

JUCM™

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Urgent Care
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of America



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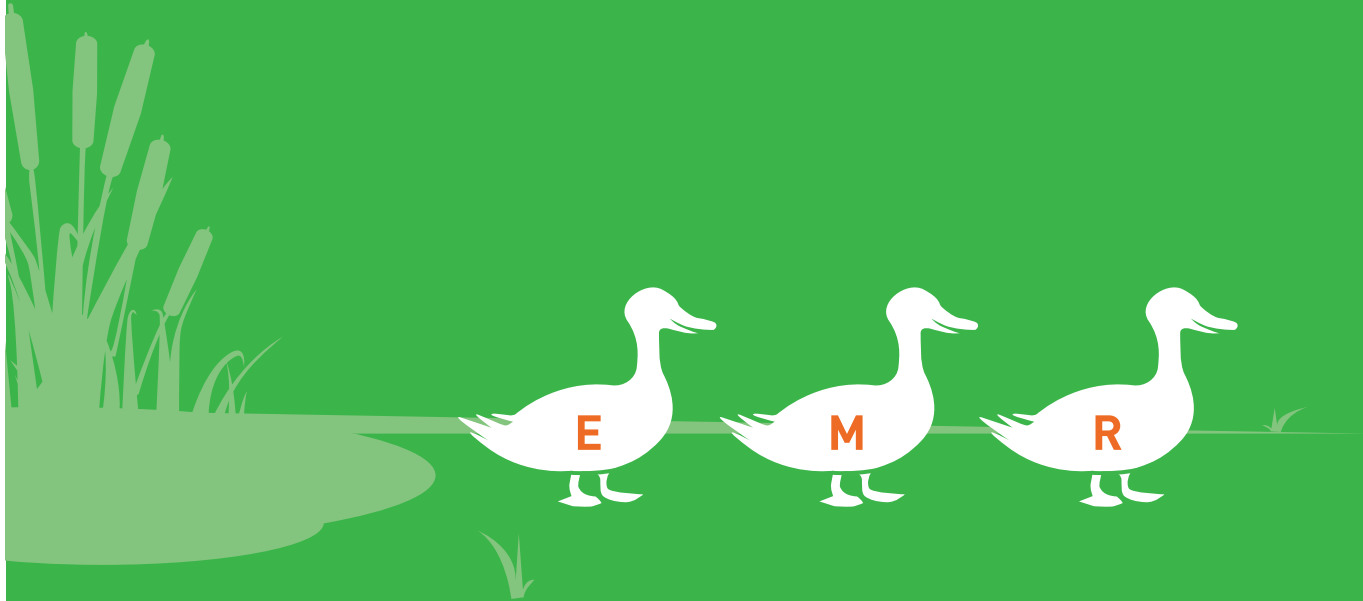
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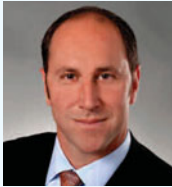
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LETTER FROM THE EDITOR-IN-CHIEF

Where Do We Go From Here?



As I was writing this column about visioning for the new year in urgent care, I couldn't help but think of the Alan Parsons Project tune, "Where Do We Go From Here?" Opportunity abounds but risk remains, and there are gaps, so we must not pursue opportunity blindly. Consider the following:

Urgent Care Achievements

- Strong organized medicine representative (UCAOA and its branches)
- Proven, stable trade association (UCAOA)
 - Conferences
 - Education
 - Vendor community
 - Member community
 - Benchmarking
- Creation of appropriate support organizations
 - Urgent Care College of Physicians (UCCOP)
 - Physician-led society (of utmost importance to specialty development goals)
 - Clinical training and education
 - Urgent Care Foundation (UCF)
 - Mission to support education and research on behalf of the discipline and industry
 - Fellowships
 - Clinical and health services research that demonstrates the contributions and value of urgent care in the health care delivery system and within the "House of Medicine."
- JUCM, *The Journal of Urgent Care Medicine*
 - The only peer-reviewed journal in the discipline
 - Uninterrupted monthly publication for the last 7 years
 - A critical forum for both clinical and management aspects of urgent care
- Fellowships in Urgent Care Medicine
 - 8th year of the only clinical specialty training programs
 - Supported and accredited by UCAOA / UCCOP
 - Critical to any specialty development initiative

Urgent Care Gaps and Shortfalls

- UCAOA / UCCOP
 - Lack of quality volunteer army ready to invest the time and donate their expertise on behalf of the discipline and industry

- Member and vendor involvement a must
- Slow growth of individual memberships
 - We only have strength in numbers, and even passive participation is important.
- Muted national health care voice
 - PR/media campaign is needed
 - Political Action Committee/lobbying activities are out of reach financially without significant member/vendor support and organizational initiative

■ JUCM

- Need for quality contributions (articles / research) from the urgent care community, which are very much appreciated but hard to come by.
- Need for advertising support for future growth.

■ Research and Education

- No nationally published research to date, a much-needed megaphone for the urgent care story. Without it, we have no voice.
- Need for an accelerated and generous investment from the urgent care community to support the critical mission of the Urgent Care Foundation.
- Stagnant fellowship growth. Without more fellowships, we cannot generate recognition as a developing specialty.
- Foundation must raise money to support fellowships.

UCAOA and its many branches create the foundation for our discipline and the urgent care industry. We cannot succeed, and perhaps, not even survive without a strong foundation. If we don't rally as an urgent care community with open wallets and a volunteer spirit, we will all be sitting on a house of cards. Get started today by exploring member and vendor opportunities at www.ucaoa.org, www.uccop.org, www.urgentcarefoundation.org, and www.jucm.com. ■

Lee A. Resnick, MD
Editor-in-Chief
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CLINICAL

9 Management of Ocular Complaints in Urgent Care: Part 1

Triage of eye conditions in urgent care to ensure the best patient outcome requires knowing what equipment to use and understanding when to refer to an ophthalmologist. Always remember to document acuity of vision in all patients presenting with an eye complaint.

Sarvotham Kini, MD

PRACTICE MANAGEMENT



16 Identifying Risks and Finding Shelter in an Urgent Care Compliance Program

The escalating pressure on the industry to decrease health care costs has resulted in an increase in audit activity from government and private payors for everything from billing and coding to HIPAA and kickbacks. Therefore, it's more important than ever for urgent care centers to build a culture of compliance.

Damaris L. Medina

CASE REPORT

21 Dilute Proparacaine

The use of dilute proparacaine appears to be a safe and cost-effective way to treat the pain associated with many acute corneal injuries.

Jacqueline Dancy, PA-C, MPAS



IN THE NEXT ISSUE OF JUCM

In next month's cover story, we round out our discussion of eye care in the urgent care setting with expert advice on management of subconjunctival hemorrhage, uveitis, iritis, keratitis, acute angle closure glaucoma, and eyelid conditions. Part 2 of our series on ocular complaints includes a wealth of photos to assist with differentiation of benign versus vision-threatening conditions and it underscores the importance of documenting visual acuity and knowing when to refer to a specialist to ensure that a patient's vision is preserved.

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

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This month's cover story—the first of a two-part series—is designed to equip urgent care providers with the information they need to identify the most common eye complaints, distinguish between benign and sight-threatening conditions, and determine when to treat and when to refer to an ophthalmologist to ensure a good outcome. Patients with ocular problems often present to urgent care centers, yet the capacity to provide high-quality eye care varies from center to center. As author Sarvotham Kini, MD, notes, having the right equipment available and ensuring that clinicians are knowledgeable about eye disorders are both important to providing high-quality eye care.



Dr. Kini is a Professor at the Georgia Regents University/UGA medical partnership, in the department of Emergency Medicine.

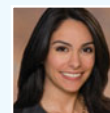


Our eye care theme continues in this month's case report, with the results of a small informal study of dilute proparacaine for acute corneal injury. Author Jacqueline Dancy, PA-C, MPAS details findings in a series of 24 patients with acute corneal injury who had no contraindication to use of dilute proparacaine solution. At \$15 or less for a 15-mL bottle, proparacaine ophthalmic solution may be a safe, inexpensive option for urgent care providers to consider in selected patients.

Ms. Dancy is Lead Physician Assistant at MedStop Urgent Care Center in San Luis Obispo, CA.

Audit activity from government and private payors for everything from billing and coding to HIPAA and kickbacks has

increased as a result of escalating pressure on the health care industry to decrease costs. Therefore, building a culture of compliance is more important than ever for urgent care providers and it's the subject of this month's practice management feature. In it, attorney Damaris L. Medina provides a step-by-step guide for identifying risk in areas such as coding and billing, documentation, and kickbacks and referrals. She also explains how to find shelter in a compliance program that is centralized, incorporates training, and facilitates reporting, monitoring, and enforcement.



Ms. Medina is an experienced business and litigation attorney in the Healthcare Department of Michelman & Robinson, LLP.

Also in this issue:

In Health Law this month, **John Shufeldt, MD, JD, MBA, FACEP**, discusses the current state of the rollout of the Patient Protection and Affordable Care Act.

Nahum Kovalski, BSc, MDCM, reviews new abstracts on literature germane to the urgent care clinician, including studies of consequences of insufficient sleep, sulfonyleureas and metformin in Type 2 diabetes, and multivitamins and cardiovascular disease.

In Coding Q&A, **David Stern, MD, CPC**, discusses changes in coding that urgent care providers will face with the advent of ICD-10.

Our Developing Data end piece this month looks at the percentage of patients who have a regular primary care physician outside of the urgent care center. ■

To Submit an Article to JUCM

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

Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, pictures, and references. Articles that are longer than this will, in most cases, need to be cut during editing. The information you provide should be of practical use to our readers, who have come to practice in an urgent care setting from a variety of clinical backgrounds. Your article should take their perspective into account by considering several key issues, such as: What immediate management is indicated? What labs or diagnostics are required? What are the next steps; with whom should the patient follow up? Who should be admitted or referred to the emergency

room? Imagine yourself in the reader's shoes and ensure your article includes the answers to questions you'd be asking.

Please send tables, graphs, sidebars (boxes) and digital or film pictures whenever possible. Digital images should be a minimum of 300 dpi. Our readers appreciate well-chosen graphics that add practical value to an article. We prefer that you submit graphics that are original to you, such as x-rays taken as part of your practice. If you wish to use graphics that have previously appeared elsewhere—in print or on the Internet—you must let the editor know. She can write the previous publisher for permission to reuse the material in JUCM. There is no guarantee, however, that the permission will be granted and, if it is not, we cannot reprint the graphics.

