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LETTER FROM THE EDITOR-IN-CHIEF

A Mathematical Model for Political Influence in Healthcare Reform

'Round and 'round it goes...and where it stops, nobody knows. Feeling dazed and confused by the dizzying display of legislative slight of hand? Now you see it, now you don't! Compromise, in theory, sounds like the right thing to do when trying to balance interests. Compromise often leads to parity and equity between competing interests. However, when competing interests have unequal power, compromise tends to favor those with the most influence.

I propose a simple mathematical formula to calculate a value for an interest group's ability to influence. It looks like this:

lobbying money x votes = influence

Our legislators depend on votes to keep their jobs, and in my model, lobbying applies a factor of influence for each one of the votes represented by an interest group. So, any interest that represents either a large number of votes or wads of lobbying cash has the power to influence disproportionately. All said, this makes legislative compromise look more like a transaction than a compromise.

Data from the Senate Office of Public Records and the Center for Responsive Politics may help put this in perspective. As of December 07, 2009:

- The top two industry spenders for lobbying in 2009 were Pharmaceuticals/Health Products and Insurance ($199 million and $122 million, respectively), a trend unchanged for much of the last decade.
- The U.S. Chamber of Commerce, which staunchly opposes healthcare reform, was the single largest individual spender in 2009 at a whopping $65 million.
- AARP came in eighth for individual group spending ($15 million).
- The AMA came in 12th ($12.6 million).
- The combination of the American Beverage Association, Coca-Cola, and PepsiCo spent $18.55 million in 2009—more than four times the $4.62 million they spent in 2008. Coincidence? I think not (more on this later).

Okay, so the money trail tells the first part of the story, what about votes?

Take retirees, for example: As a group they have the highest voter turnout on a percentage basis in both congressional and presidential elections. AARP has 40 million members. According to my formula, $15 million x 40 million = $600 million in influence for this group.

The U.S. Chamber of Commerce represents 3 million small businesses. According to the formula, $65 million x 3 million = $195 million worth of influence for small businesses.

The beverage interests spent $18.55 million representing every man, woman, and child's right to chug 13 teaspoons of sugar in every bottle! I won't even do the math, but it should be abundantly clear to you why the so-called "soda tax" disappeared.

It's hard to peg a "votes factor" to the Pharmaceutical and Health Insurance industries, but by lobbying alone, they get a combined $321 million worth of influence.

Finally, let's look at the American Medical Association. They have approximately 200,000 members, so $12.6 million x 200,000 = $2.52 million worth of influence. Even if you include every single physician in the country (approximately 1 million), the influence factor is only $12.6 million.

The bottom line is clear: Influence on Capitol Hill is dominated by interests outside of the physician community; therefore, our influence on healthcare reform is, and forever will be, marginal. The scales have been tipped in this way for some time now, and this should not be expected to change. In the end, decisions about healthcare resources, how to pay for them, and who should get them are being made by politicians, vis-à-vis the influence of money and votes.

It is sad to see, once again, the physician voice being muted on decisions that impact the care they deliver. ■

Lee A. Resnick, MD
Editor-in-Chief
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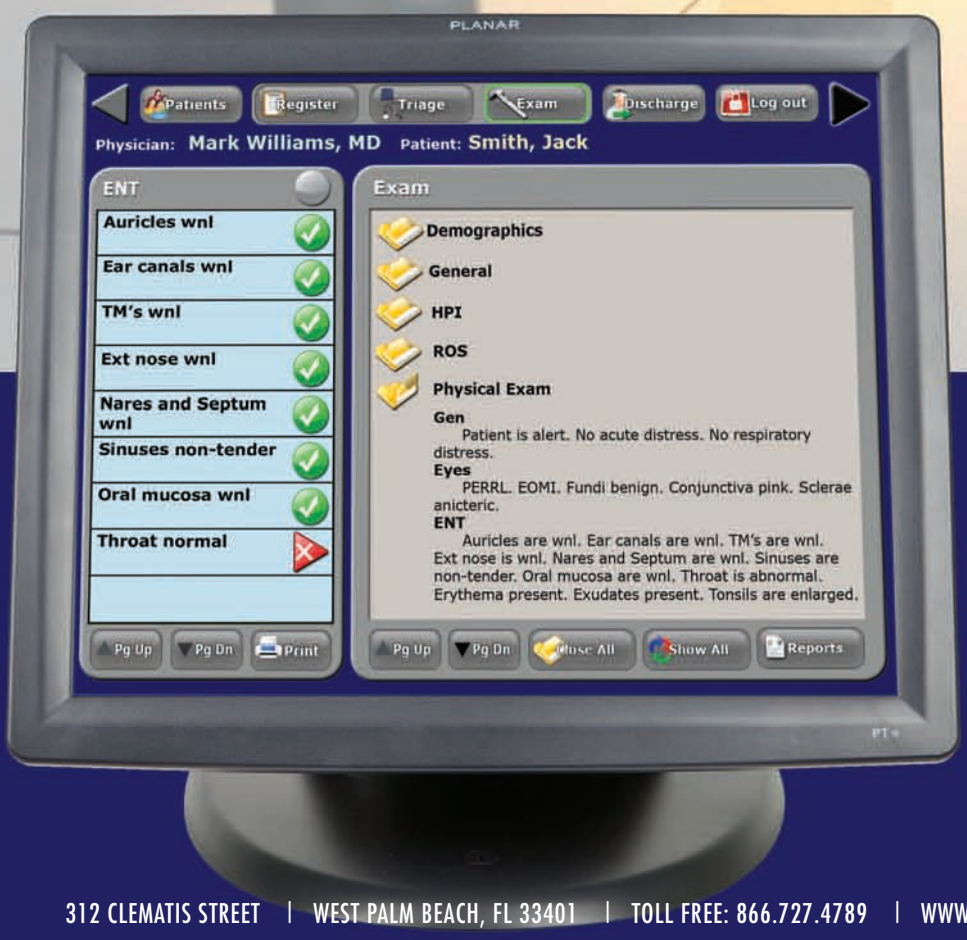

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CLINICAL

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Last-minute preparation for overseas travel may lead many a patient to the urgent care center. Are you also prepared for the patient who presents with particular symptoms after returning from a trip?

By Francine Olmstead, MD, FACP

PRACTICE MANAGEMENT

28 Building Urgent Care Referral Relationships Part 2: EDs, PCPs, and Specialists

Forging solid relationships with other clinicians in emergency, primary care, or specialty settings is good business that also benefits the patient. The second of two parts.

By Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF *JUCM*

Effective treatment of wounds promotes, rather than inhibits, the skin's natural ability to heal itself. An urgent care-specific review of principles in wound management and pitfalls to avoid.

WEB EXCLUSIVE

Case Report: Gout vs. Cellulitis

A 45-year-old Caucasian male presents with pain in his right thumb, accompanied by redness and swelling. Is it gout or cellulitis? Does he need antibiotics? A new case report available only at *www.jucm.com*.

By Paul Nanda, MD and Ramana Reddy Kankanala, MD.

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Mark Twain implored us to "Sail away from the safe harbor. Catch the trade winds in your sails." For travelers who catch more than "trade winds" while they're away from home, however, foreign lands can lose their appeal at best and, at worst, offer threats to life and limb.

Urgent care clinicians are in a great position to offer preventive care for travelers who plan ahead and treatment for those who, to their own detriment, did not. That's assuming, of course, those clinicians are up to speed on various infectious diseases and pathogens indigenous to the far reaches of the globe.

In The Traveling Patient (page 11), **Francine Olmstead, MD, FACP** offers a comprehensive overview of common—and not so common—health risks faced by those who take Twain's advice, including an introduction to a variety of resources for tracking a host of perils overseas.

A point to consider: travel medicine is more than knowing which vaccinations a patient needs before visiting a country. Would you be prepared to treat a patient with a particular galaxy of symptoms that arise after he returned from a mission trip to Ghana?

Dr. Olmstead is medical director of NM Travel Health, a division of Olmstead Health Care Services. She holds the Certificate in Travel Health from the International Society of Travel Medicine and is board certified in internal medicine. Dr. Olmstead came to our attention when she delivered a well-attended lecture on travel medicine at the UCAOA National Convention in Las Vegas in April 2009. She may be contacted at *francine.olmstead@nmtravelhealth.com*.

Building a reputation as someone well-versed in travel medicine can help your business, too, of course—especially if you've established a referral network with busy primary care physicians. Developing such a network requires initiative and strategic thinking, of course. In Building Ur-

JUCM CONTRIBUTORS

gent Care Referral Relationships Part 2: EDs, PCPs, and Specialists (page 28), **Alan A. Ayers, MBA, MAcc** offers advice on how to get started. Part 1 was published in the January 2010 issue of *JUCM* and is available on our website (*www.jucm.com*).

Mr. Ayers is vice president of strategy and execution at Concentra, as well as content advisor to the Urgent Care Association of America.

The hope, of course, is that you will need to refer as few patients as possible. Take a patient who presents with pain, redness, and swelling in his right thumb. Gout springs to mind. So does cellulitis. But which is it; will he need antibiotics? Most importantly, do you know the appropriate steps to reach the right answers? This challenge is covered thoroughly in a new case report by **Paul Nanda, MD** and **Ramana Reddy Kankanala, MD**, available exclusively at *www.jucm.com*.

Also in this issue:

Nahum Kovalski, BSc, MDCM reviews new abstracts on forearm fractures in adults, urethritis in young men, IV drugs and out-of-hospital cardiac arrest, and group A ß-hemolytic *Streptococcus*.

John Shufeldt, MD, JD, MBA, FACEP explores the difference between an apology and an admission of guilt in the context of "I'm sorry statutes" being enacted in states across the country.

Frank Leone, MBA, MPH makes a pitch for making "connectivity" an essential part of an urgent care occupational medicine marketing initiative.

David Stern, MD, CPC responds to queries about coding for new patients who visit twice in the same day and for services typically provided in a primary care setting, as well as billing on the UB-04.

Do you have an idea for an article? An interesting x-ray case to share? Describe it in an e-mail to **Lee A. Resnick, MD**, *JUCM*'s editor-in-chief, at *editor@jucm.com*. New contributors are always welcome.

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The Company We Keep

LOU ELLEN HORWITZ, MA

I'm starting to sound like a Midwesterner. After three years in Chicago, my southern accent is slipping away and my vowels are flattening out. I talk about the "El" and have become a pizza snob and think 33° is still jeans and t-shirt weather.

And yet, give me a few days at home in Georgia and the accent returns, then 55° starts to feel chilly, then you may even find me eating chain restaurant pizza.

Perhaps you are not this chameleon-like, but I think most of us start to adapt to the influences in our surroundings very, very quickly—and somewhat unconsciously. You see it when the honor student starts to hang out with the "wrong crowd" or perhaps feel it happening when you go back to your 25th high school reunion.

Put us in virtually any situation and we start to adapt—and can "adapt back" just as quickly when we return to our home base.

Those small examples remind me how important it is to pay attention to the people and influences we surround ourselves with. Little by little, day by day, those influences alter who we are—or at the very least how we think and act.

How do you feel when you return from a UCAOA conference? After spending four days with colleagues who are all walking the same path as you are in their own clinics?

Even though you may be tired and your head overwhelmed with information, what I hope you also feel is renewed and re-energized to go back home and slay some dragons. Surrounding yourself with "allies" who understand what you are going through can be a fantastic influence.

The challenging part, of course, is what to do when those influences (the "conference high") start to fade and you find yourself eating chain pizza again. How do you hang onto the influences you want when you are no longer surrounded by them?

Lou Ellen Horwitz is executive director of the Urgent Care Association of America. She may be contacted at *lhorwitz@ucaoa.org*.

As long as I have been in professional education, I have seen this struggle. It is hard to leave the chorus and go home and start singing a solo. You start "adapting back" to the existing environment without even realizing it, except for some vague sense of dissatisfaction and failure.

How do you keep the faith when you've left the spiritual retreat?

How can you be the influencer, vs. the influenced?

I think part of the answer is keeping one foot in the meeting/chorus/retreat even after you've left. Basically, keeping those connections alive so you can virtually surround yourself with the influences you want to hang onto. Friends don't let friends eat chain pizza.

I realize that heretofore we (UCAOA) have not done a great job at helping you do that, but very soon that is going to change. I can't say too much more at this point except, "stay tuned"—and become a member if you aren't one yet. The entire point of *association* is to associate, and I think you'll be as excited as I am to see the next level that's taking shape as we speak.

We're also excited about the *non*-virtual, face-to-face, head-filling, connection-making, re-energizing convention that will be here before you know it.

