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IN THIS ISSUE

FEATURES

- 11** Understanding Clinical Decision Rules Regarding Minor Traumatic Brain Injury
- 23** *Bouncebacks*: The Case of a 10-Year-Old Male with Eye Pain

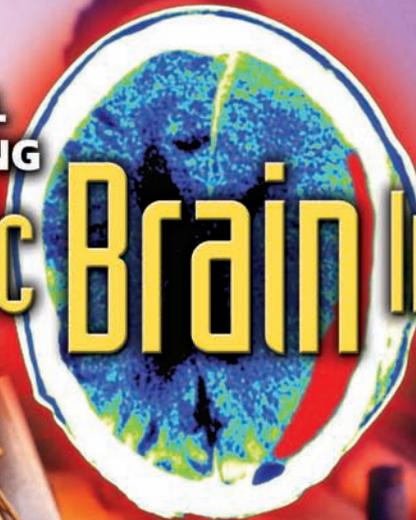
DEPARTMENTS

- 27** Insights in Images: Clinical Challenge
- 31** Health Law
- 34** Occupational Medicine
- 35** Coding Q&A
- 40** Developing Data



UNDERSTANDING CLINICAL
DECISION RULES REGARDING

Minor Traumatic Brain Injury





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TUSSIONEX[®] is indicated for the relief of cough and upper respiratory symptoms associated with allergy or a cold in adults and children 6 years of age and older. Each teaspoonful (5 mL) of TUSSIONEX[®] contains hydrocodone polistirex equivalent to 10 mg hydrocodone bitartrate and chlorpheniramine polistirex equivalent to 8 mg chlorpheniramine maleate. TUSSIONEX[®] is contraindicated in the presence of known allergy or sensitivity to hydrocodone or chlorpheniramine and in children less than 6 years of age. The most common adverse reactions associated with TUSSIONEX[®] are sedation, drowsiness, and mental clouding, which may impair the mental and/or physical abilities required for potentially hazardous tasks. As with any other drugs in this class, the possibility of tolerance and/or dependence, particularly in patients with a history of drug dependence, should be considered.

Please see full Prescribing Information on reverse.

UCB Medical Affairs Department: 1-800-477-7877

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Extended-Release Suspension

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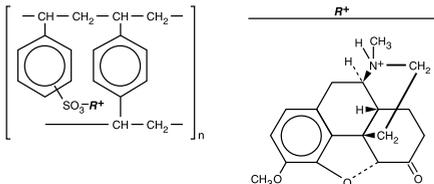
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(hydrocodone polistirex and chlorpheniramine polistirex)
Extended-Release Suspension

Rx Only

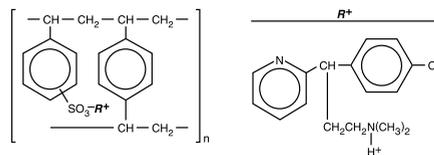
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DESCRIPTION: Each teaspoonful (5 mL) of TUSSIONEX Pennkinetic Extended-Release Suspension contains hydrocodone polistirex equivalent to 10 mg of hydrocodone bitartrate and chlorpheniramine polistirex equivalent to 8 mg of chlorpheniramine maleate. TUSSIONEX Pennkinetic Extended-Release Suspension provides up to 12-hour relief per dose. Hydrocodone is a centrally-acting narcotic antitussive. Chlorpheniramine is an antihistamine. TUSSIONEX Pennkinetic Extended-Release Suspension is for oral use only.

Hydrocodone Polistirex: Sulfonated styrene-divinylbenzene copolymer complex with 4,5 α -epoxy-3-methoxy-17-methylmorphinan-6-one.



Chlorpheniramine Polistirex: Sulfonated styrene-divinylbenzene copolymer complex with 2-[p-chloro- α -(2-(dimethylamino)ethyl)-benzyl]pyridine.



Inactive Ingredients: Ascorbic acid, D&C Yellow No. 10, ethylcellulose, FD&C Yellow No. 6, flavor, high fructose corn syrup, methylparaben, polyethylene glycol 3350, polysorbate 80, pregelatinized starch, propylene glycol, propylparaben, purified water, sucrose, vegetable oil, xanthan gum.

CLINICAL PHARMACOLOGY: Hydrocodone is a semisynthetic narcotic antitussive and analgesic with multiple actions qualitatively similar to those of codeine. The precise mechanism of action of hydrocodone and other opiates is not known; however, hydrocodone is believed to act directly on the cough center. In excessive doses, hydrocodone, like other opium derivatives, will depress respiration. The effects of hydrocodone in therapeutic doses on the cardiovascular system are insignificant. Hydrocodone can produce miosis, euphoria, and physical and psychological dependence.

Chlorpheniramine is an antihistamine drug (H₁ receptor antagonist) that also possesses anticholinergic and sedative activity. It prevents released histamine from dilating capillaries and causing edema of the respiratory mucosa.

Hydrocodone release from TUSSIONEX Pennkinetic Extended-Release Suspension is controlled by the Pennkinetic System, an extended-release drug delivery system, which combines an ion-exchange polymer matrix with a diffusion rate-limiting permeable coating. Chlorpheniramine release is prolonged by use of an ion-exchange polymer system.

Following multiple dosing with TUSSIONEX Pennkinetic Extended-Release Suspension, hydrocodone mean (S.D.) peak plasma concentrations of 22.8 (5.9) ng/mL occurred at 3.4 hours. Chlorpheniramine mean (S.D.) peak plasma concentrations of 58.4 (14.7) ng/mL occurred at 6.3 hours following multiple dosing. Peak plasma levels obtained with an immediate-release syrup occurred at approximately 1.5 hours for hydrocodone and 2.8 hours for chlorpheniramine. The plasma half-lives of hydrocodone and chlorpheniramine have been reported to be approximately 4 and 16 hours, respectively.

INDICATIONS AND USAGE: TUSSIONEX Pennkinetic Extended-Release Suspension is indicated for relief of cough and upper respiratory symptoms associated with allergy or a cold in adults and children 6 years of age and older.

CONTRAINDICATIONS: TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in patients with a known allergy or sensitivity to hydrocodone or chlorpheniramine.

The use of TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in children less than 6 years of age.

WARNINGS: Respiratory Depression: As with all narcotics, TUSSIONEX Pennkinetic Extended-Release Suspension produces dose-related respiratory depression by directly acting on brain stem respiratory centers. Hydrocodone affects the center that controls respiratory rhythm and may produce irregular and periodic breathing. Caution should be exercised when TUSSIONEX Pennkinetic Extended-Release Suspension is used postoperatively and in patients with pulmonary disease, or whenever ventilatory function is depressed. If respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride and other supportive measures when indicated (see OVERDOSAGE).

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions, which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

Obstructive Bowel Disease: Chronic use of narcotics may result in obstructive bowel disease especially in patients with underlying intestinal motility disorder.

Pediatric Use: In pediatric patients, as well as adults, the respiratory center is sensitive to the depressant action of narcotic cough suppressants in a dose-dependent manner. Benefit to risk ratio should be carefully considered, especially in pediatric patients with respiratory embarrassment (e.g., croup) (see PRECAUTIONS).

PRECAUTIONS: General: Caution is advised when prescribing this drug to patients with narrow-angle glaucoma, asthma, or prostatic hypertrophy.

Special Risk Patients: As with any narcotic agent, TUSSIONEX Pennkinetic Extended-Release Suspension should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy, or urethral stricture. The usual precautions should be observed and the possibility of respiratory depression should be kept in mind.

Information for Patients: As with all narcotics, TUSSIONEX Pennkinetic Extended-Release Suspension may produce marked drowsiness and impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly. TUSSIONEX Pennkinetic Extended-Release Suspension must not be diluted with fluids or mixed with other drugs as this may alter the resin-binding and change the absorption rate, possibly increasing the toxicity.

Keep out of the reach of children.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when TUSSIONEX Pennkinetic Extended-Release Suspension is used postoperatively, and in patients with pulmonary disease.

Drug Interactions: Patients receiving narcotics, antihistamines, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with TUSSIONEX Pennkinetic Extended-Release Suspension may exhibit an additive CNS depression. When combined therapy is contemplated, the dose of one or both agents should be reduced.

The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone.

The concurrent use of other anticholinergics with hydrocodone may produce paralytic ileus.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenicity, mutagenicity, and reproductive studies have not been conducted with TUSSIONEX Pennkinetic Extended-Release Suspension.

Pregnancy: Teratogenic Effects – Pregnancy Category C
Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. TUSSIONEX Pennkinetic Extended-Release Suspension should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.

Labor and Delivery: As with all narcotics, administration of TUSSIONEX Pennkinetic Extended-Release Suspension to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from TUSSIONEX Pennkinetic Extended-Release Suspension, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness of TUSSIONEX Pennkinetic Extended-Release Suspension in pediatric patients under six have not been established (see WARNINGS).

Geriatric Use: Clinical studies of TUSSIONEX 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. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

This drug is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function.

ADVERSE REACTIONS: Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, euphoria, dizziness, psychic dependence, mood changes.

Dermatologic System: Rash, pruritus.

Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of TUSSIONEX Pennkinetic Extended-Release Suspension may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters, and urinary retention have been reported with opiates.

Respiratory Depression: TUSSIONEX Pennkinetic Extended-Release Suspension may produce dose-related respiratory depression by acting directly on brain stem respiratory centers (see OVERDOSAGE).

Respiratory System: Dryness of the pharynx, occasional tightness of the chest.

DRUG ABUSE AND DEPENDENCE: TUSSIONEX Pennkinetic Extended-Release Suspension is a Schedule III narcotic. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, TUSSIONEX Pennkinetic Extended-Release Suspension should be prescribed and administered with caution. However, psychic dependence is unlikely to develop when TUSSIONEX Pennkinetic Extended-Release Suspension is used for a short time for the treatment of cough. Physical dependence, the condition in which continued administration of the drug is required to prevent the appearance of a withdrawal syndrome, assumes clinically significant proportions only after several weeks of continued oral narcotic use, although some mild degree of physical dependence may develop after a few days of narcotic therapy.

OVERDOSAGE: Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. Although miosis is characteristic of narcotic overdose, mydriasis may occur in terminal narcosis or severe hypoxia. In severe overdose apnea, circulatory collapse, cardiac arrest and death may occur. The manifestations of chlorpheniramine overdose may vary from central nervous system depression to stimulation.

Treatment: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonist naloxone hydrochloride is a specific antidote for respiratory depression which may result from overdose or unusual sensitivity to narcotics including hydrocodone. Therefore, an appropriate dose of naloxone hydrochloride should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation. Since the duration of action of hydrocodone in this formulation may exceed that of the antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration. For further information, see full prescribing information for naloxone hydrochloride. An antagonist should not be administered in the absence of clinically significant respiratory depression. Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated. Gastric emptying may be useful in removing unabsorbed drug.

DOSAGE AND ADMINISTRATION

Shake well before using.

Adults and Adolescents \geq 13 Years of Age

5 mL (1 teaspoonful) every 12 hours; do not exceed 10 mL (2 teaspoonfuls) in 24 hours.

Children 6-12 Years of Age

2.5 mL (1/2 teaspoonful) every 12 hours; do not exceed 5 mL (1 teaspoonful) in 24 hours.

It is important that TUSSIONEX be measured accurately. A household teaspoonful is not an accurate measuring device and could lead to overdose, especially when half a teaspoon is to be measured. It is strongly recommended that an accurate measuring device be used. A pharmacist can provide an appropriate measuring device and can provide instructions for measuring the correct dose. Please ask a pharmacist for advice.

This medicine is not intended for children under 6 years of age (see CONTRAINDICATIONS).

HOW SUPPLIED: TUSSIONEX Pennkinetic (hydrocodone polistirex and chlorpheniramine polistirex) Extended-Release Suspension is a gold-colored suspension.

NDC 53014-548-67 473 mL bottle

For Medical Information

Contact: Medical Affairs Department
Phone: (866) 822-0068
Fax: (770) 970-8859

Storage:

Shake well. Dispense in a well-closed container.

