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October 28, 2025

The Honorable Cheryl Mason
Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Ms. Mason:

I write to request the Department of Veterans Affairs' (VA) Office of Inspector General (OIG) investigate the current state of VA's teleradiology services. My office has received multiple reports of severe delays in teleradiology processing times, resulting in reduced quality of care for veterans and increased costs for the Department. Given the potentially life-threatening implications to veterans across the country, such an investigation is essential to determine the causes of these delays and to remedy any challenges effectively and expeditiously.

VA's teleradiology services are critical to the Department's emergent, diagnostic, and treatment services – often for life-threatening conditions. Many facilities benefit immensely from the VA national teleradiology program's ability to provide emergent and routine assessments of imaging, because those facilities do not have radiologists onsite to read images and provide a diagnosis and follow-up recommendations.

The need for teleradiology has only increased over the past year as facilities with onsite radiologists have lost staff and been unable to fill those positions. Of the 115 VA facilities that had onsite diagnostic radiology services as of September 2024, fifty have lost at least one radiologist and twenty-one of those have lost more than a quarter of their radiologists. Of the approximately seventy VA facilities with interventional radiologists, who not only diagnose but treat certain conditions using radiological imaging techniques, twenty four have lost more than a quarter of these highly specialized employees. Approximately thirteen VA facilities no longer have any radiologists onsite. Ninety-five percent of these losses have occurred since January 2025 and can be tied to return to office requirements, poor morale, and instability within the Department.

These staffing challenges, in addition to other challenges you may uncover in your investigation, have already caused the teleradiology program to become severely overburdened. For example, the standard turnaround time for emergency reviews is supposed to be one hour, yet for months these reviews have been delayed anywhere from three to eight hours. The typical turnaround time for routine reviews was approximately twenty-four hours, but now the backlog for these reviews is approximately six days behind. These delays cause deferrals in treatment, with possibly life-altering impacts. For emergency circumstances, absent a timely turnaround for these radiology results, most facilities are forced to send the veteran to a nearby community care hospital that is likely already overburdened with other patients. This means the veteran is waiting even longer for VA to coordinate this transfer, which will also cost more and usually means the patient must completely restart the evaluation and diagnostic process. Evidence of these delays dates back to at least July 2025, without any noticeable action by the Department to remedy this potentially deadly problem.

Specifically, I request a review of the following comparing fiscal years 2024 and 2025:

1. Average turnaround times for teleradiology services
2. Staffing levels, vacancies, turnover rates, and average time-to-fill for onsite and teleradiology services, including both radiologists and any related support staff
3. Adverse impacts of the delays in radiology services
4. Increased costs to the Department for sending or transferring emergent cases to community providers due to insufficient radiology services
5. Increased costs to the Department due to increased reliance on contract radiology services, both in-person and via telehealth
6. Reasons for declined job offers by radiologists

I appreciate your immediate attention to this issue and look forward to a thorough investigation and report outlining deficiencies in the program, adverse actions recently taken that have contributed to those deficiencies, and how the Department can expeditiously fix identified issues and challenges. As the OIG continues its oversight, my office stands ready to assist your important work in any way possible.

Sincerely,

Richard Blumenthal
Ranking Member
Senate Committee on Veterans' Affairs