

# JUCM™

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Association  
of America



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## Also in this issue

### 16 Case Report

An Old Condition Presents  
New Challenges

### 21 Practice Management

Making the Most of Locum Tenens  
in Your Urgent Care

Evaluation and Management  
of Pain (Part 1):

# Acute Pain

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# The Hidden Costs of the Professional Liability Crisis



Much attention has been paid to analyzing the cost of professional liability. Most of the focus to date has been on the financial impact of the liability crisis, including an assessment of the true dollar cost of malpractice premiums, defensive practice, and overall healthcare costs. We have seen studies that demonstrate how the fear of liability can lead to overutilization of advanced diagnostics, higher rates of specialty referral, and unnecessary procedures. We have seen high-risk specialties fleeing areas of the country subject to high premiums and a lack of real tort reform. We have watched overall job satisfaction decrease, occupational stressors increase and more physicians consider early retirement. It's a pretty bleak picture for sure, but the discussion to date has probably underestimated the impact on the profession while oversimplifying the specific reasons for much of the decline in overall job satisfaction.

In order to better appreciate the potential impact on the profession of liability and the trickle-down impact on patient care, we should explore the subject on a more deeply psychological level. How does chronic fear change a physician over time? What about the loss of control? How do these and other factors change a physician's psyche over time? How does fear affect the intellectual process of clinical decision making? Might we see an almost evolutionary change in the psychological profile of the modern physician? And finally, how might that impact patient care?

Research has clearly shown a link between chronic stress and fear and overall health. Long-term excitation of the adrenal glands leads to depletion of several neurotransmitters and also disrupts the HPA axis, leading to mental and physical health conditions like depression, addiction, and chronic pain. While the medical profession was already under the daily pressure of life-and-death decision-making and fraud and abuse fears, the additional fear of liability just may be the tipping point for chronically overstressed physicians.

Fear of liability has dramatically changed the feeling of control that the profession once enjoyed. Despite the risk and uncertainty so intimately connected with the decision making process, the physician historically has controlled the process through the mostly objective interpretation of clinical data.

*How does chronic fear change a physician over time? What about the loss of control? How do these and other factors change a physician's psyche over time?*

Clinical investigations were driven by a critical analysis of known facts, pre-test probabilities and risk stratification. While inherently imperfect and challenging, the process was mentally stimulating and scientific. Now, every conclusion is tainted, every decision questioned by the mere potential of bad outcome and liability. Decisions are made, not based on evidence, but rather, driven by fear. The physician has, essentially, lost control of the entire decision-making process itself. Might this change the neurologic profile of the physician mind? Might we evolve away from the rich and complex processing of information in the way traditionally taught in medical school? It is too soon to quantify the long-term effects, but the potential implications for negatively impacting the quality of physician judgment—and, by extension, the quality of patient care—are worrisome.

It is far easier to assess the immediate, short-term economic impact of the liability crisis. In fact, most of the attention to date has focused on analysis of the direct costs associated with the current liability climate. Much less is known about the psychological impact on a profession that has watched helplessly while others have robbed it of the joy of practice and hijacked the decision-making process. The long-term consequences are yet to be known, but the uncertainty fills me with deep skepticism and sadness about the future of our profession. ■

Lee A. Resnick, MD  
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### CLINICAL

## 9 Evaluation and Management of Pain (Part 1): Acute Pain

Urgent care providers have a clinical, legal, and moral obligation to provide appropriate treatment for patients with pain. The first article in a two-part series addresses strategies for managing acute pain.

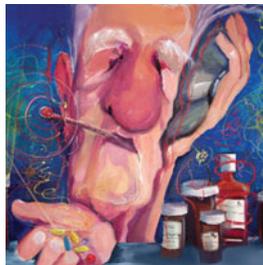
Tracey Q. Davidoff, MD

### CASE REPORT

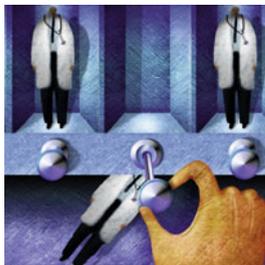
## 16 An Old Condition Presents New Challenges

Acute rheumatic fever is not common but it does still occur, underscoring the need for head-to-toe examination in patients with vague symptoms that seem unconnected.

Heather Varley, PA-C, and William Gluckman, DO, MBA, FACEP



### PRACTICE MANAGEMENT



## 21 Making the Most of Locum Tenens in Your Urgent Care

Despite the best staff planning, urgent care centers sometimes need to turn to locum tenens firms to fill the "bench." Understanding the challenges these firms face is one key to success.

Alan A. Ayers, MBA, MAcc

### IN THE NEXT ISSUE OF JUCM

Venous thromboembolism (VTE) is a major healthcare problem in the United States, particularly in the elderly. Between 2002 and 2006, the prevalence increased by 33.1% and the trend likely will continue, given the aging of the population. Next month's cover story reviews management of VTE in the urgent care setting, with a focus on clinical evaluation that incorporates pretest probability tools and judicious use of diagnostic tests. Included are a review of risk factors for and pathophysiology of VTE and recommendations on use of the Wells prediction rule for probability of deep venous thrombosis and for D-Dimer testing. Recommendations for inpatient and outpatient treatment, anticoagulation therapy, and long-term management of VTE also are provided.

### DEPARTMENTS

25 Insights in Images: Clinical Challenge

29 Health Law

31 Abstracts in Urgent Care

35 Coding Q&A

40 Developing Data

### CLASSIFIEDS

37 Career Opportunities

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[editor@jucm.com](mailto:editor@jucm.com)

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[jorvos@jucm.com](mailto:jorvos@jucm.com)

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John Shufeldt, MD, JD, MBA, FACEP  
David Stern, MD, CPC

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[bnapolitano@jucm.com](mailto:bnapolitano@jucm.com)

## ART DIRECTOR

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[tdeprenda@jucm.com](mailto:tdeprenda@jucm.com)

Braveheart  
Publishing

120 N. Central Avenue, Ste 1N  
Ramsey, NJ 07446

## PUBLISHERS

Peter Murphy  
[pmurphy@braveheart-group.com](mailto:pmurphy@braveheart-group.com)  
(201) 529-4020

Stuart Williams  
[swilliams@braveheart-group.com](mailto:swilliams@braveheart-group.com)  
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*JUCM The Journal of Urgent Care Medicine* supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing health-care marketplace. As the Official Publication of the Urgent Care Association of America and the Urgent Care College of Physicians, *JUCM* seeks to provide a forum for the exchange of ideas and to expand on the core competencies of urgent care medicine as they apply to physicians, physician assistants, and nurse practitioners.

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# JUCM CONTRIBUTORS

Urgent care clinics are filled with patients who are ill or injured, and pain—which is subjective—is a common presenting symptom. But pain scales are subjective and in treating an individual’s discomfort, providers must avoid either overtreating or undertreating the problem. Overtreatment can lead to serious morbidity or mortality and potential for addiction, whereas inadequate treatment can leave a patient both uncomfortable and dissatisfied with care. This month’s cover story, on effective management of acute pain, reviews strategies for treating discomfort adequately while simultaneously protecting yourself from dissatisfied patients and potential litigation. Included are three case studies that demonstrate application of the principles in common urgent care scenarios.



Dr. Davidoff is an urgent care physician at Accelcare Medical Urgent Care in Rochester, New York, on the CME Committee of the Urgent Care College of Physicians, and a member of the JUCM Editorial Board.



In this month’s case report, Heather Varley, PA-C, and William Gluckman, DO, MBA, FACEP, remind urgent care providers that conditions that aren’t seen in everyday practice still need to be considered to make an accurate diagnosis and reduce adverse outcomes. They review the course and treatment of a patient with a 3-week history of mild-to-moderate sore throat and otherwise unremarkable history. Diagnosis? Acute rheumatic fever, which can have long-term cardiac effects. The message here is to take a detailed history and perform a thorough head-to-toe exam when a patient presents with vague, seemingly unconnected symptoms.

Ms. Varley is a full-time Physician Assistant at and Dr. Gluckman is President & CEO of FastER Urgent Care in Morris Plains, NJ.

Having a “bench” of trusted clinicians who are available to work in your center as the need arises is the best way to avoid issues associated with locum tenens. But when unanticipated events such as provider resignations leave no choice but to use locum tenens providers to fill shifts, there are ways to mitigate the risks. Such strategies are the subject of this month’s practice management article, by Alan A. Ayers, MBA, MAcc. Among his recommendations are interviewing locum tenens providers offered by an agency, ensuring that they have prior urgent care experience, making time to orient them to your center, and incentivizing locum tenens providers based on factors such as efficiency and patient satisfaction.



Mr. Ayers is Associate Editor, Practice Management, JUCM, Content Advisor, Urgent Care Association of America, and Vice President, Concentra Urgent Care.

### Also in this issue:

**John Shufeldt, MD, JD, MBA, FACEP**, discusses the animus between physicians and lawyers and makes the case for why the two professions need to “get along.”

**Nahum Kovalski, BSc, MDCM**, reviews new abstracts on literature germane to the urgent care clinician, including studies of risk of burns with OTC topical pain relievers, acellular pertussis vaccine, prevention of falls in the elderly, and imaging for acute cholecystitis.

In Coding Q&A, **David Stern, MD, CPC**, discusses coding for medications, supplies, and x-rays.

Our Developing Data end piece this month looks at benefits for clinical staff other than physicians, PAs, and NPs. ■

### To Submit an Article to JUCM

JUCM, *The Journal of Urgent Care Medicine* encourages you to submit articles in support of our goal to provide practical, up-to-date clinical and practice management information to our readers—the nation’s urgent care clinicians. Articles submitted for publication in JUCM should provide practical advice, dealing with clinical and practice management problems commonly encountered in day-to-day practice.

Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, pictures, and references. Articles that are longer than this will, in most cases, need to be cut during editing.

We prefer submissions by e-mail, sent as Word file attachments (with tables created in Word, in multicolumn format) to [editor@jucm.com](mailto:editor@jucm.com). The first page should include the title of the

article, author names in the order they are to appear, and the name, address, and contact information (mailing address, phone, fax, e-mail) for each author.

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# If Not Us — Who?

■ P. JOANNE RAY

**U**CAOA depends on the involvement of many volunteer subject matter experts, facilitators, communicators, and leaders. As a health care association representing urgent care centers, we must also depend on our connections to and partnership with “sister” organizations to create impact, accomplish mutual goals, and extend our reach. It is our collective wisdom — across lines of specialty, institution, organization, and geography — and collegial relationships that lead us to successful outcomes.

*Please consider how you'll contribute to our collective voice. Ask yourself what you seek in return and what you are willing to contribute.*

As the new Chief Executive Officer (CEO) of UCAOA, I am working daily to learn the nuances of the association, what the key priorities are for urgent care, and how we can best serve your needs. Together with the Board of Directors and your national headquarters staff, we are already identifying ways to make UCAOA stronger, to create new and enhance existing programs and services, and to evaluate and shift our approach to be as efficient and effective as possible. As we announce the new 2012 Urgent Care Benchmarking Survey Results, we'll identify ways to highlight strengths to build industry awareness and address issues to improve our footprint. I look forward to learning from industry experts and finding new ways to partner with others to bring about change and progress that will serve our industry and our members (and ultimately the patients we serve) for a bright future.



**P. Joanne Ray** is chief executive officer of the Urgent Care Association of America. She may be contacted at [jray@ucaoa.org](mailto:jray@ucaoa.org).

### Where do you fit in?

There are opportunities to lend your expertise and assistance as a volunteer, and we welcome your enthusiasm and input! Can't make conference calls during working hours? There are even opportunities that you can fulfill on your own time. Think about the new connections you can make, what you'll learn from each other, and how YOU can make a difference.

Our collective reach depends on you and the strength we possess together. Please consider how you'll contribute to our collective voice. Ask yourself what you seek in return and what you are willing to contribute. Is it primarily access to policies and procedures, educational offerings and conference opportunities? Compare your UCAOA motivation to the characteristics that make your patients' experience successful, and apply some of the same approaches. You and your colleagues and centers are there when they need you. Your patients turn to you for answers, relief, pain management, and healthy outcomes. That is the goal of UCAOA as well!

Your patients must invest somewhat in their own health outcomes. Beyond your day-to-day operations, you must invest in the overall industry to gain the most fulfilling return on your UCAOA membership.