Store at 20-25°C (68-77°F); excursions permitted to 15-30°C (59-86°F) [see USP Controlled Room Temperature].

TUSSIONEX Pennkinetic Extended-Release Suspension

Manufactured for:

UCB, Inc.
Smyrna, GA 30080



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Strength in Numbers



It's springtime again, and for us Northerners, that is a welcome sign.

It's time to end months of hibernation holed up in our overly heated homes. It's time to break out of our winter routine of work, eat, and sleep and welcome in several months of energizing warmth and rejuvenated spirit.

At UCAOA, we use this time of year to re-energize the membership, welcome in new members, and set the agenda for the year to come.

The UCAOA spring convention is the largest gathering of urgent care professionals in the world, and represents both the growth of our discipline and the tremendous efforts of this organization. We have made it our mission to "provide leadership, education and resources for the successful practice of urgent care."

We celebrate this mission every year at the convention. Our vision, "to be the catalyst for the recognition of urgent care as an essential part of the healthcare system," can be achieved only with the support of you, the urgent care professional. Whether you are a physician, PA, or NP, whether you are a nurse or administrator, we need your voice to be represented.

Our standing in healthcare and recognition of our services depends on it.

The convention is not just a place to get good CME or learn how to better run your urgent care business. It is a place to be represented and to show support for the discipline as a whole.

UCAOA was founded on the principle of representation. Our goal was to ensure that this organization represented the interests of the majority of its constituents, not a select few. We supported this by implementing a vigorous democratic process with a voting membership, rotating board of directors, strong bylaws, and transparent governance.

UCAOA was also founded on the principle of continual improvement: Success breeds necessity for even greater success. Each achievement adds strength to the foundation on which we are building this discipline, brick by brick.

We have had some undeniable initial success: exponential membership growth, unprecedented conference attendance, exceptional vendor participation and support, development of the first and only fellowship training programs, the successful launch of a journal that now reaches over 13,000 urgent care

professionals, and an accreditation program specifically designed for urgent care clinics.

There remains considerable work to be done, however, and it requires the participation of all of us to be successful. Without it, there can be no sustainable success. We need each and every one of you to be represented.

"Our ability to represent urgent care at the national level depends on strength in numbers."

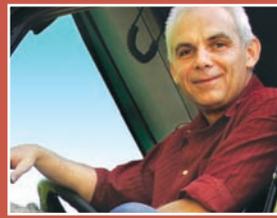
The most critical thing you can do is become a member. Our ability to represent urgent care at the national level depends on strength in numbers; the success of any democracy depends on the voice of the people. The more people we represent, the greater our standing in the healthcare delivery system and the house of medicine.

The next most important thing to do is to join us at the convention.

The convention is a visible display of strength, as well as an undeniable educational experience. Additionally, it is an opportunity to share your passion for urgent care medicine with colleagues. Finally, the convention is the place to learn about and interact with your organization's current and future leadership.

So come celebrate with us in New Orleans April 29–May 2 and help us realize our vision with a collective show of strength. ■

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



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March 2008

VOLUME 2, NUMBER 6



CLINICAL

11 Understanding Clinical Decision Rules Regarding Minor Traumatic Brain Injury

The key challenge when managing patients with minor traumatic brain injury in urgent care is identifying those who might be at risk for poorer outcomes. The first in a two-part series.

By Joseph Toscano, MD

BOUNCEBACKS

23 The Case of a 10-Year-Old Male with Eye Pain

Insufficiently insensitive tests can lead a clinician—or a patient—to believe that an injury or condition is less severe than it really is. Would you trust your clinical judgment in the face of falsely reassuring diagnostic tests?

By Ryan Longstreth, MD, FACEP and Michael Weinstock, MD



- 7 Letters to the Editor
- 9 From the UCAOA Executive Director

DEPARTMENTS

- 27 Insights in Images: Clinical Challenge
- 31 Health Law
- 34 Occupational Medicine
- 35 Coding Q&A
- 40 Developing Data

CLASSIFIEDS

- 37 Career Opportunities

Next month in JUCM:

The second installment of our series on treating patients with minor traumatic brain presents practical clinical scenarios and addresses post-care instructions and follow-up.

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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, *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.

JUCM The Journal of Urgent Care Medicine (JUCM) makes every effort to select authors who are knowledgeable in their fields. However, *JUCM* does not warrant the expertise of any author in a particular field, nor is it responsible for any statements by such authors. The opinions expressed in the articles and columns are those of the authors, do not imply endorsement of advertised products, and do not necessarily reflect the opinions or recommendations of Braveheart Publishing or the editors and staff of *JUCM*. Any procedures, medications, or other courses of diagnosis or treatment discussed or suggested by authors should not be used by clinicians without evaluation of their patients' conditions and possible contraindications or dangers in use, review of any applicable manufacturer's product information, and comparison with the recommendations of other authorities.



Regarding Our January Issue

To the Editor:

I enjoyed the article about CA-MRSA (CA-MRSA Abscess Care and Treatment Guidelines in Urgent Care Practice, Michael Dickey, MD, *JUCM*, January 2008).

Community-acquired MRSA is indeed becoming more and more common. In fact, it has been referred to as “the spider bite of the twenty-first century.”

Any abscess seen in the outpatient setting should be considered MRSA until proven otherwise and treated for both MRSA and MSSA and *Strep*. All abscesses should have an I & D, and a culture should be sent so the susceptibilities in your area can be determined.

Concerning cellulitis, MRSA should not be automatically assumed. But, if you are treating for normal skin flora and there is no improvement in a few days, or if it worsens, treatment for MRSA should be added to the current antibiotic regimen.

One other note about other organisms that cause skin and soft tissue infections: don't forget *Mycobacterium marinum*. Think of it if your patient recently was in the Caribbean or recently had a pedicure and presents with a toe infection.

Joseph A. LiMarzi, MD

Assistant Director, Milford Urgent Care Center, Milford, PA
Assistant Director, Emergency Department, Newton Memorial Hospital, Newton, NJ

Dr. Dickey responds: I agree with Dr. LiMarzi's thoughts on atypical infections. Mycobacterial and fungal infections should be suspected when an SSTI is not responsive to therapy directed at MRSA and *Streptococcus*. AFB and fungal cultures and stains, as well as biopsy of infected site, can be helpful to help determine the etiology of non-responsive infections.

These infections often require a little CSI (crime scene investigator) work; often, infectious disease consultants can be very helpful in sorting these infections out. As they are particularly infrequent, most clinicians in the trenches are going to see very few of them.

To the Editor:

The picture of an ankle x-ray on page 27 (Insights in Images: Clinical Challenge, presented by Nahum Kovalski, BSc, MDCM, *JUCM*, January 2008) points out the widened joint space on the medial side of the ankle.

Having been an orthopedic resident through the PGY3 level

prior to my emergency medicine residency, I would point out that concern over that widened space should have led the clinician to investigate whether there was a concomitant proximal fibula fracture.

The whole point of that x-ray is that the energy which was absorbed and caused disruption of the deltoid ligament often travels up through the syndesmosis between the tibia and fibula and exits through the proximal fibula.

I agree that splinting is necessary, but I do think the answer was excessively basic for physicians in urgent care. The above explanation is the reason why that x-ray is a unique teaching point, not that a splint is necessary.

Peter C. Duic, MD

President, Suncoast Healthcare Solutions
Managing Partner, Trinity Urgent Care
Managing Partner, Doctor's Choice Weight Loss
Trinity, FL

Dr. Kovalski responds: Our orthopedist notes that in such cases, a physical exam of the proximal fibular region to rule out sensitivity (consistent with a fracture) is the appropriate next step. If there is tenderness, a film to that area is necessary. If there is no proximal tenderness, then a film would not be necessary.

To the Editor:

I couldn't agree more on how important marketing is in achieving successful results in occupational medicine (The Physician's Role in Occupational Health Sales and Marketing, Frank Leone, MBA, MPH, *JUCM*, January 2008).

In our occupational division, our marketers know firsthand all the services our providers offer.

In our facility, we have implemented a quality-assurance command center which monitors all services to avoid over-utilization. The program assures that the injured worker and the employer receive efficient and professional attention.

Despite personalized and creative marketing tools, competition will always be a challenge. Open employer-physician communication, dedication to comprehensive case management, and healthcare cost containment will definitely differentiate between you and your competitor.

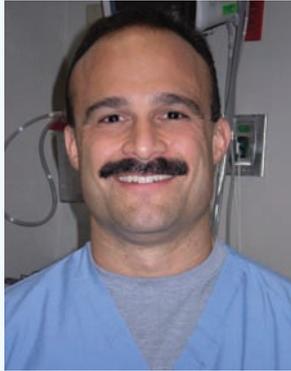
Jose Serrato, PA-C

Healthpointe Inc.
Anaheim, CA



JUCM CONTRIBUTORS

Patients with minor head injuries frequently present to urgent care clinics. While most will have minor or no difficulties, others who initially appear well can have a significant underlying injury, putting them at risk for a poorer outcome.



That challenge is addressed in a two-part article by **Joseph Toscano, MD**. In the first installment (Understanding Clinical Decision Rules Regarding Minor Traumatic Brain Injury, page 11), Dr. Toscano reviews the available guidance and applies the evidence to the urgent care setting.

Dr. Toscano practices emergency and urgent care medicine in San Ramon, CA and, in addition to caring for patients, regularly reviews journal articles, CME content, and patient education materials pertaining to acute care medicine.

Sound decision-making is also the key factor in the Bouncebacks case featured in this issue (page 23). **Ryan Longstreth, MD, FACEP** and **Michael Weinstock, MD** offer an examination of a case in which a 10-year-old boy presented with a chief complaint of eye pain. The discussion focuses on the importance of recognizing

the limits of diagnostics and when clinical judgment should take precedence.

The two coauthors work together at Mt. Carmel St. Ann's Emergency Department in Columbus, OH as attending physicians. Dr. Weinstock is also clinical assistant professor of emergency medicine at The Ohio State University College of Medicine

Rounding out this issue are fresh contributions from **John Shufeldt, MD, JD, MBA**, who shares his perspective on keeping your career on track; **David Stern, MD, CPC**, who addresses questions on proper coding procedures posed by *JUCM* readers; and **Frank Leone, MBA**, who explains the ground rules for successfully negotiating with occupational medicine clients.

If you have an idea for an article that would be of interest to your urgent care colleagues, let us know in an e-mail to editor@jucm.com.



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The Price of Success

■ LOU ELLEN HORWITZ, MA

I read an article the other day in the journal *Physician Executive*, entitled “10 Ways to Take on the Primary Care Competition”.

A few key things made this article very interesting to me:

1. It was written by Joe Flower, the gentleman who will be the keynote speaker for our National Convention in New Orleans (which starts April 29).
2. The audience for the article is, specifically, physician executives—physicians who are in managerial roles in larger healthcare organizations across the country.
3. It was primarily about how these larger organizations can compete with urgent care and retail health centers.

I had several reactions as I read it:

- “Hey, why is ‘my’ speaker shining the spotlight on urgent care for our competition and giving them ways to try to beat us?”
- The days of urgent care centers operating “under the radar” are over.
- There *are many ways* that large healthcare organizations with vast resources (and small ones) can target urgent care as competition and come after our traditional patient population.
- Our members better understand this quickly and start to adapt now (if you haven’t already).

Some of you may remember when hospitals tried to get into urgent care back in the late 1980s and early 1990s. For the most part, they were unsuccessful; can we count on their struggling for profitability this time around, though, or have they learned some valuable lessons?

And Wal-Mart, you may have heard, is planning to open 2,000 in-store clinics over the next five years.

At UCAOA, we have received many more calls from private practice offices planning to open up “after hours” this year than last year.



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

Clearly, the success of the urgent care industry is drawing the attention of others.

It seems to me that we need to begin an industry movement (revolution?) toward raising our own performance bars before someone else does it for us.

This is a scary prospect. What will this all mean to the average UCAOA member? Are most of us ready for this? How do we get on top of this wave so we can still see the shore?