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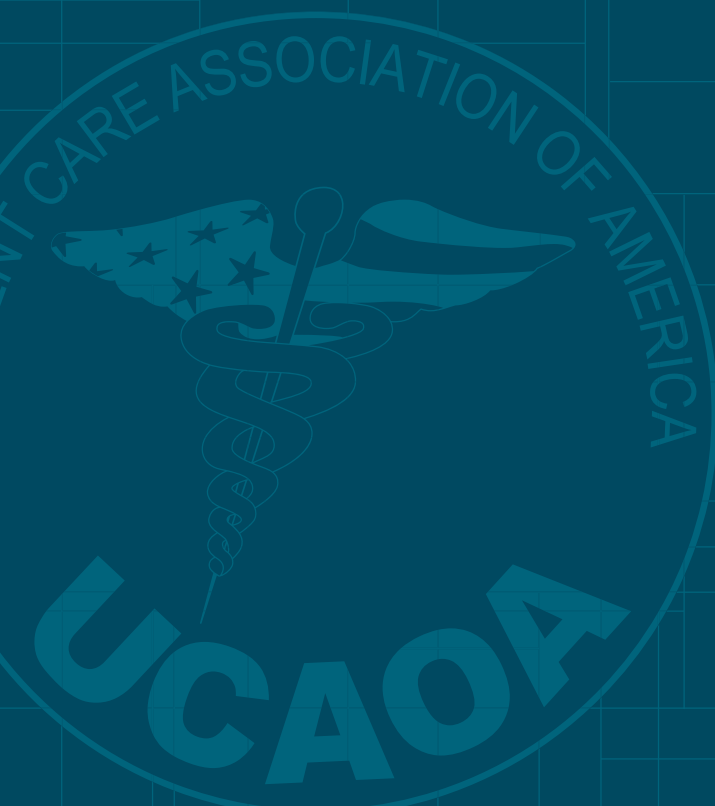
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UCAOA Professional Learning Program



FROM THE CHIEF EXECUTIVE OFFICER

UCAOA celebrates 10th Anniversary: Stronger Together

■ P. JOANNE RAY

2014 marks the 10th anniversary year of YOUR Urgent Care Association of America (UCAOA)! From a fledgling organization in 2004, the reach and power of today's UCAOA is evident — and a testimony to strong leadership. Over the years, an idea from a small group of visionaries has grown into an effective organization providing numerous valuable services and resources to those involved in every aspect of urgent care. UCAOA's early leaders set out to empower the urgent care industry, creating practice management and clinical professional development, increasing awareness and marketability, and providing urgent care-specific resources for start-up and "mature" urgent care centers and their multidisciplinary teams.

If urgent care owners, operators, supplier companies, and providers are going to compete successfully in today's health care environment and further establish the niche urgent care fills in providing convenient, quality care, they must embrace the need for professional innovation, member engagement, continued growth of professional knowledge, and a collective voice, and they must do so quickly.

This spring's National Urgent Care Convention represents an outstanding opportunity for us to celebrate as a family and as an industry. Each of you should find a way to attend and to encourage your colleagues to join you. Registration is open now. Go to the UCAOA web page (www.ucaoa.org) to access course agendas and details and plan to join us in Las Vegas, March 17-20.

Our new benchmarking study launched this month and will provide interactive, dynamic results and comparisons for participants. An updated Policy & Procedure Manual and a new accreditation program (marrying the recognition of quality and scope in the same process) will be launched. New courses,



even better access to archived educational resources, and practice management tools will be introduced. State organizations are forming and UCAOA is creating partnerships to add national recordkeeping and logistics resources to help facilitate the formation of local communities. As state issues arise with potential national impact, UCAOA is walking hand-in-hand with local leadership to create a strong voice. A focused advocacy agenda is being implemented addressing legislative and regulatory issues at the federal level. More than 40 new volunteers have been added to a new committee structure, expanding the outreach and input to programs and activities. There is room for you — please call the office if you are interested in joining us as a volunteer.

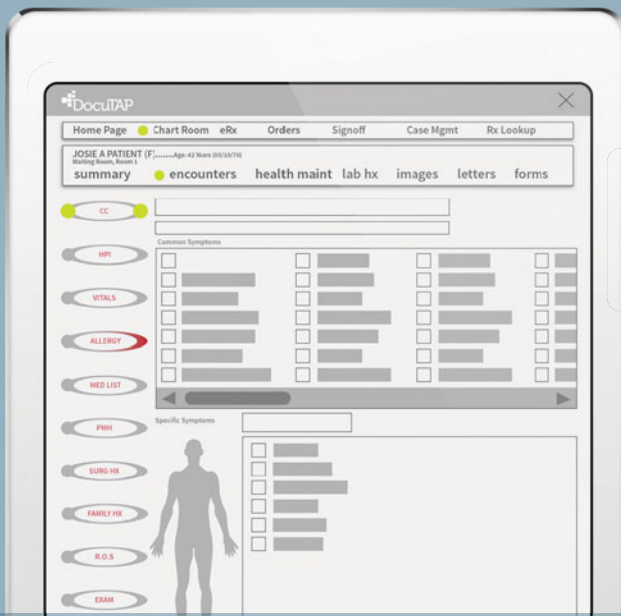
The offerings and accomplishments listed above are unique to urgent care and we will continue to develop new programs and services in response to member feedback and needs! The UCAOA Board of Directors will gather in late January to critically look at our Association today, to clarify priorities, and to create a road map for the next few years. We'll report back to you in a future issue of *JUCM*.

To ensure that all those eligible take full advantage of what UCAOA has planned this year and of the resources and opportunities created, it is more important than ever that you spread the word. If you have a practice or vendor membership, make sure all of your staff team are registered with UCAOA. If you know of others in your community, or previous leaders and members, invite them to join and share in this 10th anniversary celebration of learning and community. ■



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

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Management of Ocular Complaints in Urgent Care: Part 1

Urgent message: Triage of eye conditions in urgent care to ensure the best patient outcome requires knowing what equipment to use and understanding when to refer to an ophthalmologist. Always remember to document acuity of vision in all patients presenting with an eye complaint.

SARVOTHAM KINI, MD

Introduction

Ocular complaints are extremely common in the urgent care setting. Yet the capacity of individual urgent care centers to provide high quality eye care is variable. The equipment available and the proficiency of the clinician are equally important factors. This article intends to more clearly define the scope of acute eye care and its prevalence in the urgent care setting, while identifying the equipment and decision-making guidance necessary for high-quality and best outcomes. Understanding when to solicit the expertise of an ophthalmologist and appreciating the appropriate timing of these referrals is covered for each of the commonly encountered eye conditions discussed here. It is of utmost importance to distinguish sight-threatening from routine eye conditions to ensure appropriate rapid referral decisions. Most other acute eye conditions can be managed in the urgent care setting with basic eye care tools and best-practice management principles.

Tables 1 and 2 create the framework for this two-part series by identifying the most common eye complaints and the sight threatening conditions not to be missed in your evaluation of each. In Part 1, we will



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discuss foreign bodies, corneal abrasion, red eye, scleritis, and conjunctivitis. Part 2, in a subsequent issue, will review subconjunctival hemorrhage, uveitis, iritis, keratitis, acute angle closure glaucoma, and eyelid conditions.

Initial Evaluation

Serious eye conditions such as ocular trauma, complex

Sarvotham Kini is a Professor at the Georgia Regents University/UGA medical partnership, in the department of Emergency Medicine.

Table 1. Common Ocular Complaints

- | | |
|---------------------------|---------------------|
| • Corneal abrasion | • Painful eye |
| • Foreign body in the eye | • Eyelid conditions |
| • Red eye | |

Table 2. Vision-Threatening Conditions

- | | |
|--------------------------------|----------------------|
| • Corneal ulcer | • Orbital cellulitis |
| • Acute angle closure glaucoma | • Retinal detachment |
| • Globe rupture | |

Table 3. Indications for slit-lamp examination

- Foreign body sensation with a negative fluorescein exam
- Central corneal lacerations or deep corneal lacerations
- Failed foreign body removal
- Ocular trauma
- Chronic and sub-acute inflammatory conditions (iritis)
- Eyelid conditions
- Anterior chamber hemorrhage

eyelid lacerations, chemical burns and acute vision loss are only rarely encountered in urgent care. Patients with these conditions should be referred urgently to the nearest emergency department or to an ophthalmologist.

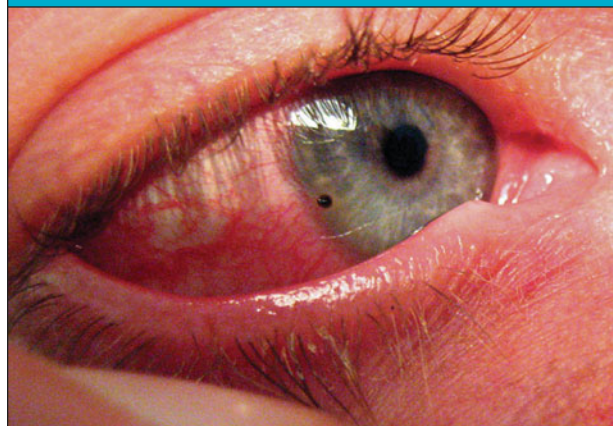
As with other urgent care presentations, evaluation of eye complaints should start with a good history and review of systems. Assessment of visual acuity is paramount to the eye evaluation and should be obtained with corrective lenses whenever possible. For patients who forget to bring their glasses to the visit, use of the “Pin Hole” technique (back of a prescription pad with a few holes created by using an 18G needle) reproduces optically corrected vision in most cases.

While the exam is focused primarily on the eyes, evaluation of the surrounding skin, head and neck may reveal clues to non-ocular causes of eye symptoms. For example, a papulo-vesicular scalp rash associated with “red eye” and pain is an important clue for herpes zoster ophthalmicus. In addition, a focused neurologic exam can reveal important clues to the diagnosis and may identify more concerning central nervous system pathology. Examples are multiple sclerosis, myasthenia gravis and cranial nerve palsies. Not every patient with an eye complaint needs a slit lamp examination.¹ Slit lamp does, however, provide many valuable findings, if one is comfortable using it. It is especially useful under the conditions listed in **Table 3**. Good training in how to use a slit lamp properly will be necessary.

Fluorescein staining should be a routine part of any eye exam when evaluating red eye, eye trauma, foreign bodies or contact lens irritation. Fluorescein is contraindicated in hyphema, chronic inflammation, most chemical exposures and for patients with high-velocity injuries.

Foreign bodies in the eye

If a patient complains of a sensation of a foreign body in the eye under the lid, resist the temptation to adminis-

Figure 1. Foreign body in the eye

Source: Wikimedia Commons
Author: E van Herk 2007

ter local anesthetic drops because the numbing will prevent the patient from confirming that the discomfort has abated when the particle is removed. Start by offering comfort and then search for the foreign body under the eyelid (**Figure 1**) or over the surface of the cornea. Flip the patient’s eyelid and, if you find a particle, wipe it off with a wet cotton swab. If, after the particle is removed, the patient confirms that the original sensation is gone, then he or she can be discharged home.

If you are unable to locate the particle, proceed with instilling a few drops of tetracaine or pontocaine in the affected eye. Then stain the eye with fluorescein and examine the cornea. Corneal abrasions that are linear suggest a foreign body under the lid and a need to search further. Sometimes abrasions are a residual finding from a particle scratching the cornea that was not found and may have washed off, leaving the patient with the sensation of a foreign body.

Fluorescein strips are considerably more hygienic than drops from a bottle and they limit the amount of dye that gets into a patient’s eye. Instillation of fluores-



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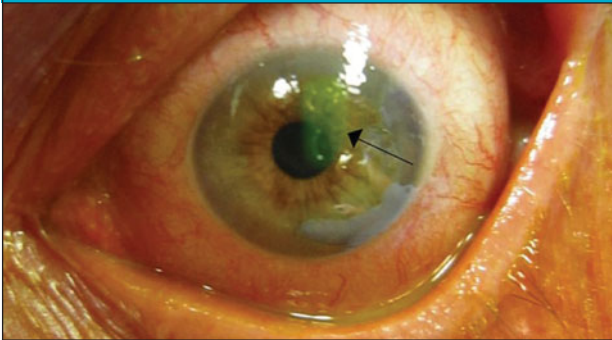


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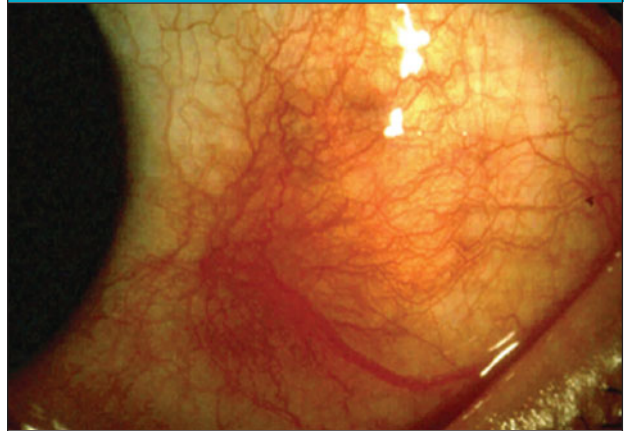
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Figure 2. Corneal Abrasion

Human cornea with abrasion highlighted by fluorescein staining.