*For more information on how you can bring your energy to the mix, please e-mail me at [jray@ucaoa.org](mailto:jray@ucaoa.org). Indicate “If not us – Who?” in the subject line, and we'll gladly help you identify the best ways for you to get involved.*

For more information on how you can bring your energy to the mix, please e-mail me at [jray@ucaoa.org](mailto:jray@ucaoa.org). Indicate “If not us – Who?” in the subject line, and we'll gladly help you identify the best ways for you to get involved. Again, I look forward to learning from you and continuing to guide our association to one that we are all proud to be a part of! ■



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## Evaluation and Management of Pain (Part 1): Acute Pain

**Urgent message:** Urgent care providers have a clinical, legal, and moral obligation to provide appropriate treatment for patients with pain. The first article in a two-part series addresses strategies for managing acute pain.

TRACEY Q. DAVIDOFF, MD

The interpretation of pain by patients is very subjective and not easily measured. That makes management of pain in the urgent care setting difficult. Current pain scales are often inaccurate or not truly reflective of a patient's real perception of pain, and may reflect other issues or agendas not specifically related to the pain itself. Failure to adequately address pain may result in discomfort for a patient, dissatisfaction with care, and litigation. On the other hand, over treating pain may result in serious morbidity and even mortality for a patient, the potential for addiction or diversion, and litigation for a provider. This is the first in a series of two articles that will address urgent care management of both acute and chronic pain, including strategies for treating pain adequately while simultaneously protecting yourself from dissatisfied patients and litigation.

### Introduction

As physicians we have a clinical, legal, and moral obligation to avoid BOTH under prescribing and over prescribing pain medications to our patients.<sup>1</sup> Furthermore we must often make prescribing decisions based on the limited information available to us. Despite recent advances in the understanding of pain control, pain is often left unrecognized and untreated by a fair amount



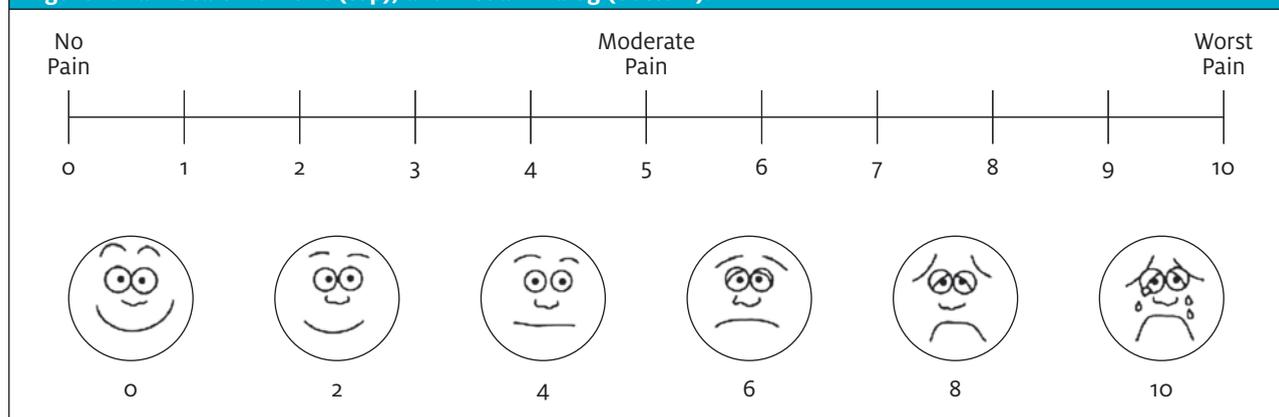
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of otherwise excellent clinicians. In 1999 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) initiated new standards in documentation of patients' pain and treatment and relief of that pain. In 2001 those standards went into effect, making pain the "5<sup>th</sup> Vital Sign," to be recorded with the other standard vital signs.<sup>2</sup> The JCAHO standards also mandated specific training in pain management for all medical students who started training after 2001.

Eleven years later, narcotic addiction—specifically prescription narcotic abuse—is being called the largest epi-

Tracey Q. Davidoff is an urgent care physician at Accelcare Medical Urgent Care in Rochester, New York, on the CME Committee of the Urgent Care College of Physicians, and a member of the JUCM Editorial Board.

Figure 1. Pain Scale Numeric (top), and Visual Analog (bottom).



demic of the 21<sup>st</sup> century.<sup>3</sup> After aggressively treating pain since 1999 to meet the JCAHO standards, we should not be surprised by this. According to the Centers for Disease Control and Prevention (CDC), misuse and abuse of prescription pain medications was responsible for more than 450,000 emergency department (ED) visits in 2009, a doubling in just 5 years. More than 1 million ED visits involved the non-medical use of pharmaceuticals.<sup>4</sup>

### Background

Acute pain and chronic pain are two very different entities and as such, require different evaluation and treatment. Pain is a complex clinical phenomenon that in most cases is a *symptom* when it occurs acutely, but a *disease* when it becomes chronic.<sup>5</sup>

*Acute pain* starts abruptly, increases over a short period of time, and can be ongoing or intermittent and recurring. Examples of acute pain include trauma, burns, renal colic, abdominal pain, myocardial infarction, gout, etc. By definition, acute pain lasts less than 3 months.

*Chronic pain* is ongoing more than 3 months and generally due to a non-reversible cause. Examples include metastatic disease, migraines, non-specific low back pain, phantom limb pain, fibromyalgia, and neuralgia. Any pain persisting beyond the usual course of the acute disease or a reasonable time for an injury to heal or associated with a chronic pathologic process that produces pain for months to years can lead to chronic pain. Per-

*Despite recent advances in the understanding of pain control, pain is often left unrecognized and untreated by a fair amount of otherwise excellent clinicians.*

sistent chronic pain is not generally amenable to routine pain control methods, making it especially hard to treat. Along with the pain comes a whole host of psychological, social, and personal factors that contribute to the difficulty in managing chronic pain.

*Addiction* refers to psychological dependence on

substances for their psychic effects, not their pain relieving effects, and is characterized by a compulsive use despite possible or actual harm. *Tolerance* is an adaptation to the effects of opioid or other medications administered long term, requiring increasing doses to achieve the initial effect of the drug. This is a natural and expected effect of these substances. Physical *dependence* is the physiologic adaptation of the body to the presence of an opioid medication. Withdrawal occurs when the medication is stopped abruptly. This is also an expected and natural effect of narcotics. Dependence is *NOT* the same as addiction.

It is our responsibility to assess the quality and severity of pain, identify pain that may represent a medical or surgical emergency, and differentiate acute and chronic pain. Furthermore, we need to be vigilant in identifying symptoms that represent withdrawal from narcotics and identify drug-seeking behavior. There is no law stating that a physician is required to treat pain by providing pain medication, specifically narcotics. Pain is a symptom and *NOT* an emergency medical condition in and of itself. Patients cannot compel a physician to provide medication or treatment that may be detrimental, life-

threatening, or to commit malpractice.<sup>6</sup>

**Quantifying Pain**

There are many ways to attempt to determine how much pain a patient is in. Once a diagnosis is made, the amount of pain an average patient with the same condition is usually in can be used to guide treatment. Clinical cues such as vital signs, restlessness, and behavior can all be used to quantify pain. "Pain scales" such as the 1-10 scale (**Figure 1, top**) where 1 is minimal pain and 10 is the most pain imaginable is the usual standard scale, but it is very subjective with many variables that make it difficult to standardize. Ethnicity, sex, and previous experiences all contribute to a patient's determination of the "number" for his/her pain. Fear of being

*It is our responsibility to assess the quality and severity of pain, identify pain that may represent a medical or surgical emergency, and differentiate acute and chronic pain.*

undertreated may lead a patient to unconsciously or consciously inflate that number to obtain adequate relief. Visual analogue scales (**Figure 1, bottom**) are better, but seldom used, except in children.

Providers should also realize that these scales have different implications for patients in acute pain vs. chronic pain. A broken bone with a pain level of 9 for an

hour may be better tolerated than low back pain with a level of 3 for 4 months. The broken bone may need a few doses of narcotic medication until healing begins, and the low back pain may need a more long-term solution.

**Selection of Pain Medication**

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Table 1: Dosing Guidelines for Selected NSAIDs				
Generic (Brand) Names	Recommended starting dose (mg)	Dosing Schedule	Maximum Daily Dose (mg)	Comments
Aspirin	650	Q4-6h	4000-6000	GI side effects may not be well tolerated
Choline Magnesium trisalicylate (Trilisate)	500-1000	Q12h	4000	No effect on platelets, available as a liquid
Diclofenac (Cataflam, Voltaren)	25	Q8h	150	
Ibuprofen (Motrin and others)	400	Q6h	3200	Available as a liquid
Ketoprofen (Orudis, Oruvail)	25	Q6-8	300	Available rectally and topically
Ketorolac (Toradol)	10	Q6h	40	Use limited to 5 days, first dose should be given IM or IV
Nabumetone (Relafen)	1000	Q24h	2000	Minimal effect on platelets
Naproxen (Naprosyn, Anaprox, Alleve)	250	Q12h	1025-1375	
Salsalte (Disalcid)	500-1000	Q12h	4000	Minimal effect on bleeding time
Piroxicam (Feldene)	10	Q24h	20	

GI = gastrointestinal; NSAID = nonsteroidal anti-inflammatory drug  
 All NSAID doses should be decreased by 1/2 to 2/3 in the elderly and patients with renal insufficiency. Gastroprotective agents such as misoprostol, H2 blockers, sucralfate, and antacids can be used to make these agents more tolerable. NSAIDs should be stopped 2-3 days before surgery.  
 Adapted from McCaffery M, Pasero C: Pain: Clinical Manual, 1999, Mosby, 139-40.

pain, cause of pain, prior patient experience with medications, current medications, allergies, vital signs, and physician preferences. Goals must be set so that a patient has realistic expectations about the amount of relief his/she will obtain. For example, it is unreasonable for a patient with a large partial thickness burn to have get 100% relief from pain with one dose of medication. Clinical judgment should always be used to provide the most appropriate care to meet the unique needs of each patient.

Medications are just one facet of the pain-relieving cocktail we can provide to patients. Ice can be applied to injuries, heat to pulled muscles, exercises, and massage can all be used acutely to improve pain. Patients can be referred to pain management specialists for trigger point injections (or they can be done in urgent care if a provider is comfortable with them), steroid epidurals, or other interventional pain techniques. Chiropractic colleagues can also help with pain management for back and musculoskeletal concerns. Psychology, acupuncture, biofeedback and other complementary techniques can be added for chronic pain as desired.

Adjunctive medications can also be added. The use of muscle relaxants for back pain, neuromodulators for nerve pain such as herpes zoster, neuropathy, and radiculopathy, antidepressants, and steroids for acute exacerbations of chronic conditions all can decrease the amount of pain medications required to make a patient more comfortable. Urinary anesthetics such as phenazopyridine can be used for urinary discomfort. Topical anesthetics such as lidocaine for eyes, throat, skin, and mucous membranes are generally not recommended.

### Specific Pain Medications

*Acetaminophen (APAP)* inhibits central prostaglandin synthesis to exert its pain-relieving effect. It has no anti-inflammatory effect. Peak plasma levels are achieved in 30 minutes. Because the drug is metabolized in the liver, it should be used cautiously in patients with liver disease, alcoholism, and malnutrition. The maximum daily dose has recently been reduced to 4 g/day, which is the equivalent of 8 extra-strength tablets or 12 regular-strength tablets. Caution is recommended when using combina-

**Case Study: Acute Patient #1**

A 27-year-old woman “missed a step” and twisted her ankle. She complains of 5/10 pain, swelling of her lateral malleolus, and is unable to weight bear even one step due to severe pain. On exam, she has swelling and bruising of the lateral malleolus, point tenderness at the anterior talofibular ligament, and severe pain with inversion of the foot. X-ray shows an avulsion fracture distal to the lateral malleolus. You diagnose a second-degree sprain. The patient asks you how you are going to manage her pain.

Short leg splinting, crutches with no weight-bearing, rest, ice and elevation are the first methods of pain control in this situation. If pain medicine is required, a high-dose NSAID is all that should be provided. Go over prescription-strength doses of ibuprofen and naproxen with the patient, keeping in mind that NSAID treatment often fails because patients are not taking enough.

tion products, as overdose can occur easily.

