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Show Me the Money: Alternative Access in Acute Care Delivery



In my last column I examined the recent study by the Center for Studying Health System Change which reviewed data from the 2008 National Hospital Ambulatory Medical Care Survey (NHAMCS). I identified critical flaws in the definitions used to distinguish “appropriate” emergency department (ED) visits from “non-urgent” or so-called “routine” visits. I concluded that the study missed a tremendous opportunity to identify alternatives for the vast majority of patients with conditions deemed “non-emergent” but that required care within 24 hours. All of those patients (75% of the study population) were deemed “appropriate,” yet no alternative places of care were considered. The media, and the special interest lobby machine feeding it, used the results to renounce theories of ED overutilization and declare the case closed on potential cost savings and resource utilization gains from re-directing “non-emergent” ED visits.

Where the study failed miserably, and what the media confounded, was the missed opportunity to ask the right questions. Consider this overlooked hypothesis: Alternative points of access exist for the 88% of patients with conditions deemed “non-emergent,” and re-directing these patients will produce significant cost-savings and system efficiencies.

Let’s examine the data more closely. Certainly some of the 88% “non-emergent” patients are better served in the ED. But are there ways to examine the data and more accurately categorize groups of patients who would be better off accessing care through alternative sources? Secondly, how can we define access points such that we can objectively determine their potential impact? And what other studies exist that might give us a clue about whether the alternative access points have a quantifiable impact on cost and efficiency?

To answer those questions we first need to identify the percentage of patients presenting to EDs who have conditions that can be handled in an alternative setting, such as an urgent care center. Then we need to understand how many of them present during typical urgent care center hours of operation.

A closer look at the NHAMCS data reveals that the vast majority of patients present with typical urgent care complaints such as headache and minor injury. A small number of complaints are more obvious emergencies. Then, there are complaints for which

urgency cannot be determined such as dizziness. It would be reasonable to assume that a percentage of “emergent-type” complaints are not real emergencies, and a percentage of “non-emergent-type” complaints require a higher level of care than anticipated. That division remains to be quantified, but experience tells us that it is pretty equal. A review of the raw data reveals that at least 75% of the complaints were of the “non-emergent-type” that require a level of care considered routine in the urgent care setting.

To answer the second question, time of presentation must be analyzed. Gross analysis of the NHAMCS data reveals that 75% of patients presented during typical urgent care hours of operation (8 am-10 pm).

During the study period (2008), there were 119 million ED visits. If 75% of those patients had typical urgent care complaints (89 million), 75% of which occurred during typical urgent care hours, the potential exists to re-direct 67 million ED visits to more appropriate and cost-effective places of care.

The average cost of care per patient visit in an urgent care setting is \$118, according to the UCAOA benchmarking study released in 2010. In contrast, \$500 to \$600 per patient visit is a conservative estimate, in most studies, for the average cost of care for “urgent care-type” conditions treated in the ED.

If all 89 million patient visits identified as potential candidates for urgent care diversion were re-directed accordingly, the health care system could realize \$34 to \$37 billion in cost savings. The potential impact is dramatic enough that it demands more thorough investigation. Using a more conservative algorithm, a 2010 Rand study identified 27% of ED visits that could be handled at either urgent care centers or retail health clinics.

Regardless of the ultimate figure, the potential for cost savings more than justifies a more thorough investigation and a more balanced dialogue about the impact of alternative access points for the delivery of acute care. ■

Lee A. Resnick, MD
Editor-in-Chief

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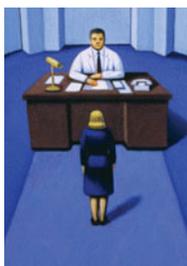
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William Marty Martin, PsyD, MPH, MA, MS

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Infectious flexor tenosynovitis is an orthopedic emergency that can cause long-lasting disability through tendon necrosis and permanent digital contracture if unrecognized or mismanaged.

Mary A. Lane, MD



IN THE NEXT ISSUE OF JUCM

In the urgent care setting, management of acute neck pain can be challenging because the differential diagnosis is broad and a determination must be made about whether the etiology is life-threatening to the patient. A systematic and effective approach to evaluation and management of neck pain in urgent care is the topic of next month's cover story. Our authors review important differences between symptoms of mechanical neck pain and neck pain associated with radiculopathy or myelopathy, signs and symptoms suggestive of cervical radiculopathy, and "red flags" that signal increased risk of a serious underlying condition requiring immediate attention. Also presented is an overview of the role of imaging studies such as plain films, computed tomography, and magnetic resonance imaging.

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A systematic approach to patient history is key to evaluating an infant who cries excessively. That's one of the take-home messages from this month's cover story, written by Toni Clare Hogencamp, MD. Estimates indicate that infants cry about 1 to 2 hours per day and stressed parents with inconsolable infants sometimes present to urgent care clinics out of concern that the etiology is serious rather than benign. Coupled with a careful history, studies say, a full physical exam demonstrates a medical cause for crying in 66% of such infants.



Dr. Hogencamp is Director, Urgent Care Program, Division of Emergency Medicine, Children's Hospital Boston, Boston, MA.



In this month's case report, Mary A. Lane, MD, presents the case of a woman with a 4-day history of progressive swelling and erythema to her index finger after tending to her garden. Her history was noteworthy for a similar occurrence in the same digit 5 years earlier. The account underscores the difficulty in distinguishing between infectious and inflammatory flexor tenosynovitis, particularly because Kanavel's Signs can be present with both diagnoses. It's important, then, to consider the possibility of suppurative flexor tenosynovitis when forming a finger infection differential.

Dr. Lane is a fast track emergency medicine physician at Florida Hospital Fish Memorial, Orange City, FL, and board-certified in Family Medicine.

What is a successful hire in an urgent care setting? This month's practice management article, written by William Marty Martin, PsyD, MPH, MA, MS, has the answer and a wealth of tips and tools for making a successful hire and preventing "crisis" hiring. Hiring well is a science and urgent care center operators should hire as if their patients' health and satisfaction depend on it—because they do.



Dr. Martin is Director and Associate Professor, Health Sector Management, DePaul University, Chicago, IL.

Also in this issue:

John Shufeldt, MD, JD, MBA, FACEP, discusses the impact of the Patient Protection Affordable Care Act on the urgent care industry.

Nahum Kovalski, BSc, MDCM, reviews news abstracts on literature germane to the urgent care clinician, including studies of genitourinary trauma from Foley catheters, urine odor and UTI, a decision rule for syncope, and risk factors for clinical failure in cellulitis and skin abscess.

In Coding Q&A, **David Stern, MD, CPC**, discusses tetanus code changes, coding for injections and infusions, and facility and after hours codes.

Our Developing Data end piece this month looks at nurse practitioner staffing at urgent care centers. ■

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. 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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FROM THE INTERIM EXECUTIVE DIRECTOR

A Bottom Line With a Heartbeat

■ LAUREL STOIMENOFF, PT

It's no secret that turnover is extremely costly at all levels of an organization, particularly when the setting is medical. Each urgent care clinic is a relatively small "work unit" and the absence of a single employee is disruptive, placing additional burden on the remaining workforce.

Given the profound importance of employee loyalty, the data circling out there are daunting. A 2011 Gallup Poll revealed that 71% of the workforce is either "not actively engaged" in or "actively disengaged" from their work. And when the Saratoga Institute researched why 60,000 employees quit their job, the answer was "the boss" 80% of the time.

What does that tell us? A loyal workforce is earned. It begins with a commitment to being *the employer of choice for the employees (talent) of choice*. The loyalty continuum includes planning, sourcing, hiring, orienting, developing and ultimately *retaining* talent. And because people "quit their bosses," it means investing in your line supervisors' leadership skills and establishing *the retention of talent* as a core business strategy.

Employees who feel valued are more likely to be productive and engaged. Therefore, smart companies aren't sacrificing profit, but instead augmenting it, when operational strategies thoughtfully consider the workforce and the bottom line metaphorically "has a heartbeat." This journal and others appropriately feature articles on enhancing the patient experience and garnering patient loyalty. Why not spend an equal amount of effort on strategies to retain our employed talent?

I have been privileged to serve as the Urgent Care Association of America's (UCAOA) Interim Executive Director as we finalize plans to fill Lou Ellen Horwitz's shoes. Shortly after stepping into this role, I began reflecting on how loyalty seems to permeate UCAOA in so many ways. We are fortunate to be an association in a growth mode, largely because

Lou Ellen's contributions are countless, but her true legacy may be the talent that remains at UCAOA, working tirelessly on behalf of the membership.

of the loyalty of our members. We are indebted to a loyal group of corporate partners who have supported us financially and consistently through the years. And, we have the ongoing wisdom and support of our founders, the Board, and leaders in the industry.

But perhaps the most compelling evidence of relentless loyalty is in the UCAOA staff. These individuals are loyal to the organization, to its members, to its mission and to each other. They are bright, energetic, committed, accountable, and innovative. Each and every day they research and respond to inquiries from members and interested parties, reach out to and address the media, oversee certification, enhance our website, find resources, analyze data, plan educational courses, coordinate conferences, and strive to elevate the industry and, therefore, the success of our membership.

It was not simply through blind luck that we arrived at this point. Considerable thought and energy went into designing new positions, identifying key attributes, interviewing, orienting, coaching, developing, rewarding, and recognizing staff. For that we need to thank Lou Ellen and her keen eye for talent and the strategy she put in place to earn this team. Lou Ellen's contributions are countless, but her true legacy may be the talent that remains at UCAOA, working tirelessly on behalf of the membership.

This organization is fortunate to be in a solid position of solvency. Financial comfort affords us opportunities to reinvest and provide greater value to our members. I am proud that its leadership has ensured that UCAOA has a bottom line with a heartbeat...and this team hasn't missed a beat. ■



Laurel Stoimenoff is currently serving as the Urgent Care Association of America's interim Executive Director. She may be reached at executivedirector@ucaoa.org.

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An Urgent Care Approach to Excessively Crying Infants

Urgent message: Infants who cry excessively pose a challenge to physicians and parents. A systematic approach to the history and physical exam can guide the diagnostic approaches to determine if a benign—or serious—condition is responsible.