Source: Wikimedia Commons
Author: James Heilman, MD

Figure 3. Scleritis

Source: Wikimedia Commons

cein drops to the point of overflowing can lead to difficulty distinguishing between excess dye from an aqueous leak versus fluid from a potential globe rupture.

Urgent care providers occasionally see patients who have a metallic foreign body on the cornea. This presentation can occur when a patient's occupation involves striking metal to metal and a small metal particle flies into the eye. A cotton-tipped swab is a good initial tool to remove such particles. If removal with a swab is not successful, the tip of a 25G hypodermic needle can be used to scrape the particle gently and carefully. Even after a metal particle is successfully removed, a residual rust ring may remain on the cornea. An ophthalmic "burr" can be used to remove this rust ring or the patient can be referred to an ophthalmologist.

Corneal Abrasion

Corneal abrasions can be small and superficial (**Figure 2**) or large and deep.² They are typically painful and associated with excessive tearing and they can be associated with redness and complaints of photophobia. A fluorescein strip and a Woods lamp are all that is needed to diagnose an isolated corneal abrasion. Slit lamp examination may show some flares and floaters in the anterior chamber secondary to iritis, especially if there was a delay in getting medical help. The treatment for small and superficial abrasion is comfort measures and dark glasses. An eye patch is unnecessary and may even cause more discomfort and delay a patient's healing. Most superficial abrasions heal within 2 to 3 days. Larger abrasions can be patched for the sake of patient comfort, but close patient follow up or referral to an ophthalmologist is necessary in those cases.

Red eye

Most patients with a red eye will assume it is a bacterial infection and ask for an antibiotic. Eye redness can be due to many causes, including a bacterial infection, but the most common cause of red eye is viral infection, usually due to adenovirus.^{3,4} It may be difficult to distinguish between viral and bacterial infection of the eye. A thorough history and exam may reveal clues.

Matting of the eyes on waking is not definitive evidence of a bacterial infection. The most common symptoms of any conjunctivitis are redness; foreign body (sand-like) sensation; excessive tearing, pain and discomfort; and discharge. On initial examination, determine the degree of redness over the globe of the eye and inside the eyelid (palpebral conjunctiva). If the palpebral conjunctiva is redder than the bulbar conjunctiva, the diagnosis is conjunctivitis. If the bulbar conjunctiva is redder than the palpebral conjunctiva, the diagnosis of a more serious condition, such as scleritis (**Figure 3**), iritis, iridocyclitis or acute angle closure glaucoma should be considered.

Occasionally patients present with a localized patch of redness from a group of injected blood vessels on the sclera (episcleritis) or a dark red, painless collection of blood under the conjunctiva (subconjunctival hemorrhage). These are very different and rather benign clinical entities.

Table 4 lists the three most important causes of conjunctivitis and their distinguishing features.

Allergic conjunctivitis

Allergic conjunctivitis (**Figure 4**) is a benign inflammation of the conjunctiva that is common in young adults. It is caused by environmental exposure and does not

Table 4.			
Clinical feature	Allergic	Bacterial	Viral
Exudate	Watery/sticky mucoid	Purulent	Profuse watery
Conjunctival scrapings	Eosinophils	Polymorphonuclear cells	Monocytes
Enlarged pre-auricular Lymph node	Absent	Absent	Present

affect vision. Patients with allergic conjunctivitis often have a history of other allergic conditions such as hay fever, asthma, and atopic dermatitis. The presentation is tearing, eye redness and significant itching. Patients may tend to downplay their itching whereas family members may notice that they rub their eyes constantly, which is a giveaway. Symptoms are usually bilateral but one eye may be worse than the other.

Allergic conjunctivitis is primarily a clinical diagnosis. Advanced testing is not usually indicated. Presence of eosinophils and mast cells in conjunctival scrapings under the microscope will help establish a diagnosis of allergic conjunctivitis. Secondary infections and corneal abrasions (due to rubbing of eyes) are relatively common complications. A sudden acute worsening, change in mucus from clear to purulent, or eye pain (secondary to abrasion), are clues to the development of these complications.

Treatment of allergic conjunctivitis consists of frequent use of artificial tears to help wash out the allergens.^{5,6} Topical antihistamines and mast cell stabilizers (Zaditor drops, or Olopatadine (brand name Patanol) will relieve the symptoms rapidly. Application of cold compresses hastens the resolution of symptoms. Advising patients to avoid exposure to known allergens is important. Patients should also be counseled to avoid wearing contact lenses until their symptoms have completely abated. Nasal corticosteroids and oral antihistamines are commonly prescribed concurrently to improve response.

Bacterial Conjunctivitis

Organisms that commonly cause acute bacterial conjunctivitis (**Figure 5**) are *Staphylococcus aureus* (common in adults), *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Moraxella catarrhalis*, which are common in children.⁷⁻⁹

Bacterial conjunctivitis can be unilateral or bilateral and is highly contagious. Common symptoms are redness and discharge, which can be white, yellow or green. The eyelids can be swollen and stuck together, especially in the mornings, a feature that is not generally useful in distinguishing the various types of conjunctivitis. The eyelids may be tender to palpation. Definitive diagnosis of bacterial conjunctivitis is established from cultures obtained from the conjunctival sac.

Conjunctivitis can also be caused by *Neisseria* species, particularly

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Figure 4. Allergic conjunctivitis

Source: Wikimedia Commons

Figure 5. Bacterial conjunctivitisSource: Wikimedia Commons
Author: Tanalai**Figure 6. Viral conjunctivitis**Source: Wikimedia Commons
Author: Joyhilllog**Figure 7. Episcleritis**Source: Wikimedia Commons
Author: Asagan

N. gonorrhea, which is more serious and carries threat to vision. This infection needs to be treated aggressively with intravenous antibiotics and an ophthalmology consult is recommended.

Common ophthalmic antibiotics that are useful for treatment of acute conjunctivitis are sulfacetamide 10% drops, erythromycin ophthalmic ointment, tobramycin drops, and polymyxin B/trimethoprim drops. Each of these therapeutic options has its problems. Sulfacetamide burns, ointment preparations are messy, polymyxin and tobramycin can be sensitizing and along with allergies to any of the components, can produce the appearance of worsening infection when sensitization is the underlying cause. Do not patch an eye affected by acute conjunctivitis. The best comfort measure, particularly outdoors, is wearing dark glasses.

Viral Conjunctivitis

Adenovirus is the major cause of viral conjunctivitis (**Figure 6**).¹⁰ It is highly contagious and can remain so for up to 10 days. Patients should be warned about this

virus and instructed to wash their hands before and after using drops and even touching their eyes. Treatment generally consists of comfort measures such as cool compresses, artificial tears, and dark glasses in the bright sun. Antibiotics do not help and should not be prescribed. Patient education goes a long way in management of this infection.

One form of viral conjunctivitis, epidemic keratoconjunctivitis (EKC), is particularly fulminant. It can involve the cornea and thus affect the vision. Keratitis is potentially vision-threatening and these patients should be referred to an ophthalmologist.

Scleritis

Scleritis (**Figure 3**) is uncommon, but often occurs with systemic disorders, specifically autoimmune diseases and infections. Scleritis is inflammation of the tenon capsule and patients with it present with dull boring pain and tenderness over the globe of the eye. Diffuse injection of the blood vessels gives a dark red or purple color to the globe and photophobia and poor vision are common. Patients

with suspected scleritis need further work up for rheumatologic disorders such as rheumatoid arthritis, Wegener's granulomatosis, seronegative spondyloarthropathies, relapsing polychondritis, and systemic lupus erythematosus. Tuberculosis, syphilis and sarcoidosis are also known to cause scleritis. Other causes of painful red eye such as iritis, keratitis, and acute angle closure glaucoma should be considered as well.

Scleritis is initially treated with systemic nonsteroidal anti-inflammatory drugs (NSAIDs) and/or topical steroids. Two drops of 1% prednisolone every 2 hours for up to 2 weeks can be tried, initially, while a patient waits to be seen by a rheumatologist or ophthalmologist. Other treatments such as systemic steroids, subconjunctival steroids, and immune modulators may need to be considered by a rheumatologist and or an ophthalmologist.

Episcleritis

Episcleritis (**Figure 7**) is most often idiopathic, but may also be associated with any of the rheumatologic diseases that cause scleritis. Episcleritis is typically benign, often segmental, but can be diffuse. Examination of the eye shows an inflamed group of conjunctival blood vessels over a segment of the globe. There may be some tenderness over the area of inflammation. Episcleritis does not cause visual loss and often resolves spontaneously. In these patients, eye redness and irritation improve by 50% in less than a week. Treatment with topical NSAIDs and/or artificial tears will resolve the redness and discomfort.

Conclusion

Eye conditions and complaints are extremely common in the urgent care setting. The ability to carefully evaluate and triage these conditions is essential to favorable outcomes. Through the use of readily accessible tools and prudent referrals, most eye problems can be initially managed in the urgent care setting. Understanding the nature and course of sight-threatening complications and the diagnostic clues that identify them helps guide the clinician through safe and effective decision-making for patients with acute eye conditions. ■

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Practice Management

Identifying Risks and Finding Shelter in an Urgent Care Compliance Program

Urgent message: The escalating pressure on the industry to decrease health care costs has resulted in an increase in audit activity from government and private payors for everything from billing and coding to HIPAA and kickbacks. Therefore, it's more important than ever for urgent care centers to build a culture of compliance.

DAMARIS L. MEDINA

The health care industry is in the throes of a dynamic regulatory enforcement climate. Federal and state regulators and third-party payors continue to closely examine the books and operations of health care providers. This high level of scrutiny will only increase with the continuing roll-out of health care reform, which is expected to accelerate the current boom in urgent care.