Aside from the fact that it's 23° degrees where I am and 73° in Orlando today, having been to a few of UCAOA's National Urgent Care Conventions I know that it's going to be a fantastic gathering—and this one is going to be better than ever. I hope you'll join us and make some new connections. The more, the merrier. ■

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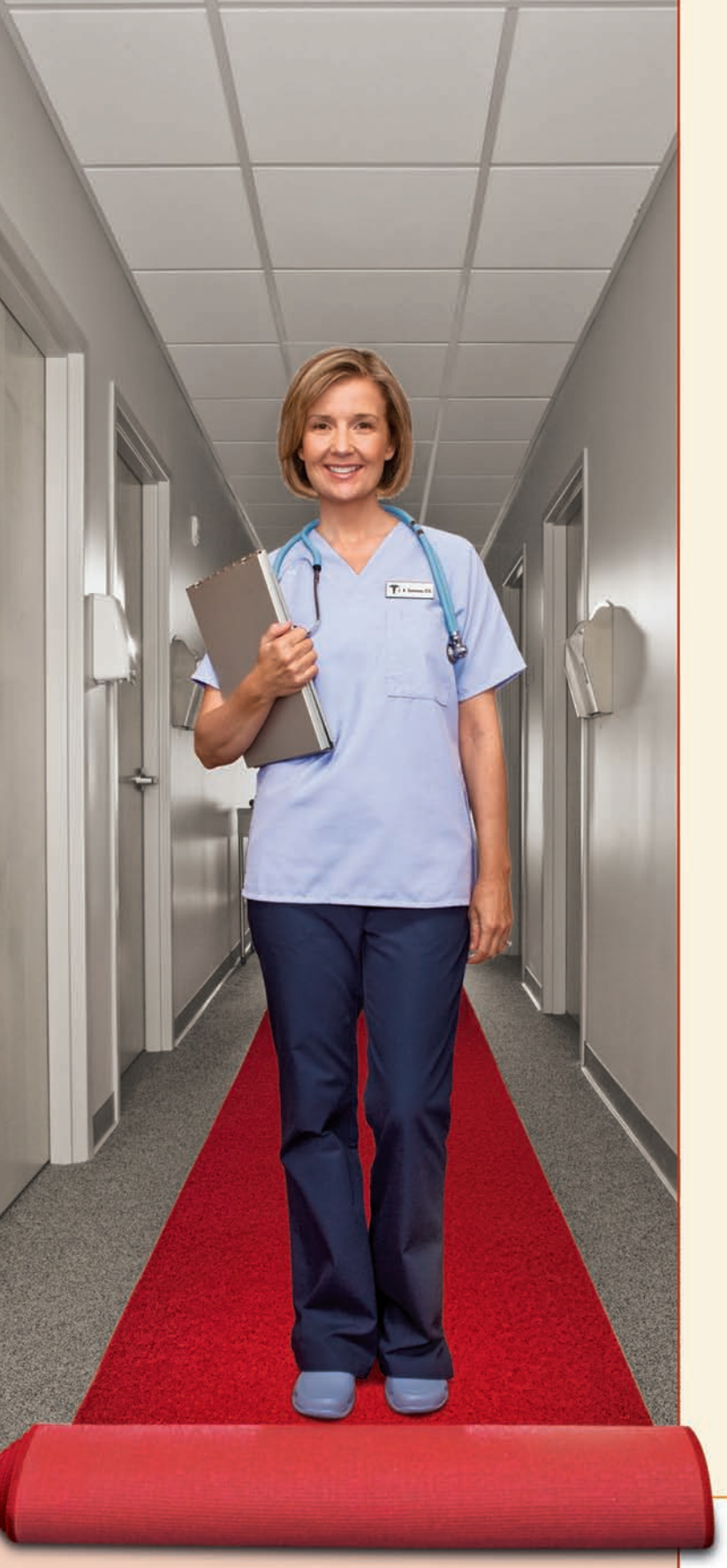

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The Traveling Patient

Urgent message: The accessibility of urgent care makes it a prime venue for patients preparing for international travel *and* patients who may have become ill due to exposure to infectious agents while traveling overseas.

Francine Olmstead, MD, FACP

Whether a patient visits an urgent care center for an infection or a primary care physician for follow-up, every healthcare provider should inquire about anticipated overseas travel. In addition, if a patient is being evaluated for a potentially infectious agent, inquiries about prior international travel should not be overlooked.

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Over 30 million U.S. residents visited overseas destinations in 2008, with approximately 68% traveling to the Caribbean, Central South America, Asia, Africa, and the Middle East.[1] Travelers will visit another country for a vacation, to visit friends and relatives, to teach, study, conduct business, or for religious or humanitarian reasons. Many (if not most) travelers do not seek medical advice before doing so.[2,3]

Most travelers prepare extensively for non-medical issues before embarking on foreign travel, but do not check recommendations from the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO) regarding health risks until the last minute, if at all.

In addition, the majority of insurance companies do not pay for vaccinations and medications recommended or required for foreign travel, placing the financial burden on the patient.

It is our responsibility as clinicians to ensure that patients are educated about the risks of traveling abroad, and to advise them accordingly.

Preparing an international traveler amounts to more than administering immunizations. The moment a patient inquires about vaccinations necessary to travel to a given country is an opportune time to provide a pre-travel consultation, administer immunizations, and prescribe appropriate medications based on their travel plans or to refer to a travel health specialist.

If you are unable to provide the pre-travel consultation and services the same day, schedule an appointment as soon as possible to avoid the patient being lost to follow-up.

Pre-travel Consultation

There are multiple components to the pre-travel consultation, including evaluating the patient's health, determining travel itinerary plans, and educating the patient.

Educating a patient about potential risks associated with travel and how to self-treat some travel-related diseases also prevents the importation of diseases; there is documentation of this having occurred with measles, hepatitis A, polio, and pertussis in the United States.[4,5]

Health Assessment

Perform a detailed assessment of a patient's medical history and current medications. Certain patients with medical conditions such as diabetics, cardiovascular disease, pregnancy, seizures, and psychiatric conditions such as depression or anxiety and immunocompromised patients will require more attention, as they could be affected more by travel and may need to take special precautions.[6]

Reviewing a patient's current medication list, including over-the-counter meds, is an important component in your assessment. Know the contraindications for antimalaria medications and vaccines before assuming a patient should receive them. Instruct patients to take along extra medication, in case they are delayed in returning home or spontaneously decide to stay longer.

Travel Plans

Learning a patient's destination and the purpose of travel is crucial in the pre-travel consultation. Often, patients do not recognize the importance of their itinerary, so instruct them to bring it—along with any immunization records they may have—to their appointment.

Ask them to detail the specific countries and exact destinations they will visit, how long they plan to be there, and the reason for their trip (e.g., missionary, business, pleasure, visiting friends and relatives [VFR], etc.).

Climate and time of year affect the risk of certain illnesses such as influenza and meningococcal disease in some countries. Will they stay in a luxury hotel, resort, hostel, missionary campsite, etc.? What are their plans while in country—VFR, sightseeing, adventurous/outdoor activities, etc.?

The answers to these questions will guide you in how to counsel patients regarding their risk. For example, a traveler who is going to be backpacking throughout Asia for three months would need detailed counseling regarding food- and water-borne illnesses, vector-borne illnesses (such as malaria, Japanese encephalitis, dengue fever), injury prevention, and other concerns.

A patient traveling on a Caribbean cruise would have limited risk for vector-borne illness, but you would want to ensure motion sickness information is included in your consultation.

Discussing jetlag, sunburn prevention, deep vein thrombosis, and other topics are also important components of the consultation.

Patients who visit destinations with altitudes anywhere from 6,000 to 10,000 feet should always be educated on altitude sickness—risks, precautions, and, possibly, use of medications such as acetazolamide (Diamox) for prevention, assuming there are no contraindications.

Routine Immunizations

Review and provide routine immunizations such as tetanus/diphtheria/acellular pertussis (Tdap) (or tetanus/diphtheria [Td] in individuals over 64 years of age), MMR, influenza, H1N1, pneumococcal, shingles, and any other deficient immunizations. Ensure your patients are up to date on their routine immunizations by providing the most current recommendations from the CDC's Advisory Committee on Immunization Practices (ACIP).

For example, any individual between 11 and 64 years of age should receive a single dose of Tdap vaccine if they are due for a Td booster.[7,8]

What do you do about an individual traveling to a pertussis risk area, but who had a Td booster less than 10 years ago? A five-year interval from the last Td dose is encouraged when Tdap is used as a booster dose; however, a shorter interval may be used if pertussis immunity is needed.[8]

Always ask patients if they have recently received any live vaccinations prior to administering another live vaccine. Live vaccines such as those for MMR, varicella, shingles, yellow fever, or the intranasal vaccine for influenza or H1N1 should be given on the same day; if this is not feasible, wait at least 28 days between doses.[9]

Required Immunizations

Yellow fever vaccine is *required* for entry into certain countries and *recommended* for others. (*Requirements* are established by countries to prevent the importation and transmission of yellow fever virus within their borders. In contrast, *recommendations* are public health measures established by CDC and WHO to protect individual travelers from acquiring yellow fever disease.) A physician

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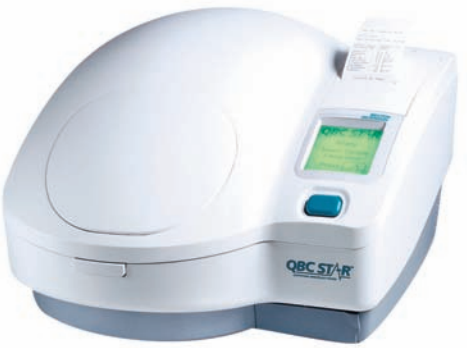

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Table 1. Yellow Fever Risk Countries*

Africa			Central and South America
Angola	Ethiopia	Sierra Leone	Argentina†
Benin	Gabon	São Tomé and Principe	Bolivia†
Burkina Faso	The Gambia	Senegal	Brazil†
Burundi	Ghana	Somalia	Colombia
Cameroon	Guinea	Sudan†	Ecuador†
Central African Republic	Guinea-Bissau	Tanzania	French Guiana
Chad†	Kenya	Togo	Guyana
Congo, Republic of the Côte d'Ivoire	Liberia	Uganda	Panama†
Democratic Republic of the Congo	Mali†		Paraguay
Equatorial Guinea	Mauritania†		Peru†
	Niger†		Suriname
	Nigeria		Trinidad and Tobago†
	Rwanda		Venezuela†

*Countries/areas where "a risk of yellow fever transmission is present," as defined by the World Health Organization, are countries or areas where "yellow fever has been reported currently or in the past, plus vectors and animal reservoirs currently exist" (see *www.who.int/ith/countries/2008_country_list.pdf* (PDF)).
†These countries are not holoendemic (i.e., only a portion of the country has risk of yellow fever transmission).
Source: *Traveler's Health—Yellow Book*. Chapter 2: The Pre-travel consultation; travel-related vaccine-preventable diseases. **A**vailable at: *wwwnc.cdc.gov/travel/yellowbook/2010/chapter-2/yellow-fever.aspx*.

must apply for and be accepted as an official yellow fever provider through the state public health department, via a process overseen by the CDC. Upon registration with the state health department, the provider is issued a yellow fever vaccination stamp bearing a unique number, which is used to validate the patient's International Certificate of Vaccination or Prophylaxis (ICVP) as proof of yellow fever vaccination.

Some state health departments require additional monthly documentation from yellow fever clinics and providers to maintain their status. The CDC website (*wwwnc.cdc.gov/ travel/yellowbook/2010/chapter-2/yellow-fever-vaccine-requirements-and-recommendations.aspx*) provides a list of countries requiring or recommending yellow fever vaccine. (Yellow fever risk countries are listed in **Table 1**). The CDC website (*wwwnc.cdc.gov/travel/yellow-fever-vaccination-clinics-search.aspx*) also provides a list of certified yellow fever providers and clinics in the United States.

Rare, but often fatal, adverse events have been associated with yellow fever vaccine administration, though these have been reported only after primary vaccination. Several risk factors have been identified, including age ≥ 60 years, as well as a history of thymus disease. Consequently, it is essential that a medical provider be familiar with the contraindications and precautions for yellow fever vaccine before deciding to vaccinate a patient.

Patients with contraindications should not receive yellow fever vaccine. In general, those with precautions should also not receive the vaccine, but may if travel to an endemic area is unavoidable and the benefits of the vaccination are judged to outweigh the risks. In the case of a patient with a contraindication or precaution to yellow fever vaccine, consideration should be given to granting a waiver of yellow fever vaccination in the form of a physician's exemption letter and appropriate documentation on their ICVP.[4] Such patients also must be advised of the increased risk of yellow fever disease associated with non-vaccination and measures of how to avoid mosquito bites.