TONI CLARE HOGENCAMP, MD

Crying is a primitive form of communication that infants rely on to communicate their distress. Because infants cannot verbalize their discomfort, they must rely on their cry to communicate with caregivers.

Estimates indicate that infants cry a total of 1 to 2 hours per day. Newborns cry the least, but crying steadily increases during the first few weeks to a peak of approximately 3 hours per day at about 6 to 8 weeks of life, after which it declines. It is often the excessive crying, when the total hours are consolidated or when the infant is inconsolable, that is the most stressful for parents.¹

Parents may complain of excessive crying or excessive fussiness and may describe their infant as “colicky” or irritable. Most parents seek care when they are concerned that there is a serious medical problem responsible for the crying, whereas others seek care when they have become exhausted.

The list of potential etiologies for excessive crying can be exhaustive, but studies suggest that from 5% to 60% of infants evaluated in an emergency department (ED) for excessive crying have a serious medical condition.²⁻³ A more recent, prospective study of 254 infants presenting to an ED for excessive crying found that 5% of those infants had a serious medical condition.²

The differential diagnosis of prolonged crying or fussiness in an infant is quite long (Table 1). It ranges



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from benign colic to serious conditions, such as meningitis, congenital heart disease (CHD), and abusive head trauma. As the physician, you must be able to differentiate between benign and serious causes of excessive crying.

A careful history and full physical exam is essential in determining the cause of excessive crying. Studies have demonstrated that 66% of infants are found to have a cause for their crying when positive findings on history and physical exam are combined.²⁻³ In 2.5% of the

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Toni Clare Hogenkamp, MD, is Director, Urgent Care Program, Division of Emergency Medicine, Children's Hospital Boston, Boston, MA.

Table 1. Differential Diagnosis of Excessive Crying in Infants

Benign	Serious/Life-Threatening
Anal Fissure	Abusive head trauma/child abuse
Colic	Congestive heart failure
Corneal abrasion	Congenital heart disease
Feeding difficulties	Supraventricular tachycardia
Gas	Drugs or drug withdrawal
Hair tourniquet	Incarcerated hernia
Hernia (unincarcerated)	Infection
Milk protein allergy	Sepsis
Nasal congestion	Meningitis
Otitis media	Respiratory distress
Oral thrush (severe)	Urinary tract infection
Gastroesophageal reflux	Injury
	Intussusception
	Metabolic disturbances
	Testicular/ovarian torsion

infants, the history or physical exam leads directly to the diagnostic evaluation necessary to determine the cause. It is also notable that 27% of the infants seen with a normal history, physical exam, and diagnostic evaluation (if performed) had “crying” as their final diagnosis.²

History and Physical Exam

When trying to understand an infant’s excessive crying, it is important to understand its onset and duration and the factors that relieve or exacerbate it. Paying careful attention to any relationship to feedings is incredibly important when trying to determine the etiology. Changes in feeding behaviors may indicate the presence of neurologic, cardiovascular, respiratory, gastrointestinal (GI) or metabolic conditions.

Past medical and social history are just as relevant as the history of present illness. The past medical history of an infant must always include maternal history, including details of labor and delivery, any maternal infections, perinatal or neonatal complications, current maternal medication history (and illicit drug history) as well as status of breastfeeding. Recent changes in care arrangement (has mother recently returned to work) can lead to behavioral changes and prolonged crying in an infant. Assessing the parents’ support system is also important. Sleep deprivation and other psychosocial stressors can lower parents’ threshold to help soothe their child and may change their perception of how excessive the crying is.

Full physical examination of a child, including removing all clothing and diapers, is imperative. During your exam, always include careful observation of the infant with the parent, taking time to observe whether and how

the infant is consoled. Parental stress and anxiety related to infant crying may impede the ability to console an infant.

History of Crying or Fussiness

To acquire a better understanding of an infant’s crying, it is important to approach the history systematically. Start by asking the parent what is most concerning. A parent’s instinct should not be dismissed.

Onset: Did the crying start today or several days ago? Was there a precipitating event? How long ago did the crying become excessive? What time of day does it typically occur?

Provocation and palliation: What seems to make the pain worse (feeding, lying down, sitting up, or holding in a certain position)? What seems to make it better (feeding, burping, passing gas or stool, swaddling or rocking)? Is there vomiting or spitting up associated with the crying and, if so, does that relieve or exacerbate it?

Quality: Does the parent consider the infant to be “in pain” or “somewhat fussy?” Understanding whether the crying is episodic/paroxysmal is important.

Region and radiation: While infants may not be able to localize their pain, pay careful attention to positions that may exacerbate or relieve the pain.

Severity: To a parent, fussiness may always seem excessive, but try to determine how it differs from other episodes of crying.

Timing: Is the crying associated with feeding or positioning? Was it sudden upon awakening? Have there been any changes in the infant’s diet or recent vaccinations?

Review of systems should also include presence of fever, weight loss or gain, interest in feeding, volume of feeding, presence of vomiting, excessive sleepiness or having to wake to feed.

Physical Exam

A complete head-to-toe physical exam of the infant—with clothing and diaper completely removed—is essential in determining a source of crying.

Vital signs: Is the infant febrile, tachycardic or tachypneic? These can be markers of infection/sepsis, cardiovascular or respiratory disease or metabolic derangements. Normal ranges for vital signs vary by infant age, but it is important to understand what is considered out of range.

General: Is the infant lethargic or asleep, but arousable? Is the infant crying or generally fussy? Has the crying subsided? If crying, is he/she easily consoled? Infants who are lethargic or remain persistently irritable during your exam are more likely to have a serious cause for their crying.

Skin: A careful skin exam for any swelling or evidence of cellulitis/abscess, especially in less-evident places such as skin folds in the neck and perirectal area, is important in the era of community-acquired multi-drug resistant *Staphylococcus aureus* infections. Skin mottling and acrocyanosis can be normal in newborns, but in the presence of other physical exam findings, such as fever or lethargy, they may be markers of shock. Petechiae and purpura are late findings in sepsis.

Head, ears, eyes, nose, and throat: Assess the fontanel for fullness/bulging (concern for meningitis) and the skull for swelling or bogging (concern for skull fracture). A bulging fontanel is a late sign of meningitis and will be accompanied by other concerns for sepsis and infection (poor perfusion, lethargy). Be sure to examine the mouth for thrush or oral lesions (using a tongue depressor) and always check the ears. Eyes may be injected or tearing if there is a corneal abrasion or foreign body, but they also may appear normal, so consider fluorescein for any irritable infant without other physical exam findings.

Cardiovascular and respiratory: Assess perfusion, peripheral pulses, heart rate, and presence of a heart murmur as indicators of congenital heart disease. Respiratory distress, marked by tachypnea, wheezing or grunting, may indicate respiratory or cardiovascular diseases. In addition, poor feeding, tachypnea/sweating during feedings or failure to thrive may indicate congenital or acquired heart disease. Congenital heart disease may also manifest as

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Table 2. Excessive crying by system	
<p>HEENT Skull fracture^a Corneal abrasion/foreign body^a Nasal congestion* Oral thrush^a Otitis Media^a</p> <p>Cardiovascular/Respiratory Congestive Heart Failure^b Congenital Heart Disease^b SVT^a Respiratory distress/infection^a</p> <p>Colic</p> <p>Gastrointestinal Anal fissure^a Feeding difficulties^b Gas^b Intussusception Milk protein allergy^b Reflux^b</p>	<p>Genitourinary Diaper dermatitis^a Hernia^a Testicular^a/ovarian torsion Urinary tract infection</p> <p>Musculoskeletal Abscess, burn, cellulitis^a Child abuse^b Hair tourniquet^a Injury/Fracture (accidental)^a</p> <p>Neurologic Meningitis Abusive head trauma</p> <p>Toxic/Metabolic Drugs or drug withdrawal Metabolic acidosis Hypernatremia, hypocalcemia, hypoglycemia Recent vaccination (DTaP)</p>
<p>DTaP = diphtheria, tetanus, and pertussis; HEENT = head, ears, eyes, nose, and throat; SVT = supraventricular tachycardia ^aPhysical exam findings are often present ^bHistory will often offer clue</p>	

The history (combined with a normal physical exam) will help in diagnosis of colic, feeding difficulties, gastroesophageal reflux, cow’s milk protein allergy and drug exposure and withdrawal.

Your physical exam will establish the diagnosis in cases of thrush, otitis media, skin infections, hair tourniquet, hernia, testicular torsion, anal fissure, musculoskeletal injury or other trauma.

A combination of history and physical exam is important in determining whether diagnostic procedures should be done to rule out meningitis, urinary tract infection (UTI), intussusception, CHD/CHF, abusive head trauma (AHT) and metabolic derangements.

Diagnostic and Therapeutic Measures for Specific Conditions
(listed alphabetically)

Abusive Head Trauma

AHT is caused by repeated shaking of an infant. The shaking initially causes cerebral injury secondary to shearing of axons as well as bridging blood vessels leading to cerebral

edema and subdural hemorrhage. This manifests early as crying and inconsolability. As the cerebral edema continues, the infant may have apnea, seizure, lethargy and coma.⁴

In most cases of AHT no history of abuse is provided during the initial visit, therefore, the clinician must have a high index of suspicion. Any concern for AHT should prompt transfer to a pediatric facility for further evaluation.

Cardiac conditions

CHD, if not detected on fetal ultrasound, may not manifest until the first week of life following changes in neonatal physiology. Infants with critical cardiac defects will present with signs of CHF and poor perfusion. Infants with milder defects may present with irritability, poor feeding or respiratory distress such as tachypnea or grunting during feeding. A murmur may or may not be present on initial exam.

Obtaining a chest x-ray, four extremity blood pressures, and electrocardiogram may help to determine the type of defect. If you are concerned about a cardiac abnormality, transfer to the nearest pediatric facility.

Supraventricular tachycardia (SVT) may present at

cardiovascular collapse, congestive heart failure (CHF) or failure to thrive.

Gastrointestinal: Palpate for abdominal masses, abdominal distension, abdominal tenderness, and tensesness. In the setting of irritability, these are concerning for intra-abdominal processes. Perform a guaiac stool test for presence of blood. Parents often complain that an infant’s abdomen is hard when crying (because of contraction of abdominal muscles), but it should be soft when an infant is relaxed.

