COVER LETTER

[redacted]
Chief, Prosthetics and Sensory Aids Service
Central Texas VA Health Care System

Address: [redacted]

Phone: [redacted]

Email: [redacted]

[redacted]
Attorney
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Washington, DC
20036

Dear Ms. [redacted]

Thank you for taking the time to assist me with OSC File No DI-24-000447. Please accept this cover letter for my response the OMI results report related to OMI Action Plan-OSC-DI-24-000195, dated September 26, 2024. Attached to this cover letter you will find the following documents:

- Whistleblower response to OMI report and recommendations labelled "OMI Report Response Notes."
- Whistleblower response to OMI action plan OSC-DI-24-000195 to perform duties out of scope labelled "OMI PSAS Action Plan - 070324."

I am extremely interested in discussing this case in detail and explain how political expedience within Central Texas VA Health Care system is leading to fraud, waste, and abuse of government funds. Thank you for taking the time to review my cover letter and response documents. I look forward further discussion on this concern.

Sincerely,

[redacted]

OMI Report Response Notes:

From: [redacted] Chief of Prosthetics and Sensory Aids Service (PSAS), Central Texas Veterans Health Care System (CTX)

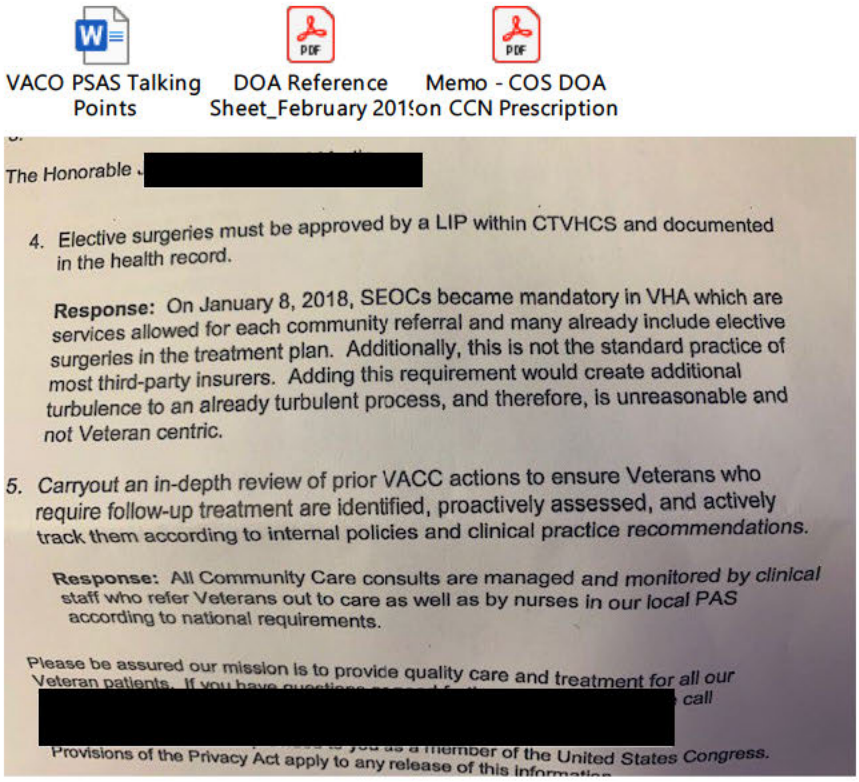
Respectfully, as the Whistleblower, I feel I received multiple prohibited personnel practices by my leadership. On May 7, 2024, my supervisor threatened me with disciplinary action however he stated he was not able to take the action because it would have been seen as retaliation, and instead he stated Labor Relations approved an "Employee Expectation Letter" which appears to condemn my actions of disclosing fraud, waste, and abuse of government funds due to Political Expedience at Central Texas. On October 30, 2024, I was removed from my position and reassigned to perform administrative duties because I feel the OMI recommendations and action plan require admin staff to perform duties out of scope and against established government rules and policies.

I feel the chairman of the OMI site visit had a preexisting relationship with members of Central Texas VA leadership. On the day of the OMI initiated its investigation at Central Texas Veterans Health Care System (CTX), the Assistant Chief of Quality Management stated he knew the OMI investigative chairman, that he has been to CTX before to investigate concerns, and the chairman was a "good guy." During the investigation, I feel my claims were not heard because the investigative team was hyper focused on a hospital bed prescription that PSAS could not fill, because the clinician was asking Prosthetics to provide an assessment Prosthetics does not provide.

Again, I question if CTX Leadership had a pre-existing relationship with the investigator, and I feel the OMI report and recommendations are continued examples of political expedience at CTX, showing CTX Leadership does not agree with the Code of Federal Regulations, Joint Commission Standards, and mandated VA policies regarding national assessment, treatment planning, and prescription practices.

Politics is how people (*polis*) get wants and needs through reasonable means, and expedience is doing what is convenient, therefore political expedience within VA is doing what is convenient rather than doing what is morally and legally right according to CFR and VA policies. I feel the OMI team repeated what Leaders have been saying for years, and that is national policies are too tough or inconvenient, therefore they are "unreasonable."

The OMI report appears to prove that CTX Leaders and Clinicians are not held accountable to carry out assigned duties, and therefore those duties are being carried out by administrative staff out of scope of practice. The same sentiment was written in the 2018 Congressional Response (pictured below) when I reported the facility for requiring Prosthetics staff to review and submit prescriptions to itself, noting that the Delegation of Authority for LIPs or Subject Matter Experts (SMEs) to review and approve Community Care Requests for Services was "unreasonable and not veteran centric." VACO deemed in 2019 that it was inappropriate and against the scope of Prosthetics admin staff to receive, medically, review, input, and prescribe devices to itself. Even though it was deemed inappropriate, Prosthetics Reps were mandated by the COS to continue, and this continued until 2023.



Conclusion for Allegation 1

- We **do not substantiate** the Chief of Staff (COS), Deputy COS, and the Medical Center Director have refused to adhere to and enforce national directives, policies, and SOP for the processing of durable medical equipment (DME) prescriptions.