In cases in which a patient with a contraindication or precaution is planning travel to an area with high risk for transmission of yellow fever virus, the provider should consider counseling the patient to postpone travel until such time that vaccination in safe, or, in the case of a permanent contraindication or precaution, altering their itinerary to travel to a country which is non-endemic for yellow fever. Further information about yellow fever vaccine, contraindications, and precautions may be obtained from the CDC Travelers' Health website at *wwwnc.cdc.gov/travel/*.

Since the 1987 outbreak of *Neisseria meningitides* infections in Hajj pilgrims, Saudi Arabia requires the meningococcal vaccine for pilgrims traveling to Mecca for the hajj or umrah.[10] There are two types of tetravalent A, C, Y, W-135 meningococcal vaccines—MCV4 and MPSV4. It is important to know the distinctions between the two vaccines, as their administration differs and there are specific age criteria. In addition, vaccine errors have been reported to be more common among "look-alike/sound-alike" vaccine groups.[11]

Recommended Immunizations

Recommended vaccines include those against hepatitis A, hepatitis B, polio, typhoid, meningococcal, yellow fever, rabies, and Japanese encephalitis. Cholera and tick-borne encephalitis vaccines are no longer available in the United States. The pre-travel consultation and patients risk will determine which vaccines are needed.

Hepatitis A is common in developing countries and is a major risk for non-immune travelers. Dosing schedule is one dose initially (preferably as soon possible) followed by the second dose six months later. Although the immune

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Table 2. Polio Risk Countries*

Region/country	AFP cases (2006)	Non-polio AFP rate† (2006)	WPV Confirmed Cases	
			January – May 2006	January – May 2007
African	12,477	4.0	377	105
Angola	203	2.4	0	0
Cameroon	193	2.3	0	0
Chad	126	2.7	0	0
Democratic Republic of the Congo	1,622	4.8	1	12
Ethiopia	815	2.1	2	0
Kenya	281	1.9	0	0
Namibia	311	11.6	0	0
Niger	316	4.0	3	3
Nigeria‡	5,179	6.5	371	90
Eastern Mediterranean	8,739	3.9	36	18
Afghanistan‡	989	6.2	8	2
Pakistan‡	4,416	5.8	3	8
Somalia	185	4.0	24	8
Yemen	274	2.7	1	0
Southeast Asian	36,643	6.1	39	60
Bangladesh	1,619	2.9	3	0
India‡	32,175	7.3	33	55
Indonesia	1,526	2.4	2	0
Myanmar	410	2.1	0	5
Nepal	263	3.5	1	0
American	2,150	1.3	–	–
European	1,555	1.1	–	–
Western Pacific	7,012	1.5	–	–
Worldwide	68,576	3.7	452	183

AFP, acute flaccid paralysis; WPV, wild poliovirus
*Data reported by World Health Organization region and country. Only countries with WPV in 2006 or 2007 are included.
†Per 100,000 persons aged <15 years.
‡Countries where polio is endemic.
Adapted from: Progress toward interruption of wild poliovirus transmission—worldwide, January 2006–May 2007. *MMWR Weekly*. 2007;56(27):682-685. Available at: *www.cdc.gov/mmwr/preview/mmwrhtml/mm5627a3.htm*.

response to aluminum-adsorbed hepatitis A vaccine has a >95% seroconversion after one single dose, it is less in elderly or immunocompromised patients.[12,13] Schedule a follow-up appointment prior to the patient leaving the appointment and advise the importance of two doses.

Hepatitis B vaccine should be recommended to patients who anticipate sexual contact in another country or traveling to hepatitis B risk developing countries for medical procedures, dental work, acupuncture, IV drug use, or anyone who may need medical attention. The combination hepatitis A and hepatitis B vaccine (hepatitis A vaccine inactivated and hepatitis B vaccine recombinant [Twinrix]) can be administered on a either routine or accelerated schedule. Visit *www.cdc.gov//vaccines/recs/schedules* for details on vaccines with accelerated schedules.

Typhoid vaccines (either oral Ty21a vaccine or intramuscular typhoid Vi polysaccharide vaccine [Typhim Vi]) should be considered for travelers visiting risk areas. Departure date, patient's age, antibiotic use, and other factors will determine which vaccine is most appropriate for a traveler.

Polio vaccination is advised for any individual traveling to a polio endemic or epidemic areas (**Table 2**). Despite polio vaccine efforts, India, Nigeria, Pakistan, and Afghanistan remain the highest polio risk areas with importation into neighboring countries.

Vaccine Adverse Events Reporting System (VAERS)

In the United States, the CDC and Federal Drug Administration (FDA) sponsor a surveillance program to collect data about adverse events after administration of vaccines. All healthcare providers should know the Vaccine Adverse Events Reporting System (VAERS) Table of Reportable Events Following Vaccination and have copies of the VAERS reporting form and brochures (available at *www.vaers.hhs.gov/resources*).

The provider should report even if unsure whether specific side effects or adverse events are related to any vaccine.

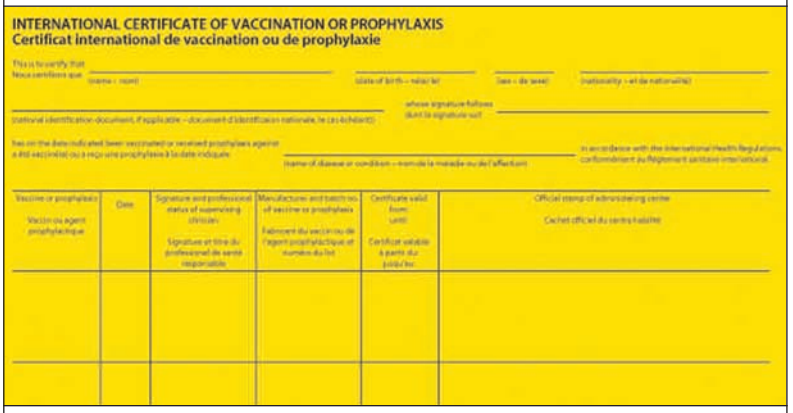
Serologic Testing

If a traveler is originally from an underdeveloped country, or if they do not know their vaccine history, serologic testing for hepatitis A, hepatitis B, measles, and varicella can be performed (assuming adequate time to obtain test and vaccinate if results are negative). If there is not enough time, or if the patient declines blood testing, consider the patient nonimmune and recommend appropriate vaccinations.

International Certificate of Vaccination or Prophylaxis

Every traveler should receive an International Certificate of Vaccination or Prophylaxis (ICVP) (*http://bookstore.gpo.gov/collections/vaccination.jsp*; see **Figure 1** as an example), which includes an official certificate page on which to document

Figure 1. International Certificate of Vaccination or Prophylaxis



INTERNATIONAL CERTIFICATE OF VACCINATION OR PROPHYLAXIS
Certificat international de vaccination ou de prophylaxie

Source: Centers for Disease Control and Prevention. Available at: *wwwnc.cdc.gov/travel/images/371.ashx.*

and validate (with signature and yellow fever vaccination stamp) yellow fever vaccination. Regardless if yellow fever vaccine is given to the patient, other vaccinations and malaria prophylaxis should also be accurately documented on this record on the "Other Vaccinations" section. Patients should be advised to carry this with their passport at all times. Patients may want to keep a copy of their vaccinations and yellow fever certificate in their luggage in case their passport is lost or stolen.

Vector-borne Illnesses

Yellow fever, Japanese encephalitis, dengue fever, malaria, and chikungunya fever are some of the illnesses transmitted by mosquito bites in certain countries.

All patients should be advised to use insect precautions, including adequate insect repellent (30% N,N-diethyl-meta-toluamide [DEET] or 20% picaridin). This also includes treating their outer clothing with permethrin spray. In fact, patients may want to treat their clothes a few days prior to departure to ensure that their clothes dry (some humid areas may pose a problem).

Also advise patients to use permethrin-impregnated bed netting and an insect screen over open windows. Travelers should also be aware of bed bugs, scabies, and other unwanted pests.

Yellow fever and *Japanese encephalitis* vaccines are the only vaccines available in the United States protecting against vector-borne illnesses.

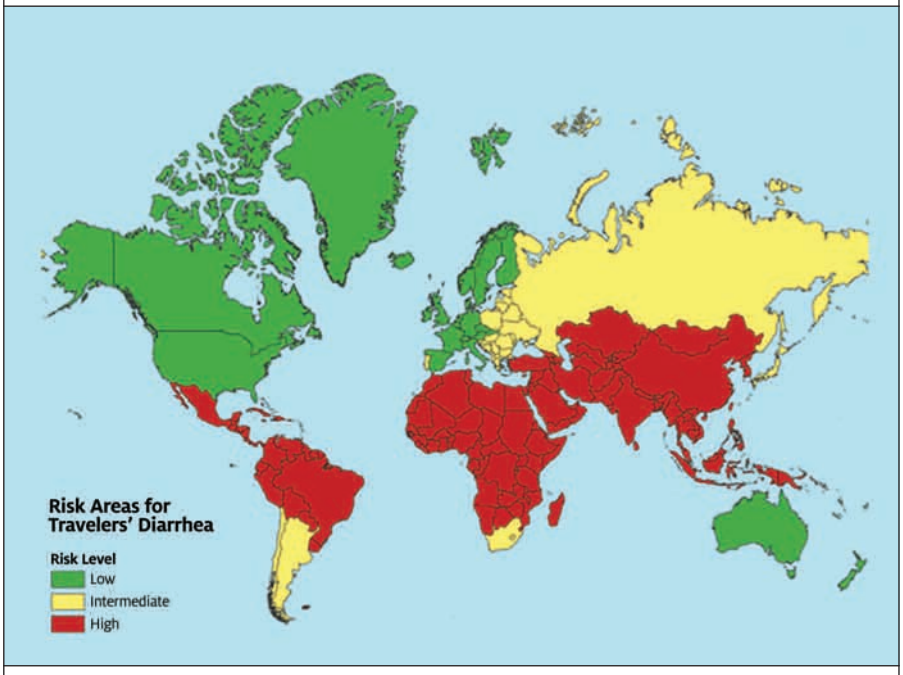
Malaria exists in many areas of the world—and resistance to medication is increasing. Malaria parasites are resistant to chloroquine and/or mefloquine in certain countries. Ensure you know which medications are appropriate for a traveler, based not only on country but also contraindications or potential noncompliance.

Because no vaccines or prophylactic medicines are available for *dengue fever* or *chikungunya*, it is essential to practice good insect precautions.

Rabies

Every traveler visiting a rabies-endemic area should receive counseling about rabies risks. Advise patients—especially children—to avoid touch-

Figure 2. Areas of risk for traveler's diarrhea.



Source: Connor BA. *Traveler's Health—Yellow Book*. Chapter 2: The Pre-travel consultation; self-treatable diseases. Traveler's diarrhea. Available at: *wwwnc.cdc.gov/travel/yellowbook/search.aspx*.

ing or petting dogs, monkeys, cats, and other animals.

Patients should be aware that *any* animal bite or scratch requires immediate attention, and that they should have a plan while in country and follow up immediately upon return to their home country. Rabies-endemic countries have shown significant deficiencies in rabies post-exposure prophylaxis (PEP) for travelers who acquire high-risk animal-associated injuries, including patients not receiving adequate PEP or experiencing a substantial delay before receiving the rabies vaccination.[14]

Although the overall risk to rabies exposure is low to international travelers, rabies transmission and death have been reported, including a fatal case in a U.S. traveler bitten by a dog in Nepal. This patient did not follow through on recommendations to receive PEP.[15,16]

Patients who have been bitten by a dog are likely aware they are at risk; however, licks on broken skin or contamination of the mucous membranes with saliva and scratches are often unknown to travelers.[17] If a traveler is likely to come into contact with a rabid animal and PEP medical treatment is limited or unavailable, including immunoglobulin and vaccinations, the traveler should receive the rabies pre-exposure immunization.[18,19]

It should also be clear to patients that they still need to seek medical care for animal-associated injuries, even if they have received the rabies pre-exposure immunization.

Food and Water Safety

The leading cause of traveler's diarrhea (TD) in developing countries are enterotoxigenic *Escherichia coli* (ETEC) and enteroaggregative *E coli* (EAEC).[20,21] In addition, nearly one-third of cases of patients diagnosed with pathogen-negative TD were confirmed as ETEC and diffusely adherent *E coli* by direct PCR.[22]

Some patients may believe that because they are staying in a nice hotel or resort, they can eat anything. However, food handlers working in popular tourist hotels have been reported to be important carriers of EAEC that could cause TD, with a high proportion of the EAEC multidrug resistant (MDR).[23]

Other bacterial pathogens that cause traveler's diarrhea include *Campylobacter jejuni, Shigella sp.,* and *Salmonella sp*. Depending on the destination (**Figure 2**), it is estimated that 30% to 70% of travelers will develop traveler's diarrhea.

