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Urgent Care
Association
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LETTER FROM THE EDITOR-IN-CHIEF

Judgment Day



Carl Jung said, “We should not pretend to understand the world only by the intellect. The judgment of the intellect is only part of the truth.” In medicine, reliance on intellect alone is a significant danger. Ignorance of cultural, social, and even psychological context can

mislead the clinician and risks misdiagnosis and error. Yet the very basis of medical decision-making is rooted in the rule of intellect. Evidence-based medicine is, after all, the accepted rule of law in clinical circles these days, and it has become the rallying cry of everyone from healthcare reformers to physician colleges. But sometimes, the evidence can mislead. We fall victim to the bias of intellectual facts and past experience, and ignore the power of context and nuance. To understand how, we must first examine the roots of medical decision-making.

The decision-making process is fed by a steady stream of facts and calculations learned through study and experience and filtered through the evidence-based guide of the scientific model. The scientific model is a rather rigid premise and leaves little room for speculation. It is not based on hope or belief, nor is it fond of irresolute thinking. The scientific model creates the framework for “answers” in medicine. It generates judgments, and while there may be debate over the “strength of evidence,” it is nonetheless a path towards relative certainty of thinking.

In practice, the scope of knowledge derived from the lifelong pursuit of the most certain and relevant of these judgments is what drives our medical decision-making. With each encounter we attempt to lump presentations into neat and factual compartments in an effort to bring definition and appropriate action. The longer you practice, the better you get, and after a while you feel like you can efficiently compartmentalize with ease and confidence. The result is a very systematic and productive machine that can generate conclusions and their associated interventions with minimal risk of error.

Consider the 30-year-old postpartum female with leg pain, swelling, and shortness of breath; the patient with runny nose, congestion, and cough for 4 days; or the man with non-traumatic back pain for 2 days with no neurologic symptoms. The decision-making machine will accurately and reproducibly determine the appropriate diagnosis and intervention for each of these clinical scenarios. Assessment is swift and painless.

And yet, despite all my calculated certainty, every day in practice

reveals cracks in the scientific armor. I see patients who can’t give me the history I want; patients with their own agendas; patients with conclusions drawn from the Internet and Aunt Susie; patients who present irrelevant clues that lead me down the wrong diagnostic path.

Consider these common presentations:

1. A 26-year-old male on his third visit for a back problem who is visibly, albeit “dramatically” in pain.
2. Anxious, 34-year-old female with dizziness and tingling in her fingers.
3. 45-year old-female, seen on multiple occasions for migraines and well known to staff as “challenging and difficult,” presents in her usual sunglasses and pajamas complaining of worsening headache.

In the middle of a busy day at the urgent care, all three of these patients run the risk of falling victim to judgments deemed factual by virtue of the certainty of our past experiences. At risk of falling victim to the drug seeker, the panicky worrywart and the “borderline” migraineur, we quickly compartmentalize and don our emotional armor to protect ourselves and our staff. Odds are that our judgments are right. But what happens when we are wrong? What opportunities did we miss to help someone in need? How many epidural abscesses, acute MIs and subarachnoid bleeds will we miss if we rely on the certainty of our judgments and experiences?

When we remove all that armor and dispense with our pre-judgments, we expose ourselves to risk and uncertainty, but we also unveil nooks of opportunity. Within these exposed cracks lie the real joys of medicine. These are the encounters you remember. These are the motivational stories from everyday practice. For all the emphasis on “calculation” in medical decision-making, and despite all the pressures to be productive and efficient, it is ability to defer judgment and challenge our intellectual biases that makes this profession so special and worthwhile. ■

Lee A. Resnick, MD
Editor-in-Chief

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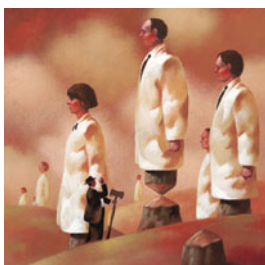
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Brendan Kilbane, MD, FAAP

PRACTICE MANAGEMENT



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Letting employees go is never easy. This article offers tips for protecting your business and yourself if termination is necessary. Among the key recommendations are compiling documentation and seeking legal advice.

Alan A. Ayers, MBA, MAcc

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Close follow up is necessary for pediatric patients with vague presentations, lest a diagnosis of childhood cancer be missed.

Janet D. Little, MD



IN THE NEXT ISSUE OF JUCM

Over the course of a lifetime, upwards of 80% of adults are likely to experience an episode of low back pain. It's the second most common reason for office visits in the United States and a frequent presentation in urgent care. Next month's cover story explores the anatomy of low back pain, steps in clinical evaluation and physical examination of the patient with this complaint, rationale for laboratory studies and radiographic tests, and options for management. To better evaluate and treat such patients, urgent care providers need a good understanding of the anatomy of the back and they must be vigilant for "red flags" that signal a potentially serious condition. When there are no "red flags," acute low back pain is usually self-limiting and neither imaging nor laboratory studies are required and management consists of a short course of nonsteroidal anti-inflammatory drugs with or without muscle relaxants, and patient education.

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Lee A. Resnick, MD
editor@jucm.com

EDITOR

Judith Orvos, ELS
jorvos@jucm.com

ASSOCIATE EDITOR, PRACTICE MANAGEMENT
Alan A. Ayers, MBA, MAcc

CONTRIBUTING EDITORS
Nahum Kovalski, BSc, MDCM
John Shufeldt, MD, JD, MBA, FACEP
David Stern, MD, CPC

MANAGER, DIGITAL CONTENT
Brandon Napolitano
bnapolitano@jucm.com

ART DIRECTOR
Tom DePrenda
tdeprenda@jucm.com

**BRAVEHEART
PUBLISHING**

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

PUBLISHERS

Peter Murphy
pmurphy@braveheart-group.com
(201) 529-4020

Stuart Williams
swilliams@braveheart-group.com
(201) 529-4004

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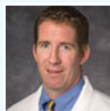
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According to one study, 91% of parents suffer from “fever phobia”—the erroneous belief that fever alone could hurt their child. It’s not surprising, then, that fever is one of the most common chief complaints in pediatric patients presenting at urgent care centers. In the vast majority of these cases, the source of the fever will be discovered on physical exam or the explanation will be a self-limited viral illness. The challenge for urgent care providers is to identify the pediatric patient with fever who is at high risk of a serious bacterial infection (SBI) such as urinary tract infection, pneumonia, bacteremia, or meningitis. This month’s cover story, by Brendan Kilbane, MD, FAAP, offers recommendations for an age-based approach to laboratory testing that is rigorous yet ensures prompt identification of the “not well” pediatric patient with fever and appropriate evaluation of the “well” pediatric patient to rule out any possible SBIs.



Dr. Kilbane is Assistant Professor, Pediatric Emergency Medicine, Rainbow Babies & Children’s Hospital, University Hospital Case Medical Center, Cleveland, OH.



Diagnosing childhood cancers accurately and in timely fashion is a challenge for urgent care providers, as underscored by this month’s case report, by Janet D. Little, MD. The patient was a 12-year-old girl with shortness of breath not relieved by her albuterol inhaler but no cough. Her presenting complaints were episodes of nausea and vomiting, sore throat, and chest discomfort. The diagnosis, based on diagnostic studies including chest x-ray? Hodgkin Lymphoma, a disease with peak incidence in the teen years and again in the third decade of life. The message? Remember to counsel patients about the need for close follow-up, particularly when their symptoms are non-specific.

Dr. Little is staff physician and Director of Education at My Care Express Urgent Care in Eldersburg, MD.

Terminating an employee means much more than simply saying “You’re fired.” It’s unpleasant and whether the rationale is job performance or economic necessity, it has an impact on the employee beyond loss of income. For an urgent care provider, termination is a business decision that also involves legal implications, as described in this month’s practice management article by Alan A. Ayers, MBA, MAcc. Meant as “food for thought” and not a substitute for legal advice, the piece emphasizes the need to do your homework before letting an employee go, balance risks and benefits if the action is “for cause,” and plan ahead for the consequences and the actual meeting with the employee.



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

Also in this issue:

John Shufeldt, MD, JD, MBA, FACEP, offers 46 “pearls” about ideas that seemed good at the time but in retrospect present potential medicolegal disasters that urgent care providers would do well to avoid.

Nahum Kovalski, BSc, MDCM, reviews new abstracts on literature germane to the urgent care clinician, including studies of DTaP injection site reactions, UTI recurrence in men, and computed tomography for evaluation of right lower quadrant pain.

In Coding Q&A, **David Stern, MD, CPC**, discusses primary care in the urgent care setting, E/M codes with other services, and penicillin injection.

Our Developing Data end piece this month looks at what methods urgent care providers are using for patient registration. ■

To Submit an Article to JUCM

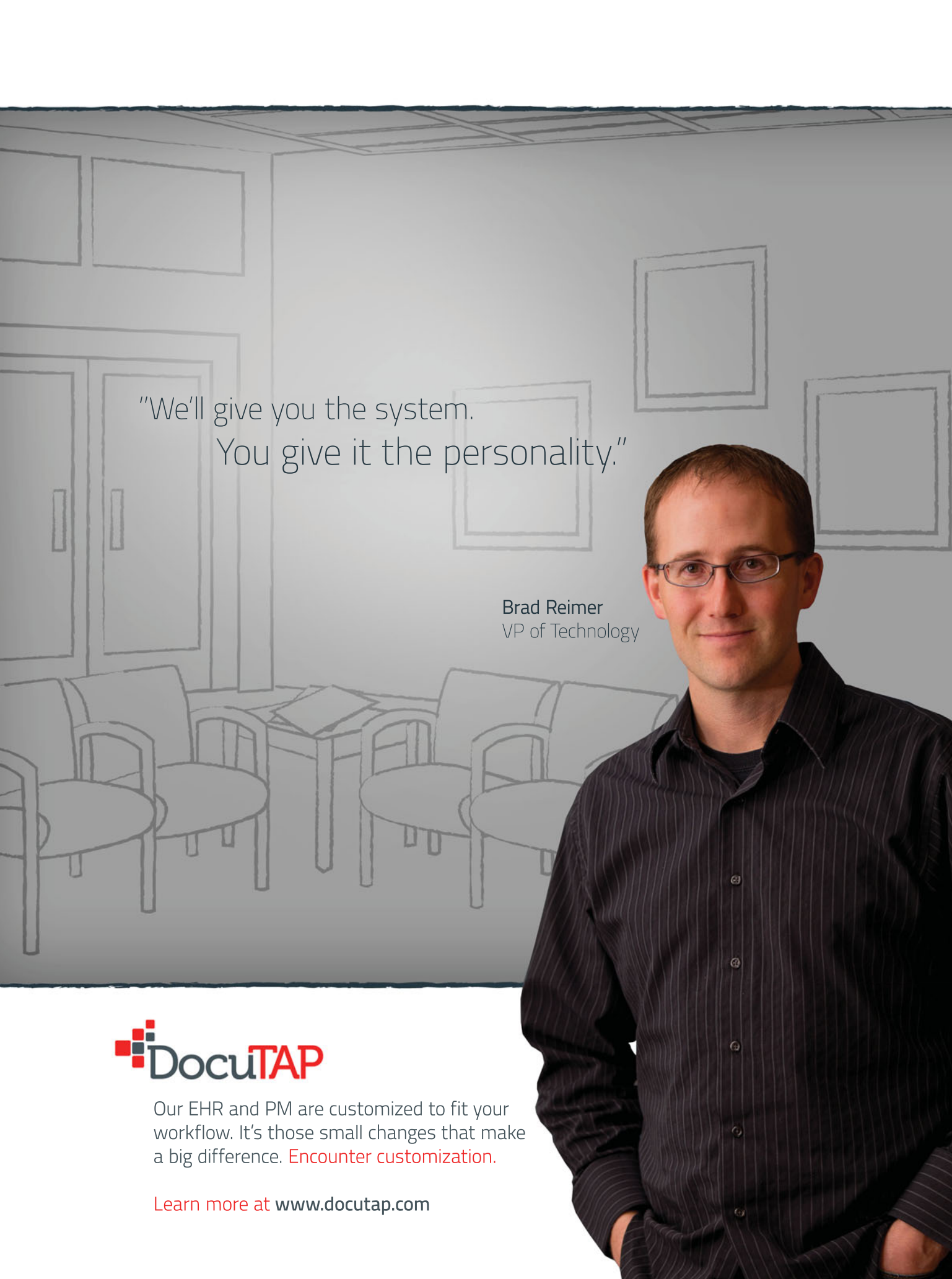
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Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, pictures, and references. Articles that are longer than this will, in most cases, need to be cut during editing.

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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A man with glasses and a dark striped shirt stands in the foreground. The background is a waiting room with chairs and a table, overlaid with a light gray line-art sketch of the same scene.

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UAB-hosted Case Competition Highlights Innovative Approaches To Urgent Care

■ P. JOANNE RAY

Urgent care took center stage in The University of Alabama – Birmingham (UAB) 7th Annual Health Administration Case Competition. With only three intense weeks to prepare, graduate students from 32 CAHME-accredited health administration programs applied their incredible knowledge to a capstone experience that tested their analytical skills, teamwork and presentation skills on a real-life, real-time case regarding the opening of urgent care centers. As I am sure my fellow judges (including Alan Ayers, Cindi Lang, Laurel Stoimenoff, and Steve Sellars) will agree, we were privileged observers and urgent care was the winner!

This is the first time that urgent care has been the subject of this type of national competition. It attests to the key role that urgent care as a specialty will continue to play in the health care arena as the focus shifts away from the hospital and toward recognition of alternative care delivery channels and issues such as the shortage of primary care physicians, overcrowding of emergency departments, and access challenges. Urgent care centers were keenly represented in the contest as playing a key role in ensuring that convenient access to quality, cost-effective healthcare services is available.

