



**Department of Veterans Affairs
Office of Inspector General**

Healthcare Inspection

**Alleged Residency Training Issues in
Nuclear Medicine Service
Northport VA Medical Center
Northport, New York**

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: <http://www.va.gov/oig/contacts/hotline.asp>)

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Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections conducted an inspection to determine the validity of five allegations regarding Nuclear Medicine Service at the Northport VA Medical Center (the medical center), Northport, NY. The allegations were:

- The medical center is operating an unaccredited residency training program in nuclear medicine and is misrepresenting the accreditation status to attending physicians.
- The Chief, Nuclear Medicine Service accepted unqualified individuals into the residency training program.
- The Chief, Nuclear Medicine Service permitted residents to function as attending physicians.
- One physician in the Nuclear Medicine Service is not licensed to practice medicine in the United States.
- The medical center is improperly submitting bills to third-party payers for services provided by Nuclear Medicine Service residents.

We substantiated the first allegation that the medical center was operating an unaccredited residency training program in nuclear medicine; although, we did not substantiate that the medical center misrepresented the accreditation status to attending staff physicians. The medical center was operating an unauthorized nuclear medicine program that fell outside established VA residency training policies and VA personnel policies. As a result, we also substantiated that the Chief, Nuclear Medicine Service allowed unqualified individuals who were not licensed to practice medicine in the U.S. to work in Nuclear Medicine Service. We could neither substantiate nor refute the allegation that trainee physicians were permitted to function as attending physicians. We did not substantiate the allegation that the medical center improperly submitted bills to third-party payers for services provided by the trainee physicians in the unaccredited training program.

As a result of our inspection, the Medical Center Director discontinued the nuclear medicine residency training program in June 2010 and removed the two unlicensed trainee physicians. In addition, the Veteran's Health Administration (VHA) Office of Academic Affiliations discontinued funding nuclear medicine resident positions at the medical center.

We recommended that (1) VA leadership conduct an administrative review of the information flow, decision making, and approval process that allowed for the unaccredited nuclear medicine residency training program to continue operating and to

take appropriate administrative action against responsible officials; (2) VHA establish a process to validate residency program data submitted by VA facilities and to verify the accreditation status of programs prior to funding allocations; and, (3) VA leadership communicate the relevant facts of this issue to the appropriate New York State Medical Licensing authority.

The Under Secretary for Health concurred with the findings and recommendations and provided acceptable action plans. (See Appendix A, pages 14–17 for the Under Secretary’s comments.) We will follow up on the planned actions until they are completed.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Under Secretary for Health

SUBJECT: Healthcare Inspection – Alleged Residency Training Issues in Nuclear Medicine Service, Northport VA Medical Center, Northport, NY

Purpose

VA's Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an inspection to determine the validity of allegations regarding Northport, NY VA Medical Center's (VAMC's) Nuclear Medicine Service. These allegations particularly pertained to licensure status, supervision, and performance of resident physicians in Northport VAMC's Nuclear Medicine Service residency training program, as well as the accreditation status of the program itself. The purpose of this inspection was to ascertain whether the allegations had merit.

Background

Northport, NY VAMC

Northport, NY VAMC (medical center) is a general medical and surgical VAMC that provides primary and secondary medical, surgical, psychiatric, rehabilitative, and skilled nursing care services to veterans on Long Island, NY. The medical center has 506 operating beds and is affiliated with the State University of New York (SUNY) Medical School at Stony Brook, NY.

In fiscal year (FY) 2009, the medical center's medical care budget was \$241 million, and its medical care collections from first- and third-party billings were approximately \$19 million. Northport VAMC is one of eight VAMCs that comprise the New York/New Jersey Veterans Integrated Service Network (VISN) 3.¹ It also serves as the parent facility for VA's Plainview Community Based Outpatient Clinic (CBOC).