I read another article later in the same week about Bart Starr and Vince Lombardi. It told the story of Lombardi’s first day coaching the Green Bay Packers and what he said that day to the team. He talked about pursuing perfection—that although they would never reach it, along the way “we will catch excellence.” He stressed the importance of the team taking the initiative to set the bar higher than what might have been acceptable previously. “I am not remotely interested in just being good,” he told his players.

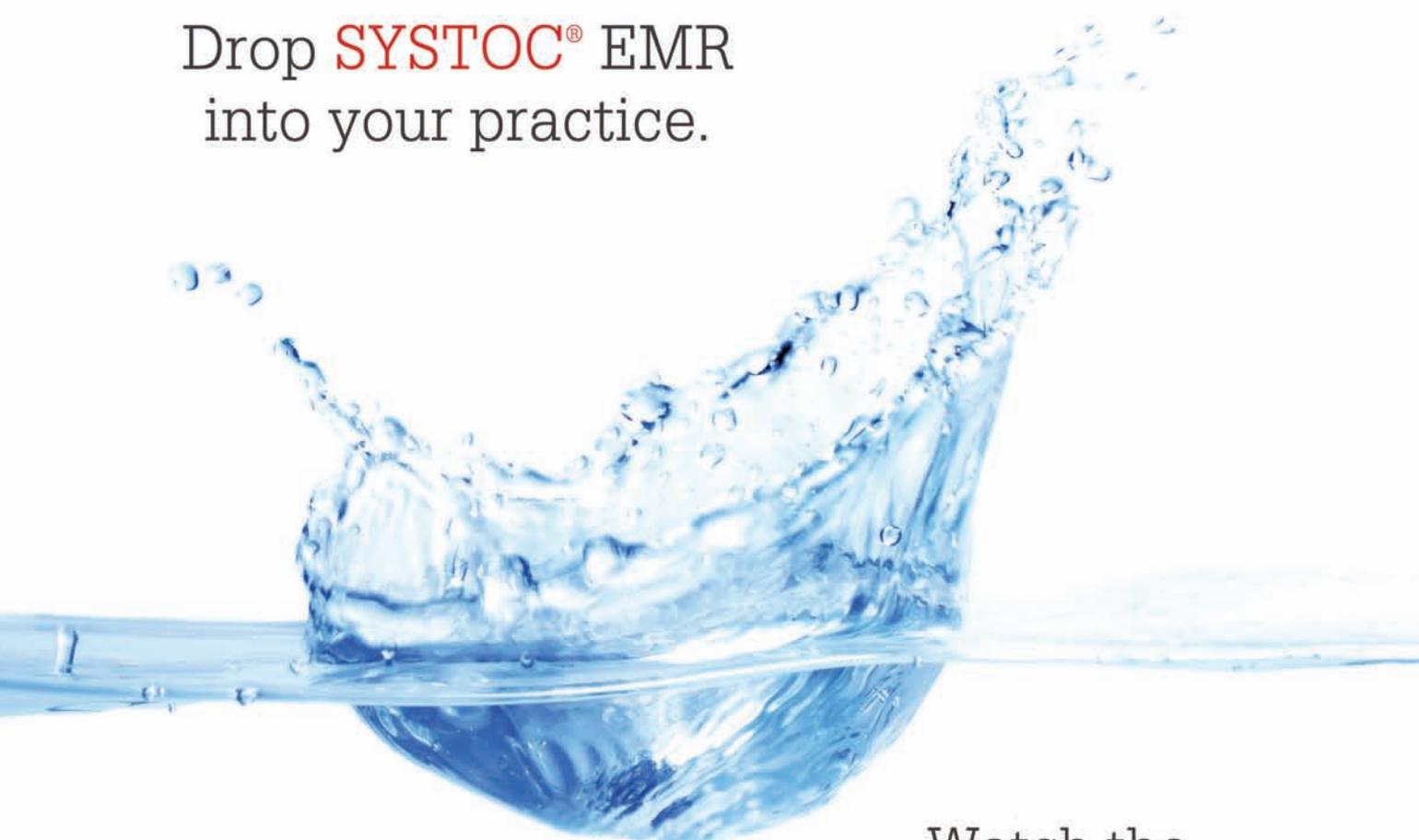
Lombardi’s expectations set a new tone immediately; during the first break of the day, Starr ran to a pay phone to call his wife. “Honey,” he told her, “we’re going to begin to win.”

You read a lot in the larger health system’s literature that sounds like the pursuit of perfection. You read about quality and process improvement, “six sigma” practices, “lean management,” performance matrices, and the like. Many healthcare organizations appear to spend a lot of time and resources at least attempting to “catch excellence”—and there is growing evidence that, although it was much harder and took much longer than everyone hoped it would, they are doing just that.

In visiting our member centers, I’ve found that some have been able to establish their own measures of quality improvement over the months or years—and significant strides have been made at these centers. But nationally, as an industry, this is not yet an integral part of the fabric of our conversations.

If we are standing as close as we seem to be to the national spotlight, this is a conversation we all need to actively participate in—and soon. The cost of not doing so is likely a higher price than we want to consider. ■

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Clinical

Understanding Clinical Decision Rules Regarding Minor Traumatic Brain Injury

Urgent message: Patients with *minor* traumatic brain injury can be difficult to assess. Identifying those at risk for poor outcomes is critically important in the urgent care setting.

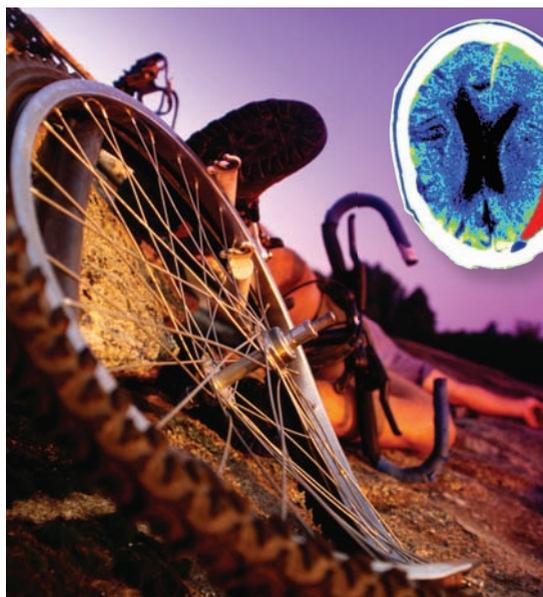
Joseph Toscano, MD

The term *traumatic brain injury* (TBI) describes various injury patterns that result from force being absorbed by the brain after a rapid acceleration or deceleration or head impact. TBIs can span a spectrum from minor changes to fatal catastrophes and can affect patients in any age and demographic group.

Patients with more than minor injury are usually clinically identifiable; proper medical care involves initiating stabilizing measures and transferring those patients to the appropriate treatment setting.

In the urgent care clinic, the primary challenge is sorting through the majority of patients with more minor complaints in order to identify those who might be at risk for poorer outcomes.

This article will review existing, urgent care-relevant medical literature and appropriate imaging criteria regarding clinical decision making.



A second article, to be published in the April issue of *JUCM*, will describe the application of this evidence-based decision-making in urgent care medicine, and discuss some of the basic elements of treating minor TBI, as well as injury prevention.

Pathophysiology

Contusive and shearing forces from an impact or acceleration/deceleration force sustained by the head can have a variety of deleterious effects, including hemorrhage in and around the brain and direct neuronal injury. For the most part, all of these lesions are

apparent on CT scanning, which is the most useful imaging modality for patients with acute TBI—both to define injuries which are obvious clinically, and to screen for occult injuries in those who are at risk.

Though MRI may be reasonable in some cases based on the clinician's judgment, CT is better studied in the

TABLE 1.
Glasgow Coma Scale

Eye Opening			
Spontaneous	4		
To speech	3		
To pain	2		
No response	1		
		(Adaptation for nonverbal children)	
Verbal Response		Verbal Response	
Alert and oriented	5	Coos, babbles	5
Disoriented	4	Irritable cry	4
Speaking, but nonsensical	3	Cries to pain	3
Moaning	2	Moans to pain	2
No response	1	No response	1
Motor Response			
Follows commands	6		
Localizes pain	5		
Withdraws to pain	4		
Decorticate flexion	3		
Decerebrate extension	2		
No response	1		

(A single GCS value is neither diagnostic of TBI nor predictive of outcome; a correlation has been shown between abnormal GCS scores over time and the probability of needing neurosurgical intervention.)

TABLE 2.
New Orleans Criteria

Patients would require a CT scan if any of the following are present:

- Headache
- Vomiting
- Age >60 years
- Drug or alcohol intoxication
- Short-term memory deficits
- Seizure
- Any evidence of bony or soft tissue injury above the clavicles

(Patients could have LOC and amnesia, but those with anticoagulation/coagulopathy, GCS <15, focal neurological deficits, and those under age 18 were under-represented.)

acute care setting and is known to be accurate, more widely available, and less expensive. MRI is more often reserved to image patients with ongoing concussion symptoms beyond the first few days.

Whether the injury is focal or diffuse, a careful history and neurological exam will usually reveal abnormalities; rarely, however, patients with significant intracranial injuries will initially appear completely normal.

The occurrence of clinically occult but significant TBI is a sobering fact for anyone caring for one of these patients.

A standardized clinical scale, the Glasgow Coma Scale (GCS) (**Table 1**), is typically used to assess patients with head injuries.

By adding points for a patient’s best response in each of three categories—eye opening, verbal responsiveness, and motor responsiveness—the GCS gives a global sense of a patient’s status at any point in time and over time. Scores range from 3 (deep coma) to 15 (normal); historically, mild injury has been defined as the presence of TBI with a GCS score of 13 to 15. Those with a GCS score between 9 and 12 are defined as having moderate injury, with GCS scores 3 to 8 defined as severe injury.

Medical Literature Review

There is no literature which directly describes an approach to evaluating patients with TBI in the urgent care setting. Until this information is available, we must extrapolate from emergency medicine studies.

There are several difficulties with doing this directly.

The spectrum of injury in the emergency department is different than that typically seen in the urgent care clinic. The mere fact that patients with a GCS of 13 might be considered to have mild TBI may be uncomfortable for most urgent care practitioners to consider.

In addition, the latitude to observe patients for several hours, with ready access to CT scanning, distinguishes an emergency medicine approach to these patients from those which might be possible in the clinic setting. Still, there are

study data that can be considered useful.

The portion of existing literature relevant to the urgent care clinician regards the development of decision instruments to select patients who need neurological imaging (i.e., to determine which patients can be discharged without CT scanning and which require this next-step in the evaluation).

Decision rules that compensate by using a larger number of criteria or more general indicators increase sensitivity (the ability *not* to miss an injury), but decrease

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Reference: 1. Task Force on Postovulatory Methods of Fertility Regulation. Randomised controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. *Lancet*. 1998;352:428-433.

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Progestin-only contraceptive pills (POPs) are used as a routine method of birth control over longer periods of time, and are contraindicated in some conditions. It is not known whether these same conditions apply to the Plan B® regimen consisting of the emergency use of two progestin pills. POPs however, are not recommended for use in the following conditions:

- Known or suspected pregnancy
- Hypersensitivity to any component of the product

WARNINGS

Plan B® is not recommended for routine use as a contraceptive.
Plan B® is not effective in terminating an existing pregnancy.

Effects on Menses

Menstrual bleeding patterns are often irregular among women using progestin-only oral contraceptives and in clinical studies of levonorgestrel for postcoital and emergency contraceptive use. Some women may experience spotting a few days after taking Plan B®. At the time of expected menses, approximately 75% of women using Plan B® had vaginal bleeding similar to their normal menses, 12-13% bled more than usual, and 12% bled less than usual. The majority of women (87%) had their next menstrual period at the expected time or within \pm 7 days, while 13% had a delay of more than 7 days beyond the anticipated onset of menses. If there is a delay in the onset of menses beyond 1 week, the possibility of pregnancy should be considered.

