark, such as Medicare rates, and creating recurring exception reports that identify transactions exceeding the benchmark would facilitate oversight of prosthetic spending, as would adding descriptors for NPPD quantity data fields.

New Pricing Tool Holds Promise for Improving Data Accuracy

A VISN prosthetic representative reported to the audit team that after the OIG initiated this audit in May 2020, the PSAS data management group developed an automated report that compares Medicare rates with the rates facilities paid vendors for prosthetic and orthotic items. Medical facilities are not required to use this report, however. The representative said the PSAS data management group started developing this report in June 2020, and it became available to the field in mid-August. Although this tool was created to compare Medicare rates with the rates paid at the facility level, the VISN prosthetic representative said it can also be used to identify data inaccuracies. For example, if there is a significant discrepancy between the Medicare rate and the rate paid for an item, he said management can follow up with the facility to determine if the discrepancy was the result of the wrong HCPCS code or the incorrect recording of the price paid for the item.

While this tool is promising, it does have limitations.[47] For example, although the report feature includes prosthetic and orthotic items that do not have established Medicare rates, it does not provide rates that facilities can use to determine if prices paid are reasonable. Finally, the report only provides insight into individual medical facility transactions. The data cannot be aggregated to the VISN or national level. Without this ability, the data cannot be used to identify network or national trends in potential overpayments or data inaccuracies. These trends would help PSAS identify systemic issues, such as incorrect use of HCPCS codes, and allow PSAS to develop and implement additional controls to help prevent these issues from occurring in the future.

Working with their data management group to improve the pricing tool to address these limitations would allow PSAS officials to better identify data inaccuracies and overpayments to vendors.

Conclusion

Weak oversight and overpayments to vendors have been a long-running problem for the $3.47 billion prosthetics program PSAS manages. This audit confirmed that inadequate oversight of spending continues. The audit team concluded PSAS leaders have not fulfilled their oversight role. They did not assess the applicability to the program of legislation requiring the use of Medicare rates or other benchmarks, and they did not define the oversight roles and responsibilities of VISN prosthetic representatives by updating policy to include monitoring of facility spending and related data. As a result, medical facilities reimbursed vendors of prosthetic and orthotic items at unreasonable rates and recorded inaccurate data in the NPPD. VHA incurred increased financial risk as a result and missed opportunities to reduce spending. As noted in appendix D, the OIG estimates that price overages amounted to $10 million during the six-month audit period. The OIG estimates VHA could save as much as $20 million per year if it takes action to ensure vendors are reimbursed at reasonable rates for prosthetic and orthotic items. Furthermore, the OIG believes VHA can strengthen its oversight of the prosthetics program by clearly establishing roles and responsibilities and implementing processes to monitor data recorded in the NPPD.

Recommendations 1–4

The OIG recommends the under secretary for health take the following steps:

1. Coordinate with appropriate officials, including the VA Office of General Counsel, and determine if 38 U.S.C. § 1703(i) and other reimbursement practices cited in this report apply to the reimbursement rates medical facilities should pay for prosthetic and orthotic items provided by vendors. If they do apply, develop and issue guidance

[47] The audit team did not perform an assessment of the tool to verify its data or determine its effectiveness to monitor pricing.

requiring medical facilities to adhere to them; if they do not apply, develop and issue guidance on steps medical facilities need to take to ensure they purchase prosthetic and orthotic items at reasonable prices.

2. Develop and implement effective procedures to monitor prosthetic spending to make sure medical facilities reimburse vendors at reasonable prices for all prosthetic and orthotic items in accordance with updated pricing policies and processes.
3. Coordinate with appropriate officials such as the Prosthetic and Sensory Aids Service executive director and the executive director, Rehabilitation and Prosthetics Service, to establish a formal oversight structure that defines the roles and responsibilities of those charged with providing oversight of the prosthetics program, rescind handbooks that reflect an outdated oversight structure, and communicate updated oversight expectations to the Veterans Integrated Service Networks to promote consistent program oversight.
4. Resolve National Prosthetics Patient Database limitations and establish requirements to routinely monitor medical facilities' input of data to improve accuracy.

Management Comments

The deputy to the deputy under secretary for health, performing the delegable duties of the under secretary for health, concurred with the recommendations and provided general and technical comments on the report. Appendix E provides the full text of the deputy's comments.

