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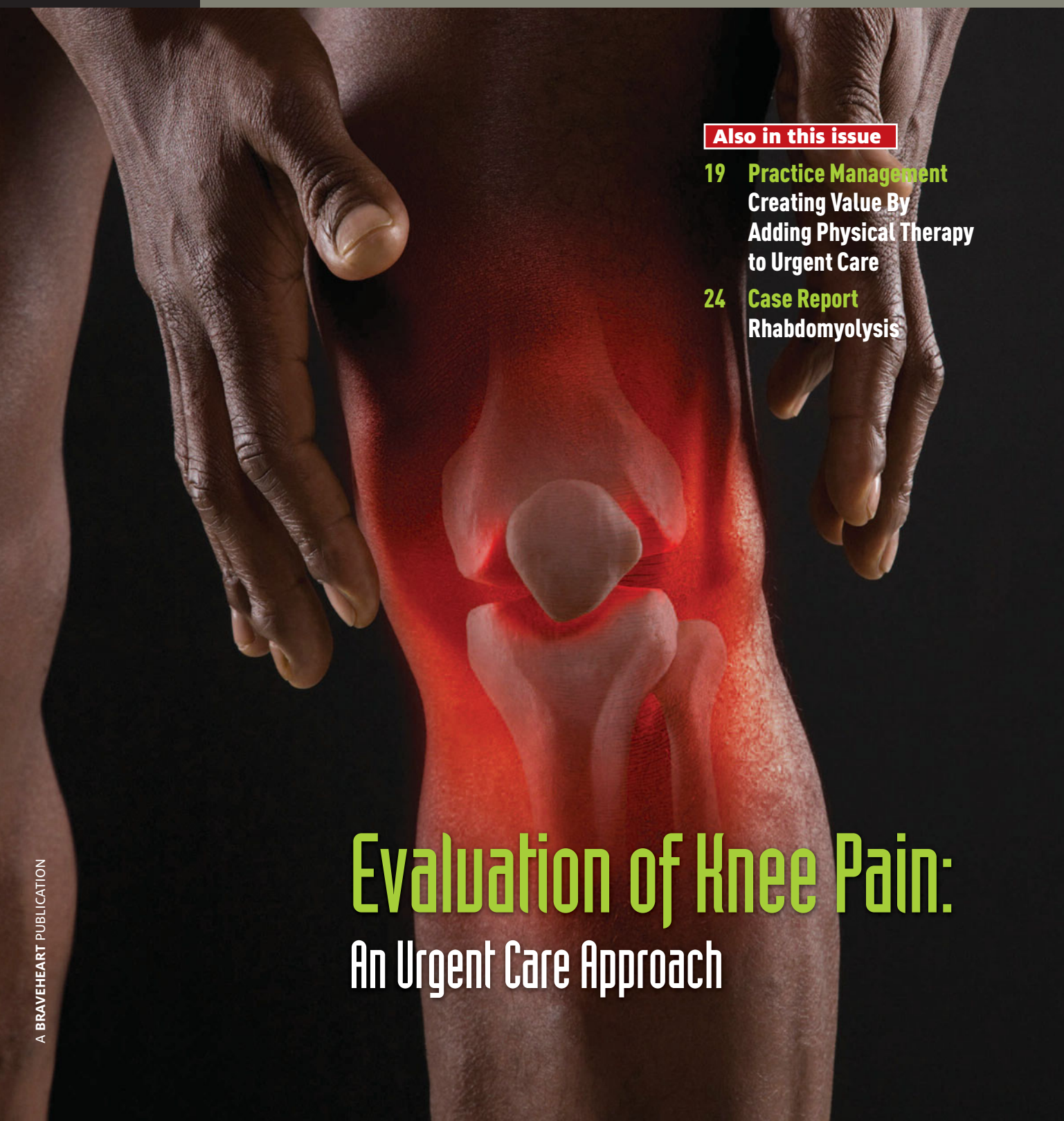

Also in this issue

Evaluation of Knee Pain:
An Urgent Care Approach

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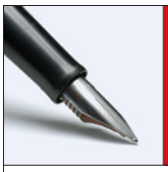
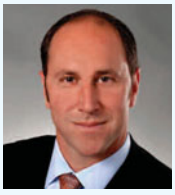


LETTER FROM THE EDITOR-IN-CHIEF

Dare We Doubt the Wisdom of Patient Empowerment?



"Patient empowerment," "patient-centered care, "patient-focused care," and "shared medical decision-making" are among a growing number of terms intended to shift the power and control of healthcare decisions from physicians to patients. The concepts are, for all intents and purposes, accepted as "good." It is merely assumed that empowered patients are better off than those who defer control of their healthcare decisions to their clinicians.

Despite an almost revolutionary change in the way we practice medicine, little or no research has ever been done to challenge the purported benefit. Are patients always better off when decisions are in their own hands? What are the risks? What is the pay-off? Are there unintended or unexpected consequences?

It is easy for a layperson to assume that an informed and empowered "consumer" is better off than an ignorant one. As a matter of logic, being informed allows for more intelligent decision-making and protects the consumer from falling prey to a slick sales pitch. As "consumers" of healthcare, then, one might easily presume the same applies, and no one would argue that to a certain extent this is true. Informed patients are more likely to be compliant, and in some cases, to make more cost-effective healthcare decisions.

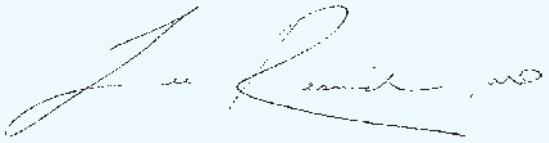
In general, consumer empowerment works best when four conditions exist: 1) The information needed to make an informed decision is finite and consumable; 2) There is a clear distinction of personal value between the options; 3) The risk of being wrong confers the lowest risk; and 4) The potential risk to the public good is minimal.

But how well does that apply to medical decision-making? How might the approach break down, or even backfire?

The challenge with medical decisions, of course, is that the information required is immense, the best option is often unclear, the risk of being wrong is potentially catastrophic, and consideration for public health is imperative. In fact, the whole purpose of educating ourselves into our 30s with hundreds of thousands of dollars in educational debt is in support of consuming indescribable amounts of information and learning the contexts within which this information needs to be applied. The potential for consequence and harm demand expertise and dedication to service devoid of self-interest. This is not a field for weekend warriors or amateur enthusiasts. Yet more and more, the patient (errr, consumer), demands power and control over the decision-making to the extent that, dare I say, the best decisions are not always made. In addition, most patients underappreciate the painful consequences of empowerment when the risk and uncertainty is high. Consider these examples:

- "Consumer demand" for antibiotics when they are not indicated has produced a public health crisis driven by resistant pathogens, innumerable adverse reactions (many deadly), and unnecessary healthcare costs in the billions of dollars.
- Complex healthcare decisions involve stratospheric amounts of information that must be processed in ever-shorter periods of time. How, for example, can you really define the need for hospitalization to a patient with chest pain of uncertain origin? Are we to review the meaning of the TIMI score and quantify the risk? What real meaning does that have for most patients?
- Power erodes trust. It is incumbent upon someone who is given responsibility and control of decision-making to look cynically at those contributing data and information for fear of being bamboozled or misled. Trust, on the other hand, requires vulnerability and transfer of control to the other party. Most everyone appreciates trust as a paramount characteristic of the doctor-patient relationship. Yet, I have heard no one express concern for this potential consequence of the patient empowerment revolution.

I am, by no means, recommending a reversal of patient-centered care. I am, in fact, a strong proponent of patient involvement and shared decision-making. But I implore everyone to pause long enough to appreciate the hidden potential for harm. We must ask the difficult questions in the interest of public health and the future of the profession. Framing these questions without insulting an ever-demanding and empowered public will be a challenge...filled with the same uncertainty and unpredictability we have endured for centuries. ■



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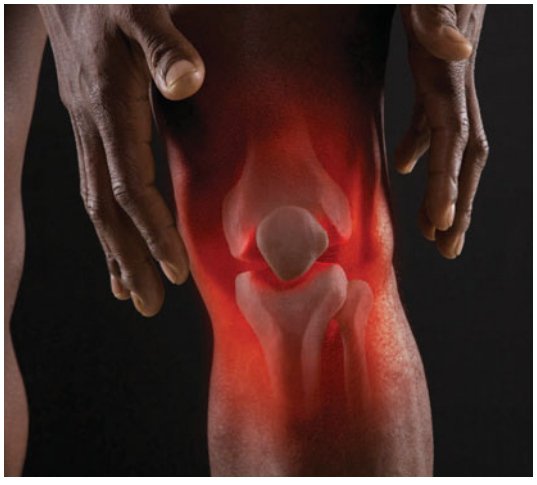

CLINICAL

9 Evaluation of Knee Pain: An Urgent Care Approach

Knee pain is a diagnostic challenge for urgent care providers, but a strong understanding of the anatomy and potential etiologies will prepare them for success.

Christopher Tangen, DO

PRACTICE MANAGEMENT

19 Creating Value By Adding Physical Therapy to Urgent Care

PART I: Initial Considerations & Rationale

Many urgent care clinics face new competition and the landscape for reimbursement is changing. One tactic for enhancing profitability is to consider the addition of new services. Adding Physical Therapy to your practice can result in more satisfied patients, better clinical outcomes and a stronger bottom line.

Laurel Stoimenoff, PT, and Hilary Hellman, SLP

CASE REPORT

24 Rhabdomyolysis

For patients with flu-like symptoms, a careful history and examination are important to rule out more threatening diagnoses.

Shrinesh V. Patel, MD

IN THE NEXT ISSUE OF *JUCM*

Urgent care centers often are patient's initial point of care for pregnancy-related issues yet there are no prospective studies of how gestation impacts an urgent care consultation. Next month's cover story—the first of a two-part series—provides urgent care providers with evidence-based guidelines for common pregnancy-related problems. Part 1 of the series addresses management of common complaints including confirmation of pregnancy, genitourinary infections, nausea and vomiting of pregnancy, gastroesophageal reflux disorder, vaginitis and cervicitis, and pediatric illnesses with pregnancy risks. Part 2, in a future issue, will review bleeding in pregnancy, preeclampsia, minor trauma, abdominal pain, and 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 healthcare marketplace. As the Official Publication of the Urgent Care Association of America and the Urgent Care College of Physicians, *JUCM* seeks to provide a forum for the exchange of ideas and to expand on the core competencies of urgent care medicine as they apply to physicians, physician assistants, and nurse practitioners.

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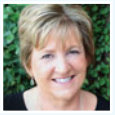
JUCM CONTRIBUTORS

This month's cover story focuses on pain in the knee—the largest hinge joint in the body—which is a common complaint in urgent care. Overuse syndromes, high-energy injuries and relatively weak growth plates tend to be the underlying cause of knee pain in younger, athletic individuals whereas discomfort in seniors is more likely to be associated with chronic conditions. Whatever the cause of knee pain, urgent care providers need to know how to navigate the vast differential and rule out limb-threatening conditions. In the cover story, author Christopher Tangen, DO, offers a template for evaluation of knee pain, from aspects of a thorough history through key steps in physical examination and testing of the knee, to review of common injuries and causes, to appropriate steps for workup and management. A strong understanding of the anatomy and potential etiologies of pain will prepare urgent care providers to make the majority of knee pain diagnoses, but in cases in which the exact etiology of the discomfort can't be clearly elucidated, referral to the proper specialist is important.

Dr. Tangen is medical director of Sports Medicine, University Hospitals Regional Hospitals, Richmond Medical Center, Richmond Heights, Ohio.

The importance of careful examination of every individual who has what at first presentation seem like common symptoms of the flu is underscored by author Shrinesh Patel, MD, in this month's case report. The patient was a 43-year-old African-American male with body aches, chills, sweats, and headache. Physical exam was unremarkable except for a slight limp. Given the man's initial presentation, flu would have seemed a likely diagnosis, but further testing revealed a much more serious condition: rhabdomyolysis.

Dr. Patel is Site Director, Wellstreet Urgent Care, Sandy Springs, GA.