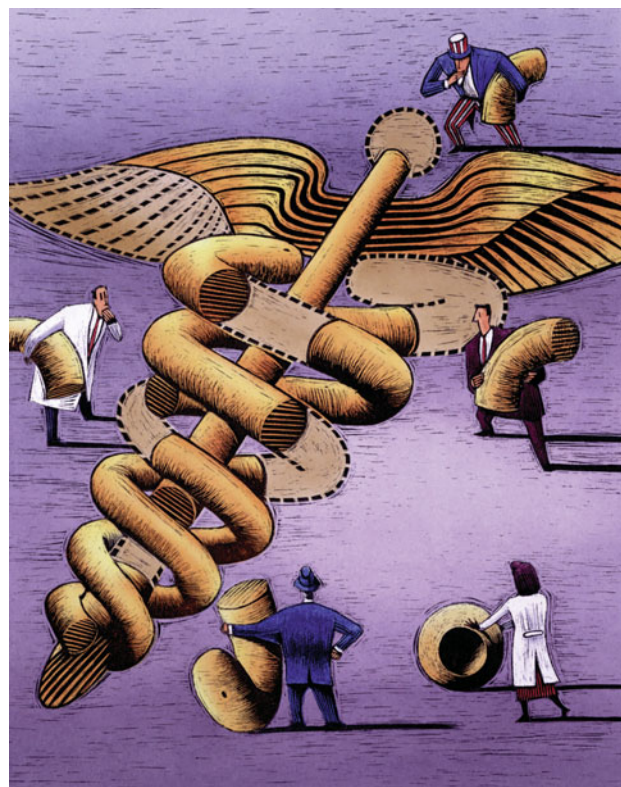
As the popularity of urgent care centers continues to rise, the industry will find itself at the center of a massive regulatory enforcement storm. A comprehensive compliance program will be more essential than ever.

Each urgent care center has a unique culture. As a result, it is important for centers to identify their risk areas and structure their compliance programs to address their particular needs.

Identifying your center's risk areas

The first step to becoming compliant is to identify the areas of risk for your urgent care center. These will typically include coding and billing, reasonable and neces-

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sary services, documentation, kickbacks and self-referrals, and HIPAA violations.

Coding and Billing. Potential problems in your coding and billing may include:

- Billing for items or services not rendered or not provided as claimed;
- Double billing resulting in duplicate payment;
- Billing for non-covered services as if covered;
- Knowing misuse of provider identification numbers, which results in improper billing;
- Unbundling (billing for each component of the service instead of billing or using an all-inclusive code);
- Failure to properly use coding modifiers;
- Clustering; and
- Up-coding the level of service provided.

Reasonable and Necessary. An urgent care center must evaluate itself to determine whether claims are being submitted only for services that the center finds to be reasonable and necessary in a particular case. If not, additional training is called for. Medicare and insurance plans may deny payment for a service that is not reasonable and necessary according to the Medicare reimbursement rules. The denial of one claim may provide the impetus for a full audit.

A determination of “reasonable and necessary” is based on evidence-based standards of care for professionals working in an urgent care center environment. As an example, a center should critically evaluate whether a particular medical test is reasonable and necessary under the particular circumstances arising from a specific patient’s visit. A large number of claims related to tests and ancillary services are denied when diagnosis codes do not match procedure codes. An urgent care center’s compliance program should provide guidance that claims are to be submitted only for services that are reasonable and necessary in a particular case to address this.

Poor Documentation. One of the most visible risk areas is the appropriate documentation of diagnosis and treatment. An urgent care center must evaluate its documentation practices. Proper documentation verifies that a bill is accurate as submitted. Potential problems may

One of the most visible risk areas is the appropriate documentation of diagnosis and treatment. An urgent care center must evaluate its documentation practices.

include:

- Illegible or incomplete medical records;
- Documentation of each patient encounter that does not include or is deficient in providing the reason for the encounter; relevant history; physical examination findings; prior diagnostic test results; assessment, clinical impression or diagnosis; plan of care; and date and legible identity of the observer;
- Medical records that lack documentation from which an independent reviewer or third party who has appropriate medical training could easily infer the rationale for ordering diagnostic and other ancillary services;
- Lack of documentation and medical records to support the CPT and ICD-9-CM codes used for claim submission; and
- Failure to identify appropriate health risk factors and patient progress, response to treatment, and any revisions in patient diagnosis.

An urgent care center must also examine its policies for corrections or amendments to medical records because it is unlawful to make false entries or to delete any entries from these records. Any additions, corrections or amendments must be made in accordance with accepted standards and principles and law. Records must never be destroyed, altered or removed from the premises unless authorized and consistent with office policy.

Kickbacks and Referrals. An urgent care center must also evaluate its standards and procedures for compliance with the anti-kickback statute and the physician self-referral law (also known as the Stark Law). It should determine whether it has policies in place that address:

- Financial arrangements with outside entities to which the practice may refer business;
- Joint ventures with entities supplying goods or services to the urgent care practice or its patients;
- Consulting contracts or medical directorships;
- Office and equipment leases with entities to which the center refers; and
- Soliciting, accepting or offering any gift or gratuity of more than nominal value to or from those who may benefit from referral of business.

HIPAA. In addition to evaluating the usual HIPAA risk areas, such as protection of patient health information, destruction and transmission procedures, and notification procedures in the event of a breach, an urgent care center must evaluate its practices to make sure that it is compliant with the additional requirements put in place by the HIPAA Rule that became effective on March 26, 2013. That includes, among other things, the need to amend all business associate agreements with contractors, vendors and service providers, such as billing companies.

Finding shelter in your compliance program

A well-crafted compliance program is a thorough set of documents, policies, and practices that ensures that an urgent care center complies fully with all federal, state, and local laws that apply to its operations; the conditions of health care programs funded by the government; and the conditions imposed by third-party payors.

Compliance programs promote early detection, reporting, and remediation of fraudulent conduct, as well as efficient staff communication and training. They demonstrate a clear commitment by an organization to abide by professional, legal, and ethical standards of practice.

All employees and physicians should make reasonable good faith efforts to closely engage with a compliance program, maintaining a high level of integrity and honesty in their dealings within the urgent care center and with outside third parties. Employees and physicians should avoid any conduct that could adversely reflect the integrity of the urgent care center.

Even if an urgent care center already has a compliance program in place, it must be periodically reviewed by counsel to make sure that it is updated to reflect changes in the law, or changes to the center's operations.

Centralized Compliance Efforts. A successful compliance program should be centralized under the control of a specific individual with authority and sufficient resources to address its design, operation and monitoring. In a larger organization, that person can be a chief compliance officer who reports directly to the CEO and enjoys the support of a compliance committee. A compliance committee can be composed of physicians in different specialty groups and staff working in different facets of the center's operations. In a smaller urgent care center, the person charged with oversight of compliance can be a qualified physician director, a business manager, or an operations manager. All three could form an ad hoc compliance committee. This function could also be assigned to the center's outside counsel.

The responsibilities of the person in charge of compliance include:

- Development and monitoring of the compliance program;
- Ensuring that all staff members are trained in fraud prevention;
- Ensuring that physicians and vendors are trained in fraud prevention;
- Investigation of any issues regarding quality of care, vendor relationships, employee screening, patient rights, billing, and record-keeping and retention;
- Investigation of possible fraudulent activity;
- Reporting any potential illegal activity or ethical violations to the appropriate person or entity; and
- Development and implementation of any policies and procedures with respect to ongoing program enhancement.

The urgent care center must take the proper steps to make sure that the authority for fraud and abuse prevention is delegated to an individual with no criminal, civil, or administrative violations.

1. *Essential education and training.* Education and training are an important part of any compliance program. This process involves three basic steps: Determining who needs training. Everyone will need some training in the general concept of compliance with regulations and the duty to report. Individual physicians and staff will need additional training depending on their responsibilities within the urgent care center.
2. Determining the type of training that best suits the urgent care center's needs, such as seminars, in-service training, self-study or other programs; and
3. Determining when and how often education is needed and how much each person should receive. Formal training upon hire and annually thereafter is a good idea.

Training in compliance should focus on the importance of complying with all applicable statutes, rules, regulations, and policies. Additional training should address documentation, coding and billing requirements.

Outside of official training sessions, standards of conduct, policies and procedures should be published and well-publicized via the employee handbook, newsletters and materials posted within the center. They should be available in the organization's business and human resources offices.

Guidelines can be posted on the center's website –

either on the main site where they can be viewed by patients and vendors (often a good idea in terms of demonstrating commitment to regulatory compliance) or on the intranet strictly for internal access.

To prove that these efforts took place, records should be maintained for all education and training programs.

Encouraging and facilitating reporting. A compliance program will be successful only in an environment in which employees and physicians feel comfortable reporting potential fraud and abuse or any violations of the program. There should be an "open door" policy between these individuals and the chief compliance officer. As part of education and training, all employees and physicians should understand their obligation to report perceived violations.

Failure to report perceived violations of the program or related policies can result in consequences for the employee or physician, including various levels of corrective action or other disciplinary action, including termination of employment or independent contractor relationships.

A successful compliance program includes creation and maintenance of a process to receive complaints, and the adoption of procedures to protect the anonymity of those making complaints. In a few circumstances, revelation of a reporting individual's identity might be mandated by law or government authority.

Under the law, employees can be compensated for "blowing the whistle" on non-compliant practices – which just might prompt them to report their employers to regulatory authorities. A compliance program provides alternative avenues for reporting to employees concerned with perceived violations in the center. A culture of compliance within the organization may serve as a deterrent for whistleblowers.

One excellent way for larger entities to encourage anonymous reporting is through the use of a hotline that is available 24 hours a day, 7 days a week and 365 days a year to facilitate reporting of violations or seek clarification of compliance issues. A more practical alternative for most smaller centers is an anonymous "drop box." Use of these processes should be emphasized in training and reinforced on a regular basis.

It is essential that individuals reporting fraud or abuse be protected from retaliation by the urgent care center or any of its employees or physicians. No one who makes a report in good faith should be subjected to retaliation, retribution or harassment because he or she made a report.

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Audits and monitoring to reveal problems. Another way to uncover instances of fraud and abuse is through auditing and monitoring. An urgent care center should conduct periodic internal audits of a sampling of claims to determine compliance with applicable documentation, coding and billing requirements. This should be supplemented with an annual audit by an external agency.

There are a number of ways to identify the claims and services from which to draw a random sample of claims to be audited. One way is to choose a random sample from all of the claims and services for which a physician has been reimbursed. Another is to choose those from a particular payor. Another is to identify risk areas or potential billing vulnerabilities (see the areas listed at the start of this article), and choose the sample by this billing code.

Even urgent care centers that use outside billing companies should have their own compliance program, separate and apart from the billing company's. Use of an outside billing company does not transfer liability for coding errors away from an urgent care center.

Enforcing standards. If a report or an audit reveals inaccurate billing, insufficient documentation or other problems at an urgent care center, appropriate corrective action must be taken. To protect against liability, an organization must respond promptly and appropriately to prevent similar offenses.

A successful compliance program includes a system to respond to allegations of improper or illegal activities and the enforcement of appropriate disciplinary actions against employees who have violated internal compliance policies, applicable statutes, regulations or federal healthcare program requirements.

Disciplinary actions could include warnings (oral), reprimands (written), probation, demotion, temporary suspension, termination, restitution of damages, and referral for criminal prosecution.

Corrective actions may require changes in documentation, coding and billing policies or procedures; additional training for physicians, billing or administrative personnel; the repayment of any overbilling, or disclosure to the third-party payor. A plan of correction should detail methods to prevent the violation from

Even urgent care centers that use outside billing companies should have their own compliance program, separate and apart from the billing company's.

happening again.

Even when no problems are revealed, an urgent care center should periodically reassess its compliance program and make changes that reflect changes within the organization.

When the auditor comes knocking. In spite of an urgent care center's best

efforts, it may become embroiled in a government or third-party payor investigation or audit. In response to these actions, an urgent care center should cooperate, while protecting its legal rights and those of its employees and physicians. Legal counsel should be informed.

If an employee or physician receives an inquiry, subpoena or other legal document relating to the urgent care center or its business, that person should immediately notify the chief compliance officer or the urgent care center's legal counsel. If an employee or physician is visited at home, that person should ask the agent to return at a later date and immediately contact the chief compliance officer.

