



**DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420**

November 30, 2015

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-14-3235

Dear Ms. Lerner:

I am responding to your June 20, 2014 letter, regarding allegations made by a whistleblower at the Olin E. Teague Department of Veterans Affairs (VA), Medical Center (Teague VAMC) in Temple, Texas. The whistleblower alleged that:

- Managers improperly directed scheduling staff to close out consultation service requests, and
- The failure to adhere to agency scheduling policies endangered public health.

The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 United States Code §1213(d)(5).

On August 18, 2014, VA's Office of Inspector General (OIG) was advised by the Federal Bureau of Investigation (FBI) that they had received an allegation from Mr. Jose Candelario, a Supervisor Orthotist and Prosthetist at Teague VAMC. Mr. Candelario is the whistleblower who had made the above allegations to the Office of Special Counsel (OSC). His allegations to the FBI and, subsequently, to the OIG were the same as those he made to OSC. The OIG interviewed Mr. Candelario on September 23, 2014, and subsequently conducted a thorough investigation into his allegations.

The OIG prepared the enclosed summary of their investigation and findings to respond to your request that VA provide you a report of VA's investigation into the whistleblower's allegations. The OIG did not substantiate the allegations. Evidence and testimony from 15 current and former employees of the Teague VAMC did not reveal the intentional inappropriate closing of consults or that consults were closed for the purpose of manipulating consult management performance measurements. The report stated that the OIG Office of Healthcare Inspections did not find that patients suffered harm and/or death as a result of consults that were closed.

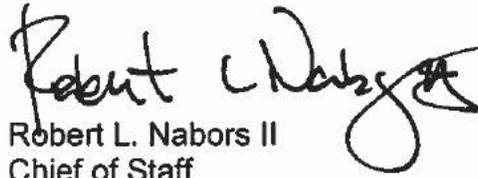
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The Honorable Carolyn N. Lerner

I have reviewed the OIG's report and find that it fully addresses the allegations we were asked to investigate in your June 20, 2014, letter. Therefore, I am submitting their report in response to that referral.

Thank you for the opportunity to respond.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert L. Nabors II". The signature is stylized and cursive, with a large loop at the end.

Robert L. Nabors II
Chief of Staff

Enclosure

**DEPARTMENT OF VETERANS AFFAIRS
REPORT FOR THE OFFICE OF SPECIAL COUNSEL PURSUANT TO THE
PROVISIONS OF TITLE 5 U.S.C. § 1213
RESULTS OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL IN
RESPONSE TO ALLEGATIONS OF VIOLATION OF LAW, RULE, REGULATION,
TEMPLE, TEXAS VA MEDICAL CENTER, ORTHOTICS AND PROSTHETICS
LABORATORY**

OSC FILE DI-14-3235

1. Summary of the Information that Initiated the Investigation

On August 18, 2014, Department of Veterans Affairs (VA) Office of Inspector General (OIG), South Central Field Office (SCFO) in Dallas, Texas, was advised by Special Agent (SA) (b) (6), (b) (7)(C) of the Federal Bureau of Investigation (FBI) in Waco, Texas, that his office had received an allegation from Jose Candelario, Supervisor Orthotist and Prosthetist of the Orthotics & Prosthetics Laboratory, which is part of the Prosthetics & Sensory Aids Service (PSAS) at the Olin E. Teague VA Medical Center (Teague VAMC) in Temple, Texas. Based on this information, on September 23, 2014, VA OIG Special Agents interviewed Candelario.

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

Candelario stated that once the consult is closed, there is no record that the patient did not receive care; however, the consult is good for 1 year, which means that the patient can come in any time during that year. Candelario opined that if a Veteran does not know that he/she has a consult and if he/she does not receive a letter, he/she will never know about the consult. Candelario said that referring physicians also do not have time to follow up on the consults they originate. Furthermore, referring physicians are supposed to inform the Veteran of the consult, but many do not and assume that the PSAS will send a letter.