To address recommendation 1, the deputy reported that PSAS will coordinate with the VA Office of General Counsel and VHA's Office of Regulation Appeals and Policy to review the applicability of 38 U.S.C. § 1703(i) and other relevant authorities to the purchase of prosthetic and rehabilitative items. This group will determine legal requirements; develop a plan to clarify what existing authority requires; and decide what, if any, additional authorities or policies are needed to develop reasonable prices for prosthetic and rehabilitative items.

To address recommendation 2, the deputy reported that PSAS will (1) explore the development of an Integrated Product Team to determine the feasibility of contracts for orthotic and therapeutic footwear to ensure consistent and standardized pricing and (2) incorporate the CMS pricing comparison tool into the VISN site review template to ensure consistent use by facilities during program reviews.

To address recommendation 3, the deputy reported that PSAS will (1) draft policy to assign responsibilities to PSAS and other staff, (2) update the VISN site review template to incorporate a review of spending to ensure price reasonableness, and (3) communicate assigned responsibilities, performance expectations, and changes made for conducting and documenting program reviews.

To address recommendation 4, the deputy reported that PSAS will (1) reeducate PSAS staff on selecting and identifying the correct HCPCS code, (2) determine if the CMS pricing tool can be enhanced to allow for aggregation of data at the VISN or national level, and (3) reeducate PSAS staff on ensuring price accuracy in NPPD, explore data tools to assist in price reconciliations, and provide guidance for correcting prices when a reconciliation issue occurs.

The deputy also provided general and technical comments on the OIG's pricing methodology. Specifically, the deputy requested that the OIG remove language in the report that the audit team shared with PSAS officials throughout the audit and that officials agreed was reasonable. The deputy commented that PSAS did not agree that the sampling and pricing methodologies were fair and consistently contested the applicability of both 38 C.F.R. § 17.56 and 38 U.S.C. § 1703. According to the deputy, "PSAS does not believe that the methodology in 38 C.F.R. § 17.56 is the standard of 'reasonableness' that should be applied for pricing."

OIG Response

The comments and corrective action plan submitted by the deputy to the deputy under secretary for health, performing the delegable duties of the under secretary for health, are responsive to the intent of the recommendations. The OIG will monitor the implementation of planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

The OIG did not make changes to the report. The audit team met with and briefed PSAS officials, including the PSAS executive director, several times throughout the audit. These briefings included status updates on the project, as well as detailed discussions about how the audit team conducted the audit and calculated the rates (Medicare rates and OIG-identified rates using the pricing methodology from 38 C.F.R. § 17.56) used to benchmark price reasonableness and the transactions that exceeded these rates. PSAS officials acknowledged that the OIG's approach was reasonable for this audit.

On page 12 of this report, the OIG acknowledged that PSAS officials were not aware whether laws and regulations related to the reimbursement of outside providers applied to the prosthetics program. Further, as discussed throughout this report, the OIG did not use the pricing methodology to set a standard for pricing. Rather, the team used 38 C.F.R. § 17.56 to identify rates that could serve as benchmarks for price reasonableness for items without Medicare rates because VHA lacked pricing guidance related to these items. Because VA has not determined if U.S.C. § 1703(i)(1) is applicable to prosthetic purchases and VA has not issued pricing guidance for prosthetic purchases, the OIG recommended VHA assess 38 U.S.C. § 1703(i)(1) and other reimbursement practices cited in this report to determine if they do apply. If they do not apply, the OIG recommended VHA should then develop and issue guidance to ensure medical facilities pay reasonable prices for prosthetic and orthotic items.

Appendix A: Additional Information

The OIG has issued three reports since 2017 involving the prosthetics program.