That said, the ongoing growth of the urgent care industry will undoubtedly lead to a greater need for administrative expertise. Steve Sellars noted, “I encourage urgent care operators to consider the many talented students completing their MHA coursework. I’m certain they will represent urgent care organizations just as well as they represented their universities at the UAB Health Administration Case Competition.” And, Alan

Ayers added, “Program directors from the graduate programs represented showed a great interest in placing students in non-hospital operating models. The sponsoring group, new to urgent care, is now clearly aware of the benefits that UCAOA will offer to them, from physician recruitment to benchmarking to resources for starting up new centers.”

The first, second, and third place teams received cash awards. All participating teams should be considered winners just by virtue of their participation in this integrative case competition. Those who excelled to the top of the competition included:

1st Place: University of North Carolina at Chapel Hill

2nd Place: University of Minnesota

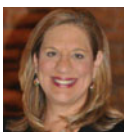
3rd Place: Rush University

Finalists: Texas A&M, University of Illinois – Chicago, and Baruch/Mt. Sinai College

Honorable Mention: Baylor University, Ohio State University, University of Florida, University of Iowa, University of Pittsburgh, and Virginia Commonwealth University

UCAOA was a significant presence in the competition. More than 25 of the students joined UCAOA to gain access to key resources as they prepared their recommendations. Our esteemed judges brought real feedback and realistic benchmarks to the evaluation of each team’s presentation. Further discussion among the participants, leaders, and sponsoring groups will be held in the coming weeks and months to explore unresolved issues from the case, which may provide opportunities to discover even more input and applicable outcomes.

Congratulations to the talented students, kudos to their astute faculty mentors, and thank you to UAB and the UCAOA judges who represented us well. Ultimately, I fully expect that a few bright leaders from this competition will find their way into our industry, bringing with them innovative approaches to the future of urgent care! ■



P. Joanne Ray is chief executive officer of the Urgent Care Association of America. She may be contacted at jray@ucaoa.org.



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An Age-Based Approach to Fever of Uncertain Origin in the Pediatric Patient

Urgent message: Fever in pediatric patients, while frequent, is rarely the result of a serious illness. Urgent care practitioners must be able to consistently distinguish between serious and benign causes with a minimum of invasive testing.

BRENDAN KILBANE, MD, FAAP

Introduction

Fever is one of the most common chief complaints in pediatric patients who present for urgent evaluation. A surprising number of families continue to suffer from “fever phobia,” with one study noting that 91% of parents believe that a fever alone could hurt their child.¹ In the vast majority of pediatric patients who present with a fever, either physical exam will lead to identification of the source or the cause will be a self-limited viral illness. In a small percentage of children, however, the source of fever is a serious bacterial illness (SBI) such as a urinary tract infection (UTI), pneumonia, bacteremia, or meningitis. The challenge for an urgent care provider is to identify the patient who is at high risk of these SBIs with the least amount of invasive testing.

Background

Over the last 30+ years, the question of how best to manage the febrile pediatric patient has been the subject of countless studies. This research has primarily resulted in a variety of guidelines that identify groups of patients who are either at high or low risk of certain

Brendan Kilbane is Assistant Professor, Pediatric Emergency Medicine, Rainbow Babies & Children’s Hospital, University Hospital Case Medical Center, Cleveland, OH.



infections. That classification allows clinicians to decide if a patient requires treatment or admission. The other main finding of these studies is that different age groups have different risks of SBIs.² As a result, it is helpful to group patients by age ranges when discussing what evaluation is required.

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- The most common adverse reactions (incidence <1%) were conjunctivitis, ocular hyperemia, eye irritation, dandruff, dry skin, and skin burning sensation

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PRODUCT APPLICATION²

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INDICATION

Sklice Lotion is a pediculicide indicated for the topical treatment of head lice infestations in patients 6 months of age and older.

ADJUNCTIVE MEASURES

Sklice Lotion should be used in the context of an overall lice management program:

- Wash (in hot water) or dry-clean all recently worn clothing, hats, used bedding and towels
- Wash personal care items such as combs, brushes and hair clips in hot water

A fine-tooth comb or special nit comb may be used to remove dead lice and nits.

IMPORTANT SAFETY INFORMATION FOR SKLICE LOTION

In order to prevent accidental ingestion, Sklice Lotion should only be administered to pediatric patients under the direct supervision of an adult.

The most common adverse reactions (incidence <1%) were conjunctivitis, ocular hyperemia, eye irritation, dandruff, dry skin, and skin burning sensation.

Please see brief summary of full Prescribing Information on following page.

For more information, please visit www.Sklice.com/HCP.

^a Two randomized, double-blind, vehicle-controlled trials in patients 6 months of age and older with head lice infestations. The primary endpoint was assessed as the proportion of patients who were free of live lice at day 2 and through day 8 to the final evaluation 14 (+2) days following a single application.²

Sklice Lotion is manufactured by DPT Laboratories Ltd. and distributed by Sanofi Pasteur Inc.

References: 1. US Food and Drug Administration. Sklice Lotion approval letter, February 7, 2012. http://www.accessdata.fda.gov/drugsatfda_docs/appletter/2012/202736s000ltr.pdf. Accessed January 9, 2013. 2. Sklice Lotion [Prescribing Information]. Swiftwater, PA: Sanofi Pasteur Inc.; 2012.

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Brief Summary of Prescribing Information

1 INDICATIONS AND USAGE

1.1 Indication

SKLICE® Lotion is indicated for the topical treatment of head lice infestations in patients 6 months of age and older.

1.2 Adjunctive Measures

SKLICE Lotion should be used in the context of an overall lice management program:

- Wash (in hot water) or dry-clean all recently worn clothing, hats, used bedding and towels.
- Wash personal care items such as combs, brushes and hair clips in hot water.
- A fine-tooth comb or special nit comb may be used to remove dead lice and nits.

2 DOSAGE AND ADMINISTRATION

For topical use only. SKLICE Lotion is not for oral, ophthalmic, or intravaginal use.

Apply SKLICE Lotion to dry hair in an amount sufficient (up to 1 tube) to thoroughly coat the hair and scalp. Leave SKLICE Lotion on the hair and scalp for 10 minutes, and then rinse off with water.

The tube is intended for single use; discard any unused portion.

Avoid contact with eyes.

4 CONTRAINDICATIONS

None.

5 WARNINGS AND PRECAUTIONS

5.1 Ingestion in Pediatric Patients

In order to prevent ingestion, SKLICE Lotion should only be administered to pediatric patients under the direct supervision of an adult.

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

The data described below reflect exposure to a single 10 minute treatment of SKLICE Lotion in 379 patients, ages 6 months and older, in placebo-controlled trials. Of these subjects, 47 subjects were age 6 months to 4 years, 179 subjects were age 4 to 12 years, 56 subjects were age 12 to 16 years and 97 subjects were age 16 or older. Adverse reactions, reported in less than 1% of subjects treated with SKLICE Lotion, include conjunctivitis, ocular hyperemia, eye irritation, dandruff, dry skin, and skin burning sensation.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category C

There are no adequate and well-controlled studies with SKLICE Lotion in pregnant women. SKLICE Lotion should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

No comparisons of animal exposure with human exposure are provided due to the low systemic exposure noted in the clinical pharmacokinetic study [see *Clinical Pharmacology* (12.3) in the full prescribing information].

Human Data

There are published reports of oral ivermectin use during human pregnancy. In an open label study, 397 women in their second trimester of pregnancy were treated with ivermectin tablets and albendazole at the labeled dose rate for soil-transmitted helminths and compared with a pregnant, non-treated population. No differences in pregnancy outcomes were observed between treated and untreated populations.

Animal Data

Systemic embryofetal development studies were conducted in mice, rats and rabbits. Oral doses of 0.1, 0.2, 0.4, 0.8, and 1.6 mg/kg/day ivermectin

were administered during the period of organogenesis (gestational days 6–15) to pregnant female mice. Maternal death occurred at 0.4 mg/kg/day and above. Cleft palate occurred in the fetuses from the 0.4, 0.8, and 1.6 mg/kg/day groups. Exencephaly was seen in the fetuses from the 0.8 mg/kg group. Oral doses of 2.5, 5, and 10 mg/kg/day ivermectin were administered during the period of organogenesis (gestational days 6–17) to pregnant female rats. Maternal death and pre-implantation loss occurred at 10 mg/kg/day. Cleft palate and wavy ribs were seen in fetuses from the 10 mg/kg/day group. Oral doses of 1.5, 3, and 6 mg/kg/day ivermectin were administered during the period of organogenesis (gestational days 6–18) to pregnant female rabbits. Maternal toxicity and abortion occurred at 6 mg/kg/day. Cleft palate and clubbed forepaws occurred in the fetuses from the 3 and 6 mg/kg groups. These teratogenic effects were found only at or near doses that were maternally toxic to the pregnant female. Therefore, ivermectin does not appear to be selectively fetotoxic to the developing fetus.

8.3 Nursing Mothers

Following oral administration, ivermectin is excreted in human milk in low concentrations. This has not been evaluated following topical administration. Caution should be exercised when SKLICE Lotion is administered to a nursing woman.

8.4 Pediatric Use

The safety and effectiveness of SKLICE Lotion have been established for pediatric patients 6 months of age and older [see *Clinical Pharmacology* (12.3) in the full prescribing information and *Clinical Studies* (14) in the full prescribing information].

The safety of SKLICE Lotion has not been established in pediatric patients below the age of 6 months. SKLICE Lotion is not recommended in pediatric patients under 6 months of age because of the potential increased systemic absorption due to a high ratio of skin surface area to body mass and the potential for an immature skin barrier and risk of ivermectin toxicity.

8.5 Geriatric Use

Clinical studies of SKLICE Lotion did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients.

10 OVERDOSAGE

In accidental or significant exposure to unknown quantities of veterinary formulations of ivermectin in humans, either by ingestion, inhalation, injection, or exposure to body surfaces, the following adverse effects have been reported most frequently: rash, edema, headache, dizziness, asthenia, nausea, vomiting, and diarrhea. Other adverse effects that have been reported include: seizure, ataxia, dyspnea, abdominal pain, paresthesia, urticaria, and contact dermatitis.

In case of accidental poisoning, supportive therapy, if indicated, should include parenteral fluids and electrolytes, respiratory support (oxygen and mechanical ventilation if necessary) and pressor agents if clinically significant hypotension is present. Induction of emesis and/or gastric lavage as soon as possible, followed by purgatives and other routine anti-poison measures, may be indicated if needed to prevent absorption of ingested material.

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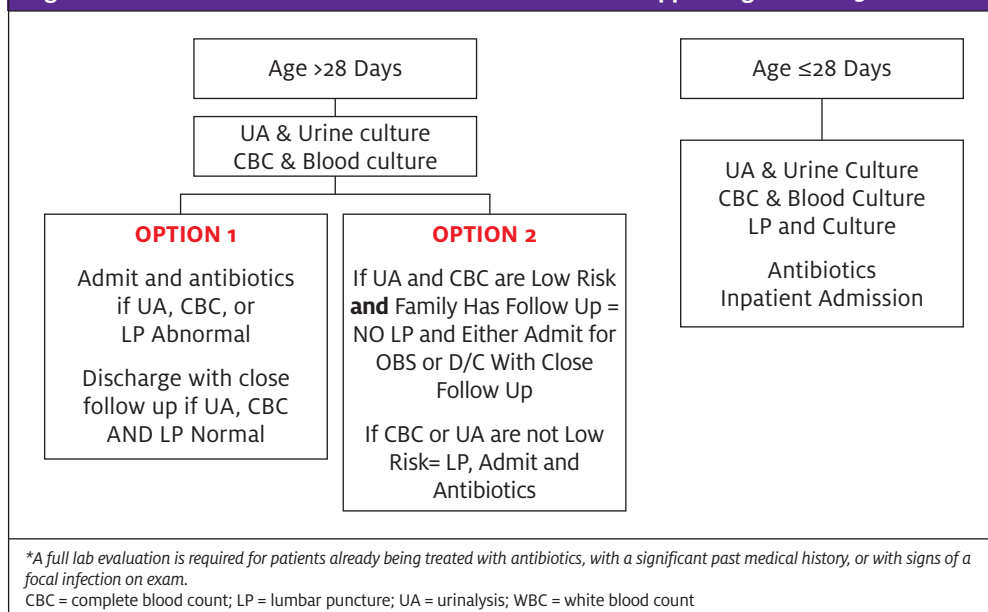
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Figure 1. Evaluation of Fever of Uncertain Source in Well-Appearing Infants <3 Months

Past medical history should include details surrounding the infant's delivery as well as a maternal history, including *Group B streptococcus* status. During the physical exam, an urgent care provider should pay particular attention to an infant's general tone and appearance. Does the child arouse easily to stimulation? Is her or she irritable or unable to be consoled? Limp or flaccid? Given the difficulty in localizing symptoms such as pain during an infant exam, it is recommend-

When evaluating a febrile pediatric patient, an urgent care provider's first and most important task is determining whether the patient is "well or not well." A good deal of research has been done in an attempt to quantify what exactly a clinician relies on to make this distinction, with limited success, and it appears that experienced urgent care providers should trust their clinical intuition because they are very good at recognizing well patients in the older age ranges. They should be more cautious, however, when making this determination in younger patients or if they have limited exposure to pediatric patients on a regular basis.^{3,4}

If a clinician determines that a patient is "not well," then the child needs appropriate laboratory studies, treatment with antibiotics and transfer to a higher level of care, independent of the lab results or the patient's age. If a patient is determined to be "well," then an urgent care provider can use the following age-based approach to guide decision-making about additional laboratory evaluation and treatment.

