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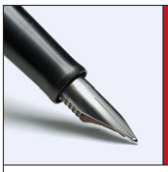


LETTER FROM THE EDITOR-IN-CHIEF

The Ruckus About 'RUC'

Perhaps you are unaware about the secretive, biased way that physician reimbursement is determined in this country. Perhaps you would be surprised to learn that the committee tasked with these determinations is composed of only 2 primary care physicians...out of 29 members! Perhaps you didn't know that their recommendations are unregulated and largely given a rubber stamp by the Centers for Medicare & Medicaid Services (CMS). Perhaps you have assumed that the process for reimbursement determinations is transparent and a matter of public record. Well then, perhaps you should wake up from your ketamine-induced sleep and sniff some ammonia salts!

Here's How it Really Works

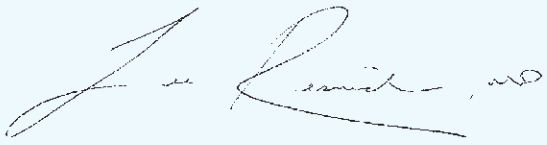
The Americal Medical Association (AMA) established the Relative Value Scale Update Committee (RUC) 20 years ago to score medical procedures based on their "relative value" (RVUs) as determined by multiple factors including physician time to perform and the training required for each procedure. This scoring system is the formula by which all recommended physician reimbursements are determined. There is, however, growing concern and outrage within the primary care community over the widening pay disparities and their link to a committee that is overwhelmingly influenced by specialists. It is being argued that the resulting bias towards proceduralists has directly contributed to skyrocketing healthcare costs and unprecedented pay gaps between primary care and specialty care.

The amount of training required to perform a procedure plays a significant role in determining its "relative value." Fair enough, but let's take a closer look. According to an analysis by Paul Fischer, MD, a family physician, and lead plaintiff in a lawsuit against CMS for their reliance on RUC for reimbursement recommendations, family physicians earn between half to a third of physicians in procedural specialties like dermatology, anesthesiology, and ophthalmology. Yet the training difference is a mere 1 year, or about 12% more medical training. This 12% training investment has netted these specialists a whopping 200% to 300% return. You don't have to be a financial advisor to deduce that a career in family medicine is a critically unwise investment. Let us also consider the societal value and prestige assigned to physicians based specifically on earnings. Is it any wonder we can't attract anyone to primary care?

Cracking the Codes

There are some 400 procedure codes for which reimbursement depends upon the RVU formulas used by RUC (codes). In addition, there are 10 non-procedural medical visits that are reimbursed using the "Evaluation and Management" codes with which we are most familiar (99211-99205). Perhaps the inherent bias of 400 codes for procedures vs a mere 10 codes for office visits raises your eyebrow? To add insult to injury, typical procedures, like cataract extractions and endoscopies, reimburse at over 12 times the hourly rate for a physician seeing a "moderately complex" office visit for a complaint such as headache or abdominal pain. It should not be difficult to understand, therefore, why specialists are defaulting to procedures in lieu of clinical management in their practices. The incentives to replace clinical evaluation and management with diagnostic procedure are inherent in the Relative Value Scale, and just too compelling to ignore. It has become so bad that patients now are referred back to primary care for most all of the "medical management" for their specialty diagnoses. Anesthesiologists are happy to perform multiple procedures for the patient with chronic back pain, but not so inclined to prescribe pain medications. When they have exhausted their procedures, they refer the patient back to primary care for the tiresome task of medication management.

There are no easy fixes. The AMA is adamantly against increasing reimbursement for some physicians at the expense of others, and society clearly has no appetite for adding any healthcare expenditures without balancing them with cuts. In my next column, I will explore some of the creative proposals being discussed and their potential impact on re-establishing parity in the physician payment system without increasing healthcare costs. ■



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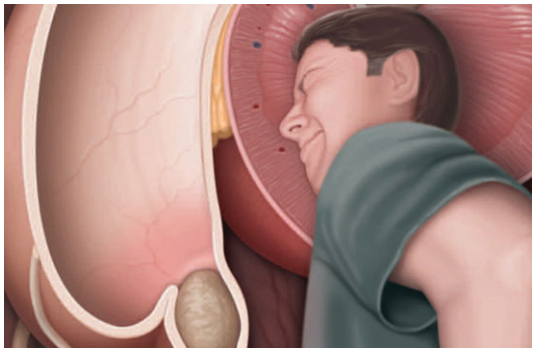

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Symptoms from stones in the ureter can mimic other conditions, making for a diagnostic dilemma in urgent care. Imaging is the key to accurate assessment and appropriate treatment.

William Gluckman, DO, MBA, FACEP and Kate Aberger, MD

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After location, how to pay for an urgent care site is crucial to your success. Here's how to think it through.

Michael Zelnik, CCIM

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More than one third of U.S. employees say they have been bullied in the workplace. Does your practice have a policy in place to thwart this insidious problem? If not, it should.

Alan A. Ayers, MBA, MAcc

CASE REPORT

28 When Serious Pathology Masquerades as a Minor Injury

The patient punctured his hand with a power screwdriver. It turned out to be the least of his problems.

Frank Fannin, MD, EMT-P

IN THE NEXT ISSUE OF *JUCM*

Urinary tract infections (UTIs) are common in children and a major source of morbidity. UTIs that involve the kidney are of particular concern because they can lead to permanent renal scarring in children. Next month's cover story looks at the challenge of accurately diagnosing UTI in infants and children in the urgent care setting who may not be able to communicate symptoms. We review methods of urinalysis, options for treatment, red flags for high-risk patients, indications for referral, and considerations for special populations.

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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.

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JUCM CONTRIBUTORS

Ureterolithiasis, or stones in the ureter, is a common cause of flank and abdominal pain that can be debilitating. Some 7% of adult females in the United States and 12% of adult men will develop stones at some time in their lives, and prevalence is rising.

In our cover story this month, William Gluckman, DO, MBA, FACEP and Kate Aberger, MD, look at the etiology of stone formation, options for imaging, and ways to tailor treatment based on stone composition.

Dr. Gluckman is President & CEO of FastER Urgent Care, Morris Plains, New Jersey, and a member of the *JUCM* editorial board. Dr. Aberger is an attending physician in the Department of Emergency Medicine at St. Joseph's Regional Medical Center in Paterson, New Jersey, and at FastER Urgent Care in Morris Plains, New Jersey

Hand injuries are common in urgent care, and in this month's Case Report, Frank Fannin, MD EMT-P, reminds us how important a thorough, focused assessment is for these patients. The history can have a significant impact on direction of care. In this case, a potentially devastating outcome was avoided because the physician took the time to build a complete picture of what happened after the 62-year-old male punctured his hand.

Dr. Fannin is Medical Director of Urgent Care Services at King's Daughters Medical Center in Ashland, Kentucky.

Does your practice have an anti-bullying policy in place? If not, it should, according to Alan A. Ayers, MBA, MAcc, author of this month's first practice management article, on preventing workplace bullying. More than one-third of U.S. employees say they have been bullied in the workplace and the problem is four times more prevalent than illegal discriminatory harassment.

Mr. Ayers is Content Advisor to Urgent Care Association of America and Vice President of Concentra Urgent Care in Dallas Texas, and a frequent contributor to *JUCM*.

In our second practice management article, Michael Zelnik, a real estate professional with more than 30 years' experience, helps you think through the benefits and risks of leasing versus purchasing a property for your practice. There is no right or wrong choice, but there are many factors to consider once you've identified a geographic location and before you sign on the dotted line.

Mr. Zelnik is President and Founder of the Zelnik Realty Group and the National UC Realty Division in Columbus, Ohio.

Also in this issue:

John Shufeldt, MD, JD, MBA, FACEP, describes how to spot a "cancer" before it spreads. He's not talking about a life-threatening disease in his Health Law column. Rather, Dr. Shulfeldt is referring to the "bad hire" that you need to avoid.

Nahum Kovalski, BSc, MDCM, reviews new abstracts on current literature germane to the urgent care clinician.

In Coding Q&A, **David Stern, MD, CPC,** discusses codes for incision and drainage, R-codes and POS 20, and coding for a compression bandage.

Our Developing Data end piece this month looks at patient flow according to average visits per month and per shift per day. ■

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Remembering One of Our Own

LOU ELLEN HORWITZ, MA

If you have been a member of the Urgent Care Association of America (UCAOA) for a while, got your urgent care center accredited in the very early days of the organization, or bought the *Policy and Procedure Sample Manual*, then your life has likely been touched by Kathy Crampton.

I first met Kathy in Lake Tahoe at UCAOA's 2nd annual meeting. I believe she was in our storage room helping the staff put together course materials after a printing problem. When I learned she was also a board member, it made very clear both what kind of an organization UCAOA was, and what kind of person she was. In that early introduction, she instantly embodied the "roll up our sleeves" attitude that underlies UCAOA still today.

In UCAOA's early history, Kathy's main contribution to the field was the development of the criteria for center accreditation (UCAOA's own independent program back then). She and her team basically set the very first standards for what a quality urgent care center should be.

Almost 6 years later, when it came time to choose an Editor for our *Policy and Procedure Sample Manual*, she was an easy choice. Kathy brought a clinical background (RN), extensive experience in urgent care operations, and an understanding of the need for policies and procedures in the average urgent care center. Besides that, we really liked her and had always found her professional and easy to work with.

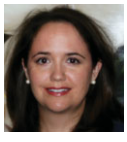
If you have ever attempted to write your own P&P manual, you know that it is a daunting task. Even though we already had a foundation of policies to work with, wading through the differences in those, organizing them into a coherent whole, and developing them into a usable finished product was a tremendous undertaking. All told, from first glance to finished product it took **11 months**. The P&P manual was finally published on December 28, 2011.

One month later, on January 25, 2012 Kathy Lou Hwass Crampton Marrapodi passed away. What I have not mentioned in this column yet is that, during most of her work on the P&P manual, Kathy was very, very sick. When Kathy accepted the role of editor of the P&P manual, her illness was in remission. During the project it returned, and although she was in and out of the hospital at least four times in 2011, she never stepped away from her dedication to completing the manual. Kathy knew from years of experience how important it was for the industry, and did everything in her power to get it done for you.

"Kathy's final gift to urgent care was the manual we had been trying to bring to fruition for a long time."

With Kathy's passing, I learned a lot more about her other contributions to the world, her dedication to community and family, her love of laughter and fun. Her final gift to urgent care was the manual we had been trying to bring to fruition for a long time, but our industry was just a small part of this amazing woman's very full life.

Kathy got married just a few weeks before she passed away, and I so appreciate the message in that for all of us. No matter how bad things may be, there is always love in the world, and something or someone to be thankful for. In her last email to me when she sent in her final draft, she signed it "Blessings and Gratitude!" That's the kind of person Kathy was, and I know I speak for many of you out there when I say that we were honored to know her, and to call her one of our own for a little while. Thanks, Kathy. ■



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Ureterolithiasis: Leaving No Stone Unturned

Urgent message: Symptoms from stones in the ureter can mimic other conditions, making for a diagnostic dilemma in urgent care. Imaging is the key to accurate assessment and appropriate treatment.

WILLIAM GLUCKMAN, DO, MBA, FACEP and KATE ABERGER, MD

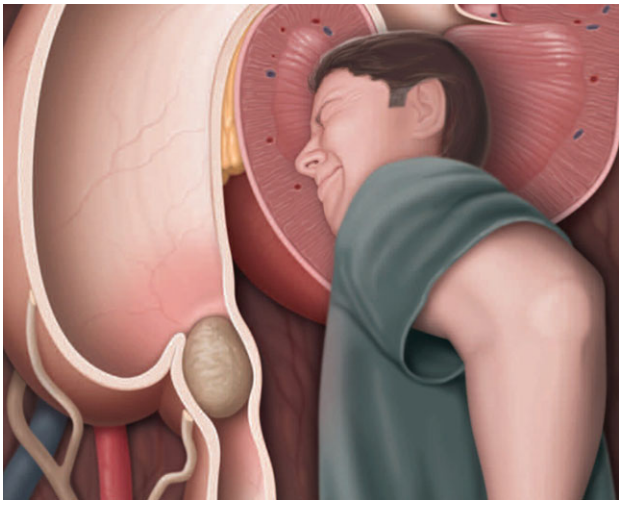
Ureterolithiasis, which literally translates to stones in the ureter, is sometimes referred to improperly as "kidney stones," which are properly known as nephrolithiasis. Although stones do form within the kidney, they do not typically cause acute pain. Ureterolithiasis can cause extreme pain, discomfort that sometimes is considered to be worse than experienced with childbirth. Such pain is referred to as renal colic because it waxes and wanes. The abdominal and back pain associated with ureterolithiasis sometimes mimic other conditions, making cases a diagnostic dilemma.

