US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Veterans Health Administration's National Teleradiology Program

National Review | 25-01255-242 | December 4, 2025

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection in January 2025 of the Veterans Health Administration (VHA) National Teleradiology Program (NTP) in response to complaints regarding the review of a teleradiology provider (radiologist) who misread a patient's imaging study and NTP delays in reporting interpretation results of imaging studies at multiple VA facilities.[1] The OIG evaluated NTP's process for radiologist oversight, timeliness in returning interpretation results, and enterprise-wide management of performance monitoring and quality assurance.

VHA facilitates the "sharing of radiology resources across Department of Veterans Affairs (VA) medical facilities through teleradiology," which is "the use of electronic telecommunications technologies to provide radiology interpretations at a distance."[2] VHA's NTP, located at VA Palo Alto Health Care System (system) in Menlo Park, California, delivers radiology services to VA facilities with a negotiated memorandum of understanding (MOU). NTP radiologists interpret radiologic imaging studies submitted by radiology technologists from various VA facilities.[3] An NTP radiologist at a distant site is assigned, interprets the image(s), and electronically transmits the report(s) containing the interpretation to the originating VA facility.[4]

[1] "What is a Radiologist?," American College of Radiology, accessed July 24, 2025, https://www.acr.org/about/radiology-overview. Radiologists are physician providers who "specialize in diagnosing and treating injuries and diseases using medical imaging and procedures." In this report, the OIG uses the terms 'read' and 'interpretation' interchangeably; the term 'misread' is used for a patient-specific allegation as this was the term used by the complainant; Included in the time frame of an interpretation is receipt of the images and return of the report of findings; The OIG reviewed allegations related to three facilities.

[2] VHA Directive 1916, *VHA Teleradiology Programs*, June 10, 2021. "The terms "radiology" and "teleradiology" include radiology, nuclear medicine and other diagnostic imaging services." The directive says teleradiology health care professionals providing services for the VA medical facility at which they are credentialed from an approved alternate worksite are not considered teleradiology. In this report, the OIG uses the term 'facility' to include VA facilities and systems.

[3] The OIG uses the term 'imaging studies' to denote radiologic images; exams; and studies, which are packages of multiple images.

[4] VHA Directive 1084, *VHA National Teleradiology Program*, April 9, 2020. "An originating site is the VA medical facility where the patient is enrolled for care, which originates the teleradiology consult" to utilize NTP services for imaging studies interpretation. "A distant site is the site where an NTP teleradiologist provides telehealth to a patient receiving care at an originating site." NTP teleradiologists read the images remotely from home; one of the reading centers in Durham, NC; Menlo Park, CA; and Honolulu, HI; and reading sites within VA facilities in New York, NY; Dallas, TX; Sacramento, CA; Los Angeles, CA; and Portland, OR.

1. Radiologist Oversight

The OIG determined that the NTP has processes in place to ensure initial and ongoing radiology provider competency through credentialing and privileging, provider professional practice reviews, and peer reviews for quality management.[5]

The credentialing process assesses and confirms the qualifications of a radiologist to provide quality care, and the privileging process authorizes providers to independently practice based on clinical competence.[6] To monitor the quality of interpretations made by NTP radiologists, the radiologists are required to participate in professional practice evaluations.[7]

The system credentialing and privileging manager confirmed that all radiologists hired by the NTP complete the system's onboarding process, which includes verification of credentials and completion of the credentialing and privileging process, resulting in a final approval and appointment by the System Director. When an NTP radiologist is due to renew privileges, the radiologist's professional practice reviews are considered, as required.[8]

The OIG found that the radiologist associated with an imaging misread had no deficiencies identified in professional practice reviews from August 2023 through March 2024. Furthermore, documentation of the radiologist's clinical competence supported renewal of privileges.[9]

While the OIG determined the NTP has processes in place for peer reviews for quality management, the OIG found conflicting guidance from the NTP to facilities outlining responsibilities for the completion of peer reviews for quality management.[10] As a result, staff at the facility (facility 1) lacked clarity as to whether the NTP or facility leaders were responsible for completing peer reviews.

In April 2024, facility 1 alerted the NTP of the radiologist's misread and completed the peer review over nine months later. The facility 1 chief of radiology explained that the peer review was delayed due to changes in NTP processes and a lack of clear understanding that the facility was responsible for completion of peer reviews on NTP radiologists.

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[5] System Policy 640/NTP, *NTP Quality Assurance Plan and Critical Results/Critical Tests Policy,* January 27, 2007, revised May 13, 2020, and February 2, 2022.

[6] VHA Directive 1100.20(2), *Credentialing of Health Care Providers,* September 15, 2021, amended September 11, 2024; VHA Directive 1100.21(1), *Privileging,* March 2, 2023, amended April 26, 2023.

[7] VHA Directive 1100.21(1); VHA Directive 1916.

[8] System Policy 640/NTP. The policy reviews the scoring methodology used for service-level quality assurance peer reviews from level 1, "Concur with interpretation"; to levels 3a and 3b, "Discrepancy in interpretation/should be made most of the time"; and "likely" or "unlikely to be clinically significant," which indicates concerns.

[9] The radiologist's competency was documented in the system privileging memorandum completed in October 2023.

[10] VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024. Peer reviews for quality management are a tool to evaluate a provider's work to identify opportunities for provider practice improvement or system issues. VHA requires peer reviews to be finalized "within 120 days from the determination that a peer review is necessary."

The OIG identified discrepancies in and changes to NTP documents outlining responsibilities for peer reviews of NTP radiologists. The OIG reviewed an MOU signed in 2011 between the NTP and facility 1 that directs facilities to conduct a peer review of duplicate imaging reads with discrepant findings but does not provide further guidance on peer review management of other exams. An attachment to the MOU directs the NTP to complete peer reviews. In recent guidance, the NTP's quality assurance plan directs facilities to complete peer reviews, while the teleradiology service agreement (TSA) template, found on the NTP's program site, directs NTP to conduct peer reviews.[11] During an interview, the NTP chief quality officer stated that the NTP does not have a peer review committee and, therefore, cannot complete the peer review process.

The OIG found that the NTP radiologist who misread the patient's imaging study did not have additional cases reported that required peer review.[12] The OIG concluded that the NTP has processes in place for radiologist oversight, however, conflicting guidance may result in delays due to confusion regarding responsibilities for peer reviews.

2. NTP Turnaround Time Delays and Contributing Factors

The OIG substantiated that turnaround times for the return of interpretation reports for stat imaging studies by NTP radiologists were delayed for patients at two facilities, facility 2 and facility 3.[13] NTP policy requires a turnaround time for the transmission of the final interpretation report of no more than 1 hour for stat or emergent imaging studies.[14]

The OIG reviewed information related to NTP services in the electronic health records of 13 patients with stat imaging studies and found all the patients (5) at facility 2 and half of the patients (4) at facility 3 had delayed interpretation reports. The OIG also determined the NTP did not meet performance monitor goals for turnaround time for individual imaging studies and average times of all imaging studies in fiscal year 2024.[15] The timely return of interpretation reports following an imaging study is important as images may contain findings that require

[11] VHA Directive 1916. TSAs define "the clinical, technical, and business requirements for a teleradiology clinical service."

