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VA Office of Inspector General
Office of Healthcare Inspections

Delay in Evaluation and Treatment of Pulmonary Metastasis from Malignant Melanoma
Danville, Illinois VAMC, Richard Rodebush Indianapolis VAMC, Iowa City VAMC
MCI # 2005-01370-HL-0856

Delay in Evaluation and Removal of a Splinter
Peoria, CBOC
MCI # 2005-03088-HL-0832

Background

The VA OIG hotline received a phone call and a letter from the wife of a veteran alleging that diagnostic and treatment delays encountered at 3 VA facilities have negatively impacted her husband's prognosis from metastatic malignant melanoma. In her letter and subsequent interview with Office of Healthcare inspectors, the patient's wife enumerated multiple allegations regarding the patients clinical care at the Iowa City VAMC and Indianapolis VAMC, and regarding administrative personnel at the Danville, Illinois VAMC. The patient's wife alleged that in the 12 week period from the time that he first complained of pain at a Peoria community based outpatient clinic (CBOC) primary care appointment; the VA had only been able to schedule an oncology appointment and do a biopsy but had not initiated treatment. In addition she alleged that had the VA moved quicker when only 2 new nodules were present in the left lung, then at the time of resection, more lung tissue could have been preserved. The complainant had requested approval from the Danville VAMC for private sector fee basis care of his melanoma. She alleged that the Danville VAMC's plan for his treatment in Indianapolis was impractical and insensitive to her husband's clinical needs. Furthermore, the complainant alleged delay in treatment and inefficient management of government resources in relation to removal of a splinter from the patient's hand. In her letter and our interview the patient's wife specifically alleged:

1. Diagnostic and treatment delays encountered at three VA facilities had a devastating effect on her husband's prognosis in battling metastatic malignant melanoma.
2. There were a series of lengthy delays for appointments and treatment decisions during which the patient's cancer "doubled in size every 2 weeks." At the start of the process one provider noted 2 tumors and by the time a private sector physician performed surgery on May 5 there were 14 tumors. The patient's wife alleged that if the VA system had moved quicker when there were fewer tumors present, then less of the patient's lung would have needed resection.

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3. The waiting time was almost 3 hours at the patient's first Iowa City oncology appointment on [redacted]
4. At a [redacted] visit, the Iowa City oncology fellow inappropriately prescribed 180 of the 15mg morphine sulfate tablets to serve as interim pain management until the patient's follow up appointment scheduled for March 10. The complainant alleged that the fellow should have scheduled an earlier follow up appointment instead.
5. At a [redacted] Iowa City follow up visit, the oncologist did not show for the appointment and the fellow had not scheduled a bone marrow biopsy as discussed at the [redacted] appointment. The patient's wife noted that the Iowa Hawkeyes were playing in an NCAA Big 10 tournament game which was locally televised. She speculated that the oncology attending physician and fellow chose to watch the game rather than show for the appointment. She also alleged that VA staff members were routinely sitting in the waiting areas watching the game and not attending to patients.
6. On [redacted] the patient's wife phoned the Indianapolis VAMC emergency room and asked about bringing the patient to the emergency room (ER) to be admitted. ER staff reportedly told her that because he already had an upcoming oncology appointment, if he came to the ER he would likely be sent home. She alleged that the oncology nurse who had offered her and the patient admission to the hospital had only "told her that in an effort to shut her up...and had lied to [her husband] about being able to be seen immediately if he went to the VA."
7. On [redacted] the patient had contacted the Danville patient advocate requesting travel assistance for an upcoming [redacted] oncology appointment in Indianapolis. The patient's wife alleged that the advocate did not try to find transportation, and the appointment had to be cancelled.
8. At a [redacted] oncology appointment at the Indianapolis VAMC, the oncology fellow recommended waiting 2 months and then rescanning the tumors. In contrast, the oncology attending then met with the patient, and recommended having the tumors removed if a surgical option was available. The patient was told that within a few weeks he would be mailed the date and time of a surgical appointment.
9. When the patient was discharged from a private hospital after the [redacted] left lung surgery, his private surgeon recommended home health care but fee basis in Danville did not feel it was necessary and would not pay for the service.
10. The Danville VA strategically and intentionally waits more than 120 days from the time of request to make decisions regarding fee basis approval. Patients will therefore seek care in the interim and the VA will then decline payment citing failure of the veteran to obtain pre-approval.
11. Although her husband's private oncologist had prescribed daily interleukon treatments, the VA had recommended only 1 treatment per week to be administered on an outpatient basis at the Indianapolis facility. The patient's wife alleged that asking the patient to make a 41/2 hour trip from his home to Indianapolis was inefficient, insensitive and un-empathic.
12. Early in 2005 the patient called the CBOC asking to have a splinter removed from his hand. The patient's wife alleged that the patient was told that due to a

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new Danville VAMC policy, the patient would first need to be referred for an evaluative surgical consult in Danville. After the evaluative consultation, another appointment would be made for the splinter removal procedure itself. The patient's wife alleged that because the area developed cellulitis, the patient instead went to a local, private hospital emergency room. The emergency room physician removed the splinter and prescribed an oral antibiotic.