Epidemiology

Seven percent of American women and 12% of American men will develop stones at some time in their lives, and prevalence is rising in both sexes. Incidence is twice as high in individuals who have a family member with stones. Every year in the United States, 2 million people seek outpatient treatment for stones, which is a 40% increase from 1994. In this country, kidney stones account for 1% of hospital admissions, and $2.1 billion in healthcare expenditures per year.

Most kidney stones occur in patients aged 20 to 49, with the peak age of onset at between ages 35 and 45. An initial stone attack in a patient older than age 50 is unusual, and it rarely happens in children up to age 16. The male to female ratio is 3:1. Stones due to infection (struvite) are more common in women, and women have a higher incidence of infected hydronephrosis. Asians and whites have a far greater incidence of stones than do African Americans, Africans, and Native Americans. The recurrence rate for urinary calculi is 50% within 5 years and 70% or higher within 10 years.

Dr. Gluckman is President & CEO of FastER Urgent Care, Morris Plains, NJ, and a member of the JUCM editorial board. Dr. Aberger is an attending physician in the Department of Emergency Medicine at St. Joseph's Regional Medical Center in Paterson, New Jersey, and at FastER Urgent Care in Morris Plains, New Jersey.



Risk

People of low socioeconomic status are at lower risk of ureterolithiasis than are those of higher socioeconomic status. The southern and southwest regions of the United States are known as the "stone belt" because the incidence of stones is higher there than in other areas of the country. Obesity, hypertension, and osteopenia

are conditions associated with the disorder. Diet plays a significant role in the incidence of stones. High intake of animal protein and salt and low fluid and calcium intake also are contributing factors.

Stone Types

The four main chemical compositions of renal calculi and their incidence are:

- Calcium (75% to 80%)
- Struvite or magnesium ammonium phosphate (10% 15%)
- Uric acid (6% to 9%)
- Cystine(1% to 3%)

The main mechanism of stone formation is super-saturation. This is a phase change in which dissolved salts condense into solids. Supersaturation depends on the balance of promoters (calcium and oxalate) and inhibitors (magnesium and citrate) of crystallization.

Calcium stones are the most common, comprising about 80% of all cases of ureterolithiasis. These calculi typically are composed of calcium oxalate with a calcium phosphate core, and stones made entirely of calcium phosphate are less common. The characteristic appearance of calcium stones under the microscope is of an envelope. They form in patients who have low urine volume and high concentrations of calcium and oxalate.

Arguably the most important factor in the formation of stones is low fluid intake. Because of that, the volume of urine production is low, which in turn produces high concentrations of stone-forming solutes—calcium and oxalate—in the urine. Hypercalciuria can result from increased dietary intake or overactive calcium absorption, or excess resorption of calcium from bone, as in hyperparathyroidism. Hypercalciuria also can be related to inability of the renal tubules to absorb the calcium in the glomerular filtrate. Decreased levels of magnesium and citrate—the inhibitors of stone formation—in the urinary tract predispose to stone formation.

Once the etiology of a patient's calcium stones is discerned, treatment can be tailored to the cause. The current trend is NOT to restrict dietary intake of calcium, especially in postmenopausal women. Many studies have shown this to be ineffective and possibly even harmful.

Struvite stones are associated with chronic urinary tract infections (UTIs) caused by gram-negative rods. These specific bacteria are capable of splitting urea into ammonium, which then combines with phosphate and magnesium. The usual bacteria that do this are *Proteus*, *Pseudomonas*, and *Klebsiella*. *Escherichia coli* cannot split urea. Urine pH usually is greater than 7.

For these types of stones, the infection will not resolve until the entire stone is removed. Underlying etiology for chronic UTIs must be investigated.

Uric acid stones are associated with low pH (less than 5.5) and elevated levels of purine related to high intake of organ meats, fish, or legumes, or because of malignancy. These stones are associated with gout; 25% of patients with uric acid stones suffer from gout. Alkalinization of the urine with sodium bicarbonate or citrate (which is converted to sodium bicarbonate) is the mainstay of therapy, plus ensuring adequate hydration. In patients with high serum uric acid levels, allopurinol is useful for lowering serum levels and helping to prevent stone formation, but it will not dissolve an already formed stone.

Cystine stones, which are the rarest type, arise from an intrinsic metabolic defect that results in failure of the kidneys to reabsorb cystine, ornithine, lysine and arginine. The urine then becomes supersaturated and stones form. Diet, binders, and alkalinizing agents can be used for treatment.

Stones typically form in the kidney and then enter the ureter. Some stones pass and never cause discomfort, whereas others become stuck in the ureter or begin to rub against the ureter during movement, triggering pain. As a result of the "trauma" to the ureter, patients with stones often have blood in their urine, which can vary from microscopic to gross hematuria.

Work-Up for The Suspected Stone

The first step in work-up for the suspected stone in the urgent care environment is a dipstick urinalysis to evaluate for presence of blood, leukocytes, ketones, and nitrite. Ketosis in the face of vomiting should warrant intravenous (IV) fluid hydration and evidence of infection also should be addressed. Determining whether infection is the sole cause of the patient's pain or presenting in conjunction with a stone is not always easy. Microscopy is helpful to identify the presence of crystals, which can help further support a stone diagnosis over other causes of urinary complaints, and a urine culture can rule in or out the presence of bacterial infection. Routine serum renal function testing is not required but should be considered for patients who have a history of renal disease or have or in whom you suspect significant hydronephrosis.

Radiographic imaging (x-ray, computed tomography [CT], ultrasound [U/S]) is very helpful in evaluating stones, as described in the next section of this article.

Stone analysis can be useful for determining stone composition, which can help determine preventative measures. Patients who are being treated at home should be given a strainer and asked to return a stone that they pass, if possible.

Imaging for Stones

Because 80% of stones are calcium-based and radiopaque, x-ray imaging is useful for diagnosis. A non-contrast-enhanced CT scan of the abdomen and pelvis (**Figure 1**) has a 95% to 100% sensitivity and 95% to 98% specificity and is our preferred initial exam because it provides all of the important initial management information: Stone location, size, number (stone burden), and extent of hydronephrosis, if present. U/S imaging is limited because it does not demonstrate the exact stone location outside of the kidney and image quality can be affect-

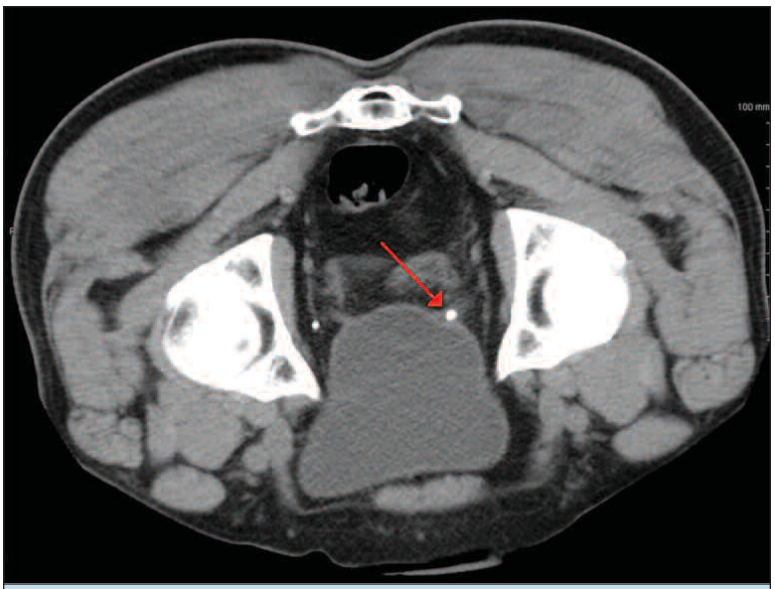


Figure 1: Axial CT scan of abdomen without contrast, showing stone (marked by an arrow) in the left distal ureter at the ureterovesical junction (UVJ).

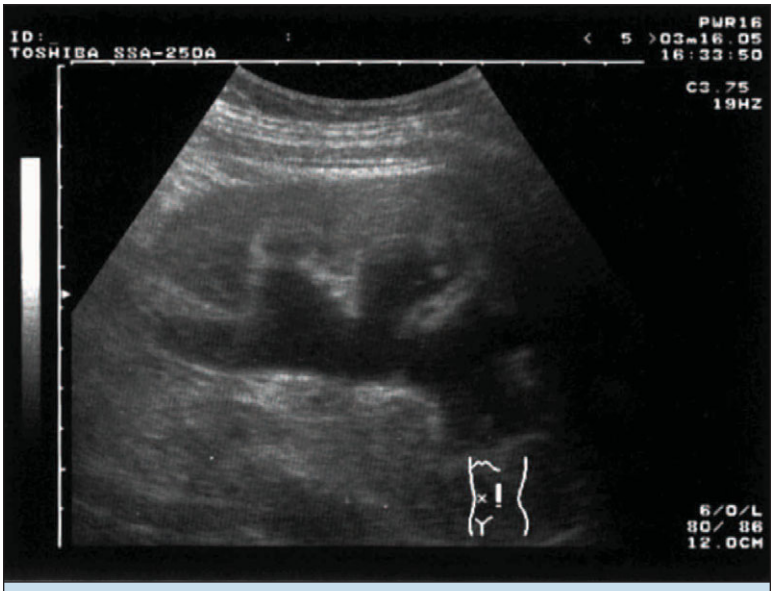


Figure 2: Hydronephrosis, as seen on ultrasound, from proximal left ureteral stone.)

ed by obesity and excessive bowel gas. U/S (**Figure 2**) has the advantage of not using ionizing radiation, which is a consideration in pregnant women, young females, and patients with recurrent stones who may have had several CT scans in the past.

Use of ultra-low dose CT scans, which delivers almost half of the radiation dose of typical CT scans, also is increasing. On these scans, organs have a more "grainy" appearance because detail is reduced, but they still demonstrate stones very well.

An abdominal x-ray or "flat plate of the abdomen" (KUB) may be useful in the urgent care setting for screening because CT scan and U/S may not be readily available. A KUB also can be used to screen patients with a known history of radiopaque kidney stones. Before the advent and advanced technology of CT scanning and U/S, plain KUB and intravenous pyelograms, in which IV contrast was injected and a series of abdominal plain films were taken, were the main diagnostic modalities. A KUB has a sensitivity of approximately 50% and sensitivity of approximately 75%, thus a negative KUB does not rule out a stone. A KUB also does not show mild or moderate hydronephrosis, although it can demonstrate severe hydronephrosis.

Management With Medication

Initial urgent care treatment of renal colic is pain management. Intramuscular (IM), or even better IV, ketorolac is a typical initial medication. The nonsteroidal effect has been shown to prevent ureteral spasm and thus provide very good pain relief. Opiates often are needed to control the pain of renal colic. IM or IV morphine or hydromorphone are good choices. If a patient is not vomiting and can tolerate medication by mouth, a nonsteroidal anti-inflammatory medication, such as naproxen or intranasal ketorolac along with oral oxymorphone or oxycodone/APAP for breakthrough pain is a good start. Encouraging the patient to drink lots of fluids such as water (with lemon) and Gatorade also is important.

Nausea and vomiting can be managed with metoclopramide or ondansetron parenterally if needed initially, and then orally.

There is literature to support the use of alpha blockers, specifically tamsulosin, administered daily at 0.4 mg. The thinking is that because the distal ureters contain alpha receptors, treatment with drugs may produce enough dilation to permit passage of more stones that reach the ureterovesical junction.

