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Urgent Care
Association
of America



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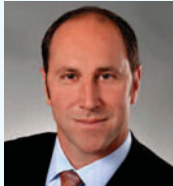


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LETTER FROM THE EDITOR-IN-CHIEF

Physicians Criticizing Physicians: A Two-Headed Snake



In the Hippocratic Oath it is written and we are bound: "To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art — if they desire to learn it — without fee and covenant."

This section of the Hippocratic Oath is a reminder, albeit a chauvinistic one, of the brotherhood of physicians. It represents the bond we share and the respect we should show each other. I dream of the time when this was a more visible and apparent part of physician life. Images of the physicians lounge (now mostly gone), with cigarette-smoking surgeons sharing war stories come to mind. But this is certainly not my time (more on this later). I have not felt it since residency, when shared sacrifice and pain built strong fraternal bonds.

Through the oath we are also sworn: "All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal." Yes, there is a history of secrets in medicine, necessary it was assumed to protect the profession first and foremost. The secrecy of the profession, it was thought, was unequivocally in the best interest of its patients, as it protected the art from the frivolous scrutiny of laypeople that, it was felt, produced more harm than good.

Well, I don't have to hyperbolize the end of those days. It is a new era for the profession for sure, and the self-governing control has been wrested, for better or worse. The scrutiny can at times feel insufferable, with the eyes of regulators, insurers, lawyers and administrators always glaring down. Yes, the demons of the profession are many, and yet, a new snake has overtaken the others, producing more venom than them all. Our colleagues, our own brothers and sisters, our sworn comrades, are spewing more defamatory slander at each other than the sensationalized malpractice lawyers. An urgent care shift almost never passes without hearing a patient referencing another physician's criticism of my work or the work of my colleagues. "The ER doctor said I didn't need to be there. That urgent care is known for transferring patients who don't need it." "Why did that doctor put you on that medicine?" "Why didn't that doctor put you on any medicine?" "That splint

Our colleagues, our own brothers and sisters, our sworn comrades, are spewing more defamatory slander at each other than the sensationalized malpractice lawyers.

is terrible!" "That doctor misread your x-rays." It goes on and on like that. I often wonder aloud: "Is it me?" "Am I incompetent?" "Am I an embarrassment to my profession?" Unfortunately, of course, these venomous communications are common to all of us now. No one is protected. And our exaggerated vulnerability drives more and more of it as we jockey for position.

Yes, our self-inflicted wounds are now one of the profession's biggest risks and we simply must find a way to stop it. The path, however, is certainly unknown. How can we find a way to reveal the problem, and cut off the head of the snake? What is the forum for demonstrating the irreversible harm? With all the distracting noise in the profession, how will we elevate the issue above the fray? I am fearful, sad to say, that it will not, but I am committed to doing my part.

I have made a promise to represent the best care for my patients at the time I see them and from the lens that I view them. I will not diminish, slander or lay blame on my colleagues (this is, of course, not to say that I will remain silent in the face of illegal or unethical conduct). I will not participate in the pervasive fault-finding that has overcome the profession that I love...and to the detriment of us all.

That is my oath. An addendum, perhaps to the one I took in medical school. The one worth revisiting from time to time for all of us. ■

Lee A. Resnick, MD
Editor-in-Chief

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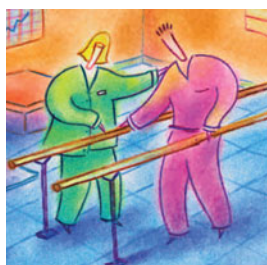
CLINICAL

9 An Urgent Care Approach to Complications and Conditions of Pregnancy

From pregnancy confirmation to the evaluation of bleeding, urgent care centers are often the initial location for management of obstetric issues. Careful use of evidence-based guidelines is the key to successful outcomes.

David N. Jackson, MD, FACOG

PRACTICE MANAGEMENT



21 Creating Value By Adding Physical Therapy to Urgent Care

PART II: Tactical Considerations

Part 1 of this article, in the June issue, looked at initial considerations for enhancing urgent care profitability by providing physical therapy services. In Part 2, the authors address tactical considerations, from revenue to staffing models.

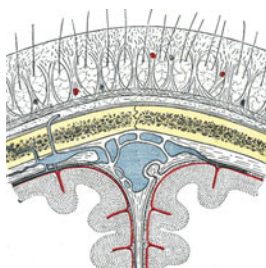
Laurel Stoimenoff, PT, and Hilary Hellman, SLP

CASE REPORT

27 Dissecting Cellulitis of the Scalp

Prompt recognition of dissecting cellulitis is important to help patients receive appropriate treatment and avoid long-term consequences such as alopecia.

Mohamed A Fayed, MD



IN THE NEXT ISSUE OF JUCM

Nearly 160 million visits are made to urgent care clinics in the United States every year, yet no prospective studies have been done to explore how pregnancy might impact these consultations. Next month's cover story—the second of a two-part series—offers urgent care providers evidence-based guidelines for management of patients who present with pregnancy-related bleeding, preeclampsia, minor trauma and abdominal pain. It also provides expert perspective on issues related to medication use in pregnancy.

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Mission Statement

JUCM The Journal of Urgent Care Medicine supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing health-care 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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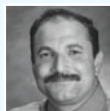
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JUCM CONTRIBUTORS

Urgent care centers are often a patient's initial point of care for conditions related to gestation and this month's cover story is Part 1 of a two-part series on common pregnancy-related issues. In this installment, David N. Jackson, MD, FACOG, provides evidence-based guidelines for confirming pregnancy and managing complaints such as genitourinary infections, nausea and vomiting of pregnancy, gastroesophageal reflux disorder, vaginitis and cervicitis, and pediatric illnesses that represent a risk during pregnancy.



Dr. Jackson is a Professor of Maternal-Fetal Medicine at the University of Nevada, Las Vegas, Nevada.

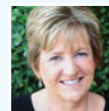


Author Mohamed A., Fayed, MD, underscores the importance of prompt diagnosis and appropriate treatment for a chronic skin condition with potentially severe consequences in this month's case report. The patient was a 39-year-old African-American male who shaved his head and presented with scalp boils. The diagnosis? Dissecting cellulitis.

Dr. Fayed is Internal Medicine Chief Resident at Wright State University, VA Dayton Medical Center, and an urgent care physician at Hometown Urgent Care, both in Dayton, OH.

Authors Laurel Stoimenoff, PT, and Hilary Hellman, SLP,

conclude our two-part series on enhancing urgent care center profitability by adding physical therapy in this month's practice management article. In it, you'll find a wealth of information on tactical considerations for implementing physical therapy, such as the revenue cycle, patient scheduling, and equipment purchases.



Ms. Stoimenoff is a Principal at Continuum Health Solutions, LLC, a consulting company headquartered in Mesa, Arizona, a member of the UCAOA Board of Directors, and a member of the JUCM Editorial Board. Ms. Hellman is a Principal at Ancillary Care Solutions, a national therapy management company with corporate offices in Scottsdale, Arizona.

Also in this issue:

In the final installment of a three-part series on a malpractice suit, **John Shufeldt, MD, JD, MBA, FACEP**, discusses jury selection, opening statements, the trial, and the aftermath.

In Coding Q&A, **David Stern, MD, CPC**, discusses 2013 Physical Therapy G Codes.

Our Developing Data end piece this month looks at the payor mix for urgent care centers. ■



Editor's note: We are proud to announce that JUCM won Gold and Silver Awards in the American Society of Healthcare Publication Editors 2013 Awards Competition.

The May 2012 cover of JUCM, with its eye-catching photo with a view from inside a patient's mouth during an oral examination, won the Gold Award for Best Cover: Photo. By almost literally putting the viewer "in the dentist's chair," it spoke eloquently to both our readers and the contest judges of the need for urgent care providers to deal with dental emergencies with both efficiency and compassion. Congratulations to Art Director Tom DePrenda for the award, JUCM's first Gold for a cover and third in the journal's history.

The May 2012 cover story—on Managing Dental Emergencies—won the Silver Award for Best Feature Article. With this article, authors Katherine Hurst, MSc, MD, and Richard E. Walton, DMD, MS, armed urgent care providers with the information they need, through text, illustrations and photos, to effectively manage common and less common, treatable dental emergencies. We're proud of our association with Drs. Hurst and Walton and their contribution and we salute them and all of our authors.

This is the sixth year in a row that JUCM has been recognized in the ASHPE competition and our third Gold Award and third Silver Award.



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■ P. JOANNE RAY

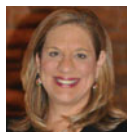
What changes are you prepared to make to position yourself and your urgent care center(s) for greater success in light of the (albeit not yet fully known) impending realities of healthcare reform?

UCAOA's diverse segments and types of providers, owner/operators and support personnel face significant change due to healthcare reform and resulting market changes, including Accountable Care Organizations (ACOs), health information exchanges, a shift toward value-based payments, and healthcare industry consolidation. In the coming months, UCAOA will provide a series of resources, tools, educational sessions, and talking points to help you navigate the landscape and position your center for success.

We began our work with a panel and leadership forum in Orlando in April focused on personalizing this discussion to the industry, practice, and management of urgent care medicine. The dialogue and information exchange was thought- and action-provoking and highlighted some of the issues many of our members and your centers will need to grapple with as this environment unfolds. The future role of urgent care, the effects of a changing healthcare delivery system and provider strategies, the importance of proactively and strategically reaching out to our customers and healthcare colleagues in our communities, and the role UCAOA should play in assisting members in doing so were all discussed. As our new president, Dr. Nate Newman, noted in this column space in the May issue of *JUCM*, there are many questions still to be answered.

Since Orlando, we have developed a work plan that will be rolled out in the coming months, including:

- Assessment tools to determine our individual members' and member centers' needs;




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

UCAOA's diverse segments and types of providers, owner/operators and support personnel face significant change due to healthcare reform and resulting market changes, including Accountable Care Organizations (ACOs), health information exchanges, a shift toward value-based payments, and healthcare industry consolidation.

- Talking points and "how-to" guides to create or strengthen partnerships in your communities;
- Dedicated 1-day course at the Urgent Care Fall Conference;
- Webinars;
- Outreach to payors to increase industry understanding and awareness; and
- A series of "what does this mean for us" messages to help you understand the implications for you and your centers both as providers and as employers.

