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Urgent Care Association of America



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# Partz Urgent Care Management of Needlestick Injuries

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# LETTER FROM THE EDITOR-IN-CHIEF

# The Urgent Care Foundation: Building a Stronger Specialty



The discipline of urgent care medicine remains in its developmental infancy. While the strong consumer-driven market lurching toward efficient and cost-effective health care delivery systems has supported astounding industry growth, our discipline continues

to struggle to define itself.

Like all new specialties, urgent care medicine has, in fits and starts, made efforts to evolve an identity, but despite early gains, it's been an up and down effort. Most every urgent care practitioner I know wants to be identified uniquely for his or her craft. As a family physician, I don't really practice the continuity primary care I was trained for, and my practice is definably different. Like many of my colleagues, I have built my "urgent care competency" over time, through years in practice and selected, urgent care-focused continuing education. That is not, however, a sufficient pathway to specialty recognition.

Within the house of medicine, a defined specialty development pathway exists, and the requirements for consideration are specific and significant. The details surrounding specialty development are determined by the Accreditation Council for Graduate Medical Education (ACGME) and beyond the scope of this discussion. However, a few absolute criteria are worth noting. To be considered by ACGME for inclusion in the American Board of Medical Specialties (ABMS), all developing specialties must have the following:

- A network of training programs of significant size and of consistent form;
- A "core competency document" that is defined and refined by the training programs;
- A physician society of sufficient size;
- A network of clinical practices of sufficient size and national scope;
- A peer reviewed journal dedicated to the clinical practice and original research of the discipline;
- A portfolio of original research that focuses on advancing clinical quality or the scientific basis of the discipline; and
- A discipline definition that represents a measurably unique clinical practice or scientific body of knowledge.

For prospective subspecialties, a sponsoring ABMS board is necessary.

Urgent care has made significant strides towards many of these

criteria, but most require considerable work. Training and research are perhaps our biggest and most critical holes to fill. Fellowship training programs in urgent care have been around for 7 years but are limited to 3 to 4 developmental sites per year. Expansion of fellowships is wholly dependent on the financial resources available to recruit talent and develop and market new and existing programs. UCAOA has sustained the existing fellowship programs, but the investment required to grow the network would create an unsupportable and unrealistic financial strain on the association. Likewise, research has been all but nonexistent in the discipline and the few projects completed have focused on industry benchmarking and urgent care census data, not clinical care.

With the Urgent Care Foundation, a 501(c)(3) nonprofit dedicated to supporting education and research that advances the discipline of urgent care medicine, we finally have an appropriate vehicle for supporting these most ambitious and resource-intensive initiatives. The Foundation has had an exceptionally busy year developing a sustainable strategy for supporting its mission. We have created a partnership with one of the most eminent primary care research departments in the country in Case Western Reserve University School of Medicine, Department of Family Medicine. Grant applications have been submitted for projects deemed most likely to receive funding and demonstrate urgent care in a relevant and positive light to national health care policymakers and stakeholders.

The Urgent Care Foundation stands tall at a critical moment with significant interest from outside of the urgent care world, but its future depends on significant support and investment from within. Every clinician, vendor, and owner with a stake in the future of urgent care should feel a mandate to participate. With proven leaders and trustworthy stewards leading the way, the time is now to contribute. Please support the Urgent Care Foundation. To find out how, go to www.urgentcarefoundation.org or email *shelley.cochrane@urgentcarefoundation.org*.

Lee A. Resnick, MD Editor-in-Chief JUCM, The Journal of Urgent Care Medicine

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Ε

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VOLUME 8, NUMBER 3



#### CLINICAL

# **9** Urgent Care Management of Needlestick Injuries: Part 2

Response to a needlestick with potential for HIV exposure requires understanding of both state laws on HIV testing and the latest USPSTF guidelines for post-exposure management.

Maya Heck, MS-2, and John Shufeldt, MD, JD, MBA, FACEP

#### Editor's Note

The reference list that appeared in Part 1 of the November issue contained a citation error. References 11 to 16 should not have been included. We should have cited in their place the 2001 U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis. We regret the error.

#### PRACTICE MANAGEMENT



#### **17** Improving Urgent Care Center Profitability Through Medical Supply Management and Accounting

Many urgent care centers lack an inventory management process and do not accurately account for their utilization of supplies. Improving how a center manages and accounts for supplies can have a direct impact on the bottom line. *Alan A. Ayers, MBA, MAcc* 

#### CASE REPORT

### 22 Erythema Infectiosum

Rashes are common in urgent care and taking a careful patient history is important for proper diagnosis of the underlying cause.

Ichha Sethi, MB,BS, Jaskaran S. Sethi, MB,BS, Mikayla Spangler, Pharm D, BCPS, and Shailendra Saxena, MD, PhD



#### IN THE NEXT ISSUE OF JUCM

Patients often present to urgent care centers with ocular complaints, yet the capacity to provide high-quality eye care varies from center to center. Having the right equipment available and ensuring that clinicians are knowledgeable about eye disorders are both important to providing high-quality eye care. Next month's cover story—the first of a two-part series—is designed to equip urgent care providers with the information they need to identify the most common eye complaints, distinguish between benign and sight-threatening conditions, and determine when to treat and when to refer to an ophthalmologist to ensure a good outcome. Part 1 will discuss foreign bodies, corneal abrasion, red eye, scleritis, and conjunctivitis.

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#### **Mission Statement**

JUCM The Journal of Urgent Care Medicine supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing healthcare marketplace. As the Official Publication of the Urgent Care Association of America and the Urgent Care College of Physicians, JUCM seeks to provide a forum for the exchange of ideas and to expand on the core competencies of urgent care medicine as they apply to physicians, physician assistants, and nurse practitioners.

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# JUCM CONTRIBUTORS

A police officer arrives at an urgent care center with a handcuffed, bloodied prisoner, who he says spit on him during an altercation. The



suspect is an IV drug abuser and the officer wants a "blood test" to determine if the man is HIV-positive; if he is, the officer wants prophylaxis to prevent seroconversion. The suspect refuses the test. What should the urgent care provider do? The answer to that question is the subject of this month's cover story—Part 2 of our series on urgent care management of needlestick injuries. In this installment, authors Maya Heck, MS-2 and John Shufeldt, MD, JD, MBA, FACEP review definitions of HIV transmission risk, HIV post-exposure prophylaxis, and appropriate steps to follow for managing needlestick injuries based on the recently updated US Public Health Service guidelines.

Ms. Heck is a second-year medical student at Oregon Health & Sciences University in Portland, Oregon. Dr. Shufeldt is principal of Shufeldt Consulting and sits on the Editorial Board of *JUCM*.



The patient was an 8-year-old child with a rash on his face and prodromal symptoms that included fever, runny nose, and a mild cough. The presentation was common and could have pointed to one of several different viral exanthems. But what told the diagnostic tale—erythema

infectiosum—was the appearance of the rash on the boy's face. As authors Ichha Sethi, MB, BS, Jaskaran S. Sethi, MB, BS, Mikayla Spangler, Pharm D, BCPS, and Shailendra K. Saxena, MD, PhD, explain in this month's case report, a "slapped cheek" appearance is the hallmark of Fifth Disease.

Ichha Sethi is a resident in Family Medicine at Creighton University School of Medicine in Omaha, NE. Jaskaran Sethi is a graduate of Dayanand Medical College in Ludhiana, India, who is pursuing a residency in internal medicine. Dr. Spangler is an Assistant Professor at Creighton University School of Pharmacy and Health Professions and School of Medicine, Department of Family Medicine. Dr. Saxena is an Associate Professor in the Department of Family Medicine at Creighton University School of Medicine in Omaha, NE.

Have you thought about how your supply closet may add to—or detract from—your urgent care practice's bottom line? If not, you should, according to Alan A. Ayers, MBA, MAcc, author of this month's



practice management article. Without a system for managing and replenishing medical supplies that connects supply utilization to patient revenue, Mr. Ayers says, an urgent care practice may buy the wrong supplies and misstate supply expenses on income statements. In our article, he explains what to do to take control of your supply management processes and how that can have a positive impact on your practice's financials.

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

#### Also in this issue:

In Health Law this month, **John Shufeldt**, **MD**, **JD**, **MBA**, **FACEP**, discusses the pitfalls of decision-making about patient transport involving paramedics.

**Nahum Kovalski, BSc, MDCM**, reviews new abstracts on literature germane to the urgent care clinician, including studies of long-term survival after pneumococcal pneumonia, antibiotics in ambulatory pediatrics, and chronic traumatic encephalopathy.

In Coding Q&A, **David Stern, MD, CPC**, discusses the 2014 CPT changes, coding for suture removal, and place of service code.

Our Developing Data end piece this month looks at the percentage of expense that urgent care centers spend on salaries.

#### To Submit an Article to JUCM

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

We prefer submissions by e-mail, sent as Word file attachments (with tables created in Word, in multicolumn format) to *editor@jucm.com*. The first page should include the title of the article, author names in the order they are to appear, and the name, address, and contact information (mailing address, phone, fax, e-mail) for each author.

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in Urgent Care Management

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JCAOA Professional Learning Program



# Preparations for a New Decade for Urgent Care

P. JOANNE RAY

Proactively embarking on renovations and changes that position us for future growth is paramount. As urgent care providers and owners, and the vendors who support our every need, you live this motto every day. And, over time, you recognize that renovation is needed to start anew, to expand and improve, to keep up, and to better serve your constituency.

UCAOA is no different and is focused on what is needed as we enter into our second decade. The growth of our industry is evident in every community, in our sold-out exhibit halls and well-attended conferences, in our steadily growing membership, in the increasing inquiries we receive from mainstream media, and in the impetus driving UCAOA programs and activities. Each step is carefully calculated and made with you in mind. In this case, the "you" is an incredibly diverse group of stakeholders with equally diverse needs-yet with very similar goals. Here are just a few examples of what we are seeing and the programs and activities UCAOA is moving ahead with on your behalf:

Getting the message out and educating influencers. Placement, interviews, and information exchanges with outlets such as: USA Today, AARP Magazine, National Public Radio, Parents Magazine, and numerous local and regional newspapers, as well as recent strategic dialogue with the Wall Street Journal. Stories covered ranged from the growth of urgent care to its role in health care reform, to the cost of health care (and the positive role of urgent care), to reducing total costs of care by substituting urgent care visits for many ER visits, to freestanding emergency departments and their effect on urgent care centers. Links to these and other stories and coverage are available on the UCAOA web site and within UConnect.