Requests dealing with multiple claims call for an entirely different response. Legal counsel might engage an outside coding expert to do a separate analysis to determine if there are coding discrepancies.

Skilled legal counsel will ensure that there is an analysis and review of the subpoena and the requested materials, that the response timeline is being met, that litigation hold letters are in place, that insurance coverage is addressed (if applicable), and that protective internal and external communication strategies are in place.

Getting started with a compliance program

A sample compliance program for individual and small group physician practices is available at <https://oig.hhs.gov/authorities/docs/physician.pdf>. This sample was created by the Office of Inspector General within the U.S. Department of Health and Human Services. While this sample provides a starting point, urgent care centers must make sure to work with legal counsel that has extensive experience in their particular industry. Experienced legal counsel will be able to craft a well-structured and complete compliance program tailored to address those issues which are specific to the urgent care industry and to those issues that are particular to your urgent care center. ■

Case Report

Dilute Proparacaine

Urgent message: The use of dilute proparacaine appears to be a safe and cost-effective way to treat the pain associated with many acute corneal injuries.

JACQUALINE DANCY, PA-C, MPAS

Editor's Note: This article deviates from our typical case report format to underscore one of the key points for management of eye conditions discussed in this month's cover story.

Introduction

Ocular injuries are often painful and can cause significant suffering. Many medical practitioners provide immediate, but temporary relief with the use of proparacaine ophthalmic drops. Given the potential toxicity of this medication, practitioners rarely dispense these medications for home use but rather, opt to provide systemic analgesia, often with narcotic pain medication. There are numerous disadvantages to systemic narcotic analgesia as well as questionable efficacy in these conditions. Therefore, the age-old concerns for home use of proparacaine are being challenged and alternatives explored.

The use of dilute proparacaine appears to be an effective, affordable and safe short-term treatment option for patients with acutely painful ocular conditions, including, but not limited to corneal abrasions and post foreign body removal.

Proparacaine ophthalmic solution at 0.5% concentration is available as a generic medication. The retail cost is approximately \$15 (and often less than \$7 through medical supply companies) for a 15-mL bottle. This topical anesthetic solution instilled in the eye provides short-term analgesia by inhibiting the sodium ion channels and therefore inhibiting the nerve impulse initiation and conduction. The onset of pain relief is rapid, within 30 seconds, and the duration of analgesia varies from 15 to 45 minutes or more. The most common



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adverse reaction is mild and temporary stinging immediately after instillation. Serious adverse reactions include hypersensitivity reaction, corneal ulceration and/or opacification (prolonged use), potential for delayed ocular wound healing, and epithelial keratopathy. The only listed contraindication known is hypersensitivity to any component of the solution.¹

Literature review

One of the earlier studies published in *Ophthalmology* in 1997 (L. Shahinian, Jr et al), found that proparacaine in dilute concentration to 0.05% was effective and non-toxic for use up to 1 week post-photorefractive keratectomy.² The authors noted no affect on healing nor any significant adverse reactions.

A more recent study published in 2010 in *The Canadian Journal of Emergency Medicine* (I. Ball, MD et al) involved 33 patients, which of whom received the dilute proparacaine (at the concentration of 0.05%), had pain

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CASE REPORT: DILUTE PROPARACAINE

relief.³ The authors reported no incidence of associated ocular injury nor adverse outcome from the medication.

Case Presentation

Given the potential to reduce the often significant pain associated with acute ocular injury, we conducted a similar informal study.

Our selection criteria were patients with acute corneal injuries who had no contraindication to use of dilute proparacaine solution. After detailed discussion about the risks and benefits with each patient, they were entered into our study log for follow up. Following the dilution guideline already studied, we used proparacaine 0.5% and diluted it with normal saline to 0.05% concentration, placing it into a sterile glass vial with a dropper top for each patient. We dispensed enough medication, calculated by volume and directions for use, for a 48-hour supply with the following directions: *1 – 2 drops in affected eye every one hour as needed for pain*. Before dispensing the medication, the patients were required to sign informed consent and waiver form and agree to a 2-day follow up recheck.

Observation and findings

- A total of 24 patients received the dilute proparacaine.
- A total of 13 patients returned within 48 hours for a recheck.
- The total number of telephone follow-ups was 3.
- The total number of patients who failed to return to the clinic or return telephone follow-up was 8.

Overall, 67% of patients followed up and 100% of them were asymptomatic at the time of follow up. All reported a reduction in pain and tolerated the dilute proparacaine well without adverse sequela.

Discussion

Our small, informal study demonstrates encouraging patient data, adding to the argument that dilute proparacaine is a safe, effective, and inexpensive option to treat the pain associated with many acute corneal injuries and should be considered as an alternative to systemic narcotic medication. ■

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ObamaCare Update or Fear and Loathing: The Affordable Care Act

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

In the conclusion of my October 2012 column on ObamaCare I wrote that no matter the outcome (of the presidential election) our future will not be boring. Fourteen months later, it has not been boring and we are just around the corner from imposing the individual mandate (aka tax penalty) on those who don't have minimal insurance coverage. However, before we cross the starting line let's review a bit of history and law.

In 2010, President Obama managed to convince both houses of Congress and a majority of the public that the Patient Protection and Affordable Care Act (PPACA) was in the best interest of our country. That remains highly controversial and was a pivotal part of the 2012 Presidential platform.

On June 28, 2012, Chief Justice Roberts, writing for the majority, published the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*. With a few exceptions, the decision upheld the bulk of the PPACA¹ and silenced any further attempts at blocking the law on constitutional grounds.

Recall that a linchpin of PPACA is "shared responsibility," which loosely translates into tax penalties for certain employers who fail to cover their employees with health insurance or fails to at least offer an accessible, affordable option for health insurance. In addition, starting this month, a tax penalty will be levied against individuals who fail to obtain health insurance.

In July 2013, the Obama Administration delayed the employer's responsibility for PPACA until 2015 but the Individual Mandate that affects employees and taxpayers started on January 1. Under PPACA, employees can opt out of employer-sponsored plans and go to the exchanges to purchase health insurance. Employers that do not offer insurance can go directly to the exchange. Employees who reside in states that have opted out of a state-sponsored "Health Insurance Marketplace" can go directly to

the federal exchange at www.healthcare.gov for coverage. Under Section 18B of the Fair Labor Standards Act "FLSA," current employees had to be notified on or before about October 1, 2013 about open enrollment.

Open enrollment on the exchanges began on October 1, 2013 and by all accounts and after at least \$600 million² spent, Healthcare.gov is not working; or, as Obama said, "Obviously my most recent concern has been that my website's not working... and we're evaluating why it is exactly that I didn't know soon enough that [it] wasn't going to work the way it needed to. But my priority now has been to just make sure that it works."

The Individual Mandate

By January 1, 2014, every person, save for some exceptions, had to demonstrate minimal essential health care coverage or meet one of the exceptions. If an individual had health care coverage at his or her place of work or through Medicare, Medicaid, Tricare or the VA, no penalty applied.

Other exemptions to the Individual Mandate:

1. Religious conscience: Members of sects who are opposed to accepting insurance benefits
2. Members of a health care-sharing ministry
3. Members of an Indian Tribe
4. Income is below the minimum threshold for filing a tax return
5. Coverage gap of less than 3 months
6. Filed for and approved as a hardship
7. Cost of minimum amount of coverage exceeds 8% of household income
8. Individual in prison
9. Individual not lawfully present in the United States

If an individual had no coverage by January 1, 2014, he or she will owe the U.S. Government a tax. The amount of the tax is the greater of the flat tax or a calculation based upon income and the cost of the "Bronze Plan." In 2014, the most that a family can be taxed for failure to have insurance is \$285. By



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2016, that amount increases to \$2085. The penalty, however, increases with income. So, if an individual makes more in salary than the threshold filing amount, the amount in excess of that threshold amount is used to calculate the penalty.

The Available Plans in the Marketplace aka ‘The Exchange’

The Marketplace is an online store where people who don't have health insurance through an employer can enroll in a health plan. In addition, businesses with fewer than 100 workers can also purchase health insurance for their employees. Health insurance exchange plans will vary somewhat by state. However, most of the exchanges have 4 levels of plans, which vary based upon the out-of-pocket cost and the plan coverage.

- Bronze Plan: Member pays for 40% of health care costs.
- Silver Plan: Member pays for 30% of health care costs.
- Gold Plan: Member pays for 20% of health care costs.
- Platinum Plan: Member pays for 10% of health care costs.

The Employer Mandate

In July 2013, the Obama administration pushed back the start date of the Employer Mandate to January 1, 2015. Basically, the employer mandate compels any large employer (more than 50 full-time employees) to offer minimum essential coverage to their employees. Full time equates to more than 30 hours per week. To determine whether an employer has more than 50 employees who work more than 30 hours, a calculation is done that includes both full-time and part-time employees. Let's take, for example, an employer with 40 employees who work 30 hours per week and 15 part-time employees who work 25 hours per week. Based upon the calculation, the 15 part-time employees would be counted as 12.5 full-time employees, so the employer crosses the threshold and is subject to the employer mandate. If the employer leases the employees from a staffing agency, these employees will not be the employees of the recipient but of the staffing agency.

If one or more employees of a large employer (greater than 50 FTEs) claim a premium tax credit, that employer will be subject to penalties. Employees who are not offered an affordable plan that provides minimum value or employees who are not offered any employer-sponsored plan will be able to obtain insurance through the exchange. For the plan to be affordable, an employee has to pay less than 9.5% of his or her household income (for self-coverage) and the plan must pay at least 60% of covered health care expenses. Interestingly, the plan needs only to be available to full-time employees not part-time employees if the part-time employees were used in the calculation to determine if the employer met the “large employer” classification.

If a large employer does not offer an affordable plan that offers minimum value, the company will be subject to a penalty. The penalty will be calculated based on the number of full-time employees minus 30 multiplied by 1/12th of \$2,000 for any

month in which coverage is not provided. If an employer does not offer any plan at all, the calculation changes from a multiplier of \$2,000 to \$3,000.

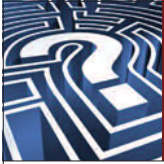
PPACA in Effect Today

- Group health plans that were in effect on March 23, 2010 are grandfathered and do not have to comply with all of the PPACA rules unless significant changes are made to the benefit designs.
- As of September 2011, health insurers had to justify any base rate increase greater than 10%.
- Starting in 2010, small businesses with 10 or fewer employees receive a 35% tax credit if the average annual wage is less than \$25,000. This credit gradually decreases until it is phased out completely for companies with more than 25 full-time employees and an average income of \$50,000 or more.
- In June 2010, the administration released 5 insurance enrollee protections under PPACA.
- Insurance companies must spend at least 80% of premium income on health care claim and quality improvement. The other 20% can be used for administration, marketing and profit.
- PPACA created a temporary pool for patients with pre-existing conditions who had been uninsured for at least 6 months. That coverage expired this month, when broader coverage provisions were effective.
- PPACA requires employers with more than 250 employees to include health care coverage costs on W-2 forms.
- For those filing individually, a Medicare tax increase of 0.9% has been imposed on wages and self-employment income greater than \$200,000. The second component is an additional 3.8% Medicare tax applied to net investment income when adjusted gross income is in excess of \$200,000 for an individual and \$250,000 for those filing jointly. Net investment income includes investment income and interest, dividends, royalties, rent, and income from passive activities.

