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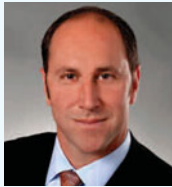


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LETTER FROM THE EDITOR-IN-CHIEF

The ED Utilization Debate: Can a Shell-Game Redirect the Scrutiny?



You might not expect one of our most prestigious medical journals to be susceptible to scientific sleight of hand. But the *JAMA* editorial board apparently fell victim to just that in publishing the latest in a string of self-serving, extraordinarily biased “studies”

supported by the American College of Emergency Physicians (ACEP), entitled “Comparison of Presenting Complaint vs Discharge Diagnosis for Identifying “Nonemergency” Emergency Department Visits.” The study’s objective was to determine if there is concordance between presenting complaint and discharge diagnosis for emergency department (ED) visits. If not, the authors would conclude that discharge diagnosis should not be used as a premise for reimbursement.

The study was a response to efforts by several state legislatures to control Medicaid costs by limiting coverage for inappropriate ED use. Federal agencies’ use of “discharge diagnosis” as the basis for determining need for emergency services has led to the complaint that such a diagnosis is frequently discordant with the presenting complaint and should not be used to determine payment. Led by current and former “consultants” to ACEP, the *JAMA* authors designed a study with limited definitions that ensured that the results would support a predetermined agenda. How did they do that without catching the eye of peer reviewers and *JAMA*’s editorial board? By allowing for only two potential case outcomes: 100% primary care treatable or 100% appropriate for emergency care.

While there are allusions to things like x-rays, “testing” and hours, no specifics are given as to how a case was determined to be 100% primary care treatable. Similarly, no such definitions or alternatives were applied to the “Emergency Appropriate” group. For this study, patients were judged 100% ED appropriate if they had a problem that was not 100% primary care treatable (100% of the time) OR they presented with any complaint deemed emergency appropriate regardless of final diagnosis. Under the predetermined definitions, a case was ED-appropriate if the complaint was ED-reasonable or required x-rays, or “testing”, or was not typically treated in a primary care setting (think lacerations), or there was zero likelihood that the problem could be treated in “primary care.”

Urgent care was completely ignored, despite the fact that it

is the most sensible comparison group given hours of operation, scope of services, and x-ray and lab capabilities. And let’s not forget the specialty’s national presence, representation in nearly every community, and provision of annual visits in numbers that approach those for emergency medicine (EM). The authors concluded that because more than 99% of ED visits are not “100% primary care treatable” and/or present with complaints deemed “emergency worthy” regardless of discharge diagnosis, then any attempt to reduce payment based on these factors is unfounded. Any self-respecting emergency physician would simply giggle at the thought that fewer than 1% of cases could be treated elsewhere in a more cost-effective way.

This is not the first time that data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) have been manipulated for self-serving benefit. In the last year, several studies with ACEP connections have been published that interpret the NHAMCS data as demonstrating that EDs are appropriately used and no cost-savings would be realized with a policy of redirecting care to more cost-effective options. None of these studies have even mentioned “urgent care,” but how can we have a reasonable and honest dialogue about alternative, more cost-effective acute care options *without* a discussion about urgent care’s role?

I personally respect and support our EM colleagues and the critical work they do. I also feel quite strongly that they are underpaid for work that really matters and overpaid for care that can obviously be treated elsewhere more efficiently. To be honest about the issue of appropriate use and distribution of finite healthcare dollars, we must move away from protectionism and studies with predetermined outcomes. No one on this planet can say with a straight face that only 1% of ED visits can or should be treated elsewhere. ■

Lee A. Resnick, MD
Editor-in-Chief

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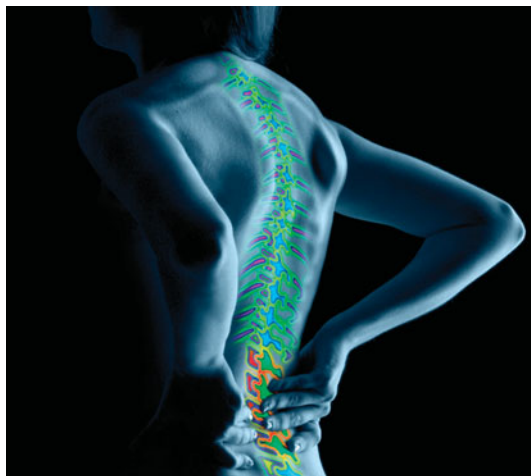
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CLINICAL

9 An Urgent Care Approach to Low Back Pain

To better evaluate and treat patients with low back pain, urgent care providers need a good understanding of the anatomy of the back and they must be vigilant for “red flags” that signal a potentially serious condition.

Shailendra K. Saxena, MD, PhD, Mikayla Spangler, Pharm D, BCPS, and Sanjeev K. Sharma, MD, MBA

PRACTICE MANAGEMENT



17 Establishing Your Online Presence: Website Basics for Urgent Care Operators

Establishing a practice website takes careful planning and execution but it can enhance traditional marketing efforts by providing a central repository of relevant information for prospective patients.

Alan A. Ayers, MBA, MAcc

CASE REPORT

25 A Slowly Healing Leg Wound

Clinical suspicion of CA-MRSA should be high for any skin wound or soft tissue infection with delayed healing, abscess, or persistent cellulitis.