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

#### "UCAOA is focused on what is needed as we enter into our second decade."

- Helping you to reposition your centers in the era of health care reform. Significant resources have been focused to provide education, guidance, and tools to help you position your centers in the best way. Additional resources will be released this month. As John Harris noted during our Fall Conference general session address (available free of charge to members), urgent care centers have three strategic responses to new payment models: active participant, good partner, and wait and see. While we don't know exactly what tomorrow will bring, we do believe that creating strategic partnerships will result in benefit from gains in market share.
- Building resources and awareness for legislative and regulatory changes. Local and regional legislative entities and payors are beginning to take positions that may not be in the best interest of urgent care. UCAOA is organizing at the state and the federal level to create positive dialogue and drive dialogue to make sure the correct facts are being presented and the proper story is told.
- Gaining further insight into the pulse and trends of our members and industry. The outcomes of recent membership and educational needs assessment surveys, along with conference surveys and our biannual Benchmarking Study (watch for this in early January), will inform UCAOA leaders as they come together at the end of January to take a critical look at the priorities and strategies needed to best represent you in the second decade of UCAOA-the leading association representing the multidisciplinary interests of urgent care.

Stay tuned! This next chapter in our history is shaping up to be even more exciting and much, much faster-moving than our first. It takes a village, and we'll be counting on you to join us and play a key role.



# Clinical

# Urgent Care Management of Needlestick Injuries: Part 2

**Urgent message:** Response to a needlestick with potential for HIV exposure requires understanding of both state laws on HIV testing and the latest USPSTF guidelines for post-exposure management.

MAYA HECK, MS-2 and JOHN SHUFELDT, MD, JD, MBA, FACEP

Two police officers arrive at your urgent care site with a handcuffed, bloodied prisoner. One officer tells you that the person in custody "spit on me" during the altercation. The officer goes on to tell you that the suspect is an intravenous drug abuser and believed to be infected with HIV. The officer is requesting a "blood test" and wants the suspect tested as well because, according to the officer, if the suspect is "positive" the officer will file different charges and wants to receive prophylaxis to prevent sero-conversion. The suspect refuses to be tested and although a bit "stunned" from being tazed, seems to be competent to refuse. What do you do?

#### Initial management of exposure

A fter the safety of the source patient is ensured, the health care worker potentially exposed to HIV should immediately flush out his or her wound or skin site.<sup>1</sup>

- Exposed mucous membranes should be flushed with tap water.
- Exposed eyes should be flushed with sterile water or eye irrigant when available.
- Although antiseptics are not known to reduce incidence of infection, they can be used to flush the wound.
- The exposed health care worker should notify his or her supervisor so the exposure can be reported and properly evaluated according to Centers for Disease Control and Prevention (CDC) guidelines (see below).

The management of occupational exposures should



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be given high priority and treated as urgent or emergent, depending on the circumstance.

#### A note about counseling

Because occupational exposures to blood-borne pathogens can elicit a strong stress reaction, the importance of counseling for health care workers who have occupational exposures should not be underestimated. Counselors should be ready to openly discuss the health care worker's recollection of the event and any relevant past traumatic experiences, provide information on stress reactions, provide information to his or her support system, and help reintegrate the health care worker back

**Maya Heck** is a second-year medical student at Oregon Health & Sciences University in Portland, Oregon. **John Shufeldt** is principal of Shufeldt Consulting and sits on the Editorial Board of *JUCM*.



### FOR THE TOPICAL TREATMENT OF HEAD LICE<sup>1,2</sup>

#### INDICATED FOR CHILDREN 6 MONTHS OF AGE AND OLDER<sup>2</sup>

- No Contraindications
- Sklice Lotion should be used in the context of an overall lice management program

#### IMPORTANT SAFETY INFORMATION FOR SKLICE LOTION

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

#### PROVEN EFFECTIVE IN TWO CLINICAL TRIALS<sup>2,a</sup>

- One tube. One time.
  - Patients received a single 10-minute treatment and were instructed not to nit comb
  - 14 days after treatment, no live lice were observed in 76.1% (54/71) and 71.4% (50/70) of patients

#### PRODUCT APPLICATION<sup>2</sup>

- 10-minute treatment
- Up to 1 tube of product
- No nit combing required
  - However, a fine-tooth comb or special nit comb may be used to remove dead lice and nits

CHOOSE TO PRESCRIBE. CHOOSE SKLICE LOTION.

AVAILABLE AT RETAIL PHARMACIES NATIONWIDE

Sklice

(ivermectin)

Lotion.0.5%

For topical use on

Keep out of reach of children. Use in children should be under

the direct supervision of an adult.

RX ONL

the scalp hair

and scalp only

For single use. Discard the tube

Do not swallow. Avoid eye contact.

### INDICATION

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

### ADJUNCTIVE MEASURES

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

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

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

### IMPORTANT SAFETY INFORMATION FOR SKLICE LOTION

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

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

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

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

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

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

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



SANOFI PASTEUR 🌍

#### (ivermectin) Lotion, 0.5% for topical use

#### **Brief Summary of Prescribing Information**

#### 1 INDICATIONS AND USAGE

#### 1.1 Indication

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

#### 1.2 Adjunctive Measures

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

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

#### 2 DOSAGE AND ADMINISTRATION

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

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

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

Avoid contact with eyes.

#### 4 CONTRAINDICATIONS

None.

#### 5 WARNINGS AND PRECAUTIONS

#### 5.1 Ingestion in Pediatric Patients

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

#### 6 ADVERSE REACTIONS

#### 6.1 Clinical Trials Experience

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

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

#### 8 USE IN SPECIFIC POPULATIONS

#### 8.1 Pregnancy

#### Pregnancy Category C

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

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

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

Animal Data

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

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

#### 8.3 Nursing Mothers

Rx Only

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

#### 8.4 Pediatric Use

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

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

#### 8.5 Geriatric Use

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

#### 10 OVERDOSAGE

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

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

Distributed by: Sanofi Pasteur Inc. Swiftwater, PA 18370

Manufactured by: DPT Laboratories LTD San Antonio, TX 78215

129685

U.S. Patent No. 6,103,248 and other patents pending.

IVE-BPLR-SA-FEB12

Table 1. Side Effects of Recommended HIV PEP Drug Combination			
Drug	Туре	Side Effects	
Raltegravir	INSTI	<ul> <li>Insomnia, fatigue, headache.</li> <li>Severe hypersensitivity reactions have been reported</li> </ul>	
Tenofovir	NRTI	<ul> <li>Asthenia, headache, nausea.</li> <li>Contraindicated for patients with acute or chronic kidney failure</li> <li>If patient has chronic hepatitis B, withdrawal of this drug may precipitate acute hepatitis</li> <li>Drug interaction</li> </ul>	
Emtricitabine	NRTI	<ul> <li>Rash, hyperpigmentation.</li> <li>If patient has chronic hepatitis B, withdrawal of this drug may precipitate acute hepatitis</li> </ul>	
Adapted from http://www.jstor.org/action/showPopup?citid=citart1&id=tbb1&doi=10.1086%2F672271			

into the occupational environment. In addition, a thorough examination of the health care worker's practices for sharp instrument—including handling and disposing—is important to prevent future accidents.<sup>2</sup>

Not only does counseling help to ease anxiety for the exposed health care worker and his or her family, but it may also increase adherence to chemoprophylaxis regimes.<sup>3</sup> If knowledgeable counselors are able to maintain close personal contact and discuss chemoprophylaxis and potential adverse side effects, a patient's adherence to the regime is likely to be enhanced.

#### ΗΙΥ

The average risk of HIV transmission is approximately 0.3% among health care workers following accidental needlestick involving an HIV-infected source patient without post-exposure chemoprophylaxis. The risk with a mucous-membrane exposure is approximately 0.09%.<sup>3</sup> These risks are significantly lower than the risk of acquiring HCV or HBC from a similar injury.<sup>3</sup> According to the CDC, there were 57 documented cases of occupational HIV transmission to health care workers in the United States through December 2001, and no confirmed cases have been reported since 1999. Occupational transmission of HIV is reported in the *Centers for Disease Control and Prevention (CDC) HIV Surveillance Report.*<sup>3</sup>

*Pre-exposure Prophylaxis.* Currently pre-exposure prophylaxis for HIV is not available.

*Post-exposure Prophylaxis.* Within hours of exposure, the health care worker and source should be evaluated and tested for HIV at baseline to establish infection status. While the risk of transmission from an occupational exposure to a source patient with an undetectable serum viral

load is thought to be very low, postexposure prophylaxis (PEP) should still be considered.<sup>4</sup> In 1997, the CDC Needlestick Surveillance Group published findings from a study looking at the risk of HIV transmission among health care workers who sustain a needlestick injury.<sup>3</sup> It was reported that zidovudine (ZDV) as PEP reduced the risk of HIV transmission by 81%.3 Now, antiretroviral (ARV) agents from six classes of drugs are available for treatment of HIV infection. These agents include the nucleoside reverse transcriptase inhibitors (NRTIs), nonnucleoside reverse transcriptase inhibitors (NNRTIs), protease inhibitors (PIs), an integrase strand

transfer inhibitor (INSTI), and a chemokine (C-C motif) receptor 5 (CCR5) antagonist.