*Nonsteroidal anti-inflammatory medications (NSAIDs)* inhibit central and peripheral prostaglandin synthesis. Analgesic effect occurs in 30 to 60 minutes, with the anti-inflammatory effect occurring somewhat later. Responses vary by patient and drug; just because one formulation doesn't work well does not mean another won't work better. Sometimes trial and error is required to find the best fit for a patient. Examples include ibuprofen, naproxen, diclofenac, ketorolac and more (**Table 1**). Enquire about the dose a patient took that did not work. Many times it is because they have been under dosing by taking only 1 or 2 ibuprofen 1 or 2 times per day (or more commonly, only one dose). Ketorolac has the added benefit of being available as a parenteral as well as a nasally administered formula. That can be helpful in patients who are vomiting or in severe pain. The role of *COX-2 selective NSAIDs* in acute pain management is unclear at this time, but they may be useful for chronic pain conditions, such as arthritis.

*Tramadol* was introduced in Europe in 1977 and later in the United States as an alternative to narcotics for pain management. It is a very weak mu opioid receptor agonist that probably has the same mechanism of action as most opioids. It is about as efficacious as APAP/codeine in clinical trials. In most states it is not considered a controlled drug, but it may still cause withdrawal when stopped abruptly, as well as respiratory depression (especially in elderly patients), and physical dependence. Some states and the US military consider it a class IV narcotic and regulate it accordingly.

*Opioid medications* act on opioid receptors in the brain, including mu ( $\mu$ ), kappa ( $\kappa$ ), and delta ( $\Delta$ ). They produce analgesia and also affect mood and behavior. Most cause respiratory depression and somnolence, euphoria or dysphoria. Most effects develop tolerance over time requiring increasing doses to achieve the desired response. Opioids can be given orally, intramuscularly (IM), subcutaneously (SQ), and some intravenously (IV). Common opioid medications are listed in **Table 2**.

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Table 2: Dosing and Conversion Chart for Opioid Analgesics				
Drug	Route	Equianalgesic Dose (mg)	Duration (hr)	Plasma Half-life (hr)
Morphine (standard)	IM	10	4	2-3.5
Morphine	PO	30	4	4
Codeine	PO	300	4	
Oxycodone	PO	30	3-4	4
Hydromorphone	IM	1.5	4	2-3
Hydromorphone	PO	7.5	4	
Meperidine	IM	75	3-4	2
Meperidine	PO	300	3-4	
Methadone	PO	20	6-8	12-24
Fentanyl	IV	0.1	0.5-1	1
Hydrocodone	PO	30	3-4	4
Tramadol	PO	100	4-5	5-5.7

Equianalgesic doses are compared to the standard, morphine 10mg given IM.  
Adapted from [www.acpinternist.org/archives/2008/01/extra/pain\\_charts.pdf](http://www.acpinternist.org/archives/2008/01/extra/pain_charts.pdf)

### Pulling it All Together

General principles of pain management should be based upon “start low and go slow.”<sup>1</sup> If possible, start with APAP and/or a NSAID. Immobilizing orthopedic injuries goes

a long way in providing pain relief. Apply ice or heat. If these simple measures are not enough, or a more severe illness or injury is present, add the lowest dose, lowest potency narcotic for only a few days. It is reasonable to start with combination hydrocodone/APAP or oxycodone/APAP. APAP/codeine has been shown in numerous studies to offer little benefit over plain APAP, adds the risk of addiction, and probably should no longer be used. It stands to reason that tramadol, which is as effective as codeine, has the same limitations, but can be used in select cases as an alternative.

Parenteral narcotics should be used with great trepidation in urgent care. The only reason they should be used is if a patient is in severe pain AND is vomiting uncontrollably. If possible, give an antiemetic, wait a bit, and then try oral methods. If that is not feasible, IM medications should be the next alternative. IV narcotic pain medication should hardly ever be given in the urgent care setting. Exceptions would include patients being transferred to a higher level of care for significant trauma, surgical emergencies, myocardial infarction or similar, or if there is no other option to treat severe pain available to you. IV narcotics allow a patient to experience an intensified euphoric effect that may contribute to abuse in the future.

Painful procedures such as reducing dislocations and large abscesses are also indications for parenteral medications. IM use requires less monitoring by the nursing staff and has less risk of complications. IV use has the

### Case Study: Acute Patient #2

A 33-year-old male presents with sudden onset of severe left flank pain radiating to the left groin 2 hours ago. He has nausea and vomiting. He is pacing around the room and unable to get comfortable. His vital signs are normal. He took 2 ibuprofen at home and then vomited. His urine is positive for blood. You diagnose a kidney stone, give a liter of normal saline IV, and ask the nurse to strain the patient's urine. The patient wants to know what the plan is for pain management, since he vomited the ibuprofen.

IV fluids alone are often great at alleviating the pain of renal colic. If the patient is vomiting, he should receive an antiemetic such as ondansetron or prochlorperazine. Ketorolac can be given IV. If his pain does not respond to these measures, narcotics may be warranted. If the patient is comfortable with just the ketorolac, he can be sent home on ibuprofen, naproxen, or oral ketorolac. A few pills of a narcotic in case his pain becomes worse may keep him out of the ED so he can get his computed tomography IV pyelogram as an outpatient. Hydrocodone or oxycodone/APAP combinations are useful in this circumstance. Be sure the patient has a prescription for an antiemetic as well so that he can keep his ibuprofen down.

**Case Study: Acute Patient #3**

An 18-year-old female comes to urgent care after spilling boiling water down both anterior thighs 3 hours ago while cooking spaghetti. At home she rinsed the area with cool water, took one ibuprofen, two APAP, and put aloe cream on the burn. She is crying. Her heart rate is 140 bpm, and the remainder of her vital signs are normal. She looks uncomfortable. Upon examining her burns, she has large blisters, mostly intact on 2/3 of both anterior thighs (about 12% total body surface area). She is going to follow up with the local burn clinic in 2 days. She asks for “something strong” for pain.

Burns hurt, and although ibuprofen is great for the pain and inflammation of burns, it is not enough pain control for this patient. Because she is following up with the burn clinic, you only need to give her 2 days of narcotics. Again, hydrocodone or oxycodone/APAP combinations are the best choice. Keep in mind 2 days of pain medicine is not 4 pills. Two tablets every 4 hours for 2 days with a maximum daily dose of 8 pills is 16 pills. If you have narcotic medicines in your clinic you may want to give her some before removing the dressings and cleaning the patient's wounds as those procedures can be painful.

benefit of rapid onset of action and possibly requiring a lower dose. Keep in mind that a patient will require a responsible party to drive him/her home and supervise after discharge.

Prescribe responsibly!! Some patients surely need narcotics for painful conditions and procedures. Think of how you would want your family members (or yourself) to be treated. Patients with kidney stones, herpes zoster, serious fractures and dislocations, severe burns, and herniated discs with nerve compression can benefit with a 2- to 3-day course of narcotics until follow-up or definitive care can be arranged. If you do decide to prescribe a narcotic, give only a few days' supply, transition to an NSAID as soon as possible, and re-evaluate if a patient is not better in a few days. Transfer care to a primary care physician or specialist for further care. Warn patients of the addictive potential and dangers of misuse of narcotics. Oddly, a lot of patients don't know and will actually be reluctant to take narcotics if you explain it to them.

Studies have shown that there is little risk of addiction in patients who have had no history of substance abuse.<sup>5</sup> Ask in your history if this has been a problem in the past. Conversely patients with untreated or under-

treated pain may engage in drug-seeking behavior not because they are addicts, but because they are still in pain! This is called pseudo-addiction. Consider this: surgeons routinely prescribe narcotics at discharge from the hospital for their postoperative patients. Most people either don't fill the prescription or leave the bottle in the medicine cabinet until it expires. These patients do not end up drug addicts. In our legal system it is better for 10 guilty men to go free than to have one innocent man falsely convicted. To parallel this in our profession, is it better for 1 or 2 drug seekers to get a few pills of narcotics they do not need for pain than to have one real patient in pain whose suffering goes unrelieved?

Be ever mindful that meeting a patient's demands for pain medication may not be in the patient's or the clinician's best interest. You can actually get sued for “causing” a patient's addiction. The state and Drug Enforcement Administration monitor your prescribing and may sanction you if you write too many narcotics. These include loss of prescribing privileges, fines, and even loss of license. More on this in Part II.

**Conclusion**

Illness and injury cause pain. Patients need relief of pain and come to us not only for a diagnosis and treatment but also for relief of pain and suffering. Management of pain should be based on the correct diagnosis, a thorough history, an understanding of both the pharmaceutical and non-pharmaceutical options available, and preferences of the physician. Patient education and open communication should always be the foundation for a therapeutic and successful patient encounter.

Part II of this series will discuss the entity of chronic pain, give a brief description of management techniques employed by pain specialists, and explain how to evaluate these patients in an urgent care setting. Strategies to identify patients who are likely to be abusing or diverting narcotics will also be discussed. ■

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# Case Report

## An Old Condition Presents New Challenges

**Urgent message:** Acute rheumatic fever is not common but it does still occur, underscoring the need for head-to-toe examination in patients with vague symptoms that seem unconnected.

HEATHER VARLEY, PA-C, and WILLIAM GLUCKMAN, DO, MBA, FACEP

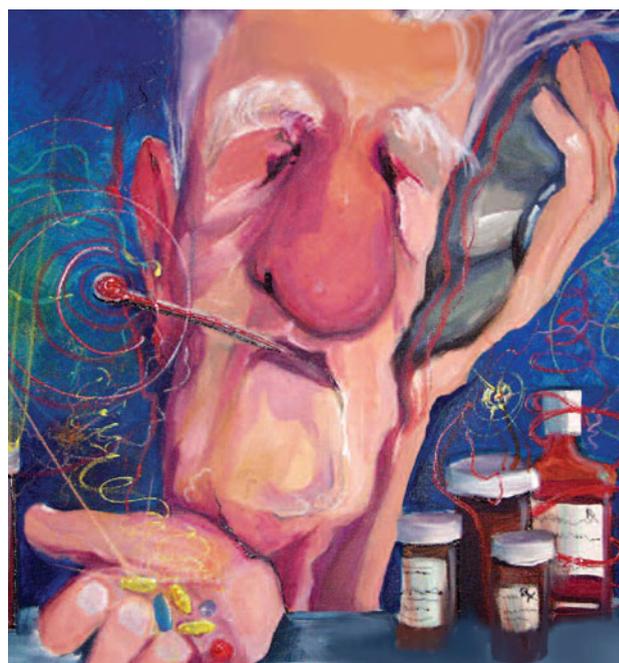
### Introduction

Patients with fever, sore throat, and malaise often present in the urgent care setting and they typically are worked up quickly with a rapid strep test or given a diagnosis of a viral syndrome. The case described here is an example of how important it is to listen carefully to all patients with such straight-forward symptoms and to evaluate them head to toe in order to draw connections between a range of common symptoms. It highlights the importance of thinking outside the box and keeping in mind conditions that may not be as common today as they were 50 years ago. The condition described here is not often encountered in everyday medical practice in the United States as it used to be, but it is one that should always be considered in order to make an accurate diagnosis and reduce adverse outcomes.

### Case Presentation

EW is a 56-year-old male who presented to the urgent care with low-grade fever ranging from 99.0°F to 101.0°F for 10 days, accompanied by malaise, myalgia, and severe diffuse joint pain. His polyarthralgia was noted to be most severe in both knees and wrists. He reported noting a diffuse red raised rash on his chest, back, bilateral legs, arms, and hands that was neither pruritic nor painful. He complained of moderate sore throat, intermittent headache, nasal congestion, and

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**Heather Varley** is a full-time Physician Assistant at and **William Gluckman** is President & CEO of FastER Urgent Care in Morris Plains, NJ.



intermittent dyspnea on exertion as symptoms related to the current presentation. After further questioning, the patient revealed that he had noted a mild to moderate sore throat intermittently over the past 3 weeks but did not seek treatment. The remainder of the history was found to be unremarkable. The patient reported no significant past medical history and no daily medications.