[12] NTP chief quality office staff informed the OIG that the NTP radiologist resigned from the NTP effective April 2024.

[13] VA, "National Teleradiology Fee for Service MOU," last revised May 5, 2023. Turnaround time is the time between when a complete study is received by the NTP and the time the final interpretation report is transmitted into the patient's EHR.; System Policy 640/NTP. For the purposes of this inspection, a delay is when the imaging studies turnaround times exceed policy timeliness requirements of 1 hour for stat exams and 48 hours for routine exams. Stat is an "emergent" exam that should be completed within one hour.

[14] System Policy 640/NTP.

[15] "Chapter 02 – VA's Budget Cycle and Fund Symbols," VA, accessed October 15, 2024, https://department.va.gov/financial-policy-documents/financial-document/chapter-02-vas-budget-cycle-and-fund-symbols/. A fiscal year is the government's accounting period beginning on October 1 and ending "on September 30 and is designated by the calendar year in which it ends."

prompt clinical intervention and, if not addressed timely, may result in delays in care with the potential to cause harm to the patient.[16]

To understand the nature of NTP-related concerns, the OIG reviewed 288 patient safety reports from October 1, 2023, to February 23, 2025, and found the reports showed a trend related to delays in the return of interpretation reports.[17] The former acting NTP Director documented awareness of the turnaround time delays and shared efforts underway to address the problem including hiring more NTP radiologists, communicating the need for facilities to establish contingency plans for use during NTP outages, and implementing mechanisms to report ongoing turnaround delays to facilities using NTP services.

However, despite the implementation of corrective actions and increased collaboration with staff at facilities using NTP services, several factors have the potential to contribute to, and increase the risk of, ongoing delays. The OIG learned that in the summer of 2024, NTP staffing levels could not meet workload demands. In response, NTP leaders reduced by 15 percent the volume of routine studies they accepted from facilities and no longer interpreted stat studies during weekday business hours.[18] NTP leaders reported difficulty recruiting radiologists, citing a national radiologist shortage.

The former acting NTP Director told the OIG that teleradiology relies on an operational computer system for the transmission and viewing of imaging studies and the return of interpretation reports. The OIG found the delay of interpretation reports for two of four patients at facility 3 in February 2024 correlated with NTP system outages. To optimize workflow efficiency, improve quality, and decrease outages, NTP plans to upgrade to a NextGen picture archive and communications system (PACS) that is anticipated to "go live" in September 2025.[19]

Facility MOUs with the NTP require that chiefs of staff ensure facilities have a local contingency plan in place during system outages and times of limited NTP staffing to prevent delays in care.[20] The facility 2 chief of radiology shared challenges implementing a contingency plan in part due

[16] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Management of Unread Radiology Examinations," memorandum to Veterans Integrated Service Network Directors (10N1-23), August 14, 2024.

[17] The OIG grouped the patient safety reports into four categories, including facility issues, delays, misreads or errors, and NTP system downtime based on the description of the event reported.

[18] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Information: Revised Reduction of the National Teleradiology Program Support (VIEWS 11986568)," memorandum to Veterans Integrated Service Network Directors (10N1-23), August 13, 2024. NTP defines business hours as 8:00 a.m. to 5:00 p.m. local time. Sites with no on-site or alternative coverage could still request services by obtaining preauthorization.

[19] "6525--National Teleradiology Program NextGen PACS (VA-22-00017790)," US Federal Contractor Registration (USFCR), accessed April 14, 2025, https://usfcr.com/search/opportunities/?oppId=e74c4ba3caf447b0b0109a25c43c9cd5.

[20] VHA Directive 1916. TSAs define "the clinical, technical, and business requirements for a teleradiology clinical service."

to the national radiologist shortage. Additionally, the OIG concluded, through interviews, facility staff may not be aware of or use the contingency plans to mitigate delays.

The OIG found that facility staff have varied knowledge of the terms and processes specified in the MOUs and TSAs. As a result, facility staff send routine imaging orders labeled incorrectly as stat and send requests to the NTP outside agreed-upon hours, creating an increase in NTP's workload. The NTP chief quality officer told the OIG that facility staff turnover contributes to the lack of familiarity with NTP policy and communication requirements.

The OIG identified that, although NTP leaders initiated actions to reduce turnaround times, anticipated and unanticipated influxes of radiology consults exceeding capacity are ongoing and may be correlated with the impact of the national radiologist shortage. While not the responsibility of the NTP, the OIG is concerned that lack of facility staff awareness of information in NTP TSAs, MOUs, and policy may result in increased NTP workload when study types and volumes outside the terms of MOU agreements are sent to NTP.

The OIG made two recommendations to the Under Secretary for Health to create a plan of action to optimize filling vacant positions and ensure all facilities using NTP services have a contingency plan to use other radiology services during NTP delays and outages.[21] The OIG made three recommendations to the NTP Director related to consistent guidance regarding completing peer reviews involving an NTP radiologist, devising a plan of action to achieve turnaround time goals that addresses staffing shortages, and exploring additional options for the recruitment and retention of radiologists.

VA Comments and OIG Response

The Acting Under Secretary for Health concurred with the recommendations and shared plans for the Acting Executive Director, National Teleradiology Program to review and update program related guidance and agreements, communicate NTP quality assurance processes to VISN and facility leaders and propose strategies to achieve turnaround time goals. The Acting Under Secretary for Health agreed to create a plan with strategies to optimize staffing of

[21] The recommendations addressed to the Under Secretary for Health are directed to anyone in an acting status or performing the delegable duties of the position.

radiologists and take steps to ensure all facilities using NTP services have a contingency plan in place (see appendix A). The OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Contents

Abbreviations

CT	computerized tomography
EHR	electronic health record
MOU	memorandum of understanding
NCPS	National Center for Patient Safety
NTP	National Teleradiology Program
OIG	Office of Inspector General
TSA	teleradiology service agreement
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection in January 2025 of the Veterans Health Administration (VHA) National Teleradiology Program (NTP) in response to complaints regarding the review of a teleradiology provider's (radiologist) practice who misread a patient's radiologic imaging study (imaging studies), and NTP delays in reporting interpretation results of imaging studies at multiple VA facilities.[1] The inspection also assessed the enterprise-wide management of NTP's radiologist oversight, quality assurance, and performance monitors.

Background

NTP "is a telehealth program that provides final interpretations of radiologic imaging studies referred from any of the 158 VA medical centers or their clinics."[2] VHA facilitates the "sharing of radiology resources across Department of Veterans Affairs (VA) medical facilities through teleradiology," which is "the use of electronic telecommunications technologies to provide radiology interpretations at a distance."[3] NTP delivers teleradiology services to VA facilities with a negotiated memorandum of understanding (MOU). An MOU between NTP and the facilities using NTP services includes a teleradiology service agreement (TSA) that specifies mutually agreed-upon workload terms, such as quantity and type of imaging studies to be interpreted as well as the hours and days services are to be provided by NTP.[4] The demand for NTP services has more than tripled from 314,874 stat imaging studies completed in fiscal year 2014 to 1,096,229 in fiscal year 2024.[5]

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[1] "What is a Radiologist?," American College of Radiology, accessed July 24, 2025, https://www.acr.org/about/radiology-overview. Radiologists are physician providers who "specialize in diagnosing and treating injuries and diseases using medical imaging and procedures." In this report, the OIG uses the terms 'read' and 'interpretation' interchangeably; the term 'misread' is used for a patient specific allegation as this was the term used by the complainant; Included in the time frame of an interpretation is receipt of the images and return of the report of findings; The OIG reviewed allegations related to three facilities.