So what do you advise travelers?

- Drink (and brush teeth) with boiled, bottled, or treated water while on travel.
- Avoid ice unless the water has been treated.
- Eat well-cooked foods and avoid raw seafood or undercooked meat/poultry.
- Peel fruits and vegetables; however, raw vegetables such as salads should be avoided.
- Avoid street vendors.
- Avoid dairy products, especially unpasteurized dairy products which may have a risk for brucellosis.
- Wash hands with soap and water before and after eating, before and after using the bathroom, and as frequently as possible while on travel. If soap and water are unavailable, use an alcohol-based hand sanitizer.

Even before leaving the U.S., patients should be encouraged to wash their hands immediately after passing through airport security, as numerous individuals touch the security bins used for carry on items. Patients should also use a bleach/antibacterial wipe on their tray, light/air vent

knobs, and surrounding seated area on the plane.

Prophylaxis and self-treatment
Patients often ask for antibiotics to prevent traveler's diarrhea and request an antibiotic or bismuth subsalicylate (BSS) for the duration of the trip. Antibiotics are not routinely prescribed to prevent traveler's diarrhea due to the risk of bacterial resistance and adverse events. BSS, the active ingredient in Pepto-Bismol, and loperamide have been reported to provide symptomatic relief, though they may not shorten the duration of traveler's diarrhea.[24] It is generally not advisable to use BSS daily due to an increased risk of tinnitus, black stools, and blackened tongue. Patients should be advised there are other effective self-treatments for traveler's diarrhea (**Table 3**) once it has occurred.[24]

Table 3. Effective Treatments for Traveler's Diarrhea[24,25]

Use	Agent	Dosage
Prophylaxis	Bismuth subsalicylate (BSS)	Not recommended
	Antibiotics*	Based on patient medical conditions
Symptomatic treatment	Bismuth subsalicylate (BSS)**	Chew two tablets (or 2 oz. of liquid) four times a day
	Loperamide	4 mg po, then 2 mg after each loose stool; not to exceed 16 mg daily
Antibiotic treatment	Fluoroquinolones†	
	Ciprofloxacin	750 mg po daily x 1-3 days **or** 500 mg po bid x 3 days
	Levofloxacin	500 mg po daily for 1-3 days
	Norfloxacin	400 mg po daily for 1-3 days
	Azithromycin‡	250 mg po bid x 3 days
	Rifaximin§	200 mg po tid x 3 days

* Prophylaxis antibiotics should not be recommended for majority of travelers; however, they may be warranted in patients with certain medical conditions, such as immunosuppression.
**BSS should be avoided in patients with renal insufficiency, gout, aspirin allergy, and those on certain medications (e.g., methotrexate, anticoagulants, and aspirin/salicylate, to name a few). Use extreme caution in children due to potential excessive salicylate absorption and Reye's syndrome associated with BSS use and viral infections.
†Fluoroquinolones should be completed for three days if there is an incomplete response to a single dose. Although not approved for children, fluoroquinolones may be safe in children (weight based) for traveler's diarrhea given the short-course therapy.
‡Azithromycin 10/mg/kg/day for three days for children over 6 months of age; 1,000 mg once in adults, though beneficial, may have more side effects such as nausea.
§Rifaximin is approved for treatment of non-invasive *E coli*. Consider giving patients a back-up antibiotic for invasive diarrhea, as patients may not know the difference between non-invasive and invasive diarrhea.

Patients will not know when to take the antibiotic, so it is important to provide detailed information. Diarrhea consisting of loose, non-bloody stools for <48 hours can be treated with hydration and loperamide. If diarrhea persists, is bloody, or includes a fever, patients should start the antibiotic. Remind patients to increase fluid intake and consider oral electrolyte replacement during a bout of traveler's diarrhea. If symptoms do not improve or worsen, patient should seek medical attention.

Water Activities

Marine hazards should be part of the pre-travel consultation if a patient is planning on snorkeling or scuba diving or visiting any water environment or ocean. Depending on the destination and plans, patients should be cautioned regarding risk of parasitic infections from schistosomiasis and leptospirosis after swimming or wading in fresh water, lakes, streams, or ponds.

Although schistosomiasis is one of the most prevalent parasitic infections in the world, there is an increased risk among travelers who visit Africa compared with other endemic countries.[26, 27] For example, U.S. Peace Corps volunteers have been reported to be most susceptible to schistosomiasis infection from recreational activities in Lake Victoria, Tanzania.[28]

Travelers may not anticipate contact with these types of water environments; however, educating about the potential risk and recommending vigorous toweling immediately after exposure may help prevent schistosomiasis infection.[28,29]

Sexually Transmitted Diseases

The value of discussing the risk of sexually transmitted diseases (STDs) with travelers should not be overlooked in the mass of other important components of the pre-travel consultation. It has been reported that short-term travelers engage in casual sex abroad between 5% and 51%, with higher rates reported among long-term travelers.[30]

It is also estimated that only 24% to 75% of travelers use condoms when having casual sex abroad,[31,32] and that 40% of travelers who had casual sex were not protected against hepatitis B.[33]

Although traveling without a steady partner and expecting a new sexual contact have been identified as two of the most important predictors of having casual sex in individuals under age 50, 49% of men and 75% of

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women who had a new sexual contact did not plan or expect it to occur.[33]

Sexually transmitted infections (STIs) ranging from urethritis to severe infections such as HIV have been reported in travelers returning from the tropics.[34,35] Patients should be counseled and given literature regarding STIs. Additional recommendations should include bringing condoms along during travel, and to get the hepatitis B series.

Anaphylaxis

Hymenoptera bites, high-risk food, exercise, and jelly fish bites are some of the most common causes of anaphylaxis. Although the beach is a potentially high-risk place, lifeguards may not know that epinephrine is the first choice treatment. In fact, 60% of lifeguards working on the beaches of the island of Crete, Greece reported steroids should be used for emergency anaphylaxis treatment; none were aware that epinephrine is the first-choice treatment.[36]

Patients who report severe allergies to bee stings and other precipitants should receive counseling and always carry an epi pen while on travel.

Dental Care

It is relatively common for travelers to have dental problems while abroad.[37,38] For example, the most frequent dental emergencies seen on a cruise include defective restoration, pulpal disease, and defective prosthesis and caries.[37] Patients should be encouraged to not only obtain a complete physical examination, but also a dental examination prior to travel whenever feasible. The importance of a dental exam increases in proportion to the length of time the patient expects to be abroad.

Travel-related Injury and Death

Travelers often receive extensive pre-travel advice regarding infectious diseases, consuming safe food and water, and insect precautions; however, the consultation often contains little or no mention of injury and death.[39]

From 2004 to 2006, 2,361 deaths of U.S. citizens abroad were due to injury, with vehicle crashes and homicides reported as the most common cause.[40] Drowning and other accidents such as pedestrian were also ranked high.

Other than a U.S. drivers license, there is no permit or specific license required to drive in most foreign countries. Travelers should be cautioned regarding driving in a foreign country, as they may be unfamiliar with foreign roadways and driving laws, increasing their risk of an accident.

Table 4. Summary of Travel Health Services

If you are providing travel health services, ensure you do the following to keep your patients safe:

1. Review a patient's chart to ensure routine vaccinations such as influenza, tetanus/diphtheria/pertussis and pneumococcal are up to date. Encourage a complete physical and dental examination prior to travel.
2. Even if a country does not have specific requirements to enter the country, don't forget recommended vaccinations such as Hepatitis A.
3. Determine specific areas within the country of travel. Some rural areas can expose patients to malaria such as in Mexico and China.
4. Ensure you know which countries are resistant to malaria medications such as chloroquine (Aralen) and mefloquine (Larium). Some countries are also resistant to ciprofloxacin used for traveler's diarrhea.
5. Use caution when prescribing malaria medication without reviewing their current medical chart. A patient who has a history of anxiety and depression (even if remote) should never be prescribed mefloquine. If you are uncertain about malaria options and contraindications, refer them to a travel health specialist.
6. Counsel patients extensively on avoiding traveler's diarrhea. If a patient returns with diarrhea, a workup is indicated and early treatment is helpful to decrease IBS occurrences.
7. Certain patients such as pregnant women, diabetics, patients taking Coumadin, or immunocompromised individuals require additional attention and counseling.
8. Malaria can lie dormant for many months. If your patient travels to malaria risk area and returns home ill with fever, malaria should be in your differential diagnosis until ruled out.
9. Remember to ask every patient presenting with a possible infectious disease if they have traveled outside of the United States. Active tuberculosis and other infectious agents are being imported from foreign countries.
10. Worker's compensation claims are likely underreported in business travelers who travel abroad. If a patient returns home ill from foreign travel, do not forget to ask if the travel was business related.

International Travel Health and Air Evacuation Insurance

International travelers have similar or even greater risks of becoming ill compared with the risk they have at home.[41] Many travelers assume their U.S. health insurance plan will cover them in another country; however, they should be advised to check their policies before traveling. Every traveler should receive counseling regarding international travel health and air evacuation insurance, especially if they waive recommended immunizations or have any medical conditions.

Referring to Travel Health Specialists

Consider referring a patient to a travel health specialist if they are leaving within two to three weeks, plan to visit multiple countries, have complex itineraries, or plan to visit remote areas. Patients who are pregnant or have certain medical conditions (e.g. immunocompromised, diabetic), those who are on anticoagulation medication, and select others will require additional time.

If you are uncertain about malaria options and contraindications, refer for specific guidance. Patients who

visit friends and relatives in developing countries may have previously been exposed to typhoid and malaria, and may not feel vaccinations or medications are important because they believe they are immune.[42] This may also necessitate additional counseling time.

A patient should also be referred to a travel health specialist if a healthcare provider is unable to remain current on travel recommendations, as these can change frequently.

Like urgent care centers, not all travel health providers or clinics are alike, as there is no medical board overseeing travel medicine specialists. Determine a travel health clinic's capabilities before referring a patient.

The International Society of Travel Medicine (ISTM; website: *www.istm.org*) provides a directory of travel clinics, and acknowledges those who have received the ISTM Certificate of Knowledge Examination. The American Society of Tropical Medicine and Hygiene (ASTMH; website: *www.astmh.org*) also provides a list of travel clinics and acknowledges those who have passed the ASTMH Certificate of Knowledge in Clinical Tropical Medicine and Traveler's Health.

The CDC (*www.cdc.gov/travelershealth/*) provides a list of certified yellow fever provider clinics. ■

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INSIGHTS IN IMAGES

CLINICAL CHALLENGE

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

If you would like to submit a case for consideration, please e-mail the relevant materials and presenting information to *editor@jucm.com*.

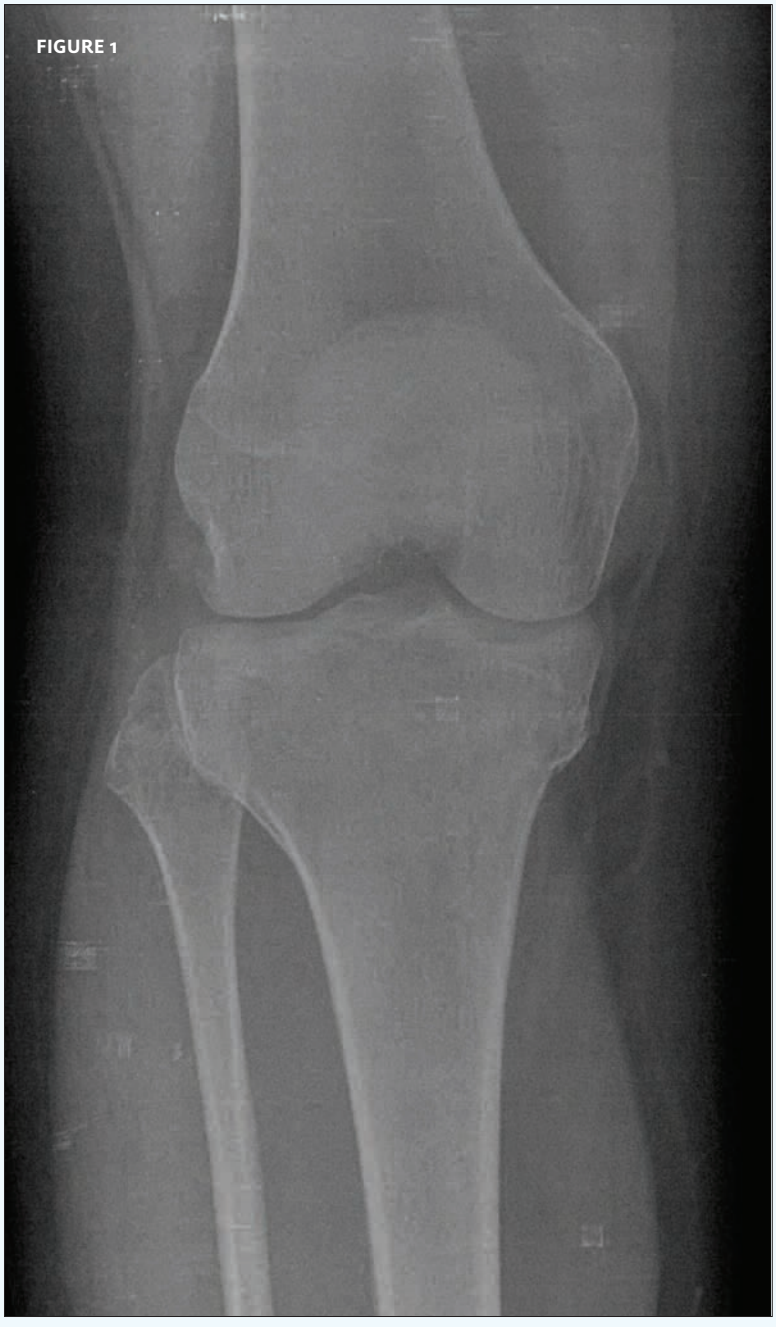

FIGURE 1

The patient is a 17-year-old male who fell and experienced a blow to the right knee.