The US Public Health Service (USPHS) no longer recommends that the severity of exposure (i.e. percutaneous versus large bore) be used to determine the number of drugs to be offered in an HIV PEP regimen, and a regimen containing 3 (or more) ARV drugs is now recommended routinely for all occupational exposures to HIV.<sup>4</sup> The recommended PEP regimens include those consisting of a dual NRTI backbone plus an INSTI, a PI (boosted with ritonavir), or a NNRTI. The preferred regimen includes raltegravir (Isentress; RAL) 400 mg PO twice daily plus Truvada, 1 PO once daily and tenofovir DF [Viread; TDF] 300 mg + emtricitabine [Emtriva; FTC] 200 mg.<sup>4</sup>

According to the National Surveillance System for Health care workers (NaSH) and the HIV Post-exposure Registry, about half of health care workers on PEP experience adverse symptoms such as nausea, malaise, headache, anorexia, and headache. In addition, approximately one-third discontinue PEP because of these symptoms.<sup>3</sup> To encourage a health care worker to complete the regimen, medications should be selected to optimize side effect and toxicity profiles and ensure a convenient dosing schedule.

#### **Management of PEP Toxicity**

If PEP was administered, the health care worker should be monitored for drug toxicity at baseline and at 2 weeks after initiation of treatment.<sup>4</sup> Throughout the course of PEP, an evaluation of acute symptoms and laboratory tests, including a complete blood count and renal and hepatic function tests, should be obtained. Considerations of medical conditions and drug interac-



tions are also important; for example, monitoring a diabetic patient for hyperglycemia who is taking a protease inhibitor.<sup>4</sup> The health care worker should be advised that reporting symptoms such as rash, fever, abdominal pain, pain on urination, or change in urine color, yellowing of the skin or whites of the eyes, or symptoms of hyperglycemia should not delayed because these may be a sign of toxicity.<sup>4</sup> Obtaining a complete history along with all alternative and traditional medications will help minimize adverse side effects and drug toxicity with PEP treatment.

**Table 1** illustrates the potential sideeffects of the newest 3-drug PEP regimen rec-ommended by the USPHS.

#### Special Considerations for Pregnant/ Breastfeeding Health Care Workers

The risk of HIV transmission is a threat to both the mother and the fetus or infant because the risk of mother-to-child transmission is increased during the acute phase of infection.<sup>4</sup> Therefore, considerations in offering PEP to a pregnant or breastfeeding health care worker should involve counseling and discussion with her health care provider regarding the potential risks of PEP. These risks depend on the duration of drug exposure, as well as the type and dosage. Stavudine and didanosine treatment should be avoided throughout gestation because they have been reported to cause fatal and nonfatal lactic acidosis. Similarly, in utero efavirenz treatment in primates has been shown to result in CNS defects and it is recommended to avoid that drug in the first trimester.<sup>4</sup> In addition, ARV drug levels in breast milk can vary among drugs. Lamivudine is found at high levels in milk, whereas PIs and tenofovir have limited penetration. Prolonged maternal ARV drug use during breastfeeding may be associated with infant hematologic toxicity.<sup>4</sup> To completely reduce the risk of transmission, the health care worker may want to consider stopping breastfeeding. Because of the complexity of the risks and benefits of receiving HIV PEP while pregnant or breastfeeding, expert consultation is recommended.

Post-exposure prophylaxis (PEP) for HIV should be started immediately and continued for 28 days. An updated recommendation from the USPHS is that if a newer fourth-generation combination HIV p24 antigen-HIV antibody test is utilized for follow-up HIV testing of an exposed health care worker, HIV testing can be concluded 4 months after exposure.<sup>4</sup>

Expert consultation from an infectious disease specialist is advised under the following circumstances: delayed (later than 72 hours) exposure report, unknown source, known/suspected pregnancy in exposed person, known/suspected resistance of the source virus to antiretroviral agents, or serious medical illness in exposed person.<sup>4</sup>

#### **Disease-specific follow up**

For HIV exposure, disease-specific follow up consists of repeat HIV testing at 6 weeks, 3 months, and 6 months following exposure. Testing also should be done at 12 months for individuals who are HIV/HCV coinfected. If PEP is administered, monitoring of live function tests should be done. Individuals who have been exposed to HIV should refrain from donating blood or plasma and they should be offered counseling.

The algorithm in **Figure 1**, which also appears in Part 1 of this article in the November issue, provides an overview

of management of needlestick injuries. The National Clinicians' Post-Exposure Prophylaxis Hotline is a 24/7 resource that offers advice on treatment and follow-up options. Call 1-888-448-4911 or visit http://www.ucsf.edu/ hivcntr/PEPline.

#### Conclusion

To return to the scenario we presented at the beginning of this article, are blood tests necessary and/or permissible for the exposed officer and suspect? Alone, saliva is not considered a fluid through which HIV is transmitted. However, if infected blood is also present in the saliva, then this mixture may be infectious. In addition, the saliva-blood mixture must have been "spit" directly into the officer's eyes, mouth or open wound for an infectious exposure. Obtaining a thorough history will help guide your clinical judgment as to whether the officer was exposed to HIV and/or other blood-borne pathogens.

The next step in medical management depends on the state in which you practice, because states have different laws regulating the permission of involuntary HIV

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#### URGENT CARE MANAGEMENT OF NEEDLESTICK INJURIES

testing. For example, in Connecticut, there are four circumstances in which HIV testing without informed consent is allowed; one is occupational exposure. Connecticut law permits a nonconsensual "HIV-related test" of the source of a "significant exposure" to HIV which occurs during a person's occupational duties.<sup>5</sup> As the law reads, a "significant exposure" is "a parenteral exposure such as a needlestick or cut, or mucous membrane exposure such as a splash to the eye or mouth, to blood or a cutaneous exposure involving large amounts of blood or prolonged contact with blood, especially when the exposed skin is chapped, abraded, or afflicted with dermatitis." In order to obtain this test, the health care worker must:

- Document the occurrence of a significant occupational exposure and complete an incident report within 48 hours.
- Have a negative baseline HIV test within 72 hours.
- With the help of a physician, have attempted to obtain and have been refused voluntary consent from the source.
- Be able to take meaningful immediate action that otherwise could not be taken without the source test results (i.e. start prophylactic regimen).
- Be evaluated by an "exposure evaluation group," which is defined as three impartial health care providers, one of whom must be a physician, to determine that the above criteria are met.<sup>5</sup>

If the source is in a health or correctional facility, a blood sample can be obtained in that location; if the source is not in such a facility, then the health care worker can seek a court order for testing. Under Connecticut law, the employer must pay the cost of the HIV test.

If there is legal uncertainty, and through a comprehensive history it is determined that the officer was indeed at risk of acquiring HIV from the suspect, it is recommended to initiate the 3-drug regimen of ARV agents. Given the suspect's competent refusal to be tested, you must base your decision on your high level of suspicion that the suspect was infected with HIV.

This scenario would be treated similarly to a situation in which the infection status of the source was unknown. At this time, it is also recommended to obtain the baseline tests for HCV as outlined above. In addition, obtaining a detailed immunization history from the officer, including dates of hepatitis B immunizations, previous testing for HIV, HBV, and HCV, tetanus immunization status, and current medications and underlying medical conditions is imperative for proper management of potential pathogen exposure.

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# Practice Management

# Improving Urgent Care Center Profitability Through Medical Supply Management and Accounting

**Urgent message:** Many urgent care centers lack an inventory management process and do not accurately account for their utilization of supplies. Improving how a center manages and accounts for supplies can have a direct impact on the bottom line.

ALAN A. AYERS, MBA, MAcc

#### Introduction

A quick and easy way to improve your urgent care center's profitability may be as close as your supply closet. Many urgent care centers lack defined processes for managing and replenishing medical supplies and their financial statements fail to accurately capture supply inventories and match supply utilization to patient revenues. This results in buying the wrong types of supplies, buying too many supplies, losing supplies to inventory shrinkage, overstating supply expense on the income statement, and understating the value of supplies as an asset on the balance sheet.

#### Issues With Medical Supply Management in Urgent Care

Medical supplies are items like Band-Aids, syringes, antiseptic, casting material and gauze that are "substantially consumed" or "materially altered" when used in patient care. In urgent care centers, supplies generally consist of consumables (including injectables and other



pharmaceuticals) but they can also include small tools and minor equipment (**Table 1**).

Some individual supplies (such as suture kits and splints) can be quite costly, but rarely do supplies account for a significant portion of a center's total

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#### Table 1. Accounting for Minor Equipment

Although most of what constitutes "medical supplies" in an urgent care setting are consumables used in patient care, there are a number of handheld diagnostic tools that have costs below the threshold of a depreciable asset. Examples include electronic thermometers, scopes, and blood pressure cuffs. Instead of carrying these items on the balance sheet as a long-term asset and expensing depreciation—as is done for furnishings, fixtures, and equipment—minor equipment is typically expensed as purchased. These items should be assigned to rooms and checked daily to prevent loss.

#### Table 2. Common Internal Control Weaknesses and Strategies to Improve Controls Related to Medical Supply Inventories

Common Internal Control Weaknesses	Strategies to Improve Control	
<ul> <li>Lack of a consensus for- mulary—duplicative or redundant SKUs are car- ried in inventory.</li> <li>Lack of utilization statis- tics—center administra- tors do not track how frequently items are used or replenished.</li> </ul>	• Engage physicians, nurses and administrators in developing a "formulary" to help eliminate duplicative SKUs and identify cheaper or more desirable alternative products when available.	
<ul> <li>Lack of visibility of current inventory—supplies are expensed as ordered, meaning the value of supplies is not accurately depicted as a center asset.</li> </ul>	<ul> <li>Interview staff and "walk through" the existing order system and identify weaknesses and procedures that are particularly time</li> </ul>	
<ul> <li>Lack of minimum on- hand or "trigger" re-order quantities—ordering occurs when items "appear" low or are close to running out with little data to support the decision.</li> </ul>	<ul> <li>Implement a structured inventory management process or system to track supplies on hand and used in patient care, and to facilitate re-orders. Use</li> </ul>	
<ul> <li>Lack of purchase approval processes—purchase orders are processed without management review.</li> <li>Lack of physical controls— supplies are stored in locations throughout the</li> </ul>	<ul> <li>system reports to create accounting entries.</li> <li>Review all the locations that are used for storage.</li> <li>Keep unopened supplies in a central, locked closet and sign out to specific storage</li> </ul>	
<ul> <li>Lack of physical controls— supplies are stored in locations throughout the center versus one central,</li> </ul>	that are used for stor Keep unopened supp a central, locked close sign out to specific st areas or to individual	

expenses. Supplies used are much less extensive than in, say, surgical centers, because most urgent care visits are for low-acuity infections, cold/flu, skin conditions, allergies, etc. Perhaps because medical supplies are viewed as "incidental" to treating patients and are not a major expense category like salaries and rent, many urgent care centers simply "write-off" supplies without further consideration.