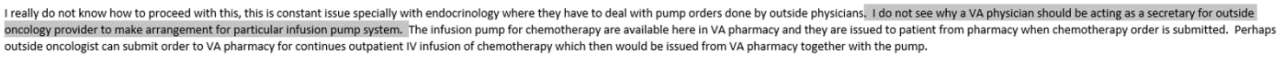
  - **The example of the delay in implementation CITC DOA in relation to 10N memo dated April 19, 2017 "Enhancements to the Community Clinical Review Process" contradicts this conclusion.**

  - 2018 Congressional Response regarding this matter echoed the same sentiments stating national VA rules regarding the reviews of Community Care recommendations that included DME prescriptions (like Spinal Cord Implants) occurred without Delegation of Authority medical oversight, reviews, and approvals because local medical leadership believed VA Community care rules to provide medical oversight by medical subject matter experts are too tough and "therefore not Veteran Centric." **The whistleblower is asking the agency to review the number of orders submitted by Prosthetics Representatives from April 19, 2017, through the end of fiscal year 2024 related to Community Care.** How many of the orders came from a Standard Episode of Care (SEOC) that was complaint under the Chief of Staff Delegation of Authority and Medical Services List (DOAMs) process, which had a medical review by an approved by a clinician or designee.

  - Care in the Community (CITC), or also known as Community Care, require Delegation of Authority for Medical Services (DOAMs) duties to be assigned to medical SMEs to review and submit prescriptions to Prosthetics were assigned to PSAS out of political experience by Chief of Staff, because clinicians stated it was too tough or time consuming. They claim that CITC

DOAMs is too tough or time-consuming and therefore cannot be followed. Video evidence from meetings and TEAMs messages from leaders saying they do not agree with VA policies was dismissed by OMI, stating "As we discussed during the interview, we will not review the recording as we have no indication there was consent and this could be a violation of VHA Directive 1078. We will look at the other data provided in this email." The videos were consented and according to VHA Directive 1078 these TEAMs records appeared to be reviewable by the team, but they would not watch the leaders actually state they do not agree with national policies.

- 2/14/24, Chief Oncology was the assigned DOAMs provider over Oncology, and stated (in writing) he not getting involved for DOAMs reviews because it is a waste of his time.


I really do not know how to proceed with this, this is constant issue specially with endocrinology where they have to deal with pump orders done by outside physicians. I do not see why a VA physician should be acting as a secretary for outside oncology provider to make arrangement for particular infusion pump system. The infusion pump for chemotherapy are available here in VA pharmacy and they are issued to patient from pharmacy when chemotherapy order is submitted. Perhaps outside oncologist can submit order to VA pharmacy for continues outpatient IV infusion of chemotherapy which then would be issued from VA pharmacy together with the pump.

• Temple leadership has taken multiple steps to try and resolve concerns in compliance with national policies, reaching out to Veterans Integrated Service Network 17 and to the Prosthetic and Sensory Aids Service (PSAS) National Program Office (NPO) for guidance.

The Whistleblower disagree, they failed to act timely as well as failed to hold their staff accountable and competent to National requirements. As stated in this report, the CITC Action plan from December 2021 is still not complete in November 2024. The reason it is not complete is because of the CPO process was not installed, and because services are not cooperating with the DOAMs Medical Reviews, coordination and oversight by clinical Subject Matter Experts assigned by the Chief of Staff. There are numerous other examples regarding supply chain management, surgical implants and stock management.

• Temple PSAS closed consults for home DME from both VA prescribers and eligible entities based on perceived inadequate assessment of education, training, and home environment.

CTX Prosthetics staff followed the Code of Federal Regulations, VA policies and Business Practice Guidelines, Joint Commission standards, as well as provided clinical staff with VA published standard operating procedures (SOP).

Code of Federal Regulations **to prescribe a Prosthetic item or service** - § 17.3200 Purpose and scope. This section and §§ 17.3210 through 17.3250 apply **only to items and services** listed in § 17.3230(a) and authorized to be provided as medical services under 38 U.S.C. 1701(6)(F) and 38 U.S.C. 1710(a). The provision of the items or services and payments in table 1 to this paragraph (b) are authorized in whole or in part by separate statutes and controlled by other implementing regulations:

Examples provided OMI for the delivery of large DME to travel trailers/RVs that have DMV plates, which do not support the DME prescribed because they are too small. Often Vendors report the items cannot be installed after they were purchased, therefore this is proof that the VA required coordination by medical staff to assess, treatment plan, and to prescribe is not occurring because clinical staff are not competent with the processes, and they do not agree to their assigned duties.

VHA DIRECTIVE 1173 PSAS 3/27/23:

The prescribing VA health care provider is responsible for:

(4) Ensuring the environment where items or equipment provided under PSAS programs will be used is considered or assessed to ensure it meets the Veteran's needs (e.g., HISA program or home medical equipment home assessment, AAE program vehicle assessment). NOTE: Not all items or equipment provided by PSAS will require a home assessment if the home environment is not relevant to the safe and effective function of the items or equipment.

(7) Ensuring the Veteran is provided training and education to ensure safe and efficient use of PSAS program items or benefits, including discussing Veteran responsibilities. NOTE: Education and training may be provided by personnel in specialty clinics that distribute items and equipment to the Veteran or other members of the clinical team.

- PSAS closed consults for VA prescribers and eligible entities based on perceived failure to provide detailed descriptions of DME specifics on their consult.

  - VHA DIRECTIVE 1173 - The prescribing VA health care provider is responsible for:

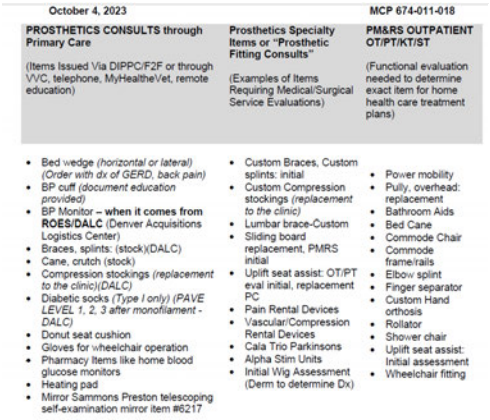
(1) Evaluating Veterans and determining whether they require **an item or service** under PSAS programs.
(2) Providing clinical justification for **the prescribed item or service** as required by the corresponding regulations. NOTE: Please refer to Appendix A for further information on regulatory authorities governing PSAS benefits, devices and equipment.