On examination, you note local swelling. The patient complains of pain over the knee and is unable bear weight on the leg.

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

Resolution of the case is described on the next page.

THE RESOLUTION

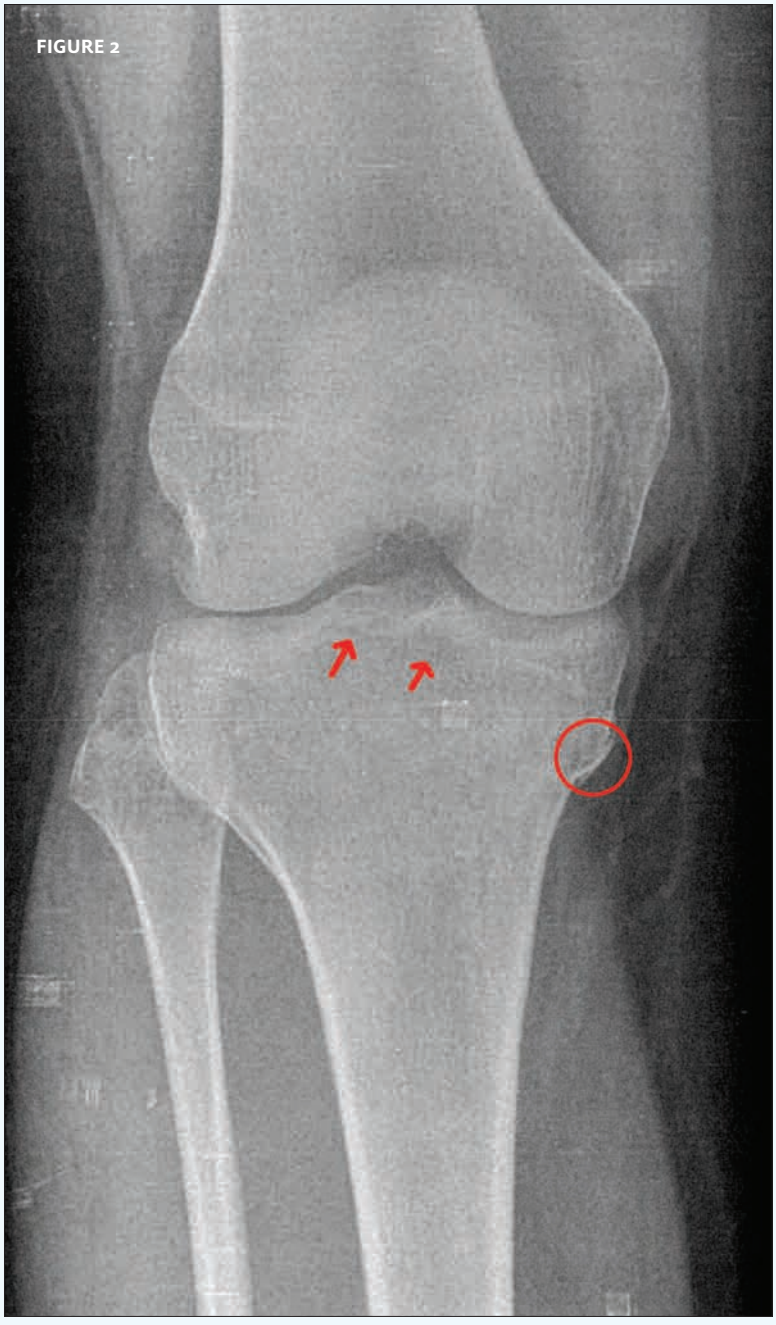

FIGURE 2

Most non-displaced tibial plateau fractures do not require surgery, but prolonged immobilization—up to three months—is often necessary. Orthopedic follow-up is mandatory, as even non-displaced fractures can displace over time.

Arthritis is a common complication, even if it appears that the articular surface is spared.

This patient was referred for orthopedic evaluation.

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

This case is one of hundreds that can be found in Terem's online X-ray Teaching File, with more being added daily. Free access to the file is available at https://www2.teremi.com/ xrayteach/. *A no-cost, brief registration is required.*

On Forearm Fractures, Urethritis in Young Men, Out-of-hospital Cardiac Arrest, and Pharyngitis in Younger Patients

NAHUM KOVALSKI, BSc, MDCM

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

Management of Forearm Fractures in Adults

Key point: Primary care evaluation and management of forearm fracture in adults is presented.

Citation: Black WS, Becker JA. Common forearm fractures in adults. *Am Fam Physician*. 2009;15;80(10):1096-1102.

Upper extremity fractures are often evaluated by primary care physicians at the patient's initial presentation or at follow-up after the initial presentation to urgent care or the emergency department.

These fractures account for approximately 2 million visits to the ED annually. Of these, 18% are for humeral fractures, 31% are for radial or ulnar fractures, and 51% are for carpal, metacarpal, or phalangeal fractures. Falls are the leading cause of upper extremity fractures.

The objectives of initial assessment of forearm fractures are to determine the mechanism of injury and extent of the fracture and to identify any additional injuries. A comprehensive history of the mechanism of injury, a thorough examination of the affected arm, and appropriate radiographic studies are all required.

To rule out the possibility of an open fracture, any skin breaks must be thoroughly examined. Neurovascular examination includes evaluation of radial and ulnar pulses and of capillary refill. Hand and wrist sensory and motor examination are needed, particularly in the median nerve distribution because of its vulnerability in forearm trauma.

Standard radiographic assessment includes posteroanterior and lateral views of the affected arm, as well as oblique views if a fracture has not been definitively visualized or excluded. Initial radiography may fail to demonstrate small, occult, intra-articular fractures.

Although an anterior fat pad is normally seen at the elbow, an effusion will cause elevation of the fat pad (sail sign); a posterior fat pad is an abnormal finding that also suggests a fracture or other intra-articular process.

Repeat radiography in 10 to 14 days may be appropriate when there is high suspicion of a fracture. Magnetic resonance imaging may be helpful if immediate confirmation or exclusion of fracture is required, or to further elucidate possible joint instability or associated ligamentous injury.

Emergent referral is warranted for patients with open fractures, joint dislocation or instability, and/or findings suggesting neurovascular injury. Orthopedic consultation may also be required for fractures with significant displacement, comminution, or intra-articular involvement.

Barring these scenarios, however, clinicians can manage many forearm fractures using the protection, rest, ice, compression, and elevation (PRICE) protocol.

Initial treatment includes splinting and a sling to protect the injured arm and place it at rest; in addition, application of ice and elevating the affected limb can help reduce pain and swelling. In the acute setting, however, compression should be avoided because of possible complications from

Nahum Kovalski is an urgent care practitioner and assistant medical director/CIO at Terem Emergency Medical Centers in Jerusalem, Israel.

swelling, such as acute compartment syndrome.

Depending on the location and extent of injury, definitive treatment of forearm fractures may range from functional bracing to surgical repair and fixation. Early mobilization is usually recommended to avoid loss of mobility, which is the most common complication.

A short arm cast is appropriate for distal radius fractures (Colles fractures) with minimal displacement. Colles fractures, which account for up to 1/6 of all fractures treated, occur most often in young adults (usually from high-energy trauma) and in older persons (usually from a simple fall or other low-impact injury).

These fractures traditionally have been treated with closed manipulation and casting. However, it is now recognized that many of these fractures are unstable, and casting may not maintain acceptable reduction.

Additionally, advancements in surgical technique have improved fracture stability, allowing for earlier motion and rehabilitation.

For isolated ulnar fractures, a short arm cast or a functional forearm brace is indicated. Therapeutic options for Mason type 1 radial head fractures include a splint for five to seven days, or a sling as needed for comfort, combined with early range-of-motion exercises.

For an olecranon fracture in patients with a stable elbow and intact extensor mechanism, non-surgical treatment may suffice.

Specific key clinical recommendations for practice, and their accompanying level of evidence rating, are as follows:

- Risk for radiocarpal arthritis is increased with non-surgical treatment of displaced intra-articular fractures of the distal radius (level of evidence, C). Even minimal articular incongruence is associated with increased complications, according to expert opinion.
- Treatment with a functional brace or short arm cast is appropriate for isolated ulnar shaft fractures that are not displaced by more than 50% of the bone diameter and that are angulated less than 10° degrees (level of evidence, C). This recommendation is based on a systematic review of treatment methodologies, but evidence from randomized controlled trials is lacking.
- For the treatment of Mason type 1 radial head fractures, early mobilization is preferred, based on consistent evidence from several randomized, controlled trials (level of evidence, A).
- Casting appears to offer no benefit in the initial treatment of Mason type 1 radial head fractures (level of evidence, B), based on findings from a single randomized controlled trial.

Because non-surgical treatment of persons with intra-articular fractures increases the risk for complications, such as radiocarpal arthritis, a referral should be strongly considered for any fracture that extends into the radiocarpal joint or the distal radioulnar joint. ■

Urethritis in Young Men: More Questions Than Answers

Key point: Known pathogens were identified in fewer than 20% of young men with urethral symptoms.

Citation: Wetmore CM, Manhart LE, Golden MR. Idiopathic urethritis in young men in the United States: Prevalence and comparison to infections with known sexually transmitted pathogens. *J Adolesc Health*. 2009;45:463-472.

Urethritis, the most common syndrome affecting the male reproductive tract, is generally associated with sexually transmitted pathogens, but its epidemiology is not well described. To determine the prevalence of urethritis in young men, investigators analyzed data from 5,447 men (age range, 18-27; 77% white) who answered in-home questionnaires and underwent urine-based screening for sexually transmitted infections (STIs) as part of the National Longitudinal Study of Adolescent Health (Wave III).

On the day of the interview, 1.2% of men reported urethral symptoms in the past 24 hours (urethral discharge, 0.3%; dysuria or frequency, 1.0%; both symptoms, 0.2%), and 3.7% reported having symptoms in the past year.

Only 17.6% of those with current symptoms had known pathogens detected (*Neisseria gonorrhoeae, Chlamydia trachomatis, Trichomonas vaginalis,* and *Mycoplasma genitalium*).

Factors associated with significantly greater likelihood of testing positive for STIs were age ≤16 years at first vaginal intercourse (adjusted odds ratio, 1.81) and urethral symptoms in the past year (AOR, 3.61).

Factors associated with significantly *decreased* risk for a positive test were attendance in school and obtaining healthcare in the past three months (AOR, 0.66 and 0.67, respectively).

Factors associated with significantly greater likelihood for idiopathic urethritis (no organism identified) were STI diagnosis in the past year (AOR, 9.29) and either zero or one to four partners (AOR, 7.24 and 7.51, respectively).

The finding that no pathogen was detected in most men who reported current urethral symptoms, even though highly sensitive nucleic acid amplification tests (NAATs) were used, is striking. The authors suggest misclassification of cases, low sensitivity of NAATs in a non-STI clinic population with a lower organism burden, and no testing for *Ureaplasma urealyticum* (another possible but uncommon pathogen) as possible explanations.

Furthermore, the epidemiologic pattern of idiopathic urethritis did not follow that of traditional STIs. *The Centers*

for Disease Control and Prevention 2006 STD Treatment Guidelines emphasize the importance of confirming that urethritis is present (discharge, white blood cells on Gram stain, or positive first-void urine leukocyte esterase test) before treating, and of testing for gonorrhea and chlamydia if urethritis is not confirmed.