Red Flags in Management

Ureteral stones in the face of infection are potentially problematic. An infection can be difficult to clear with antibiotics alone without addressing the stone. Patients who are febrile and have chills should be evaluated for infection.

Definitive Management

In approximately 80% of patients whose stones are small (that is, <4 mm) typically, the calculi will pass spontaneously. Stones larger than 4 mm often require surgical intervention such as ureteroscopy and removal with or without stent placement. Patients who have stones >4 mm with or without hydronephrosis should be referred to a urologist within a few days, and sooner than that if their pain is difficult to control.

Extracorporeal shockwave lithotripsy (ESWL) is another procedure used to treat kidney and proximal ureteral stones. A focused shockwave is generated and targeted at the stone, essentially pulverizing it into smaller fragments that are then passed easily in the urine. Advantages of ESWL include generally less anesthesia time and less risk of ureteral damage. ESWL is considered a first-line treatment and may be advantageous for patients in

whom expectant management and unexpected pain may be problematic, such as pilots and surgeons. Patients with a solitary kidney or those at higer risk from longer anesthesia time also may benefit from ESWL.

Admission Criteria

No definite laboratory or radiographic criteria have been established for admission of patients with stones. Clinical judgment should be used to make the determination, but the following situations should prompt admission:

- Ureteral obstruction in a solitary or transplanted kidney
- Ureteral obstruction associated with severe hydronephrosis and/or infected hydronephrosis
- Persistent vomiting and inability to tolerate oral fluids or pain medications
- Pain uncontrolled by oral analgesics
- Acute elevation in BUN/creatinine or worsening of underlying renal insufficiency

Conclusion

Ureterolithiasis is a common cause of flank and abdominal pain. The goal is to rule out other potentially life-threatening causes of pain such as abdominal aortic aneurysm, appendicitis, and diverticulitis, and to control the patient's pain. Use a diagnostic imagining modality early to solidify the diagnosis and determine if the patient requires urologic referral and intervention or watchful waiting and conservative therapy. ■

Bibliography

- Berrington de Gonzalez A, Mahesh M, Kim P, et al. Projected cancer risks from computed tomographic scans performed in the United States in 2007. *Arch Intern Med*. 2009;169(22):2071-2077.
- Ciaschini MW, Remer EM, Baker ME, et al. Urinary calculi: radiation dose reduction of 50% and 75% at CT—effect on sensitivity. *Radiology*. 2009;251(1):105-111.
- Dellabella M, Milanese G, Muzzonigro G. Efficacy of tamsulosin in the medical management of juxtavesical ureteral stones. *J Urol*. 2003;170(6 Pt 1):2202-2205
- Hall PM. Neprolithiasis: Treatment, Causes, and Prevention. *Cleveland Clinic Journal of Medicine*. 2009;76(10):583-591.
- Kluner C, Hein PA, Gralla O, et al. Does ultra-low-dose CT with a radiation dose equivalent to that of KUB suffice to detect renal and ureteral calculi? *J Comput Assist Tomogr*. 2006; 30(1):44-50.
- Miller JC. CT and radiation safety issues. *Radiology Rounds*. 2010;8(3).
- National Council on Radiation Protection and Measurement (2009). Report No. 160 - Ionizing Radiation Exposure of the Population of the United States. www.ncrponline.org
- Paulson EK, Weaver C, Ho LM, et al. Conventional and reduced radiation dose of 16-MDCT for detection of nephrolithiasis and ureterolithiasis. *AJR Am J Roentgenol*. 2008;190(1):151-157.
- Smith-Bindman R, Lipson J, Marcus R, et al. Radiation dose associated with common computed tomography examinations and the associated lifetime attributable risk of cancer. *Arch Intern Med*. 2009;169(22):2078-2086.
- Soto JA. Ureteral and kidney stones. In: Sahani DV, Samir AE, eds. *Abdominal Imaging*. Maryland Heights, MO: Elsevier; 2010;1:185-189.
- Wasserstein AG. Nephrolithiasis. *Am J Kidney Dis*. 2005;45(2):422-428.
- Wen CC, Coyle TL, Jerde TJ, Nakada SY. Ketorolac effectively inhibits ureteral contractility in vitro. *J Endourol*. 2008;22(4):739-742.
- Wolf SJ Jr., Fields BF. Nephrolithiasis. Medscape. emedicine.medscape.com, emedicine.medscape.com/article/437096overview#aw2aab6b2b4aa. Updated June 16, 2011. Accessed January 23, 2012.
- Wolf SJ Jr., Fields BF. Nephrolithiasis Treatment and Management. Medscape. http://emedicine.medscape.com/article/437096-treatment. Updated January 23, 2012. Accessed February 9, 2012.
- Worcester E. Kidney stone disease. *J Clin Invest*. 2005;115(10):2598-2608.

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Buy or Lease Your Next Urgent Care Site?

Urgent message: After location, how to pay for an urgent care site is crucial to your success. Here's how to think it through.

MICHAEL ZELNIK, CCIM

Introduction

Once you've found the right location for your next urgent care (see *An Urgent Care Site That Maximizes Revenue, JUCM,* September 2011), your focus can turn to analyzing the risks and benefits of leasing or purchasing property in the trade area you've identified. This analysis should be more than just a financial calculation. Each choice has a unique set of benefits and risks that could restrict or accelerate profit and expansion possibilities.

Leasing Benefits

Leasing is an option available to the largest number of potential tenants. Although credit is an issue, the criteria are not as demanding as those for securing a loan to purchase a building. Leasing space, therefore, can be good choice for start-up urgent care centers with limited capital to invest, whereas an established urgent care center may prefer to preserve capital for future expansion.

Benefit 1: Flexible Size Choices

Why purchase space if you are uncertain about the number of patients who you will see on a regular basis? Starting small and growing when patient count and cash flow warrant an expansion can be an effective strategy.

Example

An urgent care leased 4,000 square feet of space for 5 years. Their patient counts increased to a level that warranted leasing additional space. The landlord agreed

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to extend the term of the lease and allow the practice to expand into the adjacent space.

Benefit to the Urgent Care Practice
The business was not disrupted by relocation or having to add space to an existing building. The other advantage was being able to grow into a space without having to pay the cost of extra space during the early years of the practice.

Benefit 2: Faster Start-Up Time
Leasing space typically involves locating an existing building. Buildings that have never been occupied are called first-generation or "shell" buildings. Second-generation spaces are locations that have had a previous tenant. In each case, the space needs to be customized for use by an urgent care practice. The time required to build out the interior of the space typically ranges from 60 to 90 days.

Example
An urgent care operator wanted to be open by the end of December to capture a large percentage of patients needing flu vaccination before the end of the flu season. Negotiations to lease a space in a shopping center started at the beginning of October. Terms were agreed to and a lease was executed by the middle of October. Once the lease was signed, construction commenced and the clinic was completed by the end of December.

Benefit to the Urgent Care Practice
Within 90 days, the provider was able to find a building, negotiate the lease, complete construction, and be open for business in time to serve patients need flu vaccination.

Benefit 3: An Exit Strategy
No one can predict what factors will influence the viability of a location over a period of 5 to 10 years. A lease agreement has a specific termination date that gives an urgent care center the flexibility to close or relocate to a better location if the current site is no longer profitable.

Example
An urgent care leased space for 5 years. The location was in the back of a shopping center and did not have sufficient signage or visibility. Because of these issues, the patient counts never reached the anticipated level of profitability. Once the current lease expired, the provider was able to move to a new location with improved visibility and signage, which helped to increase the number of patient visits.

Benefit to the Urgent Care Practice
The fact that this lease had a specific termination date enabled the provider to find a new location without having any uncertainty about when he could relocate.

Leasing Risks

Not all aspects of leasing are beneficial. Leasing has risks that can seriously impact a business operation.

Risk 1: Property Foreclosure
Your lease agreement is typically subject to an existing mortgage agreement. If your landlord is having financial difficulty, the property could go into foreclosure and your lease could be terminated.

Example
The building occupied by an urgent care practice is under foreclosure by the lender. If the lease agreement did not provide for a "subordination and non-disturbance" (SNDA) clause, the tenants may run the risk that the lender will terminate all lease agreements and force the tenants to relocate.

Risk to the Urgent Care Practice
The financial problems of the landlord could result in loss of time and money spent building the urgent care practice at a leased location.

Risk 2: Other Tenants
A leased space may provide all the desired benefits of signage, visibility, and access. But the surrounding tenants may have a negative impact on the operations of the other tenants in the shopping center.

Example
An urgent care provider shared a parking lot with all of the tenants in a shopping center. A new restaurant moved into the center and was open for lunch and dinner times. The restaurant was so successful success, that the common parking lot was was at full capacity during lunch and dinner hours.

Risk to the Urgent Care Practice
The lack of parking could make the location undesirable to potential patients, which could decrease the number of daily visits.

In considering leasing vs buying, there is no intrinsically right or wrong choice. Each option has its own set of risks and benefits.

Risk 3: Lack of Options
A lease agreement will have a specific termination date. If the lease does not provide an option for the tenant to extend the term, the tenant could be forced to leave a profitable location.

Example
An urgent care practice leased space for 5 years in a location that generated a considerable number of daily patient visits. The practice wanted to remain at that location but a competitor approached the landlord and offered a higher rent then the current tenant was willing to pay, so the landlord leased the space to the competitor.

Risk to the Urgent Care Practice
All the time and money spent promoting this location will now benefit the competing urgent care practice, which was able to take over the space without spending any of the typical costs associated with starting a new center.

Buying Benefits

Owning a property rather than merely renting a location offers benefits that cannot be achieved by tenants. The results of these benefits are not automatic, however, and are subject to risks that in many instances are out of the owner's control.

Benefit 1: Value Creation
The value of real estate is influenced by the length of a lease, quality of the tenant's credit, and use of the space. In today's market, investors are aggressively pursuing medical buildings with long-term leases in place. In many instances, this has caused sales values to increase.

Example
An urgent care practice agreed to lease a 5,000-square-foot building for 15 years. In return, an investor was willing to purchase the property for a value that was 8.5 times annual net income.

Benefit to the Urgent Care Practice
The value of this property would only have been $500,000 if the property did not have a long-term lease in place. Because the tenant was willing to commit to a long-term lease, the value of the property more than doubled to $1,050,000. The owner then sold the building and leased back the property for 15 years. The profit from the sale provided the capital to build a new building and open a new clinic.

Benefit 2: Custom Design
As the owner of a property, you will have the ability to design the space to meet your needs and desires.

Example
The owner of an urgent care practice wanted a reception area that was comfortable and homey. His design included a functional fireplace in the waiting area.

Benefit to the Urgent Care Practice
The owner was able to have a specific finish, which would have been impossible in a traditional shopping center with multiple tenants.

Benefit 3: Management Decisions
As the owner of the property, you will be able to make all the decisions regarding how the interior and exterior of your building should be managed. This would include signage, landscaping, and snow removal.

Example
An urgent care leased a building in a town that permitted digital signage. The landlord did not want to have any digital displays on his property, so the practice was unable to take full advantage of enhanced signage.

Benefit to the Urgent Care Practice
If the property was owned by the urgent care provider, it would be in a position to take full advantage of all signage that was acceptable under local zoning regulations.

Buying Risks

There is a downside to ownership. The fact that you are the owner means you have total control of your property. Unfortunately there are numerous factors that are totally out of your control.

Risk 1: Market Area Changes
Picture a former shopping center, once the focal point of an area for shopping, offices and entertainment, now reduced to a group of lifeless vacant buildings.

Example
A major grocery store anchor ceases operations. The other tenants in the shopping center whot relied on the grocery store for a steady flow of customers must now also close their doors. Outparcel buildings that once sold for over $1 million are now selling at a 30% to 40% discount.

Risk to the Urgent Care Practice
The owner of this type of property has no control over other retail traffic generators. When a major retail anchor closes, the ability to sell a property for more than your original cost could be compromised.

Risk 2: Lending Risk
Most loans require repayment in 5 to 7 years, many with what is known as a balloon payment. A balloon payment protects the lender from having money tied up for long periods of time at unfavorable rates.

Example
The current terms of a loan are favorable to the owner. The loan had a balloon payment due when interest rates were at a higher rate than that currently being paid on the loan. The owner must refinance the property, pay all the costs associated with refinancing, and accept the current interest rate.