Ectopic Pregnancy

Ectopic pregnancies account for approximately 2% of reported pregnancies (19.7 per 1,000 reported pregnancies). Up to 10% of pregnancies reported in clinical studies of routine use of progestin-only contraceptives are ectopic. A history of ectopic pregnancy need not be considered a contraindication to use of this emergency contraceptive method. Health providers, however, should be alert to the possibility of an ectopic pregnancy in women who become pregnant or complain of lower abdominal pain after taking Plan B®.

PRECAUTIONS

Pregnancy

Many studies have found no effects on fetal development associated with long-term use of contraceptive doses of oral progestins (POPs). The few studies of infant growth and development that have been conducted with POPs have not demonstrated significant adverse effects.

STD/HIV

Plan B®, like progestin-only contraceptives, does not protect against HIV infection (AIDS) and other sexually transmitted diseases.

Physical Examination and Follow-up

A physical examination is not required prior to prescribing Plan B®. A follow-up physical or pelvic examination, however, is recommended if there is any doubt concerning the general health or pregnancy status of any woman after taking Plan B®.

Carbohydrate Metabolism

The effects of Plan B® on carbohydrate metabolism are unknown. Some users of progestin-only oral contraceptives (POPs) may experience slight deterioration in glucose tolerance, with increases in plasma insulin; however, women with diabetes mellitus who use POPs do not generally experience changes in their insulin requirements. Nonetheless, diabetic women should be monitored while taking Plan B®.

Drug Interactions

Theoretically, the effectiveness of low-dose progestin-only pills is reduced by hepatic enzyme-inducing drugs such as the anticonvulsants phenytoin, carbamazepine, and barbiturates, and the antituberculosis drug rifampin. No significant interaction has been found with broad-

spectrum antibiotics. It is not known whether the efficacy of Plan B® would be affected by these or any other medications.

Nursing Mothers

Small amounts of progestin pass into the breast milk in women taking progestin-only pills for long-term contraception resulting in steroid levels in infant plasma of 1-6% of the levels of maternal plasma. However, no adverse effects due to progestin-only pills have been found on breastfeeding performance, either in the quality or quantity of the milk, or on the health, growth or development of the infant.

Pediatric Use

Safety and efficacy of progestin-only pills have been established in women of reproductive age for long-term contraception. Safety and efficacy are expected to be the same for postpubertal adolescents under the age of 16 and for users 16 years and older. Use of Plan B® emergency contraception before menarche is not indicated.

Fertility Following Discontinuation

The limited available data indicate a rapid return of normal ovulation and fertility following discontinuation of progestin-only pills for emergency contraception and long-term contraception.

ADVERSE REACTIONS

The most common adverse events in the clinical trial for women receiving Plan B® included nausea (23%), abdominal pain (18%), fatigue (17%), headache (17%), and menstrual changes. The table below shows those adverse events that occurred in \geq 5% of Plan B® users.

Table 3: Adverse Events in \geq 5% of Women, by % Frequency

Most Common Adverse Events	Plan B® Levonorgestrel N=977 (%)
Nausea	23.1
Abdominal Pain	17.6
Fatigue	16.9
Headache	16.8
Heavier Menstrual Bleeding	13.8
Lighter Menstrual Bleeding	12.5
Dizziness	11.2
Breast Tenderness	10.7
Other complaints	9.7
Vomiting	5.6
Diarrhea	5.0

Plan B® demonstrated a superior safety profile over the Yuzpe regimen for the following adverse events:

- Nausea: Occurred in 23% of women taking Plan B® (compared to 50% with Yuzpe)
- Vomiting: Occurred in 6% of women taking Plan B® (compared to 19% with Yuzpe)

DRUG ABUSE AND DEPENDENCE

There is no information about dependence associated with the use of Plan B®.

OVERDOSAGE

There are no data on overdosage of Plan B®, although the common adverse event of nausea and its associated vomiting may be anticipated.

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February 2007

specificity (the ability to safely exclude it).

The first of several groups to more recently publish a decision instrument for TBI was Haydel, et al in 2000.¹ In a single paper, the authors described the derivation of their decision instrument (**Table 2**), usually referred to as the New Orleans Criteria. They found it to be 100% sensitive in detecting injuries when applied to a subsequent group of patients. The study has been criticized, however, for not being specific enough to decrease the need for neuroimaging in general; indeed, it employs the criterion of “any evidence of trauma above the clavicles” as an indication for a CT scan.

In 2001, the Canadian CT Head Rule (**Table 3**) was published.² Though the rule was quite sensitive, study patients included only those over age 16, and up to two hours of observation were used to clear patients clinically, which limits its applicability in some patient-care settings.

Still, the use of the Canadian high-risk criteria was 100% sensitive for injuries requiring neurosurgical intervention, and only 32% of patients in their study population would have required scanning with this strategy; these patients included those with loss of consciousness, some amnesia, and disorientation, as well as those with a GCS as low as 13.

Several studies have confirmed the high sensitivity of both the New Orleans criteria and the Canadian CT Head Rule, while the conclusions reached in at least one study were less supportive. In addition, several studies from outside the U.S. have shown that implementation of either of these decision rules might actually *increase* imaging rates compared with general clinician judgment, without leading to the detection of additional intracranial injuries.

A group from the University of California, Davis and the Oregon Health & Science University sought to create a similar decision instrument specifically for children. The Davis Rule (**Table 4**), published in 2003, was found to be 99% sensitive for any traumatic brain injury and 100% sensitive in detecting injuries which required intervention.³

The study's strength was the inclusion of patients as young as 10 days of age. In children ≤ 2 -years-old (which

TABLE 3.
Canadian CT Head Rule

Patients would require a CT scan if any of the high-risk (to identify lesions requiring neurosurgical intervention) or medium-risk (to identify any significant CT abnormality) criteria are present:

High-Risk Criteria

- Failure of GCS to reach 15 within 2 hours of injury
- Suspected open or depressed skull fracture
- Any sign of basal skull fracture
- Two or more episodes of vomiting
- Age 65 years or over

Medium-Risk Criteria

- Amnesia extending back more than 30 minutes before injury
- Dangerous mechanism of injury (e.g., pedestrian struck by vehicle, fall from more than 3 feet or down more than 5 stairs, ejection from vehicle during a collision)

(Patients could have LOC, some amnesia, and disorientation, as well as a GCS as low as 13 initially; those under age 16 and with focal neurological deficits or anticoagulation/coagulopathy were not included.)

TABLE 4.
Davis Rule

Children would require a CT scan if any of the following are present:

- Abnormal mental status
- Clinical signs of skull fracture
- History of vomiting
- Headache
- Scalp hematoma in children 2 years of age or under

(Applied to children with or without loss of consciousness.)

includes 16% of the 2,043 patients included), the presence of scalp hematoma was found to be a significant predictor of injury. However, this study also had the lowest level of inter-observer agreement of any of the variables, underscoring the need for a very careful scalp examination in these children.

Though it has yet to be externally validated, this rule is frequently used in the emergency department to make decisions about imaging in children after TBI.

A more recent publication is the NEXUS-II study,⁴ which included children and adults with head trauma who had a GCS of 15, with or without loss of consciousness.

Published in 2005 (a pediatric subgroup analysis was published in 2006⁵), the NEXUS-II criteria (**Table 5**) proved to be 98.3% sensitive at identifying clinically important TBI. The rule would have missed one

TABLE 5.
NEXUS-II Decision Rule

Patients (adults and children) would require a CT scan if any of the following are present:

- Evidence of skull fracture or scalp hematoma
- Neurological deficit
- Altered level of alertness
- Abnormal behavior
- Coagulopathy or anticoagulation (including warfarin, aspirin, and other antiplatelet agents)
- Age 65 years or older
- Persistent vomiting

(Applied to children and adults with or without loss of consciousness.)

patient in that study who required immediate neurosurgical intervention, but most of those who would not have been scanned according to the rule had relatively minor injuries.

Unfortunately, specificity was low (13.7%), and these criteria have yet to be validated beyond the initial study population.

Since NEXUS-II, other decision instruments for evaluating patients with TBI have been derived, including CHALICE⁶ and CHIP,⁷ but these have yet to be validated, too, and are considerably more complex than the earlier rules.

Specialty Society Guidelines

Apart from the individual studies described above, two specialty societies have published clinical practice guidelines regarding the care of patients with mild TBI. Each was developed using the available medical literature at that time, and, to some degree, consensus opinion.

AAP/AAFP Guidelines

In 1999, the American Academy of Pediatrics (AAP), together with the American Academy of Family Physicians (AAFP), published guidelines for the care of children with minor closed head injury.⁸ Their publication preceded the availability of any of the study data described above and has not been updated since.

The AAP/AAFP guidelines apply to patients aged 2- to 20-years-old who are evaluated within 24 hours of head injury. A thorough history and physical examination (including fundoscopic exam) is recommended, and patients with multiple trauma, known or suspected cervical spine injury, pre-existing neurological disorder, bleeding diathesis, suspected inten-

tional trauma, language barriers, or the presence of drugs or alcohol were felt to require individualized care outside of the guidelines.

Evidence of skull fracture or abnormal eye or neurological examination was felt to be an indication of the need for CT scanning and specialty consultation.

For children without any of these exclusion factors and with a normal examination and no suspected skull fracture, the decision point for using CT scanning was the presence of brief (<1 minute) loss of consciousness, though headache, seizure following the injury, lethargy, and vomiting are also mentioned as worrisome findings.

CT scanning, along with careful observation, was considered an option in the management of these children. The routine use of skull films was not recommended.

Those without loss of consciousness could be managed by observation alone. The period of observation recommended for any child with minor head injury is at least 24 hours by a competent caregiver with ready access to appropriate medical care if deterioration should occur.

If this is not available or possible, then admission to a hospital or other facility is recommended. In addition, maintaining a high index of suspicion is advised, even several days after minor head injury, if behavioral changes or other signs of worsening do occur. Clear, written instructions regarding care and follow-up should be given. Though not discussed directly by the guidelines, those with more than brief loss of consciousness likely should be managed at least as aggressively.

The subject of discharge instructions and return to normal activities will be discussed more thoroughly in part II of this article in the April issue of *JUCM*.

ACEP Guidelines

The American College of Emergency Physicians' (ACEP) Clinical Policy guidelines were published in 2002 and had both the New Orleans and Canadian studies, as well as other existing literature, on which to rely.⁹

The strongly evidence-based policy limited its scope to patients >15 years of age with blunt trauma to the head within 24 hours of evaluation and a GCS of 15.

The guideline was applicable to those with post-traumatic loss of consciousness or amnesia of any duration, but excluded those with bleeding disorders, penetrating or multisystem trauma, or focal neurological findings.

The three main conclusions of the policy were as follows:

- Skull radiographs are not recommended in the evaluation of patients with TBI.

- Head CT scanning is not necessary in patients after head injury if they do not have headache, vomiting, post-traumatic seizure, drug or alcohol intoxication, short-term memory deficits, physical exam evidence of trauma above the clavicles, or are ≤ 60 years of age (essentially mirroring the New Orleans Criteria).
- Patients who have a normal exam and CT scan (if indicated) may be safely discharged from the emergency department any time after six hours post-injury, or sooner if in the care of a competent person who can observe them for at least this duration.

Specific Considerations

The Element of Time

The value of observing patients for improvement in nonfocal symptoms (i.e., initial loss of consciousness, amnesia, headache, seizure, vomiting) or GCS 13 or 14 over time is emphasized by the findings of the Canadian CT Head Rule study, as well as the AAP/AAFP policy.

Indeed, observation should be the cornerstone of the short-, intermediate-, and longer-term management of any patient with head injury. The optimum period of observation is uncertain, but close observation for two to six hours, with attention to any change—even subtle ones—for up to several days after head injury seems advisable.

Any patient with a worsening level of consciousness or mental status, abnormal behavior, recurrent seizures, repeated vomiting, or the development of focal findings should be evaluated, preferably in the emergency department, in conjunction with CT scanning of the head.

An isolated but worsening headache after head trauma, though nonspecific, would also prompt CT scanning in most instances.