Genitourinary: Remove the diaper to check for hernias and testicular torsion. Lay the infant in the supine position and flex the hips to better visualize anal fissures or perirectal abscesses.

Musculoskeletal: Palpate all long bones and clavicles. Are there areas of swelling, bruising or erythema? Does the crying increase when you move an extremity? These would raise concerns for musculoskeletal trauma. Look at all fingers and toes to be sure there are no tourniquets.

Neurologic: Is the child consolable at all? Paradoxical irritability (crying is made worse when holding to try to console) can be seen with meningitis. Is there hyper or hypotonicity?



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any age. In infants, heart rate is >220 bpm and SVT may manifest as an asymptomatic tachycardia, irritability, respiratory distress, or poor feeding. If an episode of SVT is prolonged it may result in complete cardiovascular collapse. Treatment is aimed at stopping the arrhythmia and immediate consultation with a pediatric cardiologist is required.

Colic

Crying in excess of 3 consecutive hours per day for more than 3 days out of the week in an otherwise healthy infant is the commonly accepted definition of colic. Generally, the prolonged crying is clustered later in the day. It usually begins by age 6 weeks and lasts up to 3 to 4 months.

There are many theories as to what causes colic, ranging from gut immaturity to release from stimulation throughout the day. Infants are described as being inconsolable for prolonged periods. Colic is a clinical diagnosis based on the above history coupled with a normal physical exam.

Care for colic is supportive (of the infant and the parent). Soothing techniques such as swaddling, rocking, swinging or car rides are all variably helpful, but will not completely prevent the crying. Excessive crying due to colic usually resolves by 4 months of life.

Corneal abrasion

Corneal abrasion is usually accidental as infants begin to gain control over their extremities. It may be the result of a foreign body such as an eyelash. The eye may be injected or tearing and there may be some degree of photophobia. Although there may be no history of injury, the history of crying is often acute in onset and the infant is inconsolable despite soothing techniques.

Performing a fluorescein exam with instillation of a topical anesthetic will reveal the abrasion and relieve the pain. This procedure will be both diagnostic and therapeutic. Evert the eyelids to determine presence of a foreign body.

Most corneal abrasions will resolve within 24 hours and do not require specific treatment or follow up. Larger abrasions should be referred for follow up the next day. Consider antibiotic ophthalmic ointment for relief and prevention of superinfection for significant abrasions.

Feeding difficulties, reflux and cow's milk protein allergy

Feeding difficulties can range from problems with nursing or bottle-feeding to gastroesophageal reflux to feeding intolerance and cow's milk protein allergy.

One common cause of feeding difficulties is excessive gas. This is caused by swallowing excessive air while feeding. However, if an infant is unable to burp and release the swallowed air from the stomach it will pass further into the digestive tract. The increase in air can cause discomfort until it is passed. Parents may have already tried simethicone for gas relief, which is not consistently effective but is safe for infants.

All infants have some degree of gastroesophageal reflux. Reflux of stomach contents is physiologic due to immaturity of the lower esophageal sphincter. The practice of feeding infants in a reclined position is another contributing factor. Most reflux is asymptomatic except for some occasional "spit up." Clinically significant gastroesophageal reflux esophagitis or gastritis usually presents with crying after or between feedings. More significant reflux can present with painful episodes of crying and arching of the back. Severe reflux may lead to refusal to eat because of pain and eventually failure to thrive. Occasionally infants will seem to feed more often because the formula may coat the esophagitis and provide relief.

Supportive care is recommended for most infants. This is most often accomplished by keeping an infant in an inclined to upright position for about 30 minutes following feeding. Pharmacologic treatment is recommended for infants with significant reflux that causes failure to gain weight or those with significant irritability throughout the day. Both H₂ blockers and proton pump inhibitors are used in infants with reflux.

If you are evaluating an infant you suspect of having reflux, you can offer 2 to 4 mL of aluminum hydroxide and magnesium hydroxide liquid antacid as a therapeutic intervention. If the crying and irritability resolve within several minutes, an infant likely has esophagitis. Liquid antacid can be given at home, at a dose of 1 to 2 mL up to four times daily, as needed. I often recommend adding an acid reducer if a liquid antacid is needed on an ongoing basis.

Food protein-induced proctocolitis, formerly referred to as cow's milk protein "allergy," is caused by a non-IgE-mediated hypersensitivity to the cow's milk (or soy) protein in commercial formula. Infants who are exclusively breastfed may also develop this disorder from dairy in the mother's diet. This typically presents between 2 and 8 weeks of life. In its mildest form, there is a distal colitis, which presents with small amounts of gross or microscopic blood in the stool, but generally without vomiting or diarrhea. Symptoms of fussiness may precede the blood in the stool. More severe forms

of protein-induced sensitivity may cause both vomiting and bloody stool. Treatment is initiation of hypoallergenic formula with hydrolyzed protein and elimination of dairy from the nursing mother's diet. Improvement is expected within 3 days, but may take up to 1 week. Most infants outgrow this intolerance by 1 year. Follow up with gastroenterology is recommended if there is no improvement after elimination of the offending protein.

Hair tourniquet

Hair or other thread tourniquets can be found on the phalanges as well as the penis. They occur because of repeated exposure to the hair in a confined space such as the diaper, mittens or socks. Swelling and edema is seen distal to the tourniquet and will eventually cause vasoconstriction. In some cases, the tourniquet may be completely embedded in the skin.

Removing the tourniquet can be a challenge because of significant swelling or the nature of the fiber itself. If you can find the leading end, you may be able to unwrap it or if you are able to insert a blunt probe fully

under the hair, you can simply cut the tourniquet. However, if the hair is embedded and you are unable to remove the tourniquet, the child should be referred to the nearest pediatric center to have the constricting band incised.

Hernia

Inguinal hernias can occur at any age and may present in both boys and girls as a mass or bulge in the groin. In boys, a hernia may extend into the scrotum as a scrotal mass. Patients with incarcerated hernias that cannot be reduced should be referred immediately to a pediatric surgeon. Reducible hernias should be followed up as an outpatient for eventual surgical repair.

Intussusception

Intussusception is most common in infants aged 3 to 24 months and often presents with paroxysm of pain causing them to cry out and pull up their legs. Pain is episodic, occurring every 15 to 30 minutes, and increases in frequency as the obstruction progresses.

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These episodes may be followed by periods of lethargy. A sausage-shaped mass in the abdomen may be palpable. Bloody or “currant jelly stool” is a late finding.

The episodes of pain are caused by constriction of the intussusceptum (the ileum along with its mesentery) into the intussusciens (most often the cecum). This can lead to eventual intestinal edema, ischemia, and peritonitis.

Intussusception is a surgical emergency. Attempts at reduction with barium or air contrast enema should be done at a pediatric center as there is a risk of perforation or non-reduction that would require emergency surgery.

Meningitis

Meningitis occurs in <1% of infants younger than age 2 months. However, meningitis is a serious infection that may have long-lasting complications even if treated promptly. It is often accompanied by fever, poor feeding, and irritability. A bulging fontanel is only present in approximately 25% of infants with meningitis.

A lumbar puncture with cell count and culture will help determine the presence of meningitis. Once stabilized, promptly transfer infants with concern for meningitis. If you are unable to obtain a lumbar puncture, do not hesitate to give intravenous antibiotics if you are clinically concerned that an infant has meningitis.

Metabolic

Metabolic disturbances caused by inborn errors of metabolism may not manifest for the first few weeks of life, given the prior interaction with maternal circulating hormone and metabolism in utero. Most metabolic derangements will also be associated with poor feeding, poor weight gain, lethargy and vomiting and will rarely present as excessive crying alone.

Hypernatremia may be the result of inappropriate mixing of infant formula (adding too little water to concentrated or powder formula) and can present at any age in infancy.

Respiratory conditions

Infants with respiratory distress may present with grunting that a parent may interpret as irritability or fussiness. Respiratory distress in infants may be primary, caused by infections (bronchiolitis or pneumonia) or secondary, as a result of CHF from a congenital heart defect (see *Cardiac Conditions* above). Tachypnea, without other signs of respiratory distress, may be a compensatory response to metabolic acidosis from an inborn error of metabolism.

Treatment should be aimed at the minimizing the distress and determining the cause.

Trauma or injury

Trauma may be accidental, caused by a fall from an infant seat or changing table, or may be non-accidental and from child abuse. Infants with a fracture will present with crying especially when moving the injured body part. Palpation of the extremities is important, because swelling may not be obvious in infants who have significant subcutaneous tissue.

Clavicle injuries may occur after a fall from a raised surface (rolling off a changing table or couch). Such injuries will elicit increased pain when lifting the child from under the axillae because this causes the clavicle to elevate. Swelling initially may be minimal, but if a child is examined 1 to 2 days after the injury, a callous will be present. X-rays will help determine the presence of fracture.

If an infant's injury does not seem consistent with the history provided by the parent or if it is not consistent with the child's developmental stage, it should raise the suspicion for abuse. Bruising in infants who are not cruising or bruising to the pinna, mouth, or abdomen in any child as well as injuries to the genitalia should also raise suspicion for abuse.⁵ Do not hesitate to contact your local child protection team in these cases.

Testicular/ovarian torsion

Testicular torsion will present as a scrotal mass with tenderness and often with surrounding erythema and induration. Infants are often quite irritable and may have a history of vomiting.

Ovarian torsion in infants is rare. Although physical exam findings are non-specific, an infant will often present with signs of acute abdomen including abdominal tenderness, vomiting and irritability.

Both of these conditions are a surgical emergency. Infants should be transferred to the nearest pediatric center for further evaluation and management.

Toxins/drug withdrawal

Toxins or other drugs may be present in over-the-counter medications imported from foreign countries or in some cultural home remedies.

Even in the absence of illicit drug use, prescription narcotic drug withdrawal can be a cause of fussiness. Narcotic pain relievers are prescribed for a variety of reasons including pain associated with cesarean section or maternal mastitis. While they are safe to use during breastfeed-

ing, they are found in breastmilk and can be a source of withdrawal if abruptly discontinued by the mother. Symptoms of narcotic withdrawal in an infant are excessive crying, irritability, poor feeding and diarrhea. Care is often supportive and aimed at decreasing exogenous stimulation and giving small, frequent feeds.