With the landscape for reimbursement changing and many urgent care centers facing competitive pressure, interest in ways to enhance profitability is increasing. One tactic is to consider adding new services. In this month's practice management article—the first of a two-part series—Laurel Stoimenoff, PT, and Hilary Hellman, SLP, explain how adding physical therapy to an urgent care practice can result in more satisfied patients, better clinical outcomes, and a stronger bottom line. In Part 2 next month, the authors will provide 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 second of a three-part series, **John Shufeldt, MD, JD, MBA, FACEP**, discusses the disclosure and discovery segment of a malpractice suit, the comprehensive pretrial conference, and depositions.

Nahum Kovalski, BSc, MDCM, reviews new abstracts on literature germane to the urgent care clinician, including studies of cardiovascular events with azithromycin and clarithromycin and pertussis immunity.

In Coding Q&A, **David Stern, MD, CPC**, discusses coding for foreign body removal, hydration, and minor surgical procedures with E/M.

Our Developing Data end piece this month looks at clinical services beyond those that are general that urgent care centers provide. ■

To Submit an Article to *JUCM*

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

Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, pictures, and references. Articles that are longer than this will, in most cases, need to be cut during editing.

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

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Meadville ExpressCare and Occupational Medicine, Meadville, PA

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P. JOANNE RAY

Led by volunteers who spend each day working in the world of urgent care, UCAOA helps to keep you competitive by providing standards, guidelines and other urgent care-specific products and continuing education, specialized expertise, and focused industry benchmarking. By committing resources to help you improve your medical and professional development and practice management skill sets, UCAOA gives you the tools to impact your future and that of your center. UConnect, our online community, offers the opportunity to interact with urgent care colleagues across the nation and exchange topic-specific dialogue to help charge your thinking, solve today's queries or problems, and keep you connected. And, by offering the perspectives of many to predict, prepare for, and ensure the progress of urgent care, we are THE resource to turn to.

You may have heard of similarly named entities over the past few weeks and months. Please remember, UCAOA is what you make of it and we are here to serve you. There are ample opportunities for you to benefit from your investment and we welcome your involvement. It is certain that, as stewards of your membership and sponsorship dollars, we are responsibly focused on building a strong bottom line for the future. However, it is even more certain that we are making every decision based on what will be best for the industry and for you – our members!

In next month's column, and in our UC Access e-newsletter, you'll hear of upcoming efforts focused on health and public policy agenda relative to legislative and regulatory decision makers as well as immediately implementable tools to help you position your urgent care centers in this volatile environment of healthcare reform. At right is the UCAOA Vision Statement, which was approved in April.

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

THE POWER OF (A)

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UCAOA exists to enrich you and your urgent care centers and staff and help you run efficient and effective businesses while providing the best in urgent care medicine to your patients. Your volunteer leaders are knowledgeable and passionate about the urgent care industry, profession, and specialty and are focused on its growth and yours.

Vision Statement

Approved April 2013

The Vision of UCAOA is to be:

- The catalyst for a thriving and respected urgent care specialty deemed essential by all for its role in the delivery of on-demand, cost effective, comprehensive, evidence-based medicine.
- The premier urgent care association recognized for its innovation and unparalleled ability to serve and engage its members.
- The foremost resource for the promotion of urgent care medicine and those involved in it, so that all stakeholders understand its benefits, seek and have ready access to its valued services.
- The preeminent provider of urgent care continuing medical and practice management education and tools, certification and accreditation, as well as industry benchmarking. ■

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Evaluation of Knee Pain: An Urgent Care Approach

Urgent message: Knee pain is a diagnostic challenge for urgent care providers, but a strong understanding of the anatomy and potential etiologies will prepare them for success.

CHRISTOPHER TANGEN, DO

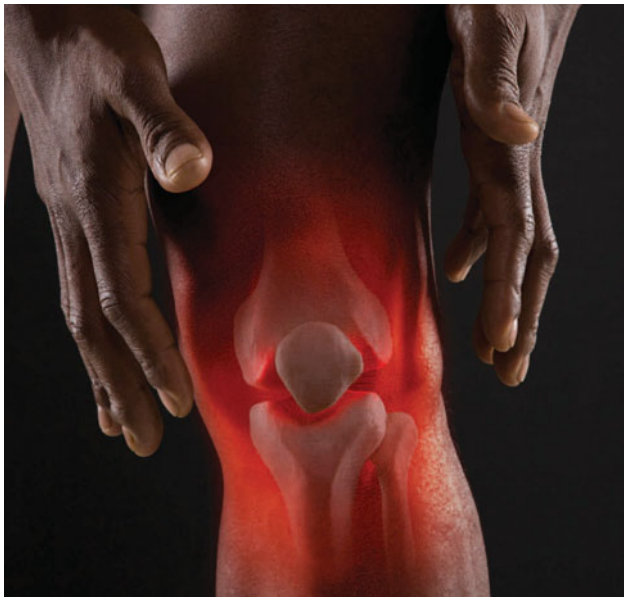
Approximately 10% of all urgent care visits are for musculoskeletal complaints and knee pain is a common such presentation. An urgent care provider's approach is different than that of specialists because patients present with more acute cases, and therefore, the physician needs to consider a vast differential and rule out limb-threatening conditions. These encounters often yield suboptimal exams, and referral to sports medicine or orthopedic surgery. This article serves as a template for urgent care providers on how to evaluate knee pain.

Introduction

The knee is the largest hinge joint in the body and houses the largest articular cartilage surface area, as well as four stabilizing ligaments and many muscles and neurovascular structures. Knee pain is one of the most common musculoskeletal complaints, especially in the younger, athletic population because of overuse syndromes, high energy injuries, and relatively weak growth plates. Seniors often experience knee pain associated with chronic conditions such as osteoarthritis. This article represents a protocol that urgent care providers should follow for all encounters in which a patient presents with knee pain.

History of Knee Pain

Obtaining a good history is the first step toward working on a solid differential diagnosis.



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Onset: Acute vs Chronic. The timing and mechanism of pain are arguably the most important pieces of the history. Anterior cruciate ligament (ACL) injuries are almost always traumatic and most commonly due to indirect forces, such as coming down from a layup or an abrupt stop in skiing. Patellofemoral pain syndrome is usually insidious and worsened with walking up and down stairs and sitting for a prolonged period of time.

Prior/Palliation/Provocation/Progression. Many seniors with osteoarthritis of the knee can easily identify exac-

Christopher Tangen is medical director of Sports Medicine, University Hospitals Regional Hospitals, Richmond Medical Center, Richmond Heights, Ohio.

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

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PRODUCT APPLICATION[2]

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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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Brief Summary of Prescribing Information

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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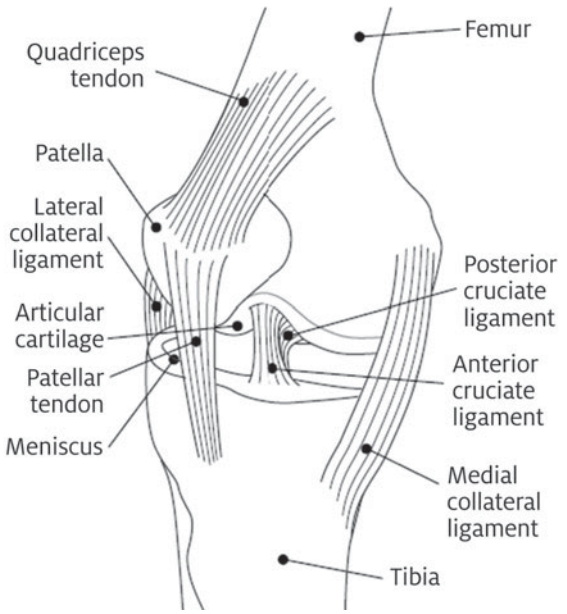
Table 1. Sites for Palpation During Knee Exam

- Distal femoral condyles
- Tibial plateau
- Patella
- Patellar facets
- Inferior pole of the patella
- Patellar tendon
- Tibial tubercle
- Medial and lateral joint lines
- Pes anserine bursa
- Gerdy's tubercle
- Distal IT band
- Medial and lateral collateral ligaments
- Posterior hamstring tendons
- Popliteal fossa

Figure 1. Anteromedial View of the Knee Showing Anatomical Features



Source: Wikipedia.org

erbations in their knee pain. Very often patients will present with their "typical" pain and swelling after a long day on their feet, or a busy day of running errands. Relief with ice and compression can lead to identification of swelling in the history, and worsening with specific motion points to tendonitis or muscle injuries. Most knee pain improves with time and rest, but worsening pain in spite of rest brings rheumatologic and infectious etiologies into consideration.

Quality. "Aching" anterior knee pain is often patellar in origin. A "pop" is worrisome for a torn ligament. "Clicking" can either be patellar or meniscal.

Radiation. Radiation of pain should lead an urgent care provider to be further concerned about non-knee etiologies, such as the hip or radicular generators of knee pain.

Severity. An ACL tear initially produces severe pain, which dissipates greatly within the first hour. Patellar tendonitis, in contrast, can be mildly painful all day long.

Knee Exam

After a focused history is obtained, a sound physical exam will lead the urgent care provider to a diagnosis in the vast majority of cases.

Inspection and palpation. Alignment and redness or skin color changes should be noted with inspection. Improper alignment often indicates patellofemoral etiologies, whereas discoloration can be seen with infection, gout, and hemarthrosis. Soft tissue swelling, bursitis, and effusions are differentiated with palpation. A large effusion from a fracture or intraarticular tear can complicate an exam and make subtle test findings difficult to differentiate. **Table 1** lists the landmarks that should be palpated on every knee exam, some of which are also shown in **Figure 1**.

Range of Motion. The hinged knee joint has an arch of approximately 0 to 130 degrees. Clearly, pain-free range of motion (ROM) is ideal, but ROM from 0 to 110 degrees is functionally desirable in the acute setting. ROM should also be tested in the hip because hip pathologies can present as knee pain.

Strength testing. Strength testing is somewhat less important in the urgent care setting because many patients present with acute pain and decreased effort because of this pain, or external factors. Testing resisted flexion and resisted extension strength in the knee is important because weakness in flexion or the inability to extend fully can indicate a hamstring tear or patellar tendon rupture, respectively. Subtleties in muscle strength testing discrepancies can be further evaluated during followup.

Stability tests. The four stabilizing ligaments in the knee are the ACL, posterior cruciate ligament (PCL), medial collateral ligament (MCL), and lateral collateral ligament (LCL). The ACL is the most important stabilizing ligament in the knee and, therefore, should be evaluated during every knee exam. The most specific test for ACL injuries in the knee is the Lachman's test (**Figure 2**), which is performed with the patient in a supine position and the knee flexed to 30°. The patient's thigh is stabilized and an anterior translation force is passively applied to the knee. A firm endpoint and little or no translation across the joint line indicates a negative Lachman's test. A soft endpoint with increased translation is a pos-

Figure 2. Lachman's Test

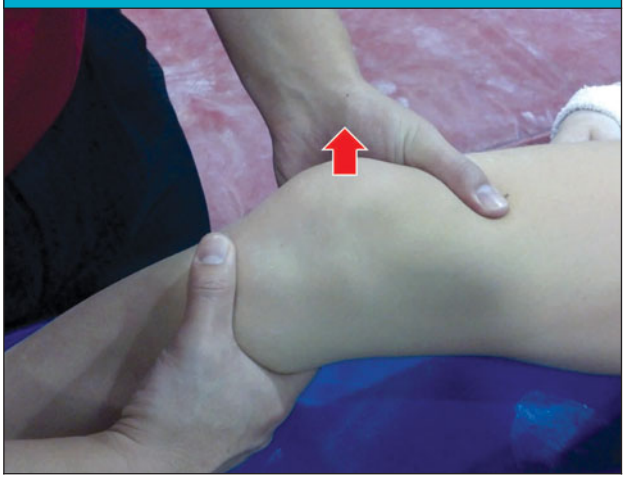
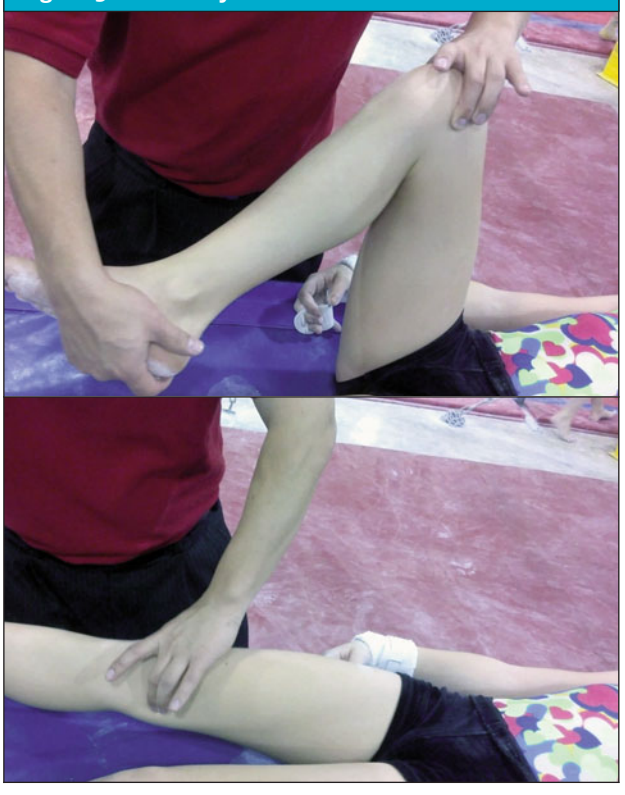


Figure 3. McMurray's Test



itive Lachman's test.