Conclusions

The rollout of PPACA has been challenging and a “sea change” in the way insurance is offered and who must be covered. At present, large employers have until 2015 to comply, that is, to provide a plan with minimum value and affordable rates. Most employers will do a cost-benefit analysis prior to paying anyone for health insurance. As of January 1, individuals had to obtain health insurance or face the penalty. As an employer, work with your benefits advisor to ensure you are in compliance with the notification provisions and with the employer mandate. ■

1. “The Effect of PPACA on Urgent Care” Journal Of Urgent Care Medicine, Vol. 6, Issue 12, October 2012; Braveheart Publishing. Mahwah, NJ
2. IT Dashboard <https://www.itdashboard.gov/investment?buscid=g61> accessed on December 1, 2013.



INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 1

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

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

FIGURE 1



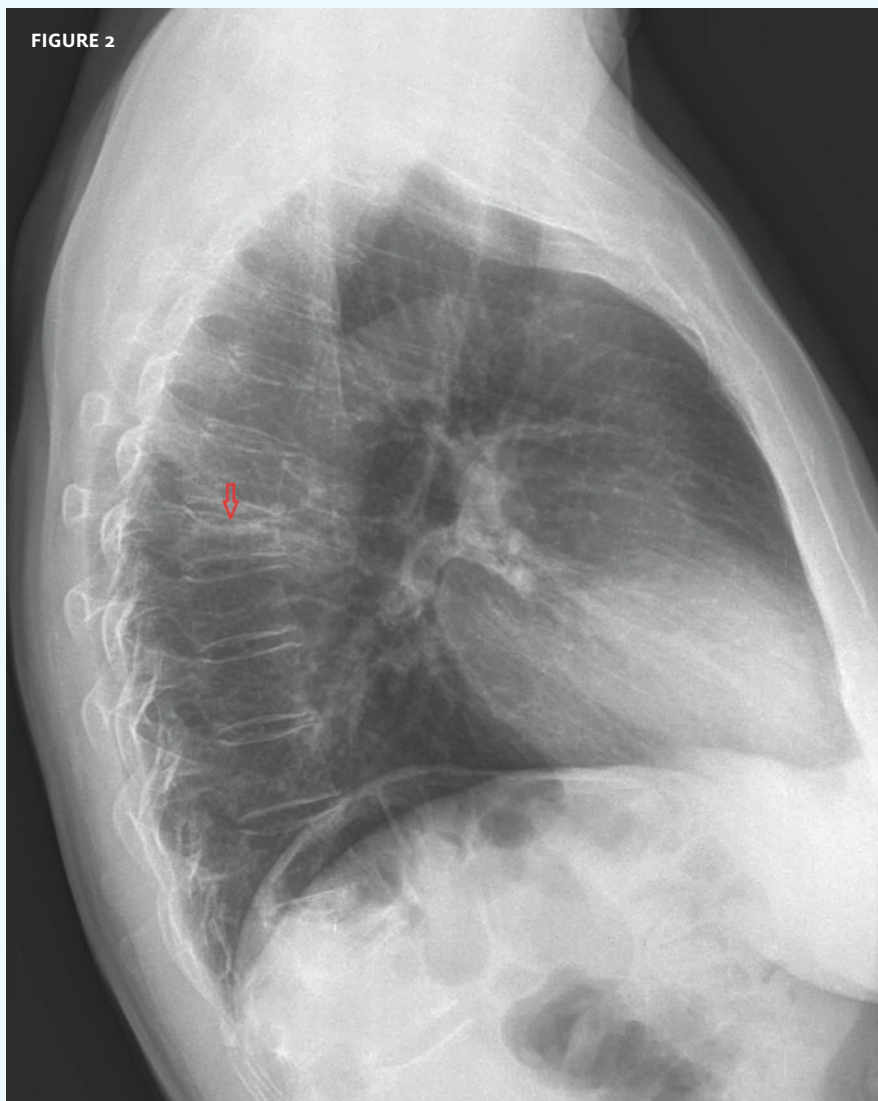
The patient, a 53-year-old man, presented with acute back pain after a fall.

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

Resolution of the case is described on the next page.

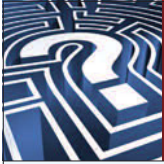
THE RESOLUTION

FIGURE 2



Diagnosis: The x-ray reveals a significant compression fracture of the thoracic spine (arrow). This patient requires an orthopedics referral for immediate evaluation and treatment.

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



CLINICAL CHALLENGE: CASE 2

FIGURE 1



This x-ray was taken on a 29-year-old man with a blow to his left elbow.

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

[Click here for the resolution of the case.](#)

THE RESOLUTION

FIGURE 2



Diagnosis: The x-ray reveals an intra-articular radial head fracture (arrows). A splint and follow up with an orthopedist are appropriate for this patient.

Acknowledgement:

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



ABSTRACTS IN URGENT CARE

- Insufficient Sleep
- Sulfonylureas and Metformin in Type 2 Diabetes
- Multivitamins and Cardiovascular Disease
- Clindamycin vs. TMP/SMX for Soft-Tissue Infections
- Evaluation of Febrile Infants
- Scrutiny of Clinical Practice Guidelines
- Flu Prevention and Control
- Management of SVT
- Isolated Sternal Fractures
- Colchicine for Acute Pericarditis
- Undervaccination of Pertussis
- Tylenol Overdose
- U.S. Hospitalizations for Pneumonia

■ 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.

Metabolic Consequences of Insufficient Sleep

Key point: A small, randomized, controlled crossover study demonstrates changes in a critical insulin-signaling pathway in peripheral tissue.

Citations: Broussard JL, Ehrmann DA, Van Cauter E, Tasali E, Brady MJ. Impaired insulin signaling in human adipocytes after experimental sleep restriction: A randomized, crossover study. *Ann Intern Med* 2012;157(8):549-557. and Cappuccio FP, Miller MA. A new challenge to widely held views on the role of sleep. *Ann Intern Med* 2012;157(8):593-594.

Small experimental studies have revealed adverse effects of reduced sleep duration on glucose tolerance and insulin sensitivity. To explore the effects of sleep restriction on metabolic activity in peripheral tissue, investigators randomized seven lean, healthy young adults (aged 18–30) to undergo 4 weeks each of normal and restricted sleep (8.5 and 4.5 hours, respectively), in random order and under controlled conditions, 4 weeks apart. The primary endpoint was change in levels of phosphorylated Akt — an important step in the insulin-signaling pathway — in abdominal subcutaneous adipocytes.

Phosphorylation of Akt was 30% lower after restricted sleep than after normal sleep ($P=0.01$). This reduction coincided with a 16% reduction in total-body insulin sensitivity, as measured

by frequently sampled intravenous glucose tolerance tests.

Published in *J Watch Card*. October 31, 2012 — Harlan M. Krumholz, MD, SM. ■

Cardiovascular Effects of Sulfonylureas and Metformin in Patients with Type 2 Diabetes

Key point: Compared with metformin, sulfonylurea was associated with a higher rate of cardiovascular events or death in a large retrospective study.

Citations: Roumie CL, Hung AM, Greevy RA, Grijalva CG, et al. Comparative effectiveness of sulfonylurea and metformin monotherapy on cardiovascular events in type 2 diabetes mellitus: A cohort study. *Ann Intern Med*. 2012;157(9):601-610 and Nissen SE. Cardiovascular effects of diabetes drugs: Emerging from the dark ages. *Ann Intern Med*. 2012;157(9):671-672.

Cardiovascular disease (CVD) is the primary cause of death in patients with diabetes. Two common classes of drugs used in treating type 2 diabetes are sulfonylureas and metformin. Their impact on cardiovascular outcomes is not well known. Using a database from the national Veterans Health Administration, researchers conducted a retrospective cohort study comparing the effects of sulfonylureas and metformin on the composite endpoint of acute myocardial infarction, stroke, or death.

Among 253,690 patients (97% men; 75% white), metformin was prescribed in 61% and sulfonylureas in 39% (55% glyburide; 45% glipizide). Those who used both medications, rosiglitazone, or pioglitazone were excluded. Differences between the metformin and sulfonylurea groups were median follow-up (0.80 years vs. 0.61 years), median age (62 vs. 67), and



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hemoglobin A_{1c} levels (7.0 vs. 7.3). Characteristics of the two groups were similar after propensity score matching of 80,648 patients in each treatment group. Unadjusted rates of the composite endpoint were 18.2 per 1000 person-years for sulfonylurea users and 10.4 per 1000 person-years among metformin users. The adjusted hazard ratio was 1.21 and was similar with glyburide and with glipizide. The authors estimated 2.2 more CVD events or deaths and 1.2 more CVD events per 1000 person-years in sulfonylurea versus metformin recipients. Results were similar in analyses stratifying patients by CVD history, age, body-mass index, and proteinuria.

Published in *J Watch Card*. November 21, 2012 — Joel M. Gore, MD. ■

No Benefit of Multivitamins for Preventing Cardiovascular Disease in Men

Key point: A randomized, controlled trial showed that myocardial infarction, stroke, and death were not affected.

Citation: Sesso HD, Christen WG, Bubes V, et al. Multivitamins in the prevention of cardiovascular disease in men: The Physicians' Health Study II randomized controlled trial. *JAMA*. 2012;308(17):1751-1760.

Observational studies of multivitamins for preventing cardiovascular disease (CVD) have yielded inconsistent and mostly negative results, as have randomized controlled trials of individual vitamins and minerals (including β -carotene, selenium, and vitamins B, C, and E). This randomized controlled trial that involved nearly 15,000 male physicians (mean age, 64) who were randomized to commercial daily multivitamins (Centrum Silver) or placebo is a companion analysis to a recently published study that showed a small benefit of multivitamin supplementation for preventing. Follow-up continued for a median of 11 years.

No difference was found between the groups in risk for any major adverse CVD event, including myocardial infarction, stroke, or cardiac-related mortality. Multivitamin supplementation also was not beneficial in the small subgroup of men with histories of CVD at study entry (5% of participants).

Published in *J Watch Gen Med*. November 15, 2012 — Thomas L. Schwenk, MD. ■

Clindamycin vs. Trimethoprim/Sulfamethoxazole for Soft-Tissue Infections — A Clinical Trial That Needs Some Marketing

Key point: A clinical trial on treatment of skin and soft-tissue infections using clindamycin vs. trimethoprim/sulfamethoxazole has widespread clinical applications, yet may receive little if any attention. The drugs were fairly evenly matched in terms of efficacy. These drugs are VERY inexpensive.

Citation: <http://blogs.jwatch.org/hiv-id-observations/index.php/clindamycin-vs-tmpsmx-for-soft-tissue-infections-a-clinical-trial-that-needs-some-marketing/2013/09/13/>

This was a randomized, double-blind trial, to compare Clindamycin vs. Trimethoprim/Sulfamethoxazole. Eligible subjects had a skin infection (abscess and/or cellulitis), were not systemically ill, diabetic, or needing hospitalization. If abscesses were present, they were drained. Participants were then randomized to clindamycin 300 mg three-times daily or TMP/SMX 1 DS tablet twice daily for 10 days, along with matching placebos. 524 study subjects enrolled at 4 US sites; they had a mean age of 27, with 30% younger than 13. 45% had purulent drainage, and virtually all had I and D as part of their management; the remainder had cellulitis alone. Among those who had cultures, more than half had MRSA; 14% of the *Staph aureus* isolates had resistance to clindamycin.

14 days after enrollment, 80% of the clinda and 78% of the TMP/SMX group were cured. (About half of the "failures" were really loss to follow-up.) Diarrhea was more common in the clindamycin arm; there were no cases of *C diff*, and no severe rashes to TMP/SMX.