Aged 0 to 28 Days

History and Physical

Fever in this age group is defined as a rectal temperature $\geq 38^{\circ}\text{C}$ and a reading should be obtained along with a full set of vital signs on every patient. In this age group, the history of present illness is often brief and should focus on the family's reporting of the infant's level of arousal as well as his or her ability to feed.

ed that even those who appear "well" be managed aggressively (**Figure 1**).

Evaluation and Management

Numerous studies have documented a high rate of SBI—approximately 10% to 20%—in febrile infants.⁵ Based on this high risk, the American College of Emergency Physicians and the American Academy of Pediatrics currently recommend that these infants receive a "full septic work up." Such a work up includes a complete blood count (CBC) with blood culture, urinalysis (UA) obtained by catheterization or suprapubic aspiration with urine culture, lumbar puncture (LP) with cerebrospinal fluid (CSF) analysis and culture, and a chest x-ray (CXR) if the patient has any focal lung findings or hypoxia.^{2,6} All infants in this age group should be treated with antibiotics and admitted for observation. Initial intravenous (IV) antibiotics of choice include ampicillin 50 mg/kg and either gentamycin 3 mg/kg or cefotaxime 50 mg/kg.

Aged 28 to 90 Days

History and Physical

Fever continues to be defined as 38°C for this age range and a reading should be obtained rectally, along with a full set of vital signs. As with younger infants, the history should focus on the family's impression of the infant's general appearance, including any excessive sleepiness or irritability, and ability to feed. During the

physical exam, the urgent care provider should again observe the infant's general tone and level of arousal. Many clinicians, depending on their experience, will be able to make a general impression as to whether the infant is "well or not well." However, additional laboratory evaluation is required for even "well"-appearing infants in this age group. Any infant that a clinician feels is "not well" should have a full evaluation and be admitted for observation, independent of any laboratory results (**Figure 1**).

Evaluation and Management

Previous research has established that 5% to 10% of infants in this age group will have an SBI, the majority of which are UTIs, whereas 1.5% to 2% will be found to be bacteremic and 0.5% will have meningitis.⁷ An urgent care provider's goal should be to classify each patient as either at high or low risk of having an SBI, which will then dictate if inpatient admission is required or management can safely be done on an outpatient basis.⁸ The process of classifying such patients by incorporating laboratory results into assessment arises from research from the 1990s that led to development of "city"-based criteria for Rochester, Boston, and Philadelphia, among others. Unfortunately, these criteria all use slightly different ages and lab values, which results in some minor variations among the recommendations.⁹⁻¹¹

A reasonable approach is that **ALL** patients should receive a CBC with blood culture and a UA with urine culture obtained by catheterization. Patients with focal respiratory findings or hypoxia should have a CXR. A Patient is considered at low risk of SBI if he or she has the following results: A CBC with 5,000 to 15,000 WBCs and less than 1,500 bands, a UA with less than 10 WBCs/high-powered field and no bacteria on gram stain, and a CXR with no focal infiltrate concerning for pneumonia. This approach is supported by a clinical policy statement from ACEP and an expert panel of pediatric emergency medicine physicians, as well as evidence-based guidelines employed at a leading children's hospital.^{2,6,12}

The question is often raised about whether a less invasive approach would also be reasonable. Currently, however, there are minimal prospective data to support this approach. In one study of outcomes in febrile infants managed by general pediatricians, a non-guideline-based approach was found to be equally effective, when judged by incidence of serious infections that were missed.¹³ However, 95% of the infants in that study had more than one encounter with their pediatrician. Because most urgent care providers cannot guar-

antee such close follow up, it is difficult to generalize these results to an acute care setting. This lack of continuity is a main driver behind the recommendations for such an aggressive approach to identify at-risk patients during an the initial patient encounter.

Another contested point when managing patients in this age range surrounds the need to perform a LP to rule out meningitis in a patient with a low-risk CBC and UA. More conservative sources advocate the necessity for LP to truly consider an infant low risk and that urgent care providers should err on the side of caution and perform an LP on all these patients because they may have inconsistent follow up. To support this position, they cite the fact that an LP is part of the Boston and Philadelphia criteria^{9,11} and that a later study documented that up to 40% of all febrile infants, both well and not well, aged less than 90 days who were eventually diagnosed with a SBI had a CBC that would have made them low risk.¹⁴

Others argue that risk of meningitis is very small in infants aged 28 to 90 days and the vast majority of such patients are either "not well" or would have a CBC or UA that would classify them as high risk. To support this position, they cite that the Rochester criteria did not automatically include a LP for all such patients and they were able to accurately classify patients as high or low risk.¹⁰


Whether LP is required in all infants aged 28 to 90 days to classify them as low risk remains debated. However, LP should be **strongly** considered in any patient with symptoms of systemic illness as well as in infants with a history of current antibiotic therapy, who have unreliable follow up or a complex medical history or who are being treated with IV antibiotics for any reason.

Infants classified as high risk based on CBC or UA results should undergo LP before receiving antibiotics and should be admitted for a period of observation. Low-risk infants by lab results are eligible for outpatient observation but an urgent care provider must be confident that they are well-appearing and that the family has established follow up and can be contacted and will return promptly for treatment. If a clinician is not confident about these factors, such patients should be admitted for observation. Several studies support not treating low-risk patients with antibiotics before discharge, however, it is also acceptable to administer a single dose of ceftriaxone 50 mg/kg IV or intramuscularly.

Aged 3 to 36 Months

Background

The focus when evaluating patients with fever in this



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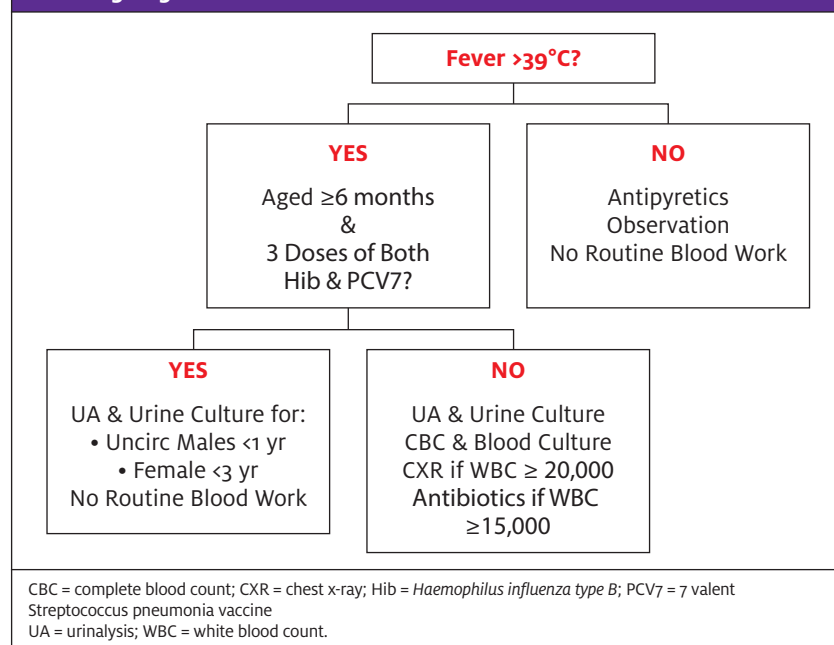
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Figure 2. Evaluation of Fever of Uncertain Source in Well-Appearing Infants 3 to 36 Months

age group shifts from the approach used in younger infants, where a high risk of SBI requires a laboratory evaluation, to one where the goal is to use selective testing to identify the very small percentage that have an occult infection that may progress into a SBI.

Research in the 1980s demonstrated that 2% to 3% of well-appearing children with a temperature 39°C had bacteria in their bloodstream.¹⁵ It also found that of these patients, up to 20% would return days later with a serious illness including osteomyelitis, sepsis, or meningitis. Thus the practice of performing a “screening” CBC, UA, and cultures was introduced as a means of identifying these at-risk children before they returned with a focal infection. However, more recent data have raised the question of whether performing such screens—especially the CBC and blood culture—is still the right approach (**Figure 2**).

History and Physical Exam

In this age range, the height of fever that triggers further evaluation increases to 39°C . That does not mean that a child with a fever of 38.5°C cannot have an occult infection but, rather, that the risk is low enough to justify outpatient observation without automatically obtaining laboratory data. It is again crucial to identify the patient as “well or not well.” If an urgent care provider judges a child to be “not well” based on the results of clinical exam, then

aggressive evaluation, treatment with antibiotics, and transfer to a high level of care is required. Only a “well” child is a candidate for selective laboratory evaluation and antibiotic therapy.

Fortunately, arriving at this clinical assessment is easier because as patients age, they are able to provide a more useful history and physical, including information on focal signs and symptoms. It is still important to continue to involve the parents as they can relate any change in a child’s normal behavior that can serve as a possible clue for a localized process, such as not using an arm as a sign of a soft-tissue infection. In addition, particular attention should be paid to a patient’s immunization status, because advances in vaccinations have made a tremendous impact on each individual’s risk. Finally, vital signs become a more sensitive marker of occult illness and it becomes

even more crucial to be aware of tachypnea and tachycardia, especially if it does not improve after administration of antipyretics.

Occult Bacteremia

As previously mentioned, the “screening” CBC and blood culture were introduced in the 1980s in an attempt to identify children whose fever was the only sign of bacteremia (ie occult bacteremia) who were at risk of developing a localized infection. However, ongoing improvements in childhood vaccinations have resulted in a re-examination of this approach.

The *Haemophilus influenzae* type b (Hib) vaccine was introduced in the late 1980s and has effectively eliminated Hib as a childhood pathogen in immunized patients. The 7-valent conjugate pneumococcal vaccine against *Streptococcus pneumoniae* (PCV7), introduced in 2000, also has had a dramatic impact. Initial surveillance has documented a decrease in *Sp pneumoniae* bacteremia by 70% to 90%.¹⁶ In addition, a 13-valent *S pneumoniae* vaccine was introduced in 2010 and is anticipated to result in an even larger decrease. Also of note is that surveillance data demonstrate that most children are actually receiving the immunizations. One study found that 85% to 90% of 3-year-olds had received at least 3 doses of PCV7.¹⁷ Finally, an impressive herd immunity has been demonstrated in patients who may not have

EXPERIENCE MATTERS

Physician: Matthew Jacobs, MD Patient: Adams, Joshua

ENT/Mouth

- Nose Bleed ☒
- Sinus Pain/Congestion ☒
- Dental Pain/Abscess ☐
- Ear Pain ☒
- Sore Throat ☐
- Hearing Problems ☐
- Other ☐

Physician

- Nurse's Note
- Summary
- HPI
- ROS
- Physical Exam
- Orders
- Procedures
- Assessment
- E&M Code
- Follow-up

Constitutional:
No chills. No fatigue. No fever. No weight loss or gain. No body aches.

Eyes:
Not blurry. No pain. No photophobia.

ENT/Mouth:
No nose bleed. (+)Sinus pain/congestion. No ear pain.

Cardiovascular:
No chest pain. No edema. No orthopnea. No palpitations. No tachycardia.

Respiratory:
(+)Cough. (+)Productive. No dyspnea. No hemoptysis. No SOB. No wheezing. No shortness of breath. No orthopnea.

Gastrointestinal:
No abdominal pain. No constipation. No heartburn. No stool changes.

Musculoskeletal:
No myalgias. No pain.
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TABLE 1. Antibiotic Options for Occult UTI

Amoxicillin-clavulanate	20-40 mg/kg/day	Divided TID
TMP-SMX	6-12 mg/kg/day	Divided BID based on the TMP
Cephalexin	50-100 mg/kg/day	Divided QID
Cefixime	8 mg/kg/day	Once a day
TMP-SMX = trimethoprim-sulfamethoxazole		

received the vaccines so that their risk of invasive pneumococcal disease is decreasing as well.

As a result of these two vaccines, the risk of occult bacteremia in an immunized febrile patient is now approximately **0.2% to 0.5%**, down significantly from the earlier rate of **2% to 3%**.¹⁸ The clinical impact of these advances is that most guidelines are recommending that fewer patients have labs done as a screen for occult bacteremia.

A reasonable approach is to continue to perform a CBC and blood culture on “well”-appearing pediatric patients with a fever 39°C who have not yet received three Hib and three *S pneumoniae* vaccinations. If the family is unsure if all three vaccinations have been given, it is reasonable to proceed as if they have not been given. Because these vaccines are currently recommended to be given at ages 2, 4, and 6 months, most patients older than age 6 months **will not** require blood work as part of their evaluation. The CBC results are currently still used to guide subsequent antibiotic therapy, with a WBC $>15,000$ or $<5,000$ indicating a slight increased risk of bacteremia. As a result, these patients should receive a dose of 50 mg/kg ceftriaxone IV/IM while their blood cultures are followed. Research is ongoing but to date there is no clear role for using other inflammatory markers—specifically C-reactive protein or procalcitonin—in place of the CBC as a screen for occult bacteremia.

Occult UTI

Although occult UTIs often receive significantly less attention than occult bacteremia, the numbers support that their diagnosis should actually be a higher priority for urgent care providers. Numerous studies have documented approximately a 2% to 5% rate of UTI in well-appearing children with fever 39°C .¹⁹ This rate is concerning because most of these patients cannot give historical factors, such as dysuria, which would assist a clinician in reaching the diagnosis. However, research has identified other factors that can mark a patient as high risk and requiring additional testing.

The most important risk factor is patient gender because the prevalence of UTIs in females is more than twice that in males. In females, the two risk factors to consider are race and age. Several studies noted up to twice the risk of UTI in white females compared with non-white females.