The data from this study support the wisdom of this approach.

[Published in *J Watch Pediatr Adolesc* Med, December 23, 2009—Alain Joffe, MD, MPH, FAAP.] ■

No Advantage Seen with IV Drugs at Out-of-Hospital Cardiac Arrest

Key point: Optimal resuscitation seems to corner on high-quality CPR (with minimal interruptions for anything, including drugs) and early defibrillation.

Citation: Olasveengen TM, Sunde K, Brunborg C, et al. Intravenous drug administration during out-of-hospital cardiac arrest: A randomized trial. *JAMA*. 2009;302:2222-2229.

A large randomized trial found that giving intravenous (IV) drugs like epinephrine and atropine in the setting of out-of-hospital cardiac arrest made it more likely that patients would be admitted to the hospital, but little difference in whether they survived to discharge.

That outcome was in spite of their undergoing resuscitation longer and receiving more defibrillations, and more often re-attaining a spontaneous circulation, compared with another group that didn't receive IV drugs during arrest.

The trial is only the latest of several in recent years to reappraise the efficacy of major elements of conventional cardiopulmonary resuscitation. While epinephrine administration has been part of the guidelines for resuscitation for many years, there has been very little evidence supporting its benefit and some convincing evidence suggesting worse outcomes with higher doses of epinephrine.

Table 1. Outcomes of Resuscitation in Out-of-Hospital Cardiac Arrest, with and without IV Drug Access

End point	IV drugs (%), n=418	No IV drugs (%), n=433	OR (95% CI)	*p*
Return of spontaneous circulation	40	25	1.99 (1.48-2.67)	0.001
Hospital admission	43	29	1.81 (1.36-2.40)	0.001
Survival to hospital discharge (this was the primary endpoint)	10.5	9.2	1.16 (0.74-1.82)	0.61

Nor was there a significant difference for the primary endpoint in an analysis that controlled for response time, whether the arrest occurred in a public place or was witnessed, or whether ventricular fibrillation was the initial rhythm.

The trial has a number of limitations, the group notes, including the inability to blind emergency responders to the randomization and the involvement of a single emergency-response system. It also doesn't preclude the potential usefulness of other IV drug regimens. ■

Looking Beyond Group A β-hemolytic *Streptococcus* in Pharyngitis

Key point: *Fusobacterium necrophorum* causes endemic pharyngitis at a rate similar to that of group A β-hemolytic *Streptococcus*.

Citation: Centor RM. Expand the pharyngitis paradigm for adolescents and young adults. *Ann Intern Med*. 2009;151(11):812-815.

Current guidelines and review articles emphasize that clinicians should consider group A β-hemolytic *Streptococcus* in the diagnosis and management of patients with acute pharyngitis. Recent data suggest that in adolescents and young adults (15 to 24 years of age), *Fusobacterium necrophorum* causes endemic pharyngitis at a rate similar to that of group A β-hemolytic *Streptococcus*.

On the basis of published epidemiologic data, *F necrophorum* is estimated to cause Lemierre syndrome (a life-threatening suppurative complication) at a higher incidence than that at which group A *Streptococcus* causes acute rheumatic fever. Moreover, these estimates suggest greater morbidity and mortality from Lemierre syndrome.

The diagnostic paradigm for adolescent pharyngitis should, therefore, be expanded to consider *F necrophorum* in addition to group A *Streptococcus*.

Expanding the pharyngitis paradigm will have several important implications. Further epidemiologic research is needed on both *F necrophorum* pharyngitis (especially clinical presentation) and the Lemierre syndrome. Clinicians need reliable diagnostic techniques for *F necrophorum* pharyngitis.

In the meantime, adolescents and young adults who develop bacteremic symptoms should be treated aggressively with antibiotics for *F necrophorum* infection. Physicians should avoid macrolides if they choose to treat *Streptococcus*-negative pharyngitis empirically.

Finally, all clinicians who treat younger patients should know the red flags for adolescent and young adult pharyngitis (specifically, worsening symptoms or neck swelling—especially unilateral neck swelling). ■

Building Urgent Care Referral Relationships Part 2: EDs, PCPs, and Specialists

Urgent message: Forging solid relationships with other clinicians in emergency, primary care, or specialty settings can help facilitate two-way referrals and prove beneficial to all parties involved—including patients. The second of two parts.

Alan A. Ayers, MBA, MAcc

Overbooked primary care offices and time-consuming (not to mention costly) trips to the emergency room leave many patients frustrated and feeling they have no place left to turn when a medical condition requires immediate attention but is not an emergency.

With its record of improving medical outcomes, reducing costs, and saving time for patients, urgent care is ideally suited to be the solution of choice for these patients—assuming they know to go there.

Establishing referral relationships with emergency departments, primary care, and medical specialists is an important tactic in building urgent care volume and establishing urgent care as an access point to the tertiary healthcare system.

Reasons for Increased Utilization of Emergency Rooms

Hospital emergency departments are designed for trauma and resuscitation. They are also an entryway for hospital admissions; due to Emergency Medical Treatment and Active Labor Act (EMTALA)[1] requirements that EDs evaluate all patients, they provide a healthcare "safety net" for society.*

Emergency rooms in the United States are overwhelmed, however. Over the past 10 years, per capita utilization of EDs has increased 18%, and median wait times there have increased 50%, while the percentage of ED patients suffer-

*EMTALA applies primarily to hospital emergency rooms but may also apply to an urgent care center on a hospital campus under limited circumstances. EMTALA requires emergency rooms to provide a screening examination to determine whether an emergency condition exists and (a) if an emergency condition exists, the facility must treat it to the best of its capabilities, or (b) if an emergency condition does not exist, the facility has no further obligation to treat the patient under EMTALA.

ing "true" medical emergencies has fallen by 32%.[2] Today, only 18% of ED visits are classified as "medical emergencies."[2]

While casual observers correlate this increase in utilization for non-emergent conditions with rising numbers of uninsured, studies show that decreased access to primary care for all patients is to blame. In fact, only 14% of ED visits involve patients without health insurance.[3] Considering that 59% of ED patients regularly receive care from a physician's office,[3] it's apparent that many insured consumers use the ED when they cannot get an appointment with a traditional office-based physician.

"Even when a patient sees a doctor regularly, only 29% of primary care physicians have made arrangements for after-hours care."

The reality is that the ED appeals to consumers because of its walk-in convenience, 24-hour/365-day operating hours, and perceptions that hospitals have more advanced capabilities than doctors' offices.

Do Emergency Rooms Want Low-acuity Patients?

Despite operational challenges, many hospitals advertise that they treat low-acuity patients in their emergency departments—sometimes with wait time or service guarantees.

According to the American College of Emergency Physicians, crowding is not due to non-emergent patients seeking care in the ED. Rather, the practice of "boarding"—holding patients who have been admitted to the hospital in ED beds—is responsible for delays in care, ambulance diversion, medical errors, negligence claims, and financial losses to ED physicians.[4]

So even if non-emergent patients have to wait, they can be profitable to a hospital if there is facility capacity and staff available because the cost of treating one additional patient in the ED is relatively low. Cash and insurance payments subsidize emergency department write-offs to Medicaid and charity care. And emergency room visits frequently result in downstream revenue for a hospital's affiliated specialists.

Hospitals, however, take exception to low-acuity patients when the emergency department is operating at or over capacity, when patients utilize the ED frequently for non-emergent conditions, and when patients cannot or will not pay their bills.

Urgent Care as a Solution to ED Woes

Studies indicate that 80% to 85% of emergency department patients could be treated in a lower acuity setting,[5] and urgent care centers offering x-ray and performing minor procedures like casting and suturing are capable of seeing moderately complex ER cases. Shifting the working uninsured to urgent care can also help an ED reduce its financial write-offs; while many uninsured patients cannot afford $600 or more incurred with an ED visit,[6] they can come up with $100 for urgent care.[7]

A good start is to raise awareness among emergency room nurses and registration staff that the urgent care is available. Although EMTALA requires a medical evaluation, which limits pre-triage referrals to urgent care, it's not uncommon for overworked ED staff to tell patients, "You know, a lot of people are going to the urgent care located at such and such address…," giving the patient the opportunity to act likewise.

Other emergency rooms place urgent care literature at their front desk or in their waiting room. And triage staff who determine a patient is non-emergent—and thus exempt from continued treatment under EMTALA—may refer patients to urgent care as a more affordable option. Direct referrals to the urgent care center also come from emergency physicians for follow-up care.

Because urgent care is not occupied with medical emergencies, it's often better positioned to tend to the details of work-related injuries. For example, many employer accident protocols require a drug screening at the first report of an injury. Not only does an ED's high overhead make drug screening unprofitable, but the paperwork is impractical for ED nurses juggling trauma and resuscitation. Urgent care can offer more focused attention and lower costs to employers in occupational medicine.

Table 1 describes urgent care referral occasions and next steps for developing a referral relationship with a hospital emergency department. Demonstrating the benefits urgent care brings to the hospital in terms of relieving excess volume, reducing write-offs, and generating downstream referrals to hospital management is key to making a convincing case.

Primary Care Shortages Anticipated

"Primary care" refers to healthcare providers—family practice, internal medicine, and pediatricians—who act as a first point of consultation and provide longitudinal

Table 1: Urgent Care Referral Occasions and Next Steps for Emergency Departments

Urgent care supports hospital EDs by:	To develop a referral relationship with a hospital ED:
• reducing non-emergent caseload to alleviate wait times and demands on staff. • providing a more affordable alternative to patients without health insurance, reducing uncollectible receivables. • providing follow-up care for initial emergency room visits. • handling overflow during seasonal or epidemic volume surges. • providing services involving detailed protocols or distinct payors such as workers compensation programs. • referring medical emergencies, automobile accidents, and reportable cases to the hospital's emergency room. • referring urgent care patients to the hospital's affiliated specialists and diagnostic facilities.	• identify hospitals within a 10-minute drive of the center and evaluate each ED's positioning in terms of reputation, wait times, advertising, clinical capabilities, and physical facility. • schedule a face-to-face meeting with the hospital's emergency director or chief operating officer to introduce the urgent care center and its capabilities. • assess challenges facing the ED that urgent care can resolve; focus on immediate needs like seasonal flu surge, as well as systemic problems like overcrowding and financial write-offs. • promote the benefits of urgent care to the hospital, such as the downstream referrals urgent care provides to diagnostic, specialist, and rehabilitation services. • secure commitment that the hospital will refer low-acuity insured and/or cash pay patients to urgent care, communicate the availability of urgent care to front-line clinical and operations staff, and place urgent care marketing materials at the ED registration desk, literature stand, and triage area. • set a schedule for follow-up to assess the relationship, improve processes and communication, and replenish marketing materials.

care for patients with chronic illnesses like diabetes, hypertension, and chronic obstructive pulmonary disease (COPD).

Like emergency rooms, many primary care offices are overwhelmed. Not only is primary care coping with falling reimbursement, but patients are aging with increased incidence of lifestyle-induced illness, and the United States is facing a labor shortage of primary care providers.

As a result, it can take weeks or months for a patient to get an appointment, and many practices are not accepting any new patients at all.

According to the American Academy of Family Physicians, by 2020, the U.S. will face a shortfall of 39,000 family physicians.[8] Considering that <2% of medical school students express an interest in generalist fields; the number of nurse practitioner graduates is falling by 4.5% per year; and there will be 25% fewer physician assistant graduates in 2020 than today, access to primary care will become increasingly constrained.[8] Even when a patient sees a doctor regularly, only 29% of primary care physicians have made arrangements for after-hours care.[9]

Such lack of convenient access to primary care is causing greater numbers of patients to seek treatment from hospital emergency rooms.[3]

Urgent care can provide continuity of care when patients are unable to get an appointment with their regular doctor, however. Differentiating "episodic" from "longitudinal" care, the urgent care center can augment the primary care office by accepting capacity overflow and after-hours referrals. For example, if a pediatrician's office closes during Spring Break, it may leave a message on its answering machine and a sign on its door directing patients to the urgent care center.

Likewise, a family practice may find it impractical to maintain a certified laboratory and refer patients to urgent care for collections and testing. Urgent care can also support primary care with imaging and surgical procedures that may be too expensive to perform in a doctor's office. Primary care patients who present at the urgent care center—and sign a release form—will have their medical chart forwarded to the primary care office for inclusion in their permanent record.

The key is for the urgent care operator to gain the trust of the primary care provider by clearly explaining services offered, communicating patient visits and progress (with patient consent), and helping the primary care provider build a high-quality panel of patients by referring urgent care patients with longitudinal needs. **Table 2** describes the value and next steps in developing reciprocal primary care referral relationships.