Infants and Children

Though toddlers and older children who appear neurologically normal after head trauma seem to be at about the same risk as adults for significant clinically occult intracranial injury, there is good evidence that infants are at increased risk of such after even minor falls (e.g., from sofas or beds).

In addition, infants and young children can be more difficult to assess reliably. Maintaining a high index of suspicion is important, and close observation should be emphasized for all of these patients, whether CT scanning is performed or not.

As noted earlier, the presence of a scalp hematoma has been shown in several studies to correlate to an increased risk of intracranial injury in infants and children,

so careful consideration should be given this finding.

Finally, head trauma can be a presenting injury in children who are victims of abuse. In situations where the mechanism of injury is uncertain or difficult to believe, additional screening for child abuse is warranted.

Elderly Patients

Many characteristics put elderly patients at increased risk of sustaining significant injury after even relatively minor head trauma and often with a delay in the development of symptoms. Maintaining an extremely low threshold for imaging and observation for elderly patients, even with a normal exam and no other worrisome features, would seem to be a safe, and not excessive, strategy.

Anticoagulation/Coagulopathy/Antiplatelet Agents

The occurrence of rapid neurological deterioration following even very minor head injury in patients with coagulopathy or those on warfarin anticoagulation is well described.

This can occur after a period of clinical normalcy or even an initial brain CT scan which shows no hemorrhage or other acute abnormality performed soon after injury. The NEXUS-II study and others also suggest that at least some increased risk extends to those on aspirin, clopidogrel, and other antiplatelet therapies.

No specific guideline has been found to be useful for excluding the chance of injury in these patients, and a strategy that incorporates a period of several hours of observation with a low threshold for hospital admission, often combined with delayed (with or without immediate) neuroimaging is becoming common for these patients in emergency medicine practice.

Summary

The concept of clinically occult but significant TBI continues to be vexing to acute care clinicians. In the studies discussed in this article, and others, the incidence of an abnormality on brain CT in patients who appear normal after a minor head injury ranges from 3% to 13%, typically with $\leq 1\%$ requiring neurosurgical intervention. Careful patient examination, combined with the appropriate use of CT scanning and observation, can help identify these patients.

Due to the overlap of symptoms in those with and without significant injuries, however, there is no proven strategy that allows practitioners to readily distinguish between those who need CT scanning and those who do not. In the end, each practitioner must decide, for each patient, the risks and benefits of the various pos-

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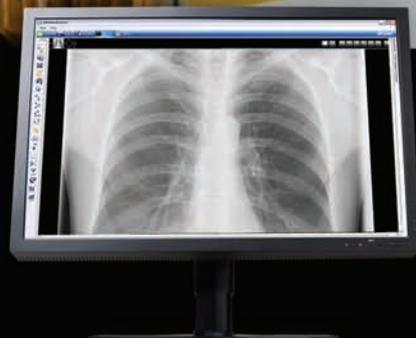
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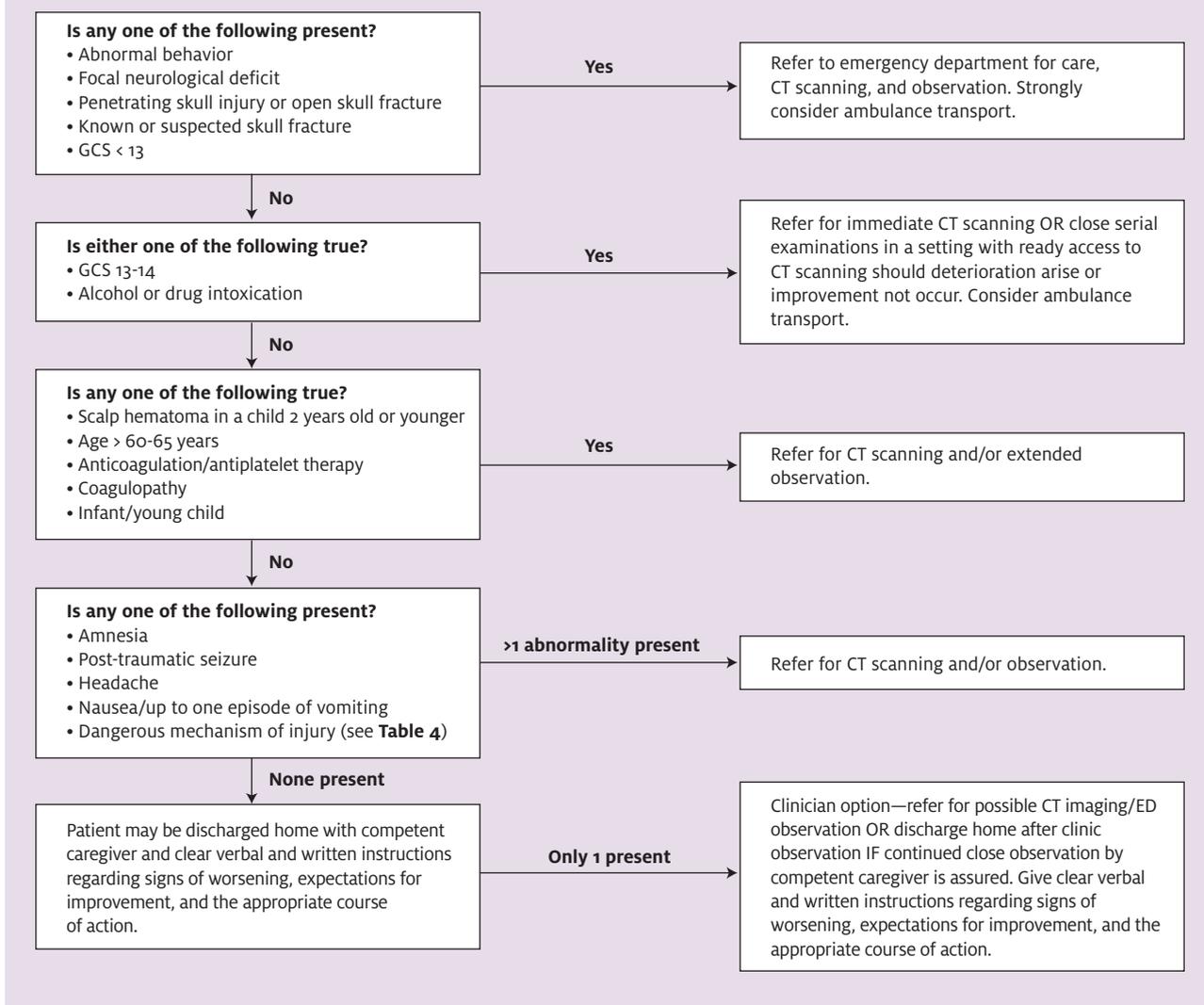
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FIGURE 1.

Proposed algorithm for evaluating patients with minor TBI in the urgent care setting.



sible courses of action.

Becoming familiar with one of the validated decision rules (New Orleans or Canadian), applying it consistently, knowing its limitations (e.g., age range, other excluded patient groups), and having a plan for patients for whom it is not applicable may be the most prudent strategy for some.

Using the information from all the studies in a more tempered approach, it is possible to clinically assign patients into one of three groups:

1. those who definitely need referral and scanning based on the results of several studies

2. those who definitely do not

3. all those in between

Such an approach would comprise the following (Figure 1):

- Patients who present to the urgent care clinic with head injury can first be promptly and rapidly evaluated (history, GCS, HEENT and neurological exam) for any of the typically clinically obvious, highest-risk indicators—abnormal behavior; penetrating, open, or closed skull fracture; neurological deficit; or GCS <13.

These patients would most safely be transported

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to the ED by ambulance, so calls to 911 should be made and provider-to-provider communication with the receiving facility initiated.

In the clinic, the staff should render all available stabilizing care, including efforts to maintain the patient's airway, breathing, oxygenation, and circulation at a BLS level, at a minimum.

- Patients with GCS 13 or 14 and those with drug or alcohol intoxication will require either prompt CT scanning and/or extended observation in a setting with prompt access to scanning, and should be transferred to the ED either by ambulance
- Patients who remain after this initial triage process will have a GCS score of 15 and a normal neurological exam, without intoxication.

At this point, a more thorough history and exam can be performed to aid decision making.

- Patients over 60 to 65 years of age, those on anticoagulation or with coagulopathies, those with repeated vomiting, and children aged ≤ 2 years of age with a scalp hematoma should be referred for CT scanning; private auto transport should suffice.

Clinicians should maintain a low threshold for referring infants and young children for scanning or ED observation, even if a scalp hematoma is not apparent.

- At the next decision level, patients may be found to have post-traumatic amnesia (memory deficits) or seizure, headache, up to one episode of vomiting, evidence of trauma above the clavicles (other than scalp hematoma in a child ≤ 2 years or penetrating injury or skull fracture in anyone), or a dangerous mechanism of injury. CT scanning would be considered appropriate for these patients.

Based on the most recent study data, however, if competent observation can be accomplished at home, it would not be unreasonable to discharge patients exhibiting one of these abnormal findings after a period of observation in the clinic during which the patient does not worsen, or particularly if he or she improves (e.g., improved memory, decreased headache, or decreased nausea).

A clear discussion supplemented with written instructions regarding the signs of worsening, expectations for

“Clinicians should maintain a low threshold for referring infants and young children for scanning or ED evaluation.”

improvement, and the subsequent appropriate course of action are important. Recommendations for such instructions will be included in part II of this article. A follow-up phone call after several hours and a scheduled appointment

the following day can also provide reassurance to both the patient and clinician in this situation.

Because of the uncertain benefits and risks associated with any approach, it is always advisable to engage the patient, and the patient's family in the case of children or other dependents, in the decision-making process.

With further study, more data may inform more efficient decision making for patients with possible mild TBI.

In the meantime, careful patient evaluation, knowledge of the prevailing literature and recommendations, utilization of observation (in clinic and at home), and close collaboration with ED colleagues when necessary, form the basis of the most appropriate management of these patients in the urgent care setting.

Decisions about referral and CT scanning of the brain can be made based on clinical variables which are typically apparent, and should be sought by the urgent care clinician. ■

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Bouncebacks

The Case of a 10-Year-Old Male with Eye Pain

Bouncebacks appears semimonthly in JUCM. Case presentations on each patient, along with case-by-case risk management commentary by Gregory L. Henry, past president of The American College of Emergency Physicians, and discussions by other nationally recognized experts are detailed in the book *Bouncebacks! Emergency Department Cases: ED returns (2006, Anadem Publishing, www.anadem.com)*.] Also available at www.amazon.com and www.acep.org.

Ryan Longstreth, MD, FACEP and Michael B. Weinstock, MD

This article is the third in a series in which we will sequentially answer the following questions:

- I. What is the incidence of bouncebacks?
- II. What is the incidence of bounceback admissions?
- III. What is the incidence of death in patients recently discharged from the ED?
- IV. What percent of bouncebacks occur because of medical errors?
- V. How can we use this information to improve patient safety?

This month, we will discuss Question IV: What percent of bouncebacks occur because of medical errors?

A 2006 case control study performed by Nunez et al compared 250 unscheduled ED returns over a four-month period with 250 similar visits in which patients did not return to the ED. The authors discovered a prognostic error in 20% of the ED returns, a diagnostic error in 20%, and a follow-up error in 26% in the un-

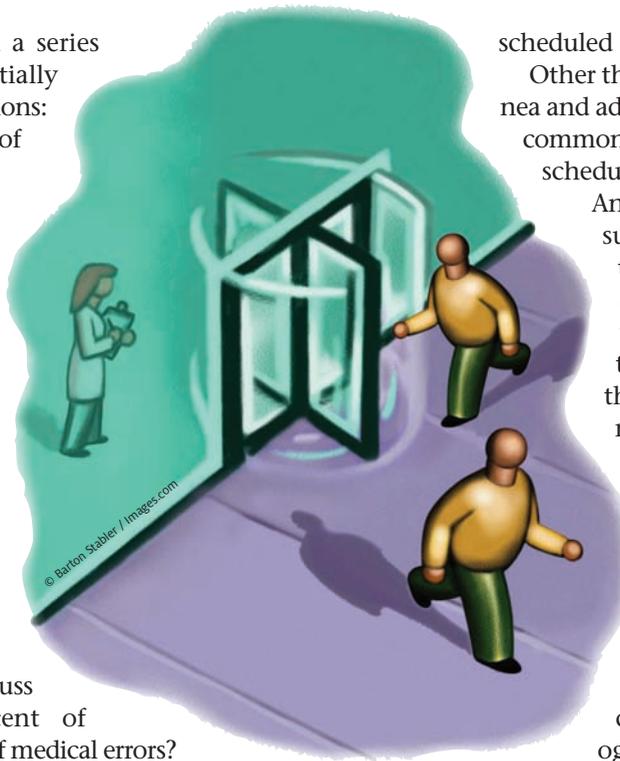
scheduled returns.