[2] The NTP provides services to 130 VA facilities.

[3] VHA Directive 1916, *VHA Teleradiology Programs*, June 10, 2021. The terms 'radiology' and 'teleradiology' include radiology, nuclear medicine, and other diagnostic imaging services. The directive states teleradiology health care professionals providing services for the VA medical facility at which they are credentialed from an approved alternate worksite are not considered teleradiology. In this report, the OIG uses the term 'facility' to include VA facilities and systems.

[4] VHA Directive 1916.

[5] System Policy 640/NTP, *NTP Quality Assurance Plan and Critical Results/Critical Tests Policy,* January 27, 2007, revised May 13, 2020, and February 2, 2022. Stat is an "emergent" exam that should be completed within one hour.; "Chapter 02 – VA's Budget Cycle and Fund Symbols," VA, accessed October 15, 2024, https://department.va.gov/financial-policy-documents/financial-document/chapter-02-vas-budget-cycle-and-fund-symbols/. A fiscal year is the government's accounting period beginning on October 1 and ending "on September 30 and is designated by the calendar year in which it ends."

NTP Radiologists and Quality Assurance

The NTP is located at VA Palo Alto Health Care System (system) in Menlo Park, California. NTP leaders report that the NTP employs about 300 teleradiologists, composed of both VA and fee basis providers, operating 24 hours per day, 7 days per week, including holidays.

NTP radiologists interpret radiologic imaging studies, "including computerized tomography (CT) scans, X-rays, magnetic resonance imaging (MRI), ultrasound, and nuclear medicine imaging studies" submitted by radiology technologists from various VA facilities.[6] An NTP radiologist at a distant site is assigned, interprets the image(s), and electronically transmits report(s) containing the interpretation back to the originating VA facility.[7]

Quality assurance is an ongoing process of reviewing performance, evaluating "the quality and safety of health care," and "ensuring continual compliance" and quality improvement.[8] Identifying opportunities for improvement in a radiologist's practice provides information to improve future performance. This is particularly important given the estimated 3 to 5 percent error rate of interpreting imaging studies.[9] The NTP has a quality assurance committee that meets quarterly and is responsible for "devising an annual performance improvement plan to present to the VAPAHCS [system] Medical Executive Committee, discussing performance monitors, reviewing incidents and complications, identifying system issues, and proposing process improvements."[10] NTP performance monitors include ongoing review of radiologist competency and accuracy of interpretations; a biannual client satisfaction survey; timeliness of care, which includes the time it takes to return an imaging report to the requesting VA facility as well as the average turnaround times for routine and emergent studies; and tracking of downtime when the teleradiology informatics system is unavailable for use.[11]

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[6] The OIG uses the term 'imaging studies' to denote radiologic images; exams; and studies, which are packages of multiple images.

[7] VHA Directive 1084, *VHA National Teleradiology Program*, April 9, 2020. "An originating site is the VA medical facility where the patient is enrolled for care, which originates the teleradiology consult" to utilize NTP services for imaging studies interpretation. "A distant site is the site where an NTP teleradiologist provides telehealth to a patient receiving care at an originating site." For the purposes of this report, NTP is the distant site. NTP teleradiologists read the images remotely from home; one of the distant site reading centers in Durham, NC; Menlo Park, CA; and Honolulu, HI; and reading sites within VA facilities in New York, NY; Dallas, TX; Sacramento, CA; Los Angeles, CA; and Portland, OR.; "6525-National Teleradiology Program NextGen PACS (VA-22-00017790)," US Federal Contractor Registration (USFCR), accessed April 14, 2025, https://usfcr.com/search/opportunities/?oppId=e74c4ba3caf447b0b0109a25c43c9cd5.

[8] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

[9] Jason N. Itri et al., "Fundamentals of Diagnostic Error in Imaging," *RadioGraphics Journal* 38, no. 6 (October 10, 2018): 1845-1865, https://doi.org/10.1148/rg.2018180021.

[10] System Policy 640/NTP.

[11] System Policy 640/NTP.

Allegation and Related Concerns

The OIG opened a healthcare inspection to evaluate aspects of the NTP based on the following allegation and concerns:

- In January 2024, staff at a facility (facility 1) submitted a patient's CT scan to the NTP for interpretation. The NTP radiologist documented in the patient's electronic health record (EHR) that there were no suspicious lesions detected. Two months later, the patient underwent another CT scan at a non-VA facility and the radiologist documented findings suspicious for malignancy that were later confirmed to be metastatic prostate cancer. In April 2024, upon notification of the missed finding, the NTP radiologist reviewed the January 2024 imaging study and added an addendum to the patient's original EHR note saying there were multiple lesions consistent with metastatic disease.[12]
- In December 2024, the OIG reviewed an OIG Care in the Community Inspections staff's concern regarding the review and monitoring of the NTP radiologist following the misreading of an imaging study for the patient at facility 1.
- In January 2025, the OIG reviewed a confidential complaint that alleged the interpretation reports for imaging studies of five patients with stat CT scans ordered by emergency department providers at another facility (facility 2) had "extensive delays" greater than four hours, "putting patients at risk."
- A month later, in February 2025, OIG Healthcare Facility Inspections staff identified concerns that staff at three VA facilities experienced delays in receiving NTP interpretation reports for imaging studies and provided 29 patient safety reports related to the delays from a third facility (facility 3).

Given the confirmation of the NTP radiologist misreading a patient's imaging and concerns with delays in NTP interpretation of reports, the OIG evaluated the process used by the NTP for radiologist oversight, NTP's timeliness in returning interpretation results of imaging studies, and NTP's enterprise-wide management of performance monitoring and quality assurance.

[12] The NTP chief quality officer reported that when the NTP is notified by an originating facility of a misread, the NTP radiologist who interpreted the study is alerted with an expectation that the radiologist reviews the initial imaging immediately and adds an addendum to the EHR regarding any missed findings, as was done in this case. The Executive Director, VHA National Radiology Program, Diagnostic Services confirmed the ordering provider is also alerted of the misread and the addendum.

Scope and Methodology

The OIG initiated the inspection on January 30, 2025, and conducted virtual interviews from March 17 through May 1, 2025.

The OIG interviewed the complainant, NTP leaders, a facility credentialing and privileging staff member, chiefs of radiology and quality management, radiology technologists, and emergency department providers. The OIG reviewed relevant regulatory requirements; VHA directives, handbooks, and memoranda; NTP policies and procedures; oversight and accreditation reports, staffing documents, action plans, patient safety reports, quality reviews, TSAs, MOUs, and committee meeting minutes related to the NTP from October 1, 2023, to February 25, 2025. The OIG also reviewed NTP quality assurance and performance monitor data for fiscal years 2022, 2023, and 2024; the OIG did not independently verify the NTP data for accuracy or completeness.