¹ The other seven VISN 3 VAMCs are: Brooklyn Campus of the VA NY Harbor Healthcare System (Brooklyn, NY), Castle Point Campus of the VA Hudson Valley Health Care System (Castle Point, NY), East Orange Campus of the VA New Jersey Health Care System (East Orange, NJ), Franklin Delano Roosevelt Campus of the VA Hudson Valley Health Care System (Montrose, NY), James J. Peters VA Medical Center (Bronx, NY), Lyons Campus of the VA New Jersey Health Care System (Lyons, NJ), and the Manhattan Campus of the VA NY Harbor

Nuclear Medicine—Brief Overview

Nuclear medicine refers to the specialty of medicine that uses radioactive elements and compounds—called radionuclides—to create medical images for diagnostic purposes, deposits radionuclides in tissue as a means of ablating (removing) it, and attaches radionuclides to molecules as a tool to make measurements in body fluids such as blood or urine.

In the U.S., the American Board of Nuclear Medicine (ABNM) is the primary certifying organization for the specialty. Thus, ABNM sets educational standards to evaluate the competence of physicians in nuclear medicine.² However, while ABNM sets standards and administers specialty board certification tests to prospective specialists in nuclear medicine, another organization, the Accreditation Council for Graduate Medical Education (ACGME) is responsible for the actual accreditation of residency training programs in the U.S., including in nuclear medicine.³

Typically, training in nuclear medicine involves a year of post degree (M.D. or D.O. [doctor of osteopathy]) internship in general medicine, followed by 3 years of specialty training in nuclear medicine.

Northport, NY VAMC—Nuclear Medicine Service

At the time of our onsite review, the Northport VAMC Nuclear Medicine Service was an independent diagnostic clinical service organizationally aligned under the medical center's Chief of Staff (COS). The service was staffed by a full-time Chief and two part-time staff physicians, as well as five technologists, and two administrative support staff. The service operates Monday through Friday from 8 a.m. until 5 p.m., with the staff physicians and technologists available for emergency after-hours coverage.

Nuclear Medicine Service provides a full complement of diagnostic nuclear medicine procedures, as well as bone density studies, which do not require the administration of radioisotopes. The service does not perform Positron Emission Tomography (PET) scans, which are performed at a local community hospital on a fee basis; however, the VA staff physicians interpret PET scan results. In FY 2009, the service performed and/or interpreted approximately 4,400 imaging procedures. Cardiac stress tests and bone density studies accounted for 59 percent of the studies (2,017 cardiac stress studies and 601 bone density studies).

Healthcare System (New York, NY). See <http://www2.va.gov/directory/guide/region.asp?ID=1003> [accessed 9/20/2010]

² See <http://www.abnm.org/index.cfm?PageID=4313&RPID=5034> [accessed 9/22/2010]

³ See <http://www.acgme.org/acWebsite/home/home.asp> [accessed 9/22/2010]

As well as local oversight engendered by being a unit of the Northport VAMC, the Veteran's Health Administration (VHA) operates a National Program Office for Nuclear Medicine and Radiation Safety that oversees VHA's nuclear medicine programs. VHA Handbook 1105.2, February 15, 2002, entitled *Nuclear Medicine and Radiation Safety Service Guidance*, "provides guidance on the administrative structure and management of services and service lines providing Nuclear Medicine in the Department of Veterans Affairs (VA) facilities and its outreach functions; [and] defines VA requirements unique to VA."

Resident Physicians—Overview

Upon successful completion of a 3 or 4 year course of study at an allopathic or osteopathic school of medicine, the graduate is awarded an M.D. or D.O. degree respectively. This degree, while indicative of successful completion of the course of study, does not confer licensure to actually practice medicine. Rather, licensure to practice medicine is a regulatory function, and medical licenses are granted by states, territories of the United States, or the District of Columbia.

Typically, newly graduated physicians perform a year of hospital-based internship followed by several years of specialty training ("residency"). While in an internship or residency program, the intern/trainee or resident/physician-in-training practices medicine under the auspices of an institution's internship and residency program. Additionally, after successful completion of the first year post-graduate ("internship"), a physician-in-training may apply to and obtain from a state an independent license to practice medicine.

In New York State, in order for a physician-in-training to practice medicine legally, he or she must have an independent license typically obtained after the completion of internship and/or be practicing within the sponsorship of an ACGME-accredited residency program.

A VA attending physician is the legal physician of record for a patient or a staff consultant, is on staff in a full-time or part-time capacity at a VAMC, is subject to the bylaws of the medical staff, and is not in a training status. A VA attending physician must have an up-to-date license in one of the 50 United States, or territory of the United States, or in the District of Columbia.