- In the September 2017 *Audit of Purchase Card Use to Procure Prosthetics*, the OIG found PSAS did not sufficiently analyze prosthetics purchase data to identify commonly used prosthetics and identify opportunities for using VHA-wide or multi-VISN contracts for purchasing items above the micropurchase limit. As a result, the OIG estimated VHA may have paid higher prices for some $256.7 million in prosthetics purchases.
- In June 2018, the OIG published *VA Southern Nevada Healthcare System's Alleged Unnecessary Use of Outside Vendors to Purchase Prosthetics*. The OIG substantiated the allegation that the 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 OIG determined that 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. Due to poor decision-making by Prosthetics Laboratory employees, laboratory personnel were underutilized, and unused inventory went undetected. The former chief of prosthetics did not effectively monitor the Prosthetics Laboratory's operations, which resulted in about $242,000 in excess spending.
- In the August 2018 report *Use of Not Otherwise Classified Codes for Prosthetic Limb Components*, the OIG estimated that VHA overpaid vendors about $7.7 million from October 2014 through July 2017 because medical facility prosthetists incorrectly used Not Otherwise Classified codes to classify prosthetic items. This occurred because PSAS issued incorrect classification guidance and because PSAS lacked effective processes and procedures to monitor the use of these codes. The OIG also found PSAS issued pricing guidance that placed VHA at risk of paying inflated prices for prosthetic items with a Not Otherwise Classified code. This occurred because PSAS lacked effective processes and procedures to ensure pricing guidance resulted in the reimbursement of fair and reasonable prices for these items.

VA has issued five regulations for reimbursement of medical services provided by non-VA providers:

- 38 C.F.R. § 17.56 – VA payment for inpatient and outpatient health care professional services at non-departmental facilities and other medical charges associated with non-VA outpatient care

  This regulation provides that in instances where a specific amount has not been negotiated, VA will pay the lowest of several amounts, the first of which is the applicable Medicare rate.

- 38 C.F.R. § 17.128 – Allowable rates and fees

  This regulation is part of the section that addresses payment and reimbursement of the expenses of medical services not previously authorized. With respect to allowable rates and fees, the regulation provides that payment of expenses shall be in accordance with §17.55 and §17.56, which both provide for the applicability of Medicare rates.

- 38 C.F.R. § 17.410 – Hospital care and medical services for Camp Lejeune family members

  This regulation provides that where VA is the sole payer for certain hospital care and medical services given to Camp Lejeune, North Carolina, family members by non-VA health care providers, then VA will pay or reimburse in accordance with §17.55 and §17.56, which both provide for the applicability of Medicare rates.

- 38 C.F.R. § 17.1005 – Payment Limitations

  This regulation is part of the section that addresses payment or reimbursement for emergency services for non-service-connected conditions in non-VA facilities. With respect to payment limitations, the regulation provides that payment or reimbursement for emergency treatment under 38 U.S.C. §1725 will be calculated in various ways depending on the specific circumstances involving the veteran's personal liability, which includes a certain percentage of the applicable Medicare fee schedule.

- 38 C.F.R. § 17.4035 – Payment Rates

  This regulation is part of the Veterans Community Care Program. With respect to payment rates, they shall not exceed the applicable Medicare fee schedule unless other provisions within the section apply.

VHA Notice 2021-06, *Rescission of VHA Prosthetic Policies*, April 6, 2021, rescinded the following policies, which were listed as:

- VHA Directive 1173, *Prosthetics and Sensory Aids Service*, dated June 27, 2008
- VHA Handbook 1173.08, *Medical Equipment and Supplies*, dated June 15, 2007

- VHA Handbook 1173.1, *Eligibility*, dated November 2, 2000
- VHA Handbook 1173.2, *Furnishing Prosthetic Appliances and Services*
- VHA Handbook 1173.10, *Orthotic Devices and Repairs*, dated January 29, 2008
- VHA Handbook 1173.11, *Ocular Prostheses and Facial Restorations*, dated January 22, 2008
- VHA Directive 2009-007, *Provision of Medical Identification (ID) Bracelets and Pendants*
- VHA Manual M-6, Part II, Chapter 6, dated November 14, 1960

Appendix B: Scope and Methodology

Scope

The audit team conducted its work from May 2020 through July 2021. The scope of the audit included an examination of data, documentation, and information related to the reimbursement of vendors from which VHA purchased veterans' prosthetic items from October 2019 through March 2020.

Methodology

To gain an understanding of the roles and responsibilities for oversight of prosthetic spending and guidelines for reimbursing vendors who provide prosthetic and orthotic items to veterans, the team reviewed applicable VHA policies, procedures, and directives, as well as public law and a regulation. Applicable criteria included the following:

- VHA Handbook 1173.1, *Eligibility*, November 2, 2000
- 38 U.S.C. § 1701
- 38 U.S.C. § 1703(i)
- 38 C.F.R. § 17.56

The team interviewed the PSAS executive director and other key staff; the former assistant deputy under secretary for health for administrative operations; officials from VA's Office of General Counsel; VISN prosthetic representatives; the assistant director for procurement operations in the Procurement and Logistics Office; the director of policy and planning in the Office of Community Care; a regulation specialist from VHA's Office of Regulations, Appeals, and Policy; and the purchase card manager in the Procurement and Logistics Office. The team spoke to each of these individuals about their roles and responsibilities and the process for providing oversight of prosthetic spending.