The OIG reviewed the EHR of one patient to review documentation entered by the radiologist following a misread image. [13] Additionally, the EHRs of all patients identified in the complaint were reviewed and 9 of 13 patients were found to have imaging studies interpreted by NTP radiologists with possible delays in result turnaround time.[14] For those 13 patients, the OIG further analyzed information related to NTP services in the EHRs and in NTP system data, from October 1, 2023, to February 25, 2025. The OIG limited the scope of these patients' reviews to the timeliness of NTP returning reports for radiologic imaging; the entireties of the patients' care were not examined.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a

[13] VHA Directive 1084; System Policy 640/NTP; When facilities have concerns with episodes of overall patient care, there are internal quality review processes that may be initiated, including informing and collaborating with NTP staff.

[14] The OIG initially received complaints related to 35 patients, including 29 patients identified in the 30 patient safety reports from facility 3; 5 patients from facility 2; and 1 patient from facility 1.

specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

1. Radiologist Oversight

The OIG determined the NTP has processes in place to ensure initial and ongoing radiology provider competency through credentialing and privileging, provider professional practice reviews, and peer reviews for quality management.[15]

Credentialing and Privileging and Professional Practice Reviews

The VHA established, with The Joint Commission, a national privileging program "that treats NTP as a unique entity for purposes of credentialing and privileging" NTP radiologists.[16] Credentialing assesses and confirms the qualifications of a radiology provider to provide quality care and privileging authorizes providers to independently practice based on clinical competence.[17] To monitor the quality of interpretations made by NTP radiologists, according to VHA and NTP policies, radiologists are required to participate in professional practice evaluations. The results of completed professional practice evaluations are used to assess provider competence and must be considered during the re-privileging process.[18] For full-time NTP radiologists, the expectation is for at least 67 imaging exams over an eight-month period to be reviewed for professional practice, using a scoring system specific to radiologists.[19]

The NTP chief of clinical operations acknowledged that errors occur, however, noted the importance of quality assurance to identify radiologists with higher-than-normal error rates. The NTP chief quality officer confirmed that errors occur and shared that misreads prompt an educational opportunity for the radiologist.

During an interview with the OIG, the system credentialing and privileging manager confirmed that all staff hired by the NTP complete the system's onboarding process, which includes

[15] System Policy 640/NTP.

[16] VHA Directive 1084, *VHA National Teleradiology Program,* April 9, 2020; System Policy 640/NTP.

[17] VHA Directive 1100.20(2), *Credentialing of Health Care Providers,* September 15, 2021, amended September 11, 2024; VHA Directive 1100.21(1), *Privileging,* March 2, 2023, amended April 26, 2023.

[18] VHA Directive 1100.21(1); VHA Directive 1916.

[19] System Policy 640/NTP. According to NTP policy "part-time or lower volume providers may require a higher percentage of cases."

verification of credentials and, when verified, completion of the credentialing and privileging process, resulting in final approval and appointment by the System Director.

The NTP chief of clinical operations told the OIG that 100 professional practice reviews are conducted anonymously by other NTP radiologists on each NTP radiologist annually. The NTP chief quality officer said NTP supervisors and radiologists are alerted of any concerns identified during professional practice reviews regardless of the threshold being met. The former acting NTP Director explained that when the threshold of multiple imaging misreads is met, actions may be taken to further assess and address the radiologist's quality of work, including the radiologist not being recredentialed. However, the NTP chief of clinical operations reported minimal radiologists have met this threshold.[20]

The system credentialing and privileging manager confirmed that during the professional practice review process, NTP radiologists have the 100 exams reviewed annually and that when an NTP radiologist is due to renew privileges, designated NTP staff submit the NTP radiologist's previous two years of professional practice reviews to be considered. The OIG reviewed NTP quality assurance committee meeting minutes and learned that, of over 32,000 professional practice reviews from October 2023 through September 2024, 63 exams were concerning (0.19 percent), far less than the estimated 3 to 5 percent error rate of interpreting imaging studies.[21]

In assessing the application of the ongoing NTP radiologist evaluation processes for the NTP radiologist associated with the imaging misread, the OIG found the NTP radiologist had no deficiencies identified in professional practice reviews from August 2023 through March 2024. In addition, the OIG reviewed documentation of the radiologist's clinical competence used to renew privileging and found the contents supported the renewed privileges.[22]

Peer Reviews for Quality Management

While the OIG determined the NTP has processes in place for peer reviews for quality management, the OIG found conflicting guidance from NTP to facilities outlining responsibilities for the completion of peer reviews for quality management. As a result, facility 1 staff lacked clarity as to whether NTP staff or facility leaders were responsible for completing peer reviews.

[20] System Policy 640/NTP. A quality indicator is a type of trigger, according to NTP policy, when a radiologist has multiple imaging misreads, or a single misread considered to be egregious. When a quality indicator threshold is met, the VAPAHCS medical staff coordinator is notified and more reviews of the provider's work is recommended.

[21] System Policy 640/NTP. The policy reviews the scoring methodology used for service level quality assurance peer reviews from level 1, "Concur with interpretation"; to levels 3a and 3b; "Discrepancy in interpretation/should be made most of the time"; and "likely" or "unlikely to be clinically significant," which indicates concerns.

[22] The radiologist's competency was documented in the system privileging memorandum completed in October 2023.

Peer reviews for quality management are a tool to evaluate a provider's work to identify opportunities for provider practice improvement or system issues. The reviews are completed by peers and are nonpunitive. VHA allows for alternate methods for completion of peer reviews for providers in specialized telehealth programs.[23] VHA policy directs peer review committees to finalize the "review of each case within 120 days from the determination that a peer review is necessary."[24] NTP policy states "when the need for a Peer Review for Quality Management involves an NTP provider," the originating facility is responsible for completion of the peer review process and alerting the NTP quality assurance staff.[25] NTP policy requires NTP staff to aggregate peer review results for all NTP radiologists including a threshold of multiple imaging misreads, or a single misread considered to be egregious, as part of the quality assurance process.[26]

The OIG identified discrepancies in and changes to NTP documents outlining responsibilities for peer reviews of NTP radiologists. The OIG found the MOU signed in 2011 between the NTP and facility 1 directs *facilities* to conduct a peer review of duplicate imaging reads with discrepant findings but provides no further guidance on peer review management of other exams. Attached to that MOU is NTP's quality assurance plan policy that was applicable at the time, which directs the *NTP* to complete peer reviews.[27] A review by the OIG of contemporary guidance provided by the NTP to facilities found NTP's quality assurance plan policy has changed to now direct *facilities* to complete peer reviews.[28] Potentially confusing to the field, an NTP TSA directs the originating site to alert the distant site when a peer review is needed and states the distant site will confirm the need and conduct the peer review. However, unlike NTP language, in the context of this TSA, distant site refers to another VA facility, not NTP.[29] During an interview, the NTP chief quality officer told the OIG that while the NTP can help with the initial

[23] VHA Directive 1916.

[24] VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024.

[25] System Policy 640/NTP.

[26] System Policy 640/NTP. Consideration should be given to further review of the NTP radiologist's work, if the total sum of categories 3A – discrepancy in interpretation/should be made most of the time, unlikely to be clinically significant and 3b – discrepancy in interpretation/should be made most of the time, likely to be clinically significant are equal to or greater than 5 percent of the number of cases reviewed for a radiologist.