We recognize that there is a swirling plethora of information in the trade and mainstream news regarding ACOs, health insurance exchanges, and other reform tactics. It is our goal to translate this information in a way that makes it relevant and personalized to urgent care. ■



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An Urgent Care Approach to Complications and Conditions of Pregnancy

Urgent message: From pregnancy confirmation to the evaluation of bleeding, urgent care centers are often the initial location for management of obstetric issues. Careful use of evidence-based guidelines is the key to successful outcomes.

DAVID N. JACKSON, MD, FACOG

Introduction

Although close to 160 million visits are made to urgent care providers each year in the United States, there are currently no prospective studies describing how pregnancy may initiate or complicate an urgent care consultation. Until further research is available, this article hopes to provide the urgent care practitioner with evidence-based guidelines for common pregnancy-related issues, from confirmation of pregnancy through infections and illnesses related to gestation.

The Most Common Complaints

An internal audit of our quick care system performed in 2012 found that vaginal discharge, urinary tract infections (UTIs), hyperemesis, vaginal bleeding, and abdominal pain were the most common pregnancy-related issues. Perez reported that vaginal bleeding, postpartum care, pelvic pain, and pelvic or vaginal infections were the most common “urgent care” complaints in a system specializing in ob/gyn.¹ These limited experiences encompass only a fraction of syndromes likely to be encountered in urgent care pregnancy services. Part 1 of this two-part series will discuss:

David N. Jackson is a Professor of Maternal-Fetal Medicine at the University of Nevada, Las Vegas, Nevada.



- Pregnancy confirmation
- Genitourinary infections
- Nausea and vomiting of pregnancy
- Gastroesophageal reflux disease (GERD)
- Vaginitis and cervicitis
- Pediatric illness with pregnancy risks

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INDICATION

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

ADJUNCTIVE MEASURES

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

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

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

IMPORTANT SAFETY INFORMATION FOR SKLICE LOTION

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

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

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

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

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

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

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

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Rx Only

1 INDICATIONS AND USAGE

1.1 Indication

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

1.2 Adjunctive Measures

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

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

2 DOSAGE AND ADMINISTRATION

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

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

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

Avoid contact with eyes.

4 CONTRAINDICATIONS

None.

5 WARNINGS AND PRECAUTIONS

5.1 Ingestion in Pediatric Patients

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

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

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

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

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category C

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

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

Human Data

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

Animal Data

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

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

8.3 Nursing Mothers

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

8.4 Pediatric Use

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

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

8.5 Geriatric Use

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

10 OVERDOSAGE

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

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

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129685

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

IVE-BPLR-SA-FEB12

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TABLE 1. Antibiotics to Treat Acute Cystitis in Pregnancy

- Nitrofurantoin (Macrobid) 100 mg twice daily. Do not use in patients with glucose-6-phosphate dehydrogenase (G6PD) deficiency (causes hemolysis)
- Cephalexin (Keflex) 250-500 mg twice daily to QID.
- Amoxicillin 250-500 mg three to four times daily. Because many strains of uropathogens in pregnancy are now resistant to ampicillin or amoxicillin, monotherapy should only be used if enterococcus is the cause of infection and sensitivities confirm efficacy.
- Amoxicillin-clavulanate (Augmentin) 875 mg twice daily
- TMP-SMX double strength (Bactrim-DS, Septra-DS) twice daily. Should not be used near the time of delivery as it may aggravate neonatal jaundice. Avoid trimethoprim in the first trimester because it is a folate antagonist.

Quinolone antibiotics such as ciprofloxacin should not be used in pregnancy.
TMP-SMX = trimethoprim-sulfamethoxazole

Part 2 will review:

- Pregnancy bleeding
- Preeclampsia
- Minor trauma
- Abdominal pain
- Medication use in pregnancy.

Pregnancy Confirmation

Pregnancy detection is frequently offered in urgent care.² We reviewed 50 consecutive web pages advertising urgent care services, and 80% confirmed that rapid “walk-in” pregnancy testing was available. Because urine tests begin to discriminate hCG levels at 25 to 32 days after the last menstrual period (LMP), a negative urine test should be repeated if it has been less than 30 days from the previous LMP. For any patient in whom bleeding, pain, or symptoms suggest ectopic pregnancy, spontaneous abortion, or molar gestation, an urgent care practitioner should preferentially recommend a quantitative serum hCG. This allows for serial comparison of hCG rise or fall in subsequent visits.

Urinary Symptoms in Pregnancy

Acute symptomatic cystitis develops in only 1% of pregnant patients. Any patient with dysuria, urgency and/or hematuria during pregnancy should be evaluated with urinalysis and culture. Approximately 80% of positive cultures will return *E coli*. The remainder typically includes *Proteus* species, *Klebsiella pneumoniae*, group B streptococci, enterococci, and staphylococci. **Table 1**

lists antibiotics appropriate for use in treatment of acute cystitis in pregnancy. All should be used for 7-14 days, followed by a test of cure 1 week after completion of the antibiotic course.

Uncomplicated urinary colonization in pregnancy. Pregnant patients without symptoms may test positive for leukocyte esterase or nitrites on urine dipstick obtained routinely during an urgent care visit. Asymptomatic bacteriuria is confirmed by the presence of >100,000 organisms/mL in midstream urine culture. If untreated, up to 25% of these patients will progress to pyelonephritis and have significant risk of morbidity. Treatment reduces pyelonephritis by 80% and reduces preterm delivery by 40%. Typical treatment for asymptomatic bacteriuria is 5 to 7 days followed by culture for cure. Because urine dipstick has high sensitivity but poor specificity, each urgent care center should decide if all pregnant women require midstream urinalysis and culture for asymptomatic bacteriuria.

Nitrofurantoin for asymptomatic bacteria appears safe in all trimesters of pregnancy. Nitrofurantoin is not active against *Proteus* spp. Alternative therapies are 3 to 7 days of sulfisoxazole (500 mg 4 times a day) or trimethoprim/sulfamethoxazole (TMP-SMX) daily or cephalexin (250 to 500 mg 4 times a day). Emerging high resistance rates limit amoxicillin use (250 mg 3 times a day) as a single agent unless sensitivities indicate efficacy. Cephalexin is not active against enterococcus and should not be used if enterococcus is identified.³ TMP-SMX should theoretically be avoided late in gestation because of the sulfonamides' ability to displace bilirubin from albumin-binding sites and cause neonatal jaundice.

If Group B *Streptococcus* (GBS) is identified, counseling includes treatment with antibiotics at the time of diagnosis. Such patients also should be flagged as high risk and requiring intrapartum antibiotics to decrease early-onset neonatal sepsis.

If culture for cure shows persistent colonization, or if recurrent infections occur, chronic suppressive therapy with nitrofurantoin, 100 mg q hs, is indicated.

Pyelonephritis. Up to 2% of pregnancies are complicated by pyelonephritis. The release of endotoxins causes patients to present with fever, leukocytosis, and kidney tissue inflammation, producing the classic symptoms of flank pain and costovertebral angle tenderness (CVAT). Symptoms in pregnancy are also characterized by a 1- to 3-day history of chills, urinary frequency, and nausea with emesis. Urinalysis will show significant bacteriuria and leukocytes. Patients in an urgent care

center who are suspected of having pyelonephritis in pregnancy should be referred for immediate inpatient management to monitor for sepsis, premature labor, or progression to significant maternal respiratory distress from adult respiratory distress syndrome. The most common recovered organism in pyelonephritis in pregnancy is *E. coli* and therapy requires intravenous antibiotics until asymptomatic, followed by 10 days of oral therapy. After acute hospital treatment, suppressive outpatient therapy with macrodantin is often indicated to avoid recurrent UTI in pregnancy.

Warning: A suspicion of UTI is often the initial incorrect diagnosis for appendicitis in pregnancy. Up to 20% of pregnant patients with appendicitis present with pyuria and/or hematuria. In these patients, nausea, vomiting, and right lower quadrant or flank pain worsens as peritoneal signs develop.

Nausea and Vomiting in Pregnancy

“Morning sickness” is the stereotypical symptom that lay people use to define early pregnancy. The progression to persistent vomiting with ketonuria and weight loss requires intensive evaluation and management.

Several clinical pearls will help the urgent care practitioner discern nausea and vomiting of pregnancy from the differential seen in **Table 2**. History determines if chronic gastrointestinal (GI) conditions precede and then continue with pregnancy. Abdominal pain is not typical with nausea and vomiting of pregnancy. The presence of abdominal pain (with or without fever) suggests a GI pathology and WBC count, metabolic panel, and abdominal ultrasound should be considered. Acute nausea and emesis after 9 weeks is also suggestive of GI pathology, and hepatitis should always be considered in patients with loss of appetite, nausea, vomiting, fever, abdominal pain, and jaundice. Headache is not typical with nausea and vomiting of pregnancy and a complete neurologic exam is mandatory. Molar gestation should be considered and confirmed or ruled out with ultrasound and quantitative hCG. Goiter suggests thyroid disease to be confirmed with free T3, free T4, and TSH analysis.