### Observations/Findings

Evaluation of the patient showed the following:

- T: 98.9°F
- RR: 18
- P: 96 bpm
- BP: 143/92
- O<sub>2</sub>: 96% RA
- Weight: 210 lb Height: 6'0"

Physical exam revealed a well-developed male in no acute distress. Positive exam findings included a diffuse maculopapular rash with mild superficial excoriation noted on bilateral arms, legs, hands, and trunk. Pharynx and tonsils were severely erythematous with mild swelling and no exudate (**Figure 1**). Submandibular and anterior cervical lymphadenopathy without tenderness was noted bilaterally. Examination of the extremities revealed mild swelling and erythema of the patient's left wrist and bilateral knees, without significant tenderness, limited range of motion or decreased strength. The heart was normal s1s2 without murmurs or rubs. The patient's lungs were clear bilaterally and there was no jugular venous distension. His abdomen was soft, nontender and without organomegaly.

### Diagnostic Studies

Tests performed in the office included the influenza A/B test, which was negative, and the Rapid *Streptococcus* Type A antigen test, which was positive.

### Diagnosis

#### *Acute Rheumatic Fever*

Based upon clinical suspicion for this diagnosis, further testing was completed in the office. An electrocardiogram (EKG) was performed which demonstrated a normal sinus rhythm, with no acute ST changes and no evidence of heart block (**Figure 2**). Blood was drawn and sent for a complete blood count (CBC) and measurements of C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), lyme antibody, alpha-hemolytic streptococci (AH), antistreptolysin O (ASO), and antideoxyribonuclease b (ADB). The patient was given a prescription for an outpatient echocardiogram to rule out involvement of heart valves and to assess cardiac output.

Lab results demonstrated an elevated white blood count (WBC) to 14.34 with bands, significantly elevated hsCRP to >100.0, as well as elevated CRP, ASO, ESR, and

rheumatoid factor.

An outpatient echocardiogram subsequently revealed normal systolic function, overall normal valve function with trace tricuspid and aortic insufficiency, and mild mitral regurgitation.

### Course and Treatment

The patient was prescribed amoxicillin 875 mg twice daily for 10 days to treat the strep infection. He was put on a prednisone taper for 10 days in order to treat the generalized inflammatory process associated with this condition. Acetaminophen and hydrocodone was prescribed for severe joint pain. The patient was referred to both an infectious disease specialist and a cardiologist for further evaluation and management. His symptoms completely resolved within 2 weeks after initiation of therapy.

### Discussion

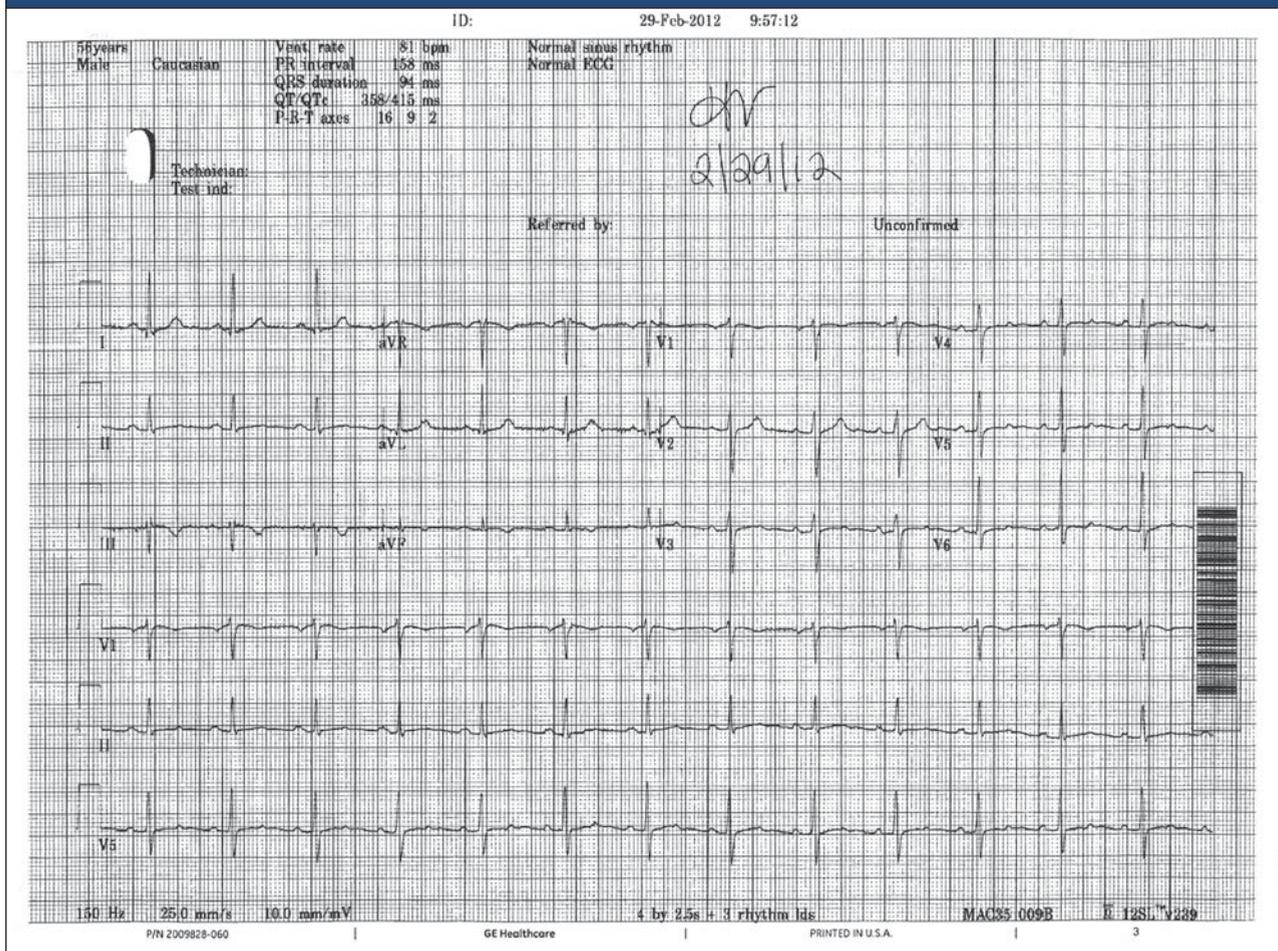
Acute rheumatic fever (ARF) is a systemic autoimmune process that develops in response to an untreated group A streptococcal pharyngitis infection. Strep pharyngitis is the only streptococcal infection associated with ARF. Streptococcal infections in other parts of the body have not demonstrated the same connection with the onset and development of ARF. ARF is characterized by inflammatory lesions of the joints, heart, subcutaneous (SQ) tissue, and the central nervous system. The likelihood of developing ARF after an occurrence of strep pharyngitis has been estimated at about 0.3% to 3%.

**Figure 1.**



Erythema of patient's pharynx.

Figure 2.



Overall, the incidence of ARF in developed nations has declined significantly over the past 50 years. This can be attributed to improved hygiene and aggressive treatment of strep pharyngitis, a clinical condition commonly encountered in the urgent care setting. ARF is most commonly noted in children aged 5 to 15 years, and is less common in those over 35. The symptoms of ARF typically begin to develop 2 to 3 weeks after the onset of pharyngitis. Symptoms include, but are not limited to, polyarthrits, carditis, chorea, erythema marginatum, fever, and sore throat. Signs include heart murmurs, cardiomegaly, rash, indications of congestive heart failure or pericarditis. The most detrimental sequelae of ARF is rheumatic heart disease. Rheumatic heart disease is the condition responsible for much of the morbidity and mortality caused by this disease process.

The *Jones Criteria* have classically been used to make a diagnosis of ARF. Major criteria include carditis, poly-

arthrits, chorea, erythema marginatum, and/or SQ nodules located over bones or tendons. Minor criteria include fever, arthralgia, previous rheumatic fever or rheumatic heart disease, acute phase reactants (leukocytosis, elevated ESR/CRP), and/or prolonged P-R interval on EKG. For diagnosis of ARF using the *Jones Criteria*, two major and two minor criteria must be met, in addition to evidence of a recent strep infection. It should be noted that if a strong clinical suspicion remains, and not all criteria have been satisfied, an appropriate work-up and treatment plan should still be implemented. It is important to keep this diagnosis in mind if a patient presents with any of the above signs or symptoms, even if the patient cannot clearly remember having a sore throat prior to the onset of the presentation.

The work-up for a patient with possible ARF includes measures to diagnose the condition, as well as those to exclude and identify the potential complications asso-

ciated with the disease process. A throat culture should be performed; however it should be noted that only 25% of patients have a positive throat culture at the time of diagnosis of ARF. Blood should be drawn to include CBC, ASO titers, deoxyribonuclease B, and anti-hyaluronidase lab tests. An EKG should be performed in the office to evaluate for cardiomegaly or potential heart block. An echocardiogram is essential to evaluate the heart valves and rule out rheumatic heart disease. The most common abnormal findings on echo noted in RHD are mitral regurgitation and aortic insufficiency.

Penicillin is the treatment of choice for treating the underlying streptococcal pharyngitis associated with ARF, because of its narrow spectrum of activity and the decreased likelihood of Group A *Streptococcus* resistance. For penicillin-allergic patients, a narrow-spectrum cephalosporin, clindamycin or a macrolide can be used. Anti-inflammatories including nonsteroidal anti-inflammatories or steroids are used to treat the inflammatory response in ARF. Aspirin and other non-opiate or opiate analgesics are used to reduce joint pain, which can be severe. If a patient presents with chorea, valproate sodium or haloperidol can be administered. The rash and SQ nodules sometimes associated with the condition are usually self-limited and don't require treatment, however, antihistamines can be used if there is any associated pruritus. A patients' immediate family and close contacts should have throat cultures performed and be prescribed appropriate antibiotic treatment if they test positive.

Acute attacks usually last about 12 weeks and usually leave no long-term damage to the brain, joints or skin, but cardiac effects may persist. ARF patients who develop endocarditis usually require short-term follow up with an infectious disease specialist, and long-term follow up with a cardiologist. Patients who have had ARF need to be counseled on the need for prophylaxis during future illnesses and medical procedures in order to decrease the likelihood of recurrence of the condition. People who have had ARF in the past are much more likely to develop ARF with future episodes of group A streptococcal pharyngitis.

ARF can have a very variable presentation and be difficult to diagnose because of the lack of a specific diagnosis

*The patient revealed that he had noted a mild to moderate sore throat intermittently over the past 3 weeks but did not seek treatment. The remainder of the history was found to be unremarkable.*

confirmative test. ARF is a strong example of the importance of taking a detailed history and performing a thorough head-to-toe exam when a patient presents with vague, seemingly unconnected symptoms. The patient here presented with a range of symptoms, and eliciting a history of a sore throat intermittently over the course of a few weeks was

important in bringing the possibility of a diagnosis of ARF to the forefront. Strong clinical suspicion based on signs and symptoms, and appropriate work-up to identify and treat potential complications associated with ARF are necessary when managing a patient with this complex condition. ■

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# Practice Management

## Making the Most of Locum Tenens in Your Urgent Care

**Urgent message:** Despite the best staff planning, urgent care centers sometimes need to turn to locum tenens firms to fill the “bench.” Understanding the challenges these firms face is one key to success.

ALAN A. AYERS, MBA, MAcc

Regardless of how aesthetically pleasing an urgent care facility, how convenient its hours, how creative its marketing, or how sophisticated its technology, the ultimate “product” is its clinicians and the solutions they provide for patients’ immediate medical problems. Without a provider ready and able to serve the public on a walk-in basis, an urgent care center is incapable of delivering value. So, what happens when an urgent care center is without a provider? It can turn patients away, it can close its doors, or it can fill schedule gaps with locum tenens and temporary clinicians. The need met by locum tenens providers is clear: They enable an urgent care center to sustain operations.

Ideally an urgent care center should be staffed by equity owners and employed clinicians whose personal interests are aligned with the long-term success of the operation. Such providers understand that positive medical outcomes and good patient experiences result in satisfied “customers” who not only return for services themselves, but tell friends and family to do likewise.

When a physician-owner or employed physician is incentivized by productivity and is vested in the financial returns of the practice, he/she focuses on providing clinically effective and cost-efficient care. Locum tenens providers are usually paid hourly for being present in the center and they’re typically self-



employed, so their personal interest is not to maximize patient satisfaction and center revenue but rather, to minimize the professional liability of an assignment. This lack of interest in the center’s success results in:

- A narrow focus on treating and discharging based on the immediate presenting medical condition versus developing collaborative relationships with patients because the locum tenens provider likely will not be at the center if/when the patient returns. Patients often complain about this lack of continuity in care.