[27] System Memorandum No. 11-08-161, *Teleradiology Quality Assurance Plan*, , May 21, 2008.

[28] System Policy 640/NTP.

[29] "Teleradiology Service Agreement for Inter-facility Teleradiology Services Template," VA National Radiology Program Office, https://dvagov.sharepoint.com/sites/VHADiagnosticservices/NRP2/SitePages/Home.aspx?OR=Teams-HL&CT=1661540515359&xsdata=MDV8MDJ8fDUxZDVjNjdmZDlhZjQyNzc5ZDg5MDhkYzkyMDYyODg4fGU5NWYxYjIzYWJhZjQ1ZWU4MjFkYjdhYjI1MWFiM2JmfDB8MHw2Mzg1NDU4MDIzNTMzMjY1MDN8VW5rbm93bnxUV0ZwYkdac2IzZDhleUpXSWpvaU1DNHdMakF3TURBaUxDSlFJam9pVjJsdU16SWlMQ0pCVGlJNklrMWhhV3dpTENKWFZDSTZNbjA9fDB8fHw%3d&sdata=aExzZjJaOFYwOGVNN2tueXhQUnJhUnVpZkdlbmNCeEZRUVdzejVqMUVCdz0%3d. (This website is not publicly accessible.)

review in the peer review process, the NTP does not have a peer review committee, and therefore, cannot complete the full peer review process.

In reviewing NTP documentation of the misread image at facility 1, the OIG confirmed NTP's awareness of the addendum made in April 2024. NTP documentation and email correspondence showed staff from facility 1's peer review committee completed a peer review of the NTP radiologist in January 2025, more than nine months following awareness of the misread.[30] The facility 1 chief of radiology told the OIG that initiation of the peer review was delayed due to changes in NTP processes and lack of a clear understanding that the facility was responsible for completion of peer reviews.

The NTP chief quality officer explained to the OIG that, as part of the NTP quality assurance process, the NTP quality assurance co-chairs conduct weekly reviews of peer review activity and tabulate peer review ratings from the preceding 12 months to determine whether an NTP radiologist has triggered the threshold for further review. The former acting NTP Director confirmed the process of aggregating facility peer review committee scores and in-depth reviews of NTP radiologists' quality of work. The NTP chief quality officer stated in addition to the peer reviews completed at the facility level, misreads identified as egregious undergo further NTP review. However, the NTP chief quality officer reported no NTP radiologists had triggered the quality indicator requiring further review in the last two years.

The OIG reviewed the NTP quality assurance log from October 2023 through February 2025, confirming NTP tracking of radiologists undergoing peer review, the dates of notification by the originating facilities to the NTP, and the final facility peer review committee ratings. In doing so, the OIG found that the NTP radiologist who misread the patient's imaging study did not have additional cases reported that required peer review.[31]

The OIG concluded that the NTP has processes in place for radiologist oversight, however, conflicting guidance may result in delays due to confusion regarding responsibilities for peer reviews.

2. NTP Turnaround Time Delays and Contributing Factors

VHA requires communication of all test results to the ordering provider "within a time frame that allows for prompt attention and appropriate action to be taken."[32] Turnaround time is the time between when a complete study is received by the NTP and the time the final interpretation

[30] Although the NTP radiologist resigned several months earlier, facility 1's chief of staff confirmed the peer review was completed.

[31] NTP chief quality office informed the OIG that the NTP radiologist resigned from the NTP effective April 2024.

[32] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

report is transmitted into the patient's EHR.[33] NTP has processes in place to monitor turnaround times as well as NTP-related concerns identified in patient safety reports.

NTP Turnaround Time Delays for Patients' Stat Imaging Study Interpretation Reports

The OIG substantiated that turnaround times for the return of interpretation reports for stat imaging studies by NTP radiologists were delayed for five patients at facility 2 and four patients at facility 3.[34]

NTP policy requires a turnaround time of no more than 1 hour for stat or emergent imaging studies.[35] The OIG reviewed information related to NTP services in the EHRs of 13 patients with 21 stat imaging studies, which consisted of 5 patients (9 images) from facility 2, and 8 patients (12 images) from facility 3.[36] The OIG found all the patients at facility 2 and half of the patients at facility 3 had delayed interpretation of reports. See table 1.

Table 1. Delayed NTP Stat Turnaround Times

	Number with Delays/ Number of Patients Reviewed	Number with Delays/ Number of Images Reviewed	Turnaround Times in Minutes
Facility 2	5/5	9/9	152–239
Facility 3	4/8	5/12	131–452

Source: OIG analysis of turnaround times for 13 patients with stat imaging studies.

NTP Performance Monitors

Given the delays identified at facility 2 and 3, the OIG reviewed NTP enterprise-wide performance data for fiscal year 2024 related to the timely transmission of final imaging study interpretation reports and determined the NTP did not meet performance monitor goals for turnaround time for individual imaging studies and average times of all imaging studies in fiscal year 2024.

NTP's goal is for 90 percent of all stat and routine imaging study interpretation reports to be returned within the standard turnaround times of 1 hour for stat and 48 hours for routine imaging

[33] VA, "National Teleradiology Fee for Service MOU," last revised May 5, 2023. Receipt of a "complete" imaging study is when all images associated with the study, 3–4 relevant prior imaging studies, and any pertinent clinical information are successfully submitted by the facility.

[34] System Policy 640/NTP. For the purposes of this inspection, a delay is when the imaging studies turnaround times exceed policy timeliness requirements of 1 hour for stat exams and 48 hours for routine exams.

[35] System Policy 640/NTP.

[36] The OIG received 35 patient names. After reviewing the EHR of each patient, 9 of 13 patients were identified who had imaging studies interpreted by NTP radiologists with possible delays in result turnaround time.

studies. A review of enterprise-wide data showed that, in fiscal year 2024, NTP radiologists did not achieve the goal of returning imaging study interpretation reports for stat and routine imaging studies within the standard turnaround times at least 90 percent of the time. See table 2.

Table 2. Fiscal Year 2024 NTP Percent of Turnaround Time Compliance

Type of Imaging Study	Total Number of Imaging Studies	Percent on Time Benchmark	Percent on Time Studies
Stat	1,086,484	90	78.9
Routine	363,820	90	69.3

Source: Annual Service Performance Improvement (PI) Summary Report to Medical Executive Board [Committee].

NTP policy also states a goal to "maintain an average STAT turn-around of less than 40 minutes and average routine turn-around within 24 hours."[37] The OIG found the NTP did not meet this goal.[38] See table 3.

Table 3. Fiscal Year 2024 NTP Average Turnaround Time Performance

Type of Imaging Study	Total Number of Imaging Studies	Turnaround Time Benchmark	NTP Average Turnaround Time of All Imaging Studies
Stat	1,086,484	less than 40m*	41m:28s*
Routine	363,820	less than or equal to 24h*	39h*

Source: Annual Service Performance Improvement (PI) Summary Report to Medical Executive Board [Committee].
*Note: *h denotes hours (1h is equal to 60m), m denotes minutes, s denotes seconds.*

The timely return of interpretation reports following an imaging study is important as images may contain findings that require prompt clinical intervention and, if not addressed timely, may result in delays in care with the potential to cause harm to the patient.[39] A facility emergency department provider told the OIG that delays [in the return of interpretation reports] have a significant impact on patient flow, expressing that imaging plays a significant role in determining whether a patient requires hospital admission or can be discharged. In a discussion of performance monitors, an NTP leader expressed to the OIG that ordering providers "don't care about averages, they care about outliers."