Allegations

On January 26, 2010, a complainant contacted OIG's Hotline Division and made allegations about the medical center's Nuclear Medicine Service. The complainant also notified the U.S. Office of Special Counsel and made an additional complaint. Specifically, the complainant alleged that:

- The medical center is operating an unaccredited residency training program in nuclear medicine and is misrepresenting the accreditation status to attending physicians.
- The Chief, Nuclear Medicine Service accepted unqualified individuals into the residency training program.
- The Chief, Nuclear Medicine Service permitted residents to function as attending physicians.
- One physician in the Nuclear Medicine Service is not licensed to practice medicine in the United States.
- The medical center is improperly submitting bills to third-party payers for services provided by Nuclear Medicine Service residents.

When interviewed and asked if the complainant was aware of specific patient harm arising due to the issues described in the above allegations, the complainant cited a Northport VAMC patient who died in the course of a radionuclide cardiac stress test, a common nuclear medicine diagnostic procedure.

Scope and Methodology

We conducted site visits May 25–26, June 2–3, and July 6–9, 2010. To address the complainant’s allegations, we interviewed the complainant; medical center leaders and Performance Improvement staff; staff physicians, trainee physicians, and technologists in the Nuclear Medicine Service; other clinical staff at the medical center; program officials in VHA’s Office of Academic Affiliations (OAA) and National Program Office for Nuclear Medicine and Radiation Safety; and an official from the New York State Office of the Professions. We also reviewed Official Personnel Folders and education records for Nuclear Medicine Service physicians-in-training, accreditation records at the medical center, and the public access website for ACGME.

We reviewed samples of patient medical records, including 30 records to review third-party billing activities and approximately 200 records to assess trainees’ patient care responsibilities and involvement. We reviewed the specific case cited by the complainant as an example of harm resulting from the irregularities alleged. We also consulted with VA’s Office of General Counsel on third-party billings issues.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President’s Council on Integrity and Efficiency.

Inspection Results

Issue 1: Accreditation Status

We substantiated the allegation that the medical center was operating an unaccredited residency training program in its Nuclear Medicine Service, but we did not substantiate that the medical center misrepresented the program's accreditation status to attending physicians.

Without proper accreditation, the medical center's program was unauthorized and fell outside established VA residency training program policies and personnel policies.

Accreditation Requirements and VA Oversight. VHA Handbook 1400.1, *Resident Supervision*, July 27, 2005, requires that residency training programs be accredited by ACGME or other accrediting or certifying bodies, such as the American Osteopathic Association (AOA).⁴ ACGME is a private professional organization that establishes national standards for graduate medical education (GME) in the U.S. In academic year (AY) 2008–2009, ACGME accredited over 8,500 specialty and subspecialty residency programs serving over 100,000 residents.⁵ ACGME accreditation is widely recognized in the medical community for ensuring consistency and quality in GME and providing independent oversight of residency training programs. Furthermore, the completion of ACGME-accredited residency training programs is a standard requirement for obtaining state medical licenses and specialty board certifications. For example, the ABNM requires applicants for certification to complete a 3-year accredited residency training in nuclear medicine to meet board eligibility requirements.

OAA's Role. Within VA, VHA's OAA is responsible for developing policies and overseeing clinical training programs, including those in medical and dental education, associated health professions education, and advanced fellowships. OAA is also responsible for allocating medical and dental resident training positions and the funds to support these positions. In FY 2010, OAA allotted \$508 million to VA facilities to support over 9,500 positions.

Nuclear Medicine Program at Northport. From 1976 through June 2007, the medical center operated an ACGME-accredited nuclear medicine residency. The program was a VA-sponsored program, which meant that the medical center fully managed and administered it, and residents were VA employees.⁶ The Chief, Nuclear Medicine Service served as the Program Director, and each year the medical center accepted two

⁴ ACGME defines a residency program as "the period of clinical education in a medical specialty that follows graduation from medical school and prepares physicians for the independent practice of medicine." During their residency programs, physicians-in-training work under the supervision of fully licensed physicians.

⁵ For Graduate Medical Education, the academic year is July 1 through June 30.

⁶ More commonly, residency training programs are university-sponsored programs that private or public universities manage and administer, and residents rotate through affiliated VA facilities.

residents for year-long training appointments. These appointments were renewable on a yearly basis.