Risk to the Urgent Care Practice
The increase in the cost of the loan could reduce the practice's profitability.

Risk 3: Aging Building
Roofs, parking lots, and the exterior of buildings have a limited useful life. As the owner of the property, you would need to make a capital investment to replace aging building components.

Example
The useful life of a roof is 15 to 20 years. The useful life of a parking lot is 10 to 15 years. The exterior of a building may require maintenance every 10 to 15 years.

Risk to the Urgent Care Practice
The condition of your building's components will affect the value of the property and you may need to make additional capital investments during slow income periods.

Conclusion

In considering leasing vs buying, there is no intrinsically right or wrong choice. Each option has its own set of risks and benefits. Your first priority should be to pick the right location for your urgent care practice. Once you have selected a location, you should devote time and attention to evaluating the benefits and risks of leasing and buying and select the option that best fits the long-term plan for your business. ■

ABSTRACTS IN URGENT CARE

- Sinusitis symptoms vs scans
- Severity of chest pain as predictor of outcome
- ED practice patterns in young children with fever
- Expanded indication for Prevnar 13
- ACP's assessment of wasteful diagnostic testing

NAHUM KOVALSKI, BSc, MDCM

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

Symptoms May Say Sinusitis, But Scans Disagree

Key point: Infection and even inflammation were not reliably present in the scans of patients with classic sinusitis symptoms.

Citation: Ferguson BJ, Narita M, Yu VL, et al. Prospective observational study of chronic rhinosinusitis: Environmental triggers and antibiotic implications. *Clin Infect Dis*. 2012;54(1):62-68. *(http://dx.doi.org/10.1093/cid/cir747)*

Chronic sinusitis can be difficult to diagnose precisely and sometimes even more difficult to treat. Increasingly, experts are suggesting that antibiotics may be wildly overprescribed for this condition.

In this prospective study, patients referred to a single sinus expert for classic sinusitis symptoms were methodically evaluated with computed tomography (CT) scans and nasal endoscopy. Of 125 consecutive patients, only 75 (60%) had evidence of sinusitis on CT scan (meatal obstruction, air-fluid levels, or mucosal thickening [one area with >10 mm thickening, or any thickening involving at least 4 sinuses]). A decreased sense of smell predicted an abnormal CT scan, but headache, facial pain and difficulty sleeping were all more common in the patients with a normal scan. Further, the worse the reported facial pain, the less likely the scan was to show abnormalities.

Purulent secretions were found on endoscopy in only 18 patients, all of whom had abnormal CT scans. Standard pathogens associated with bacterial sinusitis were identified in only five of these patients. No environmental exposures (including alcohol, tobacco, pets, and mold) could distinguish patients with normal scans from the others.

Published in *J Watch Gen Med*. January 31, 2012—Abigail Zuger, MD. ■

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Severe Chest Pain Does Not Herald Worse Outcomes

Key point: In a large study of patients presenting with chest pain, severity of pain did not predict acute myocardial infarction, death, or revascularization.

Citation: Edwards M, Chang AM, Matsuura AC, et al. Relationship between pain severity and outcomes in patients presenting with potential acute coronary syndromes. *Ann Emerg Med*. 2011;58(6):501-507.

Patients—and textbook authors—often believe that severe chest pain is more likely to indicate heart attack than is milder chest pain. Researchers conducted a secondary analysis of a prospective study of 3306 patients with chest pain who presented to an academic emergency department (ED) in from 2005 through 2009. Severity of chest pain was scored on a scale from 0 (no pain) to 10; scores of 9 to 10 were deemed severe, and scores of 1 to 8 were deemed nonsevere. Outcomes were acute myocardial in-

farction (MI) diagnosed in the ED and the composite of death, acute MI, or revascularization within 30 days.

Severity of chest pain was not significantly associated with acute MI or the composite outcome, either when patients with severe pain were compared to those with nonsevere pain or when pain score was analyzed as a continuous variable.

Published in *J Watch Emergency Med.* January 6, 2012 — Daniel J. Pallin, MD, MPH. ■

ED Practice Patterns for Children Aged 3 to 36 Months With Fever Without a Source

Key point: Testing and treatment patterns of young children do not reflect evidence-based guidelines.

Citation: Simon AE, Lukacs SL, Mendola P. Emergency department laboratory evaluations of fever without source in children aged 3 to 36 months. *Pediatrics*. 2011 Dec;128(6):e1368-1375.

Investigators analyzed data from the 2006–2008 National Hospital Ambulatory Medical Care Survey to describe emergency department (ED) practice patterns in the *Haemophilus influenza* and pneumococcal vaccine era for children aged 3 to 36 months with fever ≥38°C without a source (e.g., sore throat, diarrhea). Patients were excluded if they had a discharge diagnosis that would likely preclude diagnostic testing (e.g., croup, bronchiolitis, herpangina).

Among children aged 3 to 36 months, fever without a source accounted for 22% of visits (approximately 1.7 million visits per year), 5% of which resulted in admission. In 59% of visits, no diagnostic tests were ordered. Although girls and patients with temperatures ≥39°C were significantly more likely than boys and patients with lower temperatures to undergo testing (including urinalysis and complete blood cell count [CBC]), urinalysis was ordered for only 43% of girls aged 3 to 24 months with temperatures ≥39°C. Among children aged 3 to 24 months, CBC was performed in 22% and blood culture in 9%. Antibiotics were prescribed in approximately 25% of visits, including 20% in which no tests were ordered. Patients from zip codes with higher median incomes were significantly more likely to have a CBC or urinalysis ordered (respective odds ratios, 1.17 and 1.12 per US$10,000 increase).

Published in *J Watch Emerg Med.* January 6, 2012 — Katherine Bakes, MD. ■

FDA Expands Use of Prevnar 13 to Adults Aged 50 and Older

Citation: *http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm285431.htm*

Prevnar 13, a 13-valent pneumococcal conjugate vaccine, has been approved for use in adults aged 50 and older to prevent pneumonia and invasive disease caused by *Streptococcus pneumoniae*. The vaccine was first licensed in 2010 for children aged 6 weeks through 5 years

In randomized, multi-center studies in the United States and Europe, people 50 and older received either Prevnar 13 or Pneumovax 23, a licensed pneumococcal vaccine also approved for use in this age group. The studies showed that for the 12 common serotypes, Prevnar 13 induced antibody levels that were either comparable to or higher than the levels induced by Pneumovax 23.

The safety of Prevnar 13 was evaluated in about 6,000 people ages 50 and older who received Prevnar 13 and who had and had not previously received Pneumovax 23. Common adverse reactions reported with Prevnar 13 were pain, redness, and swelling at the injection site, limitation of movement of the injected arm, fatigue, headache, chills, decreased appetite, generalized muscle pain, and joint pain. Similar reactions were observed in those who received Pneumovax 23.

Prevnar 13 is already approved for use in children ages 6 weeks through 5 years for the prevention of invasive disease caused by 13 different serotypes of the bacterium Streptococcus pneumoniae and for the prevention of otitis media caused by seven of the serotypes of the bacterium. ■

Wasteful Diagnostic Testing Situations Listed by ACP

Key point: An ad hoc group of internists convened by the American College of Physicians has identified a series of clinical situations that frequently lead to wasteful diagnostic tests

Citation: Qaseem A, Alguire P, Dallas P, et al. Appropriate use of screening and diagnostic tests to foster high-value, cost-conscious care. *Ann Int Med*. 2012;156(2):147-149. http://www.annals.org/content/156/2/147.abstract

By consensus, the group identified some 40 situations, which include the following:

- Assessing brain natriuretic peptide in the initial evaluation of typical heart failure findings
- Ordering imaging studies for nonspecific low back pain
- Utilizing MRI instead of mammography to screen for breast cancer in women at average risk
- Conducting serologic testing for suspected early Lyme disease

The *Annals of Internal Medicine*'s editor invites readers to comment on or add to the list by taking a survey on the journal's website. She remarks that "unnecessary testing abounds," and cites a Congressional Budget Office estimate that "up to 5% of the nation's gross national product is spent on tests and procedures that do not improve patient outcomes." ■

Workplace Bullying and its Costs to the Urgent Care Operation

Urgent message: More than one third of U.S. employees say they have been bullied in the workplace. Does your practice have a policy in place to thwart this insidious problem? If not, it should.

ALAN A. AYERS, MBA, MACC

What is the Difference Between Diversity and Tolerance?

According to one definition, diversity is *anything that makes you different* while tolerance is *not persecuting people* who are different. Many urgent care operators strive for a unified team focused on building the practice and delivering an outstanding patient experience. An array of experiences, perspectives, and talents should thus strengthen their organizations. Yet in many workplaces, honest, respectful communication gives way to politics, game playing, and power grabs, with the resulting behavior being "workplace bullying."

If you think that workplace bullying isn't relevant to your urgent care operation, consider these facts:

- 37% of the U.S. workforce—54 million Americans—report repeated abusive behavior at work.
- 41% of Americans say they have been psychologically harassed at work.
- 50% of all workers have missed time from work because of harassing behavior directed at them.
- 70% to 80% of Americans report recurring rudeness and incivility at work.

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- 82% of individuals targeted for workplace harassment leave their jobs.
- Workplace bullying is four times more prevalent than illegal discriminatory harassment.

Sources: Waitt Institute for Violence Prevention, American Psychological Association, the University of Manitoba, and National Institute for Occupational Safety and Health.

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Table 1. Examples of Workplace Bullying

- Intimidating a person through stated or implied threats.
- Spreading malicious rumors or gossip that is not true.
- Excluding or isolating someone socially, such as routinely not including an individual for company events.
- Being short, curt, or impatient with the intention of limiting communication.
- Undermining or deliberately impeding a person's work, such as moving items around, "misplacing" documents, etc.
- Physically abusing, threatening abuse, or appearing to want to commit abuse.
- Establishing impossible deadlines or requirements that will set up the person to fail.
- Withholding training, resources, or time to develop the skills necessary to complete a task.
- Withholding information, omitting from important meetings, or giving out wrong information.
- Yelling, speaking sarcastically, or using profanity.
- Critiquing a person persistently, either one-on-one or in front of others.
- Making accusations of incompetence, despite a history of objective excellence.
- Blocking applications for an individual's training, transfers or promotions.
- Enforcing "policies" inconsistently and creating multiple performance standards that hold one person accountable but not others.
- Taking credit for someone else's work.

Adapted from "Bullying vs. Harassment: Understanding the Physiological, Neurological and Strategic Costs," Scott Warrick, JD, 2011.

Odds are workplace bullying has either occurred or has the potential to occur in your operation and the results can be devastating to employees, patients, and the long-term success of your practice.

What is Workplace Bullying?

Workplace bullying is a form of *repeated aggression* by one or more "perpetrators" upon one or more "targets." Bullying is most often hierarchal (between a supervisor and employee) but can also be lateral (among co-workers) and the bully's actions can be obvious or subtle, verbal or non-verbal .[1] Bullying is driven by the perpetrator's need to control the targeted individual, perpetrators typically co-opt others (either voluntarily or through coercion) in the bullying behavior, and the bully's personal agenda takes precedence over actual work and undermines legitimate business goals. Bullying manifests in the workplace as verbal abuse, offensive conduct or behavior, and work interference (sabotage). **Table 1** provides some common examples.

Who are Bullies and Their Targets?

The vast majority of workplace bullies are bosses (managers, supervisors and medical directors) who are competitive and driven but lack emotional security. Bullies crave power and control, have a sense of superiority due to position but are often unsure of their own abilities, resent the successes of others, and above all are threatened by a co-worker's or employee's show of independence.

While one might believe that the targets of workplace bullying are the same as schoolyard bullying—those who are loners, weaklings, or physically different—actually quite the opposite is true. Targets tend to be the most skilled individual in a workgroup—the "go to" people whose promotion, special recognition, or confidence create envy in bullying supervisors.

Moreover, targets typically refuse to be subservient. This causes a problem for the bully who seeks to separate vulnerable individuals from the group and make them feel bad. When targets take steps to preserve their dignity—their right to be treated with respect—bullies escalate their campaigns of hatred and intimidation, gossiping and cliquishness, to wrest control of the target's work using shame, humiliation, and domineering behavior.

