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Administrative Closure

9d.
6/12/08

Alleged Quality of Care Issues
Martinsburg VA Medical Center, Martinsburg, West Virginia
(2007-01893-HI-0331)
(2007-01893-HL-0536)

Purpose

The Washington DC Office of Healthcare Inspections (OHI) reviewed allegations of improper orthopedic treatment and inadequate pain management at the Martinsburg VA Medical Center, Martinsburg, WV (medical center). The purpose of our review was to determine whether the allegations had merit.

Background

The complainant is a (b)(3):3 year-old retired (b)(3):38 U.S.C. 5701,(b)(3):38 U.S.C. 7332,(b)(6) who moved from Texas to West Virginia in 2006. His medical history includes chronic neck pain, post-cervical spine fusion, chronic low back pain, left shoulder pain from an injury sustained while deployed oversees and substandard foreign medical treatment, cluster headaches, vertigo, and dermititis.

In (b)(3):38 U.S.C. 5701,(b)(3):38 U.S.C. 7332,(b)(6) the complainant fell in his rural West Virginia home and injured his right shoulder. He was taken by ambulance to the Hampshire County Hospital and evaluated for altered mental status. A urine drug screen done in the Emergency Department (ED) recorded tricyclic antidepressants, methadone, benzodiazepines, opiates, cocaine, and propoxyphene. X-rays showed a fractured right humerus. He was agitated and hallucinating, according to ED staff, and was given Narcan, Haldol, Ativan, and Versed and transferred to the VA medical center, where he was enrolled as a patient. His medications at the time of the injury included included diazepam, doxepine, daroxetine , methadone, morphine sulfate, and quetiapine

He was admitted to the medical center ICU. X-rays confirmed a fractured right humerus at the surgical neck, with moderated displacement of the shaft medially and upward. The soft tissue of the shoulder was swollen. He was seen the next day by an orthopedist, who examined him and recommended conservative treatment – placing an over-the-shoulder fracture brace to immobilize the shoulder. He was discharged on November 2 with the same medications he was taking prior to admission.

On (b)(3):38 U.S.C. 5701,(b)(3):38 U.S.C. he returned to the medical center – about an hour and ½ drive from his home – for follow-up with the orthopedist. The examination showed the shoulder 16 percent healed and intact neurovascular status of the right hand. X-rays showed the position of the fracture fragments had improved, most likely due to gravity traction on the right arm. He was prescribed calcium and his diazepam was increased to three times a day for two weeks. Repeat x-rays were scheduled for the next visit.

He was next seen at the medical center by his primary care provider on November 14. Continued drug therapy included diazepam, methadone, morphine sulfate, paroxetine, quetiapine and promethazine. Treatment options were reviewed with the complainant,

and opioids were continued. The next primary care appointment was scheduled for (b)(3):38 U.S.C. 5701,(b)(3):38 U.S.C. 7332,(b)(6)

After the (b)(3):38 U.S.C. 5701, appointment, the Associate Chief of Primary Care became aware of the (b)(3):38 U.S.C. 5701,(b)(3):38 U.S.C. positive drug screen, and determined that the presence of cocaine in the drug screen was a breach in the complainant's Opiod Pain Medication Contract with the medical center. The complainant's future primary care was transferred to the Associate Chief.

The complainant cancelled his (b)(3):38 U.S.C. 5701,(b)(3):38 U.S.C. follow-up orthopedic appointment because he did not have transportation to the medical center.

On (b)(3):38 U.S.C. 5701, (b)(3):38 U.S.C. 7332,(the complainant called the medical center seeking refills for methylphenidate. The request was declined and he was informed that his care would be assigned to a new provider – the Associate Chief of Primary Care. The Associate Chief discussed the case with the Director of the Chronic Pain Service, VA Maryland Healthcare System, and determined not to prescribe opiates to the complainant.

The complainant cancelled his (b)(3):38 U.S.C. 5701, (b)(3):38 U.S.C. 7332,(appointment with primary care and orthopedics. The same day the Associate Chief recorded the following note:

> This patient on tremendous doses of methadone and percocet, said to have been given by a Texas VA but maybe not well documented, at least in the electronic portion of the record, was hospitalized here recently. He had decreased level of consciousness and had fallen and broken a humerus [shoulder].
>
> Drug screen at local hospital showed cocaine and darvon (darvon was not being prescribed).
>
> He was assigned to my care.
>
> PCP declined recently to renew his considerable dose of methylphenidate.
>
> He called recently to cancel ALL of his VA care. Says he is going elsewhere, but does not say where.
>
> This patient should never have narcotics prescribed to him by the VA system.