Medical Specialists as an Urgent Care Resource

Urgent care centers encounter many patients requiring additional care beyond the center's capabilities. Common specialist referrals include general and specialized surgery, dermatology, gynecology, podiatry, and orthopedics. Being connected to a network of medical special-

Table 2: Urgent Care Referral Occasions and Next Steps for Primary Care

Urgent care supports primary care practices by:	To develop a referral relationship with a primary care practice:
• accepting "overflow" volume when the primary care office is at capacity. • providing coverage during evenings, weekends, vacations, and holidays when the primary care office is closed. • providing services not routinely offered in a doctor's office, including x-ray, lab testing, and medical procedures such as suturing and casting. • providing services involving detailed protocols or complex payors such as workers compensation. • referring patients with chronic illness—such as diabetes or hypertension—who require longitudinal care in a "medical home" to the primary care office.	• identify independent and group primary care offices within a 10-minute drive of the center, compare insurance plans, and assess whether new patients are accepted, the availability of non-scheduled appointments, and number of days to get an appointment. • become acquainted with the primary care physician(s) personally in an informal setting, such as a breakfast gathering. • explain the scope of services and operating model of the urgent care center, including capabilities for lab, x-ray, and medical procedures. • assess the services offered by the primary care practice related to specific chronic conditions, including specialist relationships and hospital admitting privileges. • agree upon a process for communicating patient progress and follow-up, such as forwarding a copy of the patient's chart (with consent) or scheduling recheck appointments. • provide maps and other marketing collateral to facilitate primary care referrals to the urgent care center. • set a schedule for follow-up to assess the relationship, improve processes and communication, and replenish marketing materials.

ists increases the urgent care center's relevance as a point of triage; when patients do not know where to go, they know they can rely on urgent care to get them to the appropriate provider.

In order for urgent care to effectively function as "front door" to the healthcare system, however, processes and systems to facilitate referrals must be in place. The ability to schedule a patient's appointment with a medical specialist before they leave the urgent care center is much more effective than leaving the patient to find his/her own specialist. This requires the urgent care provider to maintain a listing of specialists who are accepting new patients, to understand insurance network affiliations and limitations, and to have ready access to the specialist's schedule.

Urgent care may also benefit from referrals from specialists. For example, some urgent care centers provide pre-surgical physical examinations or post-surgical rehabilitation. An obstetrics practice may refer pregnant women to the urgent care for conditions not involving the fetus, while an orthopedist may display the urgent care center's marketing material in his or her waiting room to raise awareness in the community.

Summary

Urgent care is a vital part of a community's healthcare system, but in order to function fully, urgent care must be connected to other healthcare providers and facilities. Establishing mutually beneficial referral relationships can help an urgent care center increase its own visits, alleviate capacity issues in primary and emergency care, and brand urgent care as an access point for medical specialists. ■

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Note: This article is part 2 of a two-part series on building referral relationships for urgent care. Part one described urgent care referral sources and downstream providers, including pharmacies and retail health clinics. It is available in the Past Issues Archive section of the JUCM *homepage,* www.jucm.com.

Make Connectivity Part of Your Marketing Strategy

FRANK H. LEONE, MBA, MPH

We live in an entirely new business world these days: a world in the midst of rapid change and new rules. Three words seem to embody this new reality:

- *leverage*
- *integration*
- *alliances.*

These three words apply well to urgent care clinic sales and marketing. They can also be viewed as essential to the concept of connectivity.

Here, we will review how connectivity can be used to enhance an urgent care clinic's occupational medicine sales and marketing practices.

Leverage

Given that your clinic has—or will soon have—an external contact base, the question becomes how you can best leverage these relationships to expand your book of business.

Here are some ways that you might gain leverage from existing relationships:

1. Ask supportive human resource directors at client companies to send an e-mail blast to other human resources directors recommending your clinic. You could even provide them with a sample "script" to jumpstart the process.
2. Obtain *personal* e-mail addresses from the main contacts at your client companies. With job turnover in excess of 20% annually, chances are that many of your best contacts will be "here today/gone tomorrow." Staying in touch via personal e-mail positions your clinic to cultivate a relationship with your contact's next employer.
3. Send an e-mail to multiple people within your own clinic organization asking them for the names/e-mails of appropriate contacts they may have with local employers. Or, depending on your colleagues' seniority and dependability, you might even ask them to call/e-mail contacts on your behalf.
4. Leverage your own organization's directors. Board members tend to be well-connected and respected, and to know a disproportionate number of CEOs. Ask board members if they are willing to send an e-mail (or letter, or make a phone call) to several of their best business contacts.

Frank Leone is president and CEO of RYAN Associates and executive director of the National Association of Occupational Health Professionals. Mr. Leone is the author of numerous sales and marketing texts and periodicals, and has considerable experience training medical professionals on sales and marketing techniques. E-mail him at *fleone@naohp.com*.

Integration

In recent years, many new services have been integrated into the occupational health fabric, and urgent care providers have increasingly aligned with other provider groups to offer more synthesized and packaged services.

I believe that we are poised for yet another phase, in which vastly more services will be packaged within the typical occupational health umbrella, and considerably more innovative delivery systems will emerge.

Breadth of Services

An occupational health component within an urgent care clinic that limits itself to traditional core clinic services is unlikely to prosper. Yet these core services do provide a clinic with an instant client base and a platform upon which to add other services.

In many cases, appropriate add-on services may already be offered piecemeal. The list of potential services is almost limitless, including women's health, sports medicine, and a galaxy of wellness services. However, clinics often sacrifice compelling economies of scale (and their associated savings in unnecessary expenses) by offering many potentially related services independently of one another. Considerable

Continued on page 34

'Sorry' Shouldn't Be the Hardest Word

JOHN SHUFELDT, MD, JD, MBA, FACEP

The following movies, in my opinion, are non-starters on first dates. In no particular order:

- *Sophie's Choice* (tragic)
- *Schindler's List* (depressing)
- *The Exorcist* (freaky)
- *The English Patient* (mind-numbing boredom)
- *Terms of Endearment* (heart-wrenching)
- and finally, *Love Story* (sappy).

You may, if you were born before 1960, remember the tagline and memorable quote in *Love Story*: "Love means never having to say you're sorry."

Oh please, even in 1970, when I was 10-years-old, I knew that was a bunch of crap. Maybe that holds true in the Walton's house; however, growing up in my family, not saying you're sorry was a quick way for me to get my ass kicked by my sister.

Medical providers in the past were much like Jennifer Cavalleri (Ali MacGraw) in *Love Story*. Medical errors, like love, meant you should never say you're sorry.

Well, to quote, Bob Dylan, "The times they are a-changin'." Many states have enacted the so-called "I'm sorry statute" which protects providers (with caveats) who apologize for medical errors. Today, more than 20 states have adopted some version of an I'm Sorry statute.

Even though the various state I'm Sorry laws have marked differences, they all attempt to permit healthcare providers to make an apology to patients and their families for errors without trepidation that their admissions will be used against them in court as admissions of their accountability.

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Virginia's version of the law provides:

> "In any civil action brought by an alleged victim of an unanticipated outcome of healthcare, or in any arbitration or medical malpractice review panel proceeding related to such civil action, the portion of statements, writings, affirmations, benevolent conduct, or benevolent gestures expressing sympathy, or general sense of benevolence, which are made by a healthcare provider or an agent of a healthcare provider to the patient, a relative of the patient, or a representative of the patient shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest. A statement of fault that is part of or in addition to any of the above shall not be made admissible by this section."
>
> *Va. Code § 8.01-581.20:1 (2006).*

This statute, as well as others like it, permits a healthcare provider to apologize for a medical error without having that admission used as an admission of liability in a medical malpractice case. There is, however, one very important caveat: an admission of *fault* is admissible as a statement against interest in a medical malpractice case.

For example, a physician I know wrote the following note to a patient after the patient was subsequently diagnosed with a stroke post-discharge from the emergency department: "I am sorry I did not accurately asses (sic) you and correctly diagnose you (sic) stroke. I have never missed a stroke in the past, and will never fail to make an accurate diagnosis of stroke again."

Spelling errors not withstanding, he admitted fault in this letter and, no surprise, was served with a lawsuit about 15 days after he mailed the apology to the patient. The complaint

savings are possible through more centralized delivery and a more synergistic approach to sales and marketing.

General branding

Branding or creating a common brand name across multiple offerings within a clinic or clinic network in order to enhance the brand name provides a "halo effect" for each delivery component. Yet urgent care clinics often get in the way of pulling related services together by offering them separately even though they are branded similarly; this is an inherent contradiction in terms.

Branding, of course, is a good idea and an occupational health component is an ideal setting for pulling together and leveraging multiple services under a common banner. It is another example of effective integration.

New Alliances

Economic recessions tend to trigger new alliances, and a deep recession renders even more creativity in developing such alliances.

Alliances can be with other healthcare institutions (e.g., a local specialty group), non-institutional healthcare players (e.g., the local chapter of the American Heart Association), or even organizations outside of healthcare (e.g., the Chamber of Commerce).

Well-conceptualized alliances create win-win scenarios. Often, one organization can provide skills or expertise that the other lacks. Or, the alliance can generate economies of scale in such areas as sales and marketing, in which you basically double down on your sales and marketing effort.

Further, an alliance offers an opportunity to merge each organization's client or prospect base, thus creating a considerably larger and highly qualified client universe.

The aforementioned halo effect applies to alliance building, as well. For example, assume your clinic has created an alliance with the local Chamber of Commerce to jointly sponsor a community-wide wellness initiative. In most cases, the Chamber name would add credibility to your clinic name and your clinic would inherit much of the goodwill that the Chamber name is likely to represent in your community.

In sum, it would be foolhardy for most urgent care clinics to cast their lot with the old 1990s "go it alone" strategy. Challenging times call for innovative solutions. As we enter the second decade of the millennium, organizations that master leverage, integration, and alliance building are poised to significantly increase their likelihood of success. ■

had his photocopied note attached as an addendum.

What he should have written or said to the patient is, "I am sorry that you suffered a stroke and all the problems which go along with that condition." He may have even gone on to say, "We did everything medically indicated to rule out a stroke in the emergency department; however sometimes these can be very subtle or manifest themselves after a few days, which is why we caution you to follow up with your primary care doctor."

The other small issue he had was that he sent the later on April 15, and the law did not go into effect until July 1. Who knew?

To be effective, an apology should be:

1. heartfelt
2. genuine
3. remorseful
4. fully disclosed.

Here is the rub: medical providers should apologize as soon as the error is known, admit responsibility, not deflect blame, communicate all known information clearly and without medical jargon, and not make excuses. Statutes like the aforementioned do not protect providers who admit fault. Consequently, there is an inherent tension between offering a heartfelt, sincere apology and not hanging yourself out to dry.

If an apology is warranted, consider the following:

- Use an appropriate setting. Do not sit across from the patient or their family. Having a desk or table between you creates a barrier. Instead, sit on a couch next to the patient or pull your chair up so that you can sit side-by-side.
- Body language speaks clearly. Do not sit with your arms folded across your chest or your legs crossed. Again, this creates a barrier and appears defensive.
- Touch the patient when appropriate. Use your judgment; if you do touch the patient, be mindful of where your hand falls. Restricting the area you touch to an area between the elbows and hand is safe.
- Offer the patient the ability to manage the encounter. For example, let them choose the time to come discuss and also allow them to bring others into the discussion if appropriate.
- Don't make excuses. Excuses do not sit well with most people, and give the appearance that you are not sincere. Saying, "If the lab had not screwed up your results, this would have never happened" is not an apology.

At the end of the day, a sincere and honest apology is an appropriate way to begin the process of resolving untoward outcomes. However, before venturing down the path, consult with your attorney and your medical malpractice carrier. They will undoubtedly know the laws in your state and will be able to offer clear guidance on how best to offer an apology. ■

CODING Q&A

Coding for Two Visits in One Day, Billing for Atypical Urgent Care Services, and Billing on the UB-04

DAVID STERN, MD, CPC

Q. The patient in question is a new patient to the urgent care. At 10 a.m., she visited the urgent care with chief complaint of cough, headache, and myalgias. She was discharged home with a final diagnosis of cough and prescriptions for ibuprofen and cough syrup. At 3 p.m., she returned with a complaint of headache and was treated with IM headache medications and sent home with a diagnosis of headache with pain meds.

How do we code such two visits by a new patient on the same day? I had coded the initial visit with a new-patient level code and the subsequent visit on the same day as an established patient.