Younger female infants are at higher risk due to the fact that anatomical abnormalities, which predispose patients to UTIs, typically present by age 3 to 6 months. For males, the two factors to consider are age and circumcision status. Several studies have documented a risk of UTI 8 to 10 times higher in uncircumcised males than in circumcised males.^{20,21} Younger males have a higher risk, again due to the role of anatomic abnormalities. Lastly, several studies document that having either a positive test for a viral illness (influenza and respiratory syncytial virus) or a clinical syndrome matching a viral illness decreased the risk of UTI by about half.²²

Based on current recommendations, UA and urine culture are a reasonable approach to infants aged 3 to 6 months with a temperature 39°C who have no viral symptoms or whose fever has lasted longer than 2 days. For uncircumcised males, this recommendation holds true up to age 12 months. For females, this recommendation holds true until they are no longer using diapers and are able to indicate more specific symptoms by history.²³

Obtaining a catheterized urine for culture is recommended for all patients until they are able to provide a voided specimen. Use of urine bags to obtain urine for culture is unreliable because they are associated with a very high rate of contamination. Some sources advocate use of a bag for screening UA in infants older than age 6 months, followed by culture by catheterization if the UA is positive for either nitrates or leukocytes. This is not recommended for younger infants because of the concern about false-negative UA results.¹⁹ Cultures should be obtained on any pediatric patient diagnosed with a UTI to confirm the diagnosis, which is critical to informing the decision for further outpatient evaluation, as well as to monitor for resistant pathogens.

The decision about treating these patients as outpatients versus inpatients should be made in concert with the family and their regular physician. Any patient with symptoms of a systemic illness, especially vomiting, requires inpatient treatment. Strong consideration also should be given to admission for infants aged 3 to 6 months because they are at slightly higher risk of concurrent bacteremia and less able to demonstrate that

they do not have signs of systemic illness.

Ceftriaxone (75 mg/kg) is the recommended choice for either an initial dose before outpatient therapy or before transfer for inpatient admission. Oral therapy for 7 to 14 days should be guided by local resistance patterns for common urinary pathogens. Several reasonable options are listed in **Table 1**. Amoxicillin should be used cautiously because rates of resistance to common pathogens of up to 50% have been reported in some locations. As always, “not well”-appearing patients, especially those aged <1 year, will likely need transfer for a high level of care.

Occult Pneumonia

Concern for this entity arose from several studies that examined young febrile infants and included a screening CXR. The reports demonstrated signs of pneumonia on CXR in a small percentage of subjects who had no respiratory symptoms. Since that time, occult pneumonia remains a hotly debated topic with studies finding dif-

ferent rates, mainly depending on the type of patients enrolled, how a lack of respiratory symptoms was defined, and what constituted a positive finding on CXR.

Current recommendations indicate that routine screening CXR is **not required** in patients aged 3 to 36 months with fever alone. CXR should be considered in patients with unexplained tachypnea, hypoxia, focal physical exam findings or whose fever has lasted longer than would be expected with a typical viral infection. CXR should also be considered in patients with a WBC > 20,000 without a source of infection on exam.²⁴

Infants aged 3 to 6 months in whom pneumonia is diagnosed are likely to benefit from hospitalization. In addition, children with respiratory distress or oxygen saturation below 90% should be admitted for observation and IV antibiotics. For outpatient therapy, high-dose amoxicillin (80-100 mg/kg/day divided BID) for 10 days is recommended as first-line therapy. Azithromycin for atypical pneumonia is **not** routinely recommended in this age group unless indicated by the history or physical.²⁵ ■



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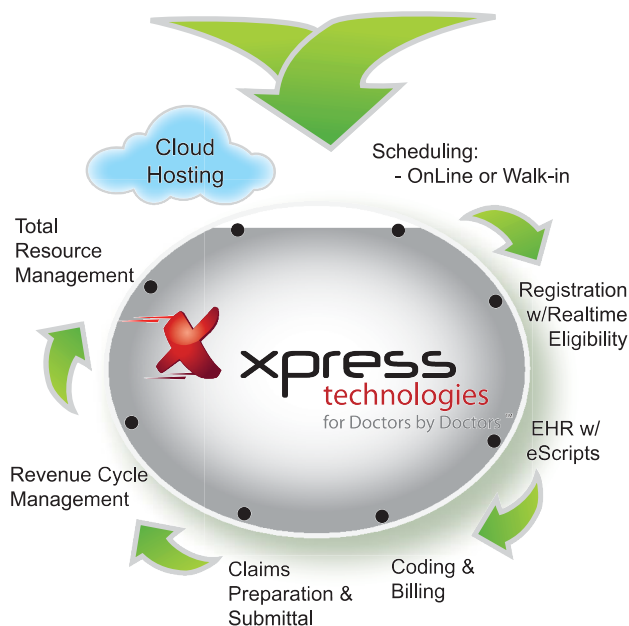
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Practice Management

Dealing With Employee Termination: Smart Strategies for Optimizing Your Team

Urgent message: Letting employees go is never easy. This article offers tips for protecting your business and yourself if termination is necessary. Among the key recommendations are compiling documentation and seeking legal advice.

ALAN A. AYERS, MBA, MACC

Letting an employee go, whether due to job performance or economic necessity, is never a pleasant situation. Although an urgent care center strives to provide high-quality patient care, it's also a business. This means that difficult decisions regarding front-line staffing must take into account the bottom line.

Despite the ease with which Donald Trump terminates his apprentices, the reality for urgent care operators is much more complicated than simply saying "You're fired." Terminating an employee affects an individual's ability to provide for him or herself and family, interrupts daily routines and social relationships, and skews the person's sense of purpose, identity, and fairness. A child's security and wellbeing—both today and in the future—is jeopardized when a parent loses a job. In this regard, the act of terminating an individual's employment is quite traumatic and, as such, it psychologically impacts everyone concerned, including co-workers and even patients.

In addition to making the difficult decisions concerning staff terminations, as well as planning how that uncomfortable meeting may play out, there are also



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legal considerations that are designed to protect the employer and the employee. Doing your homework prior to terminating an employee is necessary to limit potential adverse outcomes to the organization.

The Consequences of Ignoring Problem Employees

Because of the time, effort, and frustration that human resource issues can create for managers, sometimes it's

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

Table 1: The Effect of a Problem Employee on an Urgent Care Center

- **Loss of productivity** - An employee who arrives late to work, leaves early, and spends most of his/her working time “stirring the pot of discontent” is not committed to you or your business, which means you’re being short-changed on the wage you pay.
- **Employee morale** - An employee whose underperformance is tolerated or who is allowed to behave badly decreases morale and creates a workplace that can be detrimental to your effective and committed employees.
- **Bad behavior is contagious** - Problem workers’ bad attitudes and habits sometimes “rub off” on their fellow employees. An employee who does not face consequences for poor performance may cause other employees to believe that they, too, can get away with such behavior.
- **Breeding resentment** - Your employees who care about their jobs, the business, and your opinion of them will resent that they work harder, better, and more professionally—and may draw the unflattering conclusion that you care more about one problem employee than about the rest of the team.
- **Staff turnover** - If you want to retain staff, nipping an employee problem in the bud will prevent your most productive and happy employees who resent working with “deadweight” from leaving. “Like attracts like” so those who are disengaged or lack opportunities elsewhere stay, and over time your center spirals down to a “B-” or “C-” grade operation.
- **Potential legal issues** - Employees who cross the line with other employees may land you in hot water legally. Harassment or discrimination of one employee by another employee may involve the employer if it can be proven that the employer was aware and did nothing to remedy the situation.
- **Lost customers/revenue** - A poor employee who does not value customer service, who will not go out of his/her way to serve patients, or constantly seeks to “punish” the owners will cost you word-of-mouth and will negatively impact the ability to attract repeat visits and grow your business.

Adapted from: The Consequences for Supervisors Who Ignore Poor Business Performance. Shaddock, Dianne (2011). Articlesbase. <http://www.articlesbase.com/human-resources-articles/the-consequences-for-supervisors-who-ignore-poor-employee-performance-4191377.html>

tempting for a supervisor to ignore a chronic problem with an employee. Unfortunately, ignoring a problem won’t make it go away and will most likely compound the situation and create additional issues with other employees who are valuable to the business.

When faced with the potential for a performance issue with an employee, the manager’s first step should be some type of intervention and corrective action plan—to give an employee an opportunity to fully understand the expectations of the position, to receive coaching, and to have a “fair shot” at improving his or her performance. But assuming that doesn’t work, the employee who is chronically late, frequently absent, has a negative attitude, cannot or does not perform his or her duties, treats patients poorly, or alienates “good” employees through gossip and other forms of harassment, is a liability to the organization, and one it cannot afford to keep.

Why Urgent Care Operators Retain Poor Employees

Despite the damage they know problem employees cause the business—in addition to day-to-day impact on general morale, resources, and time—managers have been known to keep these people on board for three reasons:

- “Any staff is better than no staff.” Finding qualified employees can be difficult. There’s a learning curve

for new hires and the business continues at its regular pace without a let-up for new or short-handed staff. As a result, managers assess there’s less risk in sticking with the status quo than facing staffing issues. This commonly occurs when a manager is asked to perform the duties of the vacant position in addition to his/her own responsibilities.

- “I don’t have time to replace him/her.” It does (and should) take time to find a candidate who would be a good fit for the center’s culture and who has the skills and personal qualities desired. Posting a help wanted ad, screening resumes, and conducting interviews takes time away from a manager’s already hectic day. Plus, the manager may believe that for all the effort, there is a possibility he/she you won’t find a person with the qualities and experience needed.
- “Maybe the situation will improve if I just give it a little more time.” Terminating an employee is never enjoyable, but ignoring the situation will likely make it worse, not better. The message sent to this employee is one of tolerance. That is, management knows about it and is clearly okay with underperformance, poor attitudes, workplace harassment, and unethical conduct. Such perceptions can devastate a center’s cohesive work environment, esprit de corps, and synergy.

Keeping a bad employee will affect not only you—the urgent care operator—but also your other employees, your patients, your reputation, and ultimately your bottom line. **Table 1** lists the adverse consequences of ignoring problem employees.

Termination Tips and Considerations

When you decide an employee needs to go, termination typically occurs under one of three conditions. An employee may choose to be let go voluntarily, he or she may be fired for cause (involuntary termination), or may be let go as part of an organizational restructuring or reduction in force. The condition upon which an employee is terminated determines, in large part, both the employee's and the employer's rights and obligations.

Voluntary Termination

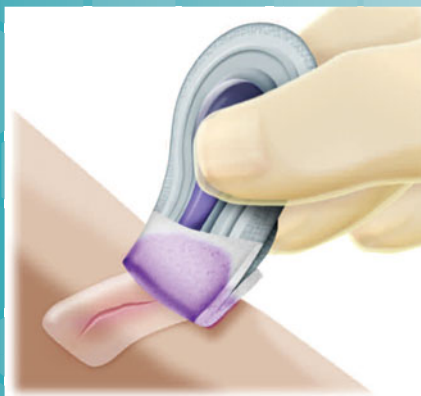
Employees sometimes choose to leave their jobs of their own volition. When an employee resigns, he or she is generally not entitled to state unemployment or

employer separation payments. Employees may “quit” for many reasons, such as a spouse's transfer, a better/ different opportunity at higher pay or more desirable hours, to pursue higher education or because they decide they don't need the money. Don't assume that someone is leaving because of unhappiness in his/her present position. If there is any doubt as to why an individual is leaving, it's a good idea to ask. If there is a problem that you are unaware of that has caused someone to feel dissatisfied, that is information that you should know—either because you may want to attempt to persuade the individual to stay or you may need to make improvements to your operation before other employees follow his/her lead out the door. This is why a standard exit interview process may answer some of these questions.

Sometimes a job is just not a good fit, and the employer and employee agree together that this is the case. This usually occurs during a 90-day post-hire “probationary period.” In other cases there is a blatant violation of company policy, such as stealing, and the

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Table 2: Failure to Document Expectations and Performance Results in Discrimination Claim*

About 15 years ago, a physician entrepreneur started his urgent care center with the intention of treating employees and patients like “family.” He hired a seasoned medical assistant who was returning to the workforce after the graduation of her teenage sons. Through focus and dedication, over the years, she learned clinical coding, medical billing, bookkeeping, payroll, and other business “basics.” As the number of patients at the urgent care center grew, the woman’s responsibilities increased, and the owners eventually added additional center locations to serve the community. Being involved with the business from the beginning, she was promoted to the role of Director of Operations.

But while the business was advancing, the operations director was falling behind. Equipped with a modest formal education but years of on-the-job training and “trench knowledge,” her capabilities had been stretched to their limits by the now multimillion dollar enterprise. Employee turnover increased, major accounts were lost, receivables bloated, and volume stagnated due to process and system issues affecting front-line service. The employee was simply incapable of taking the business to the “next level.” When outside investors evaluated the enterprise for equity funding and future expansion, one of their requirements was that a new director with an MBA and experience managing larger entities be put into place.

Because of the close relationship between the entrepreneurial-founder and the operations director—and his strong desire to not “hurt anyone’s feelings”—there were no annual performance reviews. Expectations of the changing work environment were never outlined. Nor was there a plan for the operations director to address her skill deficits. She was constantly told “great job,” “good work,” and “keep it up” by a boss who wanted to avoid confrontation and “be encouraging.” Although the business was suffering a number of cracks, the woman’s personnel file was flawless and she was promised a prosperous future with the business.

Then one day the former owner and new management sat her down with a termination agreement. They explained the new direction of the business and how they didn’t feel she was any longer a “good fit” for the role. To “clear the way” for the new director, the former director was not offered a different position, was not offered a remediation plan, and was not offered the opportunity to pursue higher education. She was given a check and her walking papers.

Her reaction? Years of praise and a flawless personnel file meant this firing could mean only one thing...age discrimination because the individual who replaced her was 20 years younger. By failing to follow a process of outlining, measuring, and providing feedback on performance expectations, the urgent care center had set itself up for a discrimination lawsuit.

**A fictional, hypothetical example, based on common circumstances in growing urgent care centers.*

employee agrees to quit rather than be fired “for cause,” which can impact the employee’s ability to secure future employment. From a management standpoint, this is the preferred result in a performance situation. After educating and coaching an employee as to your expectations of the position, he or she may realize that it isn’t a strong match.