When acute care physicians undertreat nausea and vomiting of pregnancy, the impact is extreme. A 1997 study by Mazzota indicates that fewer than 50% of women who terminated their pregnancies because of severe nausea and vomiting had been offered any sort of antiemetic therapy. Of those offered treatment, 90% were offered regimens that were not likely to be effective.⁴ This would be unacceptable in today’s setting of

TABLE 2. Selected Conditions in Differential Diagnosis of Nausea and Vomiting of Pregnancy

- Gastrointestinal Conditions: Gastroenteritis/Gastroparesis/Achalasia/Biliary tract disease/Hepatitis/Intestinal obstruction/Peptic ulcer disease/Pancreatitis/Appendicitis/Pyelonephritis/Uremia/Ovarian torsion/Kidney stones/Degenerating uterine leiomyoma
- Metabolic Disease: Diabetic ketoacidosis/Porphyria/Addison’s disease/Hyperthyroidism
- Neurologic Disorders: Pseudotumor cerebri/Vestibular lesions/Migraines/Tumors of the central nervous system

evidence-based guidelines, which make the following recommendations, based on consistent scientific evidence (Level A):⁵

1. It is important to note that Zofran (Ondansetron) is not the first line therapy in nausea and vomiting in pregnancy. Vitamin B6 or vitamin B6 plus doxylamine is safe and should be considered first-line therapy. Doses are Vitamin B6, 10 to 25 mg, 3 or 4 times per day and doxylamine, 12.5 mg, 3 or 4 times per day. The combination of doxylamine succinate and pyridoxine hydrochloride (vitamin B6), has recently been approved by the FDA for the treatment of nausea and vomiting in pregnancy. Duchesnay USA has announced the availability of Diclegis—a composition of 10 mg doxylamine succinate and 10 mg pyridoxine hydrochloride—in US pharmacies. Large-scale efficacy studies are anticipated within the next few years.
2. Second-line therapy is to add promethazine, 12.5 to 25 mg every 4 hours, orally or rectally or dimenhydrinate, 50 to 100 mg every 4 to 6 hours, orally or rectally (not to exceed 400 mg per day; not to exceed 200 mg per day if patient also is taking doxylamine).
3. In patients who have no dehydration, third-line therapy is any of the following: Metoclopramide, 5 to 10 mg q8 hrs, IM or po or promethazine, 12.5 to 25 mg every 4 hours, IM, orally, or rectally or trimethoprim, 200 mg every 6 to 8 hours, rectally.
4. In patients who have dehydration, IV fluids should be administered, plus any of the following: Dimenhydrinate, 50 mg (in 50 mL saline, over 20 min) every 4 to 6 hours, intravenously (IV) or metoclopramide, 5 to 10 mg every 8 hours IV or promethazine, 12.5 to 25 mg every 4 hours, IV.
5. Ondansetron, 8 mg, over 15 minutes, every 12 hours, IV.

6. Additional therapies with intensive counseling typically require inpatient care.

Alternative therapies. The P6 acupressure wristband and acustimulation can be considered as alternative nonpharmacologic therapies. Alternative pharmacologic therapies include ginger capsules (250 mg 4 times daily), methylprednisolone (16 mg every 8 hours, orally or IV, for 3 days. Taper over 2 weeks to the lowest effective dose). Corticosteroids should be considered as a last agent prior to enteral nutrition. Patients should respond within 3 days. In those who respond, the lowest effective dose should be continued for not longer than 6 weeks. Concern over fetal facial clefts has been suggested in animal studies only.

GERD in Pregnancy

Reflux of acid from the stomach into the esophagus is common in pregnancy because of decreased esophageal sphincter tone, elevation of the organs in the maternal

abdomen, and decreased gastric motility. Repeated reflux leads to esophageal inflammation. Sleep may be disturbed as symptoms of epigastric pain and burning progress.

Lifestyle and diet counseling are first-line therapy. Measures to reduce smoking are essential. Avoidance of greasy, acidic, or spicy foods will reduce reflux. Raising the head of the bed and avoiding lying down for 3 hours after eating may be helpful. Scheduled use of over-the-counter antacids is safe for immediate relief.

Table 3 lists medications appropriate for treatment of GERD in pregnancy.

Vaginitis and Cervicitis in Pregnancy

One of the most common complaints leading to medical consultation in pregnancy involves symptoms suggestive of vaginal or cervical infection. Inflammatory changes of the vulva or vagina will produce redness, swelling, itching, and various types of discharge. A concise review of vulvovaginitis can be found in the June



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TABLE 3. Medications for Management of GERD in Pregnancy***Antacids (Avoid antacids containing sodium bicarbonate as they may cause maternal or fetal metabolic alkalosis and fluid overload)**

- Mylanta (calcium carbonate w magnesium hydroxide)
- Maalox (magnesium hydroxide w aluminum hydroxide)
- Tums (calcium carbonate)
- Rolaids (ca carbonate w magnesium hydroxide).

Histamine-2 Receptor Blockers (H₂RA) (help heal esophagitis)

- Cimetidine (Tagament)
- Famotidine (Pepcid)
- Ranitidine (Zantac)

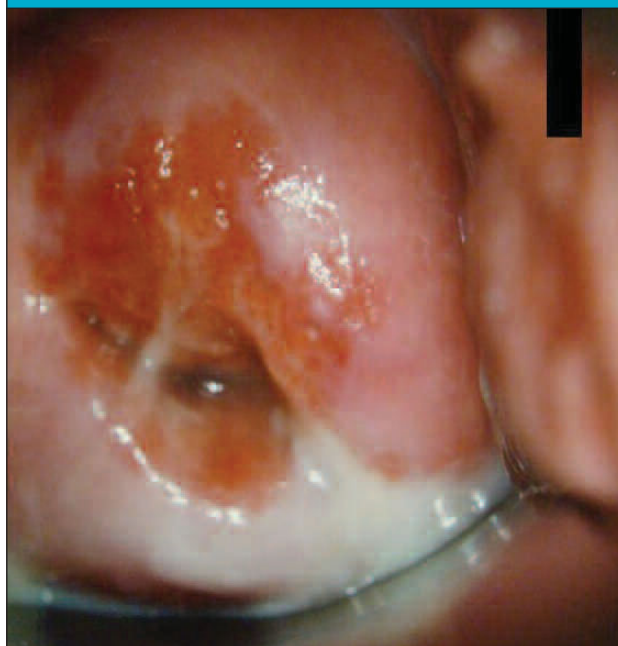
Proton pump inhibitors (inhibit gastric secretions)

- Lansoprazole (Prevacid)
- Omeprazole (Prilosec)

Prokinetic agents (increase esophageal sphincter tone and enhance gastric emptying)

- Metoclopramide (Reglan)

*Proton-pump inhibitors (PPIs) are reserved for intractable cases that do not respond to H₂ receptor antagonists. A meta-analysis of 600 women with first-trimester exposure to PPI did not show increased risk of teratogenicity. Source: Nikfar S, Abdollahi M, Moretti ME, et al. Use of proton pump inhibitors during pregnancy and rates of major malformations. A meta-analysis. *Digest Dis Sci*. 2002;47:1526.

Figure 1. Chadwick's Sign

Leukorrhea and endocervical eversion in early pregnancy are evident in this image of Chadwick's sign.

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2007 issue of JUCM (<http://jucm.com/magazine/issues/2007/0607/>). Diseases presenting with a chief complaint of vaginal discharge include bacterial vaginosis, trichomoniasis, and vulvovaginal candidiasis.

The standard approach to evaluation includes physical exam, wet prep, and cultures. An urgent care provider should first look within the vagina and sample the vaginal discharge. Normal vaginal discharge is clear and odorless. Ph is typically basic and litmus paper testing shows vaginal pH greater than 4.5. To complete a wet mount, a swab of the vaginal discharge is placed on a microscope slide and suspended in saline solution.

Any history of slow, constant leakage or dampness may represent premature rupture of membranes (PROM) and should be considered when evaluating vaginal discharge in pregnancy.

Normal pregnancy changes: Chadwick's sign and cervical eversion. Chadwick's sign in early pregnancy is represented by increased vascularity, which causes the vaginal walls to become a darker color (Figure 1). There is eversion of the endocervix and an increase in mucoid discharge (leukorrhea). These signs often give the false

impression of a pathologic cervical-vaginal infection.

One area of caution is that signs of cervical dilatation from cervical incompetence also include increased vaginal discharge. This usually occurs at 16 to 22 weeks and may be associated with backache, pelvic pressure, and scant bleeding. Speculum exam may show cervical dilatation and exposed membranes. Ultrasound will show cervical shortening and funneling.

Bacterial vaginosis. *Gardnerella vaginalis*, *Mobiluncus*, *Bacteroides*, and *Mycoplasma* make up the bacterium implicated in a common infection known as bacterial vaginosis (BV). Bacterial vaginosis is an overgrowth of anaerobic bacteria and a decrease in the normal lactobacillus flora. Physical exam discloses a thin, grey, watery, frothy discharge that has a characteristic "fishy" odor when combined with a 10% potassium hydroxide solution. This strong amine smell with KOH is a positive "whiff test." The vaginal pH is typically above 4.5. On wet prep the epithelial cells are coated with bacteria, obscuring the epithelial borders and imparting an appearance commonly referred to as "clue" cells (Figure 2).

BV has been associated with an increased risk of

spontaneous abortion, preterm PROM, preterm labor, and intrapartum infection. Asymptomatic, at-risk women with a history of prior preterm delivery should be screened for BV at approximately 24 weeks' gestation and treated if the infection is diagnosed. Symptomatic patients should be promptly evaluated at any gestational age and treated if wet mount, rapid test, or culture are positive.^{7,8} Recommended treatment regimens are metronidazole (500 mg orally twice a day for 7 days) or metronidazole (250 mg orally three times a day for 7 days) or clindamycin (300 mg orally twice a day for 7 days).⁷ Doxycycline, ofloxacin, and levofloxacin are contraindicated in pregnant women.

Candida. Vulvovaginal candidiasis frequently occurs during pregnancy. *Candida albicans* is a diploid fungus that grows both as yeast and filamentous cells and it is the etiologic agent responsible for candidiasis (Figure 3). The features of vulvovaginal candidiasis include pruritis, erythema, and discharge. The discharge is typically thick and white or yellowish. Inflammation of the walls

Figure 2. 'Clue' cells on wet prep



This photomicrograph reveals bacteria adhering to vaginal epithelial cells known as "clue cells."

Source: CDC Public Health Image Library

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Figure 3. Cervical *Candida albicans*

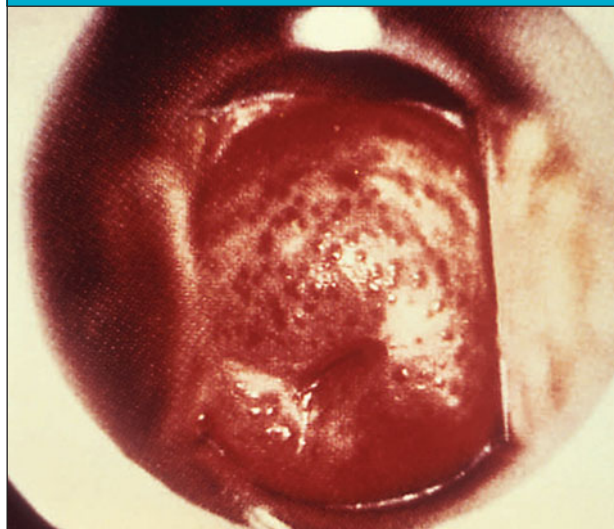
Source: CDC Public Health Image Library

of the cervix, vagina and of the vulva (external genital area) causes burning and itching.