Alan Ayers is Content Advisor, Urgent Care Association of America, Associate Editor—Practice Management, *Journal of Urgent Care Medicine*, and Vice President, Concentra Urgent Care.

- Risk-aversion (a desire to avoid potential malpractice claims) leading to conservatism in diagnosis and treatment. For example, ordering unnecessary lab tests or imaging studies, refusing to prescribe narcotics, or referring more complex cases to the emergency room. In addition to lost patient revenue, additional services can lead to financial losses on flat-rate insurance contracts.
- Shortcomings in chart documentation leading to under-coding of E/M levels of service, mis-coding of procedures, or omitting procedure and ancillary codes because the locum tenens provider gets his/her hourly rate regardless of the revenue he/she generates.
- Referring patients to specialists who don't need such referrals and not referring patients who actually require specialist care. Referral of patients to specialists the locum tenens provider knows instead of to in-system or in-network providers also is common.
- Extended wait times because locum tenens providers—not incentivized on productivity—may spend more time in patient encounters as a result of unfamiliarity with systems and processes or feel less compelled to keep flow moving.

Unlike owners and employed clinicians, locum tenens providers are usually disengaged from the culture and management of the center, which can undermine the cohesion of center teams. Friction occurs when the locum tenens provider introduces new ways of doing things or refuses to follow the center's operating procedures. When new clinicians circulate through a center, medical assistants become confused as to medical orders, patient/procedure set-ups, and chart documentation.

The financial bottom line of an urgent care center that relies on locum tenens can suffer—because in addition to these issues with coding and referrals,

*The better “fit” its candidates, the more satisfied a staffing agency’s clients, so partner with the staffing agency by setting clear expectations as to the skills, experience, and personal attributes expected of a locum tenens provider.*

inefficiency in flow, and lost patient loyalty—locum tenens are often expensive. A center not only pays the provider's hourly wage, but it also incurs agency fees and travel costs.

#### **Locum Tenens and Occupational Medicine**

For centers that provide occupational medicine services, additional issues with locum tenens providers can impact relationships with employers who send patients to an urgent care center for

workplace injuries, physical exams, and other compliance and prevention services. Temporary clinicians are often:

- Unwilling to or unskilled in communicating with employers in workers' compensation cases, resulting in dissatisfied clients and lost accounts.
- Unwilling or unskilled in selling the center's services to prospective customers (or conducting case reviews with existing customers), resulting in lost sales opportunities.
- Too quick to prescribe medications and/or assign time off/limited duty to injured workers, resulting in reportable workers' compensation cases that raise the cost of claims for employers. Time off from work (as opposed to medical claims) is the primary cost driver in workers' compensation.
- Unfamiliar with Occupational Safety and Health Administration standards or Department of Transportation procedures and forms, resulting in errors that can jeopardize a client's compliance with federal regulations.

Unless a locum tenens provider has specific experience with workers' compensation and employer services, his/her involvement with occupational medicine can result in a longer case duration for workplace injuries and increased risk to employers on compliance services.

#### **Minimizing the Risk of Locum Tenens Providers**

The surest way to avoid the issues associated with locum tenens providers is to have a “bench” of trusted clinicians available to work in the center as needs arise on the cen-

ter's schedule. Some centers establish relationships with medical residents or primary care providers willing to "moonlight" at the center—which works particularly well for planned absences including vacation, maternity leave, and continuing medical education. But unanticipated events such as provider resignations and personal and family illness still occur, so when a center has no alternative but to use locum tenens providers to fill shifts, an urgent care operator can mitigate the risks by:

- Interviewing locums tenens providers put forth by the agency—assessing their comfort level, risk tolerance, and cultural fit—before assigning them to schedule openings.
- Requiring that temporary providers have prior experience working in an urgent care setting and thus grasp the concepts of "consumer-focused health care" such as efficiency, short wait times, and positive bedside manner.
- Limiting the number of providers who circulate through the center by using the same locum tenens provider every time a schedule void arises.
- Documenting operating processes, having detailed written policies and procedures, and creating job aids such as "checklists" and "cheat sheets" to support clinicians in routine tasks.
- Taking time to orient locums tenens providers to the center's culture, processes, and systems by having locums tenens providers "shadow" the center's permanent physicians before working solo.
- Assigning an experienced staff member—such as an RN or LPN—to act as "scribe" to the locum tenens provider, assuming the tasks of chart documentation and processing orders and referrals.
- Conducting chart reviews—focusing on documentation and coding—before submitting insurance claims. Locum tenens providers should be coached on the review findings to improve their documentation going forward.
- Devising temporary employment agreements that go beyond an hourly rate to incentivize

*Locum tenens providers are usually disengaged from the culture and management of the center, which can undermine the cohesion of center teams. Friction occurs when the locum tenens provider introduces new ways of doing things.*

locum tenens providers according to their efficiency, productivity, profitability, and patient satisfaction.

- Arranging the center's staffing schedule so that locum tenens providers work solo during the least busy hours or days of the week.

It's also important to ensure that medical staffing agencies understand the center's scope of practice, culture, systems, and patient base. While some agencies have a reputation for get-

ting "warm bodies" into centers, those that "work" for their agency fees ensure that the providers they place are a great "match"—capable of meeting patient needs and functioning on the center team as a "vested" provider. The better "fit" its candidates, the more satisfied a staffing agency's clients, so partner with the staffing agency by setting clear expectations as to the skills, experience, and personal attributes expected of a locum tenens provider. Also avoid "throwing" clinicians "into the fire" by working with the agency to define a clear "on-boarding" or training process.

#### **Develop a Long-Term Staffing Strategy**

Urgent care is rapidly growing as an important component of the nation's medical delivery system. Not only do consumers embrace the convenience of extended-hours walk-in service, many find access to a regular primary care physician increasingly limited. But all statistics pointing to a primary care physician shortage in the United States also mean that recruiting physicians to work in urgent care centers is only going to become more difficult in the future. The timeline for replacing or filling a physician opening can already exceed 9 to 12 months depending on a center's geographic location. As an urgent care center sees increased utilization, expands its hours, and opens new locations, the strain on its existing providers will continue to increase. The best defense is business continuity plan that anticipates and addresses physician staffing needs.

Certainly an urgent care center should have a contingency plan to cover planned absences like paid



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time off, continuing medical education, and pregnancy as well as unplanned absences including personal and family medical leave. In addition, the contingency plan should address variations in center volume due to promotional campaigns (such as back-to-school physicals) and seasonal variations (such as summer injuries, spring allergies, and winter flu).

Long-term factors that affect a center's provider staffing needs include:

- Organic growth of the business through marketing and repeat business
- Addition of new insurance contracts and insurance benefit changes such as reduced co-pays for urgent care
- Changes in scope of practice due to reduced availability of medical services in the community
- Addition of ancillary services like travel medicine or immigration physicals
- Expansion of operating hours
- Addition of new locations

Urgent care operators can avoid being caught off-guard by incorporating provider staffing into all strategic business discussions. Business changes should be planned sufficiently in advance to ensure clinical coverage—whether by full-time, part-time, temporary or locum tenens providers. Otherwise, failure to account for provider staffing can seriously inhibit a center's ability to grow and take advantage of market opportunities.

### Conclusion

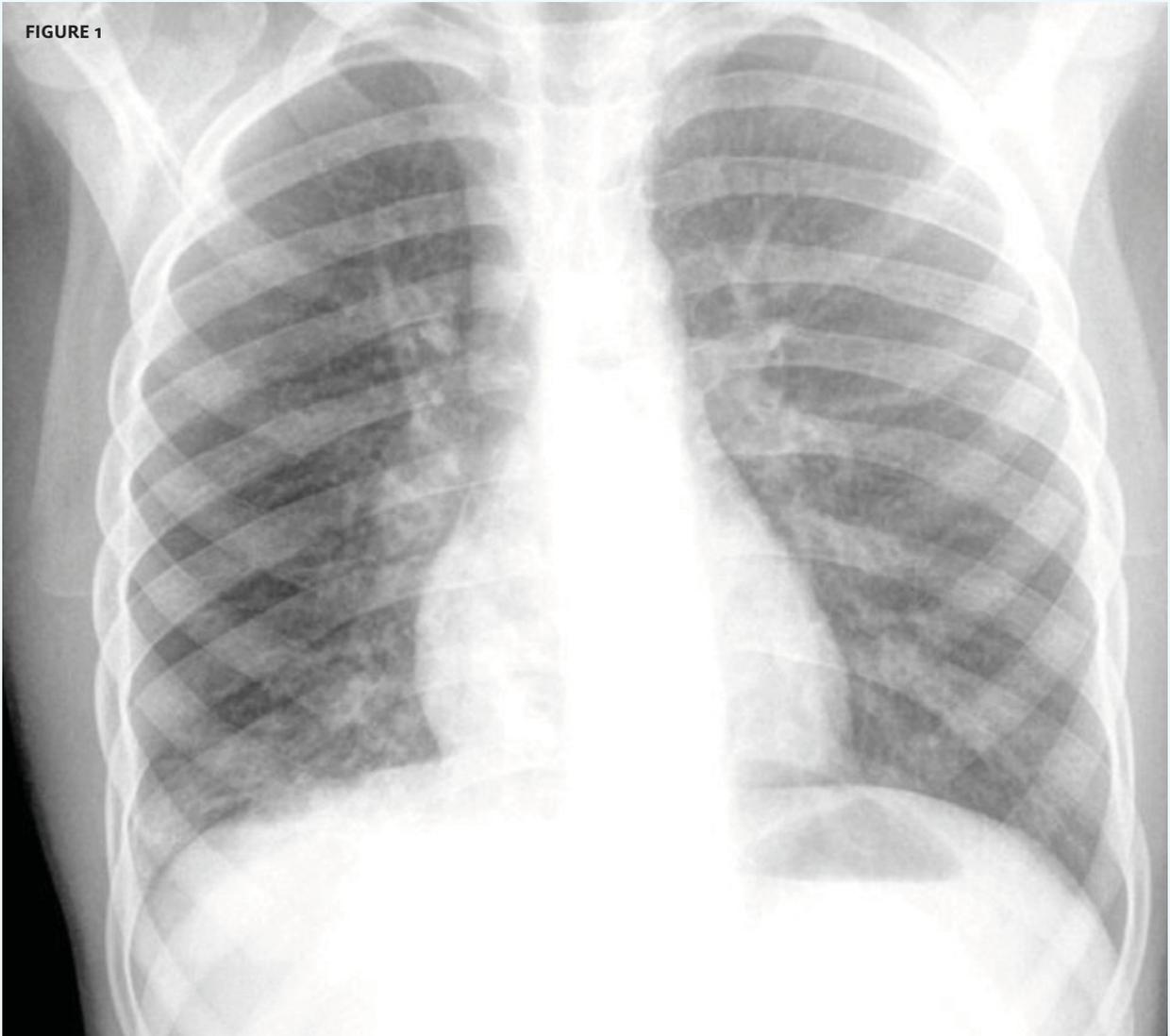
The "product" of an urgent care center is its clinicians and the services they provide. Successful urgent care centers constantly account for provider staffing—anticipating short- and long-term variations and ensuring a plan to cover all provider shifts. But despite its best efforts to cultivate a "bench" of available providers, a center may still find itself in need of the temporary support provided by locum tenens. Key to success is understanding the typical challenges of utilizing locum tenens providers, working with medical staffing agencies to ensure that temporary providers have the necessary experience and are a good cultural fit, aligning the center and the provider's financial interests, and investing time and resources in training and on-boarding. ■



In each issue, *JUCM* will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of dermatologic conditions that real urgent care patients have presented with.

If you would like to submit a case for consideration, please email the relevant materials and presenting information to [editor@jucm.com](mailto:editor@jucm.com).