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

In support of his allegation, Candelario provided a Microsoft (MS) Excel spreadsheet file, which contained data related to 677 Orthotics & Prosthetics Laboratory closed consults for May 2014, and June 2014. Candelario stated that the 677 consults were closed with no letter sent to the Veteran. Candelario and his staff reviewed 435 of the 677 closed consults. The spreadsheet is divided by tabs for May 2014, (389 patient records) and June 2014 (288 patient records). According to Candelario, the spreadsheet is further divided into groups of consults for items that were fitted (meaning the Veteran came in on his/her own); consults for items that were still outstanding (meaning the Veteran has not yet come in); and, consults that were not reviewed. Of the 389 patient records for May 2014, Candelario and his staff identified 35 consults for items that were fitted; 112 consults for items that were still outstanding; and, 242 consults that they did not review. Of the 288 patient records for June 2014, Candelario and his staff identified 65 consults for items that were fitted and 223 consults for items that were still outstanding.

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

2. Description of the Conduct of the Investigation

- a. Interviews: In addition to Candelario, VA OIG interviewed a combination of 15 current and former PSAS Purchasing Agents and Orthotics & Prosthetics Laboratory employees, in addition to the Chief and Assistant Chief of PSAS. The PSAS BPG for Prosthetics Consult Management, dated April 2010, was written and is maintained by VA Central Office. The PSAS BPG for Prosthetics Consult Management is maintained on the PSAS internal website for review and use, as a standard practice. VHA Directive 1173, *Prosthetics and Sensory Aids Service*, is the governing directive for PSAS.
- b. Records review: Candelario provided consult data for May and June 2014, to VA OIG, Office of Healthcare Inspections (OHI) in Dallas, Texas, to conduct a review of notes/charts in the Computerized Patient Record System (CPRS)/Veterans Health Information Systems and Technology Architecture (VistA). VA OIG OHI did not find any refusals to provide items when the patient presented. VA OIG OHI found no evidence that patients suffered harm and/or death as a result of consults that were closed.

3. Summary of the Evidence Obtained from the Investigation

Investigation revealed that prior to September 2014, PSAS Purchasing Agents managed all PSAS consults. Beginning in September 2014, PSAS Prosthetic Representatives helped to manage all PSAS consults to ensure that no consults were being closed without appropriate actions.

Interviews of Current and Former Employees

- A former Purchasing Agent, PSAS, Teague VAMC, stated that there was always confusing direction concerning the handling of the consults because there were a lot of changes. However, she never became backlogged on the consults she received because she stayed on top of them.
- A Purchasing Agent, PSAS, Teague VAMC, stated that she has never been asked or pressured to close a consult without taking some kind of action. She was not aware of anyone closing consults without taking some kind of action.
- An employee who works with a Purchasing Agent, PSAS, VAMC Waco, Texas, told us that it was part of his duties and responsibilities to review the Purchasing Agent's consults to ensure that they are acted upon within a 5 day window, as well as following up on his own consults and working to ensure they are completed within a 5 day window. The employee was not aware of consults being closed without contacting the patient by letter. He had no knowledge of any consults being closed without acting upon them in a timely and appropriate manner. When a letter is sent to a patient, a note is entered to reflect that a letter has been sent. The employee was never pressured in any way to change or manipulate consults, or hide consults, or close consults without taking appropriate action on them.
- Another Purchasing Agent, PSAS, Teague VAMC, said that every purchasing agent is responsible for specific consults, which are based on the last two digits of the patient's social security number. The employee said that she has closed a consult, but only because the patient has been given or received the item listed in the consult. She has not closed a consult without a reason to close it.
- Another former Purchasing Agent, PSAS, Teague VAMC, said that if a consult item had to be ordered for walk-in patients, the item was ordered and then mailed to the patient. For consults when the patient did not come to the PSAS within the 5 days, the consult item was ordered and then the consult was closed. She never sent letters to patients but was unaware if the letters were being mailed by the PSAS staff at the Waco VAMC. She also said she was never directed not to send letters.
- Another Purchasing Agent, PSAS, Teague VAMC, stated that he has never been asked or pressured to close a consult without taking some kind of action and has

never closed a consult without action. Regarding managing consults, he receives hundreds of consults a day to work. He keeps the consult open for as long as it takes to complete the task so he can close the consult. He said that the goal is to close a consult within 5 days of receipt.