Scope and Methodology

We reviewed patient medical records related to the patient's care at the Iowa City VAMC, Indianapolis VAMC, Danville VAMC, and Peoria, Illinois CBOC. With the patient's permission, we obtained and reviewed records of his treatment for melanoma in the private sector at St. Francis Hospital in Peoria. We reviewed VHA policy regarding fee basis determination. In addition, we reviewed the Danville VAMC and Peoria CBOC policies regarding guidelines and indications for referral to a surgical consultant for office based procedures such as a splinter removal. We also reviewed billing statements, letters and records sent to us by the patient and his wife.
Inspectors from the VAOIG, Office of Healthcare Inspections interviewed the patient and his wife on site at the Peoria CBOC on August 25, 2005. In addition, we made site visits at the Indianapolis VAMC and Danville VAMC on January 3-5, 2006. We interviewed the oncologist at the Iowa City VAMC by phone on March 1, 2006. We interviewed clinical staff involved in the patient's care at the Indianapolis VAMC. In addition, we interviewed senior managers, fee basis staff and the patient advocate at the Danville VAMC.

Case History

The patient is a 100% service connected, married Vietnam Veteran with a history of Agent Orange exposure. He was initially treated with chemotherapy for lymphoma presenting as right neck lymphadenopathy in 1977 and again in 1983 for recurrence. In 1993, the patient had a lesion removed from his left neck. The pathology returned malignant melanoma which was staged at Clark's level 3 with clear margins. The patient underwent a left radical neck dissection for removal of lymphatic drainage to the area at the Phoenix VAMC. The pathology was negative for residual melanoma. All 29 lymph nodes were noted to be negative for malignancy.

In 1995, the patient was found to have a soft tissue nodule in the left upper lobe of his lung which was evaluated by transbronchial biopsy and bronchial brushing and found to be negative for malignancy. Computerized tomography (CT) scans of the chest were reportedly stable in 1995 and 2001.

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On [redacted] the patient presented to his primary care physician at the Peoria CBOC for a follow up visit for hypertension, reflux esophagitis and chronic neck pain. He told the nurse that he had skin lesions on his right neck and cheek that he wanted to have checked. The patient reported to his primary care physician that he might have a new lump in his neck. His primary care physician ordered a chest radiograph (CXR) and

referred the patient to Oncology at the Iowa City VAMC. The primary care physician documented that a CXR three months earlier showed "the same left mid-lung nodule seen in 2000 and confirmed as a granuloma by CT scan at the time."

The patient was seen by Oncology at the Iowa City VAMC on [redacted] He reported a 2 week history of left flank pain, and concerns regarding a mass in the left neck at the area of previous melanoma resection. The mass had been present for four years but recently had increased in size and had become more painful. Lab work revealed thrombocytopenia. The oncologist was concerned with possible small lymphocytic leukemia/chronic lymphocytic leukemia versus a treatment related myelodysplastic syndrome. Recurrent melanoma or a new primary were noted to be possibilities but were believed to be less likely. Arrangements were made for the patient to return on [redacted] for a CXR, CT scan of the chest, abdomen and pelvis, repeat complete blood count (CBC), Chemistry 7 panel (Chem 7) and LDH level. A hematology clinic nurse noted that the patient would be seen in hematology-oncology (heme-onc) clinic after completion of the CT scans. The oncologist also planned to perform a bone marrow biopsy. A CT scan of the head and neck was schedule for [redacted] The oncologist subsequently reviewed a peripheral blood smear, ordered flow cytometry of the peripheral blood and indicated that the patient might not need a bone marrow biopsy. The flow cytometry was polyclonal.

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On [redacted] CT scan of the chest demonstrated a stable 2cm soft tissue nodule in the left upper lobe and 2 new nodules present in the left upper and left lower lobe. The patient reportedly would not stay for his clinic appointment to discuss test results but called the heme-onc clinic physician assistant after leaving to obtain results. The oncologist planned to locate prior CT scans to compare with the current CT scan noting "I would be particularly concerned with the new appearing lung nodule, if really true, since it could be a melanoma met [sic metastasis] (which could be resected) or a new lung cancer. I would not expect a low-grade NHL to present this way, but it is not impossible." The oncologist made a referral for a pulmonary consult, planned to obtain a PET scan for staging if the nodules were confirmed to be new, and planned consideration of a fine needle aspiration if indicated after evaluation of the upcoming neck CT that had previously been scheduled for [redacted]

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On [redacted] he patient notified the CBOC in Peoria that he wished to have his records and oncology care transferred from Iowa City to the Indianapolis VAMC. The patient representative from the Danville VAMC subsequently scheduled an appointment for a neck CT scan and pulmonary clinic evaluation in Indianapolis. On [redacted] the Iowa City oncologist sent the patient a letter which reviewed the significance of his [the patient's] recent blood work and imaging studies and recommended that the patient pursue a pulmonary clinic evaluation for a possible bronchoscopy and a CT scan of the neck at the Indianapolis VAMC.