Voluntary Withdrawal of Accreditation. Effective July 1, 2007, the medical center voluntarily withdrew its ACGME accreditation. ACGME permits institutions to do this for various reasons, such as the merger of two programs, loss of resources, or having no residents enrolled. According to the Chief, Nuclear Medicine Service, he voluntarily withdrew accreditation because the program lost training resources when SUNY at Stony Brook and a community hospital decided to no longer affiliate with the program. As of AY 2010–2011, the program remained in withdrawn accreditation status.

Continued Acceptance of Trainees. Despite the unaccredited status of the program, the Chief, Nuclear Medicine Service continued to recruit and accept trainee physicians in nuclear medicine and provide training to include didactic lectures, hands-on experience performing nuclear medicine studies, and supervised review of case study images. From July 2007 (the first month the program was unaccredited) until June 2010, the medical center accepted four trainee physicians into its nuclear medicine residency. Two were in the program multiple years.

In our interviews with the Chief, Nuclear Medicine Service and the medical center COS, both officials acknowledged that they did not consider the potential impact that voluntarily withdrawing ACGME accreditation would have in regard to VA policy requirements, state medical licensing issues, and third-party billings. The Chief, Nuclear Medicine Service also stated his belief that the unaccredited program was permitted by VA because OAA continued to fund the two residency positions.

Notifications of Accreditation Status. Based on our interviews with the attending staff physicians and trainee physicians in the Nuclear Medicine Service, as well as the medical center's COS and Education Coordinator, we found that the unaccredited status of the nuclear medicine residency program was known at the medical center. The two trainee physicians during AY 2009–2010 had signed letters acknowledging that the program was not accredited, and the staff physicians told us that they understood the program was not accredited. However, medical center officials and Nuclear Medicine Service staff physicians all emphasized that despite the accreditation status, the medical center was operating the program as if it was accredited in terms of resident supervision and training activities.

Notification to OAA. While the unaccredited status of the program was known at the medical center, we concluded that medical center officials did not proactively communicate the unaccredited status to VHA's OAA. We found no evidence that medical center officials included OAA in their correspondence with ACGME when they voluntarily requested withdrawal of accreditation of its nuclear medicine residency program, nor did they call OAA officials to notify them of the changed accreditation status. Instead, according to medical center officials, they notified OAA of the voluntary

withdrawal of accreditation through OAA's online Support Center website. Each year, OAA requires medical centers to submit two reports through its website.

The first report, due mid-July, shows "Program Management, Sponsorship, and Accreditation Status" for each residency program in which residents rotate through a VA medical center for the *prior* AY. Data fields in the report include the VA site or program director name, accrediting body, specialty or subspecialty, accreditation status, and sponsoring institution. On July 16, 2008—more than 12 months after voluntarily withdrawing accreditation for its nuclear medicine residency program—the medical center submitted this report to OAA for the prior AY and reported the status of the program as "Withdrawal of Accreditation." The medical center reported this status again on its July 28, 2009 report to OAA.

The second report, due in early April, is RCS 10-0145, "Filled Residency Positions by Specialty." Significant data fields in this report include facility name, affiliate name, specialty, planned number of positions, and final approved positions. This report does not include a field for accreditation status. For FYs 2008–2010, the medical center submitted this report to OAA and listed SUNY Stony Brook as the affiliate for the nuclear medicine residency program. According to an OAA official, the medical center's submission was misleading, since SUNY Stony Brook was not the sponsor for the medical center program *in nuclear medicine*. However, according to the medical center's Education Coordinator, 2009 was the first year OAA requested affiliation information in the report, and the name of the affiliate was pre-filled on the electronic form completed by the medical center. We also noted that the wording on the report was "Affiliated Institution," not "Sponsor."⁷ According to the instructions for this report, an "Affiliated Institution" is the institution where the medical center has a signed affiliation agreement on file, which is SUNY Stony Brook for the medical center. We also found that the OAA instructions used the words "affiliate" and "sponsoring institution" interchangeably, which may be confusing to reporting facilities. In short, the medical center's academic affiliation with SUNY Stony Brook for residency programs *other than nuclear medicine* (such as internal medicine), and the medical center's overall affiliation with SUNY Stony Brook, appears to have been employed to suggest an affiliation or endorsement with the nuclear medicine program, which after mid-2007, was not the case.