The complainant presented to Primary Care on (b)(3):38 U.S.C. 5701,(b)(3):38 U.S.C. 7332,(b)(6) requesting pain medication. The Associate Chief saw the complainant and told him that because of the positive urine drug screen the VA would not prescribe narcotics or opioids. Other treatment options were discussed with the complainant. The complainant was upset

about the urine drug screen, and disputed its validity and accuracy. A physical exam was not done.

On (b)(3):38 U.S.C. 5701,(b)(3):38 U.S.C. 7332 (b)(6), the complainant called and cancelled an appointment with primary care.

On (b)(3):38 U.S.C. 5701,(b)(3):38 U.S., the complainant was seen in Mental Health Services. The complainant was not currently on pain medications, experiencing pain - 5 on a scale of 1 to 10 - and restricted shoulder movement. The complainant's paroxetine dose was increased at this time.

On (b)(3):38 U.S.C. 5701,(b)(3):38 U.S., the complainant went to a private laboratory and submitted a hair sample for drug analysis. Results of the analysis were negative for amphetamines, cocaine, marijuana, codeine, and phencyclidine, and positive for morphine, which the complainant had been prescribed.

On (b)(3):38 U.S.C. 5701,(b)(3):38 U.S., the complainant presented to the medical center ED with complaints of diffuse body pain and burning nerve pain in his shoulders, neck and spine. The complainant was initially seen by a nurse practitioner, then by a physician during this visit. The complainant stated he did not have any pain medication and was requesting some at this visit. He further stated that he wanted the primary care physicians investigated for not following up on his positive urine screen with further studies, and informed the physician seeing him in the ED that he had a hair sample analyzed and brought the results with him. The physician reported that the complainant was verbally abusive and "continuously repeats that this VAMC was supposed to have a pain clinic and he needs his pain under control." A physical exam was done, noting decreased range of motion of the complainant's neck, with no mention of the complainant's right shoulder or arm. The complainant was given an intramuscular injection of morphine sulfate and was sent home with six tablets of hydrocodone bitartrate and an appointment with the Associate Chief for the following day.

The Associate Chief spoke with the complainant by telephone on (b)(3):38 U.S.C. 5701,(b)(3):38 U.S.C. 7332 (b)(6). The complainant denied having taken any narcotics since (b)(3):38 U.S.C. 5701, (b)(3):38 U.S.C. 7332. The hair analysis results were discussed; however, the Associate Chief still refused to prescribe narcotics. According to the Associate Chief, the complainant became angry and threatened trouble and lawsuit, and then hung up the phone.

On (b)(3):38 U.S.C. 5701, the Associate Chief sent a letter to the complainant, reiterating the decision not to offer narcotics for his chronic pain because of the violation of the medication agreement, but offering in hospital narcotic treatment for episodes of acute pain..

The Associate Chief saw the complainant on (b)(3):38 U.S.C. 5701,(He wanted care for a cyst on his right wrist and pain management care. The treatment plan included follow up with orthopedic services on (b)(3):38 U.S.C. 5701,(b and prescriptions for tramadol and cyclobenzaprine for pain control. X-rays showed the fracture healed with significant mal-union.

the medical center to a pain clinic in Cumberland, MD, over 2 hours drive from his home. OHI learned that because he lived in a "Non-TRICARE Prime" area his TRICARE status was changed to Standard, which meant that his primary payer was Medicare Part B and he could be seen by any willing provider.

OHI assisted the complainant in finding the names and phone numbers of orthopedic surgeons in (b)(3):38 U.S.C. 5701. – a 40 minute drive from his home. The complainant was seen by an orthopedic surgeon in (b)(3):38 U.S.C. and had surgery on his right shoulder in (b)(3):38 U.S.C. 5701 (. Additional surgery was performed in (b)(3):38 U.S.C.

The complainant reported that the surgeries had not improved his range of motion nor given significant pain relief and that his surgeon was of the opinion that had the surgery been completed within two months of the fall the outcome would have been better. Pain management is being provided by a local provider, to the complainant's satisfaction.

Issue 1: Failure to properly treat injured shoulder

We did not substantiate that the medical center providers failed to properly treat the complainant's injured right shoulder. Our consultant reviewer opined that standard of care permits treatment of the fracture "operatively or non-operatively." The indications for operative verses non-operative management of such fractures are determined by numerous factors. The medical record does not contain any reference to a discussion between the provider and patient concerning conservative versus surgical treatment. The consult stated that "considering the fracture in isolation one would tend toward open reduction internal fixation." However, "because the shoulder joint has such large range of motion, significant degrees of mal-union of proximal humeral fractures can still be compatible with acceptable range of motion and function." The consultant cautioned that the "patient has been on opioid medication for a long period of time and evidence of mental impairment is noted ... and both these factors would mitigate against open reduction internal fixation" because of the need for patient cooperation in the post-operative rehabilitation phase.