How to choose? Here are some pros and cons.

- **Clindamycin** is famously good for beta strep, and active against most (but not all) *Staph aureus*, including MRSA. But, there's that diarrhea nastiness, with or without *C diff*.
- **TMP-SMX** is active against virtually all *Staph aureus*, but whether it's a beta-strep drug depends on whom you ask (many think it isn't). And of course, it rarely can cause severe rashes and systemic hypersensitivity reactions. ■

Possible Future of Evaluating Febrile Infants

Key point: Rapid molecular analysis of blood may soon replace standard cultures in the management of young febrile infants.

Citation: Mahajan P, Ramilo O, Kuppermann N. The future possibilities of diagnostic testing for the evaluation of febrile infants. *JAMA Pediatr*. 2013;167(10):888-898.

One of the major issues in acute care pediatrics is management of febrile infants, especially those aged >3 months. Although most such episodes are not caused by serious bacterial infection (SBI), the rapidity with which life-threatening infections can develop in infants who appear only mildly ill often results in unnecessary hospitalization and use of broad-spectrum intravenous antibiotics.

Investigators have attempted to develop clinical criteria that—used in combination with laboratory screening tests—can define a group of infants who are unlikely to have SBI and thus do not require hospitalization or empirical antibiotics, but no criteria or clinical prediction rules have been sufficiently definitive to rule out SBI. False-positive results with blood and cere-

brospinal fluid cultures and the ensuing need for additional, unnecessary tests and possible hospitalization may outweigh the possible benefits of these measures.

A solution to this problem requires tests that can positively recognize patterns of bacterial disease with high sensitivity and few false-positives. Mahajan and colleagues propose that molecular assays in current development have such characteristics. Although polymerase chain reaction has become the standard for detecting many viruses, it has not yet proven sufficiently sensitive for detection of bacteria in the blood. However, microarray analysis of the RNA of blood leukocytes can reveal distinct host responses to various classes of pathogens and allow differentiation among them (e.g., bacteria vs. viruses, gram-positive vs. gram-negative bacteria) without requiring pre-incubation or culture. Based on promising small studies that have already been published, the authors call for prospective evaluation of this approach. ■

Clinical Practice Guidelines Require Scrutiny for Quality

Key point: *Two studies revealed problems with endocrine and oncology guidelines.*

Citations: Brito JP, Domecq JP, Murad MH, et al. The Endocrine Society guidelines: When the confidence cart goes before the evidence horse. *J Clin Endocrinol Metab.* 2013;98(8):3246-3252 and Reames BN, Ponto SN, Wong SL. Critical evaluation of oncology clinical practice guidelines. *J Clin Oncol.* 2013;10(31):2563.

In two critical evaluations, investigators have assessed the reliability of clinical practice guidelines.

The first study concerned guidelines issued by the Endocrine Society, which uses the GRADE system (each recommendation is rated as strong or weak, and the quality of evidence supporting each recommendation is rated as high, moderate, low, or very low). Among 357 recommendations in 17 guidelines issued between 2005 and 2011, 121 (34%) combined a strong recommendation with low-quality evidence. Such guidelines require scrutiny because they strongly advocate a particular practice despite relatively weak supporting evidence. Using an explicit process, the authors found 33 instances in which no compelling justification for a strong- recommendation/low-evidence guideline existed.

In a second study, researchers reviewed 169 guidelines on prostate, lung, breast, and colorectal cancer published between 2005 and 2010. To determine whether guidelines were trustworthy, each was scored according to 8 standards published by the Institute of Medicine. On average, guidelines fulfilled only 2.75 of the 8 standards. ■

Influenza Prevention and Control Recommendations: 2013–2014

Key point: *Updated recommendations from the AAP for use of seasonal influenza vaccine and antiviral medications in infants and children.*

Citation: Committee on Infectious Diseases. Recommendations for prevention and control of influenza in children, 2013–2014. *Pediatrics.* 2013 Sep 2; [e-pub ahead of print].

Influenza seasons vary in severity, and last year's season was associated with higher morbidity and mortality than the previous season. These recommendations apply to the 2013–2014 season.

Recommendations: The AAP recommends annual influenza vaccination for children and adolescents aged ≥6 months with either trivalent or quadrivalent vaccine.

- The number of vaccine doses depends on the child's age at the time of first dose as well as previous vaccine receipt
 - Children aged >9 years receive one dose.
 - Children aged 6 months to 9 years require two doses separated by 4 weeks unless they have previously received ≥2 vaccine doses since July 1, 2010
- Inactivated influenza vaccine (IIV) is available for intramuscular injection in both trivalent and quadrivalent formulations. These vaccines are available in both inactivated form and live attenuated intranasal form.
- These vaccines can be administered to children with mild egg allergy (hives). Children with severe egg allergy (anaphylaxis) should be referred to an allergist prior to vaccination
- Treatment with antiviral agents in children is recommended as follows (dosage and schedule recommendations for infants aged <12 months are provided):
 - Hospitalized children with presumed or proven influenza illness
 - All children with underlying conditions that predispose them to complication of influenza
 - Consider treatment for healthy children who may benefit from a shortened duration of symptoms, if the antiviral can be administered within 48 hours of illness

During the 2012–2013 season, 160 influenza-associated pediatric deaths were reported, and many of these deaths could have been prevented by the vaccine. Influenza virus is unpredictable, and infection in children frequently heralds community infection. Immunization of infants and children early in the season is crucial to reducing illness and deaths each year. Healthcare providers should be fierce advocates for this vaccine. ■

Management of Superficial Venous Thrombosis

Key point: Nearly 10% of untreated patients experienced symptomatic SVT extension.

Citation: Lizzorovicz A, Becker F, Buchmuller A, Quere I, Prandoni P, and Decousus H for the CALISTO Study Group. Clinical relevance of symptomatic superficial-vein thrombosis extension: Lessons from the CALISTO study. *Blood*. 2013;122(10):1724-1729.

Thrombi often arise in the superficial veins of the leg. Those forming near the saphenofemoral junction (SFJ) are treated by saphenous vein ligation, thrombectomy, or anticoagulation. But whether superficial vein thrombosis (SVT) distal to the SFJ requires more than analgesics and local measures has been controversial.

To examine the frequency of thrombus extension, deep vein thrombosis (DVT), and pulmonary embolism (PE) in patients with SVT who do not receive anticoagulants, investigators analyzed data from the industry-sponsored, placebo-controlled CALISTO trial (N Engl J Med 2010; 363:1222). In that study, 3002 patients were randomized to receive placebo or the synthetic low-molecular-weight heparin fondaparinux (2.5 mg subcutaneously per day) and were followed for up to 77 days.

Symptomatic extension of the index SVT occurred in 9.4% of placebo patients, of whom 6.4% had DVT and 2.7% had PE; proximity of the thrombus to the SFJ was unrelated to the incidence of DVT or PE. In contrast, only 1.9% of fondaparinux recipients developed SVT extension (relative risk, 0.21; $P < 0.001$), and none developed DVT or PE. Fondaparinux recipients also used fewer healthcare resources, such as inpatient and outpatient visits, surgical treatment of the SVT, and therapeutic-dose anticoagulants. ■

Isolated Sternal Fractures May Not Warrant Hospital Admission

Key point: Most patients with isolated sternal fractures can be safely discharged after emergency department evaluation.

Citation: Odell DD, Peleg K, Givon Ad, et al. Sternal fracture: Isolated lesion versus polytrauma from associated extrasternal injuries-analysis of 1,867 cases. *J Trauma Acute Care Surg*. 2013;75(3):448-452.

Sternal fractures are usually associated with high-energy trauma. Conventional wisdom has been that patients with sternal fractures require hospitalization because of the injury mechanism (usually motor vehicle crash), potential for occult associated injury, and severity of pain. In this retrospective study of 1867 patients with sternal fracture who were admitted to Israeli trauma centers over a 12-year period, the authors compared in-hospital events between patients with isolated

sternal fractures (26%) and those with sternal fractures associated with other injuries (polytrauma; 73%).

Patient characteristics and mechanisms of injury (mostly motor vehicle collisions and falls from significant height) were similar in the two groups. Compared with patients with polytrauma, those with isolated sternal fractures less frequently exhibited tachycardia, hypotension, tachypnea, Glasgow Coma Scale score ≤ 14 , and Revised Trauma Score ≤ 11 . No patients with isolated sternal fracture required endotracheal intubation, chest tube, thoracoscopy, or resuscitative thoracotomy; these procedures were performed in 17% of patients with polytrauma. ■

A Green Light for Colchicine to Treat Acute Pericarditis

Key point: When added to anti-inflammatory agents, the drug significantly improved outcomes after a first attack.

Citation: A randomized trial of colchicine for acute pericarditis. *N Engl J Med* 2013 Sep 1; [e-pub ahead of print]. (<http://dx.doi.org/10.1056/NEJMoa1208536>)

Although some experts have recommended the use of colchicine for acute pericarditis, the recommendation has not been based on strong clinical-trial evidence. To address this gap in knowledge, investigators conducted the randomized, double-blind, ICAP trial at five centers in Italy. They assigned 240 patients with a first episode of acute pericarditis to receive colchicine (0.5 mg twice/day for patients weighing > 70 kg and 0.5 daily for those weighing ≤ 70 kg) or placebo for 3 months. All patients were treated with anti-inflammatory agents, mostly aspirin or ibuprofen.

The primary endpoint, incessant or recurrent pericarditis during 18-month follow-up, occurred significantly less frequently in the colchicine group than in the placebo group (17% vs. 38%; relative risk, 0.56; 95% confidence interval, 0.30–0.72). Also, fewer patients in the colchicine group had persistent symptoms at 72 hours (19% vs. 40%; $P = 0.001$). The remission rate at 1 week was higher in the colchicine group than in the placebo group (85% vs. 58%; $P < 0.001$). Adverse-event rates were similar in the two groups. ■

Undervaccination Linked to Increased Risk of Pertussis

Key point: Young children who do not receive age-appropriate vaccinations for pertussis are up to 30 times more likely to acquire pertussis than children who are fully vaccinated.

Citation: Glanz JM, Norwaney KJ, Newcomer SR, et al. Association Between Undervaccination With Diphtheria, Tetanus Toxoids, and Acellular Pertussis (DTaP) Vaccine and Risk of Pertussis Infection in Children 3 to 36 Months of Age. *JAMA Pediatr*. 2013;167(11):1060-1064.

Roughly 70 children with pertussis aged 3 to 36 months were matched to nearly 300 disease-free control patients. Children who were undervaccinated — that is, they had fewer than the four recommended doses of the diphtheria, tetanus toxoids, and acellular pertussis (DTaP) vaccine — were more likely to have laboratory-confirmed pertussis than children who were vaccinated on schedule. Patients who had missed three or four doses were, respectively, 19 and 28 times more likely to acquire pertussis.

The authors estimate that over a third of all pertussis cases in this population were attributable to undervaccination.

They conclude: “Our data suggest that undervaccination, whether due to parental refusal of vaccines or other barriers to health care, is an important contributing factor.” ■

Tylenol Overdoses Spotlighted

Key point: *Acetaminophen has a significant potential for causing harm and despite being OTC, controls should be enacted on the drug.*

Citation: <http://www.propublica.org/series/overdose>

More than 150 Americans die each year from accidental acetaminophen poisoning, while tens of thousands are hospitalized for overdosing on the painkiller, according to an investigative series by ProPublica. The report says the FDA has been slow to act in protecting consumers, and the manufacturer has argued against restrictions.