The medial collateral ligament is very commonly injured with a valgus force to the knee. Patients with this presentation will often feel pain when the clinician performs a passive valgus stress to the affected knee. What is most important, however, is that the pain is not increased compared to the contralateral knee. With severe MCL injuries, recovery may be prolonged.

The PCL and LCL are less commonly injured ligaments in the knee. The PCL is best tested with a posterior drawer test, which is done by applying a passive posterior translation force to the tibia with the patient supine and the knee flexed to 90º. The test is positive when the tibia translates posteriorly in respect to the femur without an endpoint. The LCL is tested the same fashion as the MCL, but with a varus stress to the knee. (no, the MCL and LCL are tested with different stresses).

Special tests. The McMurray's test is the test most commonly performed when evaluating for a potential meniscal tear in the knee (**Figure 3**). A positive McMurray's test includes a palpable click at the medial or lateral joint line as well as pain. Very often, patients will have pain and a click with McMurray's testing, but the click usually originates at the patella and not the joint line. Apply's compression test can also be used to evaluate a potential meniscal injury. With the patient prone and the knee flexed to 90º, force is applied through the heel to the knee with internal and external rotation.

Other exam. A thorough neurovascular exam should always be performed on patients with knee pain. Functional testing such as balance testing and gait evaluation should also be considered, especially during evaluations for return to work or sports.

Common Injuries and Common Causes of Pain

Although most knee injuries are acute, it is not uncommon to evaluate a patient with chronic knee pain or overuse injuries.

Patella. Patellofemoral pain syndrome is a common reason for anterior knee pain and more common in younger females. Common symptoms include worsening pain with prolonged walking, using the stairs, and prolonged sitting or standing. Patellar subluxation is a common injury in patients who are athletic, and they often actually will notice a pop with a twisting injury during which the knee cap laterally partially dislocates and relocates. Exam findings include pain with patellar apprehension testing and tenderness to palpation over the patellar facets, soft tissue swelling and effusion, and a negative Lachman's test.

Ligament. As mentioned above the ACL, MCL, PCL, and LCL are the main ligaments in the knee. MCL (7% of knee injuries) and ACL (4%) injuries are more common than PCL or LCL injuries. Most ACL injuries are caused by indirect (approximately 75%) forces to the knee and are accompanied by acute pain and immediate knee effusion. ACL tears are often treated with phys-

ical therapy before and after reconstructive surgery.

Posteriolateral corner or fibular head dysfunction injuries are less common disruptions in knee stability. These injuries are difficult to diagnose, but a dial test can be performed to determine whether there is lateral instability. With the patient in a supine position and the hip flexed to 90° and the knee flexed to 90°, passive external rotation forces are applied to the lower leg and compared to the contralateral side.

Tendonitis. Tendonitis is a very common injury of the musculotendinous junction, but can be acute or chronic in nature. Common areas for tendonitis include the patellar tendon, distal IT band, quadriceps and hamstrings (pes anserine bursitis relation). Patients with tendonitis usually present with a history of pain with activation of the muscle as well as tenderness to palpation on exam and occasionally decreased muscle strength testing.

Bursitis/Baker's cyst. Knee bursitis is also a very common cause of pain. The most common locations are the prepatellar bursa (after direct trauma) and the pes anserine bursa (often due to hamstring hypertonicities). A Baker's cyst can be diagnosed with posterior fullness and soft tissue swelling. Baker's cysts commonly fill from swelling in the knee caused by osteoarthritis and a ruptured Baker's cyst can present as calf swelling and can prove to be a diagnostic dilemma, thus warranting a lower-extremity study for deep venous thrombosis.

Bone Fracture. Fractures are also very common around the knee joint. In the pediatric or adolescent population, Salter-Harris fractures, or growth plate fractures, are very common. Avulsion fractures can also occur after an acute injury to the knee. Patellar fractures are sometimes difficult to diagnose because bipartate patella are sometimes incidentally found on plain film examinations after a knee contusion. If a femoral or tibial plateau fracture is diagnosed, be sure that the lower extremity is neurovascularly intact, and ensure proper immobilization before orthopedic referral.

Overuse. Very common overuse injuries in the pediatric population include Osgood-Schlatter's disease, Sinding Larsen Johannsen (SLJ) syndrome, and less commonly

osteochondritis dissecans (OCD) lesions. Osgood-Schlatter's disease usually occurs in patients aged 9 to 14 years who present with anterior knee pain and tibial tubercle soft tissue swelling and tenderness to palpation. SLJ presents in slightly younger patients with anterior knee pain and tenderness to palpation and soft tissue swelling overlying the inferior pole of the patella with radiographic findings of apophysitis. An osteochondritis dessicans lesion can develop as a posttraumatic or as an overuse injury with vague pain and intermittent swelling. Plain film examination findings may reveal alucency in the distal femoral condyles, with the lateral aspect of the medial femoral condyle being the most common area affected. OCD lesions are confirmed with magnetic resonance imaging (MRI) and very often require surgery and non-weight-bearing rehab.

Meniscal Injury. The medial and lateral menisci are the two fibrocartilaginous "cushions" in the knee in between the femur and the tibia. The menisci are commonly injured (10% of knee injuries) and torn, which can cause intermittent swelling. Patients usually state that they have locking symptoms in the knee, those with tears usually present with a small joint effusion as well as tenderness to palpation along the joint line and a positive McMurray's test. Meniscal injuries are more common in adults age 40 and older.

Infections and Arthritis. By far the most common reason for seniors to develop knee pain and swelling is osteoarthritis, which should be kept in mind before necessarily jumping to other conclusions about atraumatic knee swelling. Cellulitis around the knee should be thoroughly evaluated to ensure that there is no effusion or septic arthritis present. If laboratory testing is available, a complete blood count with differential, erythrocyte sedimentation rate, and C reactive proten measurement can be obtained. Aspiration is a way to distinguish between a hemarthrosis, gouty attack, and septic joint. When there is strong suspicion of a septic joint, however, joint aspiration should be performed after consultation with orthopedic). Although knee pain and soft tissue swelling can result from complex medical etiologies such as lupus or rheumatoid arthritis, the urgent care setting is most appropriate for triaging these patients for followup.

Workup in the Urgent Care

Just as with ankle injuries, there are Ottowa rules for obtaining plain films on patients with knee injuries. These are age ≥55, isolated tenderness of the patella, tenderness of the fibular head, inability to flex to 90 degrees, and inability to walk four steps. One perceived benefit of obtaining plain films in the urgent care setting is to assist the specialists in followup. However, most knee injuries do not require plain film examination. MRI is often very helpful for the orthopedic surgeon in followup. As mentioned previously, aspiration of the knee and subsequent pathologic or laboratory analysis can be helpful when differentiating infectious versus rheumatologic etiologies of knee swelling. In cases of knee pain where an open fracture or fracture with neurovascular compromise is suspected, a computed tomography scan is warranted; however, in the vast majority of cases, a history and physical exam coupled with plain film imaging and routine blood work will suffice.

Management

In general the R.I.C.E pneumonic (Rest, Ice, Compression, Elevation) is appropriate for most knee injuries. More substantial evaluation by orthopedic surgery or transfer to the emergency department is warranted, however, in cases of open fractures, knee injuries or fractures with neurovascular compromise, or cases of abuse. Even if a knee injury such as an ACL tear or meniscal tear is confirmed on the physical examination mobilization, pain control and work restrictions or school restrictions are usually sufficient until proper followup has been done.

Limitations and restrictions are also important patient education measures, mostly with work-related injuries or sports injuries. Work restrictions should be recommended by the urgent care provider based on the patient's functional evaluation and potential for recovery. Sports restrictions should be recommended based upon the athlete's ability to protect his or her knee in addition and potential for pain-free range of motion and near full strength in the knee.

Immobilization and crutches are commonly prescribed treatments for knee pain. Immobilization with a brace such as a knee immobilizer is NOT recommended for more than 3 days because of the potential for muscle atrophy and range of motion stiffness. Crutches are very helpful in management of acute knee pain as a way to allow the patient to ambulate at work, home, or at school.

Casting is not generally done in the urgent care setting because there tends to be a large amount of soft tissue swelling after a fracture and casting is best done once much about soft tissue swelling has resolved. Thereforem proper bracing and splinting is needed in the urgent care setting for nonsurgical fractures.

Knee aspiration can be a very helpful treatment option for prepatellar bursitis or a large knee effusion

caused by chronic osteoarthritis or known rheumatoid arthritis. A local steroid injection (ex: 3 mL 1% lidocaine and 20-40 mg kenalog), if not done in the previous 3 months, can be helpful for knee osteoarthritis, pes anserine bursitis, and anterior patellofemoral pain.

Medications are commonly prescribed in the urgent care setting for musculoskeletal injuries. Over-the-counter medications such as acetaminophen (325-1000 mg po every 4-6 hours as needed) or ibuprofen (600-800 mg po every 8 hours as needed) will provide adequate analgesia for most adult patients. Naprosyn and hydrocodone are also commonly prescribed medications for knee pain. Topical analgesia medications such as diclofenac also can be prescribed.

Referrals are commonly made for knee pain from an urgent care setting to a primary care physician, occupational medicine physician, sports medicine physician, or orthopedic surgeon. In general, referrals within 1 week's time are adequate, but in the case of nonsurgical fractures or sports-related injuries, early followup is better.

Summary

Musculoskeletal complaints are extremely common in the urgent care setting and the knee is one of the most common areas for musculoskeletal pain because it is the largest joint in the body and very commonly injured by individuals of all ages.

A thorough history and physical will lead the urgent care provider to the vast majority of diagnoses, and good management and proper referral will ensure good patient care. In cases in which the diagnosis and exact etiology of a patient's knee pain are not clearly elucidated, referral to the proper specialist is important. Definitely there are individuals who present with knee pain for reasons such as avoiding work and obtaining pain medications. Such patients should be referred to the proper occupational or pain medicine specialist. ■

Suggested Reading

1. Reider B. The orthopaedic physical exam- 2nd edition. 2005. p. 201-246
2. Grover M. Evaluating Acutely Injured Patients for Internal Derangement of the Knee. *Am Fam Phys.* 2012;85(3): 247-252.
3. M. Eiff. Fracture Management for Primary Care 2nd edition. 2003. pp 263-287.

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Creating Value By Adding Physical Therapy to Urgent Care

Part 1: Initial Considerations & Rationale

Urgent message: Many urgent care clinics face new competition and the landscape for reimbursement is changing. One tactic for enhancing profitability is to consider the addition of new services. Adding Physical Therapy to your practice can result in more satisfied patients, better clinical outcomes and a stronger bottom line.