Rarely can bullies be effective on their own—they need the help of others in isolating a target and perpetuating the bullying cycle. That's why bully supervisors use other employees (called "cronies") who will support and build a positive image that the boss is actually a capable, compassionate leader and that the target somehow "deserves" the treatment received.

Impact of Power Differentials in Urgent Care

Medical practices such as urgent care centers are particularly susceptible to bullying behavior because of their hierarchical structure of authority. Not only does academic medical training reinforce a "survival of the fittest" mindset—up to 70% of medical students experience workplace bullying while in medical school—it's also well established that senior nurses frequently "break in" junior staff members.[2] Of particular sensitivity to urgent care operators is the power differential between medical doctors and front-line staff:

Table 2. How Workplace Bullying Creates an "Unhealthy" Workplace

- Increased stress resulting in increased absenteeism and turnover
- Increased body weight, incidence of heart disease and other ailments contributing to higher health care costs
- Increased costs for recruiting, onboarding, and training
- Increased costs for employee assistance programs (EAPs)
- Increased risk of accidents/incidents
- Decreased productivity and motivation
- Decreased morale and employee engagement
- Decreased customer service and diminished patient experience
- Decreased brand image, patient loyalty, and word-of-mouth referrals

Adapted from www.workplacebullying.org/2009/05/04/workplace-bullying-psychological-violence and other sources.

- Medical doctors frequently earn 10 times the pay of front-line staff.
- Medical doctors have significantly more education than their team members.
- The doctor must approve all patient care and is thus the "final authority" (bottleneck) in service delivery.
- Medical doctors have greater social prestige, credibility, and respect from the outside.

These discrepancies can create an environment in which employees are afraid to question, clarify, or correct a physician's request. Patient safety is severely affected by workplace bullying as almost half of all medical support staff surveyed by the Institute for Safe Medication Practices said they would rather keep silent than confront a hostile physician.[3] Bullying compromises the ability of workers to function as a team, diminishes the quality of patient care, and unnecessarily risks patient wellbeing—which could contribute to malpractice lawsuits even further raising the costs of bullying in the workplace.

Workplace bullying affects patients in the health care setting as attention shifts from delivering services to worrying about how one fits in with co-workers, the value placed on one's job by superiors, whether one is compensated or evaluated fairly, and one's future within or outside the organization. This means when bullying is present, not only does a charge entry specialist have to worry about accurately coding the patient visit, but she has to worry whether her boss will berate her work or he/she is gossiping about her in the break room.

Even worse is when bullying behavior occurs in the open—within view of patients. One study cited an example of a hospital patient who witnessed one nurse insult another while administering medication. The patient became afraid the nurse would retaliate if he complained about the incident, knowing that he would be returning for more treatments and had previously experienced a stressed-out nurse improperly inserting a needle. In this situation, not only was workplace bullying taking place but it actually caused the patient to experience feelings similar to a target of workplace bullying.[3]

How Does Workplace Bullying Affect Employees?

Workplace bullying is very damaging because of its repetitive nature, with the average duration of abuse being about 22 months.[4] This means that for a long period of time, targets, co-workers, and patients witness abuse, which leads to an overall unhealthy workplace.

Victims of repeated abusive behavior experience feelings that include shock, anger, helplessness, and vulnerability, as well as inability to sleep, loss of appetite, headaches, and general anxiety related to work. Longer-term, workplace bullying leads to the same health consequences as post traumatic stress syndrome—including heart disease, weight gain, and diminished cognitive capacity. The target's feelings of frustration often are brought home, affecting enjoyment of family and social relationships. Victims become withdrawn, take frequent or extended leaves of absence from work, quit their jobs, or in the most severe cases—commit workplace violence or suicide.

As illustrated in **Table 2**, workplace bullying not only has a direct negative effect on the target but it also has a negative effect on the overall operation. Job turnover can cost 100% to 150% of an employee's annual salary as a result of expenses related to recruiting, onboarding and training, service delivery disruption, and the loss of intellectual capital to competitors. Costs for existing employees escalate as absenteeism and health insurance claims increase and productivity and morale decrease. Because patients are able to notice changes in employees, the practice's image also suffers—reducing the likelihood of repeat business and positive word-of-mouth.

Managers need to know exactly what's occurring on the operation's front-line, but witnesses to workplace bullying start avoiding abusive bosses and forego any communication that may bring a "shoot the messenger" response. To avoid standing out—and becoming targets

themselves—employees buy-in to a "yes man" culture that questions nothing and agrees to everything regardless of how detrimental to the organization's long-term success. Managers begin to lose touch with the day-to-day business, leading to decisions made based upon incomplete or inaccurate information.

What Can Urgent Care Operators Do?

While 37% of those in the U.S. workforce claim to have been victims of workplace bullying and to have reported the incident, studies show that 62% of employers ignore these complaints.[5] One of the likely reasons is that employers do not know how to respond. While bullying is "harassment"—unless it's motivated by a legally protected status such as race, religion, national origin, sex, veterans status or physical disability in which case it becomes a civil rights issue—there is currently no federal law concerning workplace bullying. Likewise, while 21 states have proposed anti-bullying bills since 2003, none have yet to be enacted into law.[6]

Targets who tell their stories often face disbelief from co-workers, bosses, and Human Resources managers, who assume the abuse is "petty" or that the target is just a "problem employee." Many targets are actually blamed for their situations, and because being angry, sad or fearful is simply "not allowed" at work, targets feel imprisoned, powerless, heartbroken, and confused (**Table 3**). Therefore, it is currently up to employers to recognize the importance of creating a bully-free environment and establishing an anti-bullying policy.

An urgent care operation's anti-bullying policy should clearly define what bullying is and give examples of workplace bullying. One way to determine if particular behavior would be considered workplace bullying is to use the "reasonable person" test. Would most people consider the behavior/actions inappropriate?

The policy should list the consequences of instigating or contributing to workplace bullying as well as the responsibilities of both management and employees in taking corrective action. Everyone should sign an acknowledgement form stating that they have been made aware of the policy, will abide by its zero-tolerance standard, and understand that if they are a target of or witness to bullying behavior that they have a responsibility to express their views and concerns.

Having an anti-bullying policy on the books will not completely prevent a workplace bullying situation but acknowledging a problem exists will improve overall communication and circumvent some of the negative consequences of workplace harassment.

Table 3. Typical Employer's Response

There is little a target can do to stand up to the bully on their own. Yet, sadly, the most common response of employers is that they ignore the problem. That could be because 40% of bullied employees never report it to their employers and only 3% file lawsuits.

- Everything the bully does is arbitrary and capricious, working a personal agenda that undermines the employer's legitimate business interests.
- "Bullying" is never called such—to avoid offending the sensibilities of those who have made the bullying possible—but instead euphemisms intended to trivialize the bullying and its impact are used (including incivility, disrespect, difficult people, personality conflict, negative conduct, and ill treatment).
- Human Resources tells the target that the harassment isn't illegal and that the target and perpetrator will have to "work it out between themselves."
- Everyone—co-workers, senior bosses, HR—agree (orally, in person) that the bully is a jerk, but there is nothing they will do about it (and later, when the target asks for their support, they deny having agreed with him/her.)
- The target's request to transfer to an open position under another boss is mysteriously denied.
- Employees eventually leave on their own, are forced out of their positions through unjust and manipulated performance appraisals, or resort to workplace violence.

Adapted from How to Bust the Office Bully: Eight Tactics for Explaining Workplace Abuse to Decision-Makers; Sarah J. Tracy, Jess K. Aberts, and Kendra Dyanne Rivera; Project for Wellness and Work-Life at Arizona State University, January, 2007.

References

1. Workplace Bullying Institute. *http://www.workplacebullying.org.* Accessed January 30, 2012.
2. Stokowski LA. A Matter of Respect and Dignity: Bullying in the Nursing Profession. Medscape. *http://www.medscape.com/viewarticle/729474.* Published September 2010. Accessed January 30, 2012.
3. Vanderstar ES. Symposium on Workplace Bullying: Workplace Bullying in the Healthcare Professions. *Journal of Employee Rights and Employer Policy*. 2004. Chicago; Kent College of Law.
4, Pappas S. Your Bullying Boss May be Slowly Killing You., Live Science. January 12, 2012. *http://today.msnbc.msn.com/id/45973010/ns/today-money.* Accessed January 30, 2012.
5. Tracy SJ, Aberts JK, Rivera KD. How to Bust the Office Bully: Eight Tactics for Explaining Workplace Abuse to Decision-Makers. Project for Wellness and Work-Life at Arizona State University. January, 2007. *http://humancommunication.clas.asu.edu/files/HowtoBusttheOfficeBully.pdf* Accessed January 30, 2012.
6. Healthy Workplace Campaign. *http://www.healthyworkplacebill.com.* Accessed January 30, 2012.

Missing a 'Cancer'

JOHN SHUFELDT, MD, JD, MBA, FACEP

My worst fear: I miss a cancer. Of all the things to miss, I worry about this the most. Miss a myocardial infarction, stroke, or appendicitis and you figure it out quickly because it smacks you right in the face. Conversely, cancer simmers along. A few months or even years go by and everything seems fine, then all hell breaks loose. The symptoms reach epic—if not life-threatening—proportions. Systems fail. No matter what you do, it may be too far gone. The patient goes from seeming well to dying overnight, and you are left wondering what the hell did I miss?

Not long ago I missed a cancer. The jury's still out on the ending but the bottom line is that my poor history-taking, diagnostic skill, and not trusting my gut has led to a potentially fatal outcome affecting all involved. Even if the result isn't death, things won't ever be right again. I have to live with that. The effect it had on everyone involved, the cost, the heavy emotional toll—it all rests on my shoulders and I'll carry it to my grave.

You are probably wondering what type of cancer I missed. Gastric, lung, a glioblastoma? No; if only it were that limiting. I missed the worst type, the most insidious kind of disease. I made a bad hire.

Pathology of a Bad Hire

Bad hires are cancer. You aren't aware of the pathology at the outset. It's hidden. Much like the nodule hiding on the chest x-ray, during the interview, bad hires don't jump up and down screaming, "Don't hire me, I will infect the staff, ruin the culture, and lead to the collective downfall of the department or organization if not quickly eradicated."

In their heart of hearts, bad hires know they are bad hires. Worse, they know how to hide it—for a while. During their interview, they know how to mask their pathology. They smile, ask relevant questions, and may have even researched your organization. They "kiss" your aspirations. They have to fake it or no one would ever hire, date, marry, or befriend them.

John Shufeldt is principal of Shufeldt Consulting and sits on the Editorial Board of *JUCM*. He may be contacted at *Jshufeldt@Shufeldtconsulting.com*.

Within a few months, the "cancer" I hired reared his ugly persona. He was a master at managing up: high-fiving, fist bumping, pet names, he knew all the tricks to ingratiate himself. Behind closed doors, however, he belittled the staff, was arrogant, non-responsive, condescending. He was simply a bully and defined disingenuous behavior. His one "redeeming" quality: He was a puppet and would do whatever his superiors would tell him.

Others missed it for a bit, but after a while, you can't hide the facts. Employees left in droves, patients went elsewhere, once-loyal leaders became bitter rivals, service deteriorated, and it became "just a job" to team members. Unfortunately, he was in a leadership position, and once in place, friction took hold and he became hard to displace. Like Nero, he fiddled while Rome burned. The rest of the staff called him "The Vowels," or "AEIOU and sometimes Y." **A**lways **E**gotistical, **I**gnorant, **O**bstinate, **U**naware and sometimes a **Y**es man.

Jim Collins, reviewing the book *The Rare Find*, by George Anders wrote, "The most important thing a leader can do is to make great hires." Ok, then, I screwed that one up. What did I miss?

How Not to Make a Bad Hire

I have literally hired hundreds of people. Back in the day, I would tell new prospects to meet me at 5:30 a.m. at the base of a mountain that I hiked up four or five times a week. If they showed up, made it up the mountain, and didn't complain or make excuses, they had a foot in the door. I learned a lot about them just from those facts alone. I finally got wise to the fact that this methodology ran contrary to the Americans With Disabilities Act so I switched to behavioral interviews.