The latest story lays out nine proposals that could reduce the drug’s toll, including:

- lowering the maximum daily dose from 4 g (eight extra-strength pills) to 3 g (six pills)
- allowing only a single pediatric strength
- removing acetaminophen from prescription opioids
- restricting the number of pills consumers can buy at one time
- instructing those using extra-strength acetaminophen to start with one pill and increase to two if their pain does not improve. ■

U.S. Hospitalizations for Pneumonia after a Decade of Pneumococcal Vaccination

Key point: *Children who receive a vaccine to prevent blood and ear infections may be reducing the spread of pneumonia to the rest of the population, especially their grandparents and other older adults.*

Citation: Griffin MR, Zhu Y, Moore MR, et al. U.S. Hospitalizations for Pneumonia after a Decade of Pneumococcal Vaccination. *N Engl J Med.* 2013;369:155-163.

The introduction of 7-valent pneumococcal conjugate vaccine (PCV7) into the U.S. childhood immunization schedule in 2000

has substantially reduced the incidence of vaccine-serotype invasive pneumococcal disease in young children and in unvaccinated older children and adults. By 2004, hospitalizations associated with pneumonia from any cause had also declined markedly among young children. Because of concerns about increases in disease caused by nonvaccine serotypes, the authors wanted to determine whether the reduction in pneumonia-related hospitalizations among young children had been sustained through 2009 and whether such hospitalizations in older age groups had also declined.

The authors estimated annual rates of hospitalization for pneumonia from any cause using the Nationwide Inpatient Sample database. The reason for hospitalization was classified as pneumonia if pneumonia was the first listed diagnosis or if it was listed after a first diagnosis of sepsis, meningitis, or empyema. Average annual rates of pneumonia-related hospitalizations from 1997 through 1999 (before the introduction of PCV7) and from 2007 through 2009 (well after its introduction) were used to estimate annual declines in hospitalizations due to pneumonia.

The annual rate of hospitalization for pneumonia among children younger than 2 years of age declined by 551.1 per 100,000 children (95% confidence interval [CI], 445.1 to 657.1), which translates to 47,000 fewer hospitalizations annually than expected on the basis of the rates before PCV7 was introduced. The rate for adults 85 years of age or older declined by 1300.8 per 100,000 (95% CI, 984.0 to 1617.6), which translates to 73,000 fewer hospitalizations annually. For the three age groups of 18 to 39 years, 65 to 74 years, and 75 to 84 years, the annual rate of hospitalization for pneumonia declined by 8.4 per 100,000 (95% CI, 0.6 to 16.2), 85.3 per 100,000 (95% CI, 7.0 to 163.6), and 359.8 per 100,000 (95% CI, 199.6 to 520.0), respectively. Overall, the authors estimated an age-adjusted annual reduction of 54.8 per 100,000 (95% CI, 41.0 to 68.5), or 168,000 fewer hospitalizations for pneumonia annually.

Declines in hospitalizations for childhood pneumonia were sustained during the decade after the introduction of PCV7. Substantial reductions in hospitalizations for pneumonia among adults were also observed. ■

Had Any Interesting Cases Lately?

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

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ICD-10

■ DAVID STERN, MD, CPC

Q. My staff keeps telling me that my documentation will have to change in order for them to properly choose an ICD-10 diagnosis code. Is that true?

A. Documentation practices should not have to change but it will be helpful to understand the granularity of the new codes. There is greater specificity including laterality, temporal factors, contributing factors, symptoms, manifestations, and anatomic location. Thus, if you currently gloss over details in the medical record, you will need to document more specifics in order to support the appropriate code.

You will want to make clear the anatomical location, right or left, whether the condition is acute, chronic, or chronic with an acute exacerbation. Documenting any prior issues regarding the current condition is still important, as well as any additional information regarding the patient's environment (exposed to second hand smoke, tobacco dependence, tobacco use, etc.).

For example, a patient presents with ear pain and a fever. She has suffered bouts with acute purulent otitis media (OM) three times in the past 6 months. The patient is prescribed antibiotics, gets better, but then her condition recurs. The patient's father smokes in the home. Examination reveals a bulging, cloudy, immobile right tympanic membrane with purulent fluid. The left ear is normal. The diagnosis is right recurrent purulent OM. The coder assigns ICD-10 codes H66.004, "Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, right ear" and Z77.22, "Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic)."

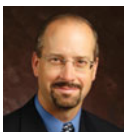
Keep in mind that external cause codes are not mandatory unless you are subject to a state-based external cause code reporting mandate or these codes are required by a particular

"Because there are so many changes in the codes, you might want to start by identifying your most-used codes and compare ICD-9 codes to ICD-10 codes. You will find that a single ICD-9 code will often map to multiple, more specific ICD-10 codes. Review your documentation to make sure that it includes enough information to select the most specific ICD-10 code available for the encounter."

payor. However, you are encouraged to report external cause codes because they provide valuable data for injury research and evaluation of injury prevention strategies.

There are hundreds of changes in the fracture code set. For example, a patient presents for a recheck of his distal radial torus fracture of the right arm. Everything is healing well and he will return the following week for possible cast removal. The appropriate ICD-10 code is S52.521D. The first part of the code (S52) represents the fracture of the forearm; the (52) after the decimal represents the torus fracture of lower end of the radius; the (1) represents the right arm; and the (D) reports that the visit is a subsequent visit. If you were billing for this visit today, you would use diagnosis code V54.12, "Aftercare for healing traumatic fracture of lower arm."

Because there are so many changes in the codes, you might want to start by identifying your most-used codes and compare ICD-9 codes to ICD-10 codes. Because ICD-10 is much more granular than ICD-9, you will find that a single ICD-9 code will often map to multiple, more specific ICD-10 codes. Review your documentation to make sure that it includes enough information to select the most specific ICD-10 code available for the encounter.



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

"You can find ICD-9 to ICD-10 translator tools online. AAPC offers a free tool at <http://www.aapc.com/icd-10/codes/index.aspx>"

You can find ICD-9 to ICD-10 translator tools online. AAPC offers a free tool at <http://www.aapc.com/icd-10/codes/index.aspx> and you do not have to be a member to use it. However, while the tool is nice to have, it should not be used in lieu of ICD-10 training, a coding book or an online coding program. ■

Q. I heard that insurance companies will deny more claims once we start using ICD-10, especially if an unspecified code is billed. Have you any insight on the subject?

A. It is difficult to be certain what the payors will do. Although there may be a transition period while all payors get onboard with the new technology to handle the new codes, the additional specificity of ICD-10 codes may actually reduce the number of requests for additional information. Along that same line, you will want to make sure your documentation is detailed enough that the coder can assign a specific code or that your EMR prompts you to code more specifically.

One concern of many coders is that payor software systems may produce many inappropriate denials for ICD-10 codes that have not been properly mapped to support CPT and HCPCS codes. I currently warn clients that these denials are likely to be frequent with many payors, and it is likely to take at least 3 to 6 months for payors to correct these issues.

In both ICD-9 and ICD-10, unspecified codes have acceptable uses. Although specific diagnosis codes should be reported when reflected in the medical record, sometimes an unspecified code most accurately reflects the encounter. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular condition, it is acceptable to report the appropriate unspecified code. For example, in almost all patients diagnosed with pneumonia in the urgent care center, the specific organism has not been identified. In these cases, the most accurate code would be J18.9, "Pneumonia, unspecified organism." ■

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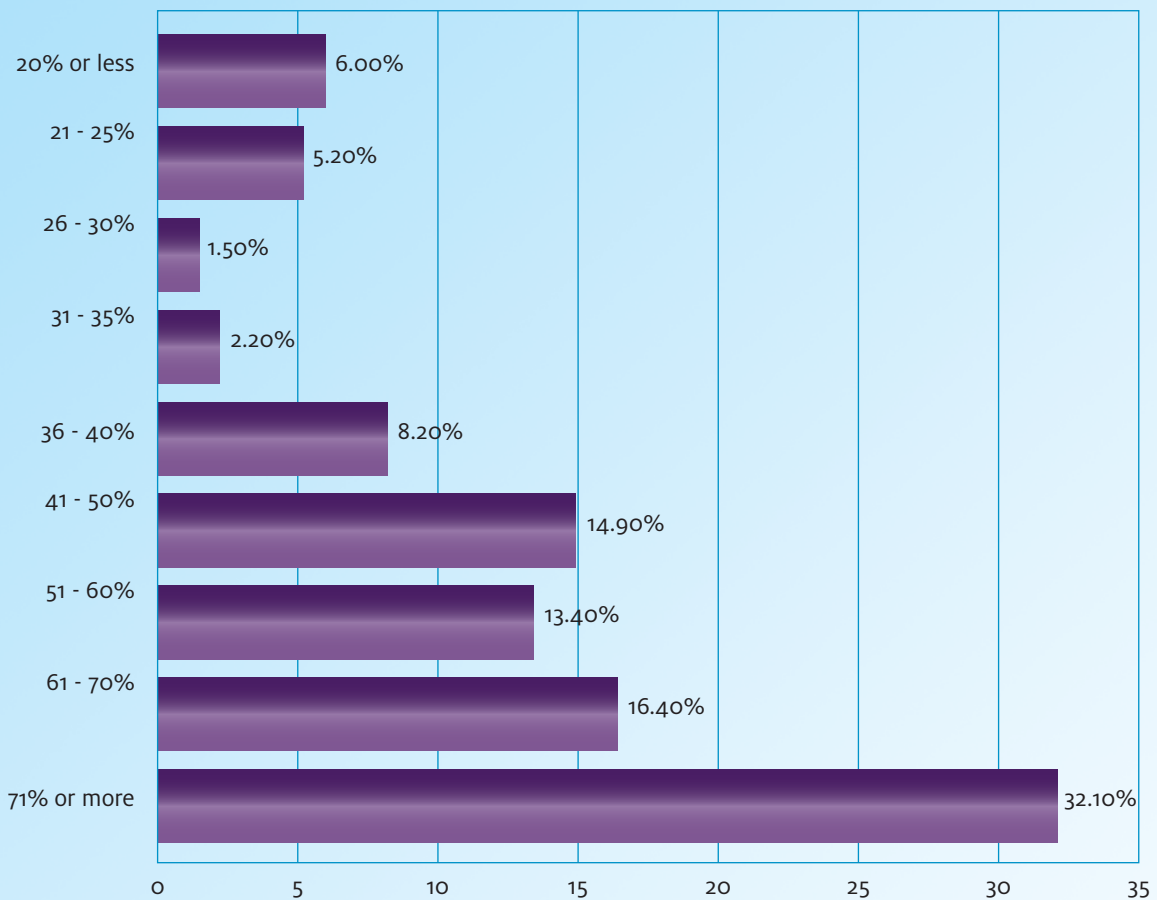


DEVELOPING DATA

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

In this issue: What Percentage of Patients Have a Regular Primary Care Physician Outside of the Urgent Care Center?

PERCENTAGE OF PATIENTS WITH A REGULAR PRIMARY CARE PHYSICIAN OUTSIDE OF CENTER



An average of 58.9% of urgent care patients already have a primary care physician (PCP) outside the urgent care center, leaving approximately 40% of patients who may be using an urgent care as their PCP. However, with 17.9% of urgent care centers also doing formal primary care, that number is likely closer to only 20% using an urgent care "in place of" having a regular PCP (n=134).

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



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