Other than these medical errors, dyspnea and advanced age were the two most common factors associated with an unscheduled return visit.

Another study looking at this issue was published in 1990 in the *Annals of Emergency Medicine* by Pierce et al. During the three-month study period, there were 17,214 new visits to their ED with 569 unscheduled returns (defined as ED return within 48 hours), equating to a bounceback rate of just over 3%.

The researchers concluded that over 18% were due to physician-related factors (e.g., misdiagnosis, treatment error, inappropriate discharge on initial visit, radiology over-reads, or lack of outpatient analgesics when indicated).

Finally, we revisit a recent study by Sklar et al published in the *Annals of Emergency Medicine* in 2007. This study analyzed unanticipated death in patients discharged home from the ED. Out of the 387,334 visits considered from 1994-2004, 117 patients died within



seven days of an ED discharge. The authors determined that 35 of these 117 (30%) had a possible medical error.

Common characteristics of Sklar's possible medical error cases included:

- atypical presentation of unusual problem
- chronic disease with decompensation. (e.g., congestive heart failure)
- abnormal vital signs (note: tachycardia occurred in 25 out of 35 (71%) of "possible error" cases)
- mental disability, psychiatric problem, or substance abuse making it less likely the patient would return for worsening problems

A 10-Year-Old Male with Eye Pain

Initial Visit

(Note: The following is the actual documentation of the providers, including punctuation and spelling errors.)

CHIEF COMPLAINT (at 20:19): Eye pain

Time	Temp	Pulse	Resp	Syst	Diast
20:30	97.5	69	16	133	85

HISTORY OF PRESENT ILLNESS (at 21:21):

This pt is a 10 y/o male who presents with OS pain s/p direct, blunt trauma to eye approx 1pm this afternoon. The pt reports playing "rubber" darts with friends at home when one accidentally struck him in OS centrally from direct throw. Now experiencing mod pain, photophobia, and tearing in OS. He does have redness and blurred vision. The pt reports no previous h/o eye injury or trauma. Denies any other ROS

PAST MEDICAL HISTORY (PER TRIAGE RN):

Medications: None

Allergies: No known allergies.

PMH: None

PSH: none

SocHx: Tobacco use: (-), Alcohol use: (-)

Visual acuity (at 20:38): Left eye: totally blind; Right eye: uncorrected 20/20.

Immunizations: The infant/child's immunizations are current.

EXAM (at 21:26)

General: Well-appearing; well nourished; A&O X 3, in no apparent distress.

Head: Normocephalic; atraumatic.

Skin: Normal for age and race; warm and dry; no apparent lesions

Eyes: Fundoscopic exam attempted, unable to visu-

alize anything. No pupillary constriction on exam.

Visual acuity 20/20 OD, contrary to triages notes, vision was 20/30 after alcaine eye drops instilled to OS; Visual fields are abnormal by confrontation. Extraocular muscles are intact. Pupils are unequal and OS is nonreactive to light. The irises are abnormal. Unable to visualize the Retina and disc margins due to injury. Lids, lashes and puncta are normal. Everted lids are normal. Cornea is not clear with abrasion noted and no foreign bodies. The anterior chamber is not clear with abnormal depth. Conjunctiva and sclera are abnormal with injection. Slit lamp exam with Fluroscein stain reveals no foreign body, increased dye uptake, abrasion w/o rust ring. ? sidels sign. Noted in ant chamber clear and bloody fluid intermixed.

RESULTS:

CT OF THE BRAIN AND CT OF THE ORBITS, TWO PROJECTIONS (at 22:36): Dedicated thin sections through the orbits obtained in the coronal and axial projection show no evidence of bone injury in the orbits or sinuses. Several small bubbles are seen in the anterior space of the orbits, presumably due to eye examination. The globes themselves appear to be intact, at least as far as morphology and internal architecture. The extraocular muscles and lacrimal glands are normal in appearance.

IMPRESSION:

Normal CT examination of the orbits.

PROGRESS NOTES (at 23:06):

This patient presented after a rubber dart struck his left eye—dart thrown by his sibling. His acuity is 20/30. His eye does reveal a hyphema. EOMI. CT reveals no globe rupture. I discussed this with the ophthalmologist on call who recommends Homatropine, Ocuflax, Predforte, analgesics, eye shield, head elevation, no anticoagulants. I gave him the patient's home phone number—he will call him tomorrow to be seen tomorrow in his office.

DIAGNOSIS:

Eye injury, contusion

Eye pain

Corneal abrasion

Visual disturbance

DISPOSITION (at 00:04):

Discharged to home ambulatory for ophthalmologist ex-

amination the next day. Sent home with homatropine drops. Prescriptions for predforte 1%, ofloxacin drops, and Tylenol elixir with codeine. Aftercare instructions for hyphema. Eye patch applied to the left eye.

Follow-up with Ophthalmology the Next Day

PROGRESS NOTES (the next day):

Patient was seen by the ophthalmologist the next day in his office and was diagnosed with a complete globe rupture with partial retinal detachment. At that point, the visual acuity in the left eye was “light perception” only, suggesting the nursing documentation of the visual acuity was more accurate than the physician’s—the documented OS 20/30 visual acuity was probably because he was “peeking” from his other eye.

He was taken to surgery that same day and the corneal laceration was repaired and he underwent a partial lens resection. He was then sent to a retina specialist who performed a complete lens removal and vitrectomy.

On the last office check, his visual acuity had improved to 20/100 in the left eye.

Per the ophthalmologist; if he has no further improvement, then he may be a candidate for a corneal transplant.

Documentation and Risk Management Issues at Initial Visit

Error 1

Error: Discrepancy in visual acuity. The visual acuity at triage noted the left eye was totally blind and the right eye was 20/20. However, according to the physician documentation, the acuity was 20/20 in both eyes and 20/30 in the affected eye after proparacaine eye drops, contrary to the triage note.

When the patient was evaluated the next morning by ophthalmology, it was noted that the patient had light perception only in the affected eye.

Discussion: Although the medical record does state that the physician documentation was different than the triage note, the physician’s assessment of the acuity was inaccurate. It appears that the physician did not correctly examine the eye to determine this acuity and that the acuity reading of 20/30 was likely aided by “peeking” from his unaffected eye.

One of the primary risk management issues is discrepancies in documentation and the ability of a plaintiff lawyer to pit different providers against each other. In a legal setting, this discrepancy may make the rest of the physician documentation less believable to the jury.

Teaching point: Visual acuity is the “vital sign” of the eye; hence, an accurate measurement of a patient’s acuity with any eye injury is essential in order to avoid medical error and minimize the physician’s medico legal exposure. Discrepancies on the chart need to be explained in a progress note or confirmed with additional history or examination.

Error 2

Error: Misdiagnosis of a closed globe injury.

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Discussion: The chart documented blurry vision with a pupil that did not react to light and pupils that were unequal in appearance. It also noted hyphema with a possible Seidel sign and a retina that could not be visualized. These findings are screaming *ruptured globe*, but the patient was ultimately diagnosed with a contusion and corneal abrasion.

Teaching point: As the old adage goes, if it looks like a duck and sounds like a duck, then it must be a duck! Blunt trauma to the eye with a hyphema, blurred vision, and an irregular-appearing pupil is a globe rupture.

Error 3

Error: Reliance on a normal orbital CT to rule out a globe rupture.

Discussion: The physician considered a ruptured globe but was inappropriately reassured by a CT scan that was interpreted as “normal.” However, a normal CT scan has a negative predictive value of only 74% when ruling out an open globe injury.

Teaching point: A globe rupture is a clinical diagnosis, as up to one in four patients with a ruptured globe will still have a normal CT.

Error 4

Error: No emergent bedside consultation by ophthalmology.

Discussion: Given the constellation of signs and symptoms previously discussed, it is clear that the patient had a significant eye injury. The physician appropriately consulted ophthalmology by telephone, but was talked out of a bedside consult in the ED.

Instead, the patient was sent to the office the next day. Only then was the patient discovered to have an open globe injury.

This probably didn’t affect the outcome, but emergent bedside consultation during the initial visit would have been most appropriate and would have avoided any potential medical legal exposure.

Another acceptable alternative with ocular injuries, and one frequently used in the urgent care, is to have the patient seen in the ophthalmologist’s office the same day.

Teaching point: The treating physician is not “off the hook” by simply talking with the consultant by phone. If the first consultant is not meeting the patient’s expectations, explore other options, keeping the patient’s best interest in mind, even in the middle of night.

DISCUSSION OF GLOBE RUPTURE

A globe rupture is a full thickness injury to the eye, in

which a force to the eye wall leads to a rapid increase in intraocular pressure and subsequent full-thickness disruption of the eye wall from an “inside-out” force (may or may not occur at the site of injury). It is believed that 1% to 2% of the million pediatric eye injuries seen in the U.S. every year are open globe injuries.

This injury occurs most often after blunt trauma to the eye, and the patient usually presents with significant eye pain.

The exam is facilitated with topical anesthetic drops. The classic appearance of an open globe rupture is an irregularly shaped pupil, hyphema/hemorrhagic chemosis, and an obvious visual disturbance; for example, the patient may only be able to count fingers or may only have light perception. Checking visual acuity with all eye complaints seems obvious, but may be overlooked in a busy urgent care clinic.

Seidel’s sign

When fluorescein is applied to an intact, closed globe, it leaves a dull yellow color to the surface of the eye. With an open globe, however, the aqueous fluid draining through the corneal laceration causes fluid to change to a brighter green color; this bright green fluid will continue to flow as the aqueous leaks through the cornea.

This is a positive Seidel’s sign and an indication of open globe rupture.

Summary

The most important lesson to be learned from this case is that when a provider has a clinical suspicion of a serious illness, the sensitivity and negative predictive value (NPV) of a test needs to be considered. The NPV of CT scan for globe rupture is 74%; missing one in four diagnoses is not acceptable.

Time is of the essence when managing an open globe. As one awaits ophthalmology, it is important to keep the intraocular pressure low; the patient should not strain or exert himself.

In the case described here, the physician was inappropriately reassured by an incorrect visual acuity, an insensitive diagnostic test, and by a specialist who had not laid eyes on the patient.

In the end, a few hours may have had no effect on the ultimate outcome, but a falsely reassured patient who left the center and did not follow up as instructed could have led to a devastating result.

