

# JUCM™

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Did bee stings cause this elderly patient's swollen joint?

### 18 An Urgent Care Lab as Profit Center?

It can be done. Here's how

## Altered Mental Status in the Urgent Care Patient



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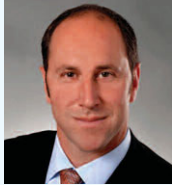
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## LETTER FROM THE EDITOR-IN-CHIEF

# Reforming Healthcare Starts With Reforming Patient Expectations



**B**ack in 2008, while the Obama administration was first evaluating healthcare reform, Peter Orszag, then the director of the Congressional Budget Office, estimated that 5% of the nation's gross domestic product, or \$700 billion per year, goes to medical tests and procedures that have no proven positive impact on outcomes.

Unaccounted for in this estimate are the billions more spent managing the often lifelong complications inherited from inappropriate tests and unproven procedures. MRIs that identify pseudo-lesions later biopsied or removed leading to surgical complications and turning previously healthy patients into diseased patients. Cardiac catheterizations with their subsequent stents and anticoagulants and myriad of complications all with unproven benefit over medical management and risk factor modification.

Much too could be said of medication overuse and abuse. Overuse of pain medications costs untold billions of dollars in lost productivity, not to mention the societal and psychological costs. Antibiotic overuse, while perhaps not directly responsible for a large share of the annual monetary waste, has certainly created a cesspool of multidrug-resistant bugs, and the downstream disasters, like MRSA and C. diff, contribute to billions more in health-related costs.

Most healthcare reform proposals addressing the overuse of high-cost tests and procedures have targeted the built-in incentive of fee-for-service payment systems as a key driver of unnecessary utilization. The more you do, the more you make. Reformers have suggested a "prospective payment" system that turns fee-for-service on its head and creates incentives to provide *less* care instead of more.

So where's the rub? Well, prospective payment encourages cherry-picking of healthy patients and financial incentives to "underuse" what now could be *necessary* tests or procedures on a case by case basis. So health reform has taken a sick system of incentives to provide inappropriate care and proposed to replace it with a sick system of disincentives ... brilliant!

### Unrealistic Patient Expectations

What all efforts at reform have failed to address to date is this:

American society, and therefore healthcare recipients, has perhaps the most unrealistic expectations of the medical community of any country in the world. The perception is that active intervention and testing are almost universally better than medical wisdom, and therefore we have come to expect these active responses without regard to cost, risk, or benefit. It is this very expectation, I believe, that has given this country the notorious position of having the highest healthcare costs per capita alongside one of the worst outcomes-based ROI's in the world.

Societal expectations represent the demand curve in healthcare economics 101. They drive payers, hospitals, and physicians to meet their demands or suffer the consequences. If you bite the hand that feeds you, even when it is deserved, you will lose. While healthcare reform is essentially driven by socialist goals of supporting the well-being of all through individual sacrifices, healthcare economics is still driven by free-market principles. Sorry, America, but you can't have it both ways.

### Two Options Moving Forward

We have only two choices: Embrace socialized medicine and let Big Brother decide who gets what, or embrace a new societal contract that empowers *and* pays physicians to choose the best course of care for their patients, free of the risk of lawsuits and free of the lopsided payment system that rewards utilization. If we want to cover all reasonable healthcare costs, for all reasonable healthcare needs, for all the people of this nation, then we must adequately incentivize and compensate physicians who agree to commit to the principles of proper utilization. We can then embark on a physician-led mission to re-educate the country one patient at a time and shift societal expectations to a more sustainable level. ■

Lee A. Resnick, MD  
Editor-in-Chief

*JUCM, The Journal of Urgent Care Medicine*



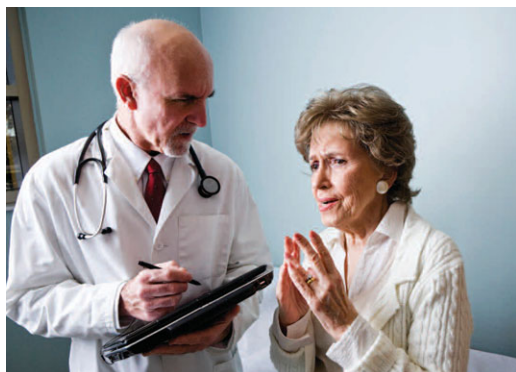
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### CLINICAL

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*Raul E. Rodon, MD*

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The patient had two recent bee stings. Did they cause his problem or were they red herrings?

*Paul Bures, DO, and Lee A. Resnick, MD*



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An onsite lab can generate significant revenue for your practice. Lab expert Tim Dumas shows how.

*Tim Dumas, MLT, CLS*

### WEB EXCLUSIVE

#### How Profitable Are Drug Screens? Very!

Much is appealing about offering drug screens as an ancillary business: low staffing, no mandatory doctor involvement, low start-up costs, and the promise of a lucrative return on investment.

*Tim Reynolds, MD*

### IN THE NEXT ISSUE OF JUCM

Hand injuries are a common presenting complaint in the urgent care center. Loss of function can have a profound impact on the remainder of a patient's life. Improper management can result in permanent disability for the patient—and litigation for you. Learning everything you can about hand injuries, developing a process of examination that encompasses all aspects of hand function, and knowing when to refer patients to a hand specialist are key in successfully treating these injuries and ensuring an optimum outcome for both you and your patients. Here is how to assess and manage closed hand injuries, including distal phalanx injuries, injuries to the middle and proximal phalanx, metacarpal fractures 2-5, thumb metacarpal injuries, dislocations, and closed tendon injuries.

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**"**Altered mental status" (AMS) denotes an undifferentiated assortment of disorders of mentation that may include impaired cognition, attention, awareness, and level of consciousness. Such alterations may be transient, sustained, fluctuating, or progressive, they are particularly prevalent in elderly patients, and they carry with them a heightened risk for adverse events subsequent to discharge.



So observes Raul E. Rodon, MD, author of our cover article this month, adding that "altered mental status is a not uncommon complaint in urgent care." Dr. Rodon offers a clarifying perspective on disorders of cognition. He discusses the signs and symptoms of delirium, dementia, and psychiatric psychosis. He offers suggestions for conducting a history and physical for patients with mental status change (MSC), acute confusional state (ACS), or organic brain syndrome (OBS). And he reviews the evaluation, treatment, and disposition of these patients.

Dr. Rodon is owner of North Atlanta Urgent Care in Atlanta, Georgia. He attended medical school at Universidad de Zulia in Maracaibo, Venezuela, and was trained as an emergency physician at Emory University in Atlanta. He is board certified in emergency medicine.

Hot, swollen, tender joints are a common initial complaint in the urgent care setting. But what if the patient is elderly, presents with five days of left wrist and hand swelling, and suffered two bee stings to his upper left arm two days prior to the current complaint? Are the bee stings the culprit, or are the patient's symptoms due to something else?

In our Case Report this month, Paul Bures, DO, and Lee A. Resnick, MD, point out that a correct diagnosis can be easily missed when the patient presentation is familiar and similar to that of other conditions. See if your differential diagnosis includes the patient's final diagnosis.



Dr. Bures is a Family Medicine Resident at Richmond Heights Hospital in Cleveland, Ohio. Lee A. Resnick is Assistant Clinical Professor of Family Medicine at University Heights Urgent Care in Cleveland, Ohio, and the Editor-in-Chief of JUCM.



Many urgent cares offer onsite labs as a service to patients, not as profit centers. In our practice management article this month, physician office lab guru Tim Dumas, MLT, CLS, maintains that a correctly run lab should produce significant revenue. A key problem, he says, is not calculating return on investment before deciding to perform a certain test. This includes understanding the cost per test, the reimbursement for that test, and the cost of the blood chemistry or hematology analyzer needed to run the test, whether it is a rapid strep test, a CBC, or a CMP. He shows you how to do the math so that you come out ahead. Some practices, he says, earn as much on labs than they do on office visits.



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Mr. Dumas, a Clinical Laboratory Scientist for nearly 35 years, serves as adviser to 54 physician office labs across the US. He is based in Raleigh, North Carolina.

## Also in this issue:

**John Shufeldt, MD, JD, MBA, FACEP**, maintains that urgent care is more challenging than emergency medicine because in the emergency department he has all the diagnostic tests and help he needs at his fingertips, whereas, when he wears his urgent care hat, he must sift through hundreds of “well” patients to identify the one, who may have a similar presentation, who is really “sick.” In his Health Law column this month, he offers tips from the clinical literature and from his own experience for finding that “needle in the haystack.”

**Nahum Kovalski, BSc, MDCM**, reviews new abstracts on current literature germane to the urgent care clinician, including the effect of adrenaline on survival in out-of-hospital cardiac arrest; the high variability in admission decisions for patients with pneumonia; the effect of delay in presentation on rate of perforation in children with appendicitis; the fact that a GCS score of <15 represents a greater risk in elders than in younger patients; and the need to rule out occult serious bacterial infection in in-

fants younger than 60-90 days with bronchiolitis.

In Coding Q&A, **David Stern, MD, CPC**, discusses the modifier for 69210, HCPCS for IM Zofran, S9088 vs 99051 regarding which reimburses more, and billed amount for 99051.

Our Developing Data end piece this month looks at anticipated changes in urgent care hours of operation, which approximately one in three urgent cares are planning to increase. How many say they will add weekdays only, add weekends only, stay open seven days a week, and stay open 24/7? You'll find the answers on the last page of this issue. ■

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## FROM THE EXECUTIVE DIRECTOR

# Promises, Promises

■ LOU ELLEN HORWITZ, MA

2012 is going to be such a big year I can hardly contain myself. There are eight things on a big flipchart on my wall labeled “2012 Initiatives” and they all feel huge. I alluded to some of them in my October column, and thought I’d end the year by unveiling a few more. Plus, saying all this out loud before it’s done certainly makes us stay accountable to you, our members and stakeholders!

We’ve talked here about the new “unlimited” membership structure for our Practice Members, and that rollout has already begun. If you are part of a current Practice Membership, we’ll be contacting you soon to let you add people (and to make sure we have all your centers on our list!), even before your renewal is due. If you don’t want to wait to hear from us, go ahead and contact Jami Kral, our membership manager, at [jkral@ucaoa.org](mailto:jkral@ucaoa.org), and she can get those expanded benefits started for you right away.

We’ve also talked a bit about the 2012 Benchmarking Survey. I’m only bringing it up again now to tell you how important it is for *every center* that is invited to participate. Now that you’ve seen how compelling the results were in the 2010 survey, I’m sure you realize that it’s a big contribution to report all that data—but you also see the rewards for doing it. UCAOA members have always been a “help each other” kind of group, and this is the NUMBER ONE way you can contribute to the industry. When you get that invitation email from us, remember that.

So, what haven’t we told you about yet?

### New “Awareness” Initiatives

The watchword for 2012 is AWARENESS. You told us loud and clear that it’s one of your top priorities for us, so we are all over it. The UCAOA Board voted to take a sizable set of funds and launch a truly national awareness campaign next year for the industry.

The first change you will notice is with UCAOA itself. We are doing “us” first because, when the world comes calling on the association as a resource on the industry, we want to do you

*“When the world comes calling on the association as a resource on the industry, we want to do you proud.”*

proud. That means some re-working of our image, and creation of several resources for external stakeholders in addition to the “Case for Urgent Care” white paper.

We also have to make it easier for outsiders to find information about the industry. We have gotten better at talking to each other, but we’re not yet great enough at providing information for the media, legislative bodies, payors, and other influencers. So that’s the second change you will see—an overhaul of [www.ucaoa.org](http://www.ucaoa.org). We’ll not only make it easier for these influencers to hear our messages, we’re going to do a better job of organizing our resources for you, too.

The third change is the most exciting, and we’ll do that together. This is where most of the special Board funds are going—to a national awareness campaign for our industry. I say that we will do this “together” because, while UCAOA will be taking the lead, we’re setting up the campaign so that every single center can have access to specially-created national campaign materials that you can use locally. We plan to roll it out in Las Vegas in April for the first time ... so make plans to be there to see it.