Topical azole therapy applied for 7 days is the most frequently recommended therapy for pregnant women. Over-the-counter intravaginal agents that can be used are clotrimazole 1% cream (5 g intravaginally for 7 days) or miconazole 2% cream (5 g vaginally for 7 days) or miconazole (100 mg vaginal suppository, one for 7 days). Prescription agents include terconazole (0.4% cream 5 g intravaginally for 7 days). Only topical azole therapies are recommended by the CDC for use in pregnant women. Oral luconazole (150 mg oral tablet, one tablet in a single dose). Is category C and is typically ordered for medically compromised patients (diabetics, immunocompromised) or those with recurrent candidiasis.

Trichomoniasis. *Trichomonas vaginalis* is a pear-shaped mobile protozoan parasite with flagellae. Infection is characterized by a greenish to yellow odorous vaginal discharge with a frothy appearance. Prevalence of *T vaginalis* infection has been estimated as high as 9% to 22% in pregnant women. Patients will complain of itching, dyspareunia, and/or dysuria from vulvar irritation. The cervix has a characteristic “strawberry” appearance (Figure 4). The diagnosis is typically made by seeing motile protozoa on wet mount light microscopy or rapid testing. Testing should be offered together with testing for chlamydia and gonorrhea. Up to 17% of neonates born to untreated mothers will be infected. Women can be treated with 2 g metronidazole in a single dose at any stage of pregnancy. Metronidazole 500 mg BID for 5 to 7 days is an alternative. Partners should also be treated to avoid recurrence of this sexually transmitted disease.

Rapid tests. The Affirm™ VPIII Microbial Identification Test (BD) is a single-sample DNA probe for identification

Figure 4. ‘Strawberry’ cervix

The “strawberry” appearance of the cervix is characteristic of trichomoniasis.

Source: CDC Public Health Image Library

of *Candida* spp, *G vaginalis*, and *T vaginalis*. Results are available in less than 60 minutes. The OSOM® Trichomonas Rapid Test (Genzyme Diagnostics) is an antigen-detecting test for trichomoniasis that can be completed in 10 minutes. The vaginal swab is placed within the buffered test tube, mixed vigorously by hand, and then a test strip is inserted for results.

GC and Chlamydia. Both chlamydia and *Neisseria gonorrhoeae* selectively invade the endocervical epithelial cells, causing endocervicitis (Figure 5). Both pathogens may be asymptomatic. Women at highest risk are those aged 25 years, those with more than one sexual partner, with a history of sexually transmitted infection or drug use, and those seen in emergency settings for vaginal bleeding or abdominal pain in pregnancy.

All pregnant women should be routinely screened for *Chlamydia trachomatis* and *N gonorrhoeae* during pregnancy, usually at the first prenatal visit.⁷ If an urgent care visit occurs before this screening, a high degree of suspicion should be maintained because *C trachomatis* is the most common sexually transmitted pathogen in the United States. In pregnant women, these infections can be associated with ectopic pregnancy, preterm premature rupture of membranes (PPROM), and preterm delivery.

Treatment of chlamydia in pregnancy is with azithromycin (1 g orally in a single dose) OR amoxicillin (500 mg orally three times a day for 7 d) or erythromy-

cin base (500 mg orally four times a day for 7 days) OR erythromycin ethylsuccinate (800 mg orally four times a day for 7 days). There is up to a 10% failure rate with initial treatment. A test of cure should be done 2 to 3 weeks after the initial treatment and patients should be retested 3 months after treatment.⁷ In nonpregnant patients, tetracycline and doxycycline show the greatest activity against chlamydia; however, these agents are contraindicated in pregnancy. The patient's partner should always be treated, and tetracycline or doxycycline is appropriate.

N gonorrhoeae can produce devastating sequelae to the female upper genital tract. The cervicitis has an extensive mucopurulence from the cervical os and often friability with bleeding when touched.

The updated recommendation for treatment of *N gonorrhoeae* in pregnancy is with ceftriaxone (250 mg in a single intramuscular dose) PLUS azithromycin (1 g orally in a single dose). Alternative regimens if ceftriaxone is not available are cefixime (400 mg in a single oral dose) PLUS azithromycin (1 g orally in a single dose). A "test-of-cure" should occur within 1 week. If a patient with *N gonorrhoeae* has severe cephalosporin allergy, treat with azithromycin (2 g in a single oral dose) with test-of-cure in 1 week. Either azithromycin or amoxicillin is added for treatment of presumptive *C trachomatis* infection when *N gonorrhoeae* is found during pregnancy (see Chlamydial Infections).

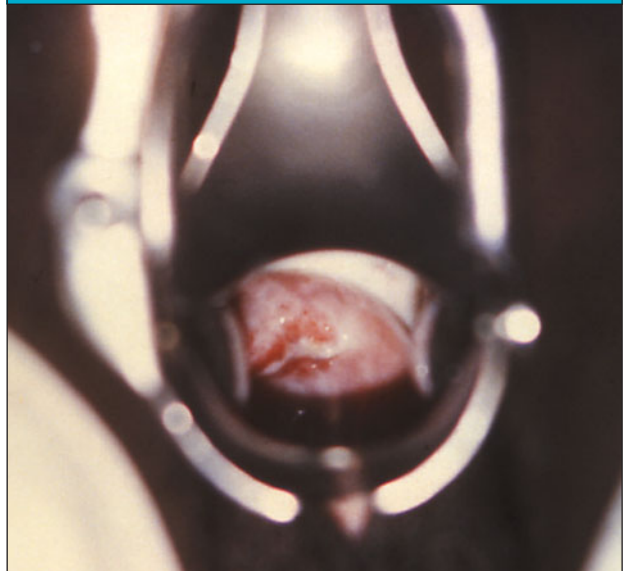
Pregnant women found to have gonococcal infection during the first trimester should be treated and retested in the third trimester. Uninfected pregnant women who remain at high risk of gonococcal infection should also be retested during the third trimester.⁶ All patients with gonococcal infection should be reported to the state health agency. Screening for other sexually transmitted diseases such as chlamydia and syphilis is appropriate. Partners also require full treatment.

Syphilis. Patients with primary syphilis may present with lesions on the vulva, but the cervix typically has no lesions. Inguinal adenopathy is often present. Laboratory evaluation of a patient with a suspicious vulvar lesion should include rapid plasma reagin test with reflex treponemal testing, herpes simplex virus culture, and HIV testing. If the T. pallidum particle agglutination test result is positive, a patient should receive 2.4 MU benzathine penicillin G. If a patient is allergic to penicillin, she should be hospitalized for controlled desensitization as the standard of care treatment for syphilis and pregnancy.⁶

Pediatric Illness With Pregnancy Risks

Urgent care services are becoming the location for first-

Figure 5. Speculum exam



This exam shows cervicitis and discharge of gonorrhea.

Source: CDC Public Health Image Library

line evaluation of febrile illness in a young child.⁸ The urgent care practitioner should be cautious to warn parents of reproductive age about the risks of cytomegalovirus, parvovirus, TORCH infections, and Influenza. Not only is the pregnant patient at risk of severe illness due to the relative immunocompromised state of pregnancy, but the developing fetus is at risk of multiple syndromes as outlined below.

Influenza. Influenza season brings a 26.0% patient volume increase in pediatric urgent care. In fact, pediatric urgent care centers now see a larger portion of the burden of H1N1 influenza than does the pediatric emergency department.⁹ Influenza vaccination is specifically recommended in pregnancy to protect the mother and to enhance childhood immunity. Influenza vaccination is recommended in all trimesters. This protects the mother and also results in decreased febrile respiratory illnesses in the newborn, likely through passive antibody transfer.

Treatment of influenza in pregnancy is important, because pregnant women are more prone to severe illness, including need for hospitalizations and increased mortality. Pregnant woman with influenza are also at increased risk of premature labor and delivery. The Centers for Disease Control and Prevention (CDC) recommends that women in any trimester of pregnancy who have a suspected or confirmed influenza infec-

tion receive prompt antiviral therapy with Tamiflu (oseltamavir) or Relenza (zanamivir).

Parvovirus. The best test to confirm the diagnosis of maternal infection following exposure to the affected child would be IgM and IgG serology. The most likely severe fetal complication of this infection is hydrops.

Varicella. A child with chickenpox is contagious from 1 to 2 days before the rash appears until all blisters have formed scabs. The mother may develop chickenpox 10 to 21 days after contact with the infected child. Pregnant women who get varicella are at increased risk of developing pneumonia and meningitis. Counseling in the urgent care center includes warnings that symptoms of cough or headache should prompt immediate evaluation. For adults with varicella pneumonia or meningitis, immediate hospitalization and antivirals are required to reduce the 10% to 25% mortality associated with this syndrome in pregnancy.

If a pregnant woman gets varicella in her first or early second trimester, the fetus has a 0.4% to 2.0% risk of being born with congenital varicella syndrome. The baby may have scarring on the skin leading to contractures, abnormalities in limbs, brain, eyes, and low birth weight.

For pregnant mothers exposed to varicella, maternal varicella antibody can be evaluated to confirm IgG and IgM status. The majority of women will be immune, even those with no recollection of prior varicella infection. Presumed evidence of protection includes documentation of two prior doses of varicella vaccine, a maternal serum blood test showing immunity to varicella, or verification of a history of chickenpox or herpes zoster.

If a woman develops varicella rash from 5 days before to 2 days after delivery, the newborn will be at risk for neonatal varicella. In the absence of treatment, up to 30% of these newborns may develop severe neonatal varicella infection. Therefore, newborns of mothers with confirmed or suspected varicella require careful follow-up and potential treatment with antivirals.

Any woman found to be at risk of varicella should receive varicella vaccine. However, the live attenuated virus should not be given during pregnancy. As soon as a pregnant woman (who is not protected against chickenpox) delivers her baby, she should be vaccinated. The vaccine is safe for mothers who are breastfeeding.