LAUREL STOIMENOFF, PT and HILARY HELLMAN, SLP

Eighty percent of Americans will experience low back pain at some time in their lives. Many of these patients will present to an urgent care clinic in search of relief, particularly when onset is acute. Some cases may be work-related injuries whereas others will be covered by commercial or other insurance. Early intervention with physical therapy is well documented to influence the most favorable and timely return to prior levels of function for patients and also to mitigate risks of re-injury. For the most cost-effective outcomes, urgent care clinics should either have referral relationships with local therapy clinics that offer same-day or next-day appointments and can make services available to the clinics' patients or the urgent care clinics should consider providing these early intervention therapy services themselves.

UCAOA's 2012 Benchmarking Survey indicated that 13% of reporting organizations included physical therapy as a part of their urgent care business. In addition, 36.8% indicated that they added *new* services during 2011. Depending on the mix and volume of patients being seen in an urgent care business, the addition of physical therapy as a new line of service can make excel-

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A Case for Physical Therapy in an Era of Accountable Care

Virginia Mason Health System in Seattle, WA assessed, the total process and associated outcomes when managing uncomplicated back pain. An important customer, Starbucks, had expressed concerns to Virginia Mason about the total cost of low back care for its employees. Recognizing that a significant relationship was at risk, Virginia Mason embarked on a mission to eliminate waste and inefficiency in their system.

Virginia Mason's conclusion was that the most effective treatment for uncomplicated spinal pain was physical therapy, yet physical therapy was typically not initiated until considerable expense had been invested in the care of a patient. Subsequent patient recovery also took longer, not only because of "time to care" but also as a result of the effects of inactivity once therapy was finally initiated. The study by Virginia Mason was evidence-based and demonstrated that 80% of patients presenting with back pain were considered to be "uncomplicated." When serious etiology was ruled out, "the only thing evidence showed was worth anything was physical therapy." The researchers determined that therapy had to be initiated the very same day as a quality indicator when a patient presented and red flag symptoms were ruled out.

Source: Transforming Health Care, Kenny, Charles, CRC Press, 2011, p.129-148

lent business sense both clinically and financially. As the industry seeks to identify methodologies to demonstrate value under accountable care (beyond the obvious savings associated with emergency department diversion), early intervention and access to care, *including* physical therapy, should be a fundamental benefit we offer.

This article is Part 1 of 2 and addresses early considerations, rationale for implementation and legal considerations that must be addressed when adding this new line of service. Part 2, in a subsequent issue, will address more tactical considerations and the "how" of implementing physical therapy in your practice.

Establishing the Legal Entity

In most states, a physical therapy program can be included as an *ancillary service* provided by an urgent care entity, even one that is physician-owned. Among the states that prohibit or restrict physician ownership of a physical therapy practice are Missouri, Colorado, Delaware, and South Carolina, typically because of concerns associated with overutilization secondary to "self-referral." Urgent care center owners should seek legal counsel related to specific state nuances before establishing their own therapy service. Our industry also must ensure that prescriptions and motivations are directed toward cost-effectively addressing soft tissue, pain, and movement disorders. Practice benchmarks for physical therapy care and utilization by diagnostic code are available through resources such as the Official Disability Guidelines (ODG), The Medical Disability Advisor (MDA), and the American College of Occupational & Environmental Medicine Practice Guidelines.

Stark Regulations

Final Stark Regulations provide that the "in-office ancillary services" exception to the Stark prohibition on referrals apply to physician ownership of a physical therapy practice if the supervision, location, and billing requirements are satisfied. "Because the *therapist in private practice rules* do not require personal or direct physician supervision, physician groups billing therapy under these rules can satisfy the Stark supervision requirements with or without a physician on site."[1]

In addition, if the in-office ancillary services exceptions are met, the physical therapy practice can be located either at the same address as the medical office or at another location. This may be beneficial if the organization has several urgent care locations that are in close enough proximity to establish one physical therapy location convenient to the majority of its patients.

Contracting/Credentialing

Each physical therapist should have his or her own Medicare provider number as well as a unique National Provider Identifier (NPI) number. This will allow each therapist to treat Medicare patients and eliminate the need for a physician to be onsite in order for a therapy visit to be billed.

The need to credential therapists for each commercial payor will vary, but it is often advantageous to bill *incident to* the physician when possible. This is because the reimbursement rate under physician contracts is likely to be higher than for physical therapists not associated with a physician practice or hospital. Whenever possible, it is recommended that physical therapy be included as part of the physician contracts for ease of submitting claims and to ensure the most favorable rates. It is imperative to know the cost of delivering a therapy visit in order to favorably position yourself for payors moving to visit rate payments. Establishing case rates for an episode of care that include physician services and imaging and therapy services is more complicated and requires a complete understanding of the costs of providing all services. Protocol-driven care by

"In many urgent care settings, the addition of a physical therapy service is a low-risk expansion opportunity."

diagnosis is an effective way to control cost and ensure quality outcomes in a case-rate payment system.

Compliance With Legislation at the State Level

Just as in the practice of medicine, physical therapy is regulated by State Boards whose charter is public protection. Physical Therapists are licensed in every state and the District of Columbia. Therapy professionals should be familiar with the regulations and restrictions around the provision of care; however, it is best for each urgent care center offering this service line to be cognizant of the regulations. State Physical Therapy Practice Acts often limit the number of support staff that can be supervised by each licensee and typically define their scope of services. Both the Practice Act and State physical therapy/occupational therapy rules should be reviewed at least annually to ensure compliance with any changes. In addition, individual licensees should understand that they have a responsibility to protect their own licenses and to practice ethically and lawfully.

Caseload to Support a Financially Solvent Practice

Key drivers for physical therapy are similar to those in an urgent care center, with the exception that recurring visits to complete a patient's course of care should be factored in when assessing total cost of care to the payor or patient. Reimbursement for therapy services can be on a fee-for-service basis or a global rate. In the latter case, the intensity of care provided is irrelevant as it relates to ultimate compensation for services rendered.

Other less frequent but emerging methodologies include case rates (one payment for all services, irrespective of intensity or number of visits with expectations for outcomes and quality) and capitation. Medicare Beneficiaries have historically been limited to an annual "cap" of $1,880 for combined Physical & Speech Therapy Services. New in 2013, the "cap" now also applies to hospital-based and/or -owned outpatient programs.

One *full-time* physical therapist can typically remain productive and profitable for the practice when the urgent care clinic can produce 10 to 12 new physical therapy patients per week. Before implementing a full-time therapy service, an urgent care provider should analyze his or her clinic's historical caseload and determine if a full- or part-time service is appropriate. Many therapists seek part-time work and many therapy referrals call for services one to three times per week. Therefore, a 3-day-per- week on-site clinician may be the best way to test the viability of physical therapy and it also affords

Table 1. Selected CPT Codes for Physical Therapy*

97001	Physical Therapy Evaluation
97002	Physical Therapy Re-Evaluation
97010	Application of a modality to one or more areas/ Hot or Cold Packs
97012	Application of a modality to one or more areas; traction, mechanical
G0283	Application of Modality to one or more areas; electrical stimulation (unattended)
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises
97112	Therapeutic procedure, one or more areas, each 15 minutes; Neuromuscular reeducation
97116	Therapeutic procedure, one or more areas, each 15 minutes; Gait training (includes stair climbing)
97140	Manual Therapy techniques; one or more regions, each 15 minutes
97760	Orthotic(s) Management and training
97035	Ultrasound, each 15 minutes
97033	Iontophoresis, each 15 minutes

*Source: AMA's Current Procedural Terminology: CPT 2012

the practice same- or next-day appointments for early intervention.

A 2010 survey completed by Corvel found that 77% of Workers' Compensation cases manifested in a physical therapy referral and the average number of therapy visits per claimant were 11 to 15. (That number includes postoperative rehabilitation, so an urgent care center's visits per patient would likely be lower [per case]).[2]

Workers' Compensation as a percentage of an urgent care center's business is only a single consideration for potential new patient volume. Physical therapists are highly trained in analysis of movement and posture disorders. In addition, they are adept at caring for patients who present with balance disorders, benign paroxysmal positional vertigo, chronic headaches, overuse disorders including carpal tunnel syndrome, gait disorders, generalized weakness, neurological deficits and acute and chronic pain. Therapists may also have earned specialty certifications in orthopedics, sports, neurology, cardiovascular & pulmonary, geriatrics, pediatrics, clinical electrophysiology and women's health.

When analyzing an urgent care clinic's diagnostic mix, it is important to consider all cases—not just musculoskeletal disorders—in which therapy intervention may improve function and quality of life. Therefore, when assessing a practice's historical coding for services, it is important to not only consider ICD-9 codes that are related to the musculoskeletal and connective tissues (710-739) but also neurologically based codes (320-389), and injuries (800-959).

As an example, the baby boomer generation is aging and the risk associated with falls and muscle wasting will become increasingly prevalent. Urgent care clinics often have the opportunity to identify red flags for fall risk when patients seek care. An example is the "Five Times Sit to Stand" test and its associated benchmarks for fall risk and morbidities. Research strongly supports that a comprehensive therapy program that addresses strength, endurance, balance and flexibility can greatly reduce the risk of falls in older adults.[3]

The addition of a physical therapy component to an urgent care center also opens up opportunities to more aggressively pursue the 80% of people experiencing low back pain at some time in their lifetime or to increase community outreach by working with local schools to offer comprehensive "bump & bruise" clinics following sporting events. An urgent care center's customers typically extend beyond the patient, often including the payor or the employer. No matter who the customer is, rapid return to prior level of function is the ultimate objective and ready access to medical care at the urgent care clinic coupled with ready access to professional therapy services is the formula for success.

Despite the many opportunities for therapy intervention, consideration must be given to consumer behaviors as patients experience increasing co-payments and co-insurance responsibilities. Therapists must also be sensitive to their financial obligations and strive to establish home exercise programs and encourage personal responsibility towards goal achievement. While this is the ethically right thing to do, it manifests in fewer visits per patient. Because services provided to injured workers are 100% covered, they are more likely to complete the course of care toward established goals. Therapists also may run up against annual limits on therapy services based on their therapy benefit. Many physical therapists respond to this situation by establishing cash payment programs so patients can affordably continue care. One example in which that scenario might apply would be rehabilitation of a young athlete who anticipates a return to sports following surgery on an anterior cruciate ligament and for whom 12 to 15 visits per year are not likely to suffice.

Physical therapists should also communicate regularly with the providers and staff relative to their skill sets and opportunities to provide value. New providers to the practice should have time with the therapist to under-

stand when an appropriate referral can be initiated. Specialty programs can be developed and cash pay services related to personal training programs or physical activities to support weight loss programs can also be offered to augment the practice and increase foot traffic to the urgent care center. Practice owners should consider whether external referrals are an option, based on organizational structure and relationships in the medical community. Free-standing clinics or separate entryway access will support the impression that access to physical therapy services is not simply limited to urgent care-generated referrals. To accomplish this objective, the physical therapist must be involved in marketing the business to employers, primary care physicians, orthopedists, and neurologists.

Coding and Appropriate Utilization of Services

In most states physical therapy services are billed using the Physical Medicine & Rehabilitation CPT Codes. They are distinguished as either "time-based" where more than one may be billed per session or non-time-based, allowing for only one billed code per session. Most rehabilitation codes for services can be found in the CPT range of 90000 to 99600. **Table 1** lists some, but not all, of the typical codes that are used in the urgent care setting.

Appropriate utilization of therapy services is essential for payment and must require the skills and intervention of the therapist. Documentation must support not only the services billed, but that the skills of the therapist are necessary. Take, for example, a patient who is issued crutches as the result of an injury and for whom the urgent care provider orders gait training. The physical therapist's intervention should involve not only assessment of the patient for safety and selection of crutches over alternative assistive device options (e.g, a walker), evaluation of triceps strength, and review of fitting considerations for the crutch pad space in the axilla and appropriate elbow flexion, but also cueing during training and safety instructions and training for navigating ramps, stairs, and curbs.