In closing, I want to thank everyone for their participation in the 2011 Urgent Care Awareness Week on November 14-18. In addition to UCAOA and individual member center efforts, many of our Corporate Support Partners got involved this year, and that added support was much appreciated. There was a lot more participation and media coverage this year than last, so even our small collective efforts are continuing to build upon each other. We hope it was a fun and motivational event for you and your staff as well. With our new year-long national awareness campaign coming next year, 2012’s Awareness Week should be even bigger.

I’d best stop writing now or JUCM is going to have to give me another page! There’s obviously more to come, but hope this gets you excited for what is coming! ■



**Lou Ellen Horwitz** is Executive Director of the Urgent Care Association of America. She may be contacted at [lhorwitz@ucaoa.org](mailto:lhorwitz@ucaoa.org).

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## Altered Mental Status in the Urgent Care Patient

**Urgent message:** As the population of seniors swells, more cases of senile dementia, delirium, and psychosis are apt to present in urgent care. Here is how to assess and manage these patients.

RAUL E. RODON, MD

### Introduction

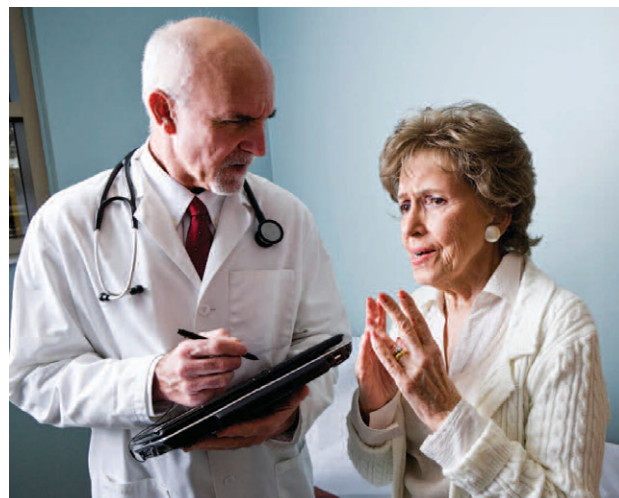
Evaluating patients presenting with altered mental status in the urgent care setting requires a modified skill set, one that varies from the assessment of patients with a similar profile in a hospital emergency department. Limited access to standard and immediate laboratory test results, including CT and MRI imaging in many urgent cares, often complicates the appropriate and complete evaluation of these patients.

“Altered mental status” is a term that denotes an undifferentiated assortment of disorders of mentation. These disorders may include impaired cognition, attention, awareness, and level of consciousness. Alterations may be transient, sustained, fluctuating, or progressive. Altered mental status is not an uncommon complaint in urgent care.

### Perspective on Disorders of Cognition

Mental status impairment is particularly prevalent among elderly patients, and these patients may carry an increased risk for adverse outcomes subsequent to discharge. Patients with delirium often have acute underlying illnesses and have been shown to have higher morbidity and mortality rates than their counterparts without delirium.

Patients with dementia may have difficulty with



medication and discharge instruction compliance, which can also result in increased morbidity and mortality. In addition, the presentation of impaired mental status in elderly individuals might be subtle and go unrecognized, making it a challenge for the unsuspecting physician to detect.

While a standard presented complaint in urgent care, altered mental status is also a common underlying condition in patients presenting with other primary complaints. Although alterations in mental status occur in patients of all ages, the elderly are at especially high risk. Other risk factors include prior cognitive impairment, underlying chronic disease, and systemic infection. One study showed altered mental status to be present in 40% of patients older than 70 years of age.<sup>1</sup> Approximately

Raul E. Rodon is owner of North Atlanta Urgent Care in Atlanta, Georgia ([www.northatlantaurgentcare.com](http://www.northatlantaurgentcare.com)). He attended medical school at Universidad de Zulia in Maracaibo, Venezuela, and was trained as an emergency physician at Emory University in Atlanta. He is board certified in emergency medicine.



Table 1. Features of Delirium, Dementia, and Psychiatric Psychosis			
Characteristics	Delirium	Dementia	Psychiatric Psychosis
Onset	Sudden	Insidious	Sudden
Course	Fluctuating	Stable	Stable
Consciousness	Reduced or clouded	Alert	Alert
Attention	Disordered	Normal	May be disordered
Cognition	Disordered	Impaired	May be impaired
Orientation	Impaired	Often impaired	May be impaired
Hallucinations	Usually visual	Often absent	Usually auditory
Delusions	Transient, poorly organized	Usually absent	Sustained
Movements	Asterixis, tremor may be present	Often absent; if present, usually	unrelated Absent

Table 2. Common Causes of Altered Mental Status	
Cause	Signs and Symptoms
Infection	<ul style="list-style-type: none"> <li>• Meningitis/encephalitis</li> <li>• Sepsis</li> <li>• Urinary tract infection</li> <li>• Pneumonia</li> </ul>
Toxic	<ul style="list-style-type: none"> <li>• Drug toxicity (including alcohol)</li> <li>• Drug withdrawal (eg, alcohol)</li> <li>• Environmental exposure (eg, carbon monoxide)</li> </ul>
Metabolic	<ul style="list-style-type: none"> <li>• Electrolyte disturbance (eg, hypernatremia/hyponatremia, hypercalcemia)</li> <li>• Endocrine disorders (eg, hyperglycemia, hypoglycemia, hyperadrenalism, hypoadrenalism, hyperthyroidism, hypothyroidism)</li> <li>• Hepatic encephalopathy</li> <li>• Uremia</li> <li>• Environmental exposure (hypothermia)</li> </ul>
Hypoxemia/hypercarbia	<ul style="list-style-type: none"> <li>• Congestive heart failure</li> <li>• Pulmonary embolism</li> <li>• Chronic obstructive pulmonary disorder</li> </ul>
Cerebrovascular	<ul style="list-style-type: none"> <li>• Trauma-related (eg, subdural hematoma)</li> <li>• Cerebrovascular accident (bland, hemorrhagic)</li> <li>• Central nervous system vasculitis</li> <li>• Hypertensive encephalopathy</li> </ul>
Central nervous system (other)	<ul style="list-style-type: none"> <li>• Trauma (diffuse injury with increased intracranial pressure)</li> </ul>

25% of patients with altered mental status had alterations in levels of consciousness; 25% had delirium, and 50% had cognitive impairment without delirium.

### Signs and Symptoms

Delirium, dementia, amnesia, and certain other alter-

ations in cognition are subsumed under more general terms such as mental status change (MSC), acute confusional state (ACS), or organic brain syndrome (OBS). Organic brain syndrome can be divided into two major groups: acute (delirium or acute confusional state) and chronic (dementia) (**Table 1**).

The final pathway for all forms of organic brain syndrome is an alteration in cortical brain function. This condition results from an exogenous insult or an intrinsic process that affects cerebral neurochemical functioning or physical or structural damage to the cortex. Some etiologies include trauma, mass lesions, hydrocephalus, stroke (ie, multi-infarct dementia), atrophy, infection, toxins, or dementing processes.

The prevalence of dementia doubles every five years between the age 60 to about age 90, with 1 percent of individuals 60-64 years old developing dementia and up to 30%-50% of individuals over 85 years old experiencing a decline in intellectual faculties. Approximately 60% of nursing home beds are occupied by patients diagnosed with dementia.

### History

MSCs may evolve acutely, with rapid, fluctuating, and usually transient course (delirium), or they may advance insidiously and inexorably over months or

years with gradual worsening or stuttering course (dementia).

### Delirium

Delirium presents with acute onset of impaired awareness, easy distraction, confusion, and disturbances of

perception, which may include illusions, misinterpretations, or visual hallucinations. Recent memory is usually deficient, and the patient is typically disoriented as to the present time and place. The patient may also appear agitated or obtunded and the level of awareness may fluctuate over brief periods. Speech may be incoherent, pressured, nonsensical, perseverating, or rambling, which may complicate a physician's capacity to perform and obtain an accurate medical history from the patient or make it impossible. However, such a patient is most likely to present at an ED.

If you do get an individual with delirium, it is important to attempt to obtain a current and past history of the patient from other available resources, including family or friends of the patient and/or past medical records. The information should include time and acuity of onset, trauma (including falls), fluctuations of symptoms, course over time, and possible environmental exposure (eg, carbon monoxide). In addition, obtain information regarding associated symptoms, including headaches, fever, seizure, change in speech, and changes

in the habits of daily living.

Specifically look for indications and signs of street drug, alcohol, and medication use and abuse; pre-existing endocrine disorders; and recent activities that may have resulted in exposure to toxins or environmental injury. It is also critical to inquire about prior psychiatric illness and similar episodes of confusion in the past.

### *Dementia*

Individuals with dementia present with a history of chronic, steady decline in short-term and, later, long-term memory. Dementia is associated with difficulties in social relationships, work, and activities of daily life. In contrast to delirium, the sensorium is clear. However, an acute confusional state can be superimposed onto an underlying dementing process. The patient who presents with moderate to severe symptoms has usually been previously diagnosed. Such patients most commonly present in the urgent care setting, and most of the time, dementia is accompanied by other chief complaints.

Earlier states of dementia may appear understated in



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**Table 3. Management of Patients With Altered Mental Status**

History	Utilize all resources
Initial assessment	<p><i>Primary survey</i></p> <ul style="list-style-type: none"> <li>• Establish unresponsiveness/protect cervical spine</li> <li>• ABCs</li> </ul> <p><i>Resuscitation/life-saving intervention</i></p> <ul style="list-style-type: none"> <li>• Oxygen supplementation</li> <li>• Establish intravenous access/draw initial blood sample</li> <li>• Cardiac monitor</li> <li>• Pulse oximetry monitor</li> <li>• Thiamine: 100 mg IV (adults only)</li> <li>• Glucose: 500 mL of 50% dextrose solution or glucose test</li> <li>• Naloxone: administer 2 mg (or more) IV or subcutaneously</li> </ul> <p><i>Secondary assessment</i></p> <ul style="list-style-type: none"> <li>• Complete vital signs and general physical examination</li> <li>• Neurological examination <ul style="list-style-type: none"> <li>– Respiratory pattern</li> <li>– Observation of posture and movements</li> <li>– Verbal and motor response to stimulation</li> <li>– Reflexes</li> <li>– Assignment to rating system/serial examinations</li> </ul> </li> </ul>
Definitive care	<p><i>Supportive, monitoring</i></p> <p><i>Transfer to ED for further evaluation</i></p>

presentation, and patients may minimize or attempt to hide their impairments. Often, patients at this stage have an associated depression. Depression alone can present as a dementia-like condition in elderly patients. Of note, a recent study indicated dementia of relatively recent onset had higher likelihood of a potentially reversible etiology.<sup>2</sup> It is essential to conduct a careful medical history of the patient—particularly noting signs of past or present drug or alcohol abuse, current medications, chronic or acute medical illnesses, and psychiatric disorders—to uncover a treatable or modifiable cause for the cognitive impairment.

Elderly patients with depressed mood, hopelessness, and suicidality may be suffering from “pseudodementia” (false dementia). When the depression is alleviated with treatment, the dementia-like condition fully resolves.

### Examination

Any patient who presents with an altered mental status needs a complete physical examination, with particular attention to general appearance, vital signs, hydration status, evidence of physical trauma, and neurologic signs. All patients should have an exam done in the urgent care even if they are being prepared for emergent transport to an ED. Evaluation and simple diagnostic tests could be performed while waiting for EMS to arrive.

General appearance (eg, unkempt and/or malnourished) may suggest the possibility of drug or alcohol abuse. Studies have shown a correlation between tattoos and substance use and abuse in adolescents.<sup>3,4</sup> In the author’s experience, this correlation exists at all ages. Other trace marks for substance abuse include:

- Smell of alcohol, the musty odor of fetor hepaticus, or the fruity smell of ketoacidosis
- Icterus and asterixis point to liver failure with an elevation of the serum ammonia level
- Agitation and tremulousness suggest drug and alcohol withdrawal

Close attention to vital signs is essential. Vital signs are easy to overlook in the setting of extreme behavioral difficulties in a delirious patient.