CMV. CMV is the most common viral cause of congenital infection. The fetus may show echogenic bowel and symmetrical intrauterine growth restriction. Trans-

mission occurs primarily through contact with children actively shedding the virus in nasopharyngeal secretions, urine, saliva, tears, genital secretions, breast milk or blood. After primary infection during pregnancy, the rate of transmission to the fetus ranges from 15% to 50% and sequelae include congenital mental retardation and deafness. Pregnant women should minimize close contact with infectious children. Frequent hand washing and appropriate handling of potentially infectious secretions have been shown to be effective in minimizing viral transmission.

Pertussis immunization with Tdap is now recommended for all pregnant women during the late second (>20 weeks) or third trimester, with the intent to both protect the mother and provide passive antibody to their infants before vaccination at age 2 months. Provider support for these recommendations regarding both annual influenza vaccination and postpartum Tdap vaccination during pregnancy is felt to be critical to improve both maternal and fetal health.¹⁰ This is supported by the CDC and ACOG. Health care personnel should administer a dose of Tdap during each pregnancy irrespective of the patient's prior history of receiving it. To maximize the maternal antibody response and passive antibody transfer to the infant, optimal timing of Tdap administration is between 27 and 36 weeks' gestation, although Tdap can be given at any time during pregnancy.

For women not previously vaccinated with Tdap, if it is not administered during pregnancy, it should be administered immediately postpartum.¹¹ ■

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Practice Management

Creating Value By Adding Physical Therapy to Urgent Care

PART II: Tactical Considerations

Urgent message: Part 1 of this article, in the June issue, looked at initial considerations for enhancing urgent care profitability by providing physical therapy services. In Part 2, the authors address tactical considerations, from revenue to staffing models.

LAUREL STOIMENOFF, PT and HILARY HELLMAN, SLP

Babe Ruth said, “Yesterday’s home runs don’t win today’s games.” Consumers have gravitated to on-demand medical services and the market has responded. Urgent care centers now face competition, not only from new urgent care sites but also other on-demand services such as telemedicine, freestanding emergency rooms, primary care physicians extending hours and accepting walk-ins, and retail hot-model clinics. Without some innovation and new home runs in its arsenal, urgent care’s market share has the potential to erode.

In Part I of this article, we addressed the natural synergies between the urgent care scope of care and physical therapy. In most injuries, early therapy intervention expedites healing and returns the patient to prior levels of function faster. We therefore suggested that urgent care centers either have a referral relationship with a local therapy provider who can provide same- or next-day appointments or consider establishing a physical therapy department to support the urgent care clientele. Adding this service not only distinguishes your urgent



care from the competitors but can also enhance the patient experience through the convenience of a single destination for initial and follow-up care and improved clinical outcomes.

Part II of this article addresses tactical considerations associated with implementing physical therapy in an urgent care practice and transforming this new service line into a profitable service valued by patients and the community.

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Making the Decision to Implement Therapy Services

Determining the need for and viability of physical therapy within an urgent care center is fairly simple. A *Service Line Needs Assessment* can be performed in less than 60 days by evaluating the center's demographics, patient diagnoses at time of service, and the likelihood that the current patient population would benefit from therapy intervention. Patients who are motivated to return to their pre-injury or illness activity quickly tend to be a favorable demographic. This can be a geriatric tennis player or a high school athlete who value interventions that are likely to accelerate the healing process. In addition, any patients who have limitations in strength and mobility secondary to trauma are obvious candidates but the assessor should not overlook patients with safety issues (fall risks), gait anomalies, balance/vestibular disorders, acute or chronic pain, incontinence, edema and hyper- or hypomobility in joints because they are also potential candidates who would benefit from on-site, skilled therapy services.

Patients are most likely to seek therapy close to home because it typically involves multiple visits. There are financial considerations because most commercial and public insurance plans require copayments or deductibles, resulting in out-of-pocket expense for patients at each and every visit. These costs may be perceived as prohibitive. Some patient choices may be limited because their insurance carrier has restricted contracts for in-network care. Patients seeking services covered by Workers Compensation have a higher likelihood of attending and completing a therapy prescription because these visit types are considered conservative treatment (as opposed to surgery) and the services are covered with no out-of-pocket obligation by the patient once medical necessity is established and authorization is secured. Injured workers are also often compensated for any lost time from work to attend medical and therapy care and may consider completing all authorized therapy as a "right."

In Part I, we represented that 10 to 12 new patients in a physical therapy department per week will typically create a patient load for one full-time therapist of approximately 12 to 14 patients per day. Lower volumes may require creativity, such as part-time availability (for example, Monday/Wednesday/Friday Services), establishing a therapy service site supporting multiple urgent care centers, or continuing to outsource therapy services to responsive community-based therapy practices.

The Pro Forma

Once you confirm that patient demand will support a full- or part-time physical therapy practice via your urgent care clinic's *Service Line Needs Assessment*, you should create a financial pro forma. An urgent care pro forma can assume approximately \$40,000 to \$50,000 in start-up capital used principally for furniture, fixtures and equipment (FFE). The pro forma should also assume **initial** staffing of 2.0 FTEs, including a physical therapist, a part-time physical therapy aide and part-time front office support. Assuming the physical therapy space is contiguous to the physician space, the front desk staff for the physician services could also be responsible for physical therapy scheduling, authorizations, insurance verification, daily statistics, and time-of-service collections.

Just as in urgent care practice, additional success factors included in the analysis should be the anticipated:

- # of therapy referrals/week
- # of therapy visits/day
- # of visits/referral
- Net revenue/ visit (NRPV)
- Revenue/cost per episode of care

Typical payment formats for NRPV include global rates or fee for service. Global rates often account for the additional time involved in the therapist's initial evaluation and the creation of the plan of care.

Expenses are relatively low in the physical therapy practice when compared to the urgent care or other specialty services. They are heavily weighted toward the costs of human resources associated with staffing the site. Therefore, tracking labor cost per visit against your pro forma will be an important operations activity once implemented. The pro forma should assume one therapist caring for 12 to 14 patients per 8-hour day depending on acuity and support.

While profit margin in a typical physical therapy practice can be 15% to 20% of net revenue, the service line can also bring additional opportunities to an urgent care center by increasing credibility for your services with employers through extended occupational medical services and capturing word-of-mouth repeat business as a more comprehensive provider of choice for on-demand medical services. The physical therapy department can also support marketing and community outreach activities with schools, sporting events, and employer services.

Self-Pay and Out-of-Pocket Considerations

The 2012 UCAOA benchmarking survey provided the

TABLE 1. Basic Equipment and Supplies for a Physical Therapy Clinic

- Treatment Tables (2-4)
- Ultrasound & Electrical Stimulation Units
- Carts, Stools, Step Stools
- Hydrocollator/Hot Packs and/or Thermofors
- Freezer for Cold Packs
- Treadmill
- Upright Bike
- Wall-Mounted Pulley System
- Set of Hand Weights
- Balance Pads, Balls, Foam Rollers, Theraband
- Home Exercise Software Program
- Laptop or computer with Rolling Cart for Documentation

payor distribution of urgent care survey respondents. It represented that 12% of the participating urgent care clinic's revenue was "self-pay." This supports the need to implement a payment plan that extends to therapy services. Many urgent care clinics offer a medical discount plan and should consider adding therapy services to the plan agreement with patients. Just as a medical discount program can be heavily marketed as a patient loyalty program, so can a cash pay program for physical therapy services. Because physical therapy is a service that typically requires return visits over time to achieve therapy goals, policies related to handling self-pay or patient responsibilities must be determined and communicated in writing and up front.

The Physical Plant—Creating an Appealing Environment

The physical environment of the physical therapy clinic is a key component tied to staff efficiency as well as the likelihood that patients will complete their prescribed course of therapy and/or achieve the goals of care. Patients have a choice about where to seek care and whether to return for ongoing care. Operators need to create an environment that makes patients want to choose your physical therapy services over others and complete their course of treatment once started. One owner indicated that he placed a glass wall between his practice, including the reception area, and the physical therapy gym. Patients receiving care could see the new equipment and professional staff working with the patients one-on-one, and therefore *selected* his clinic over others.

Physical therapy services typically require use of

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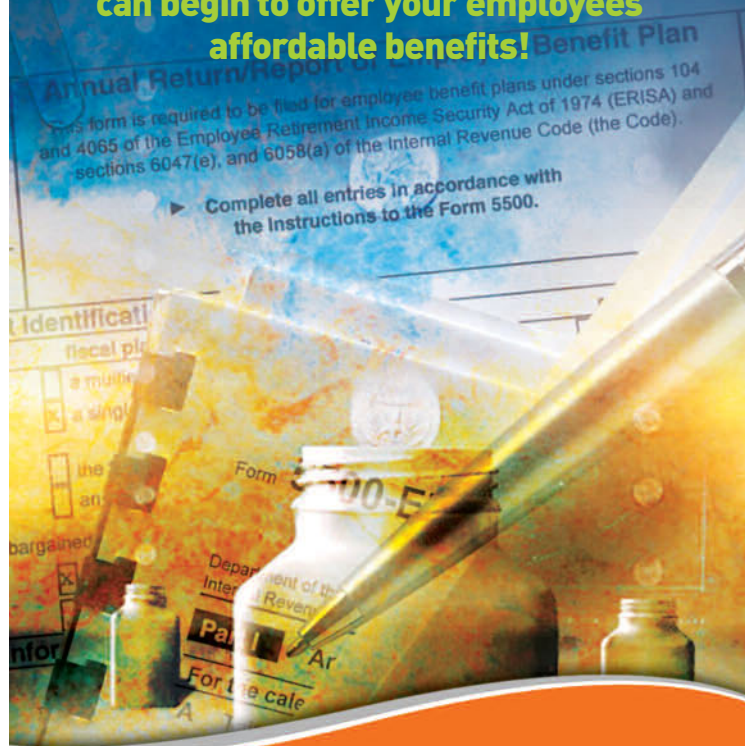
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one to two private rooms or curtained areas for patient evaluations and administration of some care and therapy modalities where patient privacy or modesty must be respected. The majority of therapy services, however, take place in an open area that includes exercise equipment and supports active patient participation in the plan of care. This area is the “hub” and should be a professional one, but also upbeat. Patients socialize with one another and there is often a flat screen television with sports or other universally appealing content or videos. It should be immaculately clean and uncluttered with the feel of an upscale health club. Staffing and scheduling must support an environment where patients can be closely monitored and receive frequent cues and therapist involvement at every visit. Positive therapist and staff interactions with patients combined with an inviting physical plant are essential components to fostering patient loyalty and a desire to return for care. Include physical therapy services in not only your overall assessment of quality and clinical outcomes, but also patient satisfaction monitors and action plans.