[37] System Policy 640/NTP.

[38] The average turnaround times are computed by adding up all stat or all routine study turnaround times and dividing by the total number of stat or routine studies interpreted in fiscal year 2024.

[39] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Management of Unread Radiology Examinations," memorandum to Veterans Integrated Service Network Directors (10N1-23), August 14, 2024.

Patient Safety Reports

In addition to what is learned through monitoring turnaround times, information regarding NTP's performance is also gleaned through reviews of patient safety reports. The OIG found that NTP follows a collaborative process regarding patient safety concerns, with bidirectional communication between the NTP and VA facilities to ensure awareness of concerns affecting care so that appropriate actions can be initiated.

According to VHA, events that may result in, or have the potential to result in, patient harm should be reported by facility staff in a patient safety report submitted to the National Center for Patient Safety (NCPS).[40]

The OIG learned that when NTP staff identify errors by facility staff or quality issues, the NTP chief quality officer submits patient safety reports to the associated facility. In fiscal year 2024, NTP staff submitted 185 patient safety reports. The NTP chief quality officer reported also having responsibility for receiving and responding to all patient safety reports routed to the NTP from facilities.

To understand the nature of NTP-related concerns in the patient safety reports, the OIG reviewed 288 patient safety reports from October 1, 2023, to February 23, 2025, provided to the OIG by NTP for any issue including NTP radiologist concerns, system downtimes, or delays. The reports showed a trend related to delays in the return of interpretation reports.[41]

The OIG learned from email correspondence sent to the NTP by NCPS staff that the NCPS received five patient safety reports from different Veterans Integrated Service Networks (VISNs) about NTP delays, during one week in August 2024. In response, the former acting NTP Director reported awareness of the turnaround time delays and shared efforts underway to address the problem including hiring more NTP radiologists, communicating the need for facilities to develop and enact contingency plans for providing radiology interpretation services when NTP is unable to do so, and implementing mechanisms to report current turnaround delays to facilities using NTP services. In September 2024, the former acting NTP Director collaborated with NCPS staff to disseminate communication of those actions to facility patient safety managers and VISN patient safety officers.

Also in September 2024, NTP leaders developed an electronic messaging banner on the system facility radiology technologists' access to submit imaging studies that shows current turnaround times and total number of pending stat imaging studies. As a result, prior to submission of images, facility technologists can check current NTP turnaround times and communicate with

[40] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024; VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023.

[41] The OIG reviewed the patient safety reports that were deidentified for patient and facility names, and grouped into four extracted themes of facility issues, delays, misreads or errors, and NTP system downtime based on the event description reported.

ordering providers or facility leaders to determine if the turnaround time threshold for implementing a contingency plan has been reached.

The OIG concluded that the NTP uses a collaborative process to address radiology service-related adverse events, close calls, and delays. However, despite the implementation of corrective actions and increased collaboration with staff at facilities using NTP services, several factors have the potential to contribute to, and increase the risk of, ongoing delays.

Factors with Potential to Contribute to NTP Delays

The OIG identified factors that, when present, have the potential to contribute to NTP's challenge managing workload and returning imaging study interpretation reports within target time frames.

Staffing

In reviewing NTP performance monitor data, the OIG learned that NTP customer feedback for July 1 through September 30, 2024, identified a decrease in customer satisfaction attributed to delays in the return of interpretation reports. NTP and facility staff interviewed consistently expressed the belief that delays in the return of interpretation reports were generally from a demand for NTP services that, at times, exceeded NTP staff resources. In summer 2024, NTP staffing levels could not meet workload demands and NTP leaders reduced by 15 percent the volume of routine studies it accepted from VA facilities and no longer interpreted stat studies during weekday business hours.[42]

NTP policy states that staff continuously evaluate turnaround times, investigate the circumstances of outliers, and implement corrective actions, such as altering duty hours or staffing of teleradiologists to accommodate the volume of work.[43] NTP leaders explained, to determine NTP staffing necessary to manage the incoming workload, NTP staff assess workload demand, available staffing, and timeliness statistics. The NTP chief of clinical operations reported use of a specialized software and computer workload system for managing staffing and workload prediction. When staffing shortages are expected, NTP leaders may email facility service chiefs and staff in advance to communicate turnaround times may be delayed. A facility chief of radiology reported that NTP staff repeatedly communicated to facility staff that they did not have sufficient staffing and the volume of the studies that were going to NTP after hours had significantly increased.

[42] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Information: Revised Reduction of the National Teleradiology Program Support," memorandum to Veterans Integrated Service Network Directors (10N1-23), August 13, 2024. NTP defines business hours as 8:00 a.m. to 5:00 p.m. local time. Sites with no on-site or alternative coverage could still request services by obtaining preauthorization.

[43] System Policy 640/NTP.

NTP's chief of clinical operations described a "huge national shortage" of radiologists impacting the recruitment and retention of NTP radiologists. In interviews with the OIG, NTP leaders reported challenges in recruiting radiologists to include uncertainties regarding hiring freezes and workplace flexibilities in early 2025, resulting in the loss of 10 full-time, and roughly 20 fee basis, radiologist applicants. NTP's business manager estimated 10 or more radiologist positions were pending at the end of March 2025. Radiologist pay was also noted as a factor affecting recruitment for full-time radiologists due to limitations on the upper amount NTP can pay a radiologist. NTP's business manager noted that shortages of radiologists at originating sites increases the demand for NTP services. To address the need, the NTP chief of clinical operations shared that NTP has approximately 100 staff radiologists supplemented by approximately 200 fee basis staff with recruitment for more described as "non-stop." NTP leaders reported use of email or texts, sometimes multiple times per week, to request help from NTP radiologists and fee basis staff when gaps in coverage are identified. In addition, the NTP Director reported holding at least weekly meetings with each of the VISNs' lead radiologists to discuss NTP staffing shortages.

Operating System Downtime

The former acting NTP Director told the OIG that teleradiology relies on an operational computer system for the transmission and viewing of imaging studies and the return of interpretation reports. Given the risk of delays associated with the system being unavailable, the OIG reviewed NTP's informatics system data for outages that may affect the turnaround times for imaging studies.

The OIG found the delay of interpretation reports for two of four patients at facility 3 in February 2024 correlated with NTP system outages that ranged from three to seven hours, but that the delayed reports for five patients at facility 2 did not correlate with any NTP system outages.

The NTP policy states that the teleradiology informatics system downtime "will be monitored, aggregated, and a remediation plan made."[44] The NTP's goal is for a 99.9 percent average system uptime. NTP is required to maintain a continuity of operations plan to minimize or eliminate service interruptions, which includes continuous operations support.[45]

The OIG learned that NTP tracks all system downtime, reports data quarterly at the quality assurance committee, and publishes data annually with an action plan in a performance improvement report. The OIG found NTP system uptime for fiscal year 2024 was 99.41 percent with 16 reports of outages ranging from one to nine hours in length.

[44] System Policy 640/NTP.

[45] VA, "National Teleradiology Fee for Service MOU," last revised May 5, 2023.