– Radhika Sitaram, Bangalore, India

A. Only one E/M is allowed per day for any given patient. In your example, the documented history, physical exam, and complexity of medical decision-making for both visits should be combined; and the resulting new-patient E/M code (99201-99205) should be billed along with appropriate procedures and supplies. The two encounters are billed as a single encounter for that date.

Q. Can CPT codes 99381-99397 (preventive visit, established, ages vary by code) be used for urgent care? If not, when are they applicable?

– Question submitted by Eureka Haney, Southwest Medical Billing, San Jacinto, CA

David E. Stern, MD, CPC is a certified professional coder. He is a partner in Physicians Immediate Care, operating 12 urgent care centers in Oklahoma and Illinois. Stern serves on the Board of Directors of the Urgent Care Association of America and speaks frequently at urgent care conferences. He is CEO of Practice Velocity (*www.practicevelocity.com*), providing urgent care software solutions to more than 500 urgent care centers. He welcomes your questions about coding in urgent care.

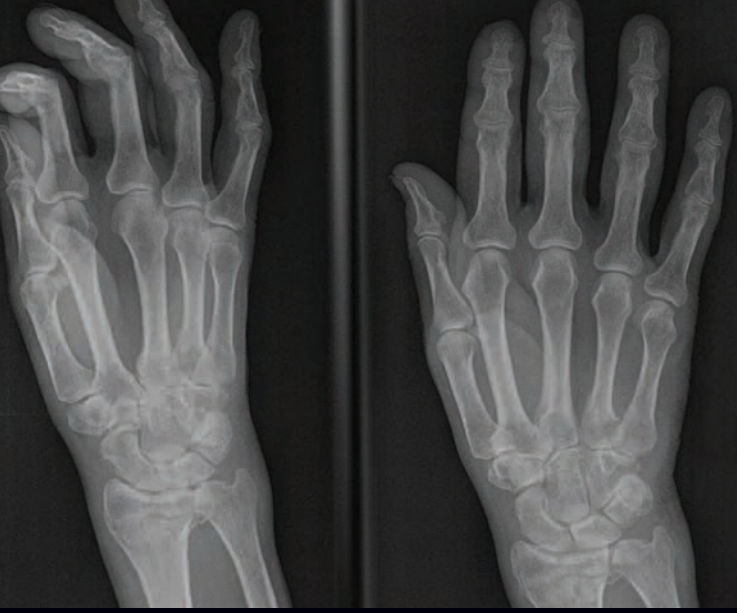
A. This question is more a scope-of-practice question than a true coding question. Generally, urgent care centers may perform any services that may otherwise be performed in a physician office. In regard to these codes, they are typically used in a primary care setting, and some urgent care centers do offer primary care services.

The business of urgent care does not usually involve these comprehensive medicine evaluations and management services. If an urgent care center decides to perform such services, it is generally legal to do so. Unless an urgent care center is forbidden by state statute (and I am not aware of any such laws) or managed care contract from performing comprehensive medicine evaluations and management or from performing routine primary care medicine, then the urgent care center may perform these services.

When an urgent care center performs primary care services, it is important for both provider and patient to be clear on what obligations for follow-up, on-call services, and hospital admissions are to be provided. Providers should seek legal advice as to their obligations under federal and state statutes and rules.

For Medicaid preventive services, states operate under the federal Medicaid program Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); each state may require specific (and/or unique) codes for billing under this program.

For non-Medicaid commercial insurers, the evaluation and management CPT codes for preventive medicine services are coded for the basic service (history, physical examination, and counseling/anticipatory guidance). Report separately CPT codes, as appropriate, for additional screening (hearing, vision, and development), laboratory services, and immunization administrations.



Share Your Insights

At its core, ***JUCM**, The Journal of Urgent Care Medicine* is a forum for the exchange of ideas and a vehicle to expand on the core competencies of urgent care medicine.

Nothing supports this goal more than **Insights in Images**, where urgent care practitioners can share the details of actual cases, as well as their expertise in resolving those cases. After all, in the words of UCAOA Executive Director Lou Ellen Horwitz, everyday clinical practice is where "the rubber meets the road."

Physicians, physician assistants, and nurse practitioners are invited to submit cases, including x-rays, EKGs, or photographic displays relating to an interesting case encountered in the urgent care environment. Submissions should follow the format presented on the preceding pages.

If you have an interesting case to share, please e-mail the relevant images and clinical information to *editor@jucm.com*. We will credit all whose submissions are accepted for publication.

JUCM
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CODING Q & A

Q. We operate an urgent care center. On the UB-04, we are using place-of-service code 831, which I know is for an ambulatory surgery center (ASC). I have looked into it and feel that my provider should be using a 731 (Clinic/FQHC/Admit through discharge). Could this be the reason for our many denials that state we are not an ASC? Are we using the wrong POS?

– Question submitted by Kayla Deaver

A. The UB-04 form has replaced the old UB-92 form. It is used for facilities that qualify to bill separate facility fees. This form does not use the same place-of-service (POS) codes as the CMS-1500 form. The code that you are describing is the type-of-bill (TOB) code, which is placed in Form Locator 4 in the top right-hand corner of the paper UB-04 form.

Yes, this TOB code is the likely source of your denials that state you are not an ASC. Code 831 is specifically for use in a "Special Facility or Hospital ASC/ASC for Outpatients/Admit Through Discharge."

The term "special facility" is confusing. Most payors seem to ignore the "special facility" term, and apply this code only to ambulatory surgery centers. You are definitely not an ASC, so you should not use a code for ASCs.

Depending on your situation, you might use one of the following TOB codes on your UB-04:

- 131 Hospital/Outpatient/Admit Through Discharge
- 711 Clinic/Rural Health Clinic (RHC)/Admit Through Discharge
- 731 Clinic/FQHC/Admit Through Discharge

UB-04 billing is appropriate if your center is part of a Rural Health Clinic (RHC) or a Federally Qualified Health Center (FQHC). Hospital-owned urgent care centers should seek legal advice to determine whether the urgent care qualifies as a "hospital/outpatient" facility. If none of the above TOB codes apply to your facility, then it is likely that your urgent care center does not qualify to bill on the UB-04.

Many simple outpatient practice management systems cannot bill UB-04 claims. Thus, if you need to bill on a UB-04, then you need to select urgent care billing software that can bill UB-04 claims. ■

Disclaimer: JUCM and the author provide this information for educational purposes only. The reader should not make any application of this information without consulting with the particular payors in question and/or obtaining appropriate legal advice.

Career Opportunities

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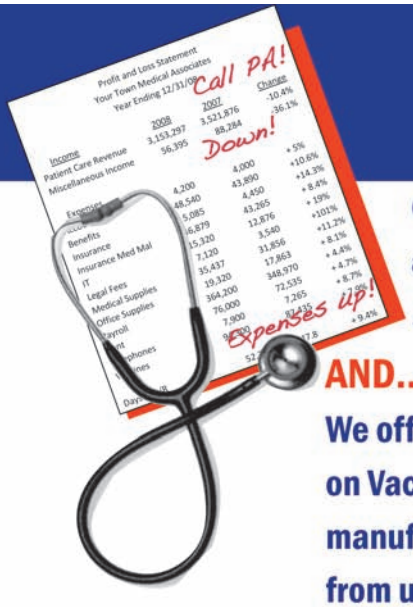

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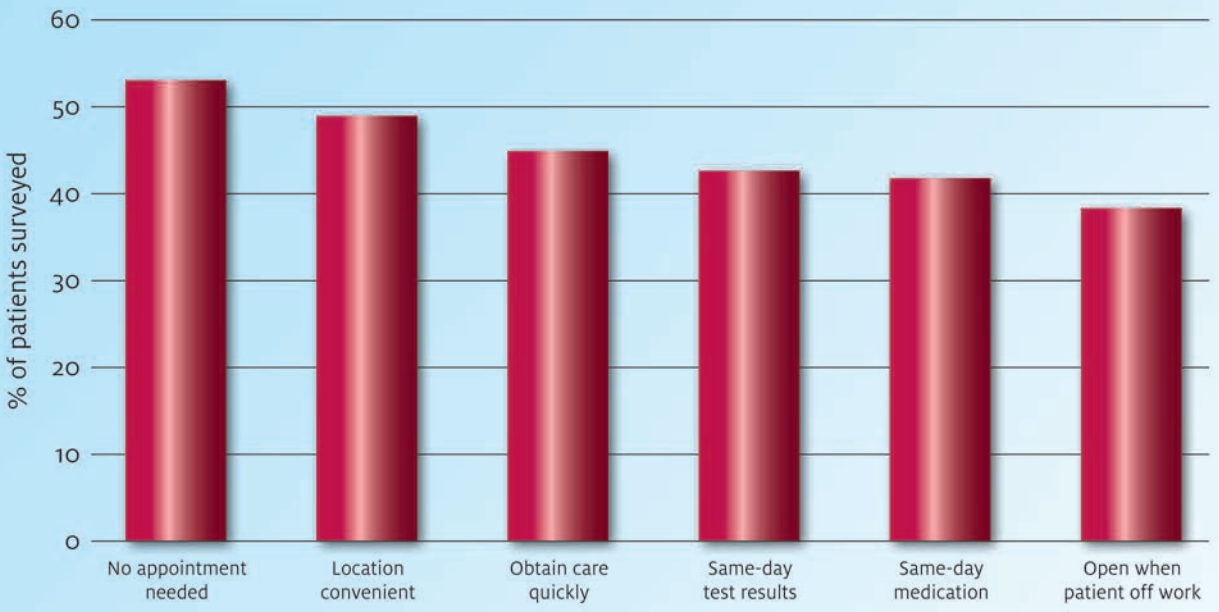
Website Design

DEVELOPING DATA

In each issue on this page, we report on research from or relevant to the emerging urgent care marketplace. This month, we share insight into the most common reasons patients choose to visit an urgent care center. These data reflect the results of a cross-sectional survey of 1,006 patients who visited an urban urgent care clinic.[1]

REASONS PATIENTS CHOSE URGENT CARE



Reasons named by less than 40% of patients included:

- transportation available at that time
- told to come by outside medical provider
- told to come by friend or relative
- no payment necessary at time of visit.

The authors concluded that "this study suggests that patients choose the urgent care setting based largely on convenience and more timely care."

Does your marketing message speak to this rationale? (And, more importantly, would patients who have visited your facility tell their family, friends, and coworkers they received convenient, timely, and highly competent care?)

Reference

1. Scott DR, Batal HA, Majeres S, et al. Access and care issues in urban urgent care clinic patients. *BMS Health Services Research.* 2009;9:222. Available at: *www.biomedcentral.com/1472-6963/9/222.*

If you are aware of new data that you've found useful in your practice, let us know via e-mail to *editor@jucm.com*. We'll share your discovery with your colleagues in an upcoming issue of *JUCM*.

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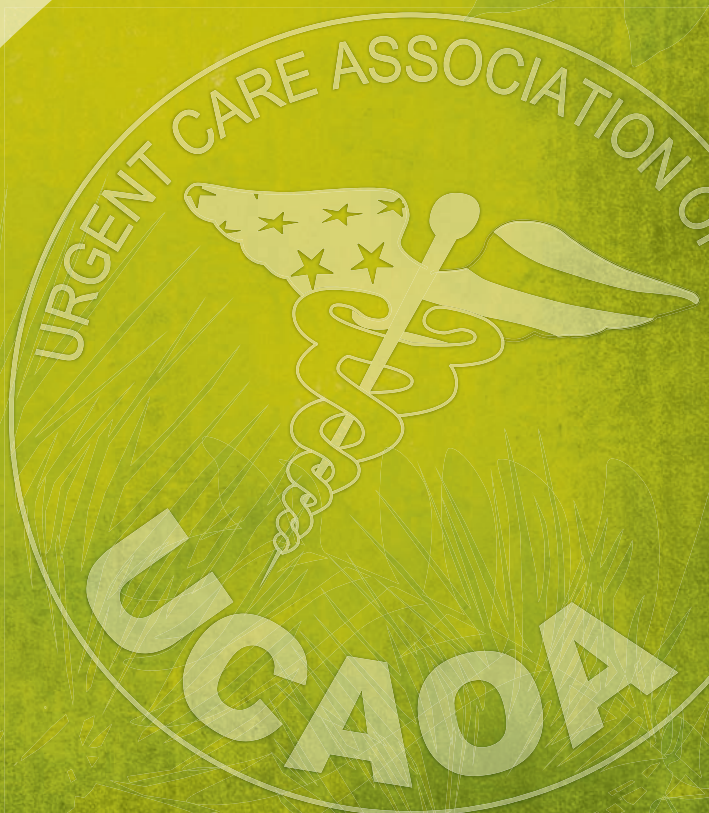

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