(3) Performing and documenting in the Veteran's electronic health record (EHR) an evaluation of the Veteran to establish any clinical requirements under PSAS programs**, including a justification for a PSAS item or service**. NOTE: For documentation requirements, see VHA Directive 1907.01, VHA Health Information Management and Health Records, dated April 5, 2021.

(4) Ensuring the environment where **items or equipment** provided under PSAS programs will be used is considered or assessed to ensure it meets the Veteran's needs (e.g., HISA program or home medical equipment home assessment, AAE program vehicle assessment). NOTE: Not all items or equipment provided by PSAS will require a home assessment if the home environment is not relevant to the safe and effective function of the items or equipment.

(5) Coordinating equipment trials for the Veteran, if indicated, documenting trial results in the EHR and determining whether the trialed item or service is optimal for the Veteran's needs. NOTE: Not all items will require an equipment trial. The determination on whether an item must be trialed is based upon manufacturer or clinical requirements.

  - MCP 674-011-018 was negotiated between PMRS OT Chief, Nursing and Primary Care Leadership for these items, and it clearly states what service/practice assess:



October 4, 2023 — MCP 674-011-018

PROSTHETICS CONSULTS through Primary Care (Items Issued Via DIPPC/F2F or through VVC, telephone, MyHealtheVet, remote education)	Prosthetics Specialty Items or "Prosthetic Fitting Consults" (Examples of Items Requiring Medical/Surgical Service Evaluations)	PM&RS OUTPATIENT OT/PT/KT/ST (Functional evaluation needed to determine exact item for home health care treatment plans)
• Bed wedge *(horizontal or lateral) (Order with dx of GERD, back pain)* • BP cuff *(document education provided)* • BP Monitor – **when it comes from ROES/DALC** (Denver Acquisitions Logistics Center) • Braces, splints: (stock)(DALC) • Cane, crutch (stock) • Compression stockings *(replacement to the clinic)(DALC)* • Diabetic socks *(Type I only) (PAVE LEVEL 1, 2, 3 after monofilament - DALC)* • Donut seat cushion • Gloves for wheelchair operation • Pharmacy Items like home blood glucose monitors • Heating pad • Mirror Sammons Preston telescoping self-examination mirror item #6217	• Custom Braces, Custom splints: initial • Custom Compression stockings *(replacement to the clinic)* • Lumbar brace-Custom • Sliding board replacement, PMRS initial • Uplift seat assist: OT/PT eval initial, replacement PC • Pain Rental Devices • Vascular/Compression Rental Devices • Cala Trio Parkinsons • Alpha Stim Units • Initial Wig Assessment (Derm to determine Dx)	• Power mobility • Pully, overhead: replacement • Bathroom Aids • Bed Cane • Commode Chair • Commode frame/rails • Elbow splint • Finger separator • Custom Hand orthosis • Rollator • Shower chair • Uplift seat assist: Initial assessment • Wheelchair fitting

October 4, 2023 — MCP 674-011-018

PROSTHETICS CONSULTS through Primary Care (Items Issued Via DIPPC/F2F or through VVC, telephone, MyHealtheVet, remote education)	Prosthetics Specialty Items or "Prosthetic Fitting Consults" (Examples of Items Requiring Medical/Surgical Service Evaluations)	PM&RS OUTPATIENT OT/PT/KT/ST (Functional evaluation needed to determine exact item for home health care treatment plans)
• Nebulizer and Acorns (in CBOCs)(DALC) • Pedometers *(only if in the MOVE! Program)* • Scales of digital and (analog for pacemaker • Shoe orthotics/lifts/inserts: replacement • Shoe, healing, rocker bottom: replacement • Sock assist • TENS, replacement pads or leads (DALC) • Urinals • Walker • Wig Replacements (Use template, current wig must be unrepairable) • Wheelchair repair shop • Cervical Collar (soft): initial • Commode riser or raised toilet seat-no measurement needed		• Home Evaluations for home health equipment • Driver's Training

- VA/Medicare/TJC require home evaluations and assessment for certain items, and some of those items are specifically listed in SPHMT SOP; these assessments are not occurring in many cases and/or PSAS funds are being used.

compromises safety for the Veteran and their caregiver(s). Examples of such devices for home settings include but are not limited to powered and non-powered, standard and bariatric versions of the following:

- Hospital beds with enhanced features (e.g., power controls, specialty support surfaces)
- Powered mobile floor-based lifts
- Overhead lifts including ceiling mounted or portable gantry systems
- Wall mounted lifts
- Slings that interface with the lift or mobility aid, as recommended by the manufacturer of SPHM equipment
- Standing or ambulatory aids
- Ergonomic shower chairs or bedside commodes
- Pneumatic (air) assist devices
- Friction reducing lateral transfer board
- Repositioning and/or anti-friction devices for movement or positioning in bed
- Emergency evacuation devices
- Vehicle transfer/extraction devices

Authority: 38 CFR 17.150

- COS/AD Patient Care Published CITC Standard Work Process with Appendix C saying who may order: [dvagov.sharepoint.com/sites/vhactxcitc/Shared Documents/Forms/AllItems.aspx?id=%2Fsites%2Fvhactxcitc%2FShared Documents%2FStandard Work- DME Updated%2Epdf&parent=%2Fsites%2Fvhactxcitc%2FShared Documents]