Behavioral interviews, at least to me, help you look from the "bottom up" on a resume. I start by looking at "what else" people do. Are they runners? Have they done a marathon? Are they tri-athletes? What have they read? How has it changed their way of thinking or how they approach challenges? Have they gone back to school? What other hobbies do they have? Where have they failed in the past, how did they respond, and how have they changed their approach? Do they demonstrate empathy? In other words, what have they learned? Do they volunteer, play an instru-

ment, mentor? Are they constantly trying to improve themselves? Can they identify their deficiencies? What are they doing to correct them? We all have deficiencies upon which we can improve. The best marker for future success is not "What is the deficiency?" but what someone is doing to improve upon their deficiencies. All these things help you better understand the person sitting in front of you.

Although it's great if someone has been successful on every one of their previous assignments, you really don't learn much about them, (nor they about themselves), from their successes. It may have been pure luck (right place at right time). They may have had others on the team who did most of the heavily lifting. They may be taking credit for accomplishments for which they had little impact. Contrast that with a person who has started a venture that failed or worked tirelessly on a business that only achieved a modicum of success. Given the chance, you can bet that what they learned from that experience will help them (and your business) in the future.

Conclusion

So what did I learn? In the end, persistence and the ability to communicate effectively are the two "must have" traits in people I hire. As Calvin Coolidge said, "Nothing in this world can take the place of persistence. Talent will not; nothing is more common than unsuccessful people with talent. Genius will not; unrewarded genius is almost a proverb. Education will not; the world is full of educated derelicts. Persistence and determination alone are omnipotent. The slogan 'press on' has solved and always will solve the problems of the human race."

Take home points: Trust your gut. Read the resume from the bottom up. Ask the tough questions; go deep to probe beyond the canned answers. Ask why and what did you learn and how will you change your approach in the future?

Great organizations are made up of great people. Finding and retaining great teammates takes a concerted and unrelenting effort. If you persist, your organization will flourish beyond your expecations. But if you let your guard down just once, a bad hire, like an undiagnosed cancer, will slowly destroy your organization. ■

Case Report

When Serious Pathology Masquerades as a Minor Injury

Urgent message: The patient punctured his hand with a power screwdriver. It turned out to be the least of his problems.

FRANK FANNIN, MD, EMT-P

Introduction

Hand Injuries are common and a major concern in urgent care settings as a source of potential significant disability and liability. A detailed history and focused exam are paramount to appropriate treatment and disposition. In the following case, a potentially devastating finding turns out not to be all that it seems. A good assessment and use of resources in this case helps avoid the need for costly and potentially invasive treatment.[1,2]

Case Presentation

BS is a 62-year-old male who presented to the urgent care with pain in his non-dominant hand after a minor injury. The event occurred about 7 hours earlier while he was at home using a power screwdriver. The bit over-penetrated and managed to pass through a hole in BS's glove and into his hand. He stated that he continued to work after the injury, but the discomfort and swelling had increased since then and now extended up into his arm. BS described the feeling as "tight" but with no significant pain per se. There were no concerns with the patient as a historian or in his representation of events. The remainder of the history was found to be unremarkable.

Observations/Findings

Evaluation of the patient revealed the following:

- T: 98.7° F
- R: 16
- P: 72
- BP: 131/86

Frank Fannin is Medical Director of Urgent Care Services at King's Daughters Medical Center in Ashland, Kentucky.

Physical exam revealed a healthy-appearing male in no apparent acute distress or discomfort. His vital signs were noted to be normal and there were no other significant findings outside the area of concern.

The site of injury was noted to be at the base of the first digit and just medial from the midline (**Figure 1**). The wound was small, with a flap noted. There was no significant bleeding and BS related that he never had significant bleeding. Diffuse edema of the hand was obvious (**Figure 2**). BS had good active range of motion with no complaints of numbness or weakness. Upon palpation of his hand, there was mild tenderness, with normal skin appearance and temperature. Gross subcutaneous emphysema was noted over the entire dorsum

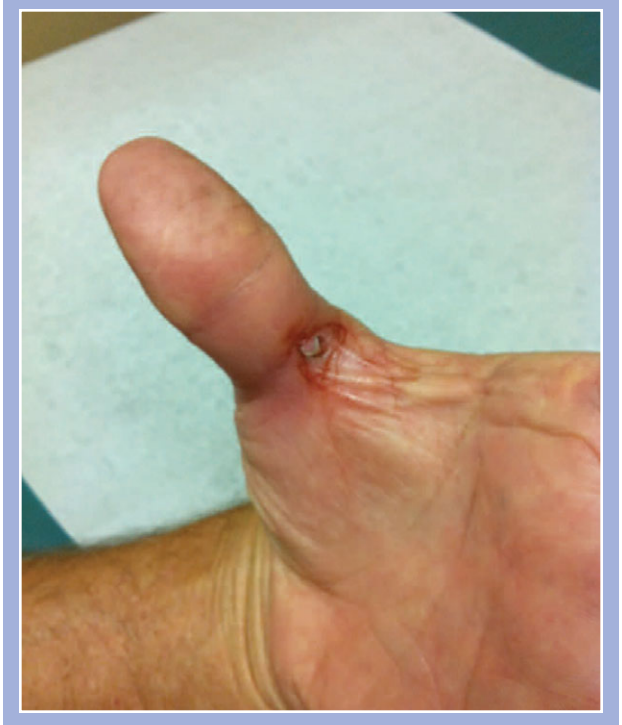


Figure 1. Puncture wound at base of thumb

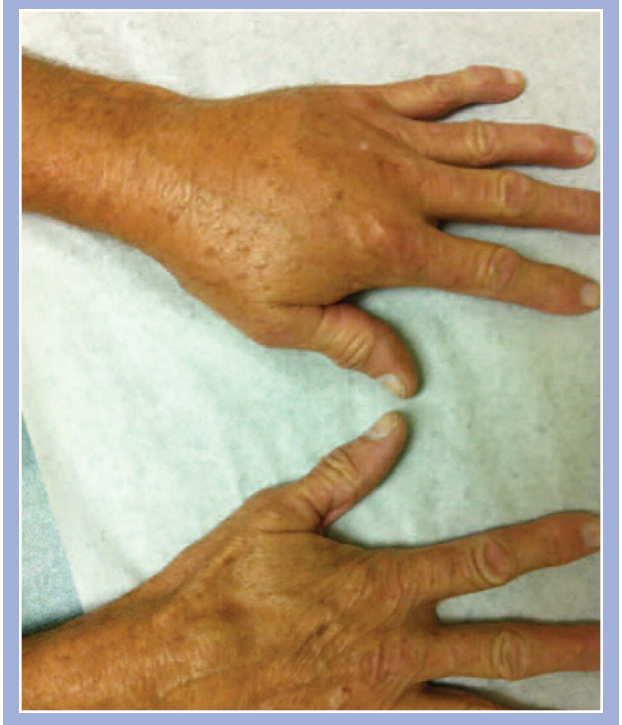


Figure 2. Marked edema of affected left hand

of the hand extending up into the forearm to just proximal to the antecubital fossa. There was no gross tenderness on palpation of the arm or noted discomfort with use of the extremity. No other signs of injury or trauma were appreciated.

Diagnostic Studies

Imaging of the hand revealed neither fractures nor foreign bodies (**Figure 3**). A diffuse pattern of subcutaneous air was noted throughout the hand and proximal wrist. This film was read by radiology as being consistent with significant cellulitis.

Diagnosis

Traumatic subcutaneous emphysema.

Course and Treatment

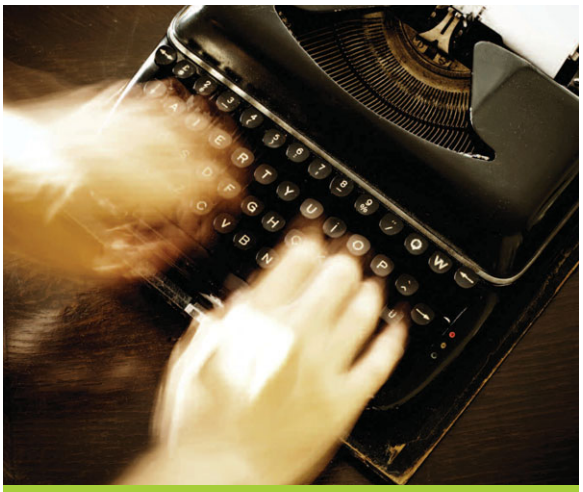
BS's concerning exam and x-ray findings did not fit with his history and overall presentation. The differential for this wound included infectious process and high-pressure injury. The ability to trust in a solid history of events and exam gave us reassurance. It was hypothesized that the wound was a port with the flap acting as a ball valve to allow in and trap air within the compartment of the hand.

The case was discussed with the surgeon on call for hand services, who agreed with our premise. A plan to apply a petroleum-based dressing to the site and wrap with a compressive dressing was undertaken. BS was to follow up in 12 hours with explicit instructions to monitor for spread of crepitus and erythema. He was to go to the emergency department with any concerning changes. His tetanus vaccination was updated and a prophylactic antibiotic regimen was initiated.

BS presented the next day with marked improvement in edema and crepitus, with none noted in the arm and minimal affliction in his hand. By day 3, his symptoms had completely resolved and he was able to return to work without issue, as noted on a follow-up call 2 weeks later.

Discussion

The finding of subcutaneous air in association with injury should always raise concerns for serious pathology, and if needed, aggressive surgical treatment at an appropriate facility.[3-4] A thorough history and focused exam play an important role in directing care of these patients and ensuring the appropriate disposition.



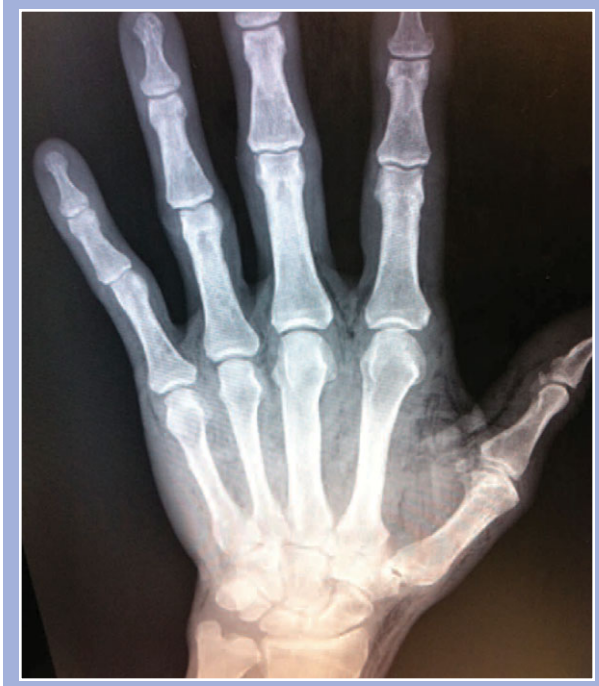


Figure 3. Diffuse subcutaneous air extending proximally from puncture site

In this case, the definitive time of injury and mechanism type, coupled with the absence of systemic symptoms suggestive of an infectious process, helped eliminate the major concerns on our differential. This left our hypothesis about the ball valve mechanism. Even in light of this, an abundance of precaution and education was undertaken because of the nature of the complaint.

In general, hand injuries require a high level of suspicion and a more thoroughly focused exam. In this case, as in most such presentations, the history can have a significant impact on the direction of care. Failure to build a complete picture or to use appropriate resources could have led to a potentially devastating outcome for BS. ■

References

1. Constantine T, Umayya M, Rammal A, et al. Non-infectious subcutaneous emphysema of the hand: a case report and review of literature. *Emerg Med J* 2010; 27(5):383-386.
2. van der Molen AB, Birndorf M, et al. Subcutaneous tissue emphysema of the hand secondary to noninfectious etiology: a report of two cases. *J Hand Surg AM*. 1999;24(3):638-641.
3. Stevens D. Necrotizing infections of the skin and fascia. UpToDate website. Available at: http://www.uptodate.com/contents/necrotizing-infections-of-the-skin-and-fascia?source=search_result&search=Necrotizing+infections+of+the+skin+and+fascia&selectedTitle=1~150. Accessed December 1, 2011.
4. Stevens D, Bryant A. Clostridial myonecrosis. UpToDate website. Available at: http://www.uptodate.com/contents/clostridial-myonecrosis?source=search_result&search=Clostridial+myonecrosis&selectedTitle=1~150. Accessed December 1, 2011.