Metrics for Success

Just as in traditional medicine, the quality of a physical therapy visit and, by extension, the level of success in achieving a prompt return to function for a patient relates to access and face time with the therapist. Therefore, productivity expectations must be reasonable and aligned with an organization's quality objectives. Therapy productivity is impacted by the acuity of the patient population and the intensity of services provided. Most therapists, when supported by an aide or Physical Therapist Assistant (PTA), are comfortable seeing 10 to 15 patients in an 8-hour day. Reimbursement per visit, like other aspects of medicine, continues to experience reimbursement pressures. The 2010 Corvel Study indicated that reimbursement for Workers' Compensation-related therapy visits ranged from $80 to $175.[2]

Table 2. Key Performance Indicators for Physical Therapy

- Procedures/provider work hour
- Procedures/visit
- Therapist visits/8- hour provider day
- Average visits/patient
- Payment/procedure
- Payment/visit
- Show rate (evaluations and follow-ups)

Despite these ongoing pressures, urgent care clinics must remain committed to providing the highest quality of care with the best clinical outcomes and the highest level of patient satisfaction while at the same time remaining profitable. Reliable data are essential to effectively manage an outpatient physical therapy ancillary service.

Recommended key performance indicators (KPIs) are listed in **Table 2**.

Conclusion

The urgent care industry undeniably plays a role in reducing the cost of health care. Just as early intervention in management of disease typically manifests in more favorable outcomes and fewer complications, the same holds true for implementation of a quality physical therapy program. In many urgent care settings, the addition of a physical therapy service is a low-risk expansion opportunity.

In the next issue of *The Journal of Urgent Care Medicine*, Part 2 of this article will provide more tactical considerations for implementation of physical therapy, including the revenue cycle from referral to payment, patient scheduling, equipment purchases, space needs, creating a 3-year pro forma, recruitment of the physical therapist, and staffing models. ■

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Case Report

Rhabdomyolysis

Urgent message: For patients with flu-like symptoms, a careful history and examination are important to rule out more threatening diagnoses.

SHRINESH V. PATEL, MD

Overview

In late winter/early spring, urgent care providers often encounter patients with flu or flu-like illnesses. It is easy to assume that an individual with a typical pattern of flu-like symptoms has the flu and not consider other pathologic processes.However, alternative diagnoses should always be in the differential, and careful history, examination, and testing can provide the clues necessary to identify more threatening diagnoses. Patients often present with attempts at self-diagnosis, but a clinician should be sure to gather a more open-ended history of present illness that focuses on signs and symptoms rather than accepting a patient's interpretation.

Case Presentation

A 43-year-old African-American male presents with a history of "the flu" for the past 6 days. Over the past 2 days, he reports feeling worse, with complaints of increased body aches. The patient denies current sore throat, stuffy nose, or cough, but reports chills, sweats, and headache.

The man has generalized abdominal pain but denies burning on urination, urinary urgency or frequency, or penile discharge, and he has no nausea, vomiting, or diarrhea. However, he has noticed some blood in his urine. Socially, the patient drinks 2 to 3 beers on the weekend but denies illicit drug abuse and is a nonsmoker. On initial presentation of the man, nothing abnormal is observed and he is alerted and oriented to person, place, and time. When questioned, he is cooperative and talks in complete sentences, while periodically playing with a video game on his phone.

Shrinesh Patel is Site Director, Wellstreet Urgent Care, Sandy Springs, GA.

Observation and Findings

Physical examination of the patient reveals the following:

Height: 6 feet
Weight: 160 kg
Temp: 98.6°F
RR: 15
BP: 130/70; P: 67
S_pO_2: 97% on RA
HEENT: PERRL EOMI, anicteric sclerae, pink oral mucosa, no lesions, no LAD, TM normal bilaterally
Chest: CTA b/l no wheezing or rales

Heart: RRR no murmurs

Abd: Soft, n/d, mild TTP around umbilicus, no suprapubic tenderness, +bs

Ext: No edema +2 pulses

Neuro: CN II-XII intact, light touch sensation intact, negative Romberg, no asterixis

As the patient is walking to the bathroom to gather a urine sample, he is noted to drag his right leg. He also has tenderness to palpation in his mid back, forearms, and especially in his right upper thigh.

Labs/Imaging

Urinalysis reveals slightly tea-colored urine and the following:

Bld: 250 Ery/microliter +++
Protein: 5 g/L +++
Nitrite: Neg
Ket: Neg
Glu: Neg
pH: 5.0
SpG: 1.025
Leu: 25 leukocytes/microliter +

Differential Diagnosis

Initially, this patient was thought to have a flu-like viral syndrome or a urinary tract infection, given his initial presentation. However, the significant musculoskeletal tenderness in his right quadriceps muscle and the dramatic limp observed led to a concern about rhabdomyolysis as the cause of the man's symptoms. This preliminary conclusion was reinforced by the profound proteinuria and hematuria reported on urinalysis. Venipuncture for complete metabolic panel was attempted, but it was unsuccessful.

Initial Management

Because of the presence of leukocytes in the patient's urine and the possibility of an infectious cause of rhabdomyolysis, he was given ceftriaxone 1g IM prior to transfer to the emergency department.

Hospital Course

Although detailed records of the patient's hospital course were not obtained, follow-up with him confirmed the diagnosis of rhabdomyolysis. The patient's creatine kinase was over 100,000. Vigorous hydration over the course of 4 days resulted in normalization of his renal function and CK. Infection was ruled out and no antibiotics were subsequently administered. The final cause of his rhabdomyolysis was not determined.

Table 1. Clinical Practice Pearls for Rhabdomyolysis

Keys to Evaluation and Management

- Muscle pain and tenderness, often severe, suggesting inflammation and breakdown.
- Non-localizing flu-like syndrome
- Signs of renal dysfunction presenting as anuria, oliguria, proteinuria and/or hematuria.
- Identification of risk factors:
  - Medications
  - Crush injury
  - Excessive muscle use (vigorous training, marathon runner)
- Identification of predisposing genetic disorders
- History of inflammatory muscle disease

Keys to diagnosis

- Profoundly elevated creatine kinase levels definitive
- Tea-colored urine with significant proteinuria and hematuria in the setting of muscle pain and tenderness highly suggestive

Red Flags and Complications

- Anuria or oliguria
- Profound edema
- Signs of compartment syndrome
- Cardiac arrhythmias from hyperkalemia
- Bruising (a potential sign of disseminated intravascular coagulopathy)

Discussion

Rhabdomyolysis is as an acute, fulminating, potentially fatal disease of skeletal muscle that entails destruction of muscle as evidenced by myoglobinemia and myoglobinuria.[1] Many cases of rhabdomyolysis are associated with crush injuries, overexertion such as in marathon runners, use of medications such as corticosteroids, and exposure to toxic substances such as alcohol and cocaine. Inflammatory muscle disease such as polymyositis predisposes a patient to rhabdomyosis. In rare cases, a muscular genetic disorder can lead to the syndrome.

An infectious prodrome, including common viral and bacterial illnesses, is common in patients with rhabdomyolysis and it can lead to delayed diagnosis due to overlapping symptomatology. Clinical features include fatigue, severe muscle aches, and tea-colored urine. Screening tests include urinalysis with positive dipstick for blood, and creatine kinase levels (**Table 1**).[2] According to 2005 non-federal hospitals discharge data, 23,000 cases of rhabdomyolysis were documented out of roughly 34.7 million hospital discharges.[3] Even though the incidence is low, rhabdomyolysis has profound consequences for patients. It is only a matter of

An infectious prodrome, including common viral and bacterial illnesses, is common in patients with rhabdomyolysis and it can lead to delayed diagnosis.

time before their myoglobinuria leads to intrinsic renal failure. With such acute renal failure, ensuing metabolic and electrolyte derangements can lead to lactic acidosis, arrhythmias, and eventually mortality.

The mainstay of treatment for rhabdomyolysis is vigorous hydration to preserve renal function and correct any electrolyte imbalance. The rapid muscle breakdown leads to massive fluid loss and sequestration in dead muscle tissue. Therefore, fluid resuscitation should be initiated as quickly as possible. Acute renal failure can usually be reversed with hydration alone, but the myoglobin itself can cause a toxic tubular necrosis that can result in chronic renal failure despite hemodialysis. Preexisting renal dysfunction increases this risk.

Conclusion

This patient presented to the urgent care clinic complaining of a typical flu-like illness, but strikingly had worsening body aches some blood in his urine 6 days after its onset. Urinalysis confirmed significant proteinuria and examination was notable for considerable musculoskeletal tenderness, all of which raised concern for muscle injury and breakdown. In this case, risk factors for rhabdomyolysis were not obvious but the diagnosis was suspected and later confirmed. With vigorous hydration, his CK normalized and his renal function was preserved. ■

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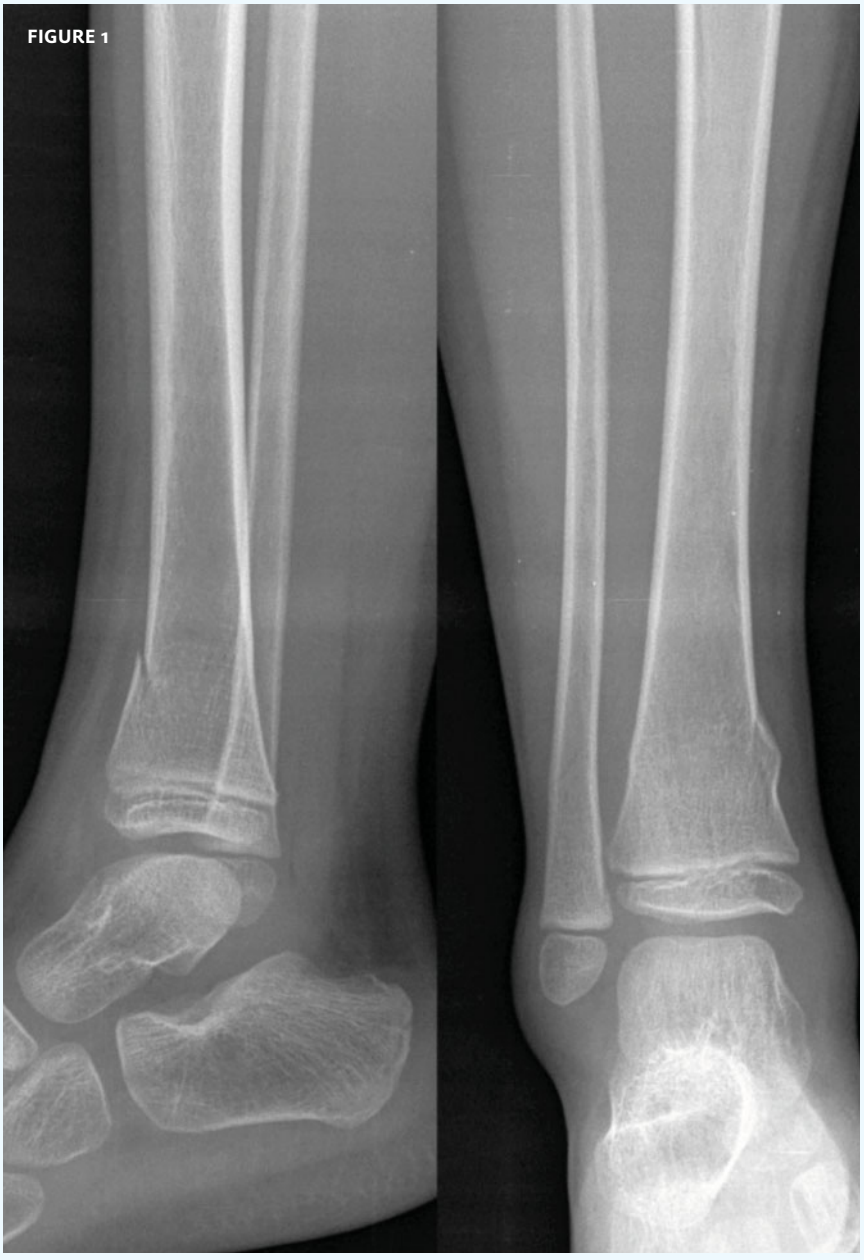
INSIGHTS IN IMAGES

CLINICAL CHALLENGE

In each issue, *JUCM* will challenge your diagnostic acumen with a glimpse of x-rays, electrocardiograms, and photographs of 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