Item	Who may Order	CPRS Order Template:
Acapella Device	Pulmonologist/ Respritory	Prosthetic Specialty- Pulmonology
Aides to Daily Living	PMRS Providers (PT/OT/KT)	Prosthetic Specialty- PMRS Staff only
Alarm: Bed, window, Chair, etc.	PMRS Providers (PT/OT/KT)	Prosthetic Specialty- PMRS Staff only
Alpha Stim Aid	MHS/ Nuerology/ Pain	Prosthetic Specialty-
Alpha stim M	Neurology/Pain	Prosthetic Specialty- Clinical Pharmacist/Neuro
ALS Portable Generator	PCP/PMRS	Prosthetic Committee-
Arm Slings	All providers within their scope of practice	Prosthetics Order Request
Bath Guard	All providers within their scope of practice	Prosthetics Order Request
Bathroom safety devices (Shower chair, Bath bench, Toilet safety frame, etc.)	PMRS Providers (PT/OT/KT)	Prosthetic Specialty- PMRS Staff only
Binders, Abdominal	All providers within their scope of practice	Orthotic/Prosthetic Lab Consult
Blender	Nutrition/Speech/BA/	Prosthetic Specialty- Nutrition Food Services
Blood Pressure Monitor	All providers within their scope of practice	ROES/DALC- Point of Service issue- Prosthetic Order Request
Bone Growth Simulator	Neurology/Pain	Prosthetic Specialty- Clinical Pharmacist/Neuro
Braces, Custom	Amputee Care Clinic (Physiatrist), Neurologist, Orthopedist, Podiatrist for below knee only	Orthotic/Prosthetic Lab Consult
Braces, Off the shelf	All providers within their scope of practice	Point of Service issue- Prosthetic Order Request
Bras, Mastectomy	All providers within their scope of practice	Prosthetics Order Request
Bras, Nursing	All providers within their scope of practice	Prosthetics Order Request
Breast Pump	All providers within their scope of practice	Point of Service issue- Prosthetic Order Request
Cam boot	ED/access/ Podiatry/ PMRS/Othopedic	Prosthetic Specialty- Point of Service issue- Prosthetic Order Request
Cane	All providers within their scope of practice	Point of Service issue- Prosthetic Order Request
Cefaly	Neuro/Pain	Prosthetic Specialty- Clinical Pharmacist/Neuro
Cervical collars	ED/access/ Podiatry/ PMRS/Orthopedics	Orthotic/Prosthetic Lab Consult

• We find guidance in PSAS Business Practice Guidelines (BPG) for PSAS Consult Management regarding detailed descriptions (for example vendor, make, and model) unreasonable and potentially a reason for delay of services.

This appears to be an example of political expedience and confirms Prosthetics staff are not receiving prescriptions according to established VA policies because clinicians are not held accountable and are not competent.

38 CFR § 17.3240 Furnishing authorized items and services.

(a)

(1) VA providers, or eligible entities and providers as defined in § 17.4005, **will prescribe items and services** in accordance with § 17.3230(a) and will do so in consultation with the veteran.

(2) **Once the item or service is prescribed** under paragraph (a)(1) of this section, VA will either fill such prescriptions directly or will pay for such prescriptions to be furnished through a VA-authorized vendor.

Recommendations to Temple

1. Educate Temple PSAS staff, including the Chief, that Veterans Health Administration (VHA) Directive 1173, Prosthetic and Sensory Aids Service, dated March 27, 2023. and Safe Patient Handling and Mobility Technology SOP, dated July 18, 2019, both support the use of an interdisciplinary team approach for evaluation, education, and training of patients on DME, and develop plans to operationalize such interdisciplinary teams.

The whistleblower took the national trainings and states Clinical staff are not competent in this process. How many leaders and clinical staff that are involved with the prescription of home medical equipment at CTX have this as a medical competency and received annual training on the policy as required under VHA Directive 1611?

- **VHA Directive 1611 – Safe Patient Handling and Mobility Program:**

  i. VA Medical Facility Director. **The VA medical facility Director is responsible for:**

  (11) **Ensuring that all individuals and work groups that** handle and mobilize patients or provide or **approve equipment for patients** are included in the SPHM program, including but not limited to nursing units; SCI/D Centers; Community Living Centers; treatment areas; diagnostic and imaging areas; procedure areas; perioperative areas; rehabilitation units; physical, occupational, recreation and kinesiotherapy clinics; mental health areas; outpatient clinics including community-based outpatient clinics (CBOCs); morgues; Prosthetic and Sensory Aids Service; home care; volunteers; and patient transportation.

  (13**) Ensuring that staff who are directly involved with handling and mobilizing Veterans maintain competence** in SPHM technology and methods.
  TMS Trainings:
  34318 Basic Safe Patient Handling and Mobility (SPHM) Training for Direct Care Providers
  34319 Basic Safe Patient Handling and Mobility (SPHM) Training for VA Employees

- **CTX MCP 674-006PS-001(1) Safe Patient Handling:**

  n. Physical Medicine and Rehabilitation (PM&R) employees. **PM&R employees are responsible for:**

  (1) Collaborating with SPHM FC, Nursing, and other clinical services to drive mobilization of patients using SPHM technology to ensure safety.

  (2) **Completing consults and communicating recommendations with care teams** for mobilizing patients.

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2. Reschedule the postponed in-depth review and education by the combined PSAS and Physical Medicine and Rehabilitation (PMR) NPOs.

This was completed October 2024. I was intentionally held out of the exit briefing, but my supervisor emailed the following to me on 10/15/24 with his bullet points showing the OMI recommendations and the VACO site visit findings conflict with each other. To date, he has not met with me despite my requests to meet and negotiate (through email).

[redacted] Below are my notes from the site visit exit. Apologize for the delay but I wanted to type all of this up and send it to you so that you could review BUT **I would still like to meet with you to discuss**. **(This never occurred)** Please understand these are my notes and they are not comprehensive, therefore the final report may contain more information and recommendations.

Observations:

1. Current process for securing prosthetic devices is sufficient, however there is room for **improvement from providers in providing more information in consults.**
2. Chief or Prosthetics seems to over-interpret policies which may hinder progress. Examples provided included 1) the extreme interpretation of the requirement for home evaluations and assessments **2) questioning of providers competency to order specific devices (determination not within his authority)**
   - COS/AD Patient Care Published CITC SWP with Appendix C saying who may order what, from where: dvagov.sharepoint.com/sites/vhactxcitc/Shared Documents/Forms/AllItems.aspx?id=%2Fsites%2Fvhactxcitc%2FShared Documents%2FStandard Work- DME Updated%2Epdf&parent=%2Fsites%2Fvhactxcitc%2FShared Documents
3. **Prosthetic Funds are being used to pay for clinical services when they should not (example provided included Numotion) – Fraud/waste/abuse of VA funds because clinicians do not agree to their duties according to policy?**
4. While the over-interpretation of certain directives/polices may have led to actional consults not being acted on, **clinical teams also need to take responsibility** and work towards reducing the number of non-actionable consults.
5. There are significant concerns regarding the division of responsibilities between Prosthetics and PMRS teams relating to wheelchair management. Clear delineation of responsibilities is lacking, leading to inefficiencies. While it would be ideal if these responsibilities were clearly defined, certain wheelchair issues require an administrative POC while others require clinical input. The teams must collaborate to determine how these responsibilities will be shared as the current situation is not sustainable.