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The patient was seen by the pulmonary consultant at the Indianapolis VAMC on [redacted] He reported left mild chest discomfort and a history of recent low grade fevers. A CT scan of the neck was remarkable for a 10x15mm soft tissue nodule in the

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subcutaneous tissues of the left neck at approximately the level of the C3 vertebral body. Fine needle aspiration of the neck lump was nondiagnostic. The pulmonary consultant scheduled a CT guided biopsy of the pulmonary nodules for the next day, planned to discuss the case at multidisciplinary chest conference that week, and noted that metastases was at the top of the differential diagnosis, however, granulomatous disease was also a consideration.

A CT of the chest with contrast showed "multiple noncalcified lung nodules worrisome for melanoma metastases. The largest nodule measures 2.5 cm and is markedly enlarged from the exam in 2001. Many of the smaller nodules are new from the previous exam. The patient is scheduled for biopsy on [redacted] Small hypodense lesion of the left liver which is too small to fully characterize." (b)(3);38 U.S.C. 5701.(b)(6)

A CT guided lung fine needle aspiration was performed the next day which was complicated by a small pneumothorax which resolved shortly after Heimlich valve/chest tube placement. The case was presented at Chest conference on [redacted] and the plan was to re-present at a subsequent chest conference when the final pathology would be available. The case was reviewed by a thoracic surgeon who noted that fine needle aspiration of one of the lung nodules showed malignancy, pathology was pending, and the treatment would depend on the type of malignant tissue present. The patient was discharged from the Indianapolis VAMC on [redacted] (b)(3);38 U.S.C. 5701.(b)(6)

The pulmonologist subsequently called the patient on [redacted] and discussed the pathology results which were consistent with metastatic melanoma. A referral was made to medical oncology at the Indianapolis VAMC and appointment was scheduled for [redacted] (b)(3);38 U.S.C. 5701.(b)(6)

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On [redacted], the patient's wife call the Veteran's Affairs Office in Washington D.C. regarding concerns she had regarding the patient's care in Iowa City and Indianapolis. The following day, the patient's wife called Oncology and Hematology Associates of Central Illinois in Peoria and scheduled an appointment to see a private oncologist on [redacted] In addition, she initiated a request with his primary care provider ant the Danville VAMC for fee basis care at a private hospital in Peoria, and spoke with Nate Hurn, a liaison in Congressman La Hood's office. (b)(3);38 U.S.C. 5701.(b)(6)

The patient's wife also called the heme-onc clinic at the Indianapolis VAMC. She was noted to sound angry and anxious and was upset over the fact that his appointment there had been scheduled for [redacted] She expressed concern that this seemed to her a significant delay in getting him to the oncology clinic. A clinic nurse explained that she had conferred with the in-house oncology fellow who felt that the [redacted] appointment was appropriate based on the patient's cancer. The clinic nurse suggested that the oncology service could admit the patient to the inpatient service so that he could be sooner, but the patient's wife declined this option. The clinic nurse rescheduled the patient's clinic appointment for [redacted] The patient's wife asked the clinic nurse to send her his medical records overnight and to fax his records to the private oncologist in Peoria. The nurse gave the medical records office the release of information that the (b)(3);38 U.S.C. 5701.(b)(6)

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patient had provided and arranged for his records to be faxed from the Indianapolis VAMC and the Iowa City VAMC. The clinic nurse asked the patient's wife to bring any notes or treatment plans from the private oncologist to his [redacted] appointment in [redacted] Indianapolis. (b)(3):38 U.S.C. 5701.(b)(6)

(b)(3):38 U.S.C. 5701.(b)(6) On [redacted] the case was re-presented at chest conference. It was suggested that the patient needed a full body exam to rule out a possible new skin primary lesion, complete work up for metastatic disease to include a PET scan, MRI of the brain, and evaluation by medical oncology. The thoracic surgeon indicated that after search for other metastatic sites with PET and CT scans, if only two lung metastases were found, than metastases resection would be suggested. He noted "the result of this treatment of melanoma is not proven to be beneficial to patients over all, but this man is only 53 years old and in otherwise good health. The nodules are both in the left lung. If other sites are found of metastasis, non-surgical treatment will be suggested."

(b)(3):38 U.S.C. 5701.(b)(6) On [redacted] the patient was seen by a private oncologist at OSF St. Francis Medical Center in Peoria, Illinois. The oncologists clinical impression was recurrent metastatic melanoma involving lungs and also liver. He recommended completing a staging work-up with PET scan along with MRI of the head. He planned to evaluate the patient for eligibility for a phase II trial of oxaliplatin based research regimen at the University of Chicago. He discussed different kinds of regimens, outcome expectations and the incurable nature of the disease. The patient wanted to start treatment as soon as possible.