The diphtheria, tetanus, and pertussis vaccine (DTaP) can cause excessive crying, usually beginning within 4 to 6 hours after administration and lasting for 6 to 24 hours. In the case of recent vaccination, be sure to check the extremities for signs of swelling at the injection site, which may be a source of pain and inflammation (but rarely a source of infection).

Urinary tract infection

Signs and symptoms of urinary tract infection (UTI) in infants include fever, vomiting, diarrhea and irritability. One study suggests that infants who present for emergency care with chief complaint of crying, even in the absence of fever, may have a UTI. Overall risk of UTI changes with age and gender. Although the authors do not advocate screening for UTI in the crying infant, UTI should be considered in the differential for an irritable infant.²

Age-specific considerations

Infants <28 days

Even to the most experienced pediatrician, infants younger than age 28 days are always a diagnostic challenge because they provide few clues to the etiology of their crying. If you are evaluating an infant who remains inconsolable, in the absence of abnormal physical exam findings, you should always consider serious bacterial infection as a cause, even without fever. Signs and symptoms of neonatal sepsis may be non-specific and may include temperature instability (hypothermia or fever), apnea, irritability or lethargy.

Although the overall risk of serious infection is low (<1%), the morbidity and mortality remain high (10%), therefore you should have a very low threshold to transfer the persistently irritable neonate to a pediatric center for further evaluation and management.

Psychosocial Support

Excessive crying in an infant often triggers feelings of inadequacy and frustration on the part of the parent, especially when coupled with sleep deprivation. Acknowledging to the parent that caring for a crying infant is challenging and giving the parent permission to take a break from the seemingly incessant crying is



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an important piece of anticipatory guidance. Parents should be encouraged to seek support from other family members and friends in caring for their crying infant.

It is extremely important to counsel parents about the dangers of shaken baby syndrome (abusive head trauma).

Conclusion

A crying infant poses a challenge to both parents and clinicians. Taking the time to review a thorough history and physical exam will often lead to the diagnosis. In the urgent care setting, it is important to rule out the most acute and life-threatening illness or injuries.

Infants who are not well appearing, who remain inconsolable during your evaluation or who have other worrisome signs such as lethargy, fever, poor feeding, difficulty breathing, persistent vomiting or failure to thrive should be referred to the emergency room for further evaluation.

Otherwise well-appearing infants with excessive crying often will be diagnosed with colic or feeding difficulties/formula intolerance. In cases of colic, providing information about the natural history will be helpful in letting parents know that there is an end in sight. In cases of reflux or formula intolerance, close follow up with a pediatrician or family practitioner will ensure continued support and possible further diagnostic work up on an outpatient basis.

All infants evaluated for irritability or excessive crying should be referred back to their primary care provider for close follow up. ■

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Practice Management

Hiring As If Your Patients' Health and Satisfaction Depended Upon It

Urgent message: Hiring the right candidate for a job at an urgent care center is an art and a science, but a variety of tools exist to facilitate the process.

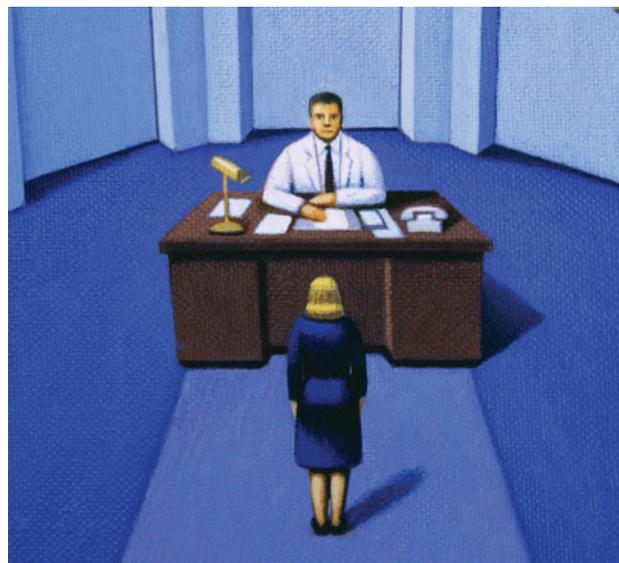
WILLIAM MARTY MARTIN, PSYD, MPH, MA, MS

This article is designed to equip urgent care clinic owners with the tools they need to hire better than they have in the past. After reading it, you will be able to: (1) organize your hiring process around the high-impact hiring model; (2) align your hiring process with the vision, mission, and strategies of your urgent care center; and (3) leverage the science of selection to hire well more systematically and routinely. Those goals seem understandable enough, but many of us get in our own way in reaching them.

What is a successful hire?

Selection of a candidate to fill a particular position is outcomes driven. Your hiring decisions and processes should be aimed at successful hiring. That is, attracting, selecting, and retaining high performers for every position in your urgent care center, from the receptionist to the board-certified physicians. Table 1 lists the six indicators of successful candidate selection, but keep in mind that performance is the ultimate test of whether you made a good selection decision or not. Do not leave selection to chance. There is both an art and science to hiring well.

William Marty Martin, PsyD, MPH, MA, MS, is Director and Associate Professor, Health Sector Management, DePaul University, Chicago, Illinois.



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Models of Hiring

The selection of a high-performer is no accident. It is an outgrowth of following four specific high-impact hiring processes:

- Forecasting the number and type of professionals to hire, which is the first step. As such, hiring needs must be anticipated by employing forecasting models that take into account fluctuations in patient demand; changes in available staff at your urgent care center; substitution of labor by technol-

Table 1. Six Indicators of a Successful Hire

1. The new hire quickly learns the tasks of the job and integrates well with the urgent care center and staff members.
2. The new hire not only creates value but also adds value beyond that which is required for "simply doing your job."
3. Other members of the staff comment on how this was a great hiring decision and demonstrate their investment in the success of the new hire.
4. The new hire tells others in his/her family, personal, and professional networks about how well organized and just your hiring process happened to be and how proud he/she is to be associated with a well-run organization, not just an urgent care center.
5. The new hire is "up and running" faster than you anticipated.
6. You feel proud about your hiring decision and you do not have to make excuses for or rationalize about why you hired this new staff member.

Table 2. Five Evidence-Based Tips for Employer-of-Choice Branding

1. Make sure that the work environment and the role align with the candidate's interests.
2. Make sure that the work environment is based upon collegiality and a focus on teamwork.
3. Make sure that your total rewards package is at a minimum not distracting or a seed for resentment but serves as a motivator.
4. Make sure that you intend to invest in further development of the new hire and that he/she knows about your orientation, training, coaching, and career development programs.
5. Make sure that your application process is a meaningful and respectful experience for the applicant, particularly if you are in a small town and people talk.

ogy, outsourcing or deskilling; and alignment of hiring goals with strategic goals.

- Defining the elements of successful job performance. All recruitment and selection devices must be tailored with those specifications in mind, in contrast to "warm-body" hiring, in which the goal is to fill a vacancy quickly.
- Implementing a process for attracting high-performing applicants. This is known as employment

Table 3. Five Ways to Prevent 'Crisis' Hiring

1. Focus on hiring the "best person" from the beginning.
2. Orient the "best person" to the community, the center, the department, the team, and the job.
3. Check-in with the "best person" at 30, 60, 90, and 120 days to test for "fit" and cut your losses early.
4. Give feedback about how the "best person" is doing in their job, first focusing on his/her strengths and then areas of improvement.
5. Pre-qualify candidates for positions for which you would hire them, if you had other vacancies. Put these "best pre-qualified candidates" on your short list to cut down on the time to hire in case a staff member resigns with short notice and you need to make a quick (but qualified) hire.

branding. Make sure that the "word on the street" is that your urgent care center is really selective and not anybody can work there. Table 2 lists five evidence-based tips that you can use to make working at your urgent care center an experience worth talking about in town.¹

- Identifying the "diamonds in the rough" and "panning for gold" is warranted after you have attracted top-notch candidates through your branding initiative. You are not looking for "fool's gold." To protect you against hiring "fool's gold," this article will present empirical evidence on selection methods with an emphasis on three tools designed to separate the "wheat from the chaff": work sample, cognitive tests, and behavior-based interviewing.

High-impact hiring begins with the end in mind, not just for a single applicant being selected for a single position but also in terms of aligning your urgent care center's staffing model with its overall strategy.

Strategic Staffing: Beyond Staff Scheduling Systems

A strategic staffing perspective begins with attracting talent but does not end with bringing the newly hired employee on board. The three other key steps in strategic staffing are developing, optimizing, and retaining talent. Theoretically, combining these four steps increases employee engagement, which increases productivity, which increases business results.

For example, if your urgent care center is implementing an electronic health record (EHR) and expanding into workers' compensation services, then you will need talent that can drive implementation and use of the technology. You will also need staff who have expertise and

Table 4. Selection Tools for Urgent Care Centers	
Selection Tool	Best Used When Selecting for...
<i>Work samples:</i> The legendary typing test is an example of work sample. The purpose of the work sample is to determine how well a candidate can perform essential duties associated with a position. The benefits are a closer relationship between the predictor and the criterion because they are the same and a more realistic view of the job for the candidate, which increases retention.	Technical Dimensions of Performance <ul style="list-style-type: none"> • Knowledge • Skills • Abilities
<i>General mental ability tests:</i> These types of tests are also known as intelligence tests. At first blush, there is a negative reaction to assessing intelligence in a work setting or falsely assuming that individuals in all positions have or do not have a certain level of intelligence. Academic achievement is correlated with intelligence but there are many individuals who have not achieved academically but are highly intelligent.	Technical Dimensions of Performance and Adaptability: <ul style="list-style-type: none"> • Intelligence • Adaptability • Cognitive capacity regardless of years of formal education
<i>Structured interviews:</i> These are also known as behavior-based interviews. These interviews ask candidates questions seeking to tap their past ability to handle specific tasks and situations. Unlike a hypothetical interview question, behavior-based interview questions are framed in the past not the future. These types of interviews add value for not only predicting use of knowledge, skills, and ability but also “fit” with the team and urgent care center. An example is “Tell me about a time when you had a conflict with another employee and how handled that situation”	Interpersonal Dimensions of Performance and Organizational Fit: <ul style="list-style-type: none"> • Alignment with vision, mission, and values. • Interpersonal competency • Communication skills • Emotional intelligence

interest in workers compensation. In short, you need to recruit and retain talent with the skill and the will to perform at a high level. You must have both. Skill is not a substitute for will and vice versa. As an urgent care center grows over time, talent is needed that can grow with it or push the organization toward strategic growth. As with other relationships, talent can “grow apart over time” from the vision, mission, and strategy of your urgent care center. For instance, a one-site urgent care center in a rural community will attract, select, and retain different talent than a multi-site operation owned by a hospital with

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plans to open up in other communities and expand services behind urgent care. The aforementioned discussion on strategic staffing assumes that everything goes according to plan. That is not reality. As such, it is critical to adopt best practices in hiring well in a crisis.