Recommendations

1. Review and Revise MCP 674-011-018 as it is too restrictive. Revising the policy will allow for wider distribution of DME ordering, improve collaboration and reduce care delays.
2. Including a Prosthetic Rep in the Wheelchair Clinic to enhanced teamwork, improved planning, and aide in prevention of improper ordering (ie reducing waste)
3. Objective approach and implementation of a closed loop communication system thru the sharing of data. Capture a listing of devices (i.e. beds, chairs, etc.) that do not fit in the Veterans home and sharing it with the PMRS Service Chief at an agreed upon interval. This will allow the PMRS Chief to utilize the data to address and educate the clinical team.
4. **Correct the usage of Prosthetic funding to pay for clinical services. For the time being we will perform cost transfers to ensure expenses are reflected appropriately. *(We will discuss the process in greater detail)***
5. PSAS maintain a master list of items refused or returned equipment being stored off-site and/or warehouses on the VA Campus. Through the integration of Prosthetic Reps into clinical teams, attempts should be made to re-issue these items. PSAS should also develop a time period *(team used 2 years during the discussion)* for which they will store these items while they try to reissue them and after that point, they should work with Logistics to transfer or sale the items on GSA.
6. Work toward reducing the number of non-actionable consults. (Focus here were requests coming from CITC)
7. Implementation of a data driven process to gather information by clinician for which consults were non-actionable (NR Code) and by working with ELT to determine where this information will be reported so that corrective action can be taken.
8. **Specialty Bed Flow Chart requires updating as it a) does not indicate if it is to be used for Basic and/or specialty beds b) leaves decision making capacity to Prosthetics c) process should enforce clear medical justification to enhance clarity and efficiency.**
9. Invite NCOD
10. Clinical denial occurs when a clinician determines that a requested service is inappropriate based on their evaluation, while and Administrative denial happens when a clinician finds the request medically appropriate but it cannot be fulfilled due to regulatory constraints or ineligibility. **Clinical team is responsible for handling clinical denials** while Prosthetics is responsible for handling administrative denials.

Best Practices:

1. PMRS IDT Wheelchair clinic is highlighted as an excellent example of and IDT among physiatrists and rehab clinicians. (would be further strengthened with a Prosthetic rep)
2. Clinical seating specialists conduct VVCs post delivery to ensure mobility devices function properly in Veterans home.
3. Strong working relationship between [redacted]
4. Relationship between Prosthetics and CITC has significantly improved.
5. Prosthetic led initiative to redesign the consult template has received positive feedback from clinicians, resulting in a more streamlined order process via radio buttons and drop-down menus.

Recommendation to VHA

1. Clarify guidance in PSAS BPG for PSAS Consult Management that the detailed description for DME is the responsibility of all care team members to include PSAS representatives, not just those providers or eligible entities submitting a PSAS consult.

This is an example of Political Expedience because subject matter experts know the items/services they are prescribing and recommending; therefore, the Prescribers need to coordinate with the other services/SMEs to create a treatment plan that includes DME. This contradictory because Prosthetics staff do not assess and prescribe devices, and the National BPG states PSAS needs specifics, and findings include Chief of Prosthetics. This does not follow CFR, VA policies, prescription rules, etc. and the Whistleblower will not allow his staff to pick and choose what a Veteran might need, rather it must be documented as part of a treatment plan, and it must be a specific item or service. Example, if a rental item (like a hospital bed) is determined to be medically necessary, then the prescription Prosthetics will need to specifically state the make/model of the bed, the type of mattress, the medically necessary bed attachments (like full length or half rails), and the prescription will need to include the time/length of the rental in either days, months, or a year.

Conclusions for Allegation 2

- We **do not substantiate** that PSAS consistently expends agency funds on improper orders.

The allegation was two-fold, that PSAS is spending money when it should not, and that the DOAMs review process was not being followed by those who were assigned to do the duties by the Chief of Staff. The prescriptions, documents, and info provided to OMI does not appear to have been considered and previous CITC approvals were not reviewed to substantiate PSAS Chief's Claim. It appears they did not investigate all the orders reported, as they state they reviewed only 10 orders. The auditor of the NR Code appeared to review over 12,000 prescriptions, therefore the OMI report appears to show political expedience because the OMI investigators were hyper focused on a hospital bed for a Veteran rather than reviewing the entirety of the evidence presented to them.

- We noted approximately $100,000 in excess or improper equipment stored in the Temple contract warehouse in September 2021 and $84,000 at the end of FY 2022 due to rejection or non-delivery. These values represent approximately 0.2% of the total Temple PSAS annual budget.

All evidence provided was not considered. PSAS staff have started a documentation (leaf) system to capture the number of items that are denied, returned, etc. because of poor assessments and treatment planning through an IDT. Not everything is being captured, just the items we cannot return for partial refund.

Allegation 3
Patient care is delayed because patients are not receiving prescribed DME on a timely basis.

Findings
We reviewed 10 examples submitted by the whistleblower and noted that in 7 of the cases, the information provided by the prescribing provider requesting DME appears adequate. All cases provided were closed by PSAS without ordering the DME with the rationale there was too little information to proceed; these instances delayed Veteran care.

Chief of PSAS submitted a folder over 50 examples and uploaded numerous more to a share drive with Quality Management Service. Chief of PSAS also had a folder of over a hundred of examples of paper prescriptions received, reviewed, and entered under the COS DOA for Prosthetics to accept and enter prescriptions against our scope of practice from 2017 to current.