(b)(3):38 U.S.C. 5701.(b)(6) The patient called the Indianapolis VAMC on [redacted] to cancel his appointment for that day. He reported that his Father-in-Law had suffered a stroke and he [the patient] did not have transportation because his wife was at the hospital. The heme-onc nurse asked if the patient advocate had suggested the Danville shuttle. The patient reported that she had but that he wanted a taxi to pick him up and bring him to the VAMC. The heme-onc nurse explained that the clinic was only on Mondays and the next clinic date would not be until [redacted] She offered to direct admit the patient to the inpatient service later during the week of [redacted] but the patient declined this option. The nurse asked the patient about his appointment with the private oncologist. The patient stated that he was told that he could get some type of "chemo," that he planned to see the private oncologist again, and that the Danville VA would have to pay for it. The heme-onc nurse called the patient later that day and relayed to his wife the VAMC oncologists recommendation that the patient have an MRI of the brain and a PET scan done that week. The wife stated that the outside oncologist had ordered both and the patient would be getting both tests that week. The heme-onc nurse explained to the wife that the VAMC would like to have the results of the tests because the VAMC consulting surgeon had not ruled out surgery as an option. The patient's wife was noted to remain frustrated over her husband's care and the heme-onc nurse again offered the option of directly admitting the patient to the VAMC inpatient service.

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The patient's wife called the heme-onc nurse on [redacted] and expressed frustration over the information presented during their phone call the previous day. The heme-onc nurse indicated that the patient's wife was angry and stated that she felt that the heme-onc nurse (b)(3):38 U.S.C. 5701.(b)(6)

had given her and her husband false hope by informing her of the surgeon's opinion that surgery might be an option depending on the results of the MRI and PET scans. The patient's wife stated that the outside oncologist had determined that the patient was not a surgical candidate. She reportedly stated that the "VA had obviously not read the CT scan report from [redacted]" The heme-onc nurse attempted to explain that her intent was to try to help the patient and that the oncology department wanted to ensure that all potential and definite options were explored for the patient. The patient's wife repeated her concerns regarding false hope and reportedly stated "the VA didn't know what they were doing."

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The acting director of the Danville VAMC received an inquiry from Congressman LaHood on [redacted] pertaining to the patient's request for fee basis in order to receive oncology treatments from a non-VA provider. In addition, a letter of inquiry was sent by the Congressman to the Veterans Affairs Office of Congressional and Legislative Affairs.

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An MRI of the brain completed on [redacted] at St. Francis Medical Center was read as no evidence for metastatic disease. The whole body PET scan completed on [redacted] showed "two lung masses in the left lower lobe suspicious for recurrence of melanoma. Otherwise normal study." The private oncologist referred him to a thoracic surgeon at St. Francis Medical Center who evaluated the patient on [redacted]. The surgeon noted that the PET scan demonstrated 2 isolated lesions, however patient with multiple lung lesions on CT scan of chest done in Indianapolis. The surgeon planned a left anerolateral thoracotomy, biopsy and resection with consideration of the right sided lesions pending results of the left sided surgery.

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On [redacted], the Indianapolis VAMC hem-onc nurse called the Danville patient advocate on behalf of the patient to request fee basis to reimburse the family for the PET scan and MRI that had been completed at the private facility. She asked the advocate to assist the patient, if he needed help in obtaining copies of the outside scans for examination at his upcoming [redacted] appointment in Indianapolis.

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At the [redacted] oncology appointment in Indianapolis the Oncology fellow discussed the diagnosis, prognosis and therapy options with the patient. The fellow indicated that the patient could be referred for interleukin-2 therapy which has some potential for cure but only 5-10% for long term remissions; could be referred for ongoing research trials at the university; or he could be treated with DTIC palliative chemotherapy with a 10-15% chance of response but no cure. The fellow noted that it was his belief that he should refer the patient to thoracic surgery because the PET scan was negative other than the 2 lung spots and the brain MRI was negative as well. He explained that the chances of benefit in terms of long term cure was not a guarantee with surgical metastatectomy as the patient could have other metastesis. The fellow ordered a thoracic surgery referral for metastectomy, documented that the patient needed to be seen within 1-2 weeks and asked to be paged if this could not be arranged. The attending oncologist concurred. On exam he palpated a 1cm node and recommended a CT of the neck and excision of the node even though prior fine needle aspiration had been negative.

(b)(3):38 U.S.C. 5701.(b)(6) On [redacted], the patient underwent surgery at St. Francis Medical Center in Peoria with multiple left lung wedge resections, lingular segmentectomy, superior segmentectomy of the left lower lobe and thoracic lymphadenectomy. Final pathology revealed metastatic melanoma 2.2 cm in greatest dimension in the left superior segmentectomy, left lower lobe wedge resection with malignant melanoma 2 cm in greatest dimension diameter and a smaller piece with melanoma 0.2 cm in diameter. All left five, nine, ten and eleven nodes were negative.

(b)(3):38 U.S.C. 5701.(b)(6) The patient underwent resection of multiple right lung nodules with wedge resection on [redacted] at St. Francis Hospital. No metastatic melanoma was revealed on final pathology.