The Mini-Mental Status Examination (MMSE) is a formalized way of documenting the severity and nature of mental status changes. The MMSE, modified from Folstein, is outlined below.<sup>5</sup> The maximum score per item is indicated in parentheses.

- Orientation (five points): What are the year, date, day, and month?
- Orientation (five points): Where are we? State? Country? Town? Hospital? Floor?
- Registration (three points): Name three objects. Ask the patient to repeat the names of these three objects
- Attention and calculation (five points): The serial seven test (counting down from 100 by sevens) awards one point for each correct answer. Stop after five answers. Spelling *word* backward is optional
- Recall (three points): Ask for the three objects from the registration test (item three in this list) to be recalled. One point is scored for each correctly recalled object
- Language (two points): Name a pencil and a watch
- Repetition (one point): Repeat the following: “No ifs, ands, or buts”
- Complex commands (six points): Follow a three-stage command, such as: “Take a paper in your



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## Urgent Care Policy and Procedure SAMPLE MANUAL

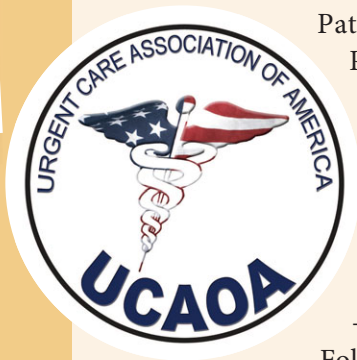
UCAOA thanks the following  
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their participation in this project:



Phillip Disraeli, MD; Sara Jensen, RN;  
Cindi Lang, RN, MS; Bruce McIntosh, MD;  
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right hand, fold it in half, and put it on the floor”

- Complex commands (three points): Read and follow these printed commands: “Close your eyes” (one point); “Write a sentence” (one point); and “Copy a design” (one point)

### Causes

Common causes of altered mental status include infection, toxic reactions, metabolic disturbances, hypoxia/hypercarbia, cerebrovascular conditions, and central nervous system conditions (**Table 2**).

### Evaluation and Treatment

Obtaining an accurate and thorough medical history of a patient with altered mental status is an essential component of the database that must be collected at a time when the patient is least able to provide it. In patients with an alteration in cognition, the alteration may be subtle and may not be evident to the physician on initial evaluation, making it fundamental to interview the patient’s family members, friends, care providers, etc., regarding the patient’s baseline for normality. For many patients with altered mental status, a timely history may not be available and practicable. In the absence of knowledge of the patient’s condition, it must be assumed to be an acute change from baseline. Even when information is available, it is imperative to not accept a predetermined diagnosis without adequate consideration of the medical history, physical examination, and selected diagnostic studies.

For all patients with altered mental status, initial consideration should focus on airway adequacy and potential for cervical spine injury. All patients also require rapid glucose determination/dextrose administration and oxygen saturation measurement, which should be available at any urgent care.

Of note, considerable controversy exists concerning routine use of the “coma cocktail” (thiamine, glucose, and naloxone), as the medical literature suggests that glucose may be detrimental to brain ischemia; routine use should be guided by the clinical situation and rapid glucose determination. Adverse effects of naloxone and thiamine are strongly outweighed by their benefits when there is reasonable suspicion of opioid overdose or nutritional deprivation (**Table 3**).

In the emergent evaluation of patients with altered mental status, the most available imaging study is currently non-contrast brain CT. Most urgent cares lack this imaging capability. Patients who require it should be transferred to an ED.

### Disposition

The potential for serious clinical consequences in patients with mental status impairment is considerably high. Patients suffering from dementia and its associated symptoms may have difficulty accurately communicating their history of present illness and may sometimes omit important details that might lead to suboptimal care. The presence of dementia in the elderly patient can also affect medication and discharge instruction compliance, increasing the risk of morbidity and mortality after discharge.

Although less than 1% of all dementia is considered potentially reversible, individuals diagnosed with chronic and degenerative dementia may still benefit from a variety of treatment options that slow disease progression and prolong independence. Early referral of these patients for further evaluation and treatment may be beneficial. It is important to recognize that patients with dementia are also at increased risk for falls, which can possibly be prevented with vigilance and timely intervention (eg, medication reviews, home safety assessment, etc.) that might reduce this risk and possibly pre-empt further injury.

Delirium is an acute medical emergency. Strong consideration should be given for referral and admission of these patients to the ED.

### Conclusion

Altered mental status has a long differential diagnosis that includes many life-threatening conditions. Medical history from both the patient and bystanders is the key diagnostic tool in urgent care to determine whether a patient requires further evaluation and treatment. Physical examination plays a role comparable to other ancillary testing available in urgent care, such as rapid glucose testing, chest x-ray, urinalysis, etc.

Most patients presenting with altered mental status need a thorough evaluation in the ED. If a life-threatening condition is suspected, patients should be transported immediately via the EMS system. ■

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# Case Report

## A Painful Swollen Joint in an Elderly Male

**Urgent message:** The patient had two recent bee stings. Did they cause his problem or were they red herrings?

PAUL BURES, DO, and LEE A. RESNICK, MD

### Introduction

Hot, swollen, tender joints are a common initial complaint in the urgent care setting. Depending on the patient's HPI and PMH, a definitive diagnosis can often be concluded. A systematic evaluation of infectious, inflammatory, and traumatic causes can help narrow the differential. Judicious use of the laboratory and radiology can further support the diagnosis.

### Case Presentation

MS is a 75-year-old male who presented with five days of left wrist and hand swelling and tenderness. He stated that a day before the pain started, he twisted his left wrist while pushing himself out of the bathtub. He also had suffered two bee stings to his upper left arm two days prior to the current complaint. The redness and swelling gradually increased each day. On the day of presentation, the redness and swelling started in the distal third of his forearm and extended through the hand and wrist to the MCP joints of all digits. Pain was worsened to a 10/10 with any manipulation of the wrist.

### Observations and Findings

Evaluation of the patient revealed the following:

- PMHX: osteoarthritis, HTN, HLD, MI 3 years prior, denies history of gout or other inflammatory arthritis
- MEDS: metoprolol (Lopressor), lisinopril (Prinivil),

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- simvastatin (Zocor), clopidogrel (Plavix), aspirin
- Allergies: NKDA
- PSXH: bilateral knee replacement 15 years prior
- Social HX: no tobacco or alcohol
- FH: non-contributory
- ROS: no fever, no chills, no nausea, no vomiting, no numbness, no tingling, no weakness

Physical exam revealed the following:

- Temp: 99.9° F
- P: 86
- R: 20
- BP: 90/56
- O<sub>2</sub> Sat: 97% RA
- Gen: well-appearing, alert and oriented x 3, no acute distress
- Heart: RRR, no M/R/G
- Lung: CTA bilaterally, no W/R/R





Figure 1.



Figure 2.

Evidence for extensive chondrocalcinosis of the carpal joints, suggesting the presence of calcium pyrophosphate dihydrate (CPPD) deposition disease. Arrow identifies only an incidental finding.

- Skin: erythema and warmth beginning at distal third of left forearm extending to MCP joints of left hand. No evidence of wounds or abrasions. No red streaking up forearm
- Extremities: non-pitting edema L wrist extending one-third up left forearm and throughout metacarpals. Loss of full flexion and extension of left wrist both actively and passively secondary to edema. No pain out of proportion on passive motion of the digits. Cap refill 3 seconds. Tender to palpation directly over the wrist joint but not over the other areas of erythema
- Neuro: strength and sensation full in left hand

Diagnostics revealed the following:

- CBC: WBC 7.5
- ESR: 62
- Blood CX: negative

Radiology results revealed the following:

Wrist x-ray: There was no evidence of fracture or dislocation of the left wrist on x-ray. However, evidence for extensive chondrocalcinosis suggesting the presence of calcium pyrophosphate dihydrate (CPPD) deposition disease was seen in the carpal joints and confirmed by radiology (**Figures 1 and 2**). Severe osteoarthritic changes involving the first carpometacarpal joint were also seen.

### Diagnosis

CPPD with an acute attack of pseudogout.

### Course and Treatment

Initial evaluation of the patient by the resident considered infection to be the most likely diagnosis. The warm, erythematous, indurated skin, which extended much past the wrist, indicated a fast-growing cellulitis—not to mention that the patient had two bug bites further up the arm earlier in the week, indicating an entry site for infection. A septic joint also was high on the list;

however, the patient had no known risks or exposures.

On further examination by the attending physician, the clinical correlation for an infectious process did not fit. For one, the insect bites were too far up the arm and not within the area of suspected cellulitis. Furthermore, bee stings are rarely implicated in cellulitis. On exam, the patient was clearly tender along the joint line between the radius, ulna, and carpal bones. Also, with any manipulation of the wrist, be it in active or passive flexion, extension, adduction, or abduction, the patient had severe pain. However, no pain was elicited with any active or passive motion of the digits or on direct palpation of erythematous skin not directly over the joint.

An inflammatory process of the wrist now seemed more likely, and the patient did have minor wrist trauma at the onset. The patient denied any history of gout; however, he had had bilateral knee replacement just 15 years earlier. Supposedly this was just due to osteoarthritis and long-term wear and tear. He also denied any prior episodes such as the current one in any joint. Despite this, he was started on IV methylprednisolone (Solu-Medrol) and then sent for an x-ray of the wrist while we awaited lab results.

Over the next hour, while x-ray and lab results were pending, the patient was already experiencing relief of pain and swelling, supporting the inflammatory nature of this process. After confirmation of the diagnosis on x-ray, he was sent home on oral corticosteroids and did well.

### Discussion

CPPD deposition disease affects the elderly, with a prevalence of 15% above age 65 and 50% above age 85. Most cases are idiopathic; however, this is evidence that joint trauma may be a precipitating cause. Other possible causes include an autosomal dominant familial chondrocalcinosis, hemochromatosis, and other metabolic and genetic conditions with unclear relation to the condition.

The pathogenesis of the disease is initiated in cartilage located near the surface of the chondrocytes. The active collagen and proteoglycan-producing chondrocytes produce excess calcium or pyrophosphate or both, which leads to a supersaturation of the crystals in the nearby matrix. The dysfunction in either mineral or organic metabolism leading to the excess crystal formation has several proposed mechanisms, some with more evidence than others but none absolute.

Precipitation of the crystals in joints will often be asymptomatic; however, an acute attack of the associated synovitis is termed "pseudogout." Most patients, however, will not experience these attacks that mimic

gout, which happen to favor the knees, wrists, elbows, and MCP joints. "Chondrocalcinosis" refers to the actual radiographic crystal formations, and "pyrophosphate arthropathy" is another term for the joint disease.

The treatment of pseudogout attacks is relatively easy and there are multiple options, not to mention that cases can also be self-limited and mild. NSAIDs or colchicines can be used first-line, followed by oral or systemic corticosteroids. The European League against Rheumatism (EULAR) consensus panel prefers joint aspiration of crystals with intra-articular injection of corticosteroids for single-joint involvement.

In multiple joint involvement, medical agents, as stated above, are preferred. Ice, rest, and immobilization are always indicated. Colchicine can be used for prophylaxis in patients with multiple attacks per year.

### Conclusion

Pseudogout can be an easily missed diagnosis due to its similar presentation to other conditions. Once recognized, it is an easily treatable condition that can be managed in the urgent care setting. ■

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# Practice Management

## An Urgent Care Lab as a Profit Center?

**Urgent message:** An onsite lab can generate significant revenue for your practice. Lab expert Tim Dumas shows how.

TIM DUMAS, MLT,CLS

### Introduction

I have been a lab tech for almost 35 years and serve as advisor to 45 physician office labs around the country. I have seen many changes in that time, most for the better. Thirty—even 20—years ago, a stat CBC with differential was a 15-minute-procedure and required a skilled lab tech to get it right. Today my office labs perform CBC/diffs with an average turn-around-time of five minutes. These labs offer better accuracy and reproducibility and only require a single smart person with the right attitude and a high school diploma to run.