A “specialty hospital bed” example was provided through a private e-mail conversation between OMI and Chief PSAS was published in the OMI final report. This example was denied because the clinician is asking Prosthetics admin staff to coordinate an assessment for him, and this is not consistent with many VHA Policies. The Veteran was provided multiple bed packages, and the current bed had all the requirements addressed, however the wife wanted a bed that is not available for private homes. The Veteran was assessed again by Major Medical Equipment committee, and they found the Veteran’s

current bed was medically appropriate, however a new mattress was prescribed and purchased, and it was the wrong item, again showing that Clinicians/Subject Matter experts are prescribing devices without the necessary assessment and/or competency training.

The Prosthetics Specialty Hospital bed prescription example states the Veteran needs to be evaluated for a new type of bed through MMEC which is an IDT. No specific item was identified, and the requests asks for Veteran to be assessed for a new bed determination, which is out of scope for Prosthetics, so PSAS staff must follow Business Practice Guidelines for Consult Management and either pend the RX for more specific bed info, or we forward to a service so the Veteran may be eval'ed so a new RX may be generated. PSAS admin staff do no evaluate Veterans for hospital beds, nor may they coordinate assessments/care for PMRS staff:

CTX MCP 674-006PS-001(1) Safe Patient Handling:

n. Physical Medicine and Rehabilitation (PM&R) employees. **PM&R employees are responsible for:**

(1**) Collaborating** with SPHM FC, Nursing, and other clinical services to drive mobilization of patients using SPHM technology to ensure safety.

(2) Completing consults and communicating recommendations with care teams for mobilizing patients.

VHA Directive 1170.03: The IDT is responsible for:

(1) Collaborating with all the disciplines specialized in the evaluation and management of complex needs of Veterans who would benefit from comprehensive and intensive rehabilitation services.

(2) Developing an individualized rehabilitation treatment plan with goals and timeframes established, and clinical outcomes are monitored on a routine basis.

(3) Ensuring the Veteran and their family are integrated into the IDT.

National BPG on Consult Management:

CONSULT SUBMISSION STANDARDS AND REQUIREMENTS:

▪ Consults submitted to PSAS must contain a detailed description of the device or service required and an appropriate clinical justification for the request (at a minimum) to facilitate the issuance or procurement of the device/service. A consult would be considered to have a detailed description if it contains sufficient information (e.g. vendor, size, specs etc.) for the consult to be actionable by a PSAS Staff member.

FORWARDING CONSULTS:

It is acceptable to forward a consult to another service **only when an evaluation which cannot be performed by a PSAS staff member is required.** For example, a consult for an electric wheelchair should be forwarded to the appropriate department for evaluation and a new consult will be submitted to PSAS upon completion of the evaluation. **The rationale is that the initial consult is not actionable by PSAS** until the evaluation has been completed and as such it is more appropriate for the consult to be forwarded to the evaluating service rather than leaving the consult as a pending request

This requires Prosthetics staff to work out of scope and manage concerns for clinical staff when they should be managing and coordinating the concern directly.

Conclusions for Allegation 3

- We **substantiate** patient care was delayed in the delivery of DME. In 7 of 10 examples provided to us, documentation was adequate to fulfill the request, yet the consults were cancelled.

  They did not meet VA requirements and as stated early clinicians feel it is unreasonable for them to prescribe specific items.

- As noted previously, the Chief of PSAS failed to note the role of an interdisciplinary team, to include specialty care and PSAS staff, in the evaluation, education, and training of patients on DME in questioning the request for a new hospital bed for a veteran with a pontine stroke, causing a delay in providing necessary medical equipment.

  VACO PMRS/PSAS site visit Findings:

  - Prosthetic Funds are being used to pay for clinical services **when they should not** (example provided included Numotion)

  - There are significant concerns regarding the division of responsibilities between Prosthetics and PMRS teams relating to wheelchair management. Clear delineation of responsibilities is lacking, leading to inefficiencies. While it would be ideal if these responsibilities were clearly defined, **certain wheelchair issues require an administrative POC while others require clinical input.** The teams must collaborate to determine how these responsibilities will be shared as the current situation is not sustainable. **(PSAS concerns are medical denials, appeals, handling of Veteran complaints when involving not liking a prescribed device, and paying for assessment that should be done by VA employees)**

  - Specialty Bed Flow Chart requires updating as it a) does not indicate if it is to be used for Basic and/or specialty beds **b) leaves decision making capacity to Prosthetics c) process should enforce clear medical justification** to enhance clarity and efficiency.

  - Clinical denial occurs when a clinician determines that a requested service is inappropriate based on their evaluation, while and Administrative denial happens when a clinician finds the request medically appropriate but it cannot be fulfilled due to regulatory constraints or ineligibility. **Clinical team is responsible for handling clinical denials while Prosthetics is responsible for handling administrative denials.**

- The Chief of PSAS failed to follow procedures defined in SOP 117-21-02 in the same case.

  Correct because it requires Prosthetics staff to perform duties assigned to clinical staff in national policies, and because SOP 117-21-02 was replaced by MCP 674-121-005 on January 27, 2023. Prosthetics Reps cannot provide clinical denials and rights to the Veteran.

  
  MCP 121-005 Major Medical Equipment

  This document was provided to OMI and it appears it was not considered. I feel this is an example of political expedience because clinicians disagree with their nationally assigned duties to inform Veterans of medical decisions and appeals rights.

• The Chief of PSAS is outside their scope by offering medical treatment suggestions to VA health care providers and questioning the quality of the justification from a clinical perspective.

This is contradictory because earlier OMI recommendations for Prosthetics Reps to complete and chart DME prescriptions, educations, training. OMI also stated Prosthetics Reps need to medically document item specifics (make/model/etc.) on behalf of the prescriber, however this information is found through a medical assessment by the Subject Matter Expert(s) competent to the specific assessment(s). Pros Reps do not perform medical assessments, rather we perform the duties outlined in VHA policy, which is to attend clinics and provide advice on rules/regs and items/services on national contract. The Whistleblower can show numerous instances where Clinical Leaders ask how to assess for an item and the Clinical was provided with the VA national published SOPs:

38 CFR § 17.3240 Furnishing authorized items and services.

(a)

(1) **VA providers, or eligible entities and providers** as defined in § 17.4005, will prescribe items and services in accordance with § 17.3230(a) and will do so in consultation with the veteran.