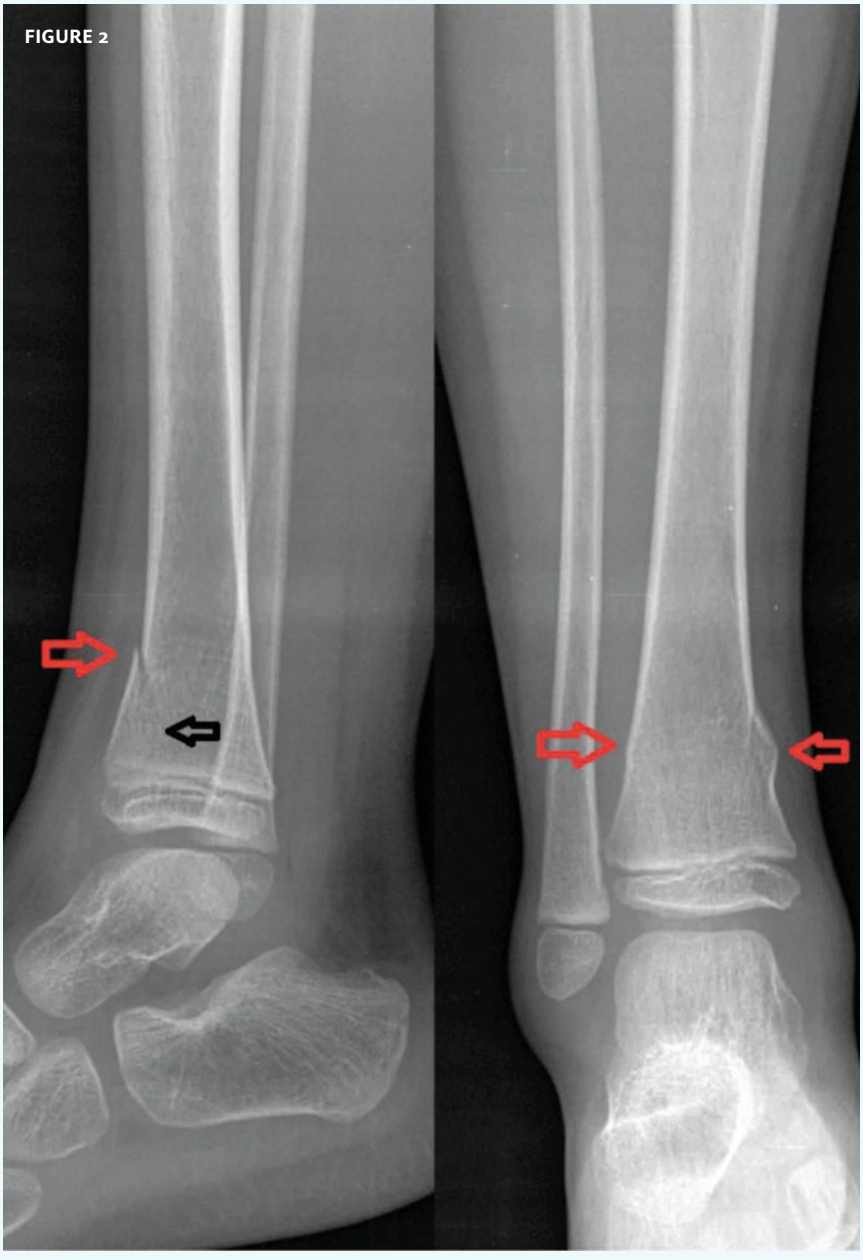
The patient, a 4-year-old boy, tripped and twisted his right ankle. He was not able to bear weight on his right foot.

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

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2



Diagnosis: The x-ray reveals a fracture of the distal tibia. A cast splint and follow up with an orthopedist are appropriate for this patient.

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

The Game Part 2

JOHN SHUFELDT, MD, JD, MBA, FACEP

Who can forget (Ok, you caught me, I did forget) the following quotes from the TV show "Perry Mason"?

> ***Lt. Tragg:*** *I don't need an autopsy to tag this one. It screams murder.*
> ***Perry Mason:*** *When it stops screaming and starts following the rules of evidence, I'll start listening.*
> ***Lt. Tragg:*** *My, we're very legal this morning.*

Or this one:

> ***Perry Mason:*** *When you pick someone to lie to Mrs. Granger, never choose your doctor or lawyer. In both cases they can be fatal.*

I used to love to watch Raymond Burr in "Perry Mason." He would get some poor witness on the stand and, in the middle of her testimony, look at the jury while he handed the witness an incriminating document and say very loudly, "What about this?" At which point the witness would dissolve into tears with her head in her hands and confess to basically everything including the crime for which she was on trial.

Unfortunately the days of "Perry Mason" are over. Today, our legal system does not allow such maneuvering and is purposely designed to prevent those kinds of surprises. Despite the fact that our judicial process remains adversarial, the courts require cooperation and disclosure of relevant information. The sharing of the relevant material is through a process called disclosure and discovery. Most states require that the parties disclose all relevant information to the opposing party even if that information is harmful or incriminating.

Disclosure statement

The disclosure statement is basically a recipe for your defense, thus it is important for you not to withhold any pertinent information from your attorney. If you fail to disclose information that turns out to be relevant, that information may not be allowed to be presented in court. In addition, if you fail to disclose facts that may be harmful or prejudicial to your case, the court can impose sanctions against you and your attorney. Moreover, the court can issue a default judgment against you. All cases have areas or issues that you would rather not disclose. Failure to disclose that information to your attorney, however, prevents him or her from preparing an adequate defense.

Generally speaking, the disclosure statement must contain the following:

1. The factual basis of the claim or defense.
2. Relevant legal theories upon which the defense or claim is based.
3. Contact information for any witness whom the disclosing party anticipates calling and the subject matter upon which they will be called to testify.
4. Names and addresses of all relevant parties, including those who will provide statements, those who your attorney believes has relevant information, and any expert witnesses expected to be called.
5. The calculation of the damages.
6. A list of all documents and the location of documents relevant to the case.

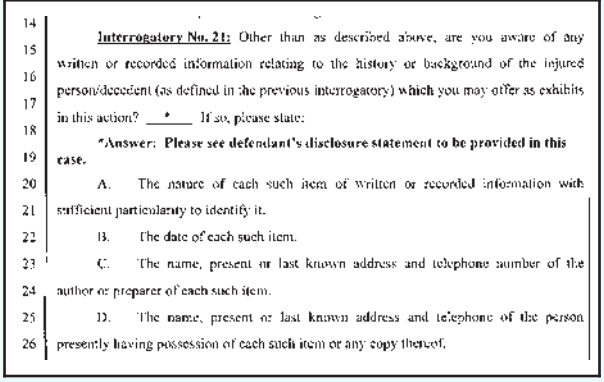
Interrogatories

Before any pretrial conference, the opposing parties go through an abbreviated discovery process. This discovery occurs through a set of written questions called uniform (developed by the courts) interrogatories. Interrogatories include some standard questions about your background training and experience (**Figure 1**).

The parties may also file non-uniform interrogatories, which are specifically drafted for that particular case. Non-uniform interrogatories are exchanged after the disclosure statement along with a request to produce documents, i.e. medical records, autopsy records, policies and procedures, medical bills, incident reports, malpractice insurance documents, lost wages information and any relevant imaging or testing (**Figure 2**).

John Shufeldt is CEO of Urgent Care Integrated Network and sits on the Editorial Board of *JUCM*. He may be contacted at *Jshufeldt@Shufeldtconsulting.com*.

Figure 1.



Interrogatory No. 21: Other than as described above, are you aware of any written or recorded information relating to the history or background of the injured person/decedent (as defined in the previous interrogatory) which you may offer as exhibits in this action? ____ If so, please state:

ANSWER: Please see defendant's disclosure statement to be provided in this case.

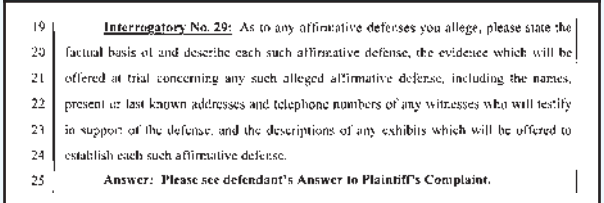
A. The nature of each such item of written or recorded information with sufficient particularity to identify it.

B. The date of each such item.

C. The name, present or last known address and telephone number of the author or preparer of each such item.

D. The name, present or last known address and telephone of the person presently having possession of each such item or any copy thereof.

Figure 2.



Interrogatory No. 29: As to any affirmative defenses you allege, please state the factual basis of and describe each such affirmative defense, the evidence which will be offered at trial concerning any such alleged affirmative defense, including the names, present or last known addresses and telephone numbers of any witnesses who will testify in support of the defense, and the descriptions of any exhibits which will be offered to establish each such affirmative defense.

Answer: Please see defendant's Answer to Plaintiff's Complaint.

Interrogatories are often very accusatory in tone and paint a picture that reflects negatively on you and upon the care delivered. Many times this is intentional inasmuch as the plaintiff's counsel attempts to posture in the belief that will give their side a tactical advantage. The best way to counteract that advantage is to remain as unemotional and factual as possible.

Your attorney will tell you that the best way to answer interrogatories is to be truthful and forthright even if it damages your case. It is best to address bad facts at the outset rather than to perpetuate a falsity that if discovered later that could ultimately destroy your case.

Comprehensive pretrial conference

Within days to a few weeks after the complaint has been received and answered the pretrial conference is scheduled. Generally the defendant does not need to participate in the comprehensive pretrial conference. Your attorney will represent your interests and report back to you.

At the pretrial conference your attorney, a member of the court and the opposing counsel will determine what further discovery is necessary and a timeframe or schedule for that discovery. In addition, a schedule will be developed and agreed upon for disclosure of plaintiff and defense experts both on standard of care and causation.

In many states the court limits each party to one standard-of-care expert as well as one expert per issue. Thus if there are multiple defendants of varying specialties or even in the same specialty, each defendant can retain one standard-of-care expert. However, typically only one expert for causation will be allowed.

Finally, the court will also set a date for a mandatory settlement conference as well as a potential trial date.

TABLE 1.

Q. Is it appropriate to continue to retake vitals if they are abnormal? **A.** It's not a yes/no answer. For example, if someone's vital signs were grossly abnormal, we would not say to waste time retaking them. We'd say to get the physician. At some point they probably will be retaken.
Q. And if they're grossly abnormal, you would take them immediately to the doctor? **A.** That's correct.
Q. So the triage technician in your role makes a decision about whether or not they're grossly abnormal or just merely abnormal? **A.** No. The electronic medical record basically makes the decision based upon normal parameters for the patient's weight, age, what have you.
Q. Are your triage technicians trained to accurately make that decision if the electronic medical record does not operate properly? **A.** I probably could not answer that across the spectrum of triage technicians.
Q. Would an LPN be qualified to make that decision? **A.** For grossly abnormal — they would be adequately qualified to determine grossly abnormal vital signs.

Depositions

The deposition is the one chance the opposing attorney has to meet you face-to-face and to question you about what you plan to say at trial. Generally, the questions start out very broad in scope, usually about your educational background and training. Next the attorney probes the actual event and finally he or she may question you about the clinic's policies and procedures regarding patients who present in similar fashion. Table 1 illustrates a typical exchange in a deposition.

The importance of the deposition cannot be overstated and how you perform during a deposition will have a far-reaching impact on the future of the case. To be clear, the attorney who takes a deposition will have learned a great deal about the medical issues involved. Prior to your deposition he or she will have consulted with experts, studied the relevant literature, studied textbooks and gone over the records with a fine-tooth comb. In other words, he or she will be extensively prepared to do battle.

As with most things in life, preparation and practice will help you tremendously during your deposition. First study the medical records and while doing so, do not make any notes in the records nor take any notes on a separate page.

Second, discuss with your attorney whether you should review the current literature. If you already know the current literature and simply need to refresh your knowledge base, that level of review should not be problematic. The challenge is if your care did not follow the guidelines or recommendations from recognized texts or the medical literature and you are now up to date on the current guidelines.

Third begin to prepare for the barrage of questions with which you'll be faced. Practice with your attorney and discuss how best to answer some of the more difficult or aggressive questions. In the end always be truthful and candid but only answer exactly what was asked. DO NOT EXPOUND!