Even though the medical center reported the voluntary withdrawal of accreditation on the mid-July reports and despite possible discrepancies on the medical center's RCS 10-0145 submission, OAA officials did not contact medical center officials to clarify the status of

⁷ In VA, the term "affiliate" typically refers to an institution (or institutions) with which a medical center has a formal, signed affiliation agreement—a legal document that enables the clinical education of trainees at a VA or non-VA medical facility. Whereas, the term "sponsoring institution" is an ACGME term that refers to the "organization (or entity) that assumes the ultimate financial and academic responsibility for a program of GME." In many cases, the affiliate and the sponsoring institution are the same, but not always. For example, the Northport VAMC has a signed affiliation agreement with SUNY School of Medicine at Stony Brook; yet, VA was the sponsoring institution for the nuclear medicine residency program when it was ACGME-accredited, not SUNY.

the nuclear medicine residency program, and they continued to fund two residency positions each year. According to an OAA official, OAA is not sufficiently staffed to verify the information that medical centers submit through the electronic reporting system. Instead, OAA relies on medical centers to submit accurate information and to be proactive about informing OAA of significant changes to residency training programs.

No Other Active Unaccredited Residency Programs. We reviewed OAA's database of filled and allocated residency positions for AY 2010–2011 to verify the accreditation status of the training programs and to determine if OAA was funding positions for any other non-authorized residency training programs. OAA's database included 2,323 unique residency training programs. We verified that 2,319 of the programs were properly accredited by either ACGME or the AOA. Although we found that four programs were not accredited, the programs were not accepting residents, and the VA facilities had reallocated the funded positions to other accredited programs. During our review, we also found minor discrepancies (about 4 percent of the database entries) in how VA facilities reported programs. Most of the facilities reported the residency program sponsors; although, some facilities reported their affiliated universities, even when the universities were not the program sponsors, which further supports our conclusion that some facilities may be confused by the terminology used in OAA's instructions.

Issue 2: Qualifications and Licensure

Because the nuclear medicine residency program was unaccredited and fell outside established VA residency training program policies and personnel policies, we substantiated the allegation that the Chief, Nuclear Medicine Service allowed unqualified individuals to work in Nuclear Medicine Service. Additionally, because the program was unaccredited, these residents were inappropriately practicing medicine in New York State. However, we could neither substantiate nor refute the allegation that the trainee physicians were permitted to function as attending physicians, because we found that their responsibilities varied and were not fully documented.

Trainee Qualifications. During the period following the program's withdrawal of accreditation status (that is, after July 1, 2007, when accreditation was voluntarily withdrawn to June 30, 2010, when the Medical Center Director discontinued the program), a total of four trainee physicians were accepted into the residency program. All four trainee physicians graduated from foreign medical schools, and three of the trainees did not have independent (that is, their own) medical licenses in the U.S. while they were working in the medical center's unaccredited program.

The two higher level trainee physicians—designated as Post-Graduate Year (PGY) 4 by the medical center—had prior residency training in accredited programs and were participating in the medical center's unaccredited program for “refresher” training in order to prepare for the United States Medical Licensing Board Exams (USMLE), a step

towards obtaining a New York State medical license. Additionally, this participation was creditable in meeting U.S. Nuclear Regulatory Commission (NRC) experience requirements to be an authorized user of radioactive materials.

- One of the physicians completed a nuclear medicine residency at the medical center in 2003, *when the program was still accredited*. In July 2006, after working at a community hospital for several years, he returned to the medical center's nuclear medicine residency program as a PGY 4. He remained as a PGY 4 at the medical center until June 2010. He was not licensed to practice medicine during the entire period.
- The other physician completed an accredited pathology residency at a community hospital in 1995. He then completed the medical center's nuclear medicine residency in 1999, when the program was still accredited, and a nuclear medicine fellowship at SUNY Stony Brook in 2001. For the next 7 years, the physician was engaged in research; during this time he also obtained his New York medical license and Board Certification in Nuclear Medicine. In 2008, the physician returned to the medical center's unaccredited nuclear medicine residency program to obtain refresher training so that he could meet NRC requirements to become an authorized user of radioactive materials.