For Suggested Readings associated with this report, visit www.jucm.com. ■



INSIGHTS IN IMAGES CLINICAL CHALLENGE

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

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

FIGURE 1

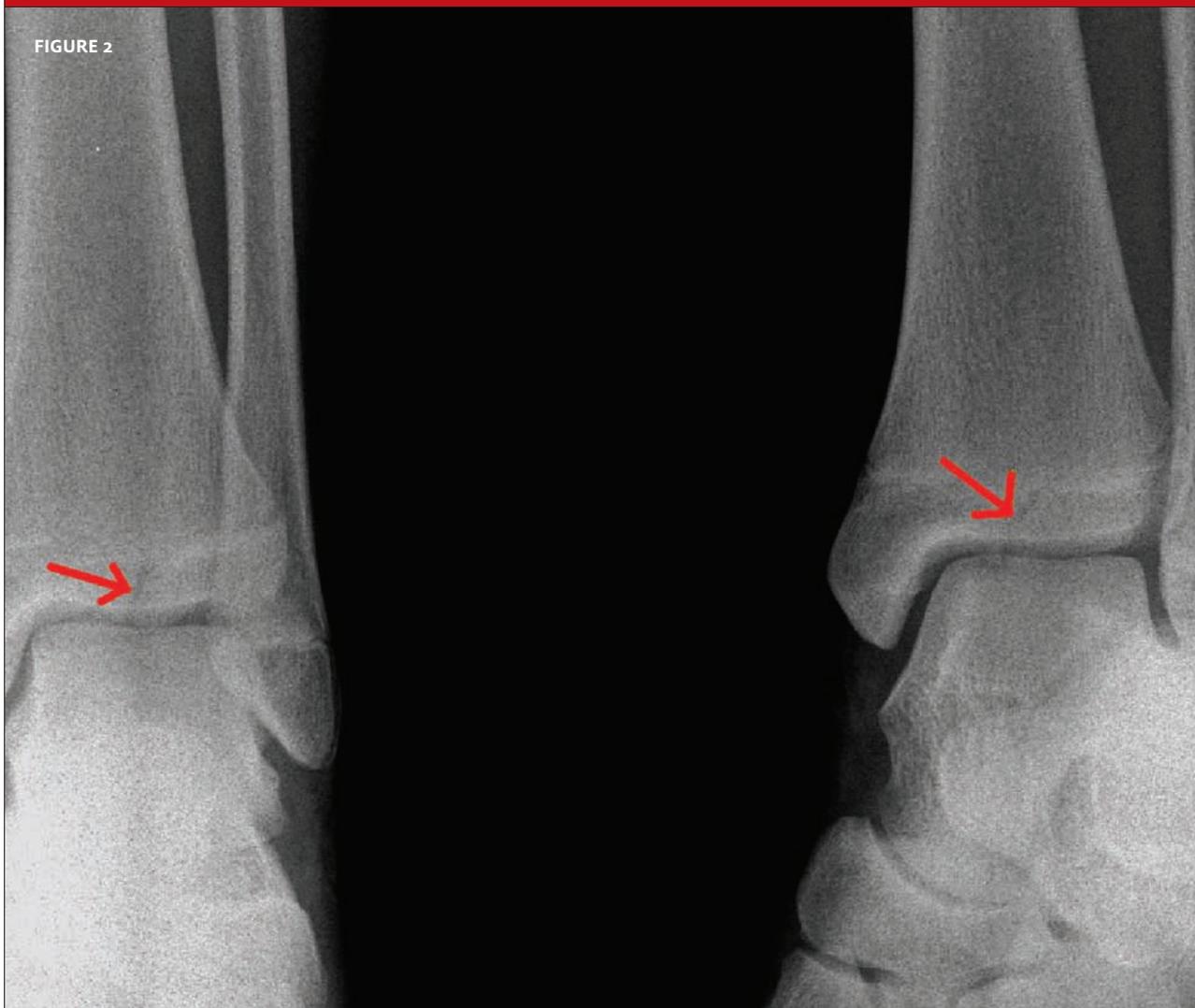


The patient is a 15-year-old boy who presented two days after experiencing a blow to both ankles and the right knee. He could bear weight minimally, with tenderness over the lateral and medial malleolus, as well as over the knee. There was marked swelling

View the x-rays taken (**Figure 1**) and consider what your diagnosis and next steps would be. Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2



The x-rays reveal an intra-articular fracture of the distal tibia.

A cast splint was applied and the patient referred for urgent orthopedic consultation.

Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM.



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What the Gray Haired Never Shared

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

For some reason, it is likely that no one with gray hair ever sat you down and shared with you some secrets to longevity, productivity, and career success in medicine. Why we in medicine tend to “eat our young” remains a mystery to me. If you have seen the movie *300* or read the book *Gates of Fire*, you understand that we tend to act very “Spartan-like.”

I am not advocating a certain manner of practice, nor am I suggesting you should sacrifice quality of life in return for career achievement. Rather, this column is meant as food for thought about whether or not your behavior and actions are limiting or enhancing your career aspirations.

Over my 22 years of medical practice, I have been a student, a resident, an attending, an employee, an independent contractor, an employer, and a practice owner. Some of the observations I will share here should be the things you digested at the dinner table along with your meatloaf while you were growing up. Others I learned early in my career by observing or through my own trials and errors. And a few of them are ones that I probably need to occasionally be reminded of.

Unfortunately, over the years, I have witnessed more than a few perfectly competent providers derailed by not adhering to modes of behavior that have nothing to do with violating the Hippocratic Oath or applicable laws and employment practices.

The following aphorisms are what I would tell someone who asked me how to be a team player, and practice conscientious, high-quality urgent care medicine while also advancing their career. They're then broken down into examples of what I mean; when you read these statements, mark each statement with a “T” for true or “F” for false and see how you fare.



John Shufeldt is the founder of the Shufeldt Law Firm, as well as the chief executive officer of NextCare, Inc., and sits on the Editorial Board of *JUCM*. He may be contacted at JJS@shufeldtlaw.com.

Practices want hard-working, efficient, reliable providers to care for their patients. Are you giving that impression?

- I show up for work before the start of my shift, I am never late, and never ask to lock the doors early.
- I don't call in sick unless I am in the hospital as a patient. Medicine is a profession and professionals do not leave their patients, their team members, or the business exposed.
- If I am forced to rearrange my schedule, I take it upon myself to secure coverage.
- I do not make patients wait for me.
- I do not take personal, non-emergency calls during the work day.
- I never answer a cell phone in the patient's room.
- I apologize for the wait when I enter a patient's room.
- Before leaving a room I ask the patient if there is anything else I can do for them and thank them for coming in.
- I take the initiative to follow up on patients who I am afraid may fall between the cracks.
- I do not stay late simply to get overtime pay.
- I embrace and comply with company policy, even if I don't understand it or agree with it. If I have a concern with a policy, I use the appropriate channels to address it.
- I understand that every patient should be valued and that his or her time is important.
- I seek out others and ask what I can do to perform better.
- I can treat more than one patient at a time.
- I am not technologically challenged.
- I ask the staff to initiate treatment while I am taking care of other patients.
- I complete the chart during the encounter, as opposed to after the encounter or at the end of the shift.
- I use ancillary testing appropriately to support my actions and documentation.
- I can multitask with the best of them.
- I return patient or pharmacy phone calls promptly.
- I don't use the Internet inappropriately at work.

Practices want competent providers to care for their patients.

- I keep abreast of journal articles and I attend CME events to stay at the top of my game.
- I am very aware of the “high-risk” rule-out diagnoses and I treat and document appropriately.
- I am not afraid to consult my peers on patient care issues.
- I respond to quality concerns appropriately.
- I address patient complaints and concerns in a timely, thoughtful manner.
- I give patients informed consent prior to performing procedures or tests which are inherently risky.
- I do not get hostile or offended when a patient makes a choice to not follow my advice.
- I advocate for my patients.
- I learn how to perform procedures typically within my scope of practice, as opposed to sending everything to the emergency department.

Practices want appropriately dressed providers to care for their patients.

- I dress conservatively within the practice’s dress code while in the clinic or at the office.
- I understand that “casual dress” does not mean jeans, sandals, and a t-shirt.
- I understand that how I look and dress reflects on my judgment.
- I don’t walk around the office without shoes, in shorts, or tennis shoes.
- I am clean shaven, have no exposed tattoos, and I do not have visible piercings, save conservative earrings.

Practices want team players. Are you?

- I volunteer for assignments and pitch in before being asked.
- I help my teammates. I am not above taking vitals, cleaning and dressing wounds, putting a sheet on a bed, or helping someone to and from their car.
- I occasionally bring breakfast or buy lunch for the office.
- I check and answer e-mail in a timely manner.
- I have been known to carry around a coffee mug or wear clothing with the practice’s name on it.
- I have attended, and even organized, practice social events, community service events, or athletic teams.
- I don’t engage in malicious gossip.
- I don’t shy away from the tough, dirty, whiny, patients.
- I don’t avoid rooms containing more than one patient.
- I don’t make a big deal about every perceived slight. If upset, I go to the source to inquire about it.
- I don’t complain about the amount of work, the number of patients, or the pace because I understand that the patients pay my salary.
- I am not passive-aggressive—saying or agreeing to do one

thing and then doing another.

Would you want to work with someone like you?

- I am cheerful, optimistic and can maintain a cool head and good sense of humor even when the chips are down.
- I don’t swear or tell offensive jokes.
- I don’t share unnecessary personal information with my coworkers.
- I say “please” when I ask for help and “thank you” after I am helped.
- I demonstrate empathy and compassion by my personal interactions with patients and teammates.
- I help others without being asked.
- I am a good listener.
- I shower before work, brush my teeth after lunch, use deodorant, and carry breath mints.
- I don’t smack my gum or chew with my mouth open.
- I leave my personal crises at home.
- I share interesting articles with colleagues.
- I demonstrate the adage, “I went into medicine because I care about and want to care for people.”

Practices want well-rounded providers who behave appropriately in social situations.

- I never drink to excess at any company function.
- I dress appropriately for company parties.
- I am a good sport about attending company events.
- When I am talking to a coworker at an event, I don’t ignore their significant other.
- I don’t criticize the location, food, or music at company events.

Practices want providers who interact appropriately with staff.

- I never snap or yell at staff members.
- If I have a criticism, I discuss it in private with the person.
- I generally refrain from blaming someone for a mistake, even if it is true.
- I always remember to ask teammates how it is going, if they need help, or what I can do to assist them.
- I understand that my employer is extremely worried about sexual, religious, and racial harassment so I am very careful that my behavior reflects that,
- I am quick to compliment teammates.
- I don’t make the staff preface every question or comment directed to me with my title.

I will guarantee the following: If you answered “T” to the vast majority of the preceding statements and you are actively working on the ones where you answered “F,” you are very successful, in high demand, and should be well paid for what you bring to the practice. ■



Call for Articles

The *Journal of Urgent Care Medicine (JUCM)*, the Official Publication of the Urgent Care Association of America, is looking for a few good authors.

Physicians, physician assistants, and nurse practitioners, whether practicing in an urgent care, primary care, hospital, or office environment, are invited to submit a review article or original research for publication in a forthcoming issue.

Submissions on clinical or practice management topics, ranging in length from 2,500 to 3,500 words are welcome. The key requirement is that the article address a topic relevant to the real-world practice of medicine in the urgent care setting.

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Lee Resnick, MD at
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Life Without Limitations



Learning to be Direct in Sales Negotiations

■ FRANK H. LEONE, MBA, MPH

“We aren’t in 1939 anymore, Alice.”

In 2008, we live in a vastly different world in which we feel information-saturated, overburdened, and pressed for time. It is a world in which long dialogue is generally a nuisance and short, to-the-point interchange is embraced. It is a world that values Headline News, *USA Today*, and Internet blogs more than traditional news shows or in-depth books.

In short, we live in a world in which people want things short, simple, and digestible. That includes decision-makers to whom you are trying to explain the benefits of your services.

We all need to learn how to prosper within the confines of the sound bite world in which we operate. To do this well, we all need to “cut to the chase” to get our core message across.

Rule #1: Mince the Written Word

Whether you are writing a proposal, designing promotional material, or simply sending an e-mail, eliminate verbosity to yield big results. This can be accomplished in three simple steps:

- Review everything you write and eliminate any *paragraphs* you can.
- Then review the remaining text and eliminate any *sentences* you can.
- Finally, review your remaining sentences and eliminate any *words* you can.

The shorter a written document, the more likely a reader will read the remaining words and absorb your central point.



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

Rule #2: Enhance Your Verbal Communication Style

Cleaning up your written material is comparatively easy—provided you take the time—because you give yourself a chance to go back and clean things up. Not so with the spoken word; once said, spoken words are forever. Be vigilant about streamlining your verbal communication.

Rule #3: Set the Stage

State your objective(s) up front in clear and concise terms. Begin sales calls, phone calls or meetings with a clear declaration of your objective. Don’t be afraid to define exactly what you are doing (e.g., “My objective is...”). Be honest and keep it brief.