(2) **Once the item or service is prescribed** under paragraph (a)(1) of this section, VA will either fill such prescriptions directly or will pay for such prescriptions to be furnished through a VA-authorized vendor.

(3) The determination under paragraph (a)(2) of this section of whether a prescription will be filled by VA directly or will be furnished by a VA-authorized vendor will be based on, but not limited to, such factors as the **veteran's clinical needs**, VA capacity and availability, geographic availability, and cost.

VHA Directive 1173 Prosthetics and Sensory Aids Service:

The VA medical facility PSAS Chief is responsible for:

(2) Educating Veterans and clinicians on all PSAS programs and the administrative requirements for each.

(3) Collaborating with clinical staff to resolve PSAS administrative consult issues and ensure the streamlined provision of PSAS devices and benefits.

(4) Providing clinical staff information about devices that VA medical facility PSAS is authorized to purchase and PSAS programs available to Veterans.

VACO Business Practice Guidelines on the Provisions of Prosthetics and Sensory Aids Service:

Procedures for Consult Management

If a consult is received that lacks the necessary justification to demonstrate that it meets the regulatory requirements, PSAS staff should proceed as outlined in the Consult Management BPG. Please refer to: Consult Management BPG for further information.

- VHA Directive 1173.06 provides guidance for the WMC Team lead or prescribing VA health care provider to assess for misuse of WMD by the Veteran, placing them in a potentially adversarial position of enforcement versus a therapeutic relationship.

  This is political expedience because the Clinicians do not agree with their nationally assigned duties in VHA Directive 1173.06 Wheeled Mobility Clinic to be the point of contact and to re-eval if misuse is suspected. According to VHA Directive 1173.06, The WMC Team Lead or Prescribing VA Health Care Provider is responsible for:

  (2) Performing and documenting in the Veteran's EHR, a comprehensive functional evaluation of the Veteran to determine the needed WMD and any related equipment needs.

  (3) Documenting the Veteran's goals, clinical rehabilitation goals, and metrics and outcome measures. NOTE: It is recommended that an outcome measurement tool be used initially and at an appropriate follow-up interval (e.g., Functional Mobility Assessment).

  (5) Assessing transportation needs, including any need and ability of the Veteran and their care provider to safely transport the Veteran and WMD (e.g., vehicle modifications, vehicle lift, public transportation), and prescribing equipment or referring the Veteran for further evaluation.

  (6) Assessing the environment where the WMD will be used to ensure it will meet the needs of the Veteran (e.g., residence ingress or egress through ramp or vertical platform lift access, threshold and door width clearance, access to electrical power outlets for charging power mobility devices and sheltered storage from the weather).

  (7) Determining the need for manufacturer's representative or vendor assistance at a specific WMC.

  (8) Communicating with the Veteran, caregiver or assistant in order to share assessment findings, results, discuss mobility options, Veteran expectations, training, collaborate on mutually agreed goals and develop a treatment plan.

  (16) Serving as the point of contact for Veterans when their conditions or circumstances change in such a way that may impact their use of the WMD. This includes recommending routine follow ups to Veterans based on their needs, (e.g., phone, telehealth, in person visit) for reassessment of WMD, seating function, and safety.

  (18) Reevaluating Veteran circumstances if WMD misuse is suspected. NOTE: If the prescribing VA health care provider or WMC team agrees or independently suspects misuse, then the prescribing VA health care provider will reevaluate the Veteran's circumstances to determine whether that specific WMD continues to be the most appropriate device, or whether an alternative WMD may be more suitable.

  NOTE: Major Medical Equipment (MME) Committees at VA medical facilities may provide advice or guidance on complex cases but must not substitute for WMCs or assume these responsibilities in the place of WMC.

- Temple PSAS SharePoint site included an out-of-date link from CY 2009 that needs to be updated.

Recommendations to Temple

1. See Allegation 1, Recommendation 1.

2. During the rescheduled PSAS and PMR NPO review, include a review of the appropriateness of consults closed by PSAS FY 2023 to present and provide related training to ordering providers and PSAS.

   Completed with .007 variance, which appears to be a very good score and shows CTX Prosthetics is a Highly Reliable Organization (HRO) in the way its staff follows national prescription policies and duties to have two contact attempts with Veterans for their prescribed items/service according to VHA PSAS Business Practice Guidelines on Consult Management.

3. Enforce SOP 117-21-02 with a focus on MMSEC team responsibilities and add CITC representation to the MMSEC.

   CTX SOP 117-21-02 **MMSE SOP was replaced in 2023 as CTX MCP 674-121-005** and signed as policy by the facility director. A national change in appeals processes requires the clinical service, clinical chairman, and/or clinical subject matter expert to provide medical denials and appeals rights to Veterans, instead of Prosthetics Reps. The change was made because of a national change in responsibility in relation P.A.R.I.S. regs, the rescinding of 1173.8 requiring a MMSEC committee, and a change in medical appeals where informing Veterans of Medical Appeals rights and processes for Clinical Disputes lies on the SME or Clinician running the IDT.

   Prosthetics Reps may not make clinical decisions and do not handle Clinical Disputes: “A clinical dispute is a disagreement between a patient, or the patient’s surrogate, and the original decision maker or clinical team who made the medical determination with which the patient or surrogate disagrees.”

   VHA Directive 1041, Appeal of VHA Clinical Decisions requires Clinicians that are the Subject Matter Experts, Clinical Committee Chairs, IDT leads, etc. to medical chart and inform Veterans of Medical Denials, and medical appeals rights, which was historically a duty assigned to Prosthetics Reps., and this appears to be an example of Political Expedience because clinicians do not agree to this national change. PMRS MAS clerks are the admin support to send letter for PMRS clinicians, not Prosthetics Reps.:

   j. VA Subject Matter Expert or Medical Facility Multi-Disciplinary Team Chair. The designated VA SME or MDT Chair is responsible for timely and accurate completion of all tasks assigned the SME or MDT under paragraph 5, VA medical facility Clinical Appeals Process and paragraph 6, VISN Clinical Appeal Process.