Regardless of whether quitting is an employee’s sole decision or a mutual decision between employer and employee, formal written notice of resignation should be provided by the employee to prevent future legal issues. Because an employee who resigns surrenders legal rights, it’s very important that evidence show the resignation was not forced or compelled. When an employee resigns, it’s also important to ensure:¹

- company property is returned and accounted for (phones, laptops, keys, badges, etc);
- outstanding charges are paid;
- a discussion is held for a successful hand-off of accounts, customers, or projects;
- confidentiality/non-compete agreements are dis-

cussed;

- employee is counseled by human resources or payroll personnel regarding any insurance, retirement funds or benefits and how transition will transpire; and
- an exit interview is performed to discuss the employee’s reasons for leaving and to identify areas for improvement for the business.

When employees quit voluntarily, it is customary for them to give advance notice. However, “at will” employment does not require the employer to accept the notice. The manager may choose to end the employment relationship immediately to prevent morale problems with other staff members or the opportunity to steal information or assets. To prevent other employees from abandoning their jobs in the future, as a courtesy, the employer should consider paying the 2 weeks’ salary even in the event that the employee does not work that time.

Involuntary (For Cause) Termination

Firing a non-performing employee is never a simple or easy matter. Even with intelligent hiring, encouragement for development, and a program for performance evaluation and corrective action, there will always be situations in which termination is still necessary.

Many states have “at-will” employment, meaning that employees can be fired at any time, for almost any reason, or even for no reason at all. However, there are *exceptions* to every rule, and especially to this one. Exceptions include circumstances such as when an employee has:

- A collective bargaining agreement or other binding contract (oral or written) with the employer;
- Been subject to illegal discrimination (e.g., age, sex, race, religion, disability, sexual orientation in some jurisdictions, etc.);
- Filed a workers’ compensation claim;
- Insisted on a safe/healthy workplace;
- Reported or refused to engage in criminal acts;
- Been called for military duty or jury duty; or
- Experienced financial indebtedness (e.g., wage attachment including child support and IRS garnishment).

In addition, an employer may be subject to civil liability if harassment has occurred.

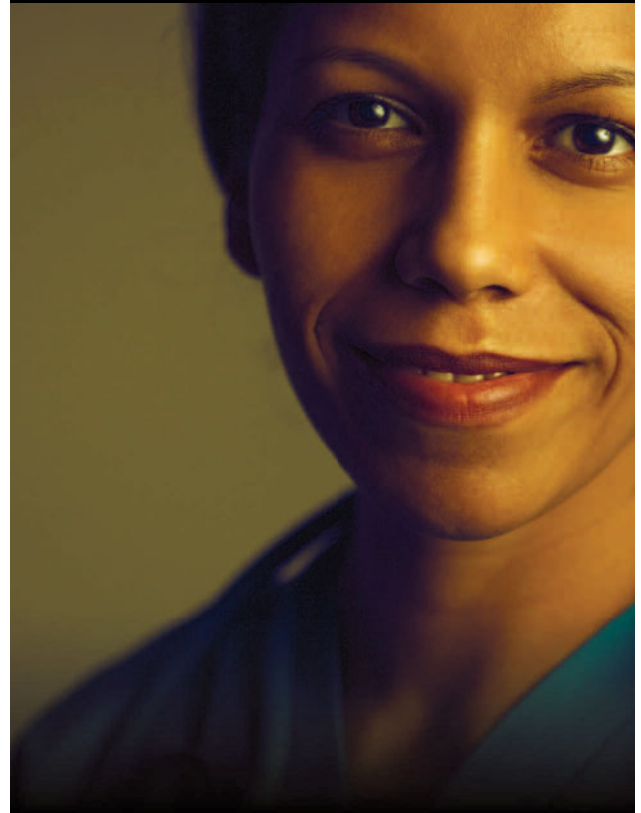
Discrimination, harassment, and hostile work environment claims may arise from a seemingly routine performance-based termination. These situations can pose traps for employers because although the direct cause of termination (e.g., performance) may be well documented, the “poor performance” could ultimately be traced to an inconsistent application of company policy or other harassing or discriminatory actions or conditions (e.g., unequal access to training, threatening or degrading statements, withholding necessary resources, etc.).

Before you decide whether to terminate an employee, you will want to ensure that no contract exists and that none of these exceptions to “at will” employment apply. The state department of human rights or employment is a valuable resource for background and education in this area. It’s always best to seek legal advice if you have any questions.²

At the conclusion of the period you have allowed to see the employee’s performance improve, you may conclude that he or she has not met the minimum expectations for the position and should be terminated for cause. The following steps should then be taken:³



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"The typical objective in a layoff is to reduce expenses through the paring down of payroll and benefit related costs. Such cost savings may make a RIF attractive, but large-scale reductions also entail substantial costs, both in upfront severance-related compensation, and in longer-term, often hidden costs, such as legal expenses associated with claims by terminated employees, attrition of valued employees, and downstream costs of hiring again when economic circumstances improve."

—Tips for Planning Reductions in Force. Rosen, Michael. (2009). Foley Hoag LLP, Foley Hoag eBook Library.

- *Make the decision by balancing risks/rewards.* If at this point you see no other way to remedy the situation and improve the employee's performance to the minimum acceptable standards, you must begin the process of protecting yourself and your company against any possible negative repercussions. Documentation is essential, and should be collected throughout the improvement process. Examples of poor performance or violation of company policy should be "written up" and addressed with the employee in a timely manner. In addition, notes about any performance meetings or discussions of write-ups should be documented. This should be a "Memo to the File" and completed immediately after the conversation.
- *Investigate the conduct/incident.* Employers should conduct an independent investigation, particularly if the issue resulting in the decision to terminate did not directly involve the employer (i.e. theft witnessed by another employee, claims of sexual misconduct between employees). Again, a written report is required. Be wary when an employee claims discrimination and be prepared to defend against such a claim. Let the employee tell his/her side of the story and interview all relevant parties to the incident/conduct. Every urgent care center should have policies and procedures for handling harassment allegations. If an employee claims that he or she has been subject to illegal discrimination, you should follow the procedures laid out by Human Resources and make sure that the issue is examined with professionalism and discretion.
- *Check the personnel file of the employee.* You should become knowledgeable regarding the employee file and any documentation therein, especially any documentation of previous problems. Check the file for mention of written/verbal warnings, employee evaluations, previous discussions with the employee, and the discipline matters or policies violated. An empty personnel file may indicate that this behavior or incident has occurred for the first time. This may play a role in your decision to give the employee another chance. In addition, an empty personnel file may also create the conditions for litigation over the employee's dismissal. [See the example in **Table 2**]
- *Examine written policies.* Make sure you are intimately familiar with your company policies in effect during the employee's tenure. *Make sure you have followed your own policies!* The employee should have received adequate written notice that his or her conduct could result in termination (written communication of verbal warnings, clear written policies in an employee handbook or obvious misconduct). Ensure that your policies do not preclude you from terminating the individual's employment, and that you have taken all of the required and prescribed actions in the organization's termination process. When legal challenges arise, one of the first questions typically asked is *"did the employer follow its own handbook?"*
- *Review any statements made to the employee.* Review written memos or notes on verbal conversations that have taken place with the employee. Ensure that oral statements have not contradicted your policies or written statements. Ensure that nothing has been said that could be construed as harassment or discrimination.
- *Examine treatment of other employees.* Make sure that you treat all employees fairly and equally. If you have treated other employees differently for engaging in the same conduct, can you defend this? That is, is there a genuine legal justification for disparate treatment?
- *Consider the possibility of a lawsuit.* Based on your knowledge of the employee do you feel that he or she might consider litigation? This may be a factor in deciding whether to offer a severance package.
- *Consider alternatives.* Ask yourself if there are any other options short of termination. Can the employee improve his or her performance? Has he or she been given ample opportunity to do so? Is there a different position that is better suited for the employee's skills? Can an accommodation be

made on the employee's working arrangements or supervision?

- *Get a second opinion.* It may be helpful to obtain a second opinion from an unbiased person within the company, or from an outside source (i.e. legal advice). Along these same lines, when appropriate, ask another manager to review the situation and your documentation.
- *Document the reasons for terminating the employee.* Document your reasoning for ending the individual's employment and the factors and reasons that support this decision. Document clearly, unemotionally, and factually. Use the tone of a newspaper article when drafting these documents. Specify the policy violation or the failure of the employee to achieve the minimum performance expectations agreed upon in the meetings and coaching sessions leading up to this point. Summarize warnings, conversations, and disciplinary meetings that have occurred.
- *Plan ahead for possible consequences.* Be careful with whom and how you discuss the employee's termination to avoid a defamation lawsuit. The best answer to any questions about an individual's termination is simply, "John is no longer with the company." Also adopt a neutral reference policy, which only includes the employee's title, salary, and dates of employment, should a future potential employer inquire, and let that person know that it is the policy of the company to only release those specific pieces of information.
- *Unemployment compensation.* Employees may ask you about their eligibility for unemployment compensation and whether you will contest such a claim. If the reason for termination is due to poor job fit or an isolated, minor or unintentional infraction, the employee may be eligible for unemployment compensation. Rules vary from state to state, so be familiar with the rules in your state. Remember, misconduct (willfully performing an action that harms the business) is open to interpretation. You may choose to waive your right to contest unemployment as part of an employee's severance package. Moreover, you should contest unemployment only if you have

"If the reason for termination is due to poor job fit or an isolated, minor or unintentional infraction, the employee may be eligible for unemployment compensation."

sufficient reason because contesting unemployment benefits usually results in angry and combative former employees.

- *Severance packages.* If you have a severance policy in place, you should treat all employees who qualify for it in the same manner. The package should be based on objective criteria. This should include the time of service and level in the organization, rather than personal or subjective factors, such as the spouse's income, the employee's ability to quickly get employment elsewhere, or the employee's perceived financial needs. The severance package should be—whenver possible—conditioned on the employee signing a release from subsequent legal claims. Nonetheless, a release does not guarantee that an employee will not try to sue. A release should: 1) offer sufficient cash payment to ease the transition for the employee; 2) avoid imposing too many future responsibilities on the employee; and 3) contain language that effectively discourages or removes the potential for future litigation.
- *During the actual meeting to terminate an individual's employment,- use objective language and provide the employee with a letter that gives a truthful and brief explanation as to why he or she is being fired.* Watch the language. Do not use any language that could be construed as biased or discriminatory. Explain clearly the reasons for the termination, such as specific behavior or actions, policy violations, and/or any discipline and the schedule agreed upon for the individual's improvement that was received prior to termination. For example, you might reference the following: "On May 1, 2013, you agreed to achieve minimum standards for your position by July 1st as indicated in my memo to you dated 04/28/2013. We have not seen that improvement within that time period." Keep a copy of this document for yourself, give one to the employee, and place one copy in the employee's file.

Plan ahead for the termination meeting. Prior to this meeting, discuss with your manager and/or Human Resources who should be present, their roles, and what should be stated. Plan who will have the conversation in which the employee is terminated. (Ideally it should be

someone in personnel or Human Resources and not someone with whom the employee has a poor or antagonistic relationship). The person who terminates should not be an unknown to the employee. This meeting should be well documented. Choose a private and comfortable location. Be firm and professional, and keep the meeting short and to the point. Do not become engaged in an argument or in any discussion about specific incidents or a defense of the action. If available, assign the Human Resources representative to explain the severance package (if offered) and to review any responsibilities that the employee must fulfill (return of equipment, etc.), as well as the company's position regarding future references. Most importantly, this brief meeting should be kept confidential. Escort the individual to his or her area to gather any personal items and then escort him or her to the exit. (Arrange for assistance from security in advance if you think the individual may not go without disrupting the work area.)

Reduction in Force

A reduction in force (RIF) is the elimination of multiple positions due to a business slow down or re-structuring. A RIF may be voluntary (voluntary separation or incentive program) or involuntary. There are advantages and disadvantages to each. Employees who leave voluntarily in exchange for immediate compensation may be less inclined to sue and may be required to sign an agreement; however, too many or not enough employees may choose this route, and you must be prepared to lose good employees who are valuable assets to your company. Typically the employees with the greatest marketability are those who take the cash and run. So, in contrast to a voluntary or incentive program, an involuntary RIF offers the employer complete control.

There are a few things that employers must keep in mind when planning a reduction in force:

- Develop unbiased and uniform selection criteria when deciding which employees are to be laid off.
- Conduct a layoff analysis. Ensure that you are not disproportionately affecting certain groups, such as older employees or members of a protected class.
- Worker's Adjustment Retraining and Notification ACT (WARN) - Federal and state laws require that a certain time period must be adhered to in noti-

“Plan ahead for the termination meeting. Prior to this meeting, discuss with your manager and/or Human Resources who should be present, their roles, and what should be stated.”

fying employees that they may be laid off (NOTE: this law often affects employers with large numbers of employees; check the laws in your state).

- Create a plan that lays out eligibility for severance.
- Ask employees to sign a release. A valid release should be obtained from workers over age 40 under the Older Workers Benefit Protection ACT (OWBPA).
- Keep immigration implications in mind if you lay off sponsored foreign workers and be sure you are aware of your legal and contractual obligations to them.

Because a reduction in force can undermine morale for all remaining employees, it's a good idea to first exhaust all alternatives to a RIF including hiring freezes, reduction/elimination of performance bonuses, reduced hours of work, engaging in selected performance-based reductions, selectively not re-hiring for positions lost to normal attrition, and postponing wage or benefit increases. Understanding that a temporary downturn is likely affecting other health care providers, employees who are content in their positions and want to keep their jobs are often willing to compromise in order to do so. "It's better to give up a little than to be seeking another job," is their rationale.