#### Supply Management Starts With a Consensus Formulary

In referring to medical supplies, a stock-keeping unit (SKU) refers to a unique item. In your kitchen cupboard, for instance, "oatmeal" may constitute a single "product" but in a supermarket, each distinct brand, flavor, and box size constitutes a separate "SKU." This grocery analogy is relevant because—just as any cereal on the shelf may satisfy your morning hunger—your urgent care center likely carries multiple SKUs that serve the same clinical purpose. Without an agreed-upon supply "formulary," if Provider A wants one brand of suture kit and Provider B (who only works weekends) wants a different brand, it's common for a center to stock both SKUs to appease both providers.

If all of a center's providers can agree on one SKU for each clinical function—giving fair consideration to quality and price—the number of SKUs ordered and stored by the center can be reduced. In addition, by concentrating all orders for a product into one SKU, the center can better take advantage of quantity discounts. To prevent providers and others in the center from ordering whatever they want or need on a whim, however, a formal policy should require that additions or deviations from the formulary be approved by the center's medical director.

#### The Need for Formal Supply Management Processes

Even when there's a consensus formulary, many centers lack formal supply management processes to ensure that the "right" quantities of supplies are always on hand. When administrators cannot track how frequently items are used or replenished, they tend to place orders when inventories "appear low" or actually run out. But because running out of a critical supply can impair patient care, it's likely the center administrator orders and stores far greater quantities than would normally be used in the subsequent weeks or months.

Given that major medical supply houses such as McKesson, PSS World Medical, and Henry Schein offer

patients if billable.

lockable supply closet.

service level agreements ensuring 48- to 72-hour delivery of nearly any item in their catalogs, a center really has no need to carry more than a couple weeks' worth of supplies at any given time. Larger inventories increase the risk of shrinkage as supplies expire, spoil, become damaged, or are pilfered. And when these excess quantities start to crowd central storage spaces, supplies end up in exam room cabinets, provider station drawers, and other locations throughout the center—further obscuring visibility as to what supplies are on hand.

#### **Electronic Supply Management Systems**

A variety of Web-based, supplier-provided and standalone inventory management systems have been designed for medical practices can be implemented in an urgent care center. These systems expand upon the use of the SKU identifier to:

- Track current inventory levels against the formulary;
- Track the date supplies were received, number of

days on hand, and days until expiration;

- Track supply utilization by category, type, SKU and lot;
- Charge supplies to specific patients, clients or business units;
- Identify minimum on-hand and trigger reorder quantities;
- Create, track and process requisitions and purchase orders;
- Integrate with supply vendors for electronic ordering and auto-replenishment;
- Reconcile accounts payable invoices to purchase orders and receipts; and
- Create inventory reports to facilitate physical counting.

Electronic inventory systems are most effective when integrated with bar code technology. Using a handheld device, staff "scans" the bar codes on individual items as they're consumed in patient care (or on boxes as

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Table 3. Comparison of Accounting Methods for Medical Supplies in Urgent Care				
Accounting Method Used by Many Centers: Expense Supplies as Used	Hybrid Method: Expense Supplies as Used but True-up Balance Sheet	Generally Accepted Accounting Principles: Accurate Valuation of Supplies on Balance Sheet		
<ul> <li>Initial Value of Supplies Not Carried as a Balance Sheet Asset</li> <li>Purchase Supplies: Debit the Expense Account</li> <li>Utilize Supplies: No Entry</li> <li>No Ending Supply Inventory Occurs</li> </ul>	<ul> <li>Starting Asset: Initial Value of Supplies</li> <li>Purchase Supplies: Debit the Expense Account</li> <li>Utilize Supplies: No Entry</li> <li>Year-end Inventory: True-Up the Asset Account; Debit or Credit the Expense Account</li> </ul>	<ul> <li>Starting Asset: Initial Value of Supplies</li> <li>Purchase Supplies: Debit the Asset Account</li> <li>Utilize Supplies: Credit the Asset Account Debit the Expense Account</li> <li>Monthly or Quarterly Inventory: True-Up the Asset Account Debit or Credit the Expense Account</li> </ul>		
<ul> <li>Benefits:</li> <li>Easy—all supplies are expensed as purchased; does not require an inventory management system</li> <li>Overstating supplies expense may reduce taxable income</li> </ul>	<ul><li>Benefits:</li><li>Considers the value of supplies held as a center asset</li></ul>	<ul> <li>Benefits:</li> <li>More accurately reflects value of supplies held as a center asset</li> <li>More accurately reflects the cost of supplies (used to serve patients) during a particular period</li> </ul>		
<ul> <li>Drawbacks:</li> <li>Typically undervalues the asset of supplies on hand</li> <li>Typically overstates the cost of supplies used in patient care</li> <li>Can trigger IRS audit for overstatement of supplies expense</li> </ul>	<ul> <li>Drawbacks:</li> <li>Supplies expense can vary significantly based on timing of purchases</li> <li>Supplies expense is not reflective of supply utilization associated with patient revenue</li> </ul>	Drawbacks: • Requires greater effort in managing supply inventories, which can be aided by technology and process improvements		

they're opened or removed from the storage closet<sup>i</sup>). The system then electronically updates inventory records, facilitating on-demand reports of supplies on hand and those used during a reporting period. Periodic inventory can be facilitated using the bar code scanner and system reports. The system can even indicate when quantities fall to preset "reorder" levels. More sophisticated systems can automatically create a purchase order and submit an electronic order to the supply vendor for fulfillment.

Not all urgent care centers will want to computerize their ordering and inventory management processes. But applying simple internal control procedures and routine authorizations for expenditures will still significantly help in managing supply costs. When an inventory system is implemented, quantities in use and on hand tend to be consistent and, therefore, accurate records lead to generation of a more consistent monthover-month supply expense on the income statement; reduction in overstock, waste and spoilage; and more efficient use of storage space.

#### **Account for Supply Utilization**

From an accounting standpoint, an urgent care center's management is responsible for the accurate presentation of financial statements prepared for use by creditors and investors under Generally Accepted Accounting Principles (GAAP). Accurately representing Supply Expense on the Income Statement and the value of Supply Inventory on the Balance Sheet requires adequate financial controls, as illustrated in **Table 2**.

Often urgent care centers do not maintain accurate supply inventories on their books because they expense all supplies at the time of purchase. The issue with this—illustrated by **Table 3**—is that an asset worth up to \$50,000 (in aggregate) is hidden away in cabinets, drawers, and under sinks while the Balance Sheet

i. Accounting rules generally consider a box containing multiple items to be "consumed" and "no longer in storage" once the box is opened. At this point the entire contents of the box should be expensed.

### "Many urgent care centers simply 'write-off' supplies without further consideration."

understates the value of owners' equity in the business.

Moreover, the common practice of expensing all supplies upon purchase violates accounting principles that call for revenue and expenses to be matched during the same period each is incurred. In any given month that a large supply order is processed, supplies expense as a percent of patient revenue may climb, leading to incorrect conclusions being drawn from the income statement. Likewise, a center could improve its profitability in a given month by just not placing any supply orders.

As illustrated in **Table 3**, center accounting for supplies could be improved by carrying a beginning supply inventory on the balance sheet, continuing to expense supplies as used, and doing a periodic "true-up" based on a physical inventory count. But the best alternative is to record purchases in the inventory (asset) account and make a periodic journal entry (weekly or monthly) to expense supplies that are used. The availability of data from an inventory management system facilitates this routine. In addition, a physical inventory will be matched to the account balances and any differences analyzed. With supply expense more reflective of utilization, a center operator can more effectively identify trends, including changes in supply costs.

#### **Payor Reimbursement for Medical Supplies**

In general, urgent care centers are not specifically reimbursed for supplies used in the ordinary treatment of patients. This is particularly true when a center has contracts that pay a "flat fee" or "global rate" per visit. But some fee-for-service contracts do reimburse some supplies—particularly supplies used in procedures like casting and suturing. Thus, center administrators should understand which supplies are reimbursed by which payors using which codes. When supplies are reimbursable, a process should be in place to accurately capture supply utilization on the patient's charge ticket. Providers, medical assistants, and charge entry staff also need to be educated as to which payors reimburse which supplies to ensure chart documentation such that the center receives its full reimbursement.

#### Conclusion

Improving your urgent care center's medical supply management processes can have a direct impact on its financials by better tying supply utilization expense to patient revenue and by better reflecting supplies on hand as an asset of the center. Effective supply management in urgent care entails establishing a formulary, implementing processes related to the storage and replenishment of supplies, capturing supply utilization and shrink, and establishing proper accounting practices.

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# Case Report

# **Erythema Infectiosum**

**Urgent message:** Rashes are common in urgent care and taking a careful patient history is important for proper diagnosis of the underlying cause.

ICHHA SETHI, MB,BS, JASKARAN S. SETHI, MB,BS, MIKAYLA SPANGLER, Pharm D, BCPS, and SHAILENDRA SAXENA, MD, PhD

#### Introduction

hysicians in both primary care and urgent care clinics encounter facial rash quite frequently. Given the high prevalence and variable number of etiologies, it is important to diagnose these patients appropriately so that they can be treated in a timely fashion.

#### **Case Presentation**

An 8-year-old male was brought into the family medicine clinic with an erythematous rash on both cheeks that had been present for 2 days (Figure 1). Also present was an erythematous rash on both arms, which was noticed just before he came in for this appointment. He had prodromal symptoms of fever, runny nose, and a mild cough for 2 to 3 days. The patient denied any shortness of breath, nausea, vomiting or diarrhea. The patient's mother was very concerned about the rash.

#### **Physical Exam**

The patient had an erythematous rash on bilateral cheeks, with classic circumoral pallor. He also had a lace-like reticulated rash on bilateral arms. The rest of the physical exam was normal.