The treating orthopedic surgeon recommended conservative treatment at the initial visit. In our interview with the orthopedic surgeon, he did not recall the complainant, but defended his choice of conservative treatment based on his interpretation of the x-rays, the complainant's age, and the exam recorded in the medical record at the time. The orthopedic surgeon noted a 16 percent healing of the shoulder fracture on the November 9 visit, and recommended that the complainant be examined again in 2 weeks and x-rays be repeated. The orthopedic surgeon anticipated that the shoulder would be 50 percent healed by the next visit. The complainant cancelled his orthopedic appointments for (b)(3):38 U.S.C. (b)(3):38 U.S.C. 5701. and (b)(3):38 U.S.C. so the progress of his recovery could not be monitored. When the complainant cancelled the (b)(3):38 U.S.C. 5701 (visit, he indicated that he was going to seek care elsewhere and did not want any future appointments.

Given the complainant's situation – living alone in rural West Virginia an hour and ½ drive from the medical center - and his decision to seek orthopedic care from the Department of Defense, OHI staff advised the complainant to seek care as quickly as possible to ensure his case would be reviewed by an orthopedic specialist. This seemed to be accomplished within 1 week after our visit with him. However, due to TRICARE rules his care was further delayed until his consultation with the orthopedic surgeon from (b)(3):38 U.S.C. 5701,(b)(3):38 U.

We spoke with the complainant on June 5, 2008 to follow-up on his case. He was satisfied with his current medical care provided through Medicare Part B and TRICARE Standard and expressed his thanks to OHI for helping him obtain that care.

We concluded that, in all medical probability, the orthopedic care provided met the expected standard of care.

Issue 2: Failure to provide adequate pain management

We could not substantiate nor refute the allegation that the medical center did not provide adequate pain management for the complainant.

The complainant established care with the medical center (b)(3):38 U.S.C. 5701. (b)(3):38 U.S.C. 7332.(and signed the medication agreement, which stated that treatment may be stopped if there is evidence that the signer abused alcohol or used illegal drugs. From that time through (b)(3):38 U.S.C. 5701,(b)(3):38 U.S.C. the complainant was provided with opiates for pain management. When it came to the attention of the Associate Chief that the complainant had tested positive for cocaine on a urine drug screen done at a private hospital on (b)(3):38 U.S.C. 5701,(b)(3):38 U.S.C. the Associate Chief took over the care of the complainant and stopped all opiates by (b)(3):38 U.S.C. 5701, (b)(3):38 U.S.C. 7332.

The laboratory report of the drug screen test from Hampshire Memorial Hospital is a hand written report. Discussion with the supervisor at that facility revealed that there is no centralized computer system in the laboratory, and urine drug screens are done in the following manner:

- A urine sample is obtained by the nursing staff and sent to the laboratory. This is considered a screening test only, and there is no documented chain of custody providing evidence that the sample came from the correct patient or had not been tampered with.

- The test is done using a kit, and the results are decided by the presence or absence of a "line" visible to the naked eye.

- The common practice is that if there is a positive test, then blood or urine would be collected from the patient and sent to an outside laboratory for confirmatory quantitative testing. ***(This was not done in this case.)***

- The medical package insert for the urine drug screen kits used states that of 684 tests done, there were eight false positive and two false negative samples.

The complainant, on his own accord, had his hair tested for the presence of illegal drugs on (b)(3):38 U.S.C. 5701,(b)(3):38 U.S.C. 7332,(b)(6). A hair analysis detects illicit drug use within the last 3 months. The private laboratory follows established protocols and ensures a documented chain of custody of the sample. The test did not show the presence of any illegal substances.

Item # 3 in the pain medication agreement states "I can get prescription renewals only at a scheduled appointment." Item # 11 states "I will not use any illegal or recreational drugs," and item # 12 states "I agree to the use of urine drug screens when requested by my provider/team."

According to the medical center progress notes, the complainant called at least once to request an increase in his pain medication dosage, and had at least three unscheduled Primary Care appointments and one ED visit, for pain management and narcotic requests. The ED progress note indicates that the complainant was very agitated that the medical center did not have a pain management clinic. He was given a prescription for six "Lorcet" (hydrocodone and acetaminophen) tablets and was to see his primary care physician the next day. The complainant did not come to the medical center the next day as requested, but talked to the Associate Chief on the telephone, when, according to the progress note, the complainant became angry and threatened a lawsuit after his request for narcotics was denied. A urine drug screen was never done at the medical center during the time the complainant was receiving narcotics from the medical center.

Conclusion:

We are closing this case administratively without issuance of a formal report.

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