(b)(3):38 U.S.C. 5701.(b)(6) On [redacted] Congressman LaHood received a letter from the Danville VAMC in support of VA Illiana's decision not to authorize payment for care provided to the patient by non-VA providers. On [redacted] the patient's wife faxed a letter to President Bush intimating that the VA was unable to provide her husband care in a timely manner and requesting fee basis program coverage for his surgeries and chemotherapy. In addition, she requested a review of the Danville VAMC patient advocate and fee basis staff. Later that day the patient received a call from someone in the VA Office of Medical Inspector with whom he discussed his concerns.

The patient followed up with his private oncologist on [redacted] and on [redacted] began adjuvant interferon alpha-2b therapy Monday to Friday for 4 weeks followed by maintenance subcutaneous interferon alpha-2b treatment on a 3 times per weeks schedule for 11 months to complete a full year of adjuvant therapy. The oncologist noted that he told the patient that there was not any data that clearly delineated the statistical benefit of adjuvant therapy in the current setting. The oncologist stated that the patient had already had "about a 12 year disease free interval which is already rather remarkable for someone who had presented with fairly high-risk disease back in 1993. (b)(3):38 U.S.C. 5701.(b)(6)

(b)(3):38 U.S.C. 5701.(b)(6) On [redacted] the patient's wife wrote President Bush a second letter in which she stated her frustration. On [redacted] the patient met with the Chief of Staff for VA Illiana Health Care System and staff from Congressman LaHood's office at which time the Chief of Staff approved the previously denied claims for fee basis service. On the same day, the patient's wife had phoned the OIG hotline and subsequently faxed a letter detailing her allegations regarding the quality of her husband's care. From [redacted] the patient participated in the blind rehabilitation therapy program at the Hines VAMC. (b)(3):38 U.S.C. 5701.(b)(6)

Findings

Allegation 1: Diagnostic and treatment delays encountered at three VA facilities had a devastating effect on the patient's prognosis in battling metastatic malignant melanoma.

The patient presented with Stage IV malignant melanoma which in the literature is almost always fatal. Treatment for those who present with or go on to develop systemic disease usually fails. Positive response to chemotherapy occurs in a small percentage of patient's

and tends to last less than 6 months. The oncologist in Indianapolis reported that after completing the diagnostic workup one reasonable approach to stage IV malignant melanoma treatment is expectant observation. He explained that if a patient turns out to have high grade disease, then over the ensuing 1-2 months a patient will have further distal involvement and initial surgical intervention would have been fruitless and ill advised. If on the other hand, the patient turns out to have low grade disease then in a 1-2 months, lack of significant further involvement would indicate the potential utility of surgical intervention. The oncologist reported that expectant observation for 1-2 months would not likely impact prognosis and response to chemotherapeutic treatment for this disease.

In addition, the complainant alleged delay in diagnosis and treatment. The patient presented to his primary care physician on [redacted] and had a first oncology appointment in Iowa City on [redacted] with further diagnostic workup on [redacted] and follow up oncology appointment on March 10 and a neck CT scheduled for [redacted] the patient notified the CBOC that he wished to have his care transferred to Indianapolis which necessitated scheduling initial evaluations in Indianapolis. In addition, the patient and his wife called the oncology clinic in Indianapolis on [redacted] and in separate conversations declined offers for direct admission later that week in order to complete the workup as an inpatient rather than to wait another week 2 weeks for the oncology appointment scheduled for [redacted]

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Conclusion: We cannot substantiate the allegation that delays in diagnosis or treatment had a devastating effect on the patient's prognosis with stage IV malignant melanoma. Furthermore, we cannot substantiate the implication that there were clinically significant delays by the VAMC in offering diagnostic workup and treatment.

Allegation 2: There were a series of delays for appointments and treatment decisions during which time the patient's disease increased from 2 tumors to 14 tumors. If the VA system had moved quicker, then less of the patient's lung would have needed resection.

An Iowa City VAMC CT scan on [redacted] demonstrated a stable 2cm soft tissue nodule in the left upper lobe and 2 new nodules present in the left upper and left lower lobe. A repeat CT scan performed at the Indianapolis VAMC on [redacted] showed multiple noncalcified lung nodules worrisome for melanoma metastases with many of the smaller nodules new from the previous exam.

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On [redacted] the patient's case was re-presented at chest conference and medical oncology consultation, PET scan, full body skin exam and MRI of the brain were recommended to complete a workup for metastatic disease. The patient was seen by a private oncologist in Peoria on [redacted] who recommended completing a staging workup with PET scan and MRI of the head. The private oncologist discussed with the patient a plan to initiate chemotherapy.

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An Indianapolis VAMC oncology clinic nurse called the patient's wife on [redacted] to relay the recommendations regarding obtaining a PET scan and MRI of the brain. The

nurse explained that the VAMC consulting surgeon had not yet ruled out surgery as an option depending on the radiologic results. The patient's wife reportedly became angry at the nurse and accused her of providing false hope that surgery might be an option and she told the nurse that an outside oncologist had determined that the patient was not a surgical candidate.