Most advances in laboratory medicine in the past decade have come in the form of computer technology. Blood chemistry analyzers now have the ability to monitor quality control internally. They can notify the operator when there is a problem and when not to accept a result. “Waived” or “kit” tests are made so that it is very difficult to perform a test incorrectly.

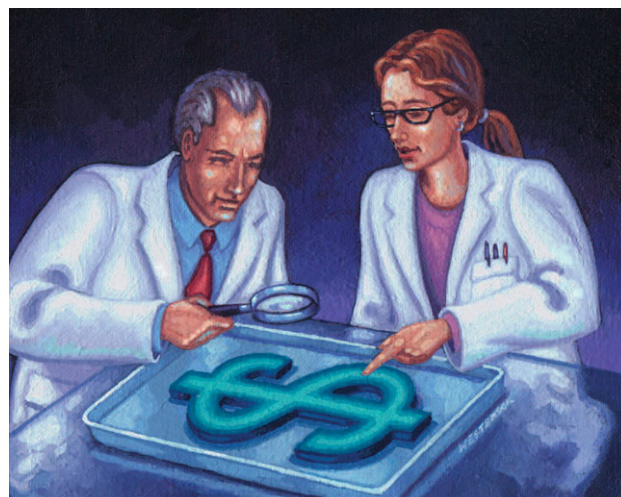
As I researched up-to-date statistics relating to lab regulations, registration, lab test usage, or some kind of graph that shows what other urgent cares are doing regarding lab procedures to make my case for onsite labs, I realized that it’s all fluff. What other centers are doing may or may not work for you. So let’s focus on the facts about lab tests—facts that should be well-known but often aren’t. Afterward, you can decide for yourself whether in-house testing is right for your practice.

### Why Run Your Own Lab Tests?

The function of lab tests in the clinical setting has

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always been to assist in the diagnosis of disease and monitor the progress of treatment. Lab tests are one set of tools in the medical tool box that is tough to do without. The quicker a provider can get the result of a lab test, the quicker that provider can make a diagnosis and start treatment—and not waste money and time on unnecessary treatments because the treatment that is offered is based on an accurate lab result when that result is actually needed: not in a day or a week but in minutes. I can think of no better usable setting for the rapid lab results than an urgent care center.

### Benefits of In-house Testing

An onsite lab offers numerous benefits to urgent cares:

- You gain the ability to diagnose and treat a patient’s problem while the patient is still in the office.



- The patient starts treatment quicker or can be referred quicker when necessary.
- Your staff does not have to spend time tracking down patient to give her the lab results and/or treatment.
- Many insurance companies now see the benefit of onsite labs to their members. If doctors can provide one-stop services (ie, onsite lab, in-office dispensing), this saves patients from having to make multiple trips to get treatment.
- How many times has a reference lab lost your blood sample and your patient had to be redrawn? Or the wrong test was ordered and/or performed? With an onsite lab, you gain control over specimens.
- If your lab tech is handling the send-out processing to a reference lab, then that individual is, in effect, working for the reference lab, because it is the reference lab that is getting paid.
- The same amount of time spent processing a send-out could have been used to run the test in-house, with your practice retaining the revenue.

### What Does It Take to Get an Onsite Lab?

Regulation and oversight are the first considerations in getting a lab into your center. The Clinical Laboratory Improvement Amendments (CLIA; [www.cms.gov/CLIA](http://www.cms.gov/CLIA)) is the federal regulatory body that oversees all laboratory testing. The purpose of CLIA is to ensure accurate and reliable lab testing for the benefit of your patients. CLIA is controlled by Centers for Medicare & Medicaid Services (CMS).

A CLIA certificate/number is required for billing. Regulatory oversight can also be achieved by several other companies, but they report to CLIA. These are:

- The Commission on Office Laboratory Accreditation (COLA; [www.cola.org](http://www.cola.org)), which was established to help physician office labs comply with CLIA regulations. COLA oversight is the most cost-effective way to be compliant.
- The College of American Pathologists (CAP) laboratory accreditation program. The oldest regulatory agency, CAP is better suited to large labs performing highly complex testing.
- The Joint Commission, which is usually used for larger institutions.

CLIA is both the certificate of accreditation and the oversight agency. There is a fee for the inspections; it is paid to whichever agency you choose for oversight.

### Applying for a CLIA certificate

To earn accreditation, your lab will need a designated lab director. This position can be filled by a physician with demonstrable lab experience. The best way to meet this regulation is to take the lab director's course through COLA. It can be completed online or you may want to attend one of COLA's semi-annual three-day symposia.

For the urgent care setting, two levels of testing certificates are important:

#### CLIA Certificate of Waiver for Waived Testing

Mostly kit tests and small, easy-to-run analyzers

No technical skill required

Minimum fee: \$150 every two years.

No regular inspections are scheduled

Waived testing is the most basic level of testing. Under CLIA law, waived tests are those tests determined by the Centers for Disease Control and Prevention (CDC) or the Food and Drug Administration (FDA) to be so simple that there is little risk of error. Most offices are already performing waived tests. They include kit tests such as rapid strep, influenza, mono, urine dip stick, and fecal occult blood. Currently, 40 tests have been approved for certificate of waiver status. There are a few chemistries and some immunoassays that can be performed on a waived basis. However, these tests are more expensive to run on a waived analyzer than on a non-waived analyzer. More on that later.

A waived test should be clearly marked "WAIVED." The package insert provides instructions for the procedure. It indicates the quality controls needed. And it gives details for storage and test limitations. Unfortunately, most clinics don't read or follow these instructions and that's where they get into trouble.

#### CLIA Certificate of Compliance for Non-waived Testing

Larger, more expensive analyzers but less expensive cost per test

Tests can be performed by non-technical personnel (minimum educational requirement: a high school diploma)

Training in quality control and quality assessment are required

The CLIA fee increases with the number of tests performed (the biennial fee ranges from \$150 for 2,000 or fewer tests performed per year to \$7,940 for greater than 1 million tests performed per year)

Requires biennial inspection by CLIA or other certifying agency

### How Much Does CLIA Reimburse Per Test?

The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the United States through the Clinical Laboratory Improvement Amendments (CLIA). To obtain the 2011 Medicare reimbursement rates listed for each state for all laboratory CPT codes, follow these steps:

1. Visit this Web address: [www.cms.hhs.gov/ClinicalLabFeeSched/02\\_clinlab.asp#TopOfPage](http://www.cms.hhs.gov/ClinicalLabFeeSched/02_clinlab.asp#TopOfPage).
2. Scroll down to the first link—11CALBMAR.ZIP [ZIP, 1.01MB]—and click on it.
3. This will take you to a “License for Use of Current Procedural Terminology, Fourth Edition (“CPT®”)” screen. Scroll down and click “Accept.”
4. A file download window will pop up; click “Open.”
5. The 11CLAB window will now open with four documents listed. The first two are spreadsheets. If you have newer software, doubleclick on either spreadsheet to view the fee schedule. If you have older software, doubleclick on the second spreadsheet to view the fee schedule.

You can enroll your laboratory in the CLIA program to get your certificate and number by completing an application (Form CMS-116) available online on the CLIA website. If you are currently running waived testing and would like to add CBCs or any other non-waived test to your lab’s capabilities, you would need to submit this application with your current CLIA information and ask to be upgraded to non-waived status.

**Table 1. Calculating Gross Revenue for Rapid Strep Tests Per Month for a Waived Lab**

Formula	
$(X \times Y) - (Z \times Y) = \text{Revenue}$ X = reimbursement/test Y = number of tests performed/month Z = cost/test	
Example	
Test Type	Rapid strep
Number of Tests/Month	250
Reimbursement/Test	\$16.01
Total Reimbursement/Month	\$4,002.50 (\$16.01 x 250)
Cost/Test	\$2.50
Total Test Cost/Month	\$625 (\$2.50 x 250)
Total Reimbursement/per month	\$3,377.50 (\$4,002.50 - \$625)
Gross Revenue/Year	\$40,530.00 (\$3377.50 x 12)

Non-waived is the next level of laboratory testing. These tests take a few more steps to perform and include CBCs, some chemistries, and some immunoassays. Running tests on a non-waived analyzer can provide more accurate results as well as being less costly per test. With the right system, this can generate more revenue for the practice. There are a handful of analyzers to choose from and it becomes a job to sort them all out. This is where a distributor’s sales rep or a laboratory consultant can be most beneficial.

How do you know if non-waived testing is right for your center? There are breakeven points for running certain tests. For example, running three to five CBCs tests per day will generally pay for a non-waived analyzer, as would running five or more comprehensive metabolic panels (CMPs) or basic metabolic panels (BMPs) for blood chemistry per day.

returns in reimbursements. I’m amazed at how often I ask for financial information about a lab and the manager doesn’t really know the cost per test or the reimbursement. She just knows the lab is costing money and therefore assumes it is losing money. A business must first know projected revenue before it can start, so let’s take a look.

### Financial Feasibility for a Waived Lab

Projecting waived lab test revenue is fairly simple. You need to know this information:

- **Cost per reportable.** This means the cost per test plus any extra items not included with the kit (eg, swabs, tubes, controls, incubators, etc.). Take the rapid strep test. A kit of 25 tests costs \$62.50—or

### Making Your Lab Profitable

I hear from many doctors and office managers that their labs are a drain on the practice. My response is usually the same: “You’re running your lab incorrectly.” Over the years, I have been called in to fix many labs that were losing money or costing too much. A lab is a business and should be run like one. Consider it a business within your business. In fact, some of my physician offices say that the lab brings in as much revenue as office visits.

I have discovered the main source of error to be overhead. Clinics often spend more money to run a test than it

\$2.50 per test. The kit includes controls and all the necessary materials to run the test. There are no extras. So the cost per reportable is \$2.50.

- **Reimbursement.** This varies from state to state and from one insurer to another. I have found that a good guide is the “CLIA minimum reimbursement fee schedule” (see *How Much Does CLIA Reimburse Per Test?* on page 20). Your office can calculate your own average. Many urgent care centers operate on a cash basis. Establish what your set fee for a procedure will be and collect it. For example, the rapid strep Medicare minimum reimbursement is \$16.01. The cash price you charge might be \$25.
- **Number of tests performed.** I usually count per month. Volume varies based on time of year. Use this information to determine inventory. Be sure to check the expiration dates on kits and don’t order too many. In the urgent care setting, it is sometimes difficult to predict volume of tests before you open a kit. If this is your situation, aim on the low side. You can always order more kits and receive them the next day. Once you have the ability to average the number of tests per month (eg, 250 rapid strep tests per month), ordering a realistic number gets easier, especially if you use a simple formula in an Excel spreadsheet (**Table 1**).

Isn’t there more to costs than the cost per test? What about CLIA fees, the cost of a tech’s time to run the tests, regulatory costs, and the cost of lab space?

- This is for a waived lab, so no lab tech is needed. If your volume is high, I recommend that a dedicated staff member run all labs. It’s much more efficient than having the nurses try to do it all. The revenue generated pays for a dedicated individual’s time.
- For a waived lab, the cost of a two-year CLIA/COLA certificate is minimal: \$150. The space requirement is also minimal: a countertop and shelves or cabinets for storage.
- Don’t bother adding in tech time, rent, insurance, and other common facility costs in an attempt to calculate net revenue to the penny. You have already have the space, pay the rent, and pay for insurance, so these costs are not really costs from adding a lab.

#### *Financial Feasibility for a Non-waived Lab*

Now let’s look at the costs and revenues for a non-waived lab. The most useful test for a non-waived lab in the urgent care setting is the CBC, so let’s use that as an example (**Table 2**).

Reimbursement is based on the Medicare minimum (\$10.94/test) and will not change much. The only real control we have to increase revenue is to decrease the cost per test. The cost here of \$1.25 per test is an average for CBC testing. Cost per test will decrease with higher volume of testing.