Conclusion

Letting an employee go is never an easy decision. It involves (or should involve) much forethought and planning in order to ensure that you have covered all the bases to protect your business. This article is not meant in any way to substitute for legal advice, but rather to provide "food for thought" if you should find yourself in the position of having to let an employee go. When in doubt it is always wise to seek competent legal counsel to protect your business and yourself. And remember to document everything! ■

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Case Report

Hodgkin Lymphoma

Urgent message: Close follow up is necessary for pediatric patients with vague presentations, lest a diagnosis of childhood cancer be missed.

JANET D. LITTLE, MD

Introduction

This case presentation reflects the challenge of diagnosing childhood cancers in a timely and accurate way. The presenting signs and symptoms are oftentimes nonspecific and can mimic those of common childhood conditions.¹ The frequency of delayed diagnosis for childhood cancers is high, and reflects the importance of close follow-up instructions for patients with vague and non-specific presentations.

Case Presentation

A 12-year-old female with a past medical history significant for mild-intermittent asthma presented to the urgent care center complaining of 3 episodes of nausea and vomiting, sore throat, mild shortness of breath, and chest discomfort. Her shortness of breath was not accompanied by a cough and was not relieved with use of her albuterol inhaler.

She had been seen by her dentist just 2 days prior to the onset of her symptoms for a dental abscess and was on penicillin, which she had taken numerous times before. She had decreased appetite at the onset of her symptoms. The patient denied any recent upper respiratory symptoms, abdominal pain, fever, chills, weight loss, fatigue, or rashes.

She was otherwise healthy with no known drug allergies. She took Albuterol as needed and Flovent for her asthma, which typically was triggered by environmental allergens and exercise. Her mother noted that the child had pneumonia in the past. There was no other significant past medical, surgical, family or social history contributory to her presentation.

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Janet D. Little is staff physician and Director of Education at My Care Express Urgent Care in Eldersburg, Maryland.



Observation and Findings

Physical examination of the patient revealed the following:

T: 98.1°F

BP: 114/76

P: 100

R: 20

SpO₂ 98% on RA.

In general, the patient was a well-developed, well-nourished female in no acute distress, respiratory or otherwise. Examination of ENT, cervical lymph nodes, cardiovascular, respiratory, and skin were normal.

Diagnostic Studies and Differential Diagnosis

Laboratory tests were negative for rapid strep. Preliminary reading of her chest x-ray was notable for lack of

Figure 1. A PA radiograph of this patient shows a widening of the superior mediastinum.



Figure 2. On the lateral chest film the retrosternal clear space is obliterated.



infiltrates and effusions, and normal cardiac size (**Figures 1 and 2**).

Differential diagnosis at the time included reaction to antibiotics or recent dental procedure. A less likely cause that was also considered was infective endocarditis seeded from her recent dental abscess/procedure. The mother was mostly concerned for pneumonia. The patient was discharged home with an antiemetic and recommendation for follow up in 1 day if her symptoms were not improving. The parent was also advised that a radiologist would do a final read of the chest x-ray and that she would be notified of the results.

The final chest x-ray report noted the lungs to be clear and the heart size within normal limits. However, there was a lobulated anterior mediastinal mass. Considerations included germ cell tumor, lymphoma, or thymic origin tumor. It was recommended that computed tomography (CT) with contrast be completed for further evaluation.

The patient was sent for a STAT CT scan of her chest 2 days after her initial visit. The preliminary report identified a very large, confluent, anterior/superior mediastinal mass, approximately 10 x 8 x 3 cm. Differential diagnosis: Lymphoma, thymoma (uniform non-enhancing tissue with no cystic area). The lungs were clear. Aside from the mass, no adenopathy was seen.

The patient and her family returned to the urgent care center to review the test results. At that time she reported feeling much better with the antiemetic but

still had some shortness of breath. The case was discussed with physicians at the nearest university hospital, to which care was then transferred.

Hospital Course (review of records obtained)

The patient was admitted by the university hospital pediatric subspecialty team for further evaluation. She was noted to have an approximately 2-cm non-tender supraclavicular lymph node near the right sternal border.

Initial positron emission tomography/CT scans were notable for abnormally increased metabolic activity of a large multilobulated anterior mediastinal mass with associated mediastinal and supraclavicular lymphadenopathy, consistent with Hodgkin Lymphoma without evidence of metastasis.

Bone marrow biopsy of the patient's left hip showed no evidence of lymphoma. An excisional lymph node biopsy of the right supraclavicular node was also completed. Preliminary results were also concerning for Hodgkin Lymphoma. A final diagnosis of Stage IIA Hodgkin Lymphoma was given at the time of discharge 1 week later. The plan was to place a PICC line and perform a bone marrow biopsy of the child's right hip. The patient currently is undergoing chemotherapy and receiving outpatient care from the hematology/oncology service. It is believed that the large mediastinal mass will respond favorably to chemotherapy without the need for surgical excision at this time.

Discussion

Differential diagnosis of anterior mediastinal masses can be remembered by the 5Ts mnemonic:

- Thymus
- Thyroid
- Thoracic Aorta
- Terrible Lymphoma
- Teratoma and germ cell tumors

Hodgkin Lymphoma is a cancer of the lymphatic system of unknown etiology. While Epstein-Barr virus has been associated with some cases of Hodgkin Lymphoma, no specific link has been consistently implicated. The disease peaks in the teen years and then again in the third decade of life.²

Painless lymphadenopathy of the cervical, supraclavicular, and axillary lymph nodes is the most common presentation. Symptoms consistent with mediastinal mass include cough, chest pain and dyspnea. When these are combined with unexplained lymphadenopathy, especial-

ly supraclavicular or axillary, an urgent care provider should have a high index of suspicion and proceed with further investigation. Fever of unknown origin, night sweats, and weight loss are also frequent presenting symptoms in Hodgkin Lymphoma as well as many other childhood cancers, and should always be taken seriously.²

Conclusion

In this case, the patient presented with very non-specific symptoms, demonstrating the difficulty of diagnosing childhood cancers, particularly because they are rare and oftentimes mimic other more common childhood illnesses. It is important for the urgent care provider to counsel patients about the importance of close follow up, especially when their symptoms are non-specific or inconsistent with the presenting history. ■

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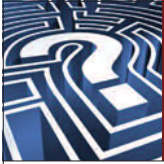


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INSIGHTS IN IMAGES

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.

FIGURE 1



The patient, a 37-year-old woman, presented after a blow to her left hand.

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

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2



Diagnosis: The x-ray reveals a fracture at the base of the distal phalanx (arrow), but what is most important is that it is consistent with a mallet deformity of the DIP. If this injury is not properly managed from the beginning, it can lead to serious complications in the future. The finger must be placed in a metal splint with the DIP in hyperextension. Immediate referral to a hand surgeon is needed for this patient.

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



It Seemed Like a Good Idea at the Time

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

Have you seen poster with the phrase, “IT COULD BE THAT THE PURPOSE OF YOUR LIFE IS ONLY TO SERVE AS A WARNING TO OTHERS?” Have you ever had “one of those days” where you believed the poster was a sign from God directed only to you?

Over the years I have heard hundreds of patients and numerous friends and acquaintances mutter the phrase, “It seemed like a good idea at the time.” I’ve even been known to say it once in a great while. (Ok, maybe even often.) I have been cataloging these “good ideas” for a number of years in the hope that if one ever pops into my head, I can refer back to the list and gain some additional and apparently much-needed perspective.

However, given the nature of some of these, I hope they never “pop” anywhere near my head! Anyway, I would be remiss in my endeavor to enlighten you or put you to sleep if I did not share. In random order, here are 46 of the more memorable, medical legally-related “good ideas at the time” I have heard, witnessed or experienced.

1. Taking creative liberties with the medical records while trying to defend a medical board complaint. *Epilogue:* Once the chart is complete, do not make ANY changes unless they are time and date stamped.
2. Being uncooperative (or lying) to the medical board in the hope that they “go away.” *Epilogue:* Medical boards don’t “go away”; they are like a pit bull on a poodle.
3. Believing that transferring your assets to your spouse (or children) will protect the assets. *Epilogue:* An improper conveyance will be struck down by the courts. In addition, I know of at least one case where, after the transfer of assets, the spouse filed for divorce.



John Shufeldt is principal of Shufeldt Consulting and sits on the Editorial Board of JUCM. He may be contacted at jshufeldt@shufeldtconsulting.com.

4. Accepting boilerplate contract language in an employment agreement and not negotiating with your prospective employer. *Epilogue:* Always negotiate; the first contract (offer) is never the best.
5. Not having a truly independent attorney represent your interests during a recapitalization event with a private equity (PE) group. *Epilogue:* PE groups do this for a living. Do not get burned by blindly believing what they verbally represent.
6. Prescribing controlled substances to yourself or members of your immediate family. *Epilogue:* Prohibited in all states and generally a very bad idea.

*Patients own their records.
You have a small window of time
to provide them with their
medical records.*

7. Sending home a patient with unexplained abnormal vital signs. *Epilogue:* The most common reason I have seen for a medical misadventure.
8. Not having a fair governance agreement negotiated before partnering or joining a group or having a mechanism for dispute resolution. *Epilogue:* The time to negotiate these is BEFORE the dispute.
9. Not negotiating who is responsible for paying for “tail coverage” or allowing your medical malpractice coverage to have gaps. *Epilogue:* Having to cover your own extended reporting endorsement (tail coverage) significantly restricts your freedom to change jobs.
10. Not taking a restrictive covenant seriously. *Epilogue:* Unless unduly restrictive, most are enforceable. Take them seriously.
11. Signing a contract with a one-sided termination provision

I have had employers call up demanding to know the results of their employee's non-work-related encounter. Don't fall for it.

where the employer can terminate you "at will." *Epilogue:* Negotiate some recourse whether it is rights upon termination or mirror language.

12. Going in blind to an interview and not conducting your own due diligence prior to an interview. *Epilogue:* Knowledge is power. Do your homework before the interview.
13. Ignoring HIPAA privacy rules and thinking that an enforcement action would never happen to you. *Epilogue:* HIPAA actions are becoming more prevalent.
14. Unnecessarily delaying or refusing to give patients a copy of their medical records. *Epilogue:* Patients own their records. You have a small window of time to provide them with their medical records.
15. Believing the word "enhanced" actually means "better." *Epilogue:* Enough said...
16. Releasing medical results over the phone without first ensuring some method of security clearance. *Epilogue:* I have had employers call up demanding to know the results of their employee's non-work-related encounter. Don't fall for it.
17. Not alerting patients to mistakes made during their care or not following up on abnormal test results. *Epilogue:* Mistakes happen. Identify, disclose, make it right, move on.
18. Upcoding of Evaluation and Management patient visit codes. *Epilogue:* Ensure that your treatment AND documentation supports the code.
19. Not properly adjudicating credit balances by keeping them on your books and not returning the money to payors. *Epilogue:* You need to address credit balances. If the insurer or patient is not owed the money, the State will claim it.
20. Releasing confidential protected information without an authorization from the patient or surrogate. *Epilogue:* Releasing protected information to the wrong party is bad on every level.
21. Terminating an employee without evaluating or considering whether or not the employee falls under a protected status. *Epilogue:* Be aware of what constitutes a "protected class" of individuals.
22. Letting panic govern your actions when responding to an audit or request for records. *Epilogue:* Take a deep breath and evaluate. Panic NEVER does anyone any good.
23. Operating without following your compliance plan or not having one. *Epilogue:* If you have one— follow it. If you don't—develop one.

24. Blaming other providers during a malpractice deposition or trial. *Epilogue:* Medical malpractice plaintiff attorneys love this!
25. Not hiring seasoned consultants in order to save money. *Epilogue:* Hire people who have already made all the mistakes you will make if you don't hire them.
26. Signing broad indemnification commitments with health plans or health systems. *Epilogue:* Don't get stuck holding the bag; misery loves company!
27. Discharging an intoxicated patient with altered mental status knowing he/she is going to drive. *Epilogue:* You, too, will be held responsible.
28. Believing that a handshake somehow trumps a written contract. *Epilogue:* Contracts are only as good as the people signing them. That said, get it in writing.
29. Going in front of the medical board unrepresented. *Epilogue:* Your medical license cost you a lot of money and time. Protect it like it is the most valuable possession because other than your health and your family, it is.
30. Contacting the plaintiff after the initiation of a medical malpractice complaint. *Epilogue:* After the suit is filed, it is "game on." Do not talk to the former patient/ current plaintiff.

Hire people who have already made all the mistakes you will make if you don't hire them.

31. Failing to negotiate a severance agreement and an indemnification provision with an employer. *Epilogue:* The time to negotiate these is BEFORE they are needed. Once the bird hits the windshield it is too late.
32. Discharging a patient with the worst headache of his/her life without a complete workup. *Epilogue:* Check the nursing notes to make sure no one else was given that history by the patient.
33. Cardioverting someone while standing in water. *Epilogue:* I used to have straight hair.
34. Not terminating or transferring an employee and hoping his/her performance will improve or conduct will change. *Epilogue:* A rotten apple never gets better tasting.
35. Disciplining an employee before conducting a thorough investigation. *Epilogue:* There are always two sides and everyone deserves their "day in court" prior to being judged.
36. Discharging a patient you thought was only attention-seeking with suicidal ideation, covered with gasoline, who happens to smoke a pack a day. *Epilogue:* It ended as badly as you are imagining.
37. Becoming argumentative or defensive during a deposi-

Your medical license cost you a lot of money and time. Protect it like it is the most valuable possession because other than your health and your family, it is.

tion. *Epilogue:* You are being judged by the opposing counsel as to how fit you are to stand trial. Prepare, stay calm, and be honest and professional.