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The [redacted] MRI of the head did not show evidence of metastatic disease and the PET performed the same day at the private hospital in Peoria showed two left lung masses suspicious for malignant melanoma but otherwise a normal study. The private oncologist then referred the patient to a private thoracic surgeon who planned a left thoracotomy with consideration of the right sided lesions pending results of the left sided surgery. At

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the [redacted] Indianapolis VAMC oncology appointment, the fellow reviewed treatment options and noted his belief that he should refer the patient to thoracic surgery because of the PET scan was negative other than the 2 left sided lesions. The fellow ordered a thoracic surgery consult.

The patient underwent left sided surgery in the private sector on [redacted] at which time the surgeon took multiple wedge resections. Final pathology revealed malignant melanoma in 3 of the resected segments with negative nodal involvement. On [redacted] the patient underwent resection of multiple right lung nodules with wedge resection. No melanoma was revealed on final pathology of the right sided resections.

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Conclusion: The work up at the Indianapolis VAMC and in the private sector appeared to parallel each other. There were more nodules present on the CT scan at the Indianapolis VAMC then had been present on the Chest CT scan on [redacted] in Iowa City. However, the PET scan seemed to indicate malignant melanoma only in 2 left sided nodules and not on the right side. The number, location and width of the left lung resections are a function of the body of radiologic evidence, intraoperative appearance and clinical judgement of the operative surgeon rather than of the number of nodules seen on CT scan. In addition, the private surgeon made a clinical judgment call to perform right sided resections. In the absence of right sided lesions on the PET scan, whether or not a VAMC surgeon would have pursued right sided resection is speculative. We could not therefore substantiate the allegation that "had the VA moved quicker less of the patient's lung would have needed resection." In fact, it is possible that the right sided resection may not have been pursued.

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Allegation 3: The waiting time was almost 3 hours at the patient's first Iowa City oncology appointment on [redacted]

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The oncologist from Iowa City reported that patients are often are scheduled to undergo other procedures such as blood work, CT scans, bone marrow biopsy or chemotherapy on the same day of their appointments. When and in what order patients are seen by the physician for evaluation and discussion of the treatment plan is somewhat dependent on the time of completion of tests and procedures and the availability of the results. In addition, the oncologist reported that often patients who become acutely ill are fit in and

seen which disrupts the previously arranged clinic schedule. As a result, the scheduling times may be subject to flux and may deviate from the schedule as planned.

Conclusion: We could not substantiate or refute whether the waiting time for this appointment was unduly lengthy. It would not be unusual in an oncology clinic for the time elapsed before the patient is seen by a physician to depend on variables other than appointment time such as; availability of the patient's test results from tests done that day, overbooking of acutely ill patients into the clinic schedule, and the duration of physician interactions with other patients (for example discussing a newly diagnosed malignancy).

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Allegation 4: At the [redacted] visit the Iowa City oncology fellow inappropriately prescribed 180 of the 15mg morphine tablets to serve as interim pain management until the follow up appointment on [redacted] instead of scheduling an earlier appointment.

The plan was for the oncologist to review a peripheral blood smear, for the patient to have repeat blood work and CT scans and for the oncologist to obtain further documentation from his treatment for leukemia or lymphoma years earlier at the VAMC in Arizona. The records from the previous treatment were not available on the EMR and at the time of the first oncology appointment at Iowa City the oncologist was initially concerned about possible lymphocytic leukemia versus a treatment related myelodysplastic syndrome. In the context of tests to be performed and records to be obtained and reviewed, a 3 week interim between appointments does not appear unreasonable. The oncology fellow had completed her fellowship prior to initiation of the hotline and was no longer at the University of Iowa or the VAMC. She was not interviewed by OHI staff. The patient reported a 2 week history of bothersome flank pain. In addition, he had a longstanding history of chronic neck pain for which he had previously received pain medication. The oncology fellow's rationale for prescribing the morphine sulfate in a quantity of 180 tablets is unknown to us. The prescription was for the intermediate release preparation every four hours as needed for pain. However, we do know that in the VA system prescriptions for narcotics have to be renewed every 30 days. If the patient were to require one tablet every 4 hours, a 30 day supply (which is a typical prescription period) would total a quantity of 180 tablets.

Conclusion: The 3 week interval between initial and follow up oncology appointments at the Iowa City VAMC does not appear unreasonable. We were unable to determine with certainty the oncology fellow's rationale in choosing a quantity of 180 morphine sulfate tablets for this prescription. However, the number prescribed would equal a 30 day supply which is not an unusual prescription quantity.

(b)(3):38 U.S.C. 5701,(b)(6)

Allegation 5: At a [redacted] Iowa City follow up visit, the oncologist did not show for the appointment and the fellow had not scheduled a bone marrow biopsy as discussed at the previous appointment. The patient waited 3 hours to see the physician. The attending physician and fellow allegedly chose to watch a National Collegiate Athletic Association (NCAA) tournament game on television rather than show up for the appointment. VA staff were in the waiting areas watching the game on television.

The oncologist in Iowa City reported that he was in clinic that day but did not see the patient because the patient left before he could be seen. The oncologist stated that he was "Indian and not a fan of the game," does not follow basketball, and was not watching the basketball game. He described the allegation as "ridiculous."