Data Collection Instrument

The audit team developed an electronic data collection instrument to review a random sample of 207 prosthetic and orthotic transactions in which it appeared VA paid vendors more than Medicare rates or rates established by the OIG. The team reviewed purchase orders and vendor invoices for selected transactions. The team also followed up with medical facility chiefs of prosthetics and VISN prosthetic representatives regarding any discrepancies between the supporting documentation and the data recorded in the NPPD. The instrument was used to assess the accuracy of the quantity, price, and HCPCS codes recorded in the NPPD for each transaction and to determine if rates paid for the selected transactions exceeded the rates used by the audit

team. The team took steps in the development of the data collection instrument to ensure the collection of accurate information and incorporated second-level reviews of the analysis of prosthetic and orthotic transactions.

Survey of VISN Prosthetic Representatives

The audit team conducted an electronic survey of 18 VISN prosthetic representatives from June 16 through June 24, 2020. The survey was designed to collect information about the roles and responsibilities of VISN prosthetic representatives, as well as their role in monitoring prosthetic spending. The team obtained 18 responses from the 18 VISN prosthetic representatives, resulting in a 100 percent response rate.

Internal Controls

The audit team assessed the internal controls significant to the audit objective related to VHA's oversight of spending on prosthetics and orthotics frequently provided to veterans by vendors. This included an assessment of the five internal control components, which include control environment, risk assessment, control activities, information and communication, and monitoring. In addition, the team assessed the principles of those internal control components. The team identified deficiencies associated with the following internal control components and associated principles:

- Component 1: Control Environment
    - Principle 3: Management should establish an organizational structure, assign responsibility, and delegate authority to achieve the entity's objectives.
- Component 3: Control Activities
    - Principle 11: Management should design the entity's information system and related control activities to achieve objectives and respond to risks.
    - Principle 12: Management should implement control activities through policies.

Fraud Assessment

The audit team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant in the context of the audit objectives, could occur during the audit. The team exercised due diligence in staying alert to any fraud indicators by considering potential fraud indicators when selecting the sample and reviewing documentation collected during data gathering, such as looking at the number of transactions that exceeded Medicare rates to determine if there were any significant overpayments to certain vendors. During the audit, the audit team referred some matters to the OIG's Office of Investigations.

Data Reliability

The OIG used computer-processed data from the NPPD to identify the number of transactions exceeding rates used by the audit team. To assess the reliability of the NPPD data, the audit team compared a sample of NPPD transactions with supporting source documentation such as purchase orders and vendor invoices. The team concluded NPPD data that included information on VHA's purchase of prosthetic and orthotic items were appropriate and sufficient for the purpose of this audit.

Government Standards

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

Appendix C: Statistical Sampling Methodology

Approach

The audit team obtained a data extract from the NPPD of transactions from October 2019 through March 2020 that the team identified as frequently provided prosthetic and orthotic items (e.g., artificial limbs, compression garments, shoes, and knee braces). The team analyzed the data to identify transactions that appeared to exceed Medicare rates or rates developed by the audit. This analysis resulted in the identification of 112,632 transactions from which the team selected a stratified random sample of 327 transactions. This sample was composed of 207 primary transactions and 120 secondary transactions. The secondary transactions were selected to replace primary sampled transactions if the latter were determined to be outside the scope of the audit. From the stratified random sample, the team reviewed 207 transactions. Because the team's results were based on the random sample of transactions, the team estimated findings from this sample to the universe of transactions from October 2019 through March 2020.

Population

The universe of transactions in which it appeared VHA paid vendors more than Medicare rates or rates established by the audit team from October 2019 through March 2020 was 112,632.

Sampling Design

The sampling design for the selection of transactions involving prices that appeared to exceed Medicare rates or rates established by the audit team was organized by VISN. Table C.1 identifies each VISN, the number of transactions that appeared to exceed rates used by the team in each VISN, and the number of transactions selected.