#### Diagnosis

Erythema infectiosum (Fifth Disease)

Icchha Sethi is a resident in Family Medicine at Creighton University School of Medicine in Omaha, NE. Jaskaran S. Sethi is a graduate of Dayanand Medical College in Ludhiana, India, who is pursuing a residency in internal medicine. Mikayla Spangler is an assistant Professor at Creighton University School of Pharmacy and Health Professions and School of Medicine, Department of Family Medicine, Omaha, NE. Shailendra K. Saxena is an Associate Professor in the Department of Family Medicine at Creighton University School of Medicine in Omaha, NE.



# gettyimages.com

#### **Differential Diagnosis**

It is very important to differentiate between viral exanthems that appear in patients in same age group but that are associated with features more varied than just facial rash. Patients with Rubella commonly present with a maculopapular facial rash associated with low-grade fever, swollen glands (suboccipital and posterior cervical), joint pain and non-exudative conjunctivitis.<sup>1</sup> Those with roseola or exanthema subitum present with a facial rash and these conditions are seen in younger infants.<sup>2</sup>

Other common differential diagnoses of rash include, but are not limited to varicella zoster virus, mumps, impetigo, contact dermatitis, heat rash (prickly heat), eczema and hives.

#### Discussion

Erythema infectiosum (Fifth Disease) is an infection caused by the human Parvovirus B19. It is most common in children aged 5 to 18 years. Fifth Disease is the "fifth" in a



Classic "slapped cheek" appearance of a child with erythema infectiosum.

series of viral exanthems found in school-age children.<sup>3</sup> The virus is transmitted from person to person, most often through respiratory secretions, but it can also be transmitted through administration of blood products and maternal/fetal transmission.<sup>4</sup> Initial symptoms of Fifth Disease can include fever, runny nose, and a headache.<sup>4</sup> Approximately 1 week later, an erythematous rash develops on the patient's bilateral cheeks, giving a "slapped cheek" appearance.<sup>3,4</sup> A second "lacy"-appearing rash may develop a few days later on the child's extremities.<sup>4</sup> A diagnosis of erythema infectiosum is based on clinical presentation, although laboratory testing for Parvovirus B19 IgM can confirm the diagnosis.<sup>3,4</sup>

#### Treatment

Erythema infectiosum is self-limiting and resolves within 1 to 2 weeks.<sup>4</sup> Treatment is supportive and includes acetaminophen for fever and antihistamines for pruritus. Children should not receive aspirin-containing products because of the risk of Reye's syndrome. Nonsteroidal antiinflammatory drugs can be prescribed to adults with arthralgias. Patients should be counseled on reducing the chance of becoming infected with Parvovirus B19 by practicing good hygiene and avoiding close contact with individuals who are sick. Patients with erythema infectiosum are contagious approximately 5 to 10 days after exposure during the viral shedding phase.<sup>4</sup> Children are not contagious after the rash has developed, therefore, return to school and normal activities is appropriate.<sup>4</sup>

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HEALTH LAW

# Help me understand....

#### JOHN SHUFELDT, MD, JD, MBA, FACEP

Please don't share this with anyone but truth be told, I love paramedics. I sometimes thought I had it bad (I really didn't think that, but it makes the story better if I sound tragic) treating the myriad disenfranchised in an inner city ED until I talked with the paramedic who wrestled the feces-covered, bath salts and meth-using, naked, combative maniac who was my patient the previous night. (The patient had an upper GI bleed, was septic and hypotensive and, actually, the meth he took probably helped him maintain his blood pressure — you can't make this up!). All in all, I have it easy compared to those on the actual scene who were tasked with treating this antithesis of Darwinism.

Despite my admiration for paramedics, like the rest of us, they sometimes do things that make me shudder. Take this case report from a physician in Arizona:

I had a strange thing happen in the urgent care on Saturday night, I wanted to get your opinion. This 57 y/o female came in with her daughter and son-in-law. She presented shaking, having paranoia and some mild hallucinations. She is a chronic pain patient secondary to back pain and took some "medical grade marijuana" given to her by a friend she trusts. On exam vitals were stable except BP 156/84, heart rate slightly elevated, pupils were constricted and breathing quickly. EKG showed sinus tach. I called EMS and just before they arrived she complained that she couldn't swallow well and that she had some chest pressure. I gave her some SL nitro. When EMS arrived, I gave report. I asked if they needed anything else from me, and they said, "no." I left the room to see other patients. Upon leaving the next room the MA said, "They left." At first I thought she was telling me they had left with the patient. As it turns out, they left without the patient. They told them she was having an expected reaction to marijuana and that she should just go home and sleep it off. Of course, I was not happy. It WAS most likely a marijuana reaction, but she



John Shufeldt is CEO of Urgent Care Integrated Network and sits on the Editorial Board of *JUCM*. He may be contacted at *Jshufeldt@Shufeldtconsulting.com*. "For paramedics on the scene, the tincture of time is only a few minutes and the information is generally only a fraction of what is needed to a make a truly informed decision and give truly informed consent."

was tachycardic and who knows what else she could have been taking that was not disclosed or if the THC was laced with another illicit substance. Her children and I discussed I felt she needed to be in the ED and that they should take her there.

Are you kidding me!!?? Sadly, and somewhat remarkably, this happens all the time. Occasionally, I see paramedics bring a patient in who is in full arrest. Typically when this particular set of facts happens, it is around 6:30 AM. For some reason I sense there is more to the story and almost always, on further questioning, they admit to being called to the patient's home a few hours earlier, evaluating him/her and then talking the patient out of being transported to the hospital.

Now, with the patient responding only to gravity, the paramedics seem to sense the gravity (pun intended) of their mistake. Now, the paramedics never say it quite so honestly; they usually say, "We evaluated the patient who decided they actually did not want to go to the hospital and signed a refusal." Sometimes, if a patient does not ultimately die, he/she says that the medics *strongly* encouraged not being transported and that it was "ok" to wait or see a PCP. Odds are that the medics are almost always correct, but when they aren't correct, a patient suffers. Even with a lot more information, I am often uncomfortable sending a patient home. Sometimes, "tincture of time" is all that is needed to determine which way a patient ultimately turns. For paramedics on the scene, the tincture of



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#### HEALTH LAW

"If a patient suffers an adverse outcome because of paramedics' refusal to transport, the urgent care provider and the center will likely be left holding the bag. Therefore, the best way to mitigate this risk is by being proactive."

time is only a few minutes and the information is generally only a fraction of what is needed to a make a truly informed decision and give truly informed consent.

I often ask myself why on earth a paramedic would take on that risk or responsibility. Arizona, like most states, gives medics and other government employees wide immunity for services performed while they are on duty.

The statutory provision below provides qualified immunity and is generally drafted like Arizona's Statute A.R.S. § 9-500.02(A) which, in relevant part, protects City employees providing emergency medical aid absent gross negligence.

A city or town or its officers and employees, a private fire or ambulance company whose services are procured by a city or town or its officers and employees, a property owner or its officers or employees, a tenant or a licensed health care provider or an emergency medical technician certified who performs emergency medical aid, when rendering emergency medical aid provided by an emergency medical technician, an intermediate emergency medical technician or a paramedic who is certified by the director of the department of health services is not liable for civil or other damages to the recipient of the emergency medical aid as the result of any act or omission in rendering such aid or as the result of any act or failure to act to provide or arrange for further medical treatment or care for the sick or injured person. This subsection does not apply if the person providing emergency medical aid is guilty of gross negligence or intentional misconduct.

If the patient in the scenario above suffered an adverse outcome, he/she would have argued that the paramedics' conduct was grossly negligent or that the statute does not provide immunity for negligently providing informed consent because the act of giving consent is not rendering care and thus not covered under the statute.

So why is this information relevant for urgent care providers? It is relevant because if a patient suffers an adverse outcome because of paramedics' refusal to transport, the urgent care provider and the center will likely be left holding the bag. Therefore, the best way to mitigate this risk is by being proactive.

If you decide that a patient needs to be transported to the hospital, make the decision collaboratively with the patient – explain the need for an ambulance as opposed to simply driving or being driven. When appropriate, give the patient the choice between a 911 call and a non-emergent transport. A patient with a shoulder dislocation that cannot be reduced in the urgent care center cannot drive him or herself to the hospital but probably does not need emergent transportation. Someone with a posterior knee dislocation, however, does need emergent transport.

Once the paramedics arrive, I would stay in the room and say something like this: "As we discussed, these paramedics are here to take you to the hospital. They will do a great job monitoring you and making sure you suffer no untoward events on the way to the hospital." I would then address the paramedics in front of the patient. "We called you because this patient is complaining of XX. Given her history, her exam and her constellation of findings (they will have no idea to what you are referring), she needs to be taken to the emergency department. We called ahead and they are expecting her."

Given that introduction and admonition, no one will attempt to talk the patient out of being transported. I usually stick around to "help load" to ensure that the patient is actually loaded on the stretcher.

If, for some reason, the medics still manage to talk the patient out of being transported, I would immediately call their supervisor and consider calling the body responsible for licensing ambulances.

At the end of the day, an urgent care provider is ultimately responsible for the patient and his or her disposition. If somehow the medics do "talk the patient out of transport," the urgent care provider remains responsible for the appropriate disposition of the patient.

#### Take-home points

- 1. Be proactive by giving the patient informed consent about the reasons for transport.
- 2. Accompany the medics into the room with the patient.
- 3. Overstate the reasons for the transport.
- 4. If able, call ahead to the ED and tell the medics that the ED is expecting the patient.



# **ABSTRACTS** IN URGENT CARE

- Long-term survival following pneumococcal pneumonia
- Pediatric concussions
- Energy drinks
- Antibiotics in ambulatory pediatrics
- Chronic traumatic encephalopathy
- Apixaban for VTE
- MMR vaccine and mumps
- Stress testing in young adults with chest pain
- Paramedics' interpretation of STEMI
- Antibiotics and COPD
- Head CTs for non-trauma in the ED

NAHUM KOVALSKI, BSc, MDCM

ach 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.