From the gross revenue per year—\$25,581.60—subtract your fixed costs (**Table 3**). I call these “fixed” because no matter how many

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**Table 2. Calculating Gross Annual Revenue for CBC Tests for a Non-waived Lab**

Test Type	CBC
Number of Tests/Month	220
Reimbursement/Test	\$10.94
Total Reimbursement/Month	\$2,406.80 (\$10.94 x 220)
Cost/Test	\$1.25
Total Test Cost/Month	\$275 (\$1.25 x 220)
Total Reimbursement	\$2,131.80 (\$2,406.80 - \$275)
Gross Revenue/Year	\$25,581.60 (\$2,131.80 x 12)

**Table 3. Calculating Net Annual Revenue for CBC Tests for a Non-waived Lab**

Gross Revenue/Year	\$25,581.60 (Table 2)
<b>Fixed Costs to Be Deducted</b>	
Hematology Analyzer	\$3,000
Service	\$1,700
Proficiency	\$350
CLIA Fee	\$600
Total Fixed Costs	\$5,650
<b>Net Revenue</b>	<b>\$19,931.60 (\$25,581.60 - \$5,650)</b>

tests you run, they remain the same. These are the average fixed costs per year:

- Hematology analyzer: \$3,000 (estimate: \$15,000 leased over five years)
- Service contract: \$1,700
- Proficiency testing: \$350
- CLIA fee for non-waived testing: approximately \$600 per year

Deduct your fixed costs from your gross revenue to calculate your net revenue (\$19,931.60 in this example).

Could your urgent care use an extra \$20,000 per year in net revenue? Even more important from the standpoint of clinical quality, how valuable is a stat CBC? It would enable you, for example, to diagnose flu vs an infection—with no need to write a prescription or call the patient back when the test result arrives. Most providers I speak to about CBCs say that they would order the tests more often if they were available stat. A send-out CBC result is not much help. Here is where you can factor in the savings from not having to call the patient back or open that chart again to review and comment on the results. It is just better medicine.

While this example is not the whole story, it can be used as a template to determine the feasibility of performing

a given test in-house. If you already perform in-house testing but have not calculated revenue, plugging your numbers into this example can help you determine it.

What can be a hidden cost not factored into the example is how well your billing personnel are capturing lab-generated revenue. This is something you really ought to monitor. If you know the projected revenue, then you can compare it to the actual revenue being brought in. Any inconsistencies can then be discovered and corrected.

#### *Other Non-waived Tests*

Blood chemistry tests are different from CBCs because there are no waived hematology analyzers (ie, blood cell counters) available. In contrast, blood chemistry analyzers—analyzers

that perform CMPs, BMPs, and electrolyte panels (lytes)—are available in both waived and non-waived platforms. Waived chemistry analyzers are more expensive per test/profile and therefore don't allow for much profit. In fact, this is where most urgent cares lose money on labs (Table 4 and Table 5). Waived test analyzers do not require proficiency testing and the service contract is usually much less expensive compared to non-waived bench-top analyzers.

The high cost per test when performing more complex tests like CMPs in a waived lab vs a non-waived lab (\$10 vs \$2.50, respectively) makes the profit margin either very small or a negative number for a waived analyzer, and that assumes you collect the full amount you bill.

A better alternative for more complex tests is a non-waived bench-top chemistry analyzer. A non-waived analyzer can perform multiple tests on multiple patients at one time, perform a larger menu of tests, is usually more accurate, and is less expensive per test than a waived analyzer. On average, a non-waived bench-top analyzer can perform CMPs for less than \$3.

Which specific analyzers to consider is beyond the scope of this article. But comparison-shop and ask lots of questions before making a buying decision.

### Challenges to Getting Paid

Even when they master everything just discussed, most physician practices are not getting paid for lab testing by insurers for the simple reason that they haven't asked to be paid. Like most things with insurers, it's all about the negotiating.

The insurance company may say they require the office to send the test out to a reference lab. That's because they have made a deal with that lab for a decreased fee for the tests. It's good business for the insurer, but this "deal" comes at a cost to the patient and to your urgent care. If the labs could be performed in-house for the same fee as the reference lab, then the practice should get paid.

That's the basic idea for negotiating with insurers.

You may be surprised at the outcome of just asking to get paid for in-house testing. Don't assume the worst. Doctors and staff must first understand the benefits of in-house testing. This understanding and belief will enable you to convince an insurer that they can save time, money, and even lives by offering onsite testing. You have the right to provide your patients (their customers) with the high level of quality and convenience that in-house testing can deliver. The importance of in-house testing can be summed up this way:

Faster Results (Saves Time) = Faster Treatment (Saves Money) =  
Faster Recovery (Saves Lives)

### Negotiating With Insurers

In the past, physicians have assumed that contracts with the insurers were not negotiable. They would not complain for fear that an insurer might not let their clients be a practice's patients. Insurers rely on that attitude. Physicians must realize that *they* provide the service that patients seek. It's a lot easier to find an insurance company than to find a doctor you trust and rely on to make you and your family feel better and healthier. Most patients will pay out of pocket for medical care they can trust. If need be, they will search for insurance that a clinic will accept.

Insurance companies are composed of businesspeople; negotiating is what they do. Don't give in. Commit to do business. If you aren't confident about your business abilities, hire a skilled negotiator who is.

When you begin negotiating, make it clear that you are not just asking for money. You must explain the benefits of the testing. Faster results and quicker treatment lead to faster recovery. This is the essence and purpose of both your position and the insurer's. People today are more educated about their own health than ever before. The Internet has empowered them with information so they know which tests and in some cases even which treatment they should receive. Like it or not, that's healthcare in the 21st century.

A strong negotiating point is the issue of liability brought on when a patient is misdiagnosed or diagnosed too late due to unavailable or delayed lab reports. Think of the complaints about over-prescribing medications.

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**Table 4. Calculating Net Annual Revenue for CMPs for a Waived Lab**

Test Type	Comprehensive Metabolic Panel (CMP)
Number of Tests/Month	220
Reimbursement/Test	\$11.54
Total Reimbursement/Month	\$2,538.80 (\$11.54 x 220)
Cost/Test	\$10
Total Test Cost/Month	\$2,200 (\$10 x 220)
Total Reimbursement	\$338.80 (\$2,538.80 - \$2,200)
Gross Revenue/Year	\$4,065.60 (\$338.80 x 12)
<b>Fixed Costs</b>	
Waived Blood Chemistry Analyzer	\$3,000
Service	\$500
Proficiency	0 (no proficiency testing is required)
CLIA Fee	\$600
Total Fixed Costs	\$5,650
Net Revenue	<b>-\$1,584.40 (\$4,065.60 - \$5,650)</b>

**Table 5. Calculating Net Annual Revenue for CMPs for a Non-waived Lab**

Test Type	Comprehensive Metabolic Panel (CMP)
Number of Tests/Month	220
Reimbursement/Test	\$11.54
Total Reimbursement/Month	\$2,538.80 (\$11.54 x 220)
Cost/Test	2.50
Total Test Cost/Month	\$550 (\$2.50 x 220)
Total Reimbursement	\$1,988.80 (\$2,538.80 - \$550)
Gross Revenue/Year	\$23,865.60 (\$1,988.80 x 12)
<b>Fixed Costs</b>	
Non-waived Blood Chemistry Analyzer	\$7,000
Service	\$6,000
Proficiency	\$400
CLIA Fee	\$600
Total Fixed Costs	\$14,000
Net Revenue	<b>\$9,865.60 (\$23,865.60 - \$14,000)</b>

What's in it for an insurer? Marketing clout. You are asking to be paid to do a better job of caring for your patients (aka "their clients"). The same Internet that allows patients to discover information about diseases and treatments also allows them to find a provider who has the medical expertise they need—and insurance that supports

that provider. It's good for an insurer to be able to advertise that their network of providers offers in-house testing.

#### *Problems With Billing*

The other area to watch for in getting paid for testing is your billing department. In 70% of the labs I have worked with to correct their revenue shortfalls, the problems were coming from the billing department. They include:

- Incorrect CPT codes
- Missing or mismatched ICD-9 codes.
- Tests not billed for at all (too much work to match the codes, tests not checked off on claim forms as performed and reimbursable expenses, etc.)
- Denials of payment not resubmitted

One medical practice failed to collect over \$150,000 in lab revenue due to billing errors.

#### **Shopping for Lab Kits and Analyzers**

Once you have chosen the test that would be beneficial to your practice, it's time to buy the equipment you will need. The first place to check is your medical supply vendor. Ask your favorite medical sales rep what he or she offers in that line of testing. And then—very important—find another vendor and pose the same question. Comparison-shopping is the key to a profitable lab. Let the product

sales reps do their job of educating you about the pros and cons of certain test kits and then use a team approach in your urgent care to choose the best ones for your situation. Several distributors may offer the same product. Shop for the best price; the manufacturers are generally brand names offered by all distributors.



One office I worked with discovered they were paying \$17 per flu test. Medicare reimburses \$16.01. Oops. After shopping around they found a similar kit, which worked just as well, for \$9 per test.

Don't sell yourself short. A difference of \$.25 per test adds up over time. Take the rapid strep test used as an example in **Table 1**. The cost per test is \$2.50. If it were just \$.25 more expensive, and you were performing 250 tests per month, that cost would balloon to an extra \$750 annually (\$.25 x 250 x 12).

### Concerns About Onsite Labs

Here are some concerns about onsite labs I have encountered, with some perspective:

#### Concern

Federal regulations are time-consuming and difficult to comply with.

#### Perspective

The regulations are intended to assure accurate results from your lab. The cost is minimal compared to the benefit and revenue generated. Your staff is responsible for testing and quality control. An ROI analysis can determine whether your staff time is worth the benefit and revenue generated by in-house testing.

#### Concern

Where will we store all those test kits and reagents?

#### Perspective

Kits are small boxes, usually shoebox-size or smaller. They contain 25-100 tests per box. Your lab will not usually need more than one or two boxes at a time.

#### Concern

It's too expensive to invest in a hematology analyzer.

#### Perspective

That's why you need to perform an ROI calculation before you purchase equipment. If you are not sure about the financial/business end of establishing a lab in your urgent care, a consultant who knows the ropes can help. Most of the time this will be well worth the investment.

#### Concern

We are concerned about the longevity of point-of-care testing (POCT). Some offices are concerned that one day Medicare will not pay for POCT.

#### Perspective

POCT is here to stay. POCT has been established as good medical practice. Insurers may shift the cost to the patient, but the tests are needed, someone will pay to have them performed, and someone will be paid to do them. Why not you? ■

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# Potential Pitfalls While Finding the Needle in the Haystack

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

It's nearly midnight on Saturday and I am between patients in an ED on an unseasonably cold November evening in Phoenix, Arizona. Among the head bleeds, overdoses, MI's, and strokes, I have had these chief complaints thrown at me:

- "Smoke inhalation after blowing out a candle"
- "I can't stop playing with my number one."
- "I'm here for my 40-year-old physical." (The patient was 43.)
- "I fell asleep at a party and woke with a sore throat. I think I have an STD in my throat."

I have often mentioned that I think urgent care medicine is much more challenging than emergency medicine inasmuch as in the ED, I have at my fingertips essentially any diagnostic test I can dream up and all the help I need.

In an urgent care center, relying on your gut and great diagnostic skills is a necessity. Although it is true that most patients who present to an urgent care are generally healthy and have non-life-threatening complaints, the challenge is sifting through the hundreds of "well" to identify the one "sick."

## The High-Risk Patient: Diagnostic Considerations

The following are some tips from the literature and from my experience to help mitigate your risks, identify the sick, and improve patient safety in the urgent care setting:

- When a patient presents with a chief complaint of headache, considering the possibility of a subarachnoid bleed is essential. CT scanning of the brain has a false negative rate of 3%-5% for warning (sentinel) bleeds. If you are ordering an outpatient CT for a headache, you may want to consider sending the patient to an ED, since, if the CT is negative, the patient should have a lumbar puncture. Advise the patient of the "game plan" prior to sending him

to the hospital and document the conversation.