How to Avoid a Hiring Crisis

A hiring crisis is the unplanned, unanticipated loss of a high performing or marginally performing employee who you need just to get through another day, week, month, or next couple of months. In short, although these employees may not be the stars of your urgent care center, their presence is better than nobody showing up at all, even if they only half-heartedly work through their shifts. Table 3 lists five approaches to avoid getting into a hiring crisis.

Most employees who leave voluntarily drop “breadcrumbs” over time in the form of subtle indicators that they intend to quit. In fact, the vast majority of employees quit “psychologically” before they actually quit “physically.” They exhibit withdrawal behaviors, such as coming in a bit later, leaving earlier, or taking longer breaks than usual; not contributing to meetings about the future; dressing more formally on some days; taking off blocks of time in a given day rather than a block of days; and expressing dissatisfaction to the urgent care center founder, owner, manager, co-workers, and even patients. All of these are signs that an employee has psychologically quit although he or she keeps punching the clock or seeing patients every day.

Hiring Well: Leveraging the Science of Selection

Whether you are assessing candidates from outside your urgent care center or determining whether an existing employee should be promoted or move to another position at the same level, it is essential that you apply empirically validated and time-tested selection techniques.² Selection, like medicine, is both an art and a science. Begin with the science and then apply the tools of the artist once you have sufficient experience and a documented track record of hiring well.

The predictors of successful hiring are selection tools, the most common of which are the resume and the interview. According to Carlson et al, the best selection tools or predictors of performance are work samples, general mental ability tests, and structured interviews,

High-impact hiring begins with the end in mind, not just for a single applicant but also in terms of aligning your urgent care center's staffing model with its overall strategy.

in that order.² Other selection tools include integrity tests, resumes, GPAs, and references. Table 4 describes each one of these selection tools.

After choosing more than one selection tool (predictor), you will synthesize the data collected from all of the selection tools you have used.

Then it is time to make your selection decision. All decisions involve risk because they are predictions. The goal is to increase the predictive validity. One of the challenges inherent in using more than one selection tool is how to analyze results from one versus another. For instance, assume that a candidate has a great resume and great references but he/she did not do so well on the interview. If you have a multiple-cut off approach, then you would not select this candidate because he/she did not meet the minimum on all three selection devices. If, on the other hand, you used a compensatory approach, then you might select the candidate because the candidate's strengths overshadowed his/her weaknesses. Clarify your decision strategy approach at the beginning, not while you are making the decision.³

If you have an interview team or more than one person contributing to the hiring decision, each individual should make a selection on his/her own before the group or committee makes a decision so as to reduce the conformity effect and “group think.”⁴ The last consideration is quickly communicating the decision to the candidate selected and to all others who were interviewed, some of whom may be pre-qualified candidates, as previously discussed.

Conclusion

Returning to the question that opened this article, how do you know if you have successfully hired? The answer set out at the beginning of this article was to hire well. After reading this article, you should be in a better position to apply specific tools to hire better and hire as if your patients' health and satisfaction depended upon that decision. In fact, they do. ■

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Case Report

Infectious versus Inflammatory Flexor Tenosynovitis: A Little, Big Problem

Urgent message: Infectious flexor tenosynovitis is an orthopedic emergency that can cause long-lasting disability through tendon necrosis and permanent digital contracture if unrecognized or mismanaged.

MARY A. LANE, MD

Introduction

Flexor tenosynovitis is an inflammation of the tendon sheath that can be caused by either introduction of infection or various inflammatory conditions ranging from autoimmune arthropathies to crystal joint depositions. Flexor tenosynovitis caused by infection is an orthopedic emergency. It can cause long-lasting disability through tendon necrosis and permanent digital contracture if unrecognized or mismanaged. On the contrary, flexor tenosynovitis caused by inflammation does not usually constitute an emergency and can be managed on an outpatient basis. Likewise, it is imperative that physicians are able to make an educated case as to which form of tenosynovitis they are dealing with—infectious versus inflammatory. Unfortunately, the two forms of flexor tenosynovitis can be difficult to distinguish in some instances.

Many cases of flexor tenosynovitis are seen in urgent care centers and on the “fast track” side of Emergency Rooms (ERs) because of the misconception among both patients and triage personnel that the condition is only

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a simple finger infection. The result is frequent misdiagnosis as “finger cellulitis” or an “allergic reaction.” Health care providers must be vigilant in recognizing cases of flexor tenosynovitis so as to prevent subsequent disability associated with the diagnosis.

Figure 1.



The patient's right fifth digit at presentation. She reported a 4-day history of pain, erythema, and edema in the digit after tending to her garden.

Figure 2.



In comparison with an unaffected digit on the patient's left hand (finger pointing up at left), the patient's right fifth digit (at right) clearly is edematous..

Case Presentation

A 52-year-old woman presented to a small community ER with a 4-day history of progressive swelling and erythema to her right fifth digit (Figure 1).

She was triaged to the “fast track” side of the ER and listed on the tracking board as having an “allergic reaction.” She stated that 4 days earlier, she had been tending her garden in the afternoon and by that night, noted gradual onset of burning pain, erythema, and edema around her right fifth digit. She denied pruritus. The patient stated that she had been wearing gloves and did not recall any trauma (abrasions, insect bites, etc.) to her fifth finger. Her symptoms had gradually worsened. In the ER, the patient’s pain was rated a 7/10 and radiated up the right forearm with any movement of the digit. She denied fevers, chills, vomiting, or other systemic symptoms.

It is noteworthy that the patient gave a history of a similar occurrence in the same digit 5 years earlier. She stated that at that time, she was seen in the ER and given a loading dose of intravenous (IV) antibiotics and dis-

charged home to continue oral antibiotics. The symptoms eventually resolved. She claimed that her finger then had been just as red, swollen, and painful as it is now. She stated that since that incident she has had reduced mobility in her right fifth digit, but that it was not permanently contracted as a base line.

Observation and Findings

Evaluation of the patient revealed the following:

- T: 98.6°F
- HR: 63
- RR: 11
- BP: 128/80
- PMHx: Negative
- Sx Hx: Negative
- FH: No known history of inflammatory arthropathies or autoimmune conditions,
- SH: Negative
- Meds: None. No known drug allergies

The patient presented with a right fifth finger flexed

Table 1. The Four Kanavel Signs

1. Fusiform edema – often described as a “sausage digit.”
2. PIP joint in flexion
3. Pain with passive extension (most specific)
4. Tenderness on palpation of the flexor tendon sheath

at the proximal interphalangeal (PIP) joint that could not be extended actively or passively without triggering severe pain. Swelling around the digit was fusiform and marked erythema extended onto the palmar aspect of the woman’s hand (Figure 2). She had tenderness along the flexor tendon. No nidus of infection could be identified. The patient’s neurovascular exam was intact.

Diagnostic Studies

Finger x-ray showed soft-tissue swelling but was otherwise within normal limits. Neither bony involvement nor radio-opaque foreign body was noted.

CBC demonstrated a normal WBC (without a left shift,) but a small elevation in eosinophils was noted.

CMP was within normal limits.

SED rate showed mild elevation at 27.

CRP showed elevation at 17.

Diagnosis

Presumed infectious flexor tenosynovitis until proven otherwise.

Suppurative flexor tenosynovitis is primarily a clinical diagnosis and neither labs nor imaging studies can confirm the diagnosis (see general discussion below.) The gold standard for confirmation is fluid sampling.

This patient met clinical criteria for this diagnosis based on Kanavel’s Signs (Table 1). These signs were identified by Dr. Allen B. Kanavel, an American Surgeon in 1912, and are considered to be sensitive for purulent flexor tenosynovitis. The signs were designed to differentiate between a deep infection of the tendon versus a more superficial infection, such as cellulitis or a localized abscess.

Differential/Decision Making

1. Allergic reaction – Eosinophils were elevated, and an acute allergic reaction could mimic the appearance of flexor tenosynovitis. Nonetheless, the clinical his-

tory of gradually worsening symptoms does not fully support this differential.

2. Inflammatory flexor tenosynovitis – The lack of nidus of infection and the patient’s prior history of a similar episode could support a possible inflammatory arthropathy. However, the patient’s presentation included all of Kanavel’s Signs, making an infectious source highly suspect.
3. Infectious flexor tenosynovitis vs. superficial infection—The incident did start after the patient had been gardening and a small puncture wound (for instance, from a thorn—a common flexor tenosynovitis culprit) would not necessarily be readily identifiable. The patient had all of the classic Kanavel’s Signs, favoring the diagnosis of a deep rather than superficial infection. Knowing that the patient’s symptoms had been gradually progressing over the course of 4 days (and that the consequences of missing a possible deep infectious etiology could be grave), a treatment approach that addressed the possibility of a deep infectious source was adopted.

Course and Treatment

The patient’s finger was splinted into the “safe position” and she was asked to keep the digit elevated. Her tetanus status was checked and a tetanus shot was administered. She was given 2 g IV cefazolin in the ER and transferred to a large tertiary care facility where hand surgery was available. A hand surgeon started IV vancomycin but no response was seen at 24 hours and the patient was taken to the operating room for surgical intervention. Purulent material was found at the level of the tendon and multiple cultures for bacteriology and mycology were obtained. A postoperative diagnosis of “tenosynovitis” was made by the hand surgery. No further imaging was performed at the accepting hospital (x-ray was negative at the transferring hospital, but that only ruled out radio-opaque foreign bodies. Plant matter is not radio-opaque.) No mention of a foreign body was noted on the postoperative note.