The other two trainee physicians—designated as PGY 1 by the medical center—had no prior residency training in the U.S., despite an ABNM requirement that trainees satisfactorily complete 1 or more years of training in an *accredited* residency training program that provides broad clinical education, such as internal medicine or surgery. These physicians reportedly participated in the program to obtain clinical experience to facilitate their future acceptance into accredited residency programs.

- One of these trainee physicians had completed a medical internship and radiology residency in his country of origin, but not in the U.S. At the time the Chief, Nuclear Medicine Service accepted the physician into the medical center's nuclear medicine residency training program, he (the trainee) did not have a medical license in the U.S. and was working as an ultrasound technologist at a private hospital.
- The other trainee physician had only completed “observerships” in various private medical practices prior to his acceptance into the nuclear medicine residency training program at the medical center.⁸ He had not completed an internship in the U.S. and was not licensed to practice medicine.

⁸According to the American Medical Association's “Observership Program Guidelines,” the intent of an observership is to “familiarize and acculturate an international medical graduate to the practice of medicine in an American clinical setting, and provide an introduction to American medicine as they will experience it in a hospital-based residency program.”

Trainee Physicians' Clinical Responsibilities. Based on our interviews and medical record and supporting documentation reviews, we found that the trainee physicians participated at varying capacities in all phases of nuclear medicine imaging procedures, including pre-procedure screenings and approval, performing procedures, and interpretation of resulting images. At the medical center, most procedures are diagnostic; the medical center performs only a few therapeutic nuclear medicine procedures each year.

Pre-Procedure Screening and Approval. According to the Chief, Nuclear Medicine Service and the Director of VHA's National Program Office for Nuclear Medicine and Radiation Safety, when a diagnostic imaging procedure is ordered by a requesting physician (such as a primary care physician), clinicians in the Nuclear Medicine Service are supposed to screen the requests to ensure the clinical appropriateness of the procedure and suitability of the patient for the procedure. The screenings typically involve reviewing patients' medical records and accepted published guidelines for imaging procedures. VHA guidelines for screening requests do not specify who should perform these screenings; that is, there is no requirement that staff attending physicians perform these screenings. Furthermore, these screenings are typically not documented in the electronic patient record; instead, documentation may be found in hardcopy log books or handwritten annotations on the procedure requests. At the medical center, we found that the trainee physicians performed the majority of the pre-procedure screenings (80 percent) and documented the screenings by initialing the hardcopy procedure requests. The remaining requests were screened by staff physicians (7 percent) or were not documented (13 percent).

Imaging Procedures. According to the Nuclear Medicine Service technologists and physicians we interviewed, the diagnostic imaging procedures are performed by the certified technologists; they explain the procedure to the patient, set up the gamma camera used to capture images, administer the radioisotopes, and acquire the images. Both the staff physicians and trainee physicians reportedly had varying levels of involvement during examinations, but their involvement is not documented in patients' medical records. According to the trainee physicians and technologists, some of the trainees only went into procedure rooms occasionally, usually when a technologist requested assistance with injecting radioisotopes or assessing a patient's symptoms during an examination. One trainee physician told us that he often participated in the cardiac stress tests and assisted the Cardiology Nurse Practitioner (who is present during all cardiac stress tests) in monitoring patients during procedures.

Interpretation of Diagnostic Images. Once a nuclear medicine procedure is completed and the images are developed, the results are interpreted by a physician and documented in the patient's medical record. Our review of 200 randomly selected medical records found that staff attending physicians signed or verified all the interpretation reports, indicating that the staff physicians participated in or reviewed all of the interpretations.

However, we cannot say with certainty that the staff physicians were present when the trainee physician interpreted the diagnostic images. During our interviews, we received mixed responses about how the images were interpreted. Some of the staff and trainee physicians told us that they routinely reviewed the images together and prepared the interpretation report. However, we were also told that the PGY 4 trainee physicians often interpreted the images independently, then the staff physicians reviewed and discussed the interpretations with them and signed off on the reviews, which is consistent with how residents are supervised in accredited nuclear medicine and radiology residency training programs.