Space. The space determination will be dependent upon the number of new referrals seen each week. Presuming each therapist will see about 10 to 12 patients per day, space needs can be less than 800 square feet to start. Assuming the practice will grow, an urgent care operator might consider seeking a first right of refusal for contiguous space if it is available. Extended hours more aligned with the urgent care schedule may also be a consideration versus adding space when limitations become problematic.

When possible it is preferable to have physical therapy located on the first floor with natural light and easy access to parking. Open area is most desirable for the physical therapy space and a clear line of sight for the therapist to all areas of the gym is preferred, especially if aides/techs and support staff are potentially going to be supporting patient care.

Therapy Equipment. The equipment for a 1- to 2-therapist urgent care clinic is relatively inexpensive and will depend upon space, the number of patients expected, and the types of diagnoses to be seen. Physical Therapy Centers typically open with the basics and add equipment, services and supplies as the program grows and the needs of the patients and practice scope are better understood. Incorporation of items patients can use as part of their home exercise and post-discharge programs is essential. These items include therapy balls/bands, foam rolls and supplies.

Table 1 lists basic equipment and supplies that should be considered in an initial Physical Therapy Clinic set up.

Recruiting and Staffing

The therapy program will begin with one physical therapist and 0.5 to 1.0 aide/technician, assuming the existing urgent care front office staff has the ability to support the administrative and intake functions. If the existing front office is already at capacity, a 20- to 25-hour-per-week support person should be considered.

It is important to recruit a therapist who fits well into the culture of your practice, is well-experienced, skilled in treating the population you serve, and capable of being self-directed. When recruiting a physical therapist you will want to include a description of the position, skills needed, and education and experience required. Because the therapist will be working independently and likely to be supervising some support staff, a therapist with experience in an outpatient setting would be more likely to flourish from the start. As with any hire, references will also be important to check prior to employment including not only clinical expertise but also service orientation, flexibility, initiative and patient interaction skills. Physical therapists typically have many career opportunities due to a national shortage of active licensees. Employers should consider differentiating the recruitment message including opportunities for job sharing and scheduling flexibility.

Operational Steps to Success

The business success of adding physical therapy is in the operational details. To provide the best care with the best clinical results, at the highest levels of patient satisfaction and greatest profitability, the workflow and processes must be focused on the patient experience and must efficiently eliminate any unnecessary time and steps so the flow is seamless.

The physical therapy patient process begins with the referral and ends with final payment with recommended processes as described below.

Referral. The referral is received at the front desk in person, via the practice management system, email, fax or phone. Once received, the order drives the patient appointment schedule for the initial evaluation. Best-in-class therapy providers contact patients <24 hours to schedule the initial evaluation appointment and ensure patients are seen within 48 to 72 hours of the referral. Some patients may need to be seen or prefer to be seen on the same day as the referral. Data support that early therapy intervention results in faster recovery and

reduced lost work time. Therefore, processes that support same-day access must be set up within the center.

Patients who are not seen within 24 to 72 hours of their physician visit have a higher incidence of cancellations/no-show rates and tend to either find another provider or another avenue for care.

Authorization. Obtain the current insurance information from the patient and verify the insurance benefit for therapy, co-pay, coinsurance and any pre-authorization requirements. This information can be obtained online or by phone. For financial transparency, we suggest determining if an authorization is needed prior to seeing the patient to ensure services will be paid by payers. Some payors will allow the first-visit evaluation without an authorization but will require an authorization for subsequent visits while others will allow a set number of visits without authorization. A cash-pay price should also be available at a discounted rate when paid at the time of service or included in your urgent care medical discount plan when available. Efforts should be made to ensure the patient will be “in-network” based on contracts as multiple visits because an out-of-network provider can place a substantial financial burden on the patient. If physical therapy services are out-of-network, all efforts should be made to refer the patient to a convenient and capable in-network therapy provider.

Scheduling. The scheduling methodology is very important and is different for physical therapy than for an urgent care practice. Physical therapy appointments are scheduled for 30 to 60 minutes and are for multiple visits over the course of 4 to 6 weeks depending on diagnosis, severity, financial coverage, and access. The front desk plays an important role in ensuring that the schedules are full and that there are adequate evaluations (10 or more) per week/per therapist. We recommend scheduling evaluations for 60 minutes that will also include initiating therapy and a home program when appropriate. Follow-up visits are generally scheduled on the half hour but extend for 45 to 60 minutes.

The benchmark for cancellations/no-shows is 10% or less. Every referred patient who is not ultimately seen results in an average revenue foregone of \$600 to \$1,000. Every patient who self-discharges because he or she cannot get an appointment at the desired time or does not see the value in continuing also results in a lost revenue opportunity. Scheduling personnel should notify the treating therapist when unable to meet a patient’s scheduling needs or when patients fail to schedule ongoing care prior to goals being met.

Access. Employed patients do not want to miss work and will usually request an appointment either before or after work, whereas Workers Compensation patients are typically less concerned because lost work time is likely to be compensated (although employers appreciate before or after shift access). When assessing access it is important to differentiate between any open appointment time and the first available of a preferred A.M./P.M. slot. It is also important to be sure the scheduled hours meet the needs of the patients and not just the convenience of the therapist or staff. Following the evaluation, the patient will frequently be scheduled for 4 to 6 follow-up visits. When possible it is preferable to provide continuity and have one therapist see the patient throughout the entire course of care.

No-Show/Cancellation Policy. A clearly defined no-show/cancellation policy is important and should be included in the initial paperwork requiring a patient signature acknowledging that he or she has read and understands the policy. If a patient no-shows for an appointment there is a good chance that he or she is self-discharging and not likely to keep future appointments. We recommend that a patient be called for any missed appointment and be called 24 hours before the next appointment to confirm attendance. If a patient does not return the call and confirm that he or she will be attending the next appointment, the front desk staff can open the slot for another patient. A no-show/same-day cancellation rate of greater than 10% has a significant impact on the productivity and profitability of a program. Discussions regarding attendance are best conducted between the therapist and the patient during the initial evaluation process because patient function and clinical outcomes are dependent on fulfilling the plan of care.

Billing/Coding. The billing system used for your urgent care practice may be able to accommodate billing for physical therapy, but there are nuances and requirements specific to therapy visits. Many choose to outsource billing to an entity familiar with the specific rules, regulations, codes and modifiers used for therapy. It is recommended that training be provided to therapy providers and billing staff to ensure the payor rules are understood and followed. Many systems now integrate the billing and documentation so these functions are integrated. An audit system is recommended to ensure that the billing is accurate, is supported by the documentation, demonstrates skilled care and captures all of the appropriate charges.

Medicare (CMS) and many other payors continue to

modify the billing/coding requirements and it is important to have the most current information at all times. As an example, CMS is currently piloting a Claims Based Outcomes Reporting (CBOR) program whereby, effective July 1st, specific “G” codes must be submitted at select intervals in order to convey patient progress toward therapy goals. Contracts and payor communications should be reviewed regularly and your therapy and billing staff should have an understanding of each payor’s requirements and their method of payment (CPT code, visit, episode of care). Your lead therapist(s) should also be providing input on payment processes and ultimately bearing responsibility for ensuring prompt payment when appropriate therapy services have been rendered.

It will be important to set processes in place for billing, collections, payment posting, denial management and education to achieve desired results.

Front Desk and Patient Arrival. The front desk employees are the first point of patient contact and their initial interaction sets the tone for the patient experience in physical therapy. It is important to provide education, training, and scripting for the front desk staff to ensure the best patient experience. Because initial evaluations are often scheduled in advance, insurance information should be verified and paperwork completed prior to beginning the therapy evaluation.

As in the urgent care setting, collecting the copay prior to the visit and setting a standard expectation that 100% of the copay will be collected daily by the front desk staff reduces costly collections issues on the back end. A close working relationship between the therapist and front desk staff ensures the most efficient processes.

Patient Visit. The patient evaluation will be approximately 60 minutes and during that time, the therapist will complete the evaluation, develop a plan of care including the patient’s goals, begin treatment and most often provide the patient with a home program of exercises he or she is to do between the evaluation and next visit. During this visit the therapist will begin to plan for discharge and will involve the patient in determining the frequency and duration of care, including consideration of scheduling and financial responsibility. Follow-up sessions will be from 45 to 60 minutes with most courses of care being 10 visits or less.

Documentation. The therapist will be responsible for documenting the visit in accordance with all professional, ethical, practice act and payor rules and regulations. The initial plan of care must be signed by the

physician if required by the payor (CMS) and/or if the recommended plan of care is different than the initial physician order. Orders are often “evaluate and treat,” which provides the therapist the freedom to establish a plan of care consistent with the evaluation and established goals.

The documentation must support the need for skilled care and must support the charges billed. While services are warranted to improve the health and function of the patient based on diagnosis and presentation, a failure to document the need for the therapist’s skills has the potential to result in payment denials.

It is important to use a documentation system that is easy to navigate and does not take unnecessary time from the patient care. It will be important to evaluate whether or not the urgent care system will meet the needs of the physical therapy program or if alternatives will need to be considered including written documentation, dictation or a therapy-specific electronic health record system.

Conclusion

Physical therapy services typically complement the urgent care scope of care. Implementing physical therapy services as an adjunct to an urgent care practice requires an initial service line needs assessment, planning, ongoing key performance indicator measurement, clinical quality oversight, and performance improvement. Successful implementation can provide a valued service to patients and a profitable service line for an urgent care center owner.

Babe Ruth knew that yesterday’s home runs wouldn’t win today’s games and baseball wasn’t experiencing the tumultuous changes taking place in today’s healthcare environment. The rules of baseball are relatively constant while the rules of healthcare delivery are being written and revised by the minute. Therapy services provide a conservative treatment solution supportive of today’s accountable care objective to secure the greatest health outcome at the lowest cost in a more holistic environment. Physical therapy complements the urgent care scope while also aligning with the future healthcare environment focused on outcomes, quality and wellness. The influence of new competition and price pressure coupled with an aging population, healthcare reform, and the potential for newly insured entering the market collectively support the implementation of a physical therapy service line. A well-planned and executed strategy will allow you to hit this one out of the park. ■

Case Report

Dissecting Cellulitis of the Scalp

Urgent message: Prompt recognition of dissecting cellulitis is important to help patients receive appropriate treatment and avoid long-term consequences such as alopecia.