IV antibiotics were continued for an additional 3 days. Clinical improvement was noted and the patient was discharged home with a prescription for 500 mg cephalexin QID x 7 days and follow up on an outpatient basis. No culture growth was ever noted. The pathology report revealed “Remnants of fibroconnective tissue displaying florid acute inflammation and extensive necrosis. Negative for Malignancy. The histological features in this case could also be consistent with abscess.”

General Discussion

The two categories of flexor tenosynovitis are infectious and inflammatory. In some cases it can be difficult to tell apart these etiologies.

Infectious flexor tenosynovitis is usually secondary to some minor skin trauma to the digit. A complication of infectious tenosynovitis is pyogenic flexor tenosynovitis—formation of an abscess at the base of the digit. The abscess is classically described as being in the shape of a “horse-shoe.” *Staphylococcus aureus* is the most common pathogen, but many other bacteria have been implicated in human bites, such as *Eikenella corodens*.

How is infectious tenosynovitis treated? Initially the patient’s tetanus status should be updated, the digit splinted, labs and an x-ray obtained, and a hand surgeon consulted. If you are practicing in an urgent care center and a patient’s presentation is suspicious for a possible infectious etiology and all four Kanavel’s Signs are present, he/she should be referred to a local ER for consultation with a hand surgeon. If you are practicing in an ER that does not have a Hand Surgery consultant on call, the patient may need to be transferred to a larger tertiary care facility. Early presentations can be managed conservatively with IV antibiotics and close observation, assuming the patient is not immunocompromised. Cefazolin is the first-line antibiotic of choice, but erythromycin or vancomycin can be used as an alternative.¹ If no improvement is noted within 24 hours, surgical intervention often is warranted. Risk factors for poor outcomes despite surgical intervention include, but are not limited to, diabetes, peripheral vascular disease, renal failure, human bite wounds (“fight bites”), late presentations (defined as >7 days,) digital ischemia, and subcutaneous purulence.

Inflammatory flexor tenosynovitis is often secondary to inflammatory arthropathies such as rheumatoid arthritis and psoriatic arthritis. However, overuse syndromes (stenosing flexor tenosynovitis “trigger finger”) and gout/pseudogout located in the PIP of a finger are other common etiologies.

How is inflammatory flexor tenosynovitis treated? That depends on the cause. Most cases are treated with nonsteroidal anti-inflammatory drugs, application of ice as needed, and splinting. A short course of oral steroids may be taken to reduce inflammation, and steroid injections may be administered. Additional medications, such as methotrexate for rheumatoid arthritis, may be initiated in certain instances, again, depending on the cause.

It can be difficult to distinguish infectious from inflammatory tenosynovitis when no obvious nidus of infection exists (and no subcutaneous purulence is seen) because

some forms of inflammatory tenosynovitis can also display Kanavel’s Signs. However, the best clinical predictor we have of tendon involvement is presence of all four Kanavel’s Signs.

Vital signs, laboratory tests, and imaging studies all can provide clues to the diagnosis, but it is difficult to confirm an infectious etiology without incision and drainage. Vital signs are variable, and a patient may be afebrile in both clinical conditions. Leukocytosis or a left shift is more likely with infectious versus inflammatory tenosynovitis, but there have been many cases reports where a patient’s white blood count and sedimentation rate were within normal limits in both instances.

Imaging studies (x-ray, computed tomography, and magnetic resonance imaging (MRI) can assess for presence of bony abnormalities and foreign bodies, but in most cases, they also cannot offer a definitive answer as to whether flexor tenosynovitis (infectious or inflammatory) is present. Findings, even on MRI, are often nonspecific.² For that reason, clinical presentation and fluid sampling remain the gold standard for diagnosis.

Case Discussion

It appears (given that purulent material was found on incision and drainage) that this was, indeed, a case of infectious tenosynovitis. The pathology report described “remnants of fibroconnective tissue displaying florid acute inflammation and extensive necrosis.” While the inflammation is acute, was the necrosis secondary to this particular infection or was the necrosis present from the presumed finger infection that the patient described having occurred 5 years earlier? Could that also have been an episode of infectious tenosynovitis?

Conclusion

The case described here underscores the importance of being vigilant when treating finger infections. It has been said, “A diagnosis you don’t think of is a diagnosis you can’t make.” Always think of the possibility of suppurative flexor tenosynovitis when forming your finger infection differential. ■

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INSIGHTS IN IMAGES

CLINICAL CHALLENGE

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.



The patient, a 3-year-old male, suffered a blow to his left 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 Greenstick/Torus fracture of the distal radius. A cast splint and follow up with an orthopedist are appropriate for this patient.

*Acknowledgement:
Case presented by
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ABSTRACTS IN URGENT CARE

- Risk Factors for Clinical Failure in Cellulitis and Skin Abscess
- Waiting Room Art
- Decision Rule for Syncope
- Foley Catheter Trauma
- Urine Odor and UTI

■ 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.

Risk Factors for Clinical Failure in Cellulitis and Skin Abscess

Key point: Hospitalized patients with obesity may experience clinical failure because of inadequate antibiotic dosing.

Citation: Halilovic J, Heintz BH, Brown J. Risk factors for clinical failure in patients hospitalized with cellulitis and cutaneous abscess. *J Infect.* 2012;65(2):128-134.

Although most individuals with cellulitis or skin abscess are managed as outpatients, hospital admission is sometimes necessary. Several risk factors for hospitalization have been identified. Now, investigators in California have conducted a retrospective cohort study to examine factors associated with clinical failure in hospitalized patients with these skin and soft-tissue infections (SSTIs) — an issue that has previously received scant attention. The study was conducted at a single academic tertiary-care hospital and involved 210 adults admitted between July 1, 2009, and June 30, 2011, for cellulitis with or without abscess. Clinical failure was defined as treatment failure (repeat incision and drainage, change in antibiotic therapy, or — at hospital discharge — extension of the originally prescribed treatment duration because of inadequate clinical response), recurrence, emergency room visit, rehospitalization, or SSTI-related death ≤ 30 days after discharge.



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Eight-two percent of the patients were admitted through the emergency department, and 39% were “bounce-backs” — that is, they had received treatment for the same problem within the preceding 30 days. Fifty-five percent of the patients had lower-extremity infections; 48% had abscesses.

Among the 106 patients with clinical outcomes evaluable at the end of therapy, 34 (32%) experienced clinical failure. Risk factors independently associated with failure were weight ≥ 100 kg (odds ratio, 5.20; 95% confidence interval, 1.49–18.21), body-mass index ≥ 40 (OR, 4.10; 95% CI, 1.21–13.84), inadequate empirical antibiotic therapy (OR, 9.25; 95% CI, 1.87–45.73), recent antibiotic therapy (OR, 2.98; 95% CI, 1.10–8.10), and low antibiotic dose at the time of hospital discharge (OR, 3.64; 95% CI, 1.41–9.41).

Published in *J Watch Infect Dis.* May 2, 2012 — Larry M. Baddour, MD. ■

Placing Art in the Waiting Room Mellows Patients and Visitors

Key point: A simple study shows that installing images of nature in the waiting room can reduce restless behavior.

Citation: Nanda U, Chanaud C, Nelson M, et al. Impact of visual art on patient behavior in the emergency department waiting room. *J Emerg Med.* 2012;43(1):172-181.

Prior evidence suggests that images of nature can lessen anxiety and perceived pain in healthcare environments. In the current study, investigators used a systematic observation tool to quantify patient and visitor behavior before and after installation of still and video images of nature in the waiting rooms of

Houston's two Level 1 trauma centers.

After the installation, there was a significant reduction in restless patient/visitor behavior (getting out of the seat, pacing, asking questions at the front desk, stretching, and fidgeting). The noise level decreased by a mean of 6 decibels — only partly attributable to a reduction in the number of TV screens with sound.

Published in *J Watch Emerg Med*. May 11, 2012 — Daniel J. Pallin, MD, MPH. ■

New Decision Rule for Syncope Safely Reduces Hospitalizations

Key point: *At a single emergency department, implementation of the Boston Syncope Criteria reduced admissions by 11% and identified all patients with adverse outcomes.*

Citation: Grossman SA, Bar J, Fischer C, et al. Reducing admissions utilizing the Boston Syncope Criteria. *J Emerg Med*. 2012;42(3):345-352.

The cost of syncope hospitalizations in the is roughly \$2 billion per year. Investigators assessed the effectiveness and safety of a clinical decision rule (the Boston Syncope Criteria) to identify syncope patients at risk for adverse outcomes. In a prospective study at a single emergency department (ED), the investigators enrolled 293 adults who presented with syncope (defined as loss of consciousness for <5 minutes with spontaneous recovery), and were managed at physician discretion before implementation of the rule, and 277 adults who presented after implementation. The rule recommends admission for patients with acute coronary syndrome, conduction disease, worrisome cardiac history (such as dysrhythmia, pacemaker), valvular heart disease, family history of sudden death, volume depletion, persistent abnormal vital signs in the ED, or primary central nervous system event.

Disposition decisions were in accordance with the rule in 96% of cases. The hospital admission rate decreased from 69% before implementation to 58% after. There were no adverse outcomes within 30 days among patients who were discharged according to the rule. The rule had a sensitivity of 100% and a specificity of 57% for identifying patients with adverse outcomes.

Published in *J Watch Emerg Med*. May 4, 2012 — Daniel J. Pallin, MD, MPH. ■

Genitourinary Trauma with Foley Catheters

Key point: *Genitourinary trauma is likely as important a complication as infection.*

Citation: Leuck AM, Wright D, Ellingson L, et al. Complications of Foley catheters — is infection the greatest risk? *J Urol*. 2012;187(5):1662-1666.