- Remember to palpate over the temporal artery for those patients with visual changes and headache. Rapid administration of IV steroids for temporal arteritis is the standard of care.
- Be wary of mild head trauma in patients who are on warfarin (Coumadin), aspirin, or clopidogrel (Plavix). Have a low threshold for CT scanning in these patients and ensure close follow-up. Delayed bleeding in an anticoagulated patient is not uncommon.
- LS spine films are of little value without a history of significant trauma to the back. A patient presenting with any red flags (eg, IV drug abuser, saddle anesthesia, myelopathic findings, incontinence, etc.) should receive an MRI (with gadolinium if epidural abscess is suspected). Avoid getting caught in the "narcotic seeker" mode and perform a thorough exam documenting strength, reflexes, and sensation. "WNL" is not sufficient.
- Most cervical injuries can be cleared clinically; in those that can't, the literature is clear that CT is superior to the three-view C-spine series. However, it delivers a significant dose of radiation to the neck and thyroid gland.
- In patients with hand/wrist injuries, the rate of occult scaphoid fractures is believed to be as high as 20%. MRI is the diagnostic test of choice. However, the common approach, which is also the standard of care, is documentation of snuff box tenderness, thumb spica splinting, and re-imaging in a week to 10 days.
- Regarding the use of midlevel providers, the rate of claims based upon "failure to supervise" are increasing. Check your state's statutes regarding what is required to supervise a midlevel provider and make sure you are in compliance.
- If a patient complains of an eye injury, ask about activities such as hammering, grinding, chiseling, etc. These activities have an increased risk of intraocular foreign bodies. CT scanning is the modality of choice to diagnose intraocular for-



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eign bodies. Always check visual acuity no matter what the eye complaint and inquire about tetanus status.

- Patching an eye for corneal abrasions is not the standard of care. Think of pseudomonas infections in patients with conjunctivitis who are also contact wearers. In these patients, patching is definitely contraindicated.
- In patients with nasal trauma, look for and document the presence or absence of a septal hematoma. If present, it must be drained. Also, evaluate for CSF rhinorrhea and consult neurosurgery if present.
- Button battery ingestion in children is an emergency. These must be removed to prevent tissue necrosis.
- For patients presenting with vertigo, the goal of the evaluation is to differentiate peripheral versus central etiology. Peripheral etiology is typically acute onset and positional. In addition, the patient often complains of ringing in the ear and nausea and has nystagmus. Twenty-five percent of patients over age 60 will have a central cause of their vertigo such as a cerebellar stroke or vertebral artery dissection.

## The High-Risk Patient: Additional Considerations

- Don't waive copays for patients or staff, especially for government-insured patients. Waiving copays is considered an inducement by the Centers for Medicare & Medicaid Services and is generally prohibited in all payor contracts.
- Follow up on all abnormal lab and x-ray results and don't fall into the trap of ordering tests unnecessary to help solve the issue at hand.
- Be careful on your discharge instructions to give patients an avenue for follow-up. Don't document, "See your provider in one week or as necessary." If a patient cannot get in to see her PCP, offer her a return appointment to your center for reevaluation. In fact, make a return appointment for the patient at discharge.

- For "complaint management," remember the mnemonic LAST: **L**isten; **A**pologize without implying or admitting error (eg, "I'm sorry that our care fell below your expectations"); **S**olve; and **T**hank you. Check to see if your state has an "I'm Sorry" law—and read it—before apologizing. Physician apology laws differ from state to state. Most I'm Sorry legislation limits evidentiary protections.
- Be careful of postings on social media sites. Never post a picture of a patient or a patient's body part on a social media site. I know of multiple providers whose "innocent rants" have come back to haunt them.
- If a chart is billed under your name, you bear responsibility for the outcome of the patient.
- The use of checklists reduces the potential for error and improves patient safety.
- Metadata records keystrokes in an EHR. A knowledgeable plaintiff's attorney will always subpoena that EHR metafile to review what was documented and when the keystrokes occurred.
- Don't ever throw colleagues under the bus in the chart. This behavior is unprofessional and unnecessary and may come back to bite you if litigation ensues. Plaintiff attorneys love nothing more than finger-pointing.
- Always generate a medical record on a patient (even if the patient is your friend or relative). No chart can equal no medical malpractice coverage.
- At the end of the day (and it literally is the end of my day), much of the risk in urgent care medicine can be mitigated by compassionate patient care, great documentation, and excellent customer service and service recovery.

In case you are still wondering about my patient who couldn't stop playing with his "number one," well, let's just say that he is now resting comfortably and continues to hold himself in high regard. ■



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## ABSTRACTS IN URGENT CARE

- Effect of Adrenaline on Survival in Out-of-hospital Cardiac Arrest
- Admission Decisions for Patients with CAP Have High Variability Among Physicians
- Perforation Rate in Pediatric Appendicitis
- GSC Score <15 Poses Higher Risk to Elder Patients
- Ruling Out UTIs in Bacterial Infection in Bronchiolitis

■ 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.

### Effect of Adrenaline on Survival in Out-of-hospital Cardiac Arrest

**Key point:** Adrenaline improves chance of return of spontaneous circulation but not survival to discharge.

**Citation:** Jacobs IG, Finn JC, Jelinek GA, et al. Effect of adrenaline on survival in out-of-hospital cardiac arrest: A randomised double-blind placebo-controlled trial. *Resuscitation*. 2011;82(9):1138-1143.

Adrenaline has been used to treat patients with cardiac arrest for more than half a century but has not been evaluated in a placebo-controlled clinical trial in humans. Indeed, there is concern that it might have untoward effects on myocardial function and cerebral microcirculation in post-cardiac arrest patients. In the first randomized, double-blind, placebo-controlled trial of adrenaline in cardiac-arrest patients, researchers in Australia randomized 534 adults (mean age, 65; 73% men) with out-of-hospital cardiac arrest from any cause to receive 1 mL of either adrenaline 1:1000 (ie, 1 mg) or normal saline every 3 minutes to a maximum of 10 mL. No other resuscitation drugs were given. Paramedics were allowed to use other standard methods of cardiopulmonary resuscitation, including defibrillation.

Rates of survival to hospital discharge—the primary outcome—did not differ significantly between the adrenaline and control groups (4.0% and 1.9%; odds ratio, 2.2). Patients receiv-

ing adrenaline had significantly higher likelihood of pre-hospital return of spontaneous circulation (ROSC) than placebo recipients (23.5% vs 8.4%; OR, 3.4) and of admission to the hospital from the emergency department (25.4% vs 13.0%; OR, 2.3).

Published in *J Watch Emerg Med*. October 14, 2011—John A. Marx, MD, FAAEM. ■

### High Variability in Admission Decisions for Patients With Pneumonia

**Key point:** Admission rates by individual physicians at a single emergency department varied twofold, and variations were not explained by patient, disease, or physician factors.

**Citation:** Dean NC, Jones JP, Aronsky D, et al. Hospital admission decision for patients with community-acquired pneumonia: variability among physicians in an emergency department. *Ann Emerg Med*. [Epub ahead of print.]

To assess variability among physicians in their decisions to admit patients with community-acquired pneumonia (CAP), researchers conducted a retrospective chart review of 2069 adult patients with diagnoses of CAP who presented to a single emergency department in Salt Lake City during an 11-year period. The decision to admit was adjusted for patient demographics and disease acuity, including vital signs, laboratory and radiographic results, and outcomes. Low acuity was defined as PaO<sub>2</sub>/FiO<sub>2</sub> ratio ≥280 mm Hg, predicted mortality <5% by eCURB (an electronic decision support tool), and <3 minor criteria for severe pneumonia per 2007 Infectious Diseases Society of America/American Thoracic Society guidelines.

Physicians' admission rates ranged from 38%-79%. The individual physician was a highly significant independent predic-



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tor of admission after adjustment for patient-specific and disease-specific variables. Individual physicians' admission rates were not associated with patient outcomes. Physician-specific factors, including age, experience, and training, were not associated with variability in physicians' admission rates. Some factors that might have influenced the decision to admit, such as home resources and access to outpatient follow-up, were not recorded.

Published in *J Watch Emerg Med*. October 7, 2011—Richard D. Zane, MD, FAAEM. ■

## Effect of Delay in Presentation on Rate of Perforation In Children With Appendicitis

**Key point:** Appendiceal perforation in children is more common than in adults and correlates with duration of symptoms before surgery.

**Citation:** Narsule CK, Kahle EJ, Kim DS, et al. Effect of delay in presentation on rate of perforation in children with appendicitis. *Am J Emerg Med*. 2011 Oct;29(8):890-993.

Appendicitis is the most common emergency operation in children. The rate of perforation may be related to duration from symptom onset to treatment. A recent adult study suggests that the perforation risk is minimal in the first 36 hours and remains at 5% thereafter. The authors prospectively studied all children older than 3 years who underwent an appendectomy over a 22-month period.

Of 202 patients undergoing appendectomies, 197 had appendicitis. Median age was significantly lower in the perforated group, but temperature and leukocytosis were not. As expected, length of hospital stay was longer in the perforated group (4-13 vs 2-6 days). The incidence of perforation was 10% if symptoms were present for less than 18 hours. This incidence rose in a linear fashion to 44% by 36 hours. Pre-hospital delays were greater in patients with perforated appendicitis. However, in-hospital delay (from presentation to surgery) was less than 5 hours in the perforated group and 9 hours in the non-perforated group.

Appendiceal perforation in children is more common than in adults and correlates directly with duration of symptoms before surgery. Perforation is more common in younger children. Unlike in adults, the risk of perforation within 24 hours of onset is substantial (7.7%), and it increases in a linear fashion with duration of symptoms. In our experience, however, perforation correlates more with pre-hospital delay than with in-hospital delay. ■

## GCS Score <15 Represents Greater Risk in Elders Than in Younger Patients

**Key point:** Any score other than a perfect GCS in patients >70 should be treated as a high-risk case.

**Citation:** Caterno JM, Raubenolt A, Cudnik MT. Modification

of Glasgow Coma Scale criteria for injured elders. *Acad Emerg Med*. 2011;18(10):1014-1021.

Some emergency medical services systems use a Glasgow Coma Scale (GCS) score cutoff of  $\leq 13$  to prompt transport of injured patients to trauma centers. To determine the correlation between GCS scores and outcomes by patient age (16–69 vs  $\geq 70$ ), researchers reviewed data from the Ohio Trauma Registry for 52,412 patients who were injured between 2002 and 2007. Outcome measures included in-hospital mortality, clinically significant brain injury, neurosurgical intervention, and emergency intubation.

Elders with GCS scores of 14 had significantly higher risk for in-hospital mortality or traumatic brain injury than younger patients with GCS scores of 13 (odds ratios, 4.68 and 1.84, respectively). Among elders, but not among younger patients, mortality risk was higher in those with GCS scores of 14 than in those with scores of 15 (OR, 1.40) and in those with scores of 13 than in those with scores of 14 (OR, 2.34).

**Comment:** Trauma systems should consider revising destination criteria to include trauma center transport for elders with acute head trauma and GCS scores <15.

Published in *J Watch Emerg Med*. October 14, 2011—Diane M. Birnbaumer, MD, FACEP. ■

## Occult Serious Bacterial Infection in Infants Younger Than 60 to 90 Days With Bronchiolitis

**Key point:** UTIs are still sufficiently common in very young children with "classic" bronchiolitis, so as to merit being ruled out.

**Citation:** Ralston S, Hill V, Waters A. Occult serious bacterial infection in infants younger than 60 to 90 days with bronchiolitis: a systematic review. *Arch Pediatr Adolesc Med*. 2011;165(10):951-956.

The authors performed a systematic search of the Medline database for studies reporting rates of serious bacterial infection in infants younger than 90 days with clinical bronchiolitis and/or respiratory syncytial virus infection.

The weighted rate of urinary tract infections in the youngest infants in the 11 studies analyzed was 3.3%. No case of bacteremia was reported in 8 of 11 studies. No case of meningitis was reported in any of the studies. Summary statistics for meningitis and bacteremia are not provided because of an excess of zero events in these samples.