# Long-term survival following pneumococcal pneumonia

*Key point: Pneumococcal pneumonia foretold considerably higher 10-year mortality than the expected rate.* 

Citation: Sandvall B, Rueda AM, Musher DM. Long-term survival following pneumococcal pneumonia. *Clin Infect Dis.* 2013;56(8):1145-1146.

Before antibiotics, pneumonia was called "the old man's friend" for carrying the old and infirm to a swift and relatively painless death. Now that short-term survival after pneumonia is the rule, does the disease provide any long-term prognostic information?

Veterans Administration researchers reviewed medical records of 392 patients in whom bacteriologically confirmed pneumococcal pneumonia was diagnosed at a single hospital during 10 years. Almost all patients were men (mean age, 63), and 48 (12%) died within 1 month of diagnosis. Among the remaining patients, the overall 10-year survival rate was <70%, which was substantially lower than the >95% expected rate for 63-year-old American men. When patients were stratified by severity of pneumonia according to a standard scoring system, 10-year mortality significantly increased with increasing severity scores, but even the mildest disease was associated with higher-than-normal long-term mortality. Bacteremic disease was associated with lower 10-year survival than was nonbacteremic disease.



Nahum Kovalski is an urgent care practitioner and Assistant Medical Director/CIO at Terem Emergency Medical Centers in Jerusalem, Israel. He also sits on the JUCM Editorial Board. Published in J Watch General Med April 16, 2013 — Abigail Zuger, MD. ■

#### What Pediatric Providers Know About Concussions

Key point: Many lack adequate training or tools to systematically diagnose and manage children with such injuries.

Citation: Zonfrillo MR, Master CL, Grady MF, Winston FK, Callahan JM, Arbogast KB. Pediatric providers' self-reported knowledge, practices, and attitudes about concussion. *Pediatrics*. 2012;130(6):1120-1125.

Reports in the press of concussions in high-profile professional athletes have renewed a focus on diagnosis and management of mild traumatic brain injury. Although most patients recover quickly, prolonged physical, cognitive, and emotional symptoms require immediate recognition and careful management. Researchers at a large pediatric network surveyed 276 pediatric primary care and emergency medicine providers about their knowledge of concussion and related symptoms.

Among the 145 respondents (53%), 91% had cared for at least 1 patient with acute concussion in the previous 3 months, and nearly all had referred at least 1 patient after the initial visit. Primary care pediatricians were most likely to refer because they were not comfortable with management or did not have adequate time or resources, and they usually referred to a sports medicine specialist, followed by a neurologist or neuropsychologist. Emergency pediatricians were most likely to refer because they did not perceive treatment of concussion to be their role or feel the emergency setting was appropriate for ongoing management, and they usually referred to trauma surgeons or clinics. The following concussion symptoms (based on an acute concussion evaluation tool: J Head Trauma Rehabil 2008; 23:230) were rated as *not* relevant to diagnosis of concussion: abnormal eye tracking (17%), difficulty concentrating (11%), vestibular disturbance (9%), decline in school performance (6%), and sensitivity to light or noise (6%). Most providers felt inadequately trained to perform neurocognitive testing, educate families, or recommend the appropriate time before resuming school or play.

Published in J Watch Ped Adolesc Med. December 19, 2012 — Louis M. Bell, MD. ■

#### **Energy Drinks**

Key point: Two viewpoints in JAMA discuss some potential harms associated with caffeinated energy drinks.

Citations: Sepkowitz KA. Energy Drinks and Caffeine-Related Adverse Effects. JAMA. 2012;():1-2. doi:10.1001/jama. 2012. 173526 and Howland J, Rohsenow DJ. Risks of Energy Drinks Mixed With Alcohol. JAMA. 2012;():1-2. doi:10.1001/ jama.2012. 187978.

Two articles in JAMA discuss the risks of energy drinks.

One viewpoint highlights the risks associated with mixing energy drinks with alcohol. Although much is still unknown, early studies indicate that the practice reduces the sensation of intoxication by offsetting alcohol's sedating effects.

Another article considers the caffeine in energy drinks. Three grams of caffeine ingested in a short time could be lethal, the author notes. To reach that level, at least 12 caffeinated energy drinks would have to be consumed within a few hours. However, drug-drug interactions may play a role in adverse effects because caffeine is metabolized via the same pathway as several medications.

The author advises: "Physicians should ask their patients about their use of energy drinks, particularly young men who are the heaviest users." Intake levels of less than 500 mg per day (equivalent to four to six energy drinks), according to the author, are generally considered safe.

#### Inappropriate Antibiotic Prescribing in Ambulatory Pediatrics

Key point: Prescriptions for broad-spectrum antibiotics are common and often inappropriate.

Citation: Hersh AL, Shapiro DJ, Pavia AT, Shah SS. Antibiotic prescribing in ambulatory pediatrics in the United States. *Pediatrics*. 2011;128(6):1053-61.

Antibiotics are among the most frequently prescribed medication in pediatrics, with more than 30 million prescriptions written for children annually. Although overall rates of antibiotic prescribing in ambulatory settings have declined, antibiotic overuse continues and contributes to development of antibiotic-resistant pathogens, unnecessary costs, and avoidable adverse events. To examine antibiotic prescribing patterns in U.S. ambulatory pediatrics, researchers analyzed two nationwide datasets representing visits to offices, outpatient departments, and emergency departments by children younger than 18 years from 2006 to 2008. Antibiotics were categorized as narrow (e.g., amoxicillin) and broad spectrum (e.g., azithromycin), based on national standards.

Antibiotics were prescribed in an estimated 49 million pediatric ambulatory visits (21% of visits). Broad-spectrum antibiotics were prescribed in 50% of these visits, with macrolides (primarily azithromycin) prescribed most often, followed by broad-spectrum cephalosporins. Respiratory conditions accounted for most (72%) visits in which antibiotics were prescribed. Of concern, prescriptions for broad-spectrum antibiotics were highest (63%) for acute respiratory tract infections for which antibiotics were not indicated (such as for nasopharyngitis, bronchitis, viral pneumonia, and influenza). For example, an estimated 2.1 million prescriptions were written for bronchitis annually. Children with public or no insurance were significantly less likely than those with private insurance to receive broad-spectrum antibiotics.

Published in J Watch Ped Adolesc Med. December 14, 2011 — Louis M. Bell, MD. ■

# The spectrum of disease in chronic traumatic encephalopathy

Key point: Even 'Mild' Repetitive Impacts Associated with Long-Term Brain Damage.

Citation: McKee AC, Stein TD, Nowinski C, et al. The spectrum of disease in chronic traumatic encephalopathy. *Brain*. (2012) doi:10.1093/brain/aws307.

A postmortem study of the brains of 85 athletes and military veterans concludes that "there may be severe and devastating long-term consequences of repetitive brain trauma that has traditionally been considered only mild."

In *Brain*, researchers characterized the stages of chronic traumatic encephalopathy on the basis of interviews with next of kin. Symptoms ranged from headache and loss of attention span in phase I, to dementia and aggression in phase IV. Neuropathology was related to the presence of tau protein outside the microtubules of axons, where they are normally found. Among football players, the stage of encephalopathy correlated with the duration of play.

A coauthor of the study told the *New York Times* that "all concussions are not created equal." He said that "parents have become paranoid about concussions and connecting the dots with [chronic traumatic encephalopathy], and that's wrong. The dots are really about total head trauma."

#### Apixaban for Extended Treatment of Venous Thromboembolism

*Key point: Treatment with apixaban for 1 year reduced recurrence of venous thromboembolism.* 

Citation: Agnelli G, Buller HR, Cohen A, et al. *N Engl J Med*. December 8, 2012 DOI: 10.1056/NEJM0a1207541

The international study comprised some 2,500 patients who had completed 6 to 12 months of anticoagulation therapy and for whom there was equipoise about stopping or continuing. The group was randomized to placebo, or to apixaban at 2.5 mg twice daily, or to apixaban at 5 mg twice daily.

After therapy for 1 year, the rate of the composite primary outcome—symptomatic recurrent VTE or death from any cause—was 11.6% with placebo, versus roughly 4% with each of the apixaban dosages. Rates of major bleeding episodes were similar among the groups (all 0.5% or less).

The authors estimate 14 as the number needed to treat to prevent one episode of recurrent VTE, and 200 as the number needed to treat to cause one episode of major or clinically relevant nonmajor bleeding.

## Would a Third Dose of MMR Vaccine Curb the Uptick in Mumps Outbreaks?

Key point: A school-based intervention reduced the mumps attack rate from 4.9% to 0.13% in one community.

Citations: Ogbuanu IU, Kutty PK, Hudson JM, et al. Impact of a third dose of measles-mumps-rubella vaccine on a mumps outbreak. *Pediatrics* 2012 Dec; 130:e1567, Barskey AE et al. Mumps outbreak in Orthodox Jewish communities in the United States. *N Engl J Med* 2012 Nov 1; 367:1704, and Centers for Disease Control and Prevention (CDC). Mumps outbreak on a university campus — California, 2011. *MMWR Morb Mortal Wkly Rep* 2012 Dec 7; 61:986.

Rates of mumps cases in the United States were at historic lows between 2000 and 2006, with fewer than 300 cases reported annually. In addition, two-dose measles-mumps-rubella (MMR) vaccine coverage in teens has been high (>87%). Nevertheless, between 2006 and 2010, mumps outbreaks in the United States have resulted in more than 10,000 reported cases.

In 2009–2010, a mumps outbreak resulted in 3502 cases in New York State and New Jersey. The index case was a fully vaccinated 11-year-old boy who developed mumps after exposure to an outbreak in the United Kingdom and then attended a summer camp in New York during the infectious period. Subsequently, 25 campers and staff developed mumps, and then the virus spread to 3,477 cases in New York City and New Jersey after infected campers returned home. Most cases (71%) occurred in boys aged 13 to 17 years.

Following the outbreak, a school-based vaccination interven-

tion was planned in one of the affected communities. A third dose of MMR vaccine was offered to 2,265 eligible students in grades 6 to 12. Of the 2,178 students (96%) with documentation of having received two previous MMR vaccine doses, 1,755 (81%) chose to receive a third dose. Mumps attack rates declined significantly from 4.9% during the 3 weeks before vaccination to 0.13% during the 3 weeks after vaccination. The greatest decline in mumps cases (96%) was among targeted students aged 11 to 17 years.