Table C.1. Transactions in Excess of Medicare and OIG Benchmark Rates, by VISN

VISN	Total transactions	Primary sample	Secondary sample
1	2,569	2	3
2	3,331	4	3
3	226	-	-
4	4,376	18	17
5	4,060	7	5
6	8,312	18	3
7	10,728	17	3
8	7,996	13	14
9	3,876	14	8
10	9,212	15	3
12	2,462	9	5
15	9,197	17	10
16	10,281	12	8
17	5,357	6	2
18	2,543	3	3
19	5,859	8	10
20	3,587	6	4
21	7,542	13	2
22	3,771	7	4
23	7,347	18	13
Total	**112,632**	**207**	**120**

Source: VA OIG analysis of statistically sampled transactions that appeared to exceed Medicare rates and rates identified by the audit team using the C.F.R. pricing methodology from October 2019 through March 2020.

Weights

The OIG calculated estimates in this report using weighted sample data. Samples were weighted to represent the population from which they were drawn. The audit team used the weights to compute estimates. For example, the team calculated the error rate point estimates by summing the sampling weights for all sample records that contained the error, then dividing that value by the sum of the weights for all sample records.

Projections and Margins of Error

The point estimate (e.g., estimated error) is an estimate of the population parameter obtained by sampling. The margin of error and confidence interval associated with each point estimate represent a measure of the precision of the point estimate that accounts for the sampling methodology used. If the OIG repeated this audit with multiple samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time.

The OIG statistician employed statistical analysis software to calculate the weighted population estimates and associated sampling errors. This software uses replication or Taylor series approximation methodology to calculate margins of error and confidence intervals that correctly account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the estimates based on the sample size, potential error rate, and logistical concerns of the sample review. While precision improves with larger samples, the rate of improvement does not significantly change as more records are added to the sample review.

Figure C.1 shows the effect of progressively larger sample sizes on the margin of error.