Rule #4: Speak Sparingly, but Carry a Big Stick

When you are engaged in dialogue, it is generally a good practice to limit each comment to two or three sentences. We often value depth of detail ahead of being concise when just the opposite should be true.

You want the other person to *feel* that they are controlling the conversation. The best way to create a perception of buyer-control is to let the buyer do most of the talking. In many respects, you are trying to create the verbal equivalent of the aforementioned written communication dictum: “eliminate paragraphs, then eliminate sentences, then eliminate words.”

Rule #5: “Because”

Tying a reason to everything you say—usually within the same sentence—saves you time. The word *because* should be used over and over again. Rather than say “We’d like to have you tour our clinic,” say “We’d like to have you tour our clinic because it is the best way for you to understand the quality of our program and compare us to other options.”

Rule #6: Call a Close a Close

Many sales professionals are uncomfortable asking for the

Continued on page 36.



Readers' Coding Inquiries

■ DAVID STERN, MD, CPC

Q. How would you define the difference between an expanded problem-focused exam and the detailed exam in the 1995 evaluation and management coding guidelines?

– Question submitted by Eddie Stahl, Medical Staff Director, Tennessee Urgent Care Associates

A. For both the expanded problem-focused exam (EPF) and the detailed exam, the provider must document between two and seven body systems. The difference is that the EPF exam requires a “limited” exam of a body area, but the detailed exam requires an “extended” exam of a body area.

The difference between the limited and extended exams has never been clearly spelled out by the Centers for Medicare & Medicaid Services (CMS), so it has been left to the coder or auditor to determine whether the exam is “limited” or “extended.”

As with beauty, the difference is simply in the eye of the beholder.

Of course, this ambiguity has left many coders frustrated with the 1995 guidelines. That is the main reason that CMS came up with the 1997 guidelines. But the 1997 guidelines were too rigid for realistic application to real-world clinical encounters, so CMS has simply allowed providers to use whichever set of guidelines they feel most comfortable using.

Q. We do not receive adequate reimbursement for B-12 injections. Can we charge out a 99211 along with the administration charge and B-12 charge?

– Question submitted by Tammy Higgins, Physicians Care, Chattanooga, TN

A. To use 99211 properly, the chart will need to demonstrate clearly that the nurse did an evaluation and management of the patient’s condition. I have previously



David Stern is a partner in Physicians Immediate Care, with nine urgent care centers in Illinois and Oklahoma, and chief executive officer of Practice Velocity (www.practicevelocity.com), a provider of charting, coding and billing software for urgent care. He may be contacted at dstern@practicevelocity.com.

written fairly extensively on the criteria for using 99211 (see Coding Q&A, *JUCM*, April 2007).

If you are not being reimbursed (i.e., are getting payment denials) for many of the B-12 injections, you may need to look at the ICD-9 that you are using with the injection code. Many payors (including Medicare) limit reimbursement to ICD-9 codes for specific conditions related to B-12 deficiency, such as pernicious anemia and dementias secondary to vitamin B-12 deficiency.

Q. We bill for four clinics that are licensed as “outpatient clinics.” We are confused on the place-of-service code because place-of-service 22 states the facility is part of the hospital, but the urgent care seems more appropriate. However, we were told it was not appropriate because it must be provider-based and the doctor-owned facility doesn’t bill separately for the facility charge. We only bill the professional charge for our doctors.

– Question submitted by Tammy A. Lovely, CMRS, Director of Coding, Apollo Information Services, Inc.

A. No matter what your location (hospital, freestanding, in multispecialty clinic, etc.) or billing structure (facility only, provider only, combination) every payor is likely to see the place-of-service issue differently. There is no hard-and-fast rule for any given payor.

You may minimize denials by using the place of service - 22 (Outpatient Hospital), but it is always best to check with each individual payor. Of course, most of us hate that “check with your payor” phrase because so often the payor representative does not know the answer—or, even worse, gives us the wrong answer.

Q. We have a radiologist read every x-ray study that we do. How should we code for this?

– Question submitted by Giridhar C. Kamath, DO, Surya Immediate Medical Care, Latham, NY

A. Physicians may use one of three coding methods in this situation. Your radiologists may have a strong preference for one or the other.

Continued on page 36.

1. Bill technical component only (modifier -TC); then the radiologist will bill the professional component (modifier -26).

2. Bill global code. The radiologist would be an employee of your clinic who would sign an independent contractor agreement and work under the guidelines provided by the IRS for independent contractors.

3. Bill global code. If the radiologist does an over-read only when you are asking a radiologist a specific question, then you may want to bill the global for the x-ray and then the radiologist will bill a second read with modifier -77 -26 (repeat procedure by another physician).

Although this is a legitimate coding method that has been specifically authorized by several Medicare carriers, the radiologists may not want to use this coding method, as some plans may not pay for the second opinion reading of the x-ray.

Whatever method you choose, you may want to specifically get an opinion from a lawyer with expertise in this field and save the written opinion in your compliance files.

Q. In reviewing one payor’s EOBs, I noted that a patient was seen and had an influenza A/B screen. The payor only reimbursed \$7.04 for the test, which does not even cover the purchase price of the test.

It seems crazy that we would not even get back 50% of our outlay. Could we code for two tests or units, as we are testing for both influenza A and influenza B?

The test manufacturer’s website seems to indicate that is acceptable, but does mention that some local payers may have different policies.

All the flu tests that we do are for A and B. If we were able to charge for two tests, at least we would come close to covering our cost for the product, which is close to \$16 per test kit.

– Question submitted by John Opyoke, Trinity Urgent Care, Trinity, FL

A. Great point! Coding influenza tests depends on the type of test being done. If the test gives a generic “positive flu” result, then use code 87804 only once. If the test gives one result for influenza A and a second result for influenza B (example: positive for flu A and negative for flu B), then use code 87804 twice.

You would want to append modifier -59 (repeat procedure, same physician) to the second code. As always, local payors may have specific policies regarding coding and reimbursement for influenza test, so it is a good idea to check with them before submitting billing for these tests.

Note: For Medicare, you will want to also add modifier -QW to this and all other CLIA-waved tests. ■

business because they fear rejection.

Consequently, closing verbiage often becomes hesitant, meandering, or even disingenuous. The best way to ask for the business is to *ask for the business* as directly as possible.

“The best rule is to look someone in the eye and say what you think.”

Rule #7: Learn from Your Written Edits

If you conscientiously edit your written correspondence (rule #1) you will begin to see patterns such as over-used words or irrelevant tangents. These tendencies tend to crop up in my verbal communiqués.

For example, my first drafts tend to be over-populated by dramatic adjectives (“very,” “extremely,” “extraordinary”) that—no surprise—find their way into my verbal expressions. It is instructive to note any “excess written verbiage” tendencies and strive to minimize these tendencies in conversation.

Rule #8: Silence is Golden

Given most conversations, you would never know it. Many sales professionals consider even a few seconds of silence an unacceptable void that must be filled with a stream-of-consciousness discourse.

To the contrary, one should sit still or steer things back to the prospect with such open-ended queries as “Anything else?” and “Your thoughts?”

Rule #9: Tighten Your Response to Questions

People tend to ramble on when answering questions. Strive to respond to questions with no more than a succinct sentence or two. Here are some hints:

Repeat the question. This gives you time to organize your response and ensure that you understand the question.

Pause between sentences. Give the other party a chance to clarify or accept your answer as sufficient.

Always conclude, “Does this adequately answer your question?”

Rule #10: Straight Talk—Above All

The best rule of all is to look someone in the eye and say exactly what you are thinking. Selling your clinic’s occupational medicine services is about creating “win-win” situations in which your clinic’s capabilities address the prospect’s needs. No hocus pocus—learn a prospect’s needs, describe your solution, define and quantify the win-win, and begin service.

The more quickly and precisely you get from point A to Point D, the better off you will be. ■

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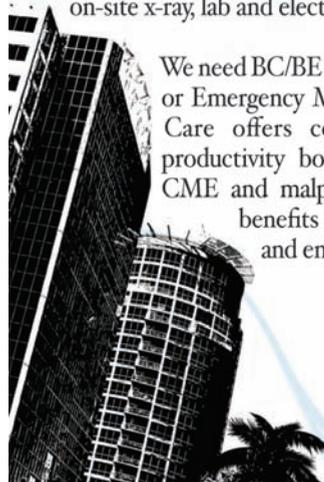
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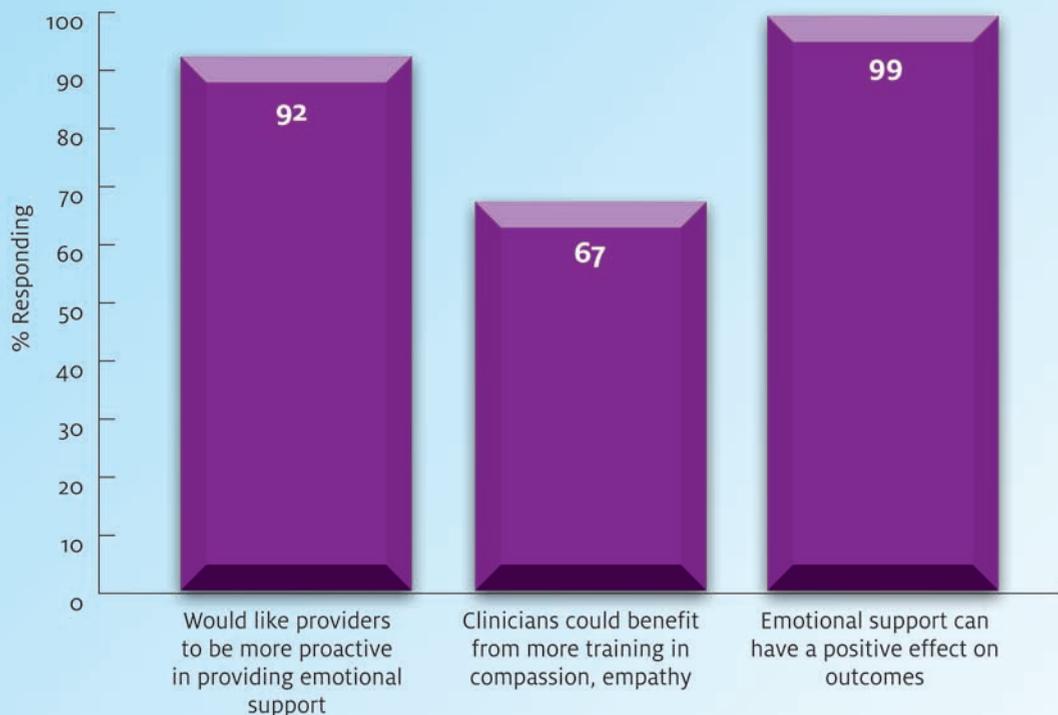
DEVELOPING DATA

As an emerging distinct practice environment, urgent care is in the early stages of building a data set specific to its norms and practices.

In *Developing Data*, *JUCM* will offer results not only from UCAOA's annual benchmarking surveys, but also from research conducted elsewhere to present an expansive view of the healthcare marketplace in which urgent care seeks to strengthen its presence.

In this issue: How do patients view the importance of "emotional support" from clinicians?

PATIENT BELIEFS ON EMOTIONAL SUPPORT FROM PROVIDERS



Source: CarePages, Inc., a Revolution Health Company.

The results of this December 2007 survey of approximately 900 caregivers and patients support notions expressed in past *JUCM* columns by Editor-in-Chief and UCAOA President Lee A. Resnick, MD, among other contributors, as well as articles and research published in other clinical journals.

The take-home message: While there is no substitute for competent clinical care, supplementing the fundamentals with a dose of humanity enhances a patient's experience and—in many patients' minds, at least—can have a positive effect on outcomes.

Are you aware of new data that highlight how urgent care is helping to fill gaps in patient satisfaction, or healthcare in general? Let us know in an e-mail to editor@jucm.com. We'll include them in an upcoming issue and on our website.



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