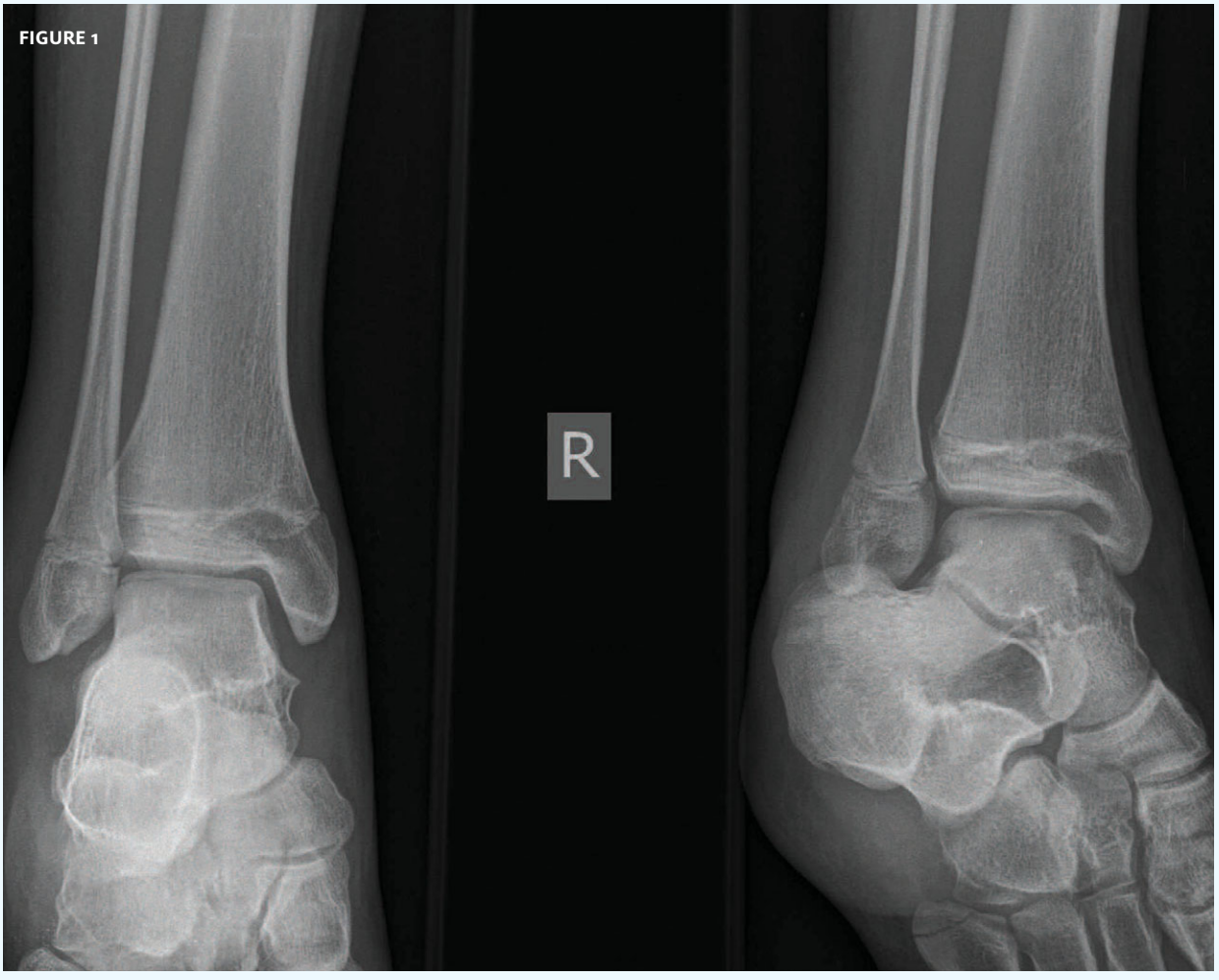
INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 1

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

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

FIGURE 1



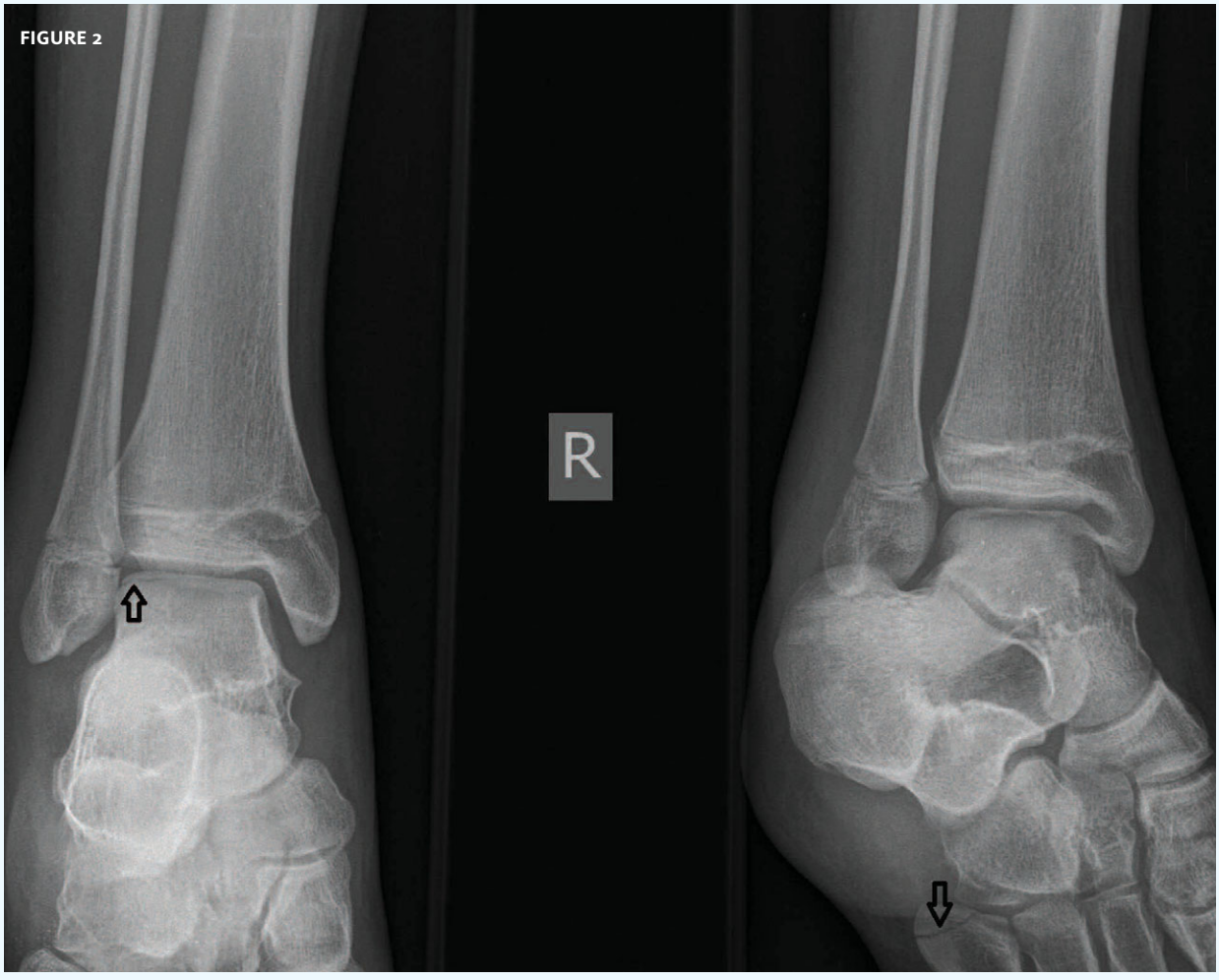
The patient, a 14-year-old male, presented with a twisted ankle and a complaint of difficulty with weight bearing.

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

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2



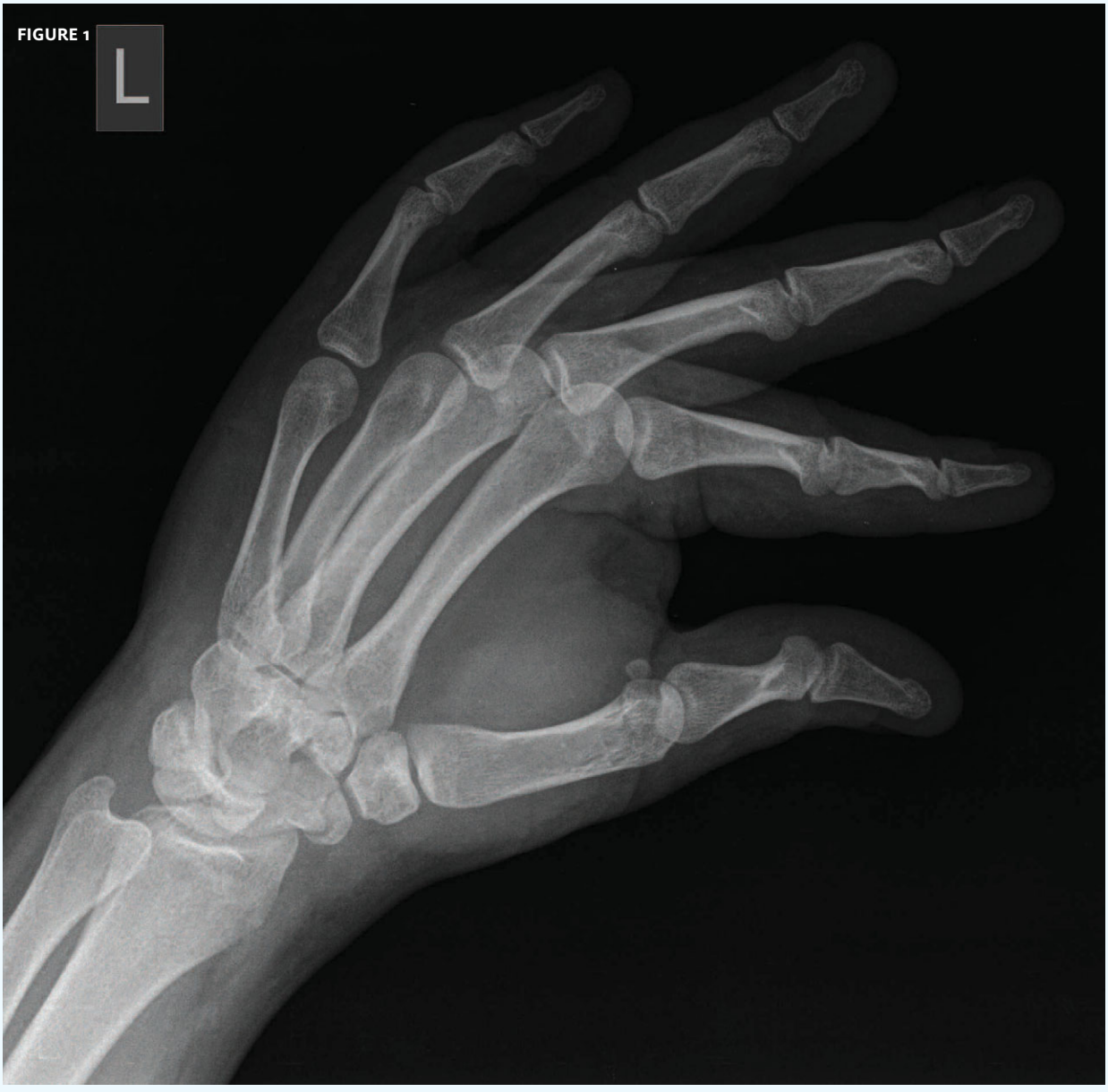
This x-ray demonstrates fractures of both the talus and the base of the fifth metatarsal (arrows). A cast or bracing with a splint, and follow-up with an orthopedist, is appropriate for this patient.