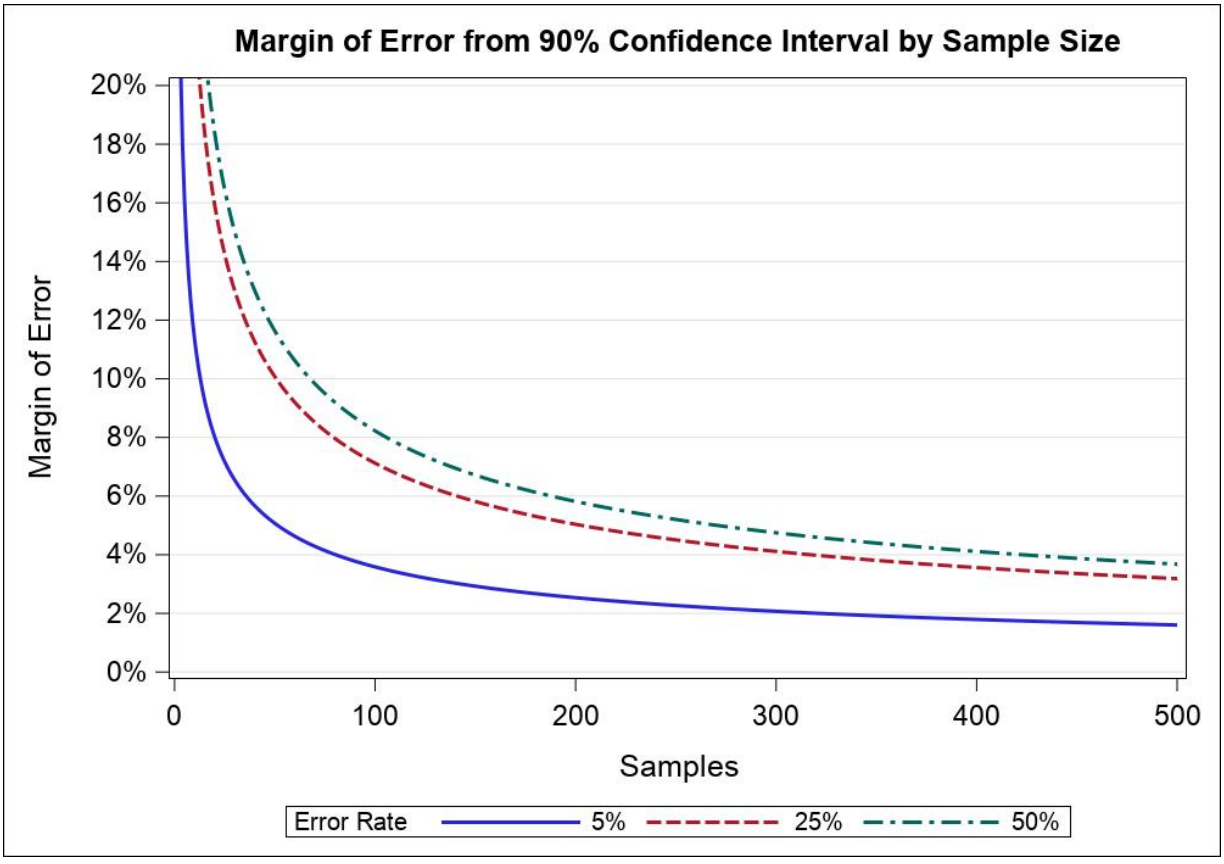

Figure C.1. *Effect of sample size on margin of error.*

Source: VA OIG statistician's analysis.

Estimates

Table C.2 details the audit team's estimates for the number of transactions that exceeded Medicare rates and the rates identified by the OIG using the C.F.R. pricing methodology. These estimates are the basis of the estimated potential monetary benefits for the audit, detailed in appendix D.

Table C.2. Transactions that Exceeded Medicare or OIG Benchmark Rates

Rates exceeded	Estimated number of transactions	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Sample size
Medicare	15,241 (23%)	4,811 (7%)	10,430 (16%)	20,052 (30%)	37
OIG benchmark	26,039 (58%)	6,028 (10%)	20,011 (48%)	32,068 (68%)	59
Total	**41,280 (37%)**	**6,880* (6%)**	**34,400* (31%)**	**48,160* (43%)**	**96**

Source: VA OIG analysis of statistically sampled transactions that appeared to exceed Medicare rates or rates identified by the OIG using the C.F.R. pricing methodology, October 2019 through March 2020.

**The margin of error and confidence intervals represent a measure of uncertainty for the row estimates and do not total.*

Table C.3 details the audit team's estimates of amounts medical facilities spent in excess of Medicare rates and benchmark rates.

Table C.3. Amounts Spent in Excess of Medicare or OIG Benchmark Rates

Comparison rate	Estimated amount over comparison rate ($)	Margin of error based on 90 percent confidence interval ($)	90 percent confidence interval lower limit ($)	90 percent confidence interval upper limit ($)	Sample size
Medicare	4,071,840	1,446,921	2,624,919	5,518,761	37
OIG benchmark	5,889,593	2,258,951	3,630,642	8,148,543	59
Total	**9,961,433**	**2,532,559***	**7,428,874***	**12,493,992***	**96**

Source: VA OIG analysis of statistically sampled transactions that appeared to exceed Medicare rates or rates identified by the OIG using the C.F.R. pricing methodology, October 2019 through March 2020.

**The margin of error and confidence intervals represent a measure of uncertainty for the row estimates and do not total.*

Table C.4 details the audit team's estimates for transactions with an incorrect HCPCS code or price recorded in the NPPD.

Table C.4. Transactions in NPPD that Contained an Error

Error	Estimated number of transactions	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Sample size
Incorrect HCPCS code or price	34,489 (31%)	6,428 (6%)	28,061 (25%)	40,916 (36%)	78
Incorrect HCPCS code, quantity, or price	36,169 (32%)	6,488 (6%)	29,682 (26%)	42,657 (38%)	88

Source: VA OIG analysis of statistically sampled transactions that appeared to exceed Medicare rates or rates identified by the OIG using the C.F.R. pricing methodology, October 2019 through March 2020.

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

Recommendation	Explanation of Benefits	Better Use of Funds (in millions)	Questioned Costs (in millions)
1–4	Value of overpayments to vendors over one year if action is not taken to ensure medical facilities reimburse vendors at reasonable rates	$20*	
	Total	**$20**	

**Note: The OIG estimated that medical facilities paid vendors about $4.1 million more than established Medicare rates and about $5.9 million more than rates developed by the OIG from the six-month period October 2019 through March 2020. The OIG summed and annualized these amounts to arrive at the potential savings of $20 million for one year.*

Appendix E: Management Comments

Department of Veterans Affairs Memorandum

Date: August 11, 2021

From: Deputy to the Deputy Under Secretary for Health
Performing the Delegable Duties of the Under Secretary for Health (10)

Subj: OIG Draft Report, VHA Better Oversight of Prosthetic Spending Needed to Reduce Unreasonable Prices Paid to Vendors (Project Number: 2020-01802-R1-0002) (VIEWS # 05513057)

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

Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report regarding oversight of prosthetic spending. We appreciate OIGs recommendations and acknowledge there are improvements to be made. We are committed to providing effective oversight of medical facility expenditures, including the prosthetic and orthotic items identified in this investigation.