On the day of the deposition dress professionally. Do not dress like it's your day off and do not come in scrubs. You are being judged. The opposing counsel will evaluate you the same way a jury will evaluate you. He or she will judge your empathy, your professionalism, your communication skills and finally, how you handle pressure. The attorney may even try to purposely push your buttons to see if you get upset or ill tempered. Obviously knowing the trap going in will help you prepare. I have been involved in cases where the only reason it was settled was because of a lack of confidence in the defendant physician's ability to take the stand in his or her own defense.

While being questioned, do not guess the answers. You can always refer back to the medical record. If you do not know something say, "I don't know." There is no prize for guessing right, and guessing wrong can have devastating future consequences. The challenge all physicians have is that we earn our living by answering questions and going out of our way to be helpful. In doing so we are used to becoming very conversational and sometimes overly conversant. Do not do the attorney's work for him or her. The deposition is the opposing side's opportunity to obtain statements that can then be shown to be incorrect or obtain admissions that will be used against you a trial. A deposition is not a conversation. Do not answer anything more than was asked and do not fall into the trap of saying, "Do you mean to ask me..."

Be very leery when the opposing counsel asks you to acknowledge a particular journal article or textbook chapter as authoritative. For the plaintiff to prevail, among other things, the opposing side must demonstrate that your care fell below the applicable standard of care. To do so, they will rely on authoritative journals, textbooks, and their experts. If you acknowledge a textbook as authoritative and your care does not follow the prescribed method of treatment in that textbook, you have essentially just endorsed the standard of care and that your care fell below it.

This is an incredibly uncomfortable position in which to find yourself. And the second it happens, you know you're sunk. Remember, no textbook can be absolutely authoritative in every particular instance or presentation of the patient. If you acknowledge the entire text as authoritative, anything contained in that book can be used against you to demonstrate the standard of care and how your care fell below.

"A deposition is not a conversation. Do not answer anything more than was asked and do not fall into the trap of saying, 'Do you mean to ask me...'"

In addition, avoid falling into the trap of hypotheticals. The way this occurs is that the opposing attorney paints a similar patient scenario and then asks you to respond and then uses your response and applies it back to the issue at hand, typically opening with the phrase, " Well then, Doctor, wouldn't you agree..." This is known as a leading question. Do not agree with those statements unless you agree with **every** word in the statement. These statements are designed to lead you down a path that only serves the opponent.

Take your time in answering the question. Go slow. Answer the question only after you have given it the appropriate amount of thought. Do not think out loud and do not interrupt the attorney while he or she is asking the question. Let counsel finish and then pause before answering to give your attorney the chance to object to the question if it is out of bounds.

At the end of your deposition your attorney may ask some additional clarifying questions. Alternatively, your attorney may offer nothing as opposed to taking the risk of exposing your defense. Do your best to not feel frustrated or angry during or after your deposition. The attorneys are simply doing the job they have taken an oath to do. Much like a provider, an attorney's role is to help his or her client.

Note that if there are additional defendants, their attorneys may question you as well and although they may have the same hope for a favorable outcome, they may be trying to shift blame to you. Thus do not let your guard down. Being on the same side of the suit does not mean you are on the same team!

If you can stomach it, your attorney may request that you attend the depositions of others. This will generally be used in a tactical nature so that your presence may help prevent an opposing expert from exaggeration.

In the final article in this series, I will discuss the settlement conference, the trial, and the appellate process. Or as they say on "Perry Mason," "Stay tuned, we will return after this word from our sponsor!" ■

ABSTRACTS IN URGENT CARE

- Cardiac warning for azithromycin
- Cardiac events after clarithromycin
- Norovirus in childhood gastroenteritis
- Diagnosis and ED visit necessity
- Pertussis immunity
- Home oxygen therapy for bronchiolitis
- DKA and type 1 diabetes

NAHUM KOVALSKI, BSc, MDCM

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

Azithromycin: FDA Issues Cardiac Warning

***Key point:** The antibiotic azithromycin (Zithromax and Zmax) can cause QT interval prolongation and torsades de pointes.*

Citation: FDA Drug Safety Communication: Azithromycin (Zithromax or Zmax) and the risk of potentially fatal heart rhythms. http://www.fda.gov/downloads/Drugs/DrugSafety/UCM343347.pdf

The agency says that healthcare providers should consider risk of fatal heart rhythms when treating patients already at high cardiovascular risk, including people with known prolongation of the QT interval, torsades de pointes, congenital long QT syndrome, bradyarrhythmias, or uncompensated heart failure; patients taking drugs that prolong the QT interval; and patients with proarrhythmic conditions (e.g., uncorrected hypokalemia). Older patients and patients with cardiac disease may also be at higher risk.

The warning follows a *New England Journal of Medicine* study last year that found a higher rate of cardiovascular and all-cause mortality in patients who took 5 days of azithromycin, compared with other antibiotics. ■

Cardiovascular events after clarithromycin use in lower respiratory tract infections: analysis of two prospective cohort studies

***Key point:** Use of clarithromycin in the setting of acute exacerbations of chronic obstructive pulmonary disease or community-acquired pneumonia may be associated with increased cardiovascular events.*

Citation: Cardiovascular events after clarithromycin use in lower respiratory tract infections: analysis of two prospective cohort studies.Schembri S, Williamson PA, Short PM, et al. *BMJ*. 2013;346:f1235

This was an analysis of two prospectively collected datasets (Chronic obstructive pulmonary disease [COPD] dataset [1,343 patients] including patients admitted to one of 12 hospitals around the United Kingdom between 2009 and 2011; Edinburgh pneumonia study cohort [1,631 patients] including patients admitted to NHS Lothian Hospitals between 2005 and 2009) to study the association of clarithromycin with cardiovascular events in the setting of acute exacerbations of COPD and community-acquired pneumonia (CAP).

Two hundred sixty-eight cardiovascular events occurred in the acute exacerbations of COPD and 171 in the CAP cohort over 1 year. After multivariable adjustment, clarithromycin use in acute exacerbations of COPD disease was associated with an increased risk of cardiovascular events and acute coronary syndrome—hazard ratios 1.50 (95% confidence interval 1.13 to 1.97) and 1.67 (1.04 to 2.68).

After multivariable adjustment, clarithromycin use in CAP was associated with increased risk of cardiovascular events (hazard ratio 1.68, 1.18 to 2.38) but not acute coronary syndrome (1.65, 0.97 to 2.80). The association between clarithromycin use and cardiovascular events persisted after matching for the propensity to receive clarithromycin. A significant association was found between clarithromycin use and cardiovascular mortality (adjusted hazard ratio 1.52, 1.02 to 2.26) but not all-cause mortality (1.16, 0.90 to 1.51) in acute exacerbations of COPD.

Nahum Kovalski is an urgent care practitioner and Assistant Medical Director/CIO at Terem Emergency Medical Centers in Jerusalem, Israel. He also sits on the *JUCM* Editorial Board.

No association was found between clarithromycin use in CAP and all-cause mortality or cardiovascular mortality. Longer durations of clarithromycin use were associated with more cardiovascular events. Use of β-lactam antibiotics or doxycycline was not associated with increased cardiovascular events in patients with acute exacerbations of COPD, suggesting an effect specific to clarithromycin. ■

Norovirus Is Now the Most Common Cause of Childhood Gastroenteritis (in the US)

Key point: Norovirus most often affects children aged <18 months and accounts for substantial healthcare costs.

Citation: Payne DC, Vinje J, Szilagyi PG, et al. Norovirus and medically attended gastroenteritis in U.S. children. *N Engl J Med*. 2013;368(12):1121-1130.

The health burden of norovirus in the pediatric population has not been determined since widespread use of the rotavirus vaccine. Researchers examined the burden of norovirus-associated gastroenteritis (sudden vomiting, diarrhea, and dehydration lasting 1–3 days) in a multicenter surveillance study of 141,000 children younger than 5 years seeking medical attention for gastroenteritis in three U.S. counties during 2009 and 2010.

Fecal samples were obtained from 1,295 children with gastroenteritis and 493 healthy controls. Norovirus was detected in 21% of cases and 4% of controls and rotavirus was detected in 12% of cases and in 1 child in the control group. Norovirus was more common than rotavirus in all clinical settings. Nearly half of norovirus infections were in children aged 6 to 18 months. Norovirus occurred year-round and peaked in January. In 2009, the GII.4 Minerva norovirus genotype accounted for 71% of norovirus infections. In 2010, GII.4 New Orleans was the most common norovirus genotype. Median costs were $3,918 for norovirus-associated hospitalizations, $435 for emergency department (ED) visits, and $191 for clinic visits. The authors estimate that norovirus accounted for 14,000 hospitalizations, 281,000 ED visits, and 627,000 outpatient visits during the 2 years and cost about $273 million each year.

Published in *J Watch Ped Adolesc Med* March 20, 2013 — F. Bruder Stapleton, MD. ■

Can We Use the Diagnosis to Determine Whether an ED Visit Was Necessary?

Key point: Emergency-department presenting complaints are similar for patients with serious and nonserious discharge diagnoses.

Citation: Raven MC, Lowe RA, Maselli J, et al. Comparison of presenting complaint vs discharge diagnosis for identifying "nonemergency" emergency department visits. *JAMA*. 2013;309:1145-1153.

Reduction in emergency department (ED) use is frequently viewed as a potential source for cost savings. One consideration has been to deny payment if the patient's diagnosis on ED discharge appears to reflect a "nonemergency" condition. This approach does not incorporate other clinical factors such as chief complaint that may inform necessity for ED care. The purpose of this study was to determine whether ED presenting complaint and ED discharge diagnosis correspond sufficiently to support use of discharge diagnosis as the basis for policies discouraging ED use.

The New York University emergency department algorithm has been commonly used to identify nonemergency ED visits. The authors applied the algorithm to publicly available ED visit data from the 2009 National Hospital Ambulatory Medical Care Survey (NHAMCS) for the purpose of identifying all "primary care–treatable" visits. The 2009 NHAMCS data set contains 34,942 records, each representing a unique ED visit. For each visit with a discharge diagnosis classified as primary care treatable, the authors identified the chief complaint. To determine whether these chief complaints correspond to nonemergency ED visits, the authors then examined all ED visits with this same group of chief complaints to ascertain the ED course, final disposition, and discharge diagnoses.

Although only 6.3% (95% CI, 5.8%-6.7%) of visits were determined to have primary care–treatable diagnoses based on discharge diagnosis and the modification of the algorithm, the chief complaints reported for these ED visits with primary care–treatable ED discharge diagnoses were the same chief complaints reported for 88.7% (95% CI, 88.1%-89.4%) of all ED visits. Of these visits, 11.1% (95% CI, 9.3%-13.0%) were identified at ED triage as needing immediate or emergency care; 12.5% (95% CI, 11.8%-14.3%) required hospital admission; and 3.4% (95% CI, 2.5%-4.3%) of admitted patients went directly from the ED to the operating room.

Among ED visits with the same presenting complaint as those ultimately given a primary care–treatable diagnosis based on ED discharge diagnosis, a substantial proportion required immediate emergency care or hospital admission. The limited concordance between presenting complaints and ED discharge diagnoses suggests that these discharge diagnoses are unable to accurately identify nonemergency ED visits. ■

Pertussis Immunity Drops Soon After the Last Vaccine Dose Is Given

Key point: The incidence of pertussis in children rises steadily in the years immediately following receipt of the fifth dose of the diphtheria-tetanus-acellular pertussis (DTaP) vaccine.

Citation: Tartof SY, Lewis M, Kenyon C, et al. *Pediatrics*. Published online March 11, 2013.

Researchers examined the incidence of pertussis among more than 400,000 children in Minnesota and Oregon who'd re-

ceived all five doses of diphtheria-tetanus-acellular pertussis, with the fifth dose given between ages 4 and 6 years. In the 6 years after the last dose was received, some 550 pertussis cases were identified. The incidence rose steadily with each passing year.

The authors say their findings "strongly [suggest] waning of vaccine-induced immunity," which "helps to explain the emergence of an increased burden of disease among 7- to 10-year-olds." (Currently, the adolescent booster is recommended at ages 11 to 12 years.)