The former acting NTP Director reported a computer system administrator was on staff 24 hours a day, seven days a week for technological support and that system downtime was rare. When a system outage occurs, facilities are notified by NTP almost immediately via modalities including email message, the system banner, and telephone call(s). The quality assurance committee minutes for July 1 through September 30, 2024, documented that NTP has contingency plans and redundant servers, and because "radiologists are distributed throughout the nation, which is a built-in contingency; technical issues affecting one radiologist's ability to read does not affect others who can continue working."

To optimize workflow efficiency, improve quality, and decrease outages, NTP plans to upgrade to a NextGen picture archive and communications system (PACS).[46] The NTP chief of healthcare technology confirmed in an email to the OIG in June 2025 that the NextGen PACS is anticipated to "go live" in September 2025. The new system has artificial intelligence components to improve identifying and expediting exams with positive findings to a higher priority status.

Originating Site Contingency Plans Not Enacted

Facility MOUs with NTP require that chiefs of staff ensure facilities have a local contingency plan in place during NTP system outages and times of limited NTP staffing to prevent delays in care.[47]

Lack of implementing a contingency plan may result in facilities continuing to send imaging studies to the NTP during times of high workload and delayed turnaround times. NTP's chief quality officer confirmed that facility staff were made aware of the requirement to have a contingency plan, noting that NTP is not responsible to verify compliance or dictate when a facility is to activate their plan. In September 2024, an NCPS physician communicated with facility patient safety managers and VISN patient safety officers, information from the former acting NTP Director to reinforce the expectation of facilities to have a contingency plan established, as required. Further, the OIG learned the Assistant Under Secretary for Health for Clinical Services addressed the management of unread radiology examinations in an August 2024 memorandum that directed VISN Directors to assign responsibility for the development of individual facility contingency plans within 90 days.[48]

The OIG discussed contingency plans with the radiology chiefs from facilities 2 and 3. The facility 2 chief of radiology shared challenges implementing a contingency plan. Specifically,

[46] "6525--National Teleradiology Program NextGen PACS (VA-22-00017790)," US Federal Contractor Registration (USFCR).

[47] VHA Directive 1916. TSAs define "the clinical, technical, and business requirements for a teleradiology clinical service."

[48] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Management of Unread Radiology Examinations," memorandum.

actions taken to contract with a private company for coverage were abandoned following credentialing and privileging issues and the impact of the national radiologist shortage limiting other facilities from helping to provide coverage. The facility 2 chief of radiology explained having difficulty supporting after-hours radiology coverage with the facility's staff due to limited staffing. Facility 2's radiology technologists were unaware if the facility had a contingency plan and reported never having used one. The facility 3 chief of radiology shared that, about a year ago, ongoing delays prompted the use of a VISN contracted teleradiology service as the facility contingency plan when there are NTP delays of 90 minutes or longer.

The OIG concluded that although the MOU between NTP and facilities requires facilities to designate contingency plans for use when NTP is unable to provide timely turnaround of reports or has system outages, facilities may be encountering difficulties putting contingency plans in place due to the limited availability of radiologists as a result of the national shortage. Additionally, facility staff may not be aware of or use the contingency plans to mitigate delays.

Lack of Staff Knowledge

The OIG found, through patient safety reports and facility staff interviews, facility staff have varied knowledge of the terms and processes specified in the MOUs and TSAs. As a result, facility staff send routine imaging orders labeled incorrectly as stat and send requests to the NTP outside agreed upon hours, creating an increase in NTP's workload.

The OIG learned the TSAs for facility 2 and facility 3 designated NTP coverage for stat studies from 3:30 p.m. or 4:30 p.m. to 8:00 a.m. on weekdays and 24 hours on weekends and holidays; no coverage for routine studies was included. However, radiology technologists at facility 2 and facility 3 reported sending studies whether stat or routine to NTP. Facility 3's chief of radiology reported not reviewing the MOU recently. Two facility quality management chiefs and four emergency department providers interviewed reported not being familiar with the NTP or the provisions of associated policies, MOUs, or TSAs that established required turnaround times, where they, or radiology technicians, can access current turnaround times, or contingency plans for delays or outages.

The NTP chief quality officer told the OIG that facility staff turnover contributes to the lack of familiarity with NTP policy and communication requirements. Quality assurance meeting minutes from January 2024 through March 2024 showed training about workflow information is provided during service activation and are sent out in ongoing newsletters. NTP meeting minutes documented discussions of facility staff sending exams with inappropriate urgency status types and volume, as well as exams received during hours and days outside those agreed upon in the MOU and that new staff may think all imaging studies are to be transmitted to NTP. Minutes reflect that NTP staff feedback to facility staff results in behavior changes.

Quality assurance committee minutes for July 1 through September 30, 2024, documented the NTP chief of clinical operations reinforced to facility staff the need for adherence to types and

amount of images sent to NTP as outlined in the MOU. However, minutes from a January 2025 NTP governance board meeting noted facilities continued to send routine imaging studies to NTP more frequently than the amount designated in their MOU agreements.

Furthermore, the OIG identified that NTP has a process in place to continually predict workload volume and staffing, and track turnaround times. NTP leaders initiated actions in response to factors contributing to delays, although anticipated and unanticipated influxes of radiology consults exceeding capacity are ongoing and may be correlated with the impact of the national radiologist shortage. While not the responsibility of NTP, the OIG is concerned that lack of facility staff awareness of information in NTP TSAs, MOUs, and policy may result in increased NTP workload when study types and volumes outside the terms of MOU agreements are sent to NTP.

Conclusion

NTP provides teleradiology services to VA facilities, with both independent and collaborative responsibilities for processes between NTP and facilities. Requirements for NTP's operational processes and provision of services are encompassed in VHA policy, NTP policy, and the MOUs, which include TSAs that specify mutually agreed upon service workload terms.

The OIG determined the NTP has processes in place to monitor NTP radiologists' competency through provider oversight such as credentialing and privileging, provider professional practice reviews, and peer reviews for quality management.

In response to a concern regarding the review of an NTP radiologist following the misreading of an imaging study for a patient at facility 1, the OIG found the NTP reviewed the radiologist's professional practice and clinical competence as required and did not identify deficiencies. While the OIG determined the NTP has processes in place for peer reviews for quality management, the OIG identified discrepancies in and changes to NTP documents outlining responsibilities for the completion of peer reviews for quality management. As a result, facility 1 staff lacked clarity as to whether the NTP or facility leaders were responsible for completing peer reviews. The peer review was not completed for more than nine months following the facility's awareness of the misread.

The timely return of interpretation reports following an imaging study (turnaround time) is important as images may contain findings that require prompt clinical intervention and, if not addressed timely, may result in delays in care with the potential to cause harm to patients. The OIG substantiated that turnaround times for stat imaging studies by NTP radiologists were delayed for five patients at facility 2. The OIG also substantiated turnaround time delays for two of four patients at facility 3 that correlated with NTP system outages ranging from three to seven hours. Given the delays identified at facility 2 and facility 3, the OIG reviewed NTP enterprise-wide performance data for fiscal year 2024 related to the timely transmission of final imaging

study interpretation reports, and determined NTP did not meet performance monitor goals for turnaround times for individual imaging studies and average times of all imaging studies.