- A Prosthetist, PSAS, Orthotics & Prosthetics Laboratory, Teague VAMC, said that, prior to April 2014, the PSAS had problems sending letters to Veterans regarding closing their consult. The letters either did not go out or were sent to the wrong Veterans, etc. As a result, PSAS management decided that, in order to address the problem, PSAS employees at VAMC Waco would be responsible for sending the letters. The employee said that, in April 2014, she was informed by Chief and Associate Chief of PSAS that PSAS was no longer required to send out letters. The employee was aware of the PSAS BPG for Prosthetics Consult Management and interpreted it as requiring notification of consults to Veterans (i.e. letters); however, the supervisors' interpretation was that PSAS did not have to notify the Veterans of consults. The employee noted that beginning in or around July 2014, PSAS resumed sending letters to Veterans as notification of their consults. The employee created a MS Excel spreadsheet file, which contained data related to 677 closed consults for May and June 2014. She believed that the MS Excel spreadsheet documented consults for items that Veterans should have been notified to pick up before closing the consult; however, the letters were not being sent to Veterans.
- A Prosthetics Representative, PSAS, Teague VAMC, stated that when she works a consult, she knows the consult is good for 1 year. The Veterans are instructed to "walk in" to prosthetics, without an appointment, between 8:00 a.m. and 4:00 p.m., to pick up their item. At that point, the consult is changed from "open" to "pending." After 60 days, she reviews the consult. If the item has been picked up, she notes that and closes the consult. If not, she sends a letter to the Veteran, reminding the Veteran of the item that should be picked up. When she sends the letter, she notates the item was not picked up, that a letter was sent, and then she closes the consult. The employee was not aware of any push by management to close consults due to the backlog of consults. She knows the service has been short staffed for some time and the backlog began to grow. Management made some changes to take pressure off the purchasing agents.
- Another Purchasing Agent, PSAS, Teague VAMC, did not recall ever being instructed to not send out letters to patients. The employee said purchasing agents have 5 days to take action on a consult and noted that once consults reach 5 days, purchasing agents have pressure to do something with the consults. (b) (6) opined that there was pressure to get the consults completed within the 5 day time frame and take care of patients. The employee said that as a result of some closed consults, there was a conflict between the Orthotics & Prosthetics Laboratory and the purchasing agents. He also said that when the purchasing agents closed a consult, it basically disappeared from the system and the Orthotics & Prosthetics Laboratory then would not see the

consult. As a result, the Orthotics & Prosthetics Laboratory would receive calls from patients regarding their consults.

- Another Purchasing Agent, PSAS, Teague VAMC, said that the PSAS attempted to manage consults within 5 days of receipt. She explained that if a consult reached day 5, it would turn red in the system and that most consults were usually managed in about 3 days. The employee said that if for some reason a consult approached the 5 day mark, she would put it in pending status with a comment noted. She never received any instructions to close consults early because of the 5 day limit. She never received instructions to not send letters out to patients. She does not close consults unless there is a legitimate reason to close the consult, and she enters the appropriate reason.
- A former Purchasing Agent, PSAS, Teague VAMC, said there was once a concern over "dropped consults." Occasionally, maybe about 5 to 10 times a month, a Primary Care consult would be managed by the clerk. The former employee explained that once the clerk received the consult for an item, the clerk would check the stock inventory, pull the item, and issue it to the patient. Once the item was issued to the patient and the clerk notated it in the system, the consult was closed. As a result, the former employee would never see the consult. He was unaware of consults being closed prior to patients receiving the consult items. He had never been instructed by anyone to close consults prior to patients receiving the consult items.
- A Supervisory Prosthetics Representative, PSAS, VAMC Waco, said he uses the Prosthetics Matrix when he reviews consults to make sure consults are being routed correctly so the Orthotics & Prosthetics Laboratory at Teague VAMC can follow up. He only gets involved with the consults when they reach the 5 day time limit. If a consult is unresolved on day 5, a letter is sent to the Veteran advising him/her that he/she needs to come in and pick up the consult item. The consult is then placed in a pending status for either 45 business days or 60 calendar days. While the consult is in the pending status, the consult is waiting for the Veteran to come.
- A Purchasing Agent, PSAS, VAMC Waco, said that until approximately September 2014, he and another Purchasing Agent, PSAS, VAMC Waco were responsible for all Orthotics & Prosthetics Laboratory consults, and they had difficulty handling the workload. While responsible for the Orthotics & Prosthetics Laboratory consults, they were instructed to wait 3 days before sending the Veteran a letter to pick up the consult item and then close the consult. The employee believed that PSAS management does not want consults to get beyond the 5 day requirement. The reason most consults go beyond the 5 day requirement is because the particular employee assigned to the consult is out on leave or out of the office. As a result, Purchasing Agents are required to catch everything back up. In approximately April 2014, the employee was instructed by the Chief, PSAS, to close consults without sending letters.