FIGURE 1



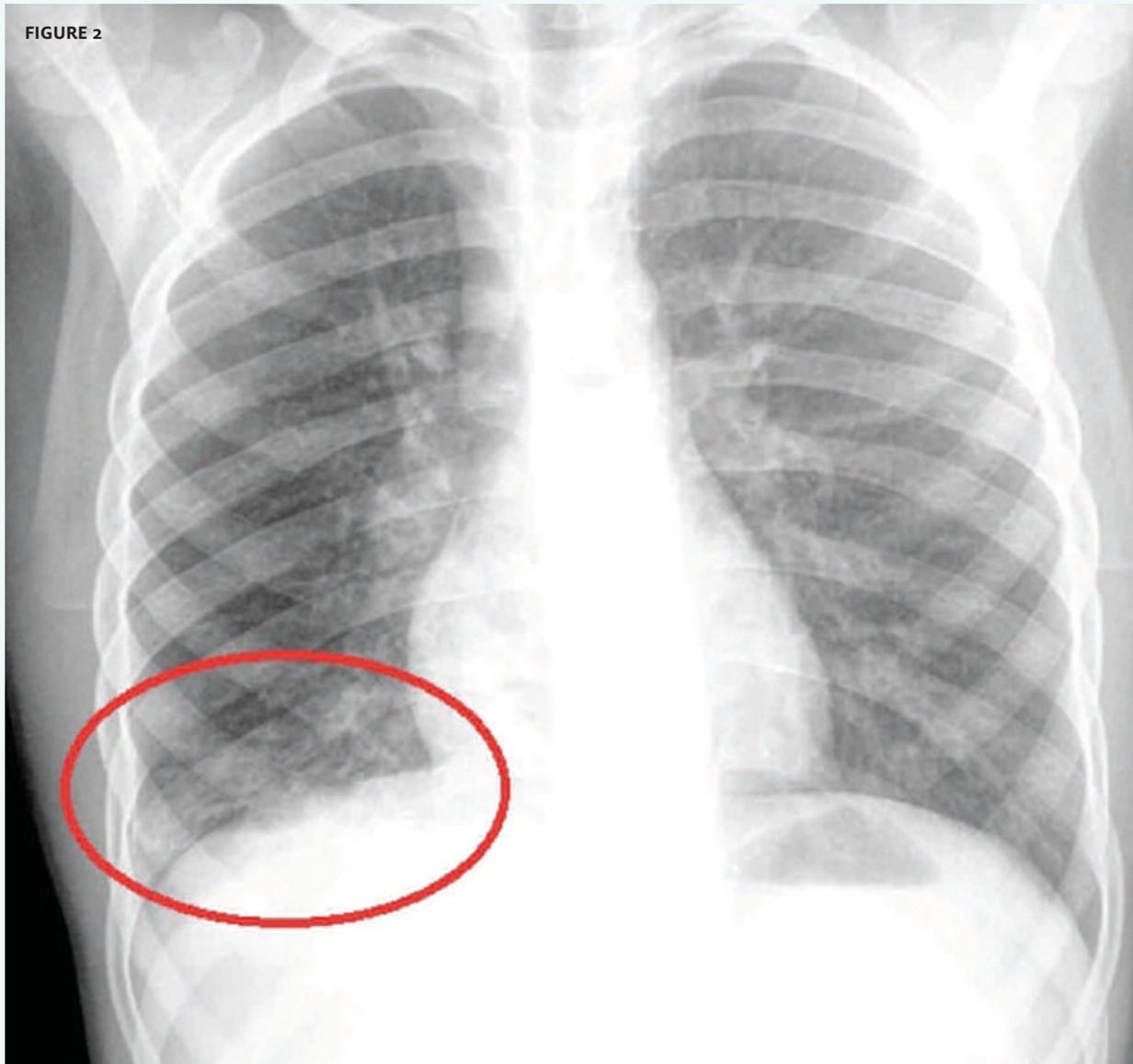
The patient, an 8-year-old male, presented with a cough and fever.

View the image taken (**Figure 1**) and consider what your diagnosis would be.

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2



Diagnosis: The x-ray reveals infiltrate in the right lower lobe of the lung (circle). This patient has pneumonia.

Acknowledgement: Case presented by Nahum Kovalski, BSc, MDCM, Terem Emergency Medical Centers, Jerusalem, Israel.



FIGURE 1



The patient, a 76-year-old woman, presented with a blow to her right wrist.

View the image taken (**Figure 1**) and consider what your diagnosis would be.

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2



Diagnosis: The x-ray reveals a fracture of the scaphoid (arrow). A spica cast and follow up with an orthopedist are appropriate for this patient.

*Acknowledgement: Case presented by Nahum Kovalski, BSc, MDCM, Terem Emergency Medical Centers, Jerusalem, Israel.*



## ‘Why Can’t We All Get Along?’

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

It’s not often you get to quote the late Rodney King, but there it is. Mr. King’s quote was made famous during the Los Angeles riots, which were arguably incited by the acquittal of the police officers accused of excessive force during Mr. King’s arrest.

In 1860, a book review on medico-legal jurisprudence argued that “law and medicine had evolved into mutually incompatible professions.”<sup>1</sup> One hundred and sixty-two years later, it appears to only have gotten worse and we, too, are still not getting along.

In 1878 a physician named Eugene Sanger wrote that medical malpractice lawyers “follow us as the shark does the emigrant ship.”<sup>2</sup> More than 100 years later, the president of the Association of American Medical Colleges reportedly told a graduating medical school class that “We’re swimming in shark infested waters where the sharks are lawyers.” Finally, in 2009, *The Wall Street Journal* published an op-ed commentary by a physician calling lawyers, “sharks” and “sleazy sneaks with shady billing practices.”<sup>3</sup>

Clearly, animus exists between the two professions and I suspect that physician animosity directed at attorneys trumps the converse. As someone who goes both ways (no, not in the Elton John sense) I believe I may be in a good position to opine upon what we can do to improve this state of mutual loathing.

First, does the state of affairs need to be improved? I believe it does. Lawyers and doctors comprise two of the most learned (and possibly well-respected) professions today. Both have similar aspirations — to help those in need of assistance. Both professions abide by ethical standards and are subject to a standard-of-care analysis if a suspected breach occurs.

What is the basis of the animosity? It is probably multifactorial. Here are some of the reasons that I believe led to it. Physicians and lawyers seek the “truth” in different ways using different standards. In health care the truth is defined as clinically proven, reproducible outcomes using rigorous scien-

*Both doctors and lawyers should have an interest in protecting what is left of our autonomy to protect and improve the stature of both professions. In addition, we need each other.*

tific methodology performed in the best interest of the patient’s mental and physical well-being.

Conversely, physicians believe that “truth” in the legal sense is highly subjective and is determined using whatever means and whichever outcome—fair or unfair, the judge or jury will believe. When I ask for specifics about why physicians hate the legal system, I always hear things like “look at OJ” or “what about Casey Anthony” or, “Did you hear about the woman who won like a zillion dollars from McDonalds after she spilled coffee on herself?”

Given the above perceptions about the integrity of the legal process, physicians fear medical malpractice suits. Because, generally speaking, an attorney is usually the person who files the suit, physicians have come to loathe the entire legal profession even if only a small percentage of attorneys engage in medical malpractice law on the plaintiff side.

Maybe we have good reason to loathe attorneys. Medical malpractice suits affect medical providers very deeply. They can damage our reputations, place personal assets at risk, drive up insurance rates, and be a contributing factor for depression, thoughts of suicide, and substance abuse.

I know of more than a few providers who have never psychologically recovered after being named in a medical malpractice suit. It affected all aspects of their life, and no matter what was said, they took the suit as a personal affront on their integrity, intelligence, medical skills, and compassion. The plaintiff’s attorney became the object of continual scorn and ridicule and was by all measures “evil incarnate.”

A study published in *The New England Journal of Medicine* demonstrated “[b]y the age of 65 years, 75% of physicians in low-risk specialties and 99% of those in high-risk specialties



**John Shufeldt** is principal of Shufeldt Consulting and sits on the Editorial Board of *JUCM*. He may be contacted at [jshufeldt@shufeldtconsulting.com](mailto:jshufeldt@shufeldtconsulting.com).

were projected to face a claim. The projected career risk of making an indemnity payment was also large. Roughly 5% of physicians in low-risk specialties and 33% in high-risk specialties were projected to make their first indemnity payment by the age of 45 years; by the age of 65 years, the risks had increased to 19% and 71%, respectively.<sup>4</sup>

I can tell you from my own experience that physicians view medical malpractice suits very differently than attorneys and with statistics like these, it is no wonder attorneys for the last 160 years have been our nemesis. Robert Gillette in his article entitled “Malpractice, Why Physicians and Lawyers Differ,” had this to say: “Lawyers, I find, appear to look upon a lawsuit as the medical professional does a case of chicken pox—unpleasant perhaps, but no cause for shame and certainly not the end of the world. To an attorney, a malpractice action means another client to be listened to and another set of papers to be filed at the courthouse.”<sup>5</sup>

It also means going at risk for the costs associated with proffering a case. These costs generally are in excess of \$70,000, which comes out of the attorney’s pocket if the plaintiff does not prevail. Despite the costs and the tediousness of medical malpractice cases, filing suits is simply an attorney’s job. And they approach their job, much as we do—once they decide to accept a case they are *all in*. To be anything less would be legal malpractice.

The good news for us is that the number of medical malpractice suit filings continues to drop year over year. In Phoenix, I am told that this number has decreased by more than 40% year over year. It is to the point where even the defense lawyers are becoming more vocal about their lack of work. Why is this? Are we getting that good? Maybe. More likely is that the cost to bring a case forward has become so burdensome that most plaintiff attorneys are only taking ones they believe are “slam dunks” (a number of plaintiff attorneys have told me that they typically only take 2 to 3 cases out of the 100 that present to their office).

Why is it important to get along? From a purely business standpoint we should learn to lower the swords to protect our own pocketbooks. It does little good to rail against a profession which, during our rapidly changing health care environment, will play an integral role in our own wellbeing. The main reason is that physicians are losing their autonomy. We practice in a highly regulated environment which will only become more intrusive. Both doctors and lawyers should have an interest in protecting what is left of our autonomy to protect and improve the stature of both professions. In addition, we need each other. We need attorneys to help us navigate our highly regulated environment and lawyers need us to provide care. Not to mention the fact that attorneys are helping us clean up our own ranks. I have seen a number of instances where physicians practicing well below the standard were allowed to continue to

harm patients until a suit exposed how poorly they performed. Finally, as doctors and lawyers duke it out who, other than the insurance companies, really wins?

Here are a few things to wrap your head around regarding the relationship between the two professions.

1. Plaintiff lawyers who accept medical malpractice cases do not undertake their decisions lightly. They know they will have to spend hundreds of hours and thousands of dollars for the possibility of being paid on a contingency basis. Typical costs for bringing a case up to trial are in excess of \$70,000.
2. A plaintiff’s attorney will pursue a case with the same zealousness we demonstrate when taking care of a sick patient. To do anything less would be legal malpractice.
3. As a profession we have not always done a great job of policing ourselves. If for no other reason, the threat of medical malpractice has helped us raise the bar.
4. Being sued is a cost of doing business. Sometimes bad things happen to patients and when they do, a patient deserves compensation. I have had close friends forever impaired from negligent acts that fell below the standard of care. As much as I hate to say it, I was thrilled when they received a judgment that helped them pay for long-term care.
5. Chances are you will be named in a lawsuit. When it happens, be prepared mentally. It is not career ending. It is not life altering. It is a cost of doing what we do. That is what insurance is for.
6. Physicians prevail most of the time and very few suits even make it to court. Most suits are dropped during discovery or settled.
7. Ways to avoid malpractice are to be as compassionate and as communicative as possible when dealing with patients. Give and document informed consent discussions with patients. Chart pertinent negatives particularly when their absence determines the path you take.
8. Apologize without admitting guilt and refund money when indicated.
9. Get to know some attorneys. I have found them to be a lot like us. Generally well meaning, thoughtful, and caring.
10. Act as an expert witness. You will get a birds-eye view of the legal profession and learn a lot of medicine while doing it.
11. Finally, remember Rodney King—at the end of the day, even in LA, we did all finally get along. ■

1. Review in New York Medical Press of John Elwell’s *A Medical Treatise of Malpractice, Medical Evidence and Insanity*.  
 2. Mohr JC. American medical malpractice litigation in historical perspective. *JAMA*. 2000;283(13):1731-1737.  
 3. Rafal RA. A doctor’s plan for legal industry reform. *Wall Street Journal*. September 4, 2009.  
 4. Jena AB, Seabury S, Lakdawalla D, Chanda A. Malpractice risk according to physician specialty. *N Engl J Med*. 2011;365(7):629-636.  
 5. Gillette R. Malpractice: Why physicians and lawyers differ. *J Legal Med*. October 1976.