38. Going into a deposition or trial unprepared, under-dressed or arrogant. *Epilogue:* Again, you are being judged.

39. Making a job offer before a pre-employment screening, (drug screen and background check) is completed. *Epilogue:* Wait for the data. A lot of seemingly normal applicants have checkered pasts—knowledge is power.

40. Believing that the interests of your medical malpractice carrier and yours are always aligned. *Epilogue:* Keep your eyes open. Sometimes interests diverge.

41. Forgetting to notify your state licensing board of a change of address, a DUI, a payment made on your behalf by a malpractice carrier (in some states), or a felony conviction. *Epilogue:* Self-disclosure and following your state's medical practice guidelines are crucial. Ignorance is not an excuse.

42. Not retaining or destroying medical records. *Epilogue:* Keep paper or electronic copies. They may be the only defense you have.

43. Failing to report adverse peer review actions on applications for credentialing. *Epilogue:* Don't forget to disclose your previous misadventures.

44. Using the medical record to air complaints against nurses or other physicians. *Epilogue:* Medical malpractice attorneys love this!

45. Not getting personal legal counsel if the malpractice claim or verdict could exceed policy limits. *Epilogue:* This is one instance in which your interests could diverge from your malpractice carrier.

46. Not timely consulting specialists when a higher level of care is necessary. *Epilogue:* Don't try to be a hero. When there is more to do and more to know, get some help.

Please tear this column out and hang it on your mirror to remind yourself of what not to do. ■

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ABSTRACTS IN URGENT CARE

- Casts for pediatric fracture
- Pertussis vaccination
- Length of UTI treatment and recurrence
- CT for right lower quadrant pain
- A 'mother's kiss'
- Curbside consults
- DTaP injection-site reactions
- Hypertension drugs, NSAIDs and kidney injury
- Antibiotics for COPD
- ED respiratory rate measurement
- FDA recommendation on zolpidem
- Adolescent suicide

■ 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.

Soft cast versus rigid cast for treatment of distal radius buckle fractures in children

Key point: Buckle fractures of the distal radius can be safely and effectively treated with a soft cast and only a single orthopedic outpatient clinic appointment.

Citation: Witney-Lagen C, Smith C, Walsh G. Soft cast versus rigid cast for treatment of distal radius buckle fractures in children. *Injury*. 2012 Dec 21. pii: S0020-1383(12)00516-5. doi: 10.1016/j.injury.2012.11.018

Buckle fractures are extremely common and their optimum management is still under debate. This study aimed to ascertain whether buckle fractures of the distal radius can be safely and effectively treated in soft cast with only a single orthopaedic outpatient clinic appointment.

A total of 232 children with buckle fractures of the distal radius were included in the study. 111 children with 112 distal radius fractures were treated in full rigid cast and 121 children with 123 fractures were treated with soft cast. The rigid cast children attended outpatient clinic for removal of cast at 3 weeks. Soft casts were removed by parents unwinding the cast at home after 3 weeks. Follow-up was conducted prospectively by telephone questionnaire at an average of 6 weeks post-injury.

Outcome data were available for 117 children treated in soft cast and for 102 children treated in rigid cast. The most common mechanism of injury was a fall sustained from stand-

ing or running, followed by falls from bikes and then trampoline accidents.

Overall, both groups recovered well. Overall satisfaction with the outcome of treatment was 97.4% in soft cast and 95.2% in rigid cast. Casts were reported as comfortable by 95.7% in soft cast and 93.3% in rigid cast. Cast changes were required for 6.8% of soft casts and 11.5% of rigid casts. The most frequent cause for changing rigid casts was getting the cast wet. None of the improved scores seen in the soft cast group were statistically significant. No re-fractures were seen in either group. Nearly all (94.9%) children in soft cast did bathe, shower or swim in their cast.

Parents of both groups preferred treatment with soft cast ($P < 0.001$). Reasons given for preferring the soft cast included the ability to get the cast wet, avoidance of the plaster saw and not having to take time off work to attend a follow-up visit for cast removal. ■

Why Do Fully Vaccinated Kids Get Pertussis?

Key point: Immunity wanes after the full series, but completing five doses is still our best option for prevention.

Citation: Misegades LK, Winter K, Harriman K, et al. Association of childhood pertussis with receipt of 5 doses of pertussis vaccine by time since last vaccine dose, California, 2010. *JAMA*. 2012; 308(20):2126-2132.

In 2010, suffered a large pertussis outbreak; in addition to significant infant mortality, a high disease burden was seen in 7- to 10-year-olds. Investigators used 2010 data from 15 counties to examine the association between pertussis and time since completion of the five-dose diphtheria, tetanus, and acellular pertussis (DTaP) series.



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

Among 682 pertussis cases in children aged 4 to 10 years and 2016 controls, cases were significantly more likely than controls to be unvaccinated (7.8% vs. 0.9%) and to be older (median age, 9 vs. 7 years). Unvaccinated children were 8.9 times more likely to contract pertussis than fully vaccinated children. Among children who completed the five-dose series, the odds for pertussis increased with time since administration of the fifth dose (odds ratios ranged from 0.02 in the 12 months since last dose to 0.29 at 60 months or longer). Vaccine efficacy decreased during this period from 98.1% within the first year to 71.2% after 60 months.

Published in *Journal Watch Ped Adoles Med*. January 16, 2013 — Peggy Sue Weintrub, MD. ■

No Relation Between Length of Treatment for UTIs and Early Recurrence in Men

Key point: *How long to continue antibiotics in men with urinary tract infections is still up for debate.*

Citations: Drekonja DM, Rector TS, Cutting AC, Johnson RJ. Urinary tract infection in male veterans: Treatment patterns and outcomes. *JAMA Intern Med*. 2013;173(1):62-6 and Trautner BW. New perspectives on urinary tract infection in men. *JAMA Intern Med* 2013 Jan 14; 173:68.

Most research to examine length of antibiotic treatment for uncomplicated urinary tract infections (UTIs) has been conducted in women, for whom clinical guidelines are well established. In a retrospective study of 33,336 veterans with uncomplicated UTIs (all outpatients; mean age, 68; median antibiotic-therapy duration, 10 days), researchers explored whether length of antibiotic therapy was associated with recurrence in men. Most patients received ciprofloxacin or trimethoprim-sulfamethoxazole; about one third were treated for <7 days, and the rest were treated for >7 days.

Researchers found 1373 cases of early recurrence (at <30 days; 4% of the cohort) and 3313 cases of late recurrence (at >30 days; 10%). In multivariate analyses, no difference was noted in risk for early recurrence between men who received longer- or shorter-duration initial treatment; risk for late recurrence was significantly higher among those who received longer-duration treatment than among those who received shorter initial courses (11% vs. 8%).

Published in *J Watch Gen Med*. January 31, 2013 — Thomas L. Schwenk, MD. ■

Computed Tomography for Adults with Right Lower Quadrant Pain

Key point: *When CTing for RLQ pain in adults, in about a third of patients, diagnoses other than appendicitis were evident.*

Citation: Pooler BD, Lawrence EM, Pickhardt PJ. Alternative

diagnoses to suspected appendicitis at CT. *Radiology*. 2012;265(3):733-742.

Most adults with acute right lower quadrant abdominal pain now undergo computed tomography (CT) when suspicion for appendicitis is at least moderate. In a study from one teaching hospital in , researchers reviewed the results of CT scans ordered explicitly to evaluate 1571 consecutive adults for appendicitis or right lower quadrant pain. All patients were referred from the emergency department or urgent-care settings.

CT revealed appendicitis in 24% of patients; according to review of clinical records, sensitivity and specificity of CT for appendicitis were 99% and 98%, respectively. CT also demonstrated specific alternative diagnoses in 32% of patients, and no specific diagnoses in 45%. Adnexal abnormalities accounted for nearly one third of alternative diagnoses in women; otherwise, the spectrum of alternative diagnoses was fairly similar in men and women. The most common alternative diagnoses (as a proportion of the 496 patients with alternative diagnoses) were inflammatory enteritis or adenitis (17%), urolithiasis (12%), diverticulitis (8%), and constipation (7%). Small bowel obstruction, inflammatory bowel disease, and cholecystitis each accounted for 4% of alternative diagnoses.

Published in *J Watch Gen Med*. January 15, 2013 — Allan S. Brett, MD. ■

A ‘Mother’s Kiss’ for Removal of Nasal Foreign Bodies

Key point: *In a systematic case review, this technique worked in most children.*

Citation: Cook S, Burton M, Glasziou P. Efficacy and safety of the “mother’s kiss” technique: A systematic review of case reports and case series. *CMAJ*. 2012;184(17):E904-E912.

The “mother’s kiss” is a technique first described in 1965 for nasal foreign body removal in children. A trusted adult occludes the unaffected nostril and blows into the child’s mouth gently until they feel resistance caused by closure of the glottis, and then they blow more forcefully to expel the foreign body. Researchers systematically reviewed eight case series and case reports involving 154 patients (age range, 1–8 years). Foreign bodies ranged from beads to a piece of sausage and a doll’s plastic shoe.

The technique was successful in 60% of cases, with similar success rates for smooth, regularly shaped objects and irregularly shaped objects. When noted, most foreign bodies were visible at presentation, and about half the children had undergone previous attempts at removal; these factors, as well as length of time since object insertion, were not described in enough detail to allow for subanalysis. One study of 31 patients noted that introduction of the mother’s kiss reduced the need

for general anesthesia for nasal foreign body removal (from 33% to 3%). No adverse events were reported.

Published in *J Watch Ped Adoles Med*. January 2, 2013 — Cornelius W. Van Niel, MD. ■

Should We Curb the Curbside Consult?

Key point: *Inpatient curbside consults are often inaccurate and incomplete and often result in flawed recommendations.*

Citation: Burden M, Sarcone E, Keniston A, et al. Prospective comparison of curbside versus formal consultations. *J Hosp Med*. 2013;8(1):31-35.

Curbside consultations are widespread in medicine, but how they relate to patient care is largely unknown. Researchers conducted a prospective single-center study that involved 18 hospitalists to compare the accuracy, completeness, and recommendations of curbside versus formal consultations for 47 hospitalized patients.

After completing a curbside consultation, a hospitalist requested verbal approval from the requesting provider to perform a formal consultation in the same patient. If granted, a formal consultation was completed by a different hospitalist within a few hours. The two hospitalists determined whether the information obtained during the curbside consultation was complete and accurate compared with that of the formal consultation, and whether the advice given led to different recommendations for patient management. A physician with >35 years of inpatient experience also evaluated independently whether the formal consultation changed management.

Information obtained from curbside consultations was inaccurate or incomplete in 51% of cases. When information from the curbside consult was inaccurate or incomplete, recommendations provided in the formal consult changed management in 92% of cases.

Published in *J Watch Hosp Med*. January 16, 2013 — Aaron J. Calderon, MD, FACP. ■

Injection-Site Reactions Less Common When DTaP Vaccine Given in Thigh

Key point: *Young children are less likely to have local reactions to the DTaP vaccine when it is administered in the thigh rather than the arm.*

Citation: Jackson LA, Peterson D, Nelson JC, et al. Vaccination site and risk of local reactions in children 1 through 6 years of age. *Pediatrics*. Published online January 14, 2013 (doi: 10.1542/peds.2012-2617)

Researchers assessed the medical records of 1.4 million children aged 1 to 6 years who received intramuscular vaccines for inactivated influenza, hepatitis A, or DTaP.

For DTaP, medically attended local reactions occurred more

often when the vaccine was administered in the arm versus the thigh (66.8 vs. 25.3 per 10,000 vaccinations). The difference was only significant in children aged 12 to 35 months.

For hepatitis A and influenza vaccines, there was no significant difference in the rate of local reactions based on injection site. ■

Hypertension Drug Combo Plus NSAIDs Associated With Risk of Acute Kidney Injury

Key point: *Common antihypertensive agents are associated with increased risk of kidney injury when used concurrent with NSAIDs.*

Citation: Lapi F, Azoulay L, Yin H, et al. Concurrent use of diuretics, angiotensin converting enzyme inhibitors, and angiotensin receptor blockers with nonsteroidal anti-inflammatory drugs and risk of acute kidney injury: nested case-control study. *BMJ*. 2013;346:e8525

Using UK national databases, researchers followed half a million patients who were prescribed antihypertensives over a mean of roughly 6 years. The incidence of kidney injury in the entire cohort was 7 per 10,000 person-years. Patients receiving “triple therapy” (an NSAID plus a diuretic plus either an angiotensin-converting-enzyme inhibitor or angiotensin-receptor blocker) had a 31% increased risk for hospitalization for acute kidney injury, relative to those not taking NSAIDs. “Double therapy” (an NSAID plus either a diuretic, ACE inhibitor, or ARB) was not associated with increased risk.

Editorialists note that the confidence interval around the double therapy estimate was wide, and thus the evidence for the absence of risk was not strong. The study’s authors urge caution, especially early in the course of treatment when risk seems highest and patients may be taking NSAIDs for arthritis or flu-like syndromes. ■

Antibiotics for COPD: Further Evidence of Benefit

Key point: *Inpatients with COPD exacerbations had better outcomes when treated with both steroids and antibiotics.*

Citation: Stefan MS, Rothberg MB, Shieh M-S, et al. Association between antibiotic treatment and outcomes in patients hospitalized with acute exacerbation of COPD treated with systemic steroids. *Chest*. 2013;143(1):82-90.

Patients who are admitted with exacerbations of chronic obstructive pulmonary disease (COPD) are treated routinely with steroids and bronchodilators. However, the incremental benefit of antibiotic therapy is unclear, despite some promising results from previous studies (e.g., *JW Gen Med* Jun 3 2010).

Investigators retrospectively studied 53,900 patients admitted to inpatient wards with acute exacerbations of COPD (not

critically ill or requiring ventilatory support). Patients were drawn from a pool of hospitals, predominantly urban (83%), nonteaching (66%), and located in the South (52%). Patients who received both steroids and antibiotics were compared with those who received steroids alone.