Trainee Physician Licensure. As noted earlier in the Background section of this report, there are two options for VA physicians-in-training to properly practice with a view towards appropriate medical licensure—physicians either hold a current, full, and unrestricted license or they are in an accredited or approved residency training program or fellowship. Furthermore, the Physician Qualification Standard cited in VA’s Handbook 5005, *Staffing*, April 15, 2002, requires that residents obtain a full and unrestricted license by their second year of VA residency. The Handbook also requires that residency training programs be accredited.

VA and VHA policies make no provisions for individuals in unaccredited programs. We discussed this issue with a senior official from the New York State Office of the Professions who confirmed that a residency training program must be accredited in order for residents in the program to be otherwise exempt from New York State licensing requirements. Because the medical center’s nuclear medicine residency program was no longer accredited and the trainee physicians were not licensed but were nevertheless engaged in clinical activities, medical center officials were permitting the trainees to practice medicine without proper licensure.

Issue 3: Third-Party Billing

Although the medical center’s nuclear medicine residency program was not in compliance with VHA policies requiring that residency training programs be accredited, based on our review of billing records and supporting medical record documentation and discussions with VA’s Office of General Counsel, we did not substantiate the allegation that billing for the services of the trainee physicians was improper.

VHA Directive 2005-054, *Revised Billing Guidance for Services Provided by Supervising Practitioners and Residents*, dated November 21, 2005, describes VA policy for billing insurance carriers for services provided by supervising practitioners (attending physicians) and residents. The policy defines “Resident” as “an individual who is engaged in an accredited graduate training program in medicine (to include all disciplines), dentistry, podiatry, or optometry, under the direction of supervising practitioners.” However, the policy also references VHA Handbook 1400.1 on resident supervision and regulations set forth by the U.S. Department of Health and Human

Services (HHS), Centers for Medicare and Medicaid Services (CMS), which provide a broader definition of residents to include physicians who are not in approved GME programs. Both the VHA policies and the CMS regulations require that medical record documentation reflect staff physician supervision of the services provided. VHA Handbook 1400.1 requires that interpretation reports be “verified by a supervising practitioner.”

From July 1, 2007, through June 30, 2010, the period that the nuclear medicine residency program was not accredited, the medical center billed third-party insurers for 512 episodes of care (value = \$93,912) provided by trainee physicians. As of July 2, 2010, the medical center had collected \$32,597. We reviewed supporting medical record documentation for a sample of 30 billing episodes and found that the staff physicians verified the interpretation reports for all 30 episodes, thereby meeting both VHA and CMS documentation requirements.

Issue 4: Patient Death During Nuclear Medicine Test

When interviewed and asked if the complainant was aware of specific patient harm due to the issues related to the accreditation status of the nuclear medicine residency program, the complainant cited a Northport VAMC patient who died in the course of a radionuclide cardiac stress test, a common nuclear medicine diagnostic procedure. However, in that the patient died in 2005, almost 2 years prior to the loss of the nuclear medicine residency program’s accreditation, this allegation is not substantiated.

Inspection Conclusions

From June 2007, through June 2010, the medical center employed unlicensed physicians in an unaccredited nuclear medicine residency program that fell outside established VHA residency training policies and VA personnel policies. We could neither substantiate nor refute an allegation that trainee physicians were permitted to function as attending physicians. We did not substantiate the allegation that the medical center improperly submitted bills to third-party payers for services provided by the trainee physicians in the unaccredited nuclear medicine training program. As a result of our inspection, the Medical Center Director discontinued the nuclear medicine training program in June 2010 and removed the two trainee physicians. In addition, OAA discontinued funding nuclear medicine resident positions at the medical center.

Recommendations

Recommendation 1. We recommend that VA leadership conduct an administrative review of the information flow, decision making, and approval process that allowed for the unaccredited Nuclear Medicine residency training program to continue operating and to take appropriate administrative action against responsible officials.

Recommendation 2. We recommend that VHA establish a process to validate residency program data submitted by VA facilities and to verify the accreditation status of programs prior to funding allocations.

Recommendation 3. We recommend that VA leadership communicate the relevant facts of this issue to the appropriate New York State Medical Licensing authority.