# ABSTRACTS IN URGENT CARE

- OTC pain relievers and burn risk
- Group A strep guidelines
- IOM report on healthcare spending
- Acellular pertussis vaccine
- Preventing falls in the elderly
- Physicians and unfit drivers
- Keys to longevity
- Imaging in acute cholecystitis
- Syncope and structural heart disease
- Asymptomatic bacteriuria
- *E. coli* and HUS

■ NAHUM KOVALSKI, BSc, MDCM

Each month, Dr. Nahum Kovalski reviews a handful of abstracts from, or relevant to, urgent care practices and practitioners. For the full reports, go to the source cited under each title.

## OTC Topical Pain Relievers Pose Burn Risk

**Key point:** Over-the-counter topical muscle and joint pain relievers containing capsaicin, methyl salicylate, or menthol (e.g., Bengay, Icy Hot) may cause serious chemical burns.

**Citation:** <http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm319353.htm>

A review of two adverse drug event databases, as well as the medical literature, found 43 reports of burns linked to these products. Those containing menthol were the most likely to cause second- and third-degree burns.

The FDA advises clinicians to warn patients about the burn risk and to provide guidance on using the products appropriately. In particular, the pain relievers should not be applied to broken or damaged skin; the area should not be bandaged tightly; and heating pads should not be used. ■

## Clinical Practice Guideline for the Diagnosis and Management of Group A Streptococcal Pharyngitis: 2012 Update by the Infectious Diseases Society of America

**Key point:** The Infectious Diseases Society of America has updated its 2002 guidelines for diagnosing and treating group A streptococcal (GAS) pharyngitis.



Nahum Kovalski is an urgent care practitioner and Assistant Medical Director/CIO at Terem Emergency Medical Centers in Jerusalem, Israel. He also sits on the JUCM Editorial Board.

**Citation:** Shulman ST, Bisno AL, Clegg HW, et al. Clinical practice guidelines for the diagnosis and management of Group A streptococcal pharyngitis: 2012 update by the Infectious Diseases Society of America. *Clin Infect Dis.* (2012) doi: 10.1093/cid/cis629

Among the recommendations, published in *Clinical Infectious Diseases*:

- Rapid antigen detection tests and/or throat culture should be performed to diagnose GAS pharyngitis. Negative antigen tests should be followed up with throat cultures in children and adolescents, but not adults. (The incidence of strep in adults is low, as are risks for complications, such as rheumatic fever.)
- In patients with viral symptoms (e.g., cough, oral ulcers, rhinorrhea), testing for GAS pharyngitis is usually not recommended.
- Testing is not necessary in children under age 3 years unless they have an older sibling with GAS infection or other risk factors.
- Ten days of penicillin or amoxicillin is recommended for nonallergic patients.
- Patients with penicillin allergies may take a 10-day course of a first-generation cephalosporin, clindamycin, clarithromycin, or 5 days of azithromycin. ■

## IOM: One Third of Healthcare Dollars Wasted

**Key point:** Roughly one third of the money spent on U.S. health-care in 2009 — about \$750 billion — didn't improve patients' health.

Citation: <http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx>

The report, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, outlined six categories of waste — unnecessary services, inefficient delivery of care, unnecessary administrative costs, inflated prices, missed opportunities for prevention, and fraud.

Among the group's recommendations to help improve care while reducing cost:

- Decision-support tools and knowledge management systems at point of care should be an integral part of the healthcare system.
- Clinicians should use digital systems to capture patient care experiences.
- Patients and caregivers should be encouraged to partner with clinicians in making healthcare decisions.
- Clinicians should partner with community-based organizations and public health agencies to coordinate interventions to improve health, including use of Web-based tools.
- The payment system should be reformed to reward quality care.

### Protection From Acellular Pertussis Vaccine Wanes After 5 Years

**Key point:** Risk for pertussis increased 42% each year after the fifth dose of DTaP.

Citation: Klein NP, Bartlett J, Rowhani-Rahbar A, Fireman B, Baxter R.

Waning protection after fifth dose of acellular pertussis vaccine in children. *N Engl J Med.* 2012;367(11):1012-1019.

In 2010, California had a large pertussis outbreak among children, many of whom were fully vaccinated. Investigators examined the duration of protection after a fifth dose of the diphtheria, tetanus, and acellular pertussis vaccine (DTaP; given between ages 47 and 84 months) in a case-control study of Kaiser Permanente Northern California members who had polymerase-chain-reaction (PCR) pertussis tests between 2006 and 2011. The researchers compared 277 children (age range, 4–12 years) who were PCR positive for pertussis, 3318 PCR-negative children with a cough illness, and 6068 matched controls.

Older children had a higher percentage of pertussis cases than younger children (range, 4.5% in 6-year-olds to 18.5% in 10-year-olds). Children with pertussis had a significantly longer time since the fifth DTaP dose and received that dose earlier than controls. The risk for pertussis increased 42% each year after the fifth dose of DTaP.

Published in *J Watch Ped Adol Med.* September 12, 2012 —

Peggy Sue Weintrub, MD. ■

### Exercise and Home Safety Interventions Prevent Falls in Older Adults

**Key point:** Group and home-based exercise programs, as well as home safety interventions, help prevent falls among community-dwelling older adults.

Citation: Gillespie LD, Robertson MC, Gillespie WJ, et al. *Cochrane Collaboration.* DOI: 10.1002/14651858.CD007146.pub3

In an update of its 2009 review, the group assessed 159 randomized trials of fall prevention interventions with nearly 80,000 participants aged 60 and older.

Among the other interventions that helped reduce the rate of falls or risk for falls:

- Multifactorial interventions, including individualized risk assessment
- Tai chi
- Pacemakers, in patients with carotid sinus hypersensitivity
- First eye cataract surgery in women
- Gradual withdrawal of psychotropic drugs
- Changes in prescribing behavior by primary care physicians
- An anti-slip shoe device in icy conditions

Some of the interventions that did not have an effect include:

- Vitamin D supplementation in people with normal vitamin D levels
- Patient education alone
- Cognitive-behavioral therapy

### Telling Dad to Get Off the Road

**Key point:** A program mandating that physicians warn and report problematic drivers almost halved the accident rate.

Citation: Redelmeier DA, Yarnell CJ, Thiruchelvam D, Tibshirani RJ. Physicians' warnings for unfit drivers and the risk of trauma from road crashes. *N Engl J Med* 2012;367(13):1228-1236.

Physicians often dread the “Dad is too old to drive” conversation, which forces them to weigh public safety against the interests of an individual patient. Studies have been equivocal as to whether these conversations actually make a difference in accident rates.

In Ontario, Canada, doctors are mandated to confront patients whom they judge to be potentially unfit drivers and to report such patients to authorities. Depending on the particulars of a case, the patient's driver's license might or might not be revoked immediately.

Researchers evaluated the policy's effectiveness by comparing patients' accident rates before and after physicians got involved. From 2006 to 2009, most of the 100,000 patients who

received physicians' formal warnings against driving were suffering from such common medical conditions as syncope (26%), diabetes (18%), and dementia (14%); epilepsy accounted for 10%. Compared with baseline accident rates among patients during the 3 years before their warnings, rates following warnings fell by about 45% in the next year. This decline was consistent among all age groups and all diagnostic groups; the decline in accident rates among patients older than 75 was particularly high (66%).

Patients' visits to physicians responsible for issuing warnings fell by about 25% in the year following warnings; 10% of patients who had made at least two visits in the previous year did not visit those physicians at all. Total rates of all visits to all physicians did not change appreciably, but emergency room visits for depression increased by about 25%.

Published in *J Watch Gen Med*. September 27, 2012 — Abigail Zuger, MD. ■

### The Key to Longevity After Age 75?

**Key point:** *Don't smoke, have rich social interactions, and engage in leisure activities.*

**Citation:** Rizzuto D, Orsini N, Qiu C, Wang HX, Fratiglioni L. Lifestyle, social factors, and survival after age 75: Population based study. *BMJ*. 2012 Aug 29;345:e5568. doi: 10.1136/bmj.e5568.

In very few studies have researchers examined the association between modifiable risk factors (e.g., smoking, alcohol consumption, and weight) and longevity in elders. Swedish investigators identified and examined these associations in a prospective, population-based, cohort study of more than 1800 older people (age, >75) who were followed for 18 years; half the participants lived beyond age 90.

In age-adjusted analyses, the median age at death was 1.1 years higher for normal-weight versus underweight participants; 1.3 years higher for never smokers versus current smokers; 1.3 years higher for alcohol drinkers versus never drinkers; 1.6 years higher for participants with rich social networks versus those with limited or poor networks; and 1.0 to 2.3 years higher for participants who engaged in mental, social, physical, and productive leisure activities versus those who did not. Multivariate analyses affirmed the salutary effects of not smoking and of social, physical, and productive (e.g., gardening, sewing, volunteer work) leisure activities. The median survival of participants with low-risk profiles (i.e., healthy behaviors, rich social network, and participation in leisure activities) was 5.4 years longer than that of participants with high-risk profiles. These associations were present in men and women, the oldest age group (>85), and those with chronic diseases.

Published in *J Watch Gen Med*. September 27, 2012 — Paul S. Mueller, MD, MPH, FACP. ■

### Imaging in Acute Cholecystitis

**Key point:** *Cholescintigraphy is more accurate in diagnosing cholecystitis, but ultrasound is more readily available. However, sensitivity and specificity of US should be considered only approximations, given the varying criteria for positive tests! Accuracy of CT for acute cholecystitis has NOT been studied adequately.*

**Citation:** Kiewiet JJS, Leewenburgh MMN, Bipat S, et al. A systematic review and meta-analysis of diagnostic performance of imaging in acute cholecystitis. *Radiology*. 2012;264:708-720.

Ultrasound (US) and cholescintigraphy (e.g., hepatobiliary iminodiacetic acid [HIDA] scanning) are used widely to evaluate patients with suspected acute cholecystitis. Additionally, emergency department clinicians sometimes order computed tomography (CT) as the initial test, especially when they are considering both biliary and nonbiliary causes of abdominal pain.

To address the diagnostic accuracy of imaging tests for acute cholecystitis, researchers performed a meta-analysis of 57 studies with explicitly stated criteria for positive tests and with surgery and clinical follow-up as reference standards. Cholescintigraphy was evaluated in 40 studies, and US was evaluated in 26 studies; CT and magnetic resonance imaging were evaluated in only 1 and 3 studies, respectively. For cholescintigraphy, sensitivity was 96% and specificity was 90%; nonvisualization of the gallbladder was the usual criterion for a positive test. For US, sensitivity was 81% and specificity was 83%; criteria for a positive test varied widely, from simple presence of gallstones to combinations of additional findings (e.g., wall thickening, distention, pericholecystic fluid, sonographic Murphy sign).

Published in *J Watch Gen Med*. September 18, 2012 — Allan S. Brett, MD. ■

### Syncope Patients with a Normal ECG Are Unlikely to Have Structural Heart Disease

**Key point:** *No syncope patients admitted with a normal electrocardiogram had any abnormality on transthoracic echocardiogram.*

**Citation:** Anderson KL, Limkakeng A, Damuth E, Chandra A. Cardiac evaluation for structural abnormalities may not be required in patients presenting with syncope and a normal ECG result in an observation unit setting. *Ann Emerg Med*. 2012;60(4):478-484.

Although the differential diagnoses for syncope are myriad, most patients who present with syncope and are evaluated in an emergency department (ED) observation unit are discharged with no diagnosis and no identified cause of the syncopal episode.

In a retrospective chart review of 323 consecutive patients

admitted to a single ED observation unit after a syncopal episode, researchers evaluated the utility of structural evaluation of the heart by echocardiography. Overall, 294 patients (91%) underwent echocardiography (transthoracic in 270, stress in 24).

Of 267 patients who presented with normal electrocardiogram (ECG) results, 235 underwent transthoracic echocardiography and none had structural heart disease identified on echocardiogram. One patient had a positive troponin, two patients showed evidence of ischemia on stress echocardiogram, and two patients exhibited transient dysrhythmia while being monitored.

Of 56 patients who presented with abnormal ECGs, 35 underwent transthoracic echocardiography and 7 (20%) were abnormal.