The Prosthetics and Sensory Aids Service (PSAS) published a final rule in the Federal Register that established new authority for providing items and services under PSAS, effective February 26, 2021. PSAS released a new Business Practice Guideline document to the field to assist with implementation of the new regulation.

VHA rescinded prosthetics policies that reflected an outdated oversight structure to address OIG's third recommendation. VHA Notice 2021-06 was issued in April 2021 after publication of the final rule that established new PSAS regulation.

PSAS created a standardized site visit template for all Veterans Integrated Site Network (VISN) site reviews. This action contributes to resolution of OIG's third recommendation for VHA to communicate updated oversight expectations to the VISNs to promote consistent program oversight.

On May 12, 2020, VHA published Directive 1045 (1) that provides Coding, Market Analysis and Contract Guidance for Prosthetic Limb and/or Custom Orthotic Device Procurement. Although OIG's data review included artificial Limbs the scope of the findings was specific to orthotic soft goods that require fitting services.

The Orthotic, Prosthetic and Pedorthic Clinical Services in collaboration with PSAS created a new national prescription for therapeutic footwear and inserts that will be released with a new related directive, which contain the Healthcare Common Procedure Coding for devices.

As noted in the report, PSAS created a Centers for Medicare & Medicaid pricing comparison tool that compares Medicare rates with the rates facilities paid vendors for prosthetic and orthotic items.

Department of Veterans Affairs' Office of Electronic Health Record Management has executed a Task Order against the original Cerner contract to conduct an assessment of current capability and develop requirements to address compatibility gaps that will exist in the Cerner solution as it does today.

VHA notes that some of the language in the report regarding PSAS could be more consistent with policy and makes the following requests and notations.

- VHA asks OIG to cite 38 C.F.R § 17.56 as a benchmark or baseline sample of reasonableness, clearly stating that it is not determined to be a legally applicable standard and asks OIG to remove the following language, "The audit team briefed PSAS officials at

the start and during the course of the audit and they agreed that OIG's pricing methodology was reasonable." Additionally, Page i, footnote 3 should read 38 U.S.C. § 1701 (6)(F)(i).

- PSAS did not agree that the sampling and pricing methodology were fair. PSAS has consistently contested the applicability of both 38 CFR 17.56 and 38 U.S.C. 1703. PSAS does not believe that the methodology in 38 CFR 17.56 is the standard of "reasonableness" that should be applied for pricing. (Page i Paragraph 2).
- Handbook 1173.1 has been rescinded. While we understand that this Handbook existed at the time of the audit, it is cited as current authority in the draft report. The statutory citation alone seems to be sufficient reference.
- Page 6, paragraph 2 (similarly lines page ii, page 10, paragraph 5), should clarify, OIG applied the requirements of 38 U.S. C. §1703(i) as if they were applicable to prosthetic and orthotic items included in this audit.
- Page 12, paragraph 1, VHA suggests some language for purposes of clarity, "Further the Executive Director of PSAS did not establish goals and objectives for the program."

VHA concurs with the OIG's recommendation to the Office of the Under Secretary for Health and provides the attached action plan.

The OIG removed point of contact information prior to publication.

(Original signed by)

Steven L. Lieberman, M.D.

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report: Veterans Health Administration: Audit of VHA's Oversight of Prosthetic spending (Project # 2020-01802-R1-0002)

Date of Draft Report: July 15, 2021

The OIG recommends the Under Secretary for Health take the following steps:

Recommendation 1. Coordinate with appropriate officials, including the VA Office of General Counsel and determine if 38U.S.C.§1703(i) and other reimbursement practices cited in this report apply to the reimbursement rates medical facilities should pay for prosthetic and orthotic items provided by vendors. If they do apply, develop and issue guidance requiring medical facilities to adhere to them; if they do not apply, develop and issue guidance on steps medical facilities need to take to ensure they purchase prosthetic and orthotic items at reasonable prices.