The physician's assistant (PA) was on maternity leave and unavailable for comment. The fellow had completed her fellowship and since left Iowa City. The chart notes indicate that x-rays were completed at 11:06 am, blood work at 11:30 am and CT of abdomen and pelvis at 12:11pm. The PA had been scheduled for 2:30 pm. The physician's assistant wrote a note at 4:41 pm stating that patient would not stay for the appointment. The PA documented that she discussed the results of the CT scan with the patient and told the patient that she would put in a request for a consultation at pulmonary clinic. The oncologist reported that he had to wait for results of blood work, x-rays and CT scan before seeing the patient. He acknowledged that the wait in clinic can be lengthy at times but stated that this is not unexpected because it is not unusual for very ill patients to require urgent evaluation which inevitably disrupts the clinic schedule. The bone marrow biopsy was not performed the day of the appointment because after reviewing a peripheral smear after the prior appointment, the oncologist felt that depending on the results of a repeat complete blood count test obtained in a blue specimen collection tube, a bone marrow biopsy would no longer be indicated. In a note dated [redacted] (b)(3):38 U.S.C. 5701,(b)(6) he documented "review of his PB [sic peripheral blood smear] shows several platelet clumps. Significant amount of cells are small to intermediate size lymphs. Repeat CBC [sic complete blood count] next time in blue tip. He may not need a BM [sic bone marrow] biopsy. Will plan to obtain flow cytometry of peripheral blood."

We were unable to substantiate or refute whether VA staff members were sitting in waiting areas watching the NCAA basketball game on television.

Conclusion: We did not substantiate the allegation that the oncologist and fellow did not show to the patient's appointment or to clinic and chose instead to watch the NCAA basketball game. At the time that he left the VAMC, the patient had been waiting 2 hours to see the physician. The bone marrow biopsy was not performed because the oncologist had determined subsequent to the [redacted] appointment that it was no longer clinically indicated. We were unable to substantiate whether staff were watching the basketball game in waiting areas.

(b)(3):38 U.S.C. 5701,(b)(6)

Allegation 6: The oncology nurse at the Indianapolis VAMC who had offered the patient and his wife admission to the hospital had "only told her that in an effort to shut her up...and had lied to her husband about being able to be seen immediately if he went to the VAMC.

The oncology nurse documented in both conversations with the patient and his wife offers to direct admit the patient to the oncology service at the Indianapolis VAMC in order to expedite and complete workup as an inpatient. The patient and his wife declined this offer. The patient's wife later called the emergency room directly without speaking

again to the oncology nurse. When the patient's wife asked ER staff unfamiliar with the patient what would happen if they showed up at the ER, she was reportedly told that he would be sent home. On interview with us, the oncology nurse explained that had the patient's wife called oncology clinic, the nurse would have arranged a direct admission. The patient would have been sent to the emergency room as the point of entry into the hospital, but the oncologists would already have committed to admit the patient and the oncology nurse would have arranged an available bed on the oncology inpatient service.

Conclusion: We did not substantiate the allegation that the oncology nurse had offered admission to the hospital to "shut the patient's wife up" and had not "lied" to the patient and his wife about the option of direct admission to oncology to complete his workup.

(b)(3):38 U.S.C. 5701.(b)(6)

Allegation 7: On [redacted] the patient contacted the Danville patient advocate requesting travel assistance for an upcoming appointment on [redacted] in Indianapolis, the advocate did not try to find transportation and the appointment had to be cancelled. (b)(3):38 U.S.C. 5701.(b)(6)

The Danville patient advocate reported that the patient and his wife wanted to be transported to the appointment in Indianapolis by ambulance. This request was denied, as a shuttle was available for transport and the patient's condition was not felt to warrant an ambulance. In addition, the patient's wife wanted to ride along which would not have been permitted in an ambulance. When the patient called the Indianapolis oncology clinic, the oncology nurse asked if the patient advocate had suggested the Danville shuttle. The patient reportedly acknowledged that she had but stated that he wanted a taxi to pick him up. Of note, the patient had seen a private oncologist in Peoria on [redacted] (b)(3):38 U.S.C. 5701.(b)(6)

(b)(3):38 U.S.C. 5701.(b)(6)
(b)(3):38 U.S.C. 5701.(b)(6)

and an MRI had been scheduled for [redacted] in Peoria. The Chief of Staff in Indianapolis reported that prior to the [redacted] appointment the patient had requested fee basis care and when the patient advocate tried subsequently to contact the patient and his wife, several phone calls went unreturned.

Conclusion: We did not substantiate the allegation that the patient advocate would not help find transportation for the patient to his [redacted] oncology appointment in Indianapolis. In addition, it appears that the patient's oncologist at the private hospital in Peoria had also scheduled an appointment for the patient to have an MRI in Peoria on April 25, which the patient had done on [redacted] and a PET scan on [redacted] (b)(3):38 U.S.C. 5701.(b)(6)

(b)(3):38 U.S.C. 5701.(b)(6)

(b)(3):38 U.S.C. 5701.(b)(6)

Allegation 8: At a [redacted] oncology appointment in Indianapolis the patient's wife alleged that the fellow recommended waiting 2 months and then rescanning the lungs while the attending oncologist recommended having the tumors removed if a surgical option was available. The patient's wife alleged that treatment recommendations were therefore contradictory and confusing. The patient was told that it would take a few weeks for a surgical appointment and he would be mailed the date and time.