In-hospital mortality was low in both groups but was significantly lower in patients treated with antibiotics (1.0% vs. 1.8%). Rates of readmission by 30 days also were lower (5.4% vs. 6.8%). These results remained significantly different after multivariable analysis and propensity-score matching. Patients who received antibiotics had a slightly but significantly longer mean length of stay and higher cost of admission. The choice of antibiotic regimen did not affect outcomes.

Published in J Watch Gen Med. January 31, 2013 — Patricia Kritek, MD. ■

Emergency Department Triage Respiratory Rate Measurements Are Often Inaccurate

Key point: Manual measurement of respiratory rate often is inaccurate.

Citation: Bianchi W, Dugas AF, Hsieh YH, et al. Revitalizing a vital sign: Improving detection of tachypnea at primary triage. *Ann Emerg Med* 2013;61(1):37-43.

Inaccurate measurement of respiratory rate can have significant implications for patient care. In this cross-sectional study of 191 emergency department patients, investigators compared the accuracy of respiratory rate measurement by usual care (direct observation of respirations by a triage nurse for 15 seconds, multiplied by 4) and by an electronic BioHarness device (detection of respirations by a thoracic pressure sensor) for identifying tachypnea. They used direct observation of respirations by a trained research assistant for 60 seconds as the criterion standard measurement.

Of 191 patients, 44 (23%) were characterized as tachypnic (respiratory rate >20 breaths/minute) by criterion standard measurement. Usual measurement identified 10 of these patients as tachypnic (sensitivity, 23%; specificity, 99%), while electronic measurement identified 40 patients as tachypnic (sensitivity, 91%; specificity, 97%).

Published in J Watch Emerg Med. January 11, 2013 — Richard D. Zane, MD, FAAEM. ■

FDA Lowers Recommended Dose for Insomnia Drug Zolpidem

Key point: Taking the insomnia drug zolpidem at night could impair alertness the next morning—especially in women—and recommended doses should be lowered.

Citation: <http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm334738.htm>

Taking the insomnia drug zolpidem (e.g., Ambien) at night could impair alertness the next morning — especially in women — and recommended doses should be lowered, the FDA warned on Thursday.

The warning applies to both generic and brand-name versions of zolpidem and is based on data showing the sedative-hypnotic stays in the body longer than previously thought. The risk for women is higher because they process the drug at a slower rate than men.

Among the agency's recommendations:

- For immediate-release products (including Ambien, Edluar, and Zolpimist), the dose for women should be lowered from 10 mg to 5 mg.
- For the extended-release product Ambien CR, the dose for women should be lowered from 12.5 mg to 6.25 mg.
- For all zolpidem and other insomnia drugs, the lowest dose needed to treat symptoms should be prescribed for both men and women. ■

Many U.S. Adolescents Have Considered Suicide

Key point: One in eight U.S. teens has seriously considered suicide, and one in 25 has attempted it.

Citation: Nock MK, Greif J, Hwang I, et al. Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents. *JAMA Psychiatry*. 2013;():1-11.doi:10.1001/2013.jamapsychiatry.55

Nearly 6500 adolescents (aged 13 to 18) were surveyed about their lifetime history of suicidal behaviors and mental disorders.

Among the findings:

- A third of those who considered suicide go on to make a plan, and nearly two thirds of those with a plan attempt suicide.
- Most of those who attempt suicide do so within a year of first considering it.
- Roughly 90% of suicidal adolescents had at least one of the 15 mental disorders included in the survey, most commonly depression.
- Between 55% and 73% of suicidal adolescents received some form of treatment before symptom onset. ■



Primary Care in the Urgent Care Setting, E/M Codes With Other Services, Penicillin Injection

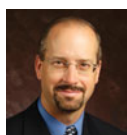
■ DAVID STERN, MD, CPC

Q. Can physicians see regular patients and schedule routine care at urgent care facilities? If so, can the urgent care center bill for those services at a separate, lower rate than the urgent care rate?

A. Special attention should be paid to payor contracts in these situations. If the insurance company views your patient's visits as urgent care even though you provided primary care, the patient could be responsible for higher urgent care co-pays or even urgent care deductibles. You would want to check with the payor to see if you must always collect urgent care co-pays. Some urgent care contracts state that follow-up visits should be handled by a patient's primary care provider, so providing primary care services could be a violation of your contract.

If an urgent care provider wants to provide primary care, I would recommend starting a new business with a new TIN incorporated as a PC, LLC, or PLLC, depending on your state. New payor contracts will also need to be initiated and there is the possibility of running into an issue where a certain payor may not allow you to do urgent care while operating a primary care facility.

You would want to seek legal counsel before making any changes because certain provisions of the federal Stark law could make it illegal to refer from an urgent care practice to primary care if any owner of the urgent care also has an ownership stake in the primary care. A few states have additional laws that are similar to Stark that may apply to all carriers and may be even more restrictive.



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.

Once your business is set up and tax documents are in place, you will want to begin the contracting and credentialing process. Although some urgent care contracts may not require you to credential all of your providers, it is very likely you will have to individually credential all of your providers who render primary care services.

If providing primary care in an urgent care center is the direction you take, it is also important to have specific guidelines for your front desk staff so that they know the differences in handling transactions between primary and urgent care visits. For example, collecting the correct co-pays and reporting visits appropriately to your billing staff. ■

Q. Would we bill with Outpatient E/M codes 99201-99215 if we are a walk-in practice that does not qualify as a true urgent care center?

A. E/M services are categorized into different settings, depending on where the service is furnished. However, for E/M services in an outpatient or other ambulatory facility (including a walk-clinic, primary care practice and an urgent care center), CPT codes 99201-99205 are used to report evaluation and management services for a new patient. Use codes 99211-99215 for established patients in this same type of setting. ■

Q. Can we bill both the S9088 and 99051 on same visit for our urgent care visits?

Yes, you can bill both codes for the same visit along with the E/M code. HCPCS code S9088, "Services provided in an urgent care center (list in addition to code for service)," is specifically for use in an urgent care center. You would bill this code for every visit. Keep in mind that Medicare does not recognize this code at all so you would bill it to all payors except Medicare.

CPT code 99051, "Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service," is another code that could be billed to insurances, with the exception of Medicare. Evening hours are generally considered to start at 5 p.m. This code was designed to compensate your practice for the additional costs of being open extended hours. This code is typically billed to patients seen after 5 p.m. Monday through Friday and all day on Saturday, Sunday, and federal holidays.

Check the policies of each of your payors for both of these codes to see if you can receive compensation from them. Try to include reimbursement fees for these codes as well when negotiating contracts. ■

Q. Can S9088 be used with an E/M code?

A. Any urgent care center can use code S9088, "Services provided in an urgent care center (list in addition to code for service)." This code is an add-on code, so it cannot be billed alone. However, you would not bill the code to Medicare, since it is not covered. You will also want to check state regulations as well as payor contracts to see whether this code should be billed or not.

An urgent care center, as defined by the Urgent Care Association of America, is a walk-in medical clinic (offering at least plain-film radiology and CLIA-waived labs) that is open to the public for walk-in, unscheduled visits during all open hours and offering significant hours beyond the typical 9:00 a.m. to 5:00 p.m., Monday through Friday. Some payors have outlined more specific requirements, including ACLS-certified personnel, on-site inspections, crash cart with specific supplies, and facility credentialing. Make sure you check for any specific requirements in your state. ■

Q. Can 95992 be billed with an E/M code on the same day of service?

A. Even though CPT code 95992, "Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver, per day,)" was added in 2009, only Physical Therapists could be reimbursed for the code and physicians had to report the procedure using an E/M code until 2011. Now physicians may also bill this code for the procedure. An Audiologist may not bill the code since it is considered a therapeutic procedure.

If, during an office visit, it is determined that the procedure needs to be performed on the same day as the visit, you may code an E/M in addition to the procedure. You would append modifier -25, "Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or

other service," to the E/M code. Alternatively, if it was determined at a prior visit that the patient needed the procedure performed and was returning for the procedure, you would only bill CPT 95992 because the evaluation and management was done at a prior visit. ■

Q. Can my facility bill for a penicillin injection? If so, what is the code and pricing? Do I need to use a modifier?

A. There are several types of penicillin that could be billed:

■ Penicillin G Benzathine	100,000 Units	J0561
■ Penicillin G Benzathine and Penicillin G Procaine	100,000 Units	J0558
■ Penicillin G Potassium	600,000 Units	J2540
■ Penicillin G Procaine	600,000 Units	J2510

For each of the HCPCS codes listed above, you would bill the administration code 96372, "Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular." If 1.2 Million Units of Penicillin G Benzathine was administered, you would bill HCPCS code J0561 at 12 units and CPT code 96372.

You will want to charge a price based on cost to you, and you might also want to get reimbursement values from some of your major payors to see how well the specific medication is reimbursed. You will need to submit the NDC code to bill for the medication.

If a separate E/M service was performed, you would bill the appropriate E/M code with a modifier -25, "Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service." Keep in mind that some payors will bundle the injection code into the E/M service (or flat rate service), so be sure to check payor agreements and payor policies. ■

Had Any Interesting Cases Lately?

Case Reports are one of *JUCM's* most popular features. Case Reports are short, didactic case studies of 1,000-1,500 words. They are easy to write and *JUCM* readers love them. If you've had some interesting cases lately, please write one up for us. Send it to Judith Orvos, ELS, *JUCM's* editor, at jorvos@jucm.com.

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ahenson@carilionclinic.org or 540-224-5241

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Find out more online at www.sphp.com and send application materials to Mark Gallucci, Physician Recruiter, at mgallucci@sphcs.org



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DEVELOPING DATA

These data from the 2012 Urgent Care Industry Benchmarking Study are based on a sample of 1,732 urgent care centers; 95.2% of the respondents were UCAOA members. Among other criteria, the study was limited to centers that have a licensed provider onsite at all times; have two or more exam rooms; typically are open 7 days/week, 4 hours/day, at least 3,000 hours/year; and treat patients of all ages (unless specifically a pediatric urgent care).

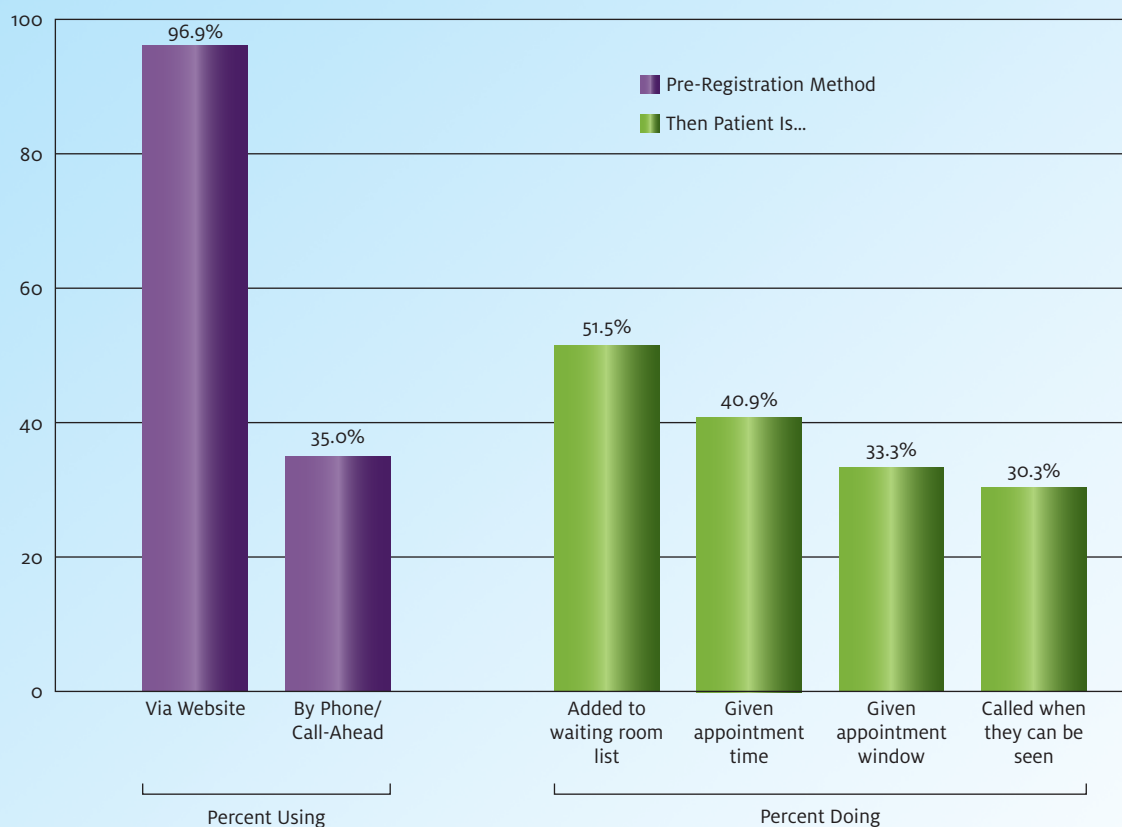
In this issue: What Methods Are Urgent Care Centers Using for Patient Registration?

USE OF PATIENT REGISTRATION SYSTEMS

The 2010 survey showed that the vast majority (92.9%) of urgent care centers were using computerized systems for practice management, though fewer (66.7%) were using them for clinical processes. The 2012 survey examined more specifically how centers were using the technology they have.

Patient Registration

47.9% of centers allow patients to complete paperwork prior to their visit, though they execute this in different ways—online being the most prevalent (n=140).



Acknowledgement: The 2012 Urgent Care Industry Benchmarking Study was funded by the Urgent Care Association of America and administered by Anderson, Niebuhr and Associates, Inc. The full report can be purchased at www.ucaoa.org/benchmarking.



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