MOHAMED A FAYED, MD

Introduction

Dissecting cellulitis of the scalp is a chronic skin condition for which patients often present to urgent care providers. Prompt recognition of such cases could have significant potential benefit to patients in ensuring successful treatment and preventing complications.

Case Presentation

A 39-year-old African-American male presented with spreading boils on his scalp. He reported having the boils for about 4 months. He had been seen by an urgent care provider several weeks before, at which time he was given azithromycin, to which his condition did not respond. During his teenage years, the man began shaving his head and also had a history of acne. He was married and denied any other sexual partners or any changes in lifestyle.

Observations and Findings

Physical examination of the patient revealed the following:

BP: 136/94

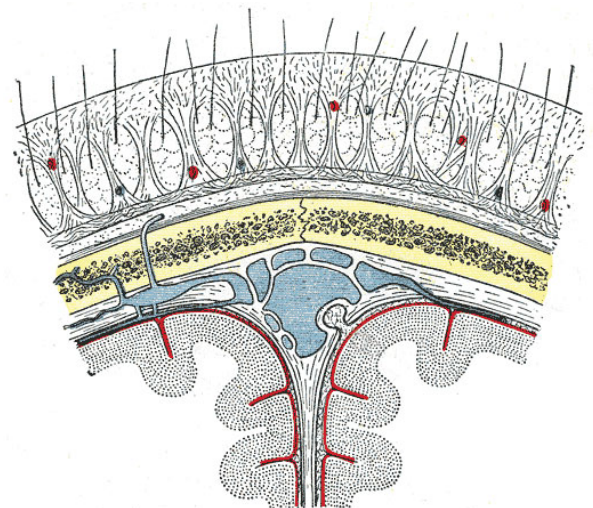
P: 86

RR: 12

T: 98.6°F

Cardiac evaluation demonstrated a normal heart rate

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© <http://en.wikipedia.org/wiki/File:Gray196.png>

and rhythm. Lung exam showed normal lung sounds. Physical examination revealed multiple nodules and papules on the scalp. Attempts at squeezing some of the lesions resulted in drainage of serous fluid. Patchy alopecia also was noted on some of the scalp lesions.

Diagnosis and Treatment

The patient had extensive folliculitis on his scalp (Figure 1 a and b). The diagnosis was dissecting cellulitis of the scalp. The patient was prescribed doxycycline and given a referral to a dermatologist.

Discussion

Dissecting cellulitis of the scalp or perifolliculitis absce-

Figure 1a and b. Folliculitis presenting as boils on the scalp



dens et suffodiens is a rare chronic skin disease affecting the scalp. It is relapsing in nature and typically causes scarring alopecia.

Dissecting cellulitis can occur alone or in conjunction with the other members of the follicular occlusion triad, which includes acne conglobata and hidradenitis suppurativa.¹ This disease affects mainly the African-American population during the second to fourth decades of life. It disease starts as small follicular lesions but rapidly transforms to pustular and nodular lesions.

In patients with dissecting cellulitis, much of the scalp—especially the crown and vertex—are covered by boggy or fluctuant nodules. Pressure on a nodule often results in extrusion of pus or serosanguinous material. The condition can wax and wane in severity for many years, but eventually will result in hypertrophic scarring and permanent hair loss. The inflammatory process tends to involve the lower portion of the dermis and the subcutaneous junction, and so the lower portion of terminal follicles is most affected.¹ This explains the scarring alopecia when the disease progresses without treatment. The presence of hair follicles appears to be essential for disease progression.

Because treatment of dissecting cellulitis is challenging and usually long, patients with the condition should be educated about the nature of the disease. Dermatology referral is usually necessary unless an urgent care provider is comfortable treating the condition. Medical options include isotretinoin, antibiotic therapy, oral zinc sulfate, and tumor necrosis factor-alpha (TNF- α) blocker. Treat-

ment typically is initiated with oral or topical isotretinoin, which produces reasonable success.² Other options include oral antibiotic and oral zinc sulphate. Case reports document success with multiple antibiotic regimens, such as ciprofloxacin 500 mg BID for a few weeks with a slow taper.³ Remission of dissecting cellulitis also has been documented with use of doxycycline for several months, and with rifampin with isotretinoin.^{4,5} Newer options for therapy that have proven successful include infliximab and use of a TNF- α inhibitor such as adalimumab.^{6,7}

Severe and resistant cases of dissecting cellulitis can be treated with selective follicular destruction, such as with electron beam radiation.⁸ Complete surgical scalp excision followed by split-thickness grafting also has been documented.⁹ ■

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INSIGHTS IN IMAGES

CLINICAL CHALLENGE

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

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

FIGURE 1



The patient, a 41-year-old male, was a construction worker who fell on his right knee. Because of the pain he opted to take a vacation from work for a week and not seek medical attention. Upon his return, he was still having pain and elected to seek medical attention.

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 hairline fractures on both sides of the tibia as well as intra-articular extension. It is particularly important not to miss this significant tibial plateau fracture. If the fracture is missed and plateau depression occurs, it would have substantial negative consequences for future joint performance.

Acknowledgement: Case presented by Vina Maniquis, MD, site director, and John Koehler, MD, Chief Medical Officer, both of Physicians Immediate Care, Chicago, IL.



The Game Part 3

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

Wouldn't this be a lot more fun if the opposing attorney made some of these statements while you were on the stand?

Lawyer: Now doctor, isn't it true that when a person dies in his sleep, he doesn't know about it until the next morning?

Lawyer: Doctor, how many autopsies have you performed on dead people?

Witness: All my autopsies are performed on dead people.

Lawyer: Do you recall the time that you examined the body?

Witness: The autopsy started around 8:30 p.m.

Lawyer: And Mr. Johnson was dead at the time?

Witness: No, he was sitting on the table wondering why I was doing an autopsy.

Lawyer: Doctor, before you performed the autopsy, did you check for a pulse?

Witness: No.

Lawyer: Did you check for blood pressure?

Witness: No.

Lawyer: Did you check for breathing?

Witness: No.

Lawyer: So, then it is possible that the patient was alive then you began the autopsy?

Witness: No.

Lawyer: How can you be so sure, Doctor?

Witness: Because his brain was sitting on my desk in a jar.

Lawyer: But could the patient have still been alive nevertheless?

Witness: It is possible that he could have been alive and practicing law somewhere.

It's game time. The big day is finally here. The trial is a bit like a sporting event: The judge is a referee, the parties are like opposing teams, and each team has a number of support staff. The referee applies the rules of the game impartially and

helps move the process along. The score or deciding who ultimately wins the game, i.e. the verdict, rests with the jury. Although on very rare occasions the judge may render the verdict, the defendant should focus his or her attention on the jury.

If the opportunity ever presents itself, it's a good idea to sit in on a medical malpractice trial so that the first one you witness isn't your own. As an impartial observer, one thing you will notice is that the jury spends a lot of time looking at the defendant-provider. They notice everything about him or her—the defendant's clothes, body language, facial expressions and gestures. The jury also observes the defendant's interaction with his or her spouse (if one is present and attorneys and his or her overall attentiveness.

The jurors watch the defendant in the hall, the cafeteria, and the parking lot and even look to see what kind of car the person drives. The implication of all these observations is very clear. The jury is attempting to see beyond the facts of the case. They are trying to ascertain the character, the integrity, the humility, and the empathy of the provider.

Jury Selection

The first part of this process begins with jury selection. The potential jurors are brought into the courtroom, where the attorneys have the chance to ask both broad and sometimes very specific questions. Each side has the ability to strike a certain number of jurors. The attorneys try to determine which jurors will be most empathetic to their cause. Before selection, you should discuss with your attorney the jury selection process they use to determine which jurors best fit for the case.

Opening Statement

Opening statements are given after jury selection. These statements can take anywhere from a few minutes to as many as a few hours. During the opening statement, the attorneys essentially tell the jury about the case in the best possible light. Opening statements can be a simple recitation of the facts or a highly emotional story about pain-and-suffering.

Opening statements are the jury's first opportunity to see the attorneys in action. In addition they will be watching your face to see how you react. Despite the pressure and despite the



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emotional toll this process is taking, it is important that you always remain confident and impassive in court. Although it is incredibly difficult, try to view the proceedings with as much detachment as possible. I call it “putting on the spacesuit.” When you’re in the spacesuit you are protected from the outside world. It may sound cliché but your demeanor may be the most important thing that you can add to the trial.

“Get your head around the fact that opposing counsel is trying to bolster their case not help you with yours and there is no way they will let you expound on an answer they don’t like.”

The Evidence

After the opening statement, the plaintiff presents their case. The plaintiff calls witnesses and takes them through the direct examination. Your attorney gets the chance to cross examine each and every witness the plaintiff presents. The objective of the cross examination is to point out weaknesses in the testimony or highlight points more favorable to your side. Not all witnesses are subject to cross-examination. Sometimes the cross-examination may be extensive and other times it may just be one or two questions.

Plaintiff’s counsel will likely call the patient (if able to testify), his or her family members, other treating physicians, and expert witnesses. Expert witnesses are generally providers who practice in your specialty. Other experts may be called for damage calculations and causation.

Again, the plaintiff has to prove that your care fell below the standard of care (negligence), that there was a compensable injury, and that the injury was caused by your negligent care. The standard of care will be defined by the physician experts.

You may also be called to appear as an adverse witness for the opposition. As one of the treating providers, you have intimate knowledge about the patient and the care you rendered. Thus, the plaintiff’s counsel has a right to question you without being constrained by the rules of direct examination. In other words, the court will allow counsel to cross examine you using leading questions. The goal of leading questions is to box you in with yes or no answers. For example, “Doctor, isn’t it true that the patient complained of chest pain when he presented

to your center?” And, “Isn’t it true, Doctor, that chest pain is often a sign of a heart attack?”