   - VACO also rolled out National SOPs for Clinicians and Admin staff with clear responsibilities and duties. PMRS therapists were told that Primary Care Clinicians must make the medical decisions when the final medical decision is not assigned the Therapist performing the assessment according to the national HISA Clinical SOP. PSAS Staff cannot carry out duties assigned to medical staff. National SOPs are located here: SharePoint
   - HISA Benefit- An Overview for VA Providers.mp4 (sharepoint.com)
   - Occupational Therapy with Older Adults in the Home and Community-20230315_052613.mp4 (sharepoint.com)
   - National Training on HISA starts at 14 mins: Meeting in General -20230413_125732-Meeting Recording.mp4 (sharepoint.com)

Clinical Guidance:

Before prescribing any item or home modification, the ***therapist must*** perform an evaluation and needs assessment.

The following areas should be addressed and ***documented*** in the electronic health record (EHR):

· Education

o Educate the Veteran on the findings from the home assessment and provide information regarding home modification recommendations and the next step in the HISA process. If the Veteran agrees with the recommendations and would like to pursue the HISA benefit, the therapist will collaborate with the local prosthetic and sensory aids service to provide the Veteran with the application to obtain the benefit.

o If the Veteran disagrees with the recommendations and would like to appeal, the Veteran should follow their local clinical appeals rights and review Directive 1041 found here: VHA Publications (va.gov)

o If the Veteran declines to pursue the benefit, they may collaborate with their therapist at a future date if it is clinically relevant.

- Local SOP requires PSAS staff to ensure Veterans to ensure an IDT occurs (providing medical oversight for the process) rather than PMRS Physiatrist to create an IDT under VHA Directive 1170.03(1), Appendix B, IDT Procedures.

d. Regardless of the origin of the rehabilitation referral, once a consult to a rehabilitation program is initiated, the Veteran must be screened by the IDT for an appropriate rehabilitation treatment plan of care based on the Veteran's rehabilitation needs within the facility's procedures.

i. Interdisciplinary Team. Disciplines represented on the rehabilitation IDT may include, but are not limited to: physiatry, Geriatric and Extended Care (GEC) medical provider, primary care provider and VA patient aligned care team (PACT), rehabilitation nursing, occupational therapy (OT), physical therapy (PT), kinesiotherapy (KT), recreational therapy (RT), speech language pathology (SLP), psychology, audiology, optometry, ophthalmology, clinical pharmacy specialist, social work, and nutrition. Other disciplines may be consulted as determined by the Veteran's needs. The interdisciplinary team (IDT) is the hallmark of rehabilitation care. The IDT is responsible for:

(1) Collaborating with all the disciplines specialized in the evaluation and management of complex needs of Veterans who would benefit from comprehensive and intensive rehabilitation services.

(2) Developing an individualized rehabilitation treatment plan with goals and timeframes established, and clinical outcomes are monitored on a routine basis.

(3) Ensuring the Veteran and their family are integrated into the IDT.

APPENDIX B:

b. Each member of the IDT administers discipline-specific evaluations based on the individual medical and surgical diagnoses, impairments, and sequelae of the Veteran. Based on these evaluations, the IDT establishes the projected achievable goals and timelines for rehabilitation. **The physiatrist or physician with extensive rehabilitation experience provides oversight** to the interdisciplinary rehabilitation plan of care. The interdisciplinary plan is recorded in the electronic health record (EHR). Any changes to the plan, made by either the IDT or the Veteran, are communicated to the interdisciplinary team by updating the EHR. The physician designates a point of contact (POC) to communicate the IDT plan to the Veteran.

4. Ensure the Chief of PSAS is aware of and complies with their responsibilities under VHA Directive 1173, paragraph 2i through 2i(17), and that these responsibilities do not include offering medical treatment suggestions to VA health care providers or questioning the quality of the justification from a clinical perspective.

   Agreed

5. PSAS provide in-service training to providers on the new Temple PSAS SharePoint after removing out of date SharePoint website link.

   Completed

Conclusions for Additional Findings

• CTVHCS MCP 674-121-001 is not an actual policy that has been signed by the Medical Center Director.

This was a draft policy I showed OMI that I was trying to get approved through the facility concurrence system. I felt this policy combined all National Clinical Assessment SOPs under one local SOP so that clinicians did not have to do a lot of research. Instead, CTX removed MCP 674-121-005, according to OMI to follow the older policy that does not conform to national policies:

MCP 674-121-001 PROCEDURES FOR F

MCP 121-005 Major Medical Equipment

CEC Minutes.pdf

See email from 4/17/24 regarding a policy vote from Assistant Chief of Staff regarding the policy being reviewed by Clinical Executive Committee:

"Hi Everyone

Further to our discussion in CEC yesterday, I wanted to circle back to ensure we are tracking our goal to expeditiously deliberate on and have a vote on attached policy. **A vote was deferred yesterday because at least one and perhaps more stake holders needed additional time to review.** It seemed reasonable to provide that opportunity given our aim to resolve several lingering challenges and to engender buy-in and compliance once the policy is approved. My recollection is that we previously deferred a vote perhaps a couple of times and it seems time to

move this along. In the light of this, my decision is to place this on the agenda of the next CEC meeting and to have a vote at that time. **Please kindly review and work with [redacted] on proposed modifications you believe are necessary.**

Thank you for your kind attention to this matter. “

- PSAS is providing incorrect interpretations of policy which impacts clinical decisions on DME.

  Conjecture and political expedience because PSAS Chief and staff are providing the national clinical SOPs to the clinicians and they do not agree with the processes because they take too much time, or they are short staffed, therefore the duties are falling on Prosthetics staff, or Prosthetics funds are being used to pay for the medical services (as confirmed by the VACO PMRS/PSAS site visit results). Just like the Pharmacy and medication, PSAS staff must receive prescriptions with specifics, or they are not actionable orders.

Recommendations to Temple

1. Conduct a review of policies currently in use by PSAS to validate accuracy.

   Agreed

Recommendation to VHA

1. Provide guidance on interpretation of VHA Directive 1173.06 regarding responsibilities of the WMC Team lead or prescribing VA health care provider, particularly paragraph 18 and its associated note.

Agreed.