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

INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 2

FIGURE 1



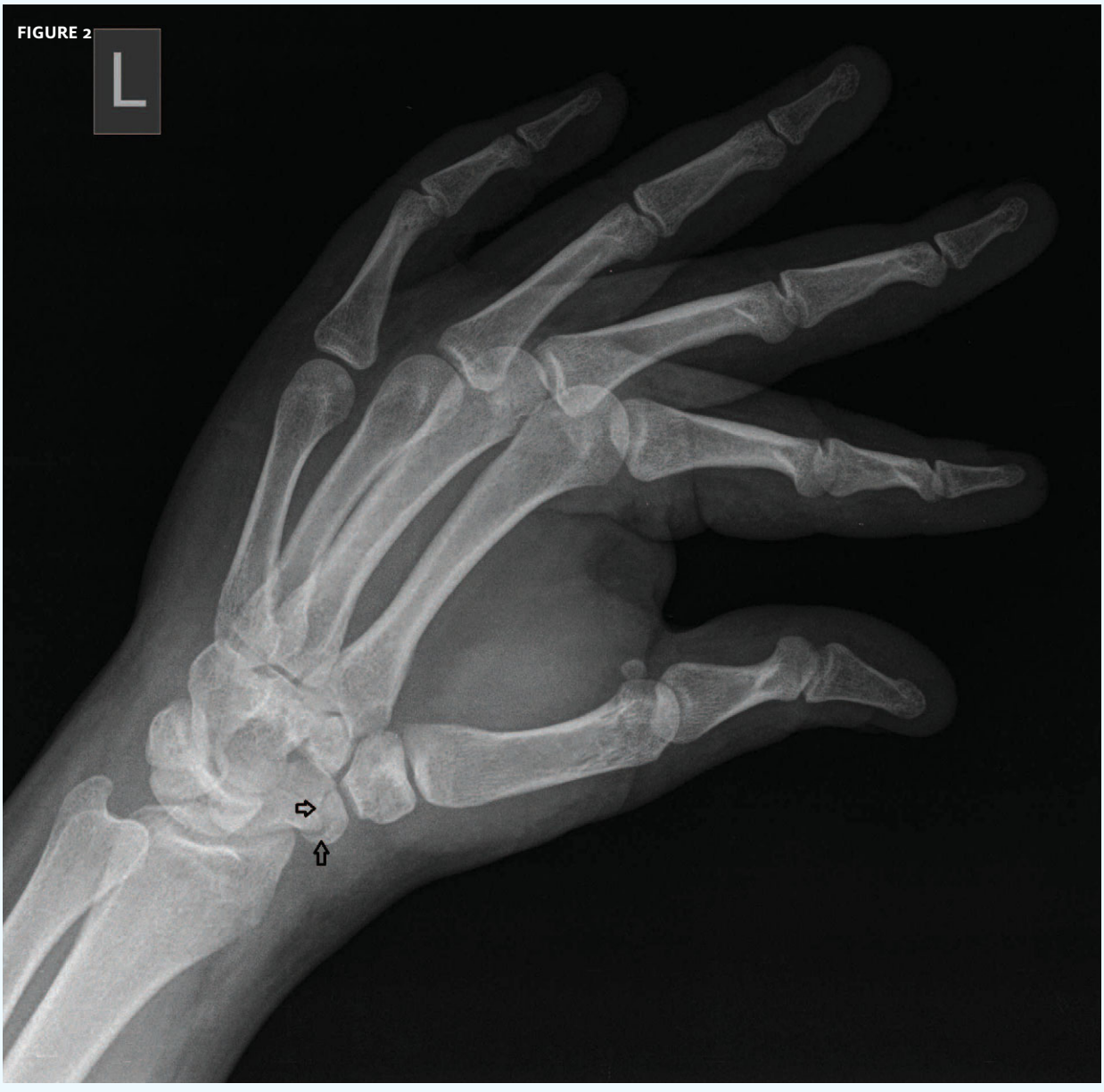
The patient, a 21-year-old female, presented with trauma to her right wrist.

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

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2



The diagnosis is a fracture of the scaphoid (arrows). A spica cast and referral to a hand surgeon for immediate follow-up are indicated for this patient.

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

CODING Q&A

Coding for I&D Follow-Up, R-codes and POS 20, Coding for Compression Bandage

DAVID STERN, MD, CPC

Q. We have so many MRSA (methicillin-resistant *Staphylococcus aureus*) I&Ds (incision and drainage). The follow-ups for changing the packing are numerous and time-consuming, and it feels wrong to have them just included in the global procedure like any other wound check or suture removal. What's the right way to handle this?

- Annie Miranda, Hopewell Junction, NY

A. This is a complicated question. To code these procedures, you can consider using the code for a complicated I&D (10061: incision and drainage of abscess – complicated or multiple). If the incision and drainage (I&D) procedure involves placing a drain or packing, many coders will consider this procedure "complicated." Neither the Centers for Medicare & Medicaid Services (CMS) nor the American Medical Association (AMA) has given specific guidance as to what constitutes "complicated," so this definition is left up to the payor and physician. Many coders believe that this definition of "complicated" is appropriate because the procedure requires a follow-up visit for packing removal and because the abscess often requires replacement of the packing or drain.

This code does carry a 10-day global period. That means that all routine follow-up care (including repacking the abscess) is included in the code. For Medicare patients, all care (including complications) is included in the global package for the initial code. However, AMA defines the global period for CPT codes as only applying to routine follow-up care. Thus, many coders will bill an E/M code for follow-up visits that involve complications, even if the visit occurs during the global period for the initial procedure.

There are other options for accurately coding some incision and drainage procedures that may also compensate your practice for the large amount of work required for these cases:

- **Additional I&D:** If, on recheck, the abscess requires additional incision and drainage, then you could again code 10060 and use modifier -76 (repeat procedure or service by same physician) for the claim with the repeat I&D. Make sure that the physician documents that the abscess requires more drainage. Some payors restricted use of modifier -76 to a repeat procedure performed on the same day as the original procedure. However, this was clarified in the AMA's *CPT Changes 2008: An Insider's View*: "Use of modifier 76 is not restricted to procedures performed on the same day. The repeated service could be surgical or diagnostic, but cannot be an evaluation and management (E&M) service." Note that "both services—the original and the repeat—must be described by the exact same CPT code." (*CPT Changes 2011: An Insider's View*)
- **Regional I&D codes for deep abscesses or hematomas:** If the abscess is "deep," then the provider can use a specific code to code for the procedure. Neither CMS nor AMA has specified what the definition of "deep" is, but the procedure note should clearly indicate the appropriate body area and "deep" tissue layer that was dissected for the I&D. These codes are defined by body area and include for extremities:
  - Upper Arm/Elbow: 23930
  - Forearm/Wrist: 25028
  - Thigh/Knee: 27301
  - Leg/Ankle: 27603 ■

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

CODING Q&A

Q. Why won't some major payors pay for POS code 20 (services rendered at an urgent care facility) for R-codes?
-Myrtle Brooks, Orlando, FL

A. If you are referring to R HCPCS codes, R-codes would probably not apply to POS 20. By definition they occur outside of an urgent care clinic. In addition, these are services that are almost never rendered by an urgent care center. R HCPCS codes are:

- **R0070:** Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen.
- **R0075:** Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen.
- **R0076:** Transportation of portable EKG to facility or location, per patient. ■

Q. Code A4460 (elastic/compression bandage used with lymphatic drainage) was deleted in 2003. In urgent care, what code would I use for a compression bandage given to a patient for foot pain or wrist pain?
- Name withheld

A. You would use one of the following codes:

- **A6448:** Light compression bandage, elastic, knitted/ woven, width less than 3 inches, per yard.
- **A6449:** Light compression bandage, elastic, knitted/ woven, width greater than or equal to 3 inches and less than 5 inches, per yard.
- **A6450:** Light compression bandage, elastic, knitted/ woven, width greater than or equal to 5 inches, per yard. ■

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

WellStreet URGENT • CARE

A message from Lee Resnick, MD, Editor in Chief, JUCM, The Journal of Urgent Care Medicine/Chief Medical Officer, WellStreet Urgent Care.

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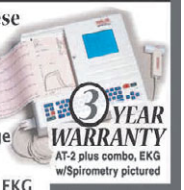

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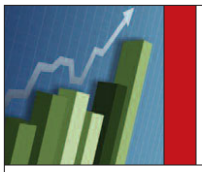


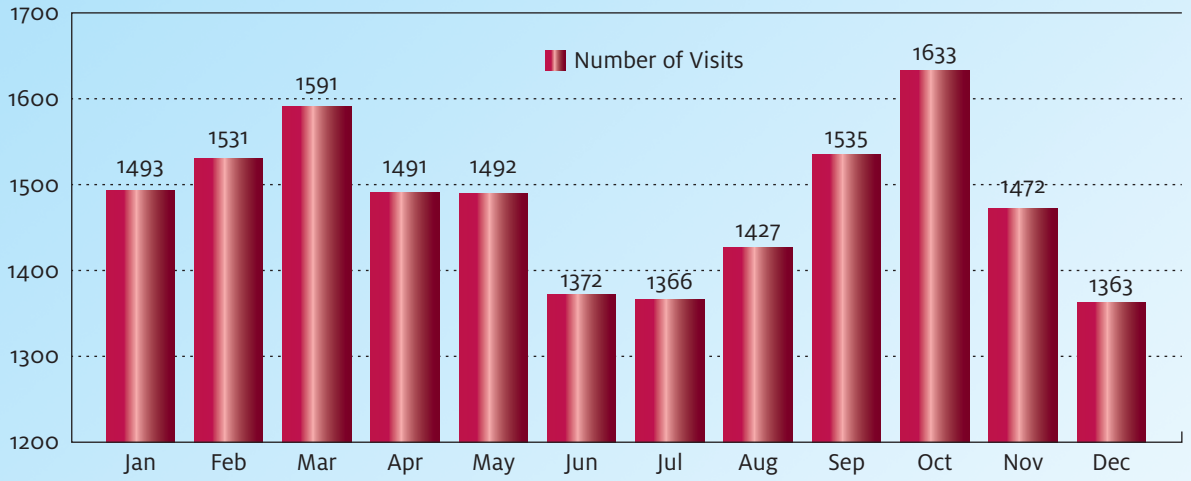
DEVELOPING DATA

These data from the 2010 Urgent Care Benchmarking Survey are based on responses of 1,691 US urgent care centers; 32% were UCAOA members. The survey was limited to "full-fledged urgent care centers" accepting walk-ins during all hours of operation; having a licensed provider and x-ray and lab equipment onsite; the ability to administer IV fluids and perform minor procedures; and having minimal business hours of seven days per week, four hours per day.

In this issue: What is your center's visit flow?

AVERAGE VISITS PER MONTH

The 2010 survey looked more closely at patient volume than the 2008 survey. In 2008, the "mean number of patient visits during the last week" was 314 visits. In the 2010 survey, the comparative number of average visits per week had increased to 342 visits. The visits flow over the months of the year as shown below:



Visits Per Shift Per Day*			
Day of Week	**8 a.m. - 12 p.m. (% visits)**	**12 - 4 pm. (% visits)**	**4 - 8 p.m. (% visits)**
Monday	38.63	28.85	35.21
Tuesday	36.49	29.92	36.66
Wednesday	36.79	29.43	36.53
Thursday	36.51	30.20	36.09
Friday	36.93	29.79	35.72
Saturday	27.89	36.50	28.44
Sunday	42.76	41.96	28.89

**Daily totals equal slightly more than 100% due to excessive reporting by some centers with additional hours beyond described shifts.*

As established in the 2008 survey data, most urgent care centers are open at least 8 a.m. to 8 p.m. on weekdays and 8 a.m. to 7 p.m. on weekends. Using that as the shift basis for per-day visit questions, information was gathered on the 2010 survey on the flow of patient volume, as shown in the table at bottom here. In general, visits are regularly spaced out throughout the weekday in most centers. On weekends, earlier visits are slightly the norm.

Acknowledgement: The 2010 Urgent Care Benchmarking Study was funded by the Urgent Care Association of America and administered by Professional Research Associates, based in Omaha, NE. The full 40-page report can be purchased at www.ucaoa.org/benchmarking.

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