The impetus to reduce Foley catheter use in hospitalized patients comes mostly from a desire to prevent catheter-associated uri-

nary infections. However, anyone who practices inpatient medicine is familiar with the agitated older man who yanks at his Foley catheter and induces traumatic injury to the bladder or urethra. Researchers at the Minneapolis Veterans Affairs hospital collected data prospectively on all hospitalized patients with Foley catheters during a 16-month period and determined the incidence of Foley-related trauma.

During 6,500 patient-days of Foley catheter use, 89 patients suffered 100 instances of catheter-associated genitourinary trauma. Among the adverse events were 11 cases of "creation of a false passage," 7 cases of prostatic or intraperitoneal catheter placement, 7 cases of penile trauma or urethral meatal erosion, and 33 cases of gross hematuria. By comparison, 116 episodes of urinary infection were documented in this same cohort, but only 21 met criteria for symptomatic infection (as opposed to asymptomatic bacteriuria).

Published in *J Watch Gen Med*. May 10, 2012 — Allan S. Brett, MD. ■

Is Urine Odor Associated with UTI?

Key point: *Parental report of malodorous urine was significantly associated with urinary tract infection in young febrile children.*

Citation: Gauthier M, Gouin S, Phan V, Gravel J. Association of malodorous urine with urinary tract infection in children aged 1 to 36 months. *Pediatrics*. 2012;129(5):885-890.

Urine has an odor, but often parents describe the odor of their child's urine as stronger or more objectionable than usual. To determine whether parent report of urine odor is a reliable indicator of urinary tract infection (UTI), Canadian researchers analyzed symptom questionnaires for 331 children (age range, 1–36 months) who presented to an emergency department with symptoms suggestive of UTI (>90% had fever without source, others had unexplained vomiting or irritability without fever). Urine obtained for culture was collected by bladder catheterization (90%), midstream clean catch (9%), or suprapubic aspiration (1%). Questionnaires were completed before urinalysis results were known.

Fifteen percent of children had a UTI (defined as a positive urine culture). Urine that was stronger or more offensive than usual was reported by parents in 57% of children with UTI and 32% of children without UTI. In multiple regression, children with malodorous urine had significantly increased odds of UTI (odds ratio, 2.73), after adjustment for sex and the presence of vesicoureteral reflux. The sensitivity, specificity, and positive likelihood ratio of malodorous urine as an indicator of UTI were 57%, 68%, and 1.8, respectively. Urine odor was more strongly associated with UTI than vomiting, diarrhea, or dysuria.

Published in *J Watch Ped Adol Med*. May 16, 2012 — Cornelius W. Van Niel, MD. ■



What Does Obamacare Mean for the Urgent Care Industry?

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

Chief Justice Roberts, writing for the majority, published the Supreme Court's decision in *National Federation of Independent Business v Sebelius* on June 28, 2012. With a few exceptions, the decision upheld the bulk of the Patient Protection and Affordable Care Act (PPACA), also known as Obamacare.

In the next few paragraphs I will attempt to make some sense out of the ruling and how, if applicable, it applies to the urgent care industry.

The Supreme Court granted certiorari (agreed to review) on four issues where the federal appellate courts were split.

The Anti-Injunction Act

The Anti-Injunction Act (AIA) generally prevents any one party from challenging the legality of a federal tax until a taxpayer has paid the tax, filed for a refund, been audited by the Internal Revenue Service (IRS), or sued for a refund in federal court. The Court appointed an *amicus curiae* (friend of the court) to argue that the AIA prevented a decision on PPACA until its shared responsibility (tax) payment was due. The amicus argued that since the shared-responsibility penalty was collected by the IRS in the same manner as a tax under the auspices of the Secretary of the IRS that the penalty was a tax, and therefore, subject to the AIA and not "ripe" for judicial review because the tax had yet to come due.

The Court rejected this argument and held that the AIA and PPACA are both creations of Congress and that how they relate to each other is up to Congress. "Congress chose to describe the shared responsibility payment, not as a tax but as a penalty." In doing so, Congress had expressed its intent that the AIA should not apply, thus permitting the case to go forward on its merits and not barred by subject matter jurisdiction

(no one paid the tax yet). So, under the AIA, the inducement to purchase health care insurance is not a tax and the Anti-Injunction Act is held not to apply.

The Constitutionality of the Individual Mandate

The cornerstone of PPACA's mandate is Congress's power to regulate interstate commerce. The Commerce Clause contained in Article 1, Section 8, Clause 3 of the Constitution holds that "Congress has the power to regulate commerce with foreign nations, and among the several states, and with Indian Tribes." The Court established long ago that this clause gives Congress "the power to regulate the channels of interstate commerce, persons or things in interstate commerce, as well as interstate or purely intrastate activities which have substantial effects on interstate commerce."ⁱⁱ

The majority of the Court rejected the argument that the Commerce Clause alone could legitimize the individual mandate and struck it down on that basis. Next, they undertook the task of defining some previously unaddressed questions on the limitations of the Commerce Clause. Are individuals part and parcel of some markets even through their own inaction, and if so, does collective inaction substantially affect interstate commerce? Finally, can failure to act be regulated and if so, where if anywhere does the Commerce Clause ever reach its limits?

The Government argued that because everyone at some point in their life will need healthcare, a decision not to purchase health insurance was a *de facto* decision about how a person without health insurance would engage the health care system in the future. Analogizing the need for health care with the need for broccoli, Scalia asked, "Could you define the market — everybody has to buy food sooner or later, so you define the market as food, therefore, everybody is in the market; therefore, you can make people buy broccoli."

Chief Justice Roberts explained that the "practical statesmen" who framed the Constitution did not anticipate that Congress's power to regulate commerce was not meant to include



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compelling commercial activity. “If the power to regulate something included the power to create it, many of the provisions of the Constitution would be superfluous.”

The Chief Justice and the dissenting Justices reasoned that the government was attempting to shoehorn two separate markets (consumers of health care and health insurance purchasers) into a single market. By forcing healthy people without insurance to buy health care insurance, PPACA was forcing them into one market when they were not actually active in the other. In other words PPACA is targeted at a class whose commercial inactivity is its defining feature. Further, under the government’s logic, this interpretation of the Commerce Clause authorizes Congress to compel citizens to act as the government would have them act.

The government supported their argument by citing two important cases. In *Wickard v Fillburn*, the Court upheld a law that capped production of wheat in order to increase wheat prices. By extension, the Court upheld that a farmer producing wheat for his own consumption could be forced to reduce his harvest even though his wheat would never make it to the public market. *Wickard* was the seminal case about how inconsequential non-commercial, purely intrastate activity could in the aggregate have an effect on interstate commerce. In *Gonzalez v Raich*, the Court previously upheld the Drug Enforcement Agency’s seizure of marijuana grown legally under state law. In that case, the Court used the Necessary and Proper Clause which gives Congress the authority to “make all laws which shall be necessary and proper for carrying into execution it enumerated powers.”ⁱⁱⁱ Thus, Congress could regulate purely intrastate commerce even if the activity fell short of what was justified under the Commerce Clause.

In the end, the majority concluded that because the individual mandate could not be authorized under the Commerce Clause, the Necessary and Proper Clause was unable to save it. In doing so the Court rejected the “mandate” by reasoning that Congress did not have the power to compel people to purchase health insurance. Thus the Court rejected the individual mandate as unconstitutional under the Commerce Clause.

The Severability of the Individual Mandate if Unconstitutional

The government anticipated that the individual mandate might not make the Commerce Clause hurdle so it argued that if even if the Court rejected the constitutionality of the individual mandate and that the penalties were truly penalties (not taxes) for the purpose of the AIA, they were taxes under a constitutional analysis and could be justified as a proper use of Congress’s power to lay and collect taxes. If successful, it would mean that even if the mandate did not survive, the Government could still tax individuals who elected not to purchase health insurance.

Before outlining the Court’s holding, Chief Justice Roberts wrote about the Court’s reticence to invalidate the acts of elected leaders. “The text of a statute can sometimes have more than one possible meaning and it is well established that if a statute has two possible meanings, one of which violates the Constitution, courts should adopt the meaning that does not do so.” This is integral to understanding how the Court determined that penalties are not taxes under the AIA but are taxes through a constitutional analysis lens. It is through this adroit legal reasoning that PPACA was saved.

To come to this conclusion, the court cited several cases where the label applied by Congress was not determinative in a constitutional analysis. In addition, as the Chief Justice pointed out, the Court’s interpretation need not be the natural one but only the fairly possible one in order to construe law as constitutional. At the end of day, despite the dissenter’s charge of judicial overreaching, the Chief Justice reminded the plaintiffs that the Court had a duty to adopt a constitutional interpretation of PPACA even if Congress and the President did not originally justify the shared responsibility payments as a tax.

The Court went to great lengths to say that it was not upholding the mandate with a tax in order to construe PPACA as constitutional under the Taxing Clause. On the contrary, the Court was simply preserving PPACA’s inducement for obtaining health insurance (tax) even though it held that the mandate to purchase insurance is unconstitutional. Thus, the penalties for violating the individual mandate are upheld under the taxing clause.

Expanded Medicaid Coverage Requirements of States

Under PPACA, states were mandated to expand Medicaid coverage to all individuals under the age of 65 with an income less than 133% of the federal poverty level or face having all their federally subsidized Medicaid funds withdrawn. By a 7-2 majority, the Court struck down this use of Congress’s spending authority because in their determination, it was simply too coercive. The states relied upon two cases. In *Steward Machine Co. v Davis*, Justice Cardoza wrote that the idea of an inducement created by conditions placed upon federal subsidies could be so severe that an inducement actually becomes compulsory. The majority applied Cardoza’s logic, opining that the withdrawal of all federal funds was impermissibly compulsive and that Congress was attempting to conscript states into a new program by threatening to punish them if they stayed with an existing one.

In summary, the Medicaid expansion program remains, albeit voluntarily; thus, PPACA’s Medicaid expansion is not binding on the states.

Conclusion

Save for individual states’ now-voluntary participation in Medicaid expansion, the essential components of PPACA remain

intact. In some respects, both sides of the aisle claimed victory. Chief Justice Roberts and the Court broke new ground while showing both judicial restraint and Congressional deference.

Unlike the Court's decision, the jury remains out for the on-demand care industry.