The document chart notes indicate that the fellow reviewed the diagnosis, prognosis and potential therapy options with the patient. The fellow's note indicates that it was his belief that the patient should be referred to thoracic surgery because of the presence of only two spots on the PET scan and an unremarkable brain MRI. The attending

oncologists note concurs with the fellows note. In our conversation with the oncology attending, he did report that expectant waiting would also have been a reasonable option in this clinical scenario. In addition, the oncology fellow placed a request for a surgical consultation appointment, and documented that he should be paged if the appointment could not be arranged for within the next 1-2 weeks.

Conclusion: We did not find evidence that the oncology fellow and attending gave contradictory and confusing treatment recommendations to the patient and his family. We did not find evidence that the oncology fellow delayed arranging a surgical consultation.

Allegation 9: When the patient was discharged following his [redacted] surgery at the private hospital, his private surgeon recommended home health care but fee basis in Danville did not feel it was necessary and would not pay for the service. (b)(3):38 U.S.C. 5701;(b)(6)

The Chief of Staff reported that before they could approve fee basis care, the patient and his wife would need to go through the fee basis process and the request would need to be reviewed. The Chief of Staff stated that the request for fee basis is supposed to be prospective for non-emergent care as emergent care would automatically be approved. The Chief of Staff noted that the fee basis decision process was complicated by a pattern on behalf of the patient's wife to request fee basis either contemporaneously or retrospectively regarding care that had already been pursued elsewhere. As a result, some initial requests for services were denied due to lack of pre-authorization.

In a letter to Congressman LaHood from the Director of the VA Health Administration Center in Denver, the Director noted that the claims regarding the patient's care in May 2005 were appropriately reviewed under the authority for unauthorized emergent care (38 USC 1728) and it was VA's determination that the care was not related to an emergency and that care within a VA facility was available. The Director noted that at a subsequent meeting with the patient, his wife, the Congressman's office and the Danville Chief of Staff, a decision was made to approve the previously denied claims of service.

Conclusion: Services obtained at the private hospital in Peoria were initially declined due to lack of pre-authorization and failure to meet eligibility requirements. However, the Danville VAMC ultimately agreed to fee basis the patient's care received at the private hospital in Peoria.

Allegation 10: The Danville VAMC strategically and intentionally waits more than 120 days from the time of request to make fee basis decisions so that families will seek care elsewhere in the interim and the VA will then decline payment citing failure of the veteran to obtain pre-approval.

Conclusions: We did not find evidence to support the speculative nature of this allegation.

Allegation 11: Although her husband's private oncologist had prescribed daily interleukin treatments, the VA had recommended only 1 treatment per week and had insisted that the patient would have to travel 4 ½ hours from his home to Indianapolis to receive ongoing chemotherapy treatments. The patient's wife alleged that requiring him to make this trip was inefficient, insensitive and un-empathic on the part of the Danville VAMC Chief of Staff.

On interview with ourselves, the Danville Chief of Staff reported that at the [redacted] meeting with the patient, his wife and staff from the Congressman's office, the VA stipulated that the patient would have to obtain interferon from the VA pharmacy, but the VA would fee basis his chemotherapy treatments at the private facility in Peoria. The Chief of Staff denied asking the patient or his wife to drive 41/2 hours each way to Indianapolis for him to receive chemotherapy treatments. (b)(3):38 U.S.C. 5701.(b)(6)

Conclusion: We did not substantiate the allegation that the Danville VAMC Chief of Staff mandated that the patient would have to travel 4 ½ hours to Indianapolis in order to receive ongoing chemotherapy treatments.

Allegation 12: The patient's wife alleged that early in 2005 the patient called the CBOC asking to have a splinter removed from his hand. The patient's wife alleged that the patient was told that due to a new Danville policy he would first need to be referred for an evaluative surgical consult in Danville after which an appointment would be subsequently scheduled for the splinter removal itself.

The Chief of Staff at Danville VAMC reported that there is no policy from Danville that would require a surgical appointment to remove a splinter. In addition, she reported that if a clinician at a CBOC could not remove a splinter then the patient would be referred to an emergency room in the community at the expense of the VAMC. She stated that in this incident it was the patient who wanted a surgeon to remove the splinter. The CBOC clinicians had not refused to remove the splinter.

(b)(3):38 U.S.C. 5701.(b)(6)

The medical record for [redacted] shows a note from a nurse at the Peoria CBOC. The note indicates a 41 minute conversation with the patient. The patient had called that day requesting a surgery consult to have a splinter removed from his finger. "Patient does not want to go to Danville and Peoria consults are booking in April. Patient states he will go privately to have this taken care of."

Conclusion: We did not substantiate the allegation that a new Danville VAMC policy required referral for an evaluative surgical consult in Danville in order to have a splinter removed.