A screening approach to culturing for serious bacterial infections in febrile infants presenting with bronchiolitis or respiratory syncytial virus infection is very low yield. The rate of urine cultures positive for bacteria remains significant, though asymptomatic bacteriuria may confound these results. ■

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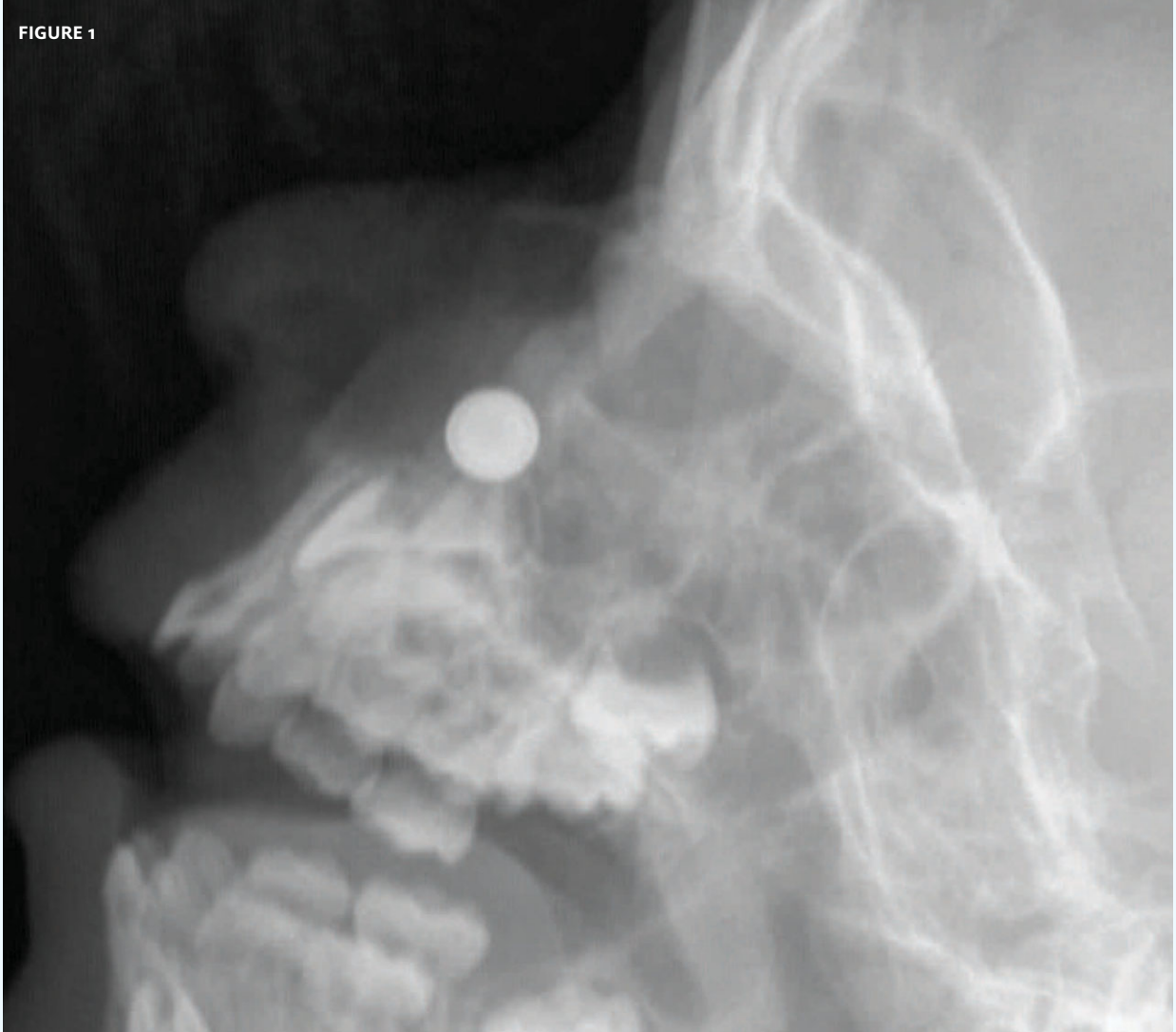
## INSIGHTS IN IMAGE

# CLINICAL CHALLENGE: CASE 1

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

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

FIGURE 1



The patient, an otherwise healthy 2-year-old, had a history of playing with button batteries and then started crying with discomfort on the left side of the nose.

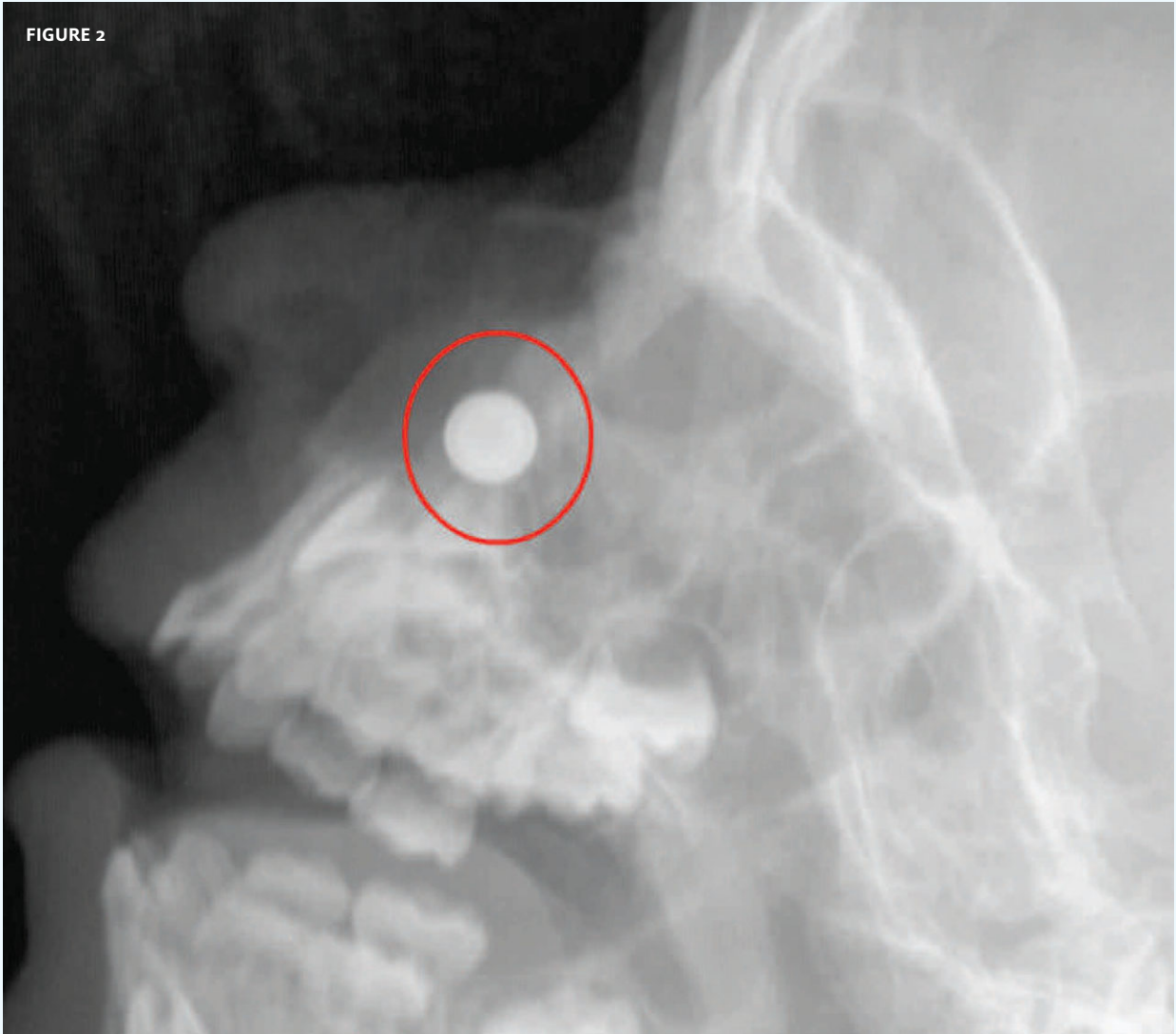
View the image taken (**Figure 1**) and consider what your diagnosis would be.

Resolution of the case is described on the next page.



THE RESOLUTION

FIGURE 2

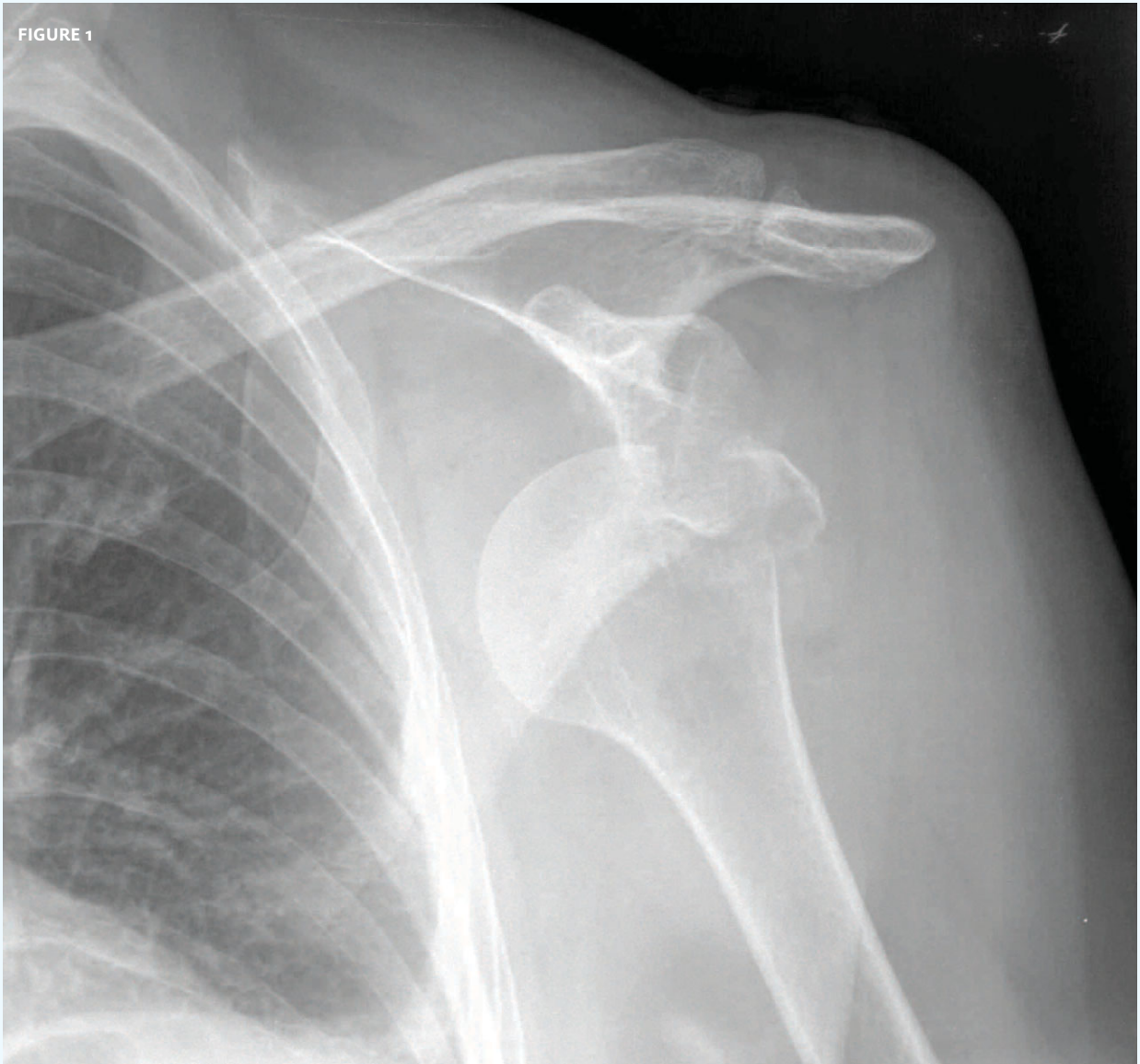


Diagnosis: button battery up the nasopharynx. Button batteries can cause devastating caustic injury to the nasal cavity and sinuses. Careful examination and x-ray/CT are critical when evaluating the possibility of this foreign body. Strong index of suspicion is necessary for toddlers presenting with unexplained bloody nose and irritability, as this can often be the only sign in this age group.