In September 2011, another outbreak occurred among students in California. The index case was an unvaccinated student, again returning from Western Europe. He was initially diagnosed with facial cellulitis. The index student's fully vaccinated roommate presented as the second case 3 weeks after exposure. In total, 29 cases were reported.

Published in J Watch Ped Adolesc Med. December 12, 2012 — Louis M. Bell, MD. ■

# Stress Testing Has Low Yield in Young Adults with Chest Pain

Key point: Observation and further testing yielded few abnormal test results, and most were false-positive.

Citation: Ely S, Chandra A, Mani G, et al. Utility of observation units for young emergency department chest pain patients. *J Emerg Med.* 2013;44(3):306-312.

To assess the yield of extended observation and testing of young patients with chest pain, researchers examined test results and adverse cardiac events within 1 year among 362 patients aged 18 to 40 (49% men; 55% black) who were evaluated for suspected acute coronary syndrome in an emergency department (ED)-based cardiac observation unit.

Of the 362 patients, 124 had negative serial cardiac marker results and were discharged directly from the ED, and 238 underwent further testing. Fifteen patients had abnormal workups; one had elevated troponin and normal angiography but was discharged with a diagnosis of myocardial infarction (MI), and 14 patients had abnormal stress test results. Five stress test results were positive and nine were considered indeterminate, mostly because the patient failed to reach the target heart rate. The five patients with positive stress test results were admitted and underwent angiography; of these, one had significant coronary stenosis. One patient with a normal stress test result had a MI after 8 months. Therefore, 3 of 238 patients had adverse outcomes within 1 year, only 1 of whom was discovered by stress testing. The positive discovery rate of observation unit testing was 0.28%, and the false-positive rate for stress testing was 80%. In contrast, the authors report a 6% rate of coronary disease requiring intervention at 1 year in the general population in their observation unit.

Published in J Watch Emerg Med March 8, 2013 — J. Stephen Bohan, MD, MS, FACP, FACEP.

#### Paramedics' Interpretation of STEMI on Prehospital ECGs Is Unreliable

*Key point: Paramedics missed nearly a quarter of anterior and half of posterior MIs.* 

Citation: Mencel F, Wilber S, Frey J, et al. Paramedic ability to recognize ST-segment elevation myocardial infarction on prehospital electrocardiograms. *Prehosp Emerg Care*. 2013 Apr;17(2):203-210.

Prehospital identification of ST-segment elevation myocardial infarction (STEMI) allows early cath lab activation, thereby reducing first medical contact-to-balloon time and mortality. Using anonymous surveys, researchers tested paramedics' abilities to recognize STEMI on electrocardiograms (ECGs). The 472 respondents worked within five counties in northeastern Ohio. Each survey contained ten standardized patient vignettes with actual prehospital ECGs representing three STEMIs (inferior, anterior, and lateral), five STEMI mimics (left ventricular hypertrophy, ventricular pacing, left and right bundle branch blocks, and supraventricular tachycardia), and two normal studies.

Of the respondents, 52% had 10 or more years of experience, 69% had received ECG training within the past year, and 74% reported they were confident in their ability to recognize STEMI. While all paramedics correctly identified the normal ECGs and most (96%) detected the inferior STEMI, 22% failed to identify the anterior STEMI and 50% missed the lateral STEMI. Overall, only 39% of paramedics correctly identified all three STEMIs, whereas only 3% also correctly answered that the remaining ECGs were not STEMIs. There was no correlation between years of experience, recent training, or confidence level and ability to interpret ECGs. Overall, sensitivity and specificity for STEMI detection were 75% and 53%.

Published in J Watch Emerg Med March 8, 2013 — Kristi L. Koenig, MD, FACEP, FIFEM. ■

# Add Antibiotics When Admitting Patients for COPD Exacerbations

Key point: A Cochrane review supports use of antibiotics in managing hospitalized patients with chronic obstructive pulmonary disease exacerbations.

Citation: Vollenweider DJ, Jarrett H, Steurer-Stey CA, et al. Antibiotics for exacerbations of chronic obstructive pulmonary disease. *Cochrane Database Syst Rev.* 2012 Dec 12; 12:CD010257.

Exacerbations of chronic obstructive pulmonary disease (COPD) are caused by bacterial infections in about half of all cases; the remaining cases are caused by viruses or environmental irritants. Cochrane investigators performed a meta-analysis of 16 randomized controlled trials in which the effects of antibiotics were compared with placebo for managing COPD exacerbations. In this summary, the reviewers focused on the seven trials that involved inpatients. Among 612 non-intensive care unit (ICU) inpatients with severe exacerbations, antibiotics significantly lowered treatment failure (defined as no resolution or deterioration of symptoms, need for additional antibiotics or other medication, or death due to exacerbation) at 4 weeks (42% vs. 52%; number needed to treat [NNT], 10) but did not prevent all-cause mortality. Among 93 ICU patients with very severe exacerbations, antibiotics significantly lowered treatment failure (11% vs. 57%; NNT, 2) as well as all-cause mortality (4% vs. 22%; NNT, 6) at 4 weeks.

Published in *J Watch Hosp Med.* April 1, 2013 — Daniel D. Dressler, MD, MSc, SFHM, FACP. ■

#### Can We Perform Fewer Head CTs for non-Trauma in the Emergency Department?

Key point: Rules can definitely reduce CT rate. The question is how much.

Citation: Wang X, You JJ. Head CT for nontrauma patients in the emergency department: Clinical predictors of abnormal findings. *Radiology*. 2013; 266(3):783-790.

The Centers for Medicare and Medicaid Services recently issued a utilization measure for cranial computed tomography (CT) scanning for nontrauma indications in the emergency department (ED), but the measure has met with strong criticism (JW Emerg Med Sep 21 2012).

To derive a decision rule for emergent head CT, researchers in Hamilton, Ontario, Canada, retrospectively examined records of 4000 adults who were scanned for nontrauma indications at three hospital EDs during 3 years. Patients with previously known intracranial pathology were excluded. An abnormality was defined as hemorrhage, acute or subacute infarction, mass lesion, or other findings that required intervention or follow-up.

In a 2000-patient derivation cohort, the prevalence of abnormal head CT was 14% (275 cases). Multivariable analysis yielded six independent predictors of abnormality: older age, nausea or vomiting, altered mental status, focal neurological deficit, cancer history, and derangement in coagulation. Findings were as follows:

- Performing CT only in patients with any of the five nonage predictors would have detected 94% of abnormalities and lowered CT scanning by 30%.
- Including all older patients (age >70), plus younger patients with any of the other five predictors, would have increased sensitivity to 96%, and 21% of scans would have been avoided.
- Although seizure was not an independent predictor, adding seizure as an indication to scan would have increased sensitivity to 99%, and 14% of scans would have been avoided.

Published in J Watch Gen Med March 14, 2013 — Allan S. Brett, MD.



# 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*.



The patient, a 12-year-old female, presented after twisting her right ankle. She could not bear weight on her right leg.

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

Resolution of the case is described on the next page.

#### INSIGHTS IN IMAGES: CLINICAL CHALLENGE

#### THE RESOLUTION



Diagnosis: The x-ray reveals a Salter-Harris III fracture of the distal tibia (arrow). Salter-Harris III fractures involve the epiphysis and physis. This child's growth plates have already begun to fuse. Urgent follow up with orthopedics is necessary for this fracture.

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

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# CODING Q&A

# 2014 CPT Changes, Suture Removal, Place of Service Code

DAVID STERN, MD, CPC

#### I understand that we will be able to bill for cerumen removal for both ears in 2014. Is that true?

Yes. In 2014, you will be able to bill CPT code 69210, "Removal impacted cerumen requiring instrumentation, unilateral" with modifier -50, "Bilateral procedure." Keep in mind, Medicare will typically not cover simple, non-impacted earwax removal. CMS requires that physicians meet the following criteria for reimbursement of the removal of impacted cerumen:

- The procedure is the sole reason for the patient encounter;
- A physician or non-physician (nurse practitioner, physician assistant, or clinical nurse specialist) carries out the treatment;
- The patient in question is symptomatic; and
- The supporting documentation shows significant time and effort spent performing the service.

#### Are there any changes to 2014 • CPT codes?

A few changes to CPT codes in 2014 that are pertinent to urgent care include:

- The deletion of 13150, "Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less." You are now directed to simple or intermediate repair codes.
- 72040, "Radiologic examination, spine, cervical; 2 or 3 views." The phrase "or less" was removed from the description of number of views. Thus, for a one-view x-ray of the cervical spine, you will code 72040 with modifier



David E. Stern, MD is a certified professional coder and board certified in Internal Medicine. He was a Director on the founding Board of UCAOA and has received the organization's Lifetime Membership Award. He is CEO of Practice Velocity, LLC (www.practicevelocity.com), PV Billing and NMN Consulting, providers of software, billing and urgent care consulting services. Dr. Stern welcomes your questions about urgent care in general and about coding issues in particular.

### "Medicare will typically not cover simple, non-impacted earwax removal."

-52 (reduced services.) Make sure that you bill your normal fee for the code because the payor will make payment reductions, generally as a percentage of what you bill or the payor fee schedule for the code, whichever is lower.

There are also some vaccine codes that were recently approved by the FDA and released for use in 2013 but not included in the CPT manual until 2014:

- 90673, "Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutnin (HA) protein only, preservative and antibiotic free, for intramuscular use."
- 90685, "Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use."
- 90686, "Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use."
- 90688, "Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use."

Still awaiting FDA approval, but added to the 2014 CPT manual is 90687, "Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use." You can find all 2014 changes in Appendix B of the 2014 CPT manual.

If a patient comes into our urgent care center for removal of sutures that were placed by another facility, would we bill an E/M code and append modifier -55?

#### CODING Q&A

### "You can find all 2014 changes in Appendix B of the 2014 CPT manual."

It is compliant in some circumstances to bill suture removals, using the wound repair code with modifier -55 (post-operative care only).