Sedative agents used included propofol, etomidate, ketamine, methohexital, and midazolam in 303, 67, 57, 17, and 13 cases, respectively (some patients required a second reduction). Adverse events (predefined as events requiring airway interventions, reversal agents, anti-dysrhythmic agents, or chest compressions) occurred in 12 patients (2.8%). Respiratory complications included apnea (1 patient) and ventilator insufficiency (8); all patients responded to airway maneuvers or brief bag-valve-mask ventilation. Two patients developed hypotension: one responded to intravenous (IV) fluids and the other to flumazenil IV. No patient required endotracheal intubation and no complication resulted in prolonged observation or hospital admission. ■

Home Oxygen Therapy for Young Children with Bronchiolitis

Key point: Combining the use of an observation unit and home oxygen therapy resulted in shorter hospital stays and cost savings for bronchiolitis.

Citation: Sandweiss DR, Mundorff MB, Hill T, et al. Decreasing hospital length of stay for bronchiolitis by using an observation unit and home oxygen therapy. *JAMA Pediatr.* 2013;()1-7.

Inpatient care for young children with bronchiolitis can cause an overcrowding crisis during peak respiratory-virus activity. Those with hypoxia may linger in the hospital to receive supplemental oxygen, even though their condition is otherwise improved. In a recent retrospective cohort study conducted at a large children's hospital in Salt Lake City, Utah, researchers tested the hypothesis that length of stay (LOS) could be reduced by providing home oxygen therapy (HOT) after a short stay in an observation unit (OU).

During the 2010–2011 bronchiolitis season, OU-HOT was offered to the families of children aged 3 to 24 months with uncomplicated bronchiolitis (i.e., low illness severity; no comorbid conditions) who tolerated oxygen delivered by nasal cannula. Duration of OU stay was >8 hours. Those whose condition deteriorated were admitted to the inpatient unit. The LOS for the 2010–2011 season (725 children; mean age, 7.5 months) was compared with that for the 2009–2010 season (625 children; mean age, 7.1 months), as well as with the expected LOS derived by extending the linear trend from the previous five seasons forward.

The mean overall hospital LOS (OU or inpatient unit) decreased from 63.3 hours in 2009–2010 to 49.3 hours in 2010–2011, which was significant by both outcome measures ($P<0.001$). In addition, the proportion of patients discharged within 24 hours increased from 20% to 38% ($P<0.001$). Cost per case decreased from $4,800 to $3,582 ($P<0.001$). The protocol appeared safe and was not associated with an increase in readmissions.

Published in *J Watch Infect Dis* March 20, 2013 — Robert S. Baltimore, MD. ■

DKA often the first recognized sign of type 1 diabetes

Key point: About a third of children are already in diabetic ketoacidosis by the time they are diagnosed with type 1 diabetes, which means that earlier signs of the disease were missed.

Citation: Otto AM. DKA often the first recognized sign of type 1 diabetes. *Fam Pract News.* 02/08/13. http://www.familypracticenews.com/specialty-focus/diabetes-endocrinology-metabolism/singleview-enewsletter/dka-often-the-first-recognized-sign-of-type-1-diabetes/503880123445970 5c70e6cfc58c0735d.html

Among 805 children in the Pediatric Diabetes Consortium's database, 34% presented in diabetic ketoacidosis (DKA), half of whom had moderate or severe DKA (pH less than 7.2). The risk of DKA was 54% in children under 3 years old and 33% in older children ($P=.006$). The findings were consistent with previous studies.

"Unfortunately, there has been no apparent change in the rate of DKA at presentation of T1D [type 1 diabetes] in children over the past 25 years; the incidence of DKA in children at the onset of T1D remains high. Effective techniques for increasing awareness of the early symptoms of T1D in both the general public and primary care providers are needed to decrease the incidence of this life-threatening complication," the investigators wrote (*J. Pediatr. 2013;162:330-4*).

The problem is that those early T1D symptoms–often an abrupt increase in thirst and urination–are "not infrequently" overlooked by parents unfamiliar with the disease and sometimes even by clinicians, especially in very young children. The classic signs of diabetes in children have a variety of harmless possible explanations. Excess thirst might be chalked up to hot weather or a growth spurt. Polyuria might be mistaken for a urinary tract infection. Weight loss, particularly in an obese child, might be attributed to dieting. It's also hard to tell the difference between normal and abnormal thirst and urination in children less than 1 or 2 years old, and they're unlikely to be able to voice any complaints.

DKA can be missed too, especially when its associated nausea and vomiting mimic a viral infection. "When a child presents with a flulike illness, it's worth getting a simple urine dipstick to make sure there's no sugar or ketones in the urine. ■

CODING Q&A

Foreign Body Removal, Hydration, and Minor Surgical Procedures with E/M

DAVID STERN, MD, CPC

Q. We removed an earring that was imbedded in the pinna using general anesthesia? Can we bill CPT code 69205?

A. No. CPT code 69205, "Removal foreign body from external auditory canal; with general anesthesia," is limited to the external auditory canal. The pinna, which also may be referred to as the auricle, is not considered a part of the auditory canal. If an incision was made to remove the embedded earring, you would bill CPT code 10120, "Incision and removal of foreign body, subcutaneous tissues; simple." ■

Q. When is it appropriate to bill for normal saline with a hydration procedure?

A. If the physician practice purchased the drugs/substances, the corresponding HCPCS Level II codes may be reported in addition to the administration codes. Thus, you would bill for the saline separately when performing hydration, CPT code 96360, "Intravenous infusion, hydration; initial, 31 minutes to one hour" and add on code 96361, "...each additional hour (List separately in addition to code for primary procedure)."

You can also bill separately for normal saline used to help facilitate drug if the normal saline was purchased by the practice. For example, a patient was given 1 g of Rocephin intravenously over a period of 30 minutes. You used one bag of 1,000 mL normal saline to dilute the Rocephin. You would bill 96365, "Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to one hour," HCPCS Level II code J7030 for the normal saline, and HCPCS Level II code J0696 (4 units since this code represents 250 mg) for the Rocephin. However, if you are infusing a drug where normal saline is already packaged with the medicine, you would not bill separately for the saline.

Some payors may bundle the normal saline with the procedure, so you will want to check individual payor policies and contracts. ■

Q. We sutured a finger laceration and also took a history and performed an exam. Can we bill an E/M code with the laceration code?

A. The following quote comes directly from the 2013 NCCI edits. The phrase in italics was added/revised as of January 1, 2013. "If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. *E/M services on the same date of service as the minor surgical procedure are included in the payment for the procedure*. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E/M service. However, a significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. The E/M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E/M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E/M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles."■

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

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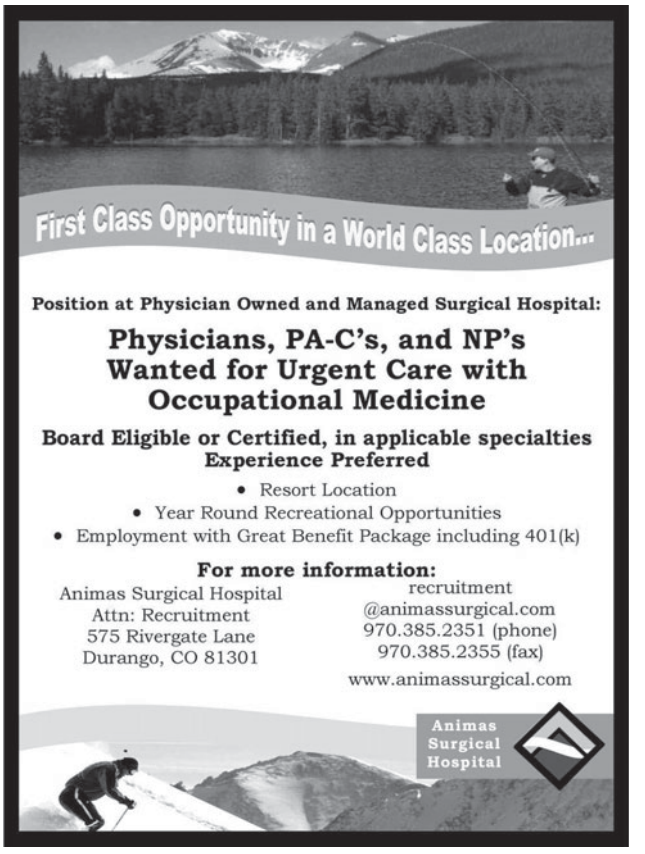

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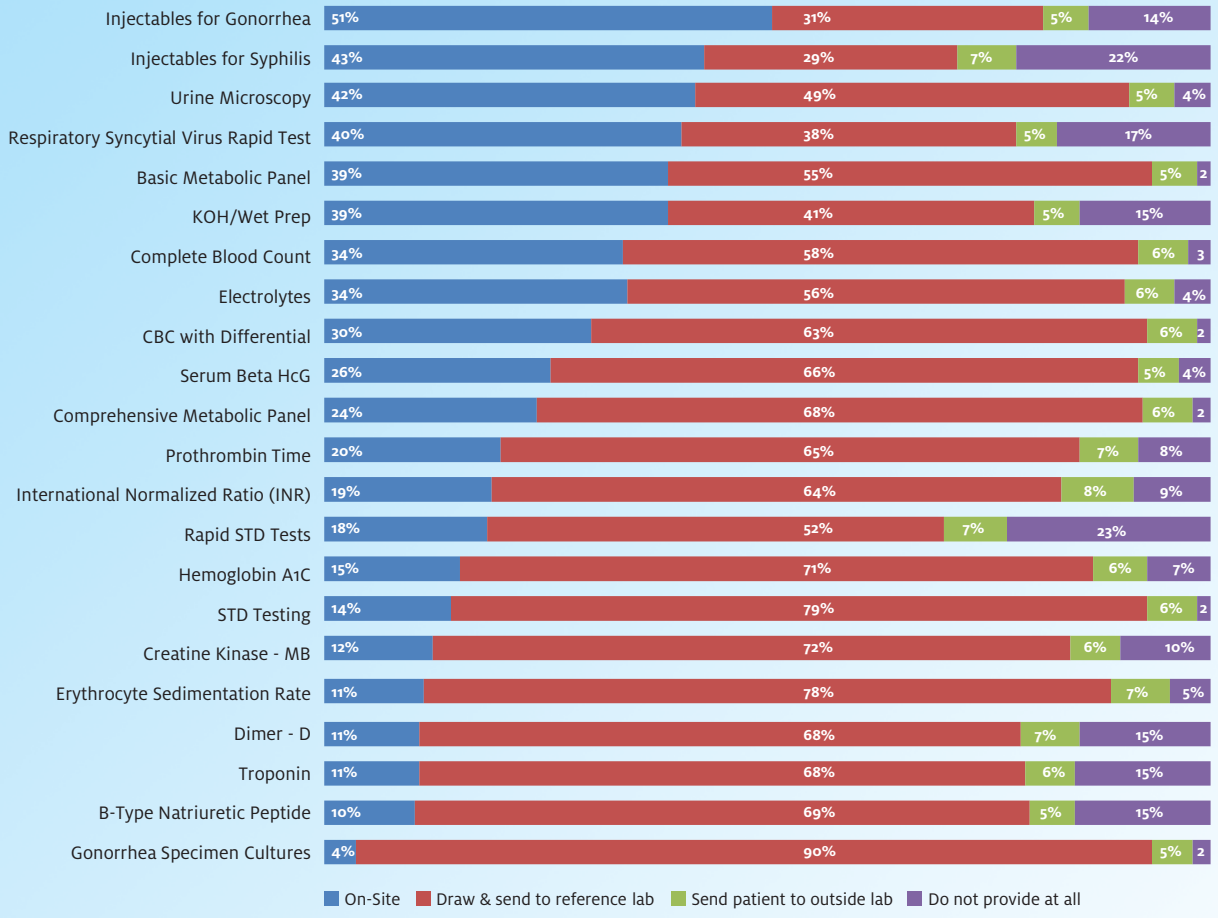
DEVELOPING DATA

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 Additional Clinical Services Are Urgent Care Centers Providing?

SERVICES PROVIDED



Clinical services beyond those that are general often are made available to patients at the urgent care center, but the actual processing of the services is done elsewhere. The graph above covers a broad variety of clinical services and how/where they are typically provided.

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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