In addition to what is learned through monitoring turnaround times, information regarding NTP's performance is also gleaned through reviews of patient safety reports. The OIG found that NTP follows a collaborative process regarding patient safety concerns, with bidirectional communication between NTP and VA facilities to ensure awareness of concerns affecting care.

In response to the delays, NTP staff initiated actions including radiologist recruitment, communication emphasizing facility development and utilization of contingency plans, and reporting mechanisms to communicate delays with facilities. NTP has processes in place to continually predict workload volume and staffing, and track turnaround times; however, anticipated and unanticipated influxes of workload demands exceeding NTP staffing level capacity are ongoing and may be correlated with the impact of the national radiologist shortage. However, despite the implementation of corrective actions and increased collaboration with facilities using NTP services, several factors were identified that have the potential to contribute to and increase the risk of ongoing delays. The OIG identified these as staffing, operating system downtime, facilities not enacting contingency plans, and lack of staff knowledge.

The Acting Under Secretary for Health concurred with the following recommendations and shared plans for the Acting Executive Director, National Teleradiology Program to review and update program related guidance and agreements, communicate NTP quality assurance processes to VISN and facility leaders and propose strategies to achieve turnaround time goals. The Acting Under Secretary for Health agreed to create a plan with strategies to optimize staffing of radiologists and take steps to ensure all facilities using NTP services have a contingency plan in place.

Recommendations 1–5

1. The Director, National Teleradiology Program ensures guidance in memoranda of understanding, teleradiology service agreements, and policies related to the entity responsible for the completion of National Teleradiology Program radiologist peer reviews is consistent and aligns with Veterans Health Administration requirements.
2. The Director, National Teleradiology Program reviews the barriers, to include staffing shortages, to achieving turnaround time goals and creates a plan of action to optimize results.
3. The Director, National Teleradiology Program, in cooperation with Veterans Health Administration's National Radiology Program, explores additional options for the recruitment and retention of National Teleradiology Program radiologists.

4. The Under Secretary for Health, in cooperation with Veterans Health Administration's National Radiology Program, reviews the tools available for the recruitment and retention of radiologists across the Veterans Health Administration and creates a plan of action to optimize filling vacant positions.[49]
5. The Under Secretary for Health ensures all facilities with an agreement for service by the National Teleradiology Program have a contingency plan.

[49] The recommendations addressed to the Under Secretary for Health are directed to anyone in an acting status or performing the delegable duties of the position.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: September 26, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Review of Veterans Health Administration's National Teleradiology Program

To: Director, Office of Healthcare Inspections (54HL05)

1. Thank you for the opportunity to review and comment on OIG's draft report on Review of Veterans Health Administration's National Teleradiology Program. The Veterans Health Administration (VHA) concurs with the recommendations and submits the attached action plan.

2. VHA greatly values the OIG's assistance in ensuring that all stakeholders are unified in supporting VHA's vision of providing all Veterans with access to the highest quality care. Your collaboration is instrumental in helping us achieve our commitment to excellence in health care services for Veterans.

3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vacovha10oicoig@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D., MBA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on September 26, 2025.]

Office of the Under Secretary for Health Response

OIG Draft Report – Review of Veterans Health Administration's National Teleradiology Program
(OIG Project Number 2025-01255-HI-1545)

Recommendation 1: The Director, National Teleradiology Program ensures guidance in memoranda of understanding, teleradiology service agreements, and policies related to the entity responsible for the completion of National Teleradiology Program radiologist peer reviews is consistent and aligns with Veterans Health Administration requirements.

VHA Comments: Concur. The Acting Executive Director, National Teleradiology Program (NTP), will:

(1) Conduct a review and revision as needed of existing memoranda of understanding (MOUs) along with NTP policies and any NTP service agreements to ensure that guidance regarding NTP radiologist peer reviews is consistent and aligns with VHA requirements.

(2) Update or recertify all MOUs over three years old and develop and implement a regular review cycle for review and recertification of all MOUs at least every three years.

(3) Communicate NTP peer review and quality assurance (QA) processes to Veterans Integrated Services Network (VISN) and facility leaders on national calls such as CMO national call, VHA Imaging VISN Lead call, National Chiefs of Staff call and VHA National Radiology Program conference call.

Status: In Progress **Target Completion Date: January 2026**

Recommendation 2: The Director, National Teleradiology Program reviews the barriers, to include staffing shortages, to achieving turnaround time goals and creates a plan of action to optimize results.

VHA Comments: Concur. The Acting Executive Director, NTP, will review current processes and barriers and propose new ways to achieve turnaround time goals, including:

(1) Establishment of a minimal NTP staffing plan to inform elective leave distribution, and tour of duty alignment to optimize coverage.

(2) Provide improved education and guidelines to VA medical facilities regarding the appropriate use of stat orders and maximize the use of alternate and new order statuses such as As Soon As Possible (ASAP) and inpatient (IP), with associated turnaround time goals.

(3) Revise the NTP QA policy to include a definition of stat radiology examination, with examples, and a requirement for client sites to develop an auditing process for stat indications.

(4) Develop a contingency plan for high-risk cases and peak volume periods to maintain stat examination turnaround times within clinically acceptable timeframes.

Status: In Progress **Target Completion Date: January 2026**

Recommendation 3: The Director, National Teleradiology Program, in cooperation with Veterans Health Administration's National Radiology Program, explores additional options for the recruitment and retention of National Teleradiology Program radiologists.

VHA Comments: Concur. The Acting Executive Director, NTP, will:

(1) Consult with Workforce Management & Consulting to explore additional options for the recruitment and retention of NTP radiologists, including targeted recruitment efforts.

(2) Review and communicate the use of additional available pay flexibilities such as recruitment and retention pay and off tour fee basis opportunities.

Status: In Progress **Target Completion Date: March 2026**

Recommendation 4: The Under Secretary for Health, in cooperation with Veterans Health Administration's National Radiology Program, reviews the tools available for the recruitment and retention of radiologists across the Veterans Health Administration and creates a plan of action to optimize filling vacant positions.

VHA Comments: Concur. The Executive Director, National Radiology Program (NRP), will:

(1) Consult with Workforce Management & Consulting to explore options for the recruitment and retention of radiologists and will produce a plan of action with strategies for use by VISNs and facilities to optimize staffing.

Status: In Progress **Target Completion Date: March 2026**

Recommendation 5: The Under Secretary for Health ensures all facilities with an agreement for service by the National Teleradiology Program have a contingency plan.

VHA Comments: Concur. VHA will:

(1) Develop and issue a memorandum to VISN and facility leaders requiring a contingency plan for all facilities using NTP services, to include the requirement for cross facility workload sharing and a collaborative on-call system.

(2) Require VISN leaders to certify annually that a contingency plan is in place for all facilities using NTP services in their VISN.

Status: In Progress **Target Completion Date: March 2026**

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Susan Tostenrude, OT, MS, Director Erin Butler, LCSW Sheena Mesa, MSN, RN Robin Moyer, MD Tywanna Nichols, MSW, LCSW Andrew Waghorn, JD
Other Contributors	Sheyla Desir, MSN, RN Barbara Mallory-Sampat, JD, MSN Nitin Patel, MPH Natalie Sadow, MBA Tammra Wood, MSSW, LCSW-S

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