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



FIGURE 1



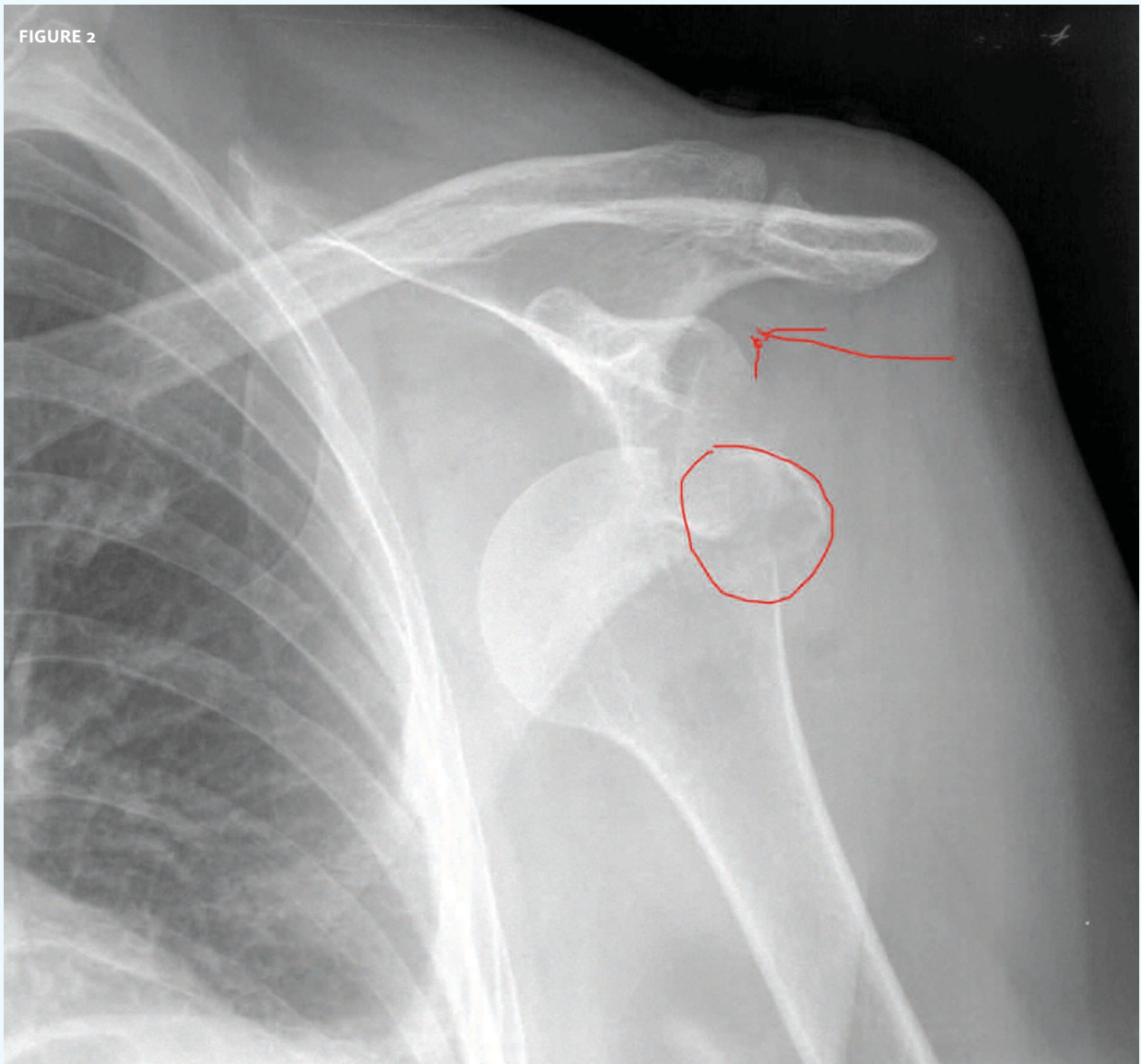
The patient, an otherwise healthy 64-year-old, fell, suffered a blow to the shoulder, and presents with clinical dislocation.

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



Dislocation of the head of the humerus is evident but there is also a fracture. This is one of the reasons it is so important to get a pre-reduction film even in classical dislocation. Fractures can complicate reductions. They can “catch” on surrounding anatomy and make reduction more difficult.

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



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# Modifier for 69210, HCPCS for IM Zofran, S9088 vs 99051, and Billed Amount for 99051

■ DAVID STERN, MD, CPC

**Q.** What modifier can I use for CPT Code 69210 (removal impacted cerumen, [separate procedure], one or both ears) for Medicare? I used left and right, but the claim was denied as an incorrect modifier.

**A.** Because the definition of the code includes either or both ear(s), you should *not* attach a modifier to indicate the right (-R), left (-L), or bilateral (50) ear(s).

**Q.** My physicians like to give Zofran injectable intramuscular; we generally don't give it intravenously. The HCPCS code I found for it is J2405 (injection, ondansetron hydrochloride, per 1 mg), which is I believe is what one would use if you give it intravenously. Is there another specific code for just IM for Zofran?

**A.** The supply code is the same for the Zofran (J2405, injection, ondansetron hydrochloride, per 1 mg), whether it is administered IV or IM. You would also add the code for the IM injection procedure: 96372 (therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular). If you are coding for an IM injection procedure on the same date you are coding for an E/M, then Medicare rules require modifier -25 (significant, separately identifiable E/M service by the same physician on the same day of a procedure or other service) on the E/M code.

**Q.** During UCAOA's fall course in Dallas, Dr. Stern gave me an add-on code that could be used with any code filed that is S9088 (services provided in an urgent

care center). However, one of my colleagues took the experienced coders course and was told that the reimbursement rate on the S-code is very little in comparison to CPT code 99051 (services rendered during extended hours). Which do you recommend using as an additional code for additional reimbursements?

**A.** Either code may be added to appropriate visits. It is even compliant to code both on the same claim if both apply. Many visits do not qualify for 99051 (ie, evening, weekends, or holidays), so your only choice for an add-on code is the S9088 on these visits. Yes, it is true that payors are more likely to reimburse for 99051 and often pay more. Some payors do not reimburse for either code. However, every payor is different, so you should consult with each payor to understand its policies.

**Q.** What would you suggest for the billed amount for CPT code 99051 (services rendered during extended hours)?

**A.** I would suggest that you evaluate your current fee schedules with payors and make sure that your charge is at least equal to or above the highest fee that a contracted payor will reimburse for this code.

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

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

## Virginia - Urgent Care Physicians

Carilion Clinic is searching for Urgent Care physicians to work at various locations in the Roanoke and New River Valley area as Carilion is expanding their UC operations due to patient need. Candidates must be BE/BC in Family Medicine or Emergency Medicine with Urgent Care experience preferred. Carilion hospitals located within a short distance for transfers of acute care. UC sites will be open 7 days a week 8 am-8 pm and include radiology and waived lab testing, along with the system wide EMR-Epic. Enjoy working 3 days one week and 4 days the next week.

Roanoke, Virginia, a five-time "All America City," population over 300,000, and one of the top rated small cities in the US. Nestled in the gorgeous Blue Ridge Mountains and close to 500 mile shoreline Smith Mountain Lake. The New River Valley region comprises the localities of Christiansburg, Blacksburg, and Radford, with a population of 175,000, home to Virginia Tech and Radford University. The region is affordable, safe, progressive and just minutes away from the Blue Ridge Parkway and the Appalachian Trail.

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Please contact **Andrea Henson, Physician Recruiter**  
[ahenson@carilionclinic.org](mailto:ahenson@carilionclinic.org) or 540-224-5241



## Urgent Care position Manchester, New Hampshire

**Elliot Health System** in Manchester, New Hampshire offers an outstanding practice opportunity for family medicine physicians with an interest in urgent care. The position offers a variety of urgent care cases including pediatric and qualified candidates should be comfortable with suturing, casting and reading x-rays and EKG's.

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Recently, Elliot Hospital was named one of healthcare's Top Wired Hospitals in the country according to Hospitals & Health Networks Magazine. Elliot Health System has made information technology a priority in patient care, implementing electronic medical records, My E Chart (which allows patients to manage their personal medical records), wireless internet access for hospitalized patients, and a wealth of information provided to both patients and staff via the internet

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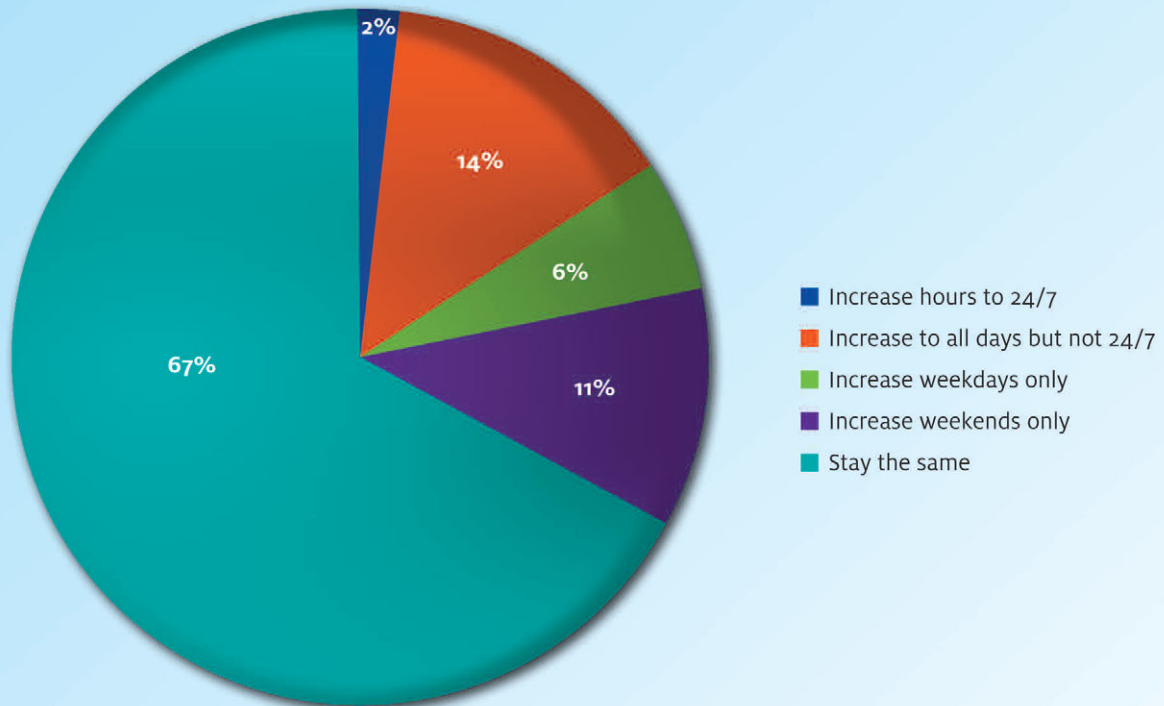


## DEVELOPING DATA

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

*In this issue:* What changes do you anticipate in your hours of operation?

### EXPECTED CHANGE IN HOURS OF OPERATION



Only one-third of urgent cares expect to increase their hours of operation in the foreseeable future. Of those, only 13% foresee increasing their hours of operation to times that would maximize the value proposition of urgent care access: 24/7 and weekends. However, as urgent cares see more competition not only from other urgent cares but also from hospitals, pharmacy chains like CVS/Caremark, and retailers like Walmart seeking urgent care business, it is likely that more centers will offer expanded hours of operation.

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

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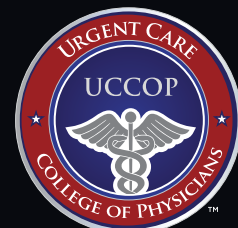
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