VHA Comments: Concur. The Office of Prosthetic and Sensory Aids Service (PSAS) agrees that coordination with VA Office of General Counsel to determine that the applicability of 38U.S.C.§1703(i) is needed. PSAS will coordinate with VHA's Office of Regulation Appeals and Policy and VA's Office of General Council on review of the applicability of 38U.S.C.§1703(i) and other relevant authorities to the purchase of prosthetic and rehabilitative items and services. The group will determine legal requirements regarding applicability of law, develop a plan to clarify for VA employees what existing authority requires, and what if any, additional regulatory authorities or policies, are needed to develop reasonable prices for prosthetic and rehabilitative items and services. At completion of this action plan, VHA will provide communication documents which outline the legal requirements and clarification documents on applicable authorities.

Status: In Progress Target Completion Date: July 2022

Recommendation 2. Develop and implement effective procedures to monitor prosthetic spending to make sure medical facilities reimburse vendors at reasonable prices for all prosthetic and orthotic items in accordance with updated pricing policies and processes.

VHA Comments: Concur. PSAS agrees that enhancements to current procedures can be implemented to ensure vendors are reimbursed at reasonable rates. PSAS will:

1. Explore the development of an Integrated Product Team to determine feasibility of orthotic and therapeutic footwear contracts to ensure consistent and standardized pricing when VA has limited capacity and items are provided in the community.

2. Incorporate the Centers for Medicare & Medicaid Services pricing comparison tool into the Veterans Integrated Services Network (VISN) Site Review template to ensure consistent use by facilities during program reviews.

At completion of this action plan, PSAS will provide OIG with the updated VISN Site Review Template and communication materials related to the creation of an Integrated Product Team and any associated charter or project scope documents.

Status: In Progress Target Completion Date: March 2022

Recommendation 3. Coordinate with appropriate officials such as the Prosthetic and Sensory Aids Service executive director and the executive director, Rehabilitation and Prosthetics Service, to establish

a formal oversight structure that defines the roles and responsibilities of those charged with providing oversight of the prosthetics program, rescind handbooks that reflect an outdated oversight structure, and communicate updated oversight expectations to the Veterans Integrated Service Networks to promote consistent program oversight.

VHA Comments: Concur. PSAS agrees that outlining an oversight structure, defining roles and responsibilities, and ensuring oversight expectations are clear to VISN leadership will encourage consistent program monitoring. PSAS previously rescinded all handbooks that reflect an outdated oversight structure. In addition, PSAS will:

1. Draft VHA policy (Directive 1173), which will assign responsibilities to PSAS and other relevant staff regarding the implementation of Title 38 regulation (38CFR17.3200-3250).

2. Update the standardized VISN Site Review template to incorporate review of facility spending data to ensure price reasonableness.

3. Communicate through VISN leadership, Prosthetic Leadership Board and respective PSAS Governance Council the assigned responsibilities as outlined by policy, performance expectations, and changes implemented for conducting and documenting program reviews.

At completion of this action plan, PSAS will provide OIG with an updated VISN Site Review Template and communication documents provided to the field which outline the updated processes.

Status: In Progress Target Completion Date: March 2022

Recommendation 4. Resolve National Prosthetics Patient Database limitations and establish requirements to routinely monitor medical facilities' input of data to improve accuracy.

VHA Comments: Concur. PSAS agrees there are data limitations within the National Prosthetic Patient Database and steps to improve data accuracy are needed. PSAS will:

1. Ensure collaboration with the PSAS Workgroup and PSAS Academic Excellence and Workforce Development team to coordinate and provide re-education to PSAS staff on the selection and identification of appropriate Healthcare Common Procedure Coding System when creating purchase orders.

2. Partner with the Data Management Council to determine if the Centers for Medicare & Medicaid Services pricing tool can be enhanced to allow for data aggregation to the VISN or National level so it is easier to identify network or national trends in potential overpayments or data inaccuracies.

3. Re-educate PSAS staff on the appropriate procedures for reconciliations and close out of prosthetic purchase orders to ensure the price reflected in the National Prosthetic Patient Database (NPPD) is accurate. Explore potential data tools to identify mismatch between Integrated Funds Distribution Control Point reconciliations and PSAS reconciliations and provide guidance to PSAS staff for price correction in the NPPD when a mismatch has occurred.

At completion of this action plan, PSAS will provide OIG with communication documents provided to the field which outline the updated processes.

Status: In Progress Target Completion Date: May 2022

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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