There are a few issues with this:

- Simple wound repairs (vast majority of suture removal visits that you will see) have a zero-day global period, so modifier -55 would not apply to the visit for suture removal. You would just use an E/M code to code for the suture removal visit, whether the wound repair was initially done in your clinic or in another facility.
- You may not be aware of whether the initial provider coded the initial visit as a simple vs. intermediate/complex wound repair, so you will often not know whether the modifier -55 would even apply.
- For any patients who are still in a global period for their wound repair (intermediate and complex wound repairs), you could code with modifier -55. Getting payment on these will generally take more than 6 months, a substantial number of phone calls, and substantial stress:
  - You will usually get an initial denial because the initial provider did not append modifier -54 (surgical care services only) to the procedure. Thus, the initial provider will have been paid the global fee.
  - You will need to get the initial provider to refile the claim (after you get a denial) with modifier -54. That provider will generally be unhappy, very slow, or refuse to do this.
  - If the initial provider agrees to refile the claim, and after you confirm that the initial provider has refiled the claim, you can rebill the claim and get it to process.

Thus, unless you have coordinated this billing process in advance with the other provider, the use of modifiers -54 and - 55 is very hard to coordinate and execute efficiently.

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



In this issue: What Percentage of expenses are spent on salaries?

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





#### (Brompheniramine Maleate 2 mg, Pseudoephedrine Hydrochloride 30 mg, and Dextromethorphan Hydrobromide 10 mg) Rx only

#### DESCRIPTION

Bromfed® DM Cough Syrup is a clear, light pink syrup with a butterscotch flavor.

Each 5 mL (1 teaspoonful) contains:

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C16H19BrN2•C4H404 M.W. 435.31 Brompheniramine Maleate, USP

(±)-2- p-Bromo-α-2-(dimethylamino)ethylbenzylpyridine maleate (1:1)



C<sub>10</sub>H<sub>15</sub>NO•HCI

M.W. 201.69 Pseudoephedrine Hydrochloride, USP (+)-Pseudoephedrine hydrochloride



C<sub>18</sub>H<sub>25</sub>NO•HBr•H<sub>2</sub>O

Dextromethorphan Hydrobromide, USP 3-Methoxy-17-methyl-9 $\alpha$ , 13 $\alpha$ , 14 $\alpha$  - morphinan hydrobromide monohydrate

Antihistamine/Nasal Decongestant/Antitussive svrup for oral administration.

#### CLINICAL PHARMACOLOGY

Brompheniramine maleate is a histamine antagonist, specifically an H1-receptor-blocking agent belonging to the alkylamine class of antihistamines. Antihistamines appear to compete with histamine for receptor sites on effector cells. Brompheniramine also has anticholinergic (drying) and sedative effects. Among the antihistaminic effects, it antagonizes the allergic response (vasodilation, increased vascular permeability, increased mucus secretion) of nasal tissue. Brompheniramine is well absorbed from the gastrointestinal tract, with peak plasma concentration after single, oral dose of 4 mg reached in 5 hours; urinary excretion is the major route of elimination, mostly as products of biodegradation; the liver is assumed to be the main site of metabolic transformation.

Pseudoephedrine acts on sympathetic nerve endings and also on smooth muscle, making it useful as a nasal decongestant. The nasal decongestant effect is mediated by the action of pseudoephedrine on  $\alpha\mbox{-sympathetic}$  receptors, producing vasoconstriction of the dilated nasal arterioles. Following oral administration, effects are noted within 30 minutes with peak activity occurring at approximately one hour

Dextromethorphan acts centrally to elevate the threshold for coughing. It has no analgesic or addictive properties. The onset of antitussive action occurs in 15 to 30 minutes after administration and is of long duration.

#### INDICATIONS AND USAGE

For relief of coughs and upper respiratory symptoms, including nasal congestion, associated with allergy or the common cold.

#### CONTRAINDICATIONS

Hypersensitivity to any of the ingredients. Do not use in the newborn, in premature infants, in nursing mothers, or in patients with severe hypertension or severe coronary artery disease. Do not use dextromethorphan in patients receiving monoamine oxidase (MAOI) inhibitors (see Drug Interactions).

Antihistamines should not be used to treat lower respiratory tract conditions including asthma.

#### WARNINGS

Especially in infants and small children, antihistamines in overdosage may cause hallucinations, convulsions, and death.

Antihistamines may diminish mental alertness. In the young child, they may produce excitation.

#### PRECAUTIONS

General: Because of its antihistamine component, Bromfed® DM Cough Syrup should be used with caution in patients with a history of bronchial asthma, narrow angle glaucoma, gastrointestinal obstruction, or urinary bladder neck obstruction. Because of its sympathomimetic component, Bromfed® DM Cough Syrup should be used with caution in patients with diabetes, hypertension, heart disease, or thyroid disease.

Information for Patients: Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating dangerous machinery.

Drug Interactions: Monoamine oxidase (MAO) inhibitors-Hyperpyrexia, hypotension, and death have been reported coincident with the coadministration of MAO inhibitors and products containing dextromethorphan. In addition, MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines and may enhance the effect of pseudoephedrine. Concomitant administration of Bromfed® DM Cough Syrup and MAO inhibitors should be avoided (see CONTRAINDICATIONS).

Central nervous system (CNS) depressants-Antihistamines have additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, antianxiety agents, etc.).

Antihypertensive drugs-Sympathomimetic may reduce the effects of antihypertensive drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Animal studies of Bromfed<sup>®</sup> DM Cough Syrup to assess the carcinogenic and mutagenic potential or the effect on fertility have not been performed. Pregnancy:

Teratogenic Effects - Pregnancy Category C: Animal reproduction studies have not been conducted with Bromfed® DM Cough Syrup. It is also not known whether Bromfed® DM Cough Syrup can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. It should be given to a pregnant woman only if clearly needed.

Reproduction studies of brompheniramine maleate (a component of Bromfed® DM Cough Syrup) in rats and mice at doses up to 16 times the maximum human doses have revealed no evidence of impaired fertility or harm to the fetus.

Nursing Mothers: Because of the higher risk of intolerance of antihistamines in small infants generally, and in newborns and prematures in particular, Bromfed<sup>®</sup> DM Cough Syrup is contraindicated in nursing mothers.

Pediatric Use: Safety and effectiveness in pediatric patients below the age of 6 months have not been established (see DOSAGE AND ADMINISTRATION).

#### ADVERSE REACTIONS

The most frequent adverse reactions to Bromfed<sup>®</sup> DM Cough Syrup are: sedation; dryness of mouth, nose and throat; thickening of bronchial secretions; dizziness. Other adverse reactions may include: Dermatologic: Urticaria drug rash photosensitivity pruritus

Cardiovascular System: Hypotension, hypertension, cardiac arrhythmias, palpitation.

CNS: Disturbed coordination, tremor, irritability, insomnia, visual disturbances, weakness, nervousness, convulsions, headache, euphoria, and dysphoria

G.U. System: Urinary frequency, difficult urination.

G.I. System: Epigastric discomfort, anorexia, nausea, vomiting, diarrhea, constipation.

Respiratory System: Tightness of chest and wheezing, shortness of breath.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis

#### OVERDOSAGE

Signs and Symptoms: Central nervous system effects from overdosage of brompheniramine may vary from depression to stimulation, especially in children. Anticholinergic effects may be noted. Toxic doses of pseudoephedrine may result in CNS stimulation, tachycardia, hypertension, and cardiac arrhythmias; signs of CNS

depression may occasionally be seen. Dextromethorphan in toxic doses will cause drowsiness, ataxia, nystagmus, opisthotonos, and convulsive seizures.

Toxic Doses: Data suggest that individuals may respond in an unexpected manner to apparently small amounts of a particular drug. A 21/2-year-old child survived the ingestion of 21 mg/kg of dextromethorphan exhibiting only ataxia, drowsiness, and fever, but seizures have been reported in 2 children following the ingestion of 13-17 mg/kg. Another 21/2-year-old child survived a dose of 300-900 mg of brompheniramine. The toxic dose of pseudoephedrine should be less than that of ephedrine, which is estimated to be 50 mg/kg.

Treatment: Induce emesis if patient is alert and is seen prior to 6 hours following ingestion. Precautions against aspiration must be taken, especially in infants and small children. Gastric lavage may be carried out, although in some instances tracheostomy may be necessary prior to lavage. Naloxone hydrochloride 0.005 mg/kg intravenously may be of value in reversing the CNS depression that may occur from an overdose of dextromethorphan. CNS stimulants may counter CNS depression. Should CNS hyperactivity or convulsive seizures occur, intravenous short-acting barbiturates may be indicated. Hypertensive responses and/or tachycardia should be treated appropriately. Oxygen, intravenous fluids, and other supportive measures should be employed as indicated.

#### DOSAGE AND ADMINISTRATION

Adults and pediatric patients 12 years of age and over: 10 mL (2 teaspoonfuls) every 4 hours. Children 6 to under 12 years of age: 5 mL (1 teaspoonful) every 4 hours. Children 2 to under 6 years of age: 2.5 mL (1/2 teaspoonful) every 4 hours. Infants 6 months to under 2 years of age: Dosage to be established by a physician.

Do not exceed 6 doses during a 24-hour period.

#### HOW SUPPLIED

 $\mathsf{Bromfed}^{\circledast}\operatorname{\mathsf{DM}}\nolimits\mathsf{Cough}$  Syrup is a clear, light pink-colored, butterscotchflavored syrup containing in each 5 mL (1 teaspoonful) brompheniramine maleate 2 mg, pseudoephedrine hydrochloride 30 mg and dextromethorphan hydrobromide 10 mg, available in the following sizes:

15 mL (Professional Sample-Not For Resale) 4 fl oz (118 ml)

1 Pint (473 mL)

RECOMMENDED STORAGE

Store at 20 ° to 25 °C (68 ° to 77 °F) [See USP Controlled Room Temperature].

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Dispense in a tight, light-resistant container as defined in the USP.

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**Charles Cooley, MD,** is passionate about seeing patients at his urgent care clinic. He also loves sharing holiday joy as the author of "Reindeer Magic," his children's book about the spirit and magic of the season.

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