What does this mean for our industry? Unlike the Court's decision, the jury remains out for the on-demand care industry. From my vantage, the following are some things to consider:

1. We should expect more patients to walk through our doors. Although not everyone will obtain insurance (some will elect to pay the tax) we will see more patients who are now covered by either private insurance or Medicaid. Using what happened post Romneycare in Massachusetts as an anecdotal barometer, the emergency departments and clinics were flooded with patients seeking treatment for their pent up health care demands.

No matter the ultimate outcome, we will continue to see an uptick in our volume. Many emergency departments across the country are starting to send non-paying patients out the door after performing emergency medical screening and documenting that they do not have an emergency medical condition.

2. If your particular state opts into the Medicaid expansion and you currently accept Medicaid patients, you will see a fairly dramatic increase in the number of patients who now qualify for assistance under the 133% of the federal poverty level determination. If you don't accept Medicaid patients, you may want to consider it.
3. As more individuals enroll in Medicaid and private insurance, I expect to see our average per patient reimbursements decline, thereby continuing the downward trend in urgent care revenue and the "you'll make it up in volume" health plan mantra. This will affect the smaller groups to a greater extent than the larger players.
4. We will start to see some new payment models and incentives. I would not be surprised to see capitation models come back into vogue, particularly in an accountable care organization-dominated world.

If, after reading this, you are considering ending it all, don't forget this could all be rendered moot after the November elections! No matter the outcome, our future will not be boring. ■

ⁱ U.S. Constitution, Article 1, Section 8, Clause 3.

ⁱⁱ *Id.*

ⁱⁱⁱ U.S. Constitution, Articles 1 & 8, Clause 18.



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Tetanus Code Change, Coding Injections and Infusions, Facility and After Hours Codes

■ DAVID STERN, MD, CPC

Q. What codes should we use in place of the discontinued 90701 (tetanus vaccines, diphtheria, tetanus toxoids, and whole cell pertussis vaccine [DTP], for intramuscular use) and 90718 (tetanus and diphtheria toxoids [Td] adsorbed when administered to individuals 7 years or older, for intramuscular use) that were discontinued effective July 1, 2012?

A. You should use 90714 (Tetanus and diphtheria toxoids [Td] adsorbed, preservative free, for use in individuals 7 years or older, for intramuscular use) because only preservative-free Td is available for administration.

DTP is a cellular vaccine that caused many untoward reactions. It is no longer used in the USA, and the Tdap vaccine is used instead. Use 90715 (Tetanus, diphtheria toxoids and acellular pertussis vaccine [Tdap], for use in individuals 7 years or older, for intramuscular use). ■

Q. When giving a TB skin test, can we charge for a subcutaneous injection?

A. Use CPT 86580 (Skin test; tuberculosis, intradermal) for purified protein derivative (PPD) testing in the office. This test is not a vaccine; rather, it is a screening test for the presence of an immune response, indicating the presence of tuberculosis. In addition, code 86580 includes intradermal injection of the substance.



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), 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.

The AMA Resource Based Relative Value System (RBRVS) does not include the work for reading the test. Therefore, you can also code 99211 for the nurse reading. However, per incident-to regulations, the physician must be in the office at the time of the reading in order to code the 99211.

If the test is positive, you can code for the additional services rendered during the visit. Typically, the physician will perform a face-to-face encounter with the patient for further evaluation and management (reviewing the diagnosis, physical exam, risk, possibility of a false-positive test, treatment options, etc.). You would code the E/M appropriately (99212-99214). You would also want to code for any additional testing (such as a chest x-ray).

The appropriate ICD-9 code is V74.1, Special screening examination for bacterial and spirochetal diseases; Pulmonary tuberculosis. ■

Q. How would I code and bill for adult and child Epi-Pens? Is HCPCS code J3490 the correct code, using the number of injectable pens as 1 unit?

A. You can bill for the injection administration using CPT 96372, “therapeutic, prophylactic, or diagnostic injection...subcutaneous or intramuscular” along with the medication itself. Some payors will accept HCPCS code J0171, “Adrenalin, epinephrine” while others may prefer HCPCS code J3490, “Unclassified drugs.” You will want to check with the payor to see which is required. Remember that if you bill J3490, you will want to include the drug name and dosage in Box 19 of the CMS 1500 form.

The code for the medicine is the same for a child and for an adult. ■

I would strongly recommend that start and stop times of each IV therapy service provided be documented.

Q. When coding for intravenous (IV) therapies, CPT says to document the time. Is it sufficient to document the length of time of the IV as opposed to the start and stop times?

A. There is no specific requirement for documenting start and stop times, but hydration therapy cannot be reported if it is performed as a concurrent infusion. For example, during hydration therapy, an IV push of a medicine was given in the same IV site. Because the push was given concurrent with the hydration, you cannot count the duration of the push towards the total time of the hydration.

In the event of an audit, you would want those times documented in order to show that services were billed appropriately. Therefore, I would strongly recommend that start and stop times of each IV therapy service provided be documented. ■

Q. I am opening a walk-in urgent care clinic as part of my primary care practice and am encountering resistance with reimbursement. A major payor has stated it will not reimburse code S9o88 and that they will only reimburse for the E/M codes. Who recognizes S9o88, 99o5o, and 99o51 codes and how much is the reimbursement for all three codes?

A. You are correct in noticing that reimbursement for certain codes can make a significant difference to the financial health of your urgent care center. We have executed 500+ urgent care contracts. It is important for centers to negotiate these rates up front, as payors are usually quite resistant to these discussions once the contract is signed.

In states that are new to private urgent care centers, we have to do a lot of education of payors in order to get them up to speed about reasonable terms for urgent care centers.

I would like to share the rates that you should expect from each payor, but unfortunately the government forbids sharing of rates as a violation of antitrust statutes. ■

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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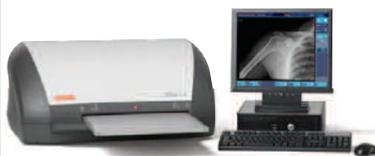
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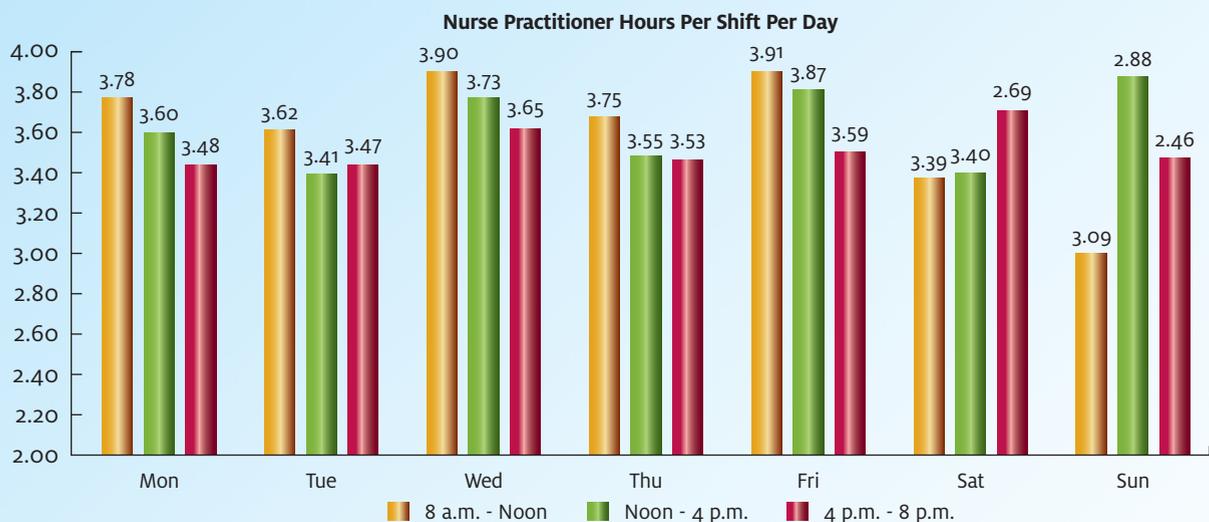
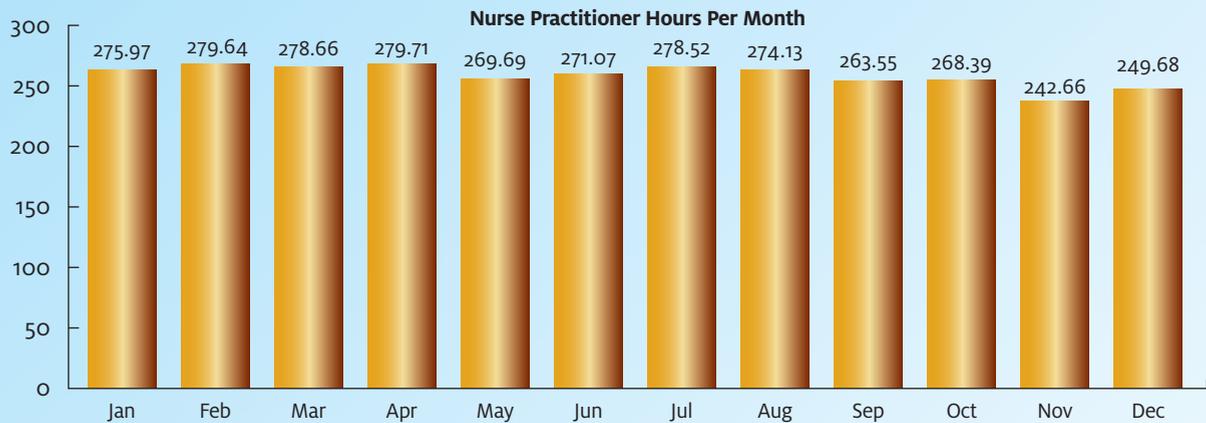
DEVELOPING DATA

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: How many hours are nurse practitioners working in your center?

NURSE PRACTITIONER STAFFING

The 2008 survey looked generally at numbers of professionals on staff, as well as at patient volume per provider, qualifications of physicians, and physician benefits. The 2010 survey delved into these aspects much more in depth and in some new areas. From January to December 2009, 44.8% of all centers reported at least one nurse practitioner working. Among these centers, the following results apply:



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.



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