Published in *J Watch Emerg Med*. October 19, 2012 — Richard D. Zane, MD, FAAEM. ■

### As Always, Asymptomatic Bacteriuria Is Best Ignored

**Key point:** A study in healthy young women confirms that treatment for asymptomatic bacteriuria leads to trouble.

Citations: Cai T, Mazzoli S, Mondaini N, et al. The role of asymptomatic bacteriuria in young women with recurrent urinary tract infections: To treat or not to treat? *Clin Infect Dis* 2012 Sep 15; 55(6):771-777. Doi: 10.1093/cid/cis534. Epub 2012 Jun 7 and Wagenlehner FME and Naber KG. Asymptomatic bacteriuria — Shift of paradigm. *Clin Infect Dis*. 2012; 55(6): Sep 15; 55:778-780. Doi: 10.1093/cid/cis541.

Many clinicians treat patients who have asymptomatic bacteriuria (AB), but studies have confirmed that AB treatment provides no benefit in many groups, including older people, diabetic patients, and those with spinal cord injuries. Similar evidence now is provided for healthy young women with recurrent urinary tract infections (UTIs).

Almost 700 sexually active premenopausal women with AB who presented to a single Italian clinic were randomized to receive unblinded treatment or to be followed without treatment. All participants had experienced at least one UTI in the previous year. Those who were treated received oral antibiotics, to which their microbial isolates were confirmed to be sensitive.

After 3 months, 3.5% of untreated women and 8.8% of treated women experienced new symptomatic UTIs. The curves continued to diverge: By 1 year of follow-up, UTI recurrence rates were dramatically higher in the treated group (by our calculations from the data provided, cumulative UTI recurrence rates were 24% in the untreated group and 83% in the treated group). Rates of pyelonephritis were similar between groups.

At the beginning of the study, most bacterial isolates were *Escherichia coli* (39%) or *Enterococcus faecalis* (33%). One year later, urine samples from most recurrence-free patients in the non-treatment group grew *E. faecalis*, whereas most samples from the few treated patients who were recurrence free grew *E. coli*.

Published in *J Watch Gen Med*. October 11, 2012 — Abigail Zuger, MD. ■

### New *E. coli* Causes HUS

**Key point:** Shiga toxin-producing *Escherichia coli* O104:H4 caused the largest outbreak of hemolytic uremic syndrome ever reported.

Citations: Loos S, Ahlenstiel T, Kranz B, et al. An outbreak of Shiga toxin-producing *Escherichia coli* O104:H4 hemolytic uremic syndrome in Germany: Presentation and short-term outcome in children. *Clin Infect Dis*. 2012;55(6):753-759. Doi: 10.1093/cid/cis531 and Tarr PL and Karpman D. *Escherichia coli* O104:H4 and hemolytic uremic syndrome: The analysis begins. *Clin Infect Dis*. 2012;55(6):760-763. Doi: 10.1093/cid/cis533.

Hemolytic uremic syndrome (HUS) is characterized by hemolytic anemia, thrombocytopenia, and acute renal failure — often together with neurologic deficits. Past outbreaks typically have involved children aged <5 years and have been attributable to gastrointestinal infection by enterohemorrhagic *Escherichia coli* — often type O157:H7. Shiga toxins (Stx) types 1 and 2, produced by these pathogens, play an important role in inducing HUS.

An outbreak of Shiga toxin-producing *Escherichia coli* (STEC) infections began in Germany in the spring of 2011, ultimately resulting in >3800 reported cases; 845 of the patients developed HUS. Uncharacteristically, 88% of the HUS patients were adults. The causative organism — *E. coli* serotype O104:H4 — produces Stx2 and is resistant to all -lactam antibiotics and cephalosporins. Analysis revealed virulence characteristics of both STEC and enteroaggregative *E. coli*.

Among the 90 children with HUS who were studied, the median age was 11.5 years (range, 0.6–17.5); only 20% of the children were aged <5 years. The median duration of the prodromal phase (mild to moderate gastrointestinal symptoms) before HUS onset was 5 days (range, 0–14), and the median duration of hospitalization was 17 days (range, 2–103). Ninety-six percent of the children had diarrhea; 73% had bloody diarrhea. Dialysis was required in 71% of patients for a median duration of 11 days (range, 2–199). Only one patient died. The other children recovered — or are still improving — most of them with supportive care alone.

Published in *J Watch Infect Dis*. October 17, 2012 — Stephen G. Baum, MD. ■



## Billing for Medications, Supplies, and X-rays

■ DAVID STERN, MD, CPC

**Q. What is the CPT code for Tetracaine Ophthalmic used in an urgent care setting?**

**A.** If you are referring to the drops used as part of the treatment in the office, then you should not charge separately for them. They are part of the E/M service.

If you are providing a bottle of the solution for a patient to use at home, there are a few practical issues to consider. Payers very rarely pay for dispensed meds, and if they do, they pay only extremely reduced fees. Thus, if you plan to dispense medications, there are several other factors for you to keep in mind:

- Dispense only prepackaged medications
- Have patients pay at time of service (cash, credit card, etc.)
- Do not bill to insurance
- Use a dispensing company that is integrated with your electronic medical record (EMR) so that
  - duplicate entry of patient demographics is eliminated
  - orders are taken right from the EMR
  - inventory is kept in the EMR
  - verification can be performed to see if the bar code on the bottle exactly matches what the provider prescribed.

That being said, unless the manufacturer has provided you with a more specific code, the HCPCS code most appropriate for Tetracaine Ophthalmic solution is J3490, "Unclassified drugs." ■



**David E. Stern** is a certified professional coder. He is a partner in Physicians Immediate Care, operating 18 clinics in Illinois, Oklahoma, and Nebraska. Dr. Stern was a Director on the founding Board of UCAOA and has received the Lifetime Membership Award of UCAOA. He serves as CEO of Practice Velocity ([www.practicevelocity.com](http://www.practicevelocity.com)), providing software solutions to over 750 urgent care centers in 48 states. He welcomes your questions about urgent care in general and about coding issues in particular.

*There is no "right" way to perform, read, code, and bill radiographs in urgent care.*

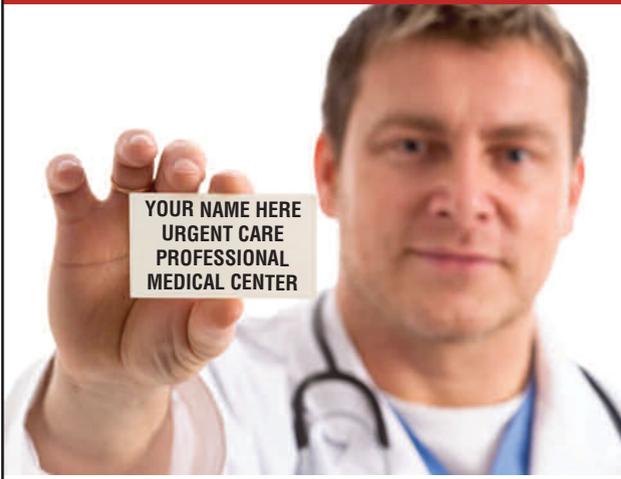
**Q. We had a patient who came in with a wrist injury. We applied a cock-up splint (HCPCS code L3908) with an Ace bandage. Can we bill out a strapping code and a splint application code together?**

**A.** No. You would not bill splint or cast application codes with strapping codes for the same procedure. Billing for the splint application depends on whether the splint applied was prefabricated or was constructed in the clinic. The American Medical Association (AMA) stated in *CPT Assistant* (May 09:8) that "splint application requires creation of the splint." According to HCPCS, L3908 is defined as "Wrist-hand orthotic (WHO), wrist extension control cock-up, nonmolded, prefabricated, includes fitting and adjustment." Therefore, billing a splint application code along with this code would not be appropriate because the fitting and adjustment is included with the code. If an elastic bandage was used to secure the splint, you would bill a HCPCS code from range A6448-A6450 depending on the size of the bandage.

Alternatively, if a short arm splint was made in the clinic from fiberglass materials for an 8-year-old, you would use HCPCS code Q4024, "Cast supplies, short arm splint, pediatric (0-10 years), fiberglass." You would then assign CPT code 29125, "Application of short arm splint (forearm to hand); static." In that case, the elastic bandage (and all other splint supplies) is included in the supply code.

If you bill a splint application code, you should also document and code the appropriate E/M code for assessing the injuries related to the accident and add modifier -25, "Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service." ■

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## CODING Q & A

**Q.** How do you bill for radiology service in an urgent care center and what modifier should be used?

**A.** There is no "right" way to perform, read, code, and bill radiographs in urgent care. Each urgent care center will need to do an analysis of what will work best in its particular center. To summarize, x-ray billing and coding options in urgent care include:

1. Performance and reading of x-rays in the urgent care center by the urgent care physicians. Bill a global code for both the professional and technical components. Having all x-rays cross-read by a second urgent care physician can help reduce the chance of significant misreading. Also, having an arrangement for a radiologist to cross-read any films that the physician(s) is unsure of will help to ensure quality. You can bill radiologist cross-reads in two different ways:
  - a. Employ the radiologist as an independent contractor (per film series). You pay the radiologist a wage and bill the global code.
  - b. Allow the radiologist to bill the professional component. For situations in which the radiologist is billing the professional component, you should bill only the technical component using modifier -TC.
2. Perform x-rays and employ a radiologist as an independent contractor to read the films. Bill the global fee, and pay the radiologist a separate wage.
3. Perform x-rays and send the films to a radiologist to read all films. This radiologist can bill the professional component, and you will bill only the technical component using modifier -TC.

Effective January 1, 2012, Medicare requires that the technical component of Advanced Diagnostic Imaging (e.g., Magnetic Resonance Imaging (MRI), Computed Tomography (CT), and Nuclear Medicine Imaging, including Positron Emission Tomography (PET)) be billed by only those providers/suppliers who are accredited by one of the following organizations:

- The American College of Radiology
- The Intersocietal Accreditation Commission
- The Joint Commission ■

*Note: CPT codes, descriptions, and other data only are copyright 2011, American Medical Association. All Rights Reserved (or such other date of publication of CPT). CPT is a trademark of the American Medical Association (AMA).*

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# DEVELOPING DATA

These data from the 2010 Urgent Care Benchmarking Survey are based on responses of 1,691 US urgent care centers; 32% were UCAOA members. The survey was limited to “full-fledged urgent care centers” accepting walk-ins during all hours of operation; having a licensed provider and x-ray and lab equipment onsite; the ability to administer IV fluids and perform minor procedures; and having minimal business hours of seven days per week, four hours per day.

*In this issue:* What employee benefits are clinical staff receiving in your center?

## BENEFITS FOR CLINICAL STAFF OTHER THAN PHYSICIANS, PAs AND NPs

The 2010 question specified full-time employed physicians. Questions were also asked about benefits coverage for independent contractors who were physicians and centers almost unanimously do not provide coverage for these types of workers, as would be expected.

<b>Benefit</b>	<b>X-ray Tech</b> <i>(9.38% of centers reported no full-time x-ray tech on staff)</i>	<b>RN</b> <i>(32% of centers reported no full-time RNs on staff)</i>	<b>LPNs</b> <i>(24.32% of centers reported no full-time LPNs on staff)</i>	<b>NA</b> <i>(26.83% of centers reported no full-time nurse asst on staff)</i>
Health Insurance	61.8	42.7	40.0	49.5
Retirement Plan	50.0	39.6	32.0	38.1
Malpractice Insurance	26.5	20.8	17.0	17.5
Life Insurance	36.3	31.3	25.0	26.8
Short-term Disability	27.5	26.0	20.0	19.6
Long-term Disability	23.5	19.8	13.0	14.4
Vision Care	33.3	25.0	23.0	25.8
Dental Care	42.2	28.1	26.0	27.8
Continuing Medical Education	29.4	21.9	11.0	13.4
State Licensure Fee	21.6	13.5	11.0	13.4
Profit Sharing	9.8	5.2	5.0	7.2
No Benefits	11.8	10.4	15.0	15.5

*Acknowledgement: The 2010 Urgent Care Benchmarking Study was funded by the Urgent Care Association of America and administered by Professional Research Associates, based in Omaha, NE. The full 40-page report can be purchased at [www.ucaoa.org/benchmarking](http://www.ucaoa.org/benchmarking).*

The background of the entire page is a tropical scene. On the left, there are dark silhouettes of palm trees against a bright blue sky with a sun flare. On the right, there are vibrant green palm fronds. A thick, light-colored woven basket or rope arches across the center of the image, framing the text.

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