Comments

The Under Secretary for Health concurred with the findings and recommendations and provided acceptable action plans. (See Appendix A, pages 14–17 for the Under Secretary’s comments.) We will follow up on the planned actions until they are completed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 28, 2010

From: Under Secretary for Health (10)

Subj: Healthcare Inspection—Alleged Residency Training Issues in Nuclear Medicine Service, Northport VA Medical Center (VAIQ 7046914)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the draft report. I concur with the report findings and recommendations.
2. The Veterans Health Administration (VHA) fully recognizes the potential risks and ramifications that lack of validating residency program data and accreditation could have on our healthcare system and patients served. A comprehensive review of the Northport VA Medical Center's Nuclear Medicine program and the overall local management of graduate medical education at the involved site has been completed. Administrative actions in response to recommendations concerning the Nuclear Medicine program have also been completed.
3. Also, the report notes that some confusion may exist in facilities about terminology or correct processes for reporting. Consequently, existing field guidance and processes will be reviewed and revised so that they are clearer. This revised guidance will be sent to the field. We will also emphasize the importance of reporting accurate residency program data. In this regard, facilities will be required to develop appropriate processes to validate the residency program data and accreditation status prior to submitting requests for funding allocations.
4. VHA agrees with the recommendation to inform the New York State Licensing Board about this isolated event.

5. A complete action plan to address the report recommendations is attached. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10B5) at (202) 461-7014.

(original signed by:)
Robert A. Petzel, M.D.

Attachment

Under Secretary for Health Comments to Office of Inspector General's Report

The following comments are submitted in response to the recommendations in the Office of Inspector General's report:

Date of Draft Report: October 12, 2010

Recommendations/ Actions	Status	Completion Date
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Recommendation 1. We recommend that VA leadership conduct an administrative review of the information flow, decision making, and approval process that allowed for the unaccredited Nuclear Medicine residency training program to continue operating and to take appropriate administrative action against responsible officials.

VHA Comments

Concur

The Office of Academic Affiliations (OAA) conducted a comprehensive review of the Northport VA Medical Center's (VAMC) Nuclear Medicine program and the overall local management of graduate medical education on July 14–15, 2010. A report containing two recommendations for the Nuclear Medicine program and additional recommendations for the entire facility residency program was submitted to the leadership at Northport VAMC and Veterans Integrated Service Network (VISN) 3 on August 22, 2010. Actions taken in response to recommendations concerning the Nuclear Medicine program and this report include:

- Realignment of the Nuclear Medicine Service at the Northport VAMC under Radiology/Imaging Services effective November 1, 2010; and
- Release of the resident physicians.

A final progress report on all recommendations is due April 15, 2011.

In process

April 30, 2011

Recommendation 2. We recommend that VHA establish a process to validate residency program data submitted by VA facilities and to verify the accreditation status of programs prior to funding allocations.

VHA Comments

Concur

VHA will review the existing field guidance (e.g., instructions, definitions, and processes) on:

- Using the resident allocation database and reporting system;
- Using the Annual Report on Residency Training Programs;
- Identifying and reporting residency program sponsors in these databases;
- Validating residency program data; and
- Verifying accreditation status of programs prior to funding allocations.

After the review, VHA will clarify and subsequently emphasize the existing guidance, or provide revised guidance to ensure that facilities are reporting as needed. The Office of the Deputy Under Secretary for Health for Operations and Management (10N) and the OAA will take the lead in the review and communication to the field. In addition, facilities will be required to certify that they have validated the residency program data and accreditation status of the program in conjunction with requests for resident position funding. Communication to the field will be completed as part of the allocation cycle. Therefore, validation of data will occur between March 15 and June 15, 2011, during the allocation cycle. In the interim, status updates will be provided to OIG every 90 days.

In process

June 15, 2011

Recommendation 3. We recommend that VA leadership communicate the relevant facts of this issue to the appropriate New York Medical Licensing authority.

VHA Comments

Concur

VHA concurs that it is a good business practice to inform the New York State Licensing Board (NYSLB) of this isolated event. The Northport VAMC leadership will contact the NYSLB to communicate, in detail, the relevant facts of this incident. Northport VAMC leadership will provide weekly status updates to VA's Office of Quality and Performance, as well as the VISN office until all issues involving licensing are resolved.

In process

December 2010

OIG Contact and Staff Acknowledgments

OIG Contact

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