- Another Purchasing Agent, PSAS, VAMC Waco, stated that, recently, a PSAS Prosthetics Representative at Teague VAMC began overseeing the consults assigned to help manage the Orthotics & Prosthetics Laboratory consults. From approximately April to September 2014, there were only two purchasing agents managing Orthotics & Prosthetics Laboratory consults. They were instructed to wait 3 days, send a letter to the Veteran and close the consult. The staff could then make an entry that the item had not been picked up. The employee noted a matrix was developed to try and assist purchasing agents with managing consults. From approximately May to September 2014, per instruction of the Chief, PSAS, there were no letters being sent out and consults were being closed with the notation that the consult item needed to be picked up in prosthetics, and consult is good for 1 year. Sometime in September 2014, letters started to be sent out again to Veterans with consults.
- The Chief, PSAS, Teague VAMC, said VHA Directive 1173, *Prosthetics and Sensory Aids Service* governs PSAS said the PSAS BPG for Prosthetics Consult Management were recommendations regarding how PSAS consults should be handled. She said the PSAS BPG for Prosthetics Consult Management should be followed to the letter and has been followed correctly since early 2014. Prior to 2014, the previous Chief of Prosthetics modified the PSAS BPG for Prosthetics Consult Management, and as a result, was not being followed exactly. She said the PSAS BPG for Prosthetics Consult Management was written by the VA Central Office to properly manage the consults and only VA Central Office was responsible for updates and revisions.

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

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

Purchasing agents have made errors when sending letters to patients regarding picking up items because the patient actually needed an appointment rather than just picking up the item. The Orthotics & Prosthetics Laboratory would sometimes complain because a patient would show up at the lab and there was no appointment for them.

She was not aware of any PSAS consults that were intentionally closed without appropriate review. (b) (6) said if this happened it would have been due to error by the purchasing agent. (b) (6) said PSAS consults have been closed without calling the Veteran or sending the Veteran a letter but attributed it to employee error due to high turnover and new employees; it was not intentional. It has always been permissible to send the patient a letter, and it is not a requirement to call the patient. PSAS consults have never been closed to eliminate a backlog.

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

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

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

There may have been consults closed without contacting the Veteran, by calling or sending a letter, but according to the PSAS BPG for Prosthetics Consult Management, any time there is an action on a PSAS consult, the ward or clinic that entered the consult is notified by CPRS or VistA. There is no requirement to call the Veteran each time; a letter is sufficient notification. He has never allowed

his employees to simply close consults to eliminate any backlog. Additionally, consults are also scrubbed quarterly to make sure none were missed, and they are being closed timely and appropriately. Closed consults are still traceable and reviewable, and they are good for 1 year even when closed.

VA OIG Office of Healthcare Inspections Review

On November 5, 2014, VA OIG SCFO provided the aforementioned MS Excel Spreadsheet file to VA OIG OHI to conduct a review of notes/charts in CPRS/VistA in an effort to substantiate whether or not PSAS consults were closed improperly without notifying the Veteran or sending the Veteran a letter. VA OIG SCFO requested a review of all consults in the MS Excel spreadsheet file for any indication the consults were improperly closed; if there is any record of a letter being sent to the Veteran related to the consult; or, if there were any questionable notes associated with the consults in the system.

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

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

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

4. A Listing of Violations or Apparent Violations of Law, Rule, or Regulation

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

5. A Description of Any Action Taken or Planned as a Result of the Investigation

No action was taken or is planned to be taken because the allegations were not substantiated.