This is when the proverbial rubber meets the road. The verdict may in fact depend upon how well you do during this difficult portion of the trial. The following are some tips to help you navigate through the questions:

1. Do your best to not get locked into only being able to answer with a yes or no. In other words make your answers complete. Try to provide the jury with enough information so that they can make an informed decision, not just a simple “yes” or “no.”
2. Although the opposing counsel will be the one questioning you, when you respond, always talk to the jury. Speak as though you are speaking to a patient. Your voice should convey empathy, kindness, and integrity. Use terms that a lay person would understand. The opposing counsel may try to distract you by walking around to try to get in your line site and by acting aggressive. No matter the attorney’s demeanor or tone, keep your voice calm, cool, and concerned. Most importantly, address the jury.
3. The opposing counsel may try to put words in your mouth. When this happens, it is okay to politely say, “That is not what I said.” Counsel may ask you to agree with a chain of questions using a hypothetical. Do your best to avoid answering those questions. In addition, you may be unable to complete your answers without the opposing attorney cutting you off. Don’t let this bother you. Get your head around the fact that opposing counsel is trying to bolster their case not help you with yours and there is no way they will let you expound on an answer they don’t like.
4. It is extremely important not to contradict testimony you gave in your deposition. Know that plaintiff’s counsel will have your deposition nearly memorized. The moment you contradict yourself the plaintiff’s attorney will use it to impeach you, which will cast doubt upon your credibility.
5. I cannot stress enough that you have to control your emotions. Despite the fact that opposing counsel will be argumentative, contradictory and in-your-face, you have to remember that you are wearing a spacesuit that nothing obnoxious can get through to harm you. If you’re able to do this, the opposing counsel will most likely look like an obnoxious jerk and you will come off as the caring, empathetic, compassionate provider that you are.
6. If your attorney objects to a question, listen to the objection and don’t continue speaking if your attorney objects. Wait until the judge rules on the objection before you start speaking again.

The Defense

After the plaintiff concludes, it is your turn to present a defense. Although you will have very credible defense experts

“Relate to the jury like they are your patients. Remember to put your answers in terms that are easily comprehensible.”

who will support your care, it is your testimony that is most important. It is likely that your attorney will prepare a list of questions he or she plans to ask you. The questions and possible responses may actually change during the course of the trial, depending upon the strengths and weaknesses of the plaintiff's case. Even when your attorney questions you, speak to the jury. Relate to the jury like they are your patients. Remember to put your answers in terms that are easily comprehensible. Do not surprise your attorney during this phase by adding additional facts or opinions not already in evidence, i.e., stick to the script.

The Defense Rests!

After you present your witnesses, the plaintiff may offer rebuttal evidence. After rebuttal evidence is presented the judge will give the jury instructions that outline their responsibilities and also define concepts such as standard of care, negligence, and damages. These instructions are read to the jury from standard forms and are presented for use during their deliberations. After the jury instructions both sides are allowed to give their closing arguments. The closing arguments essentially go over all the evidence that has been offered in the case. Much like the opening statement, closing statements can be highly charged and very emotional. Again you must sit there passively and listen intently. Do not show emotion or use body language to suggest emotion. After the closing arguments the jury begins their deliberation. This can take anywhere from a few hours to a few days, after which they will return to the court and present their verdict.

If the jury renders a verdict against you that is not ultimately overturned, plaintiff's counsel has a statutory duty to report the verdict and the amount of the award to the National Practitioner Data Bank. If you prevail the plaintiff has a chance to appeal. However, in appellate court, the process is much different than the trial court process and from this point forward, most of the work will be done by attorneys who draft motions and then argue in front of a three-judge panel.

To recap: Good providers get named in medical malpractice suits and although this process is very time consuming and angst provoking, we do prevail more often than not. So, when it happens to you, put your spacesuit on and gear up for battle! ■

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2013 Physical Therapy G Codes

■ DAVID STERN, MD, CPC

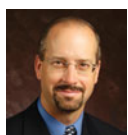
Q. We offer Physical Therapy services to patients in our urgent care center and some patients have Medicare insurance. I understand there are new codes that we must use for Medicare. What are they and how do we use them?

A. The Centers for Medicare and Medicaid Services (CMS) was mandated by the Middle Class Tax Relief Act of 2012 to collect information regarding beneficiaries' function and condition, therapy services furnished, and outcomes achieved on patient function on claim forms by using non-payable HCPCS G-codes with additional severity modifiers, along with the normal charges and therapy modifiers.

All practices that provide outpatient therapy services must include this information on the claim form. The policy applies to physical therapy, occupational therapy, and speech-language-pathology services. When Medicare is the primary or secondary payor, Functional reporting using G-codes and modifiers is required on therapy claims for certain dates of service (DOS), as described below:

- At the outset of a therapy episode of care, that is, on the DOS of the initial therapy service;
- At least once every 10 treatment days;
- For the same DOS that any subsequent evaluation or re-evaluation is submitted on the claim;
- At the time of discharge from the therapy episode of care; and
- On the same DOS the reporting of a particular functional limitation is ended, in cases where the need for further therapy is necessary.

HCPCS codes G8978-G8998 are used to describe functional limitation such as mobility, changing and maintaining body position, carrying, moving, and handling objects, and swallowing.



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.

HCPCS codes G8998 and G9158-G9186 are used to describe functional limitation for motor speech, attention, memory, voice, and other motor speech functional limitations. When functional reporting is required on a claim for therapy services, two G codes will generally be required. Two exceptions are:

- Therapy services under more than one therapy plan of care. Claims may contain more than two G codes in cases where a beneficiary receives therapy services under multiple plans of care from the same therapy provider.
- A one-time therapy visit. When a beneficiary is seen and future therapy services are either not medically indicated or are going to be furnished by another provider, the clinician reports on the claim for the DOS all three G codes in the appropriate code set (current status, goal status, and discharge status), along with corresponding severity modifiers.

The severity modifiers required with the G codes are:

- CH – 0 percent impaired, limited or restricted
- CI – At least 1 percent but less than 20 percent impaired, limited or restricted
- CJ – At least 20 percent but less than 40 percent impaired, limited or restricted
- CK – At least 40 percent but less than 60 percent impaired, limited or restricted
- CL – At least 60 percent but less than 80 percent impaired, limited or restricted
- CM – At least 80 percent but less than 100 percent impaired, limited or restricted
- CN – 100 percent impaired, limited or restricted

Beginning July 1, 2013, Medicare started denying claims that were missing these codes. ■

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

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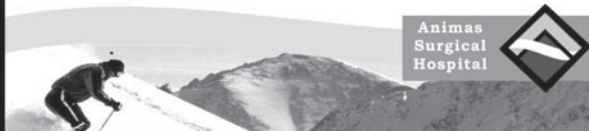
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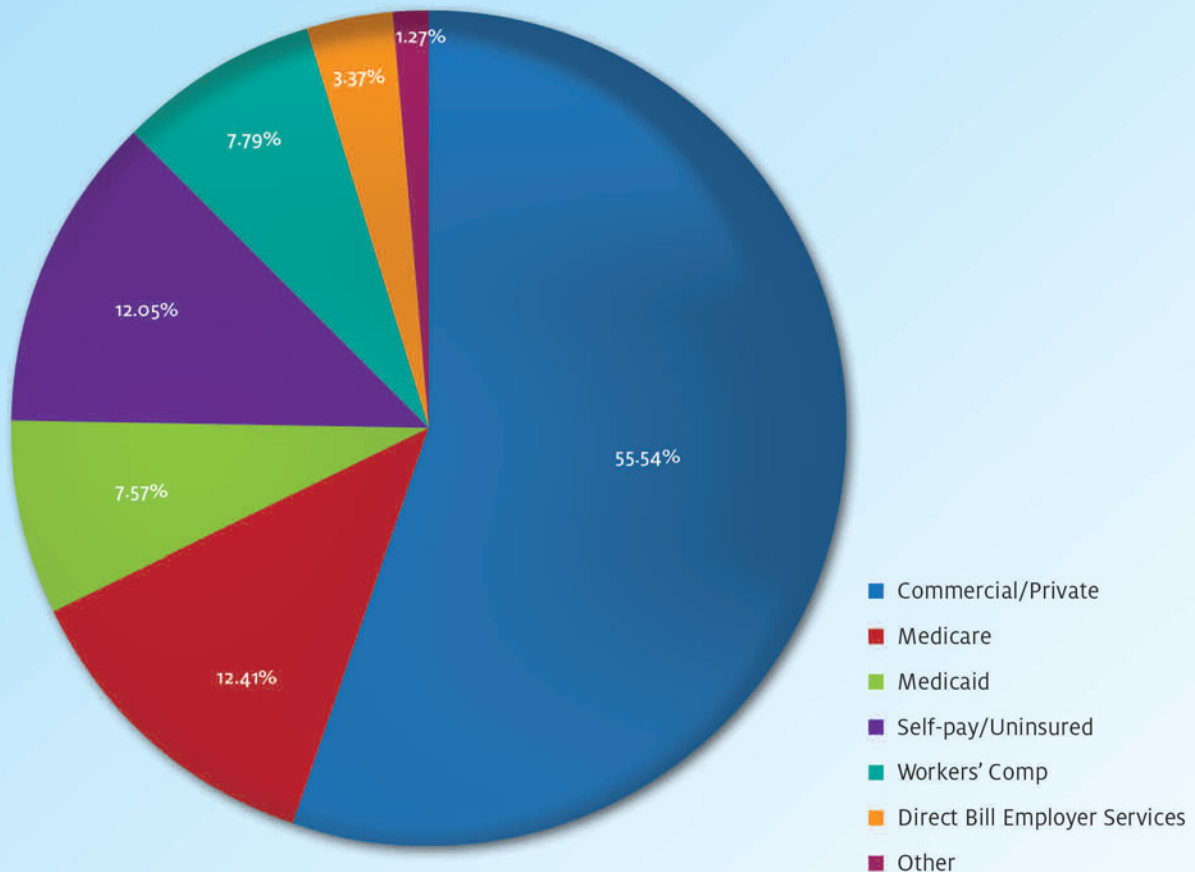


DEVELOPING DATA

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 is the Payer Mix for Urgent Care Centers?

PRIMARY PAYOR % OF VISITS



Commercial payors continue to dominate the urgent care market, and the percentage of Medicare and Medicaid have both decreased slightly since 2008. (2010 analysis looked at payors in depth but not across the spectrum as below). The largest change, however, has been in the occupational medicine market (Direct Bill Employer Services), showing a 10% decrease since 2008, likely due to economic shifting. However, self-pay and uninsured remain very steady since 2008.

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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