Ralph S. Bovard, MD, MPH, and Anne Reiner, MD, MPH



IN THE NEXT ISSUE OF JUCM

Musculoskeletal complaints account for about 10% of all urgent care visits and pain in the knee—the largest hinge joint in the body—is common. Younger, athletic individuals will present with pain because of overuse syndromes, high-energy injuries and relatively weak growth plates whereas chronic conditions are more likely the cause in seniors. In urgent care, knee pain cases tend to be acute, which requires that a provider consider a vast differential and rule out limb-threatening conditions.

Next month's cover story offers a template for urgent care providers on how to evaluate knee pain, from aspects of a thorough history through key steps in physical examination and testing of the knee, to review of common injuries and causes, to appropriate steps for workup and management.

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

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Low back pain is reportedly the second most common reason for office visits in the United States, with a lifetime prevalence as high as 84%.

The typical patient with such a complaint is aged 20 to 40, but low back pain can affect individuals at any age. For the urgent care provider, the challenge is to manage low back pain effectively while limiting diagnostic evaluations and providing a patient with adequate conservative treatment. Understanding of the complex anatomy of the back is crucial, as is vigilance in spotting red flags associated with pain that may point to a need for further work up and referral to a spine specialist. In this month's cover story, Shailendra K. Saxena, MD, PhD, Mikayla Spangler, Pharm D, BCPS, and Sanjeev K. Sharma, MD, MBA, offer a comprehensive review of evaluation and treatment of low back pain and red flags associated with it.

Dr. Saxena is an Associate Professor in the Department of Family Medicine, Creighton University School of Medicine, Omaha, NE, and a member of the JUCM Editorial Board. Dr. Spangler is an Assistant Professor in the Creighton University School of Pharmacy and Health Professions and School of Medicine, Department of Family Medicine. Dr. Sharma is an Associate Professor in the Department of Family Medicine at Creighton University School of Medicine.



The need for urgent care providers to remain vigilant and to challenge diagnoses to avoid complacency in the treatment of "common" problems is

underscored by authors Ralph S. Bovard, MD, MPH, and Anne Reiner, MD, MPH in this month's case report. The patient was a 48-year-old man who had injured his posterior lower leg 2 weeks previously and presented with swelling of the posterior ankle. The clinical course was suggestive of a slowly healing, superficial leg

wound. But the ultimate diagnosis was community-acquired methicillin-resistant *Staphylococcus Aureus* wound infection.

Dr. Bovard is a staff physician in the Department of Orthopedics & Sports Medicine, University of Minnesota Physicians, Minneapolis, MN. Anne Reiner, MD, MPH, is a resident in the Occupational Medicine Program at HealthPartners Medical Group, St. Paul, MN.

For urgent care centers today, a website and online presence are essential to reaching prospective patients. In this month's practice management article, Alan A. Ayers, MBA, MAcc, provides a step-by-step guide to establishing a practice website, from purchasing a domain name and website hosting to design and build to testing, marketing, and maintenance. The process takes careful planning and execution but the result for an urgent care provider is a central repository of relevant information for patients and an enhanced marketing presence.



Alan Ayers is Content Advisor, Urgent Care Association of America, Association Editor—Practice Management, *Journal of Urgent Care Medicine*, and Vice President, Concentra Urgent Care.

Also in this issue:

In the first part of a two-part series, **John Shufeldt, MD, JD, MBA, FACEP**, describes what happens when a medical malpractice suit goes under way.

Nahum Kovalski, BSc, MDCM, reviews new abstracts on literature germane to the urgent care clinician, including studies of ondansetron and pregnancy and NSAIDs and acute kidney injury in dehydrated children.

In Coding Q&A, **David Stern, MD, CPC**, discusses mid-level providers, resident providers, non-payment for S9088, nonpayment for E/M 99205, and POS -20 for Family Practice.

Our Developing Data end piece this month looks at the usual services provided in an urgent care center. ■

To Submit an Article to JUCM

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

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

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

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It's a Great Time to be in Urgent Care!

■ NATHAN NEWMAN, MD, FAAFP

Urgent care centers meet an enormous need for delivery of healthcare in our country's communities. Let's examine the market landscape:

Emergency rooms (ERs) are overextended. The number of ER visits continues to climb and there are fewer ERs today than 20 years ago. A main cause of overcrowding in the ER is care of patients with non-emergent conditions. Average wait times in the ER remain at 4 hours. And the cost to our system is somewhere between \$7 billion and \$28 billion, which is too much.

Our primary care colleagues are not increasing their numbers fast enough and the expectation is a deficit of 45,000 in PCPs by the year 2020. And only 57% of patients with PCPs have same-day or next-day access, whereas 63% have difficulty getting night, weekend, and holiday care except from the ER.

Urgent care centers offer a convenient, cost-effective alternative with great patient satisfaction. That's precisely what drew me into the wonderful world of urgent care medicine. As a Family Physician, I remember how great it was to evaluate acute medical issues in between chronic care patients. You weren't pressed to discuss the complete problem list issues AND their acute needs, all in about 15 minutes. And performing minor surgical procedures and casting was enjoyable.

I remember how exciting it was to have my own practice, but how many questions I had during the managed care days of "HillaryCare." Where did those rules come from? Who was deciding our patient's care from afar? I decided to get involved. I wanted to be at the table where the decisions were being made.

We find ourselves at a similar crossroads now. The Affordable Care Act (ACA) is 3 years old. It seems like we have been in a perpetual "wait and see" mode.

First, was it going to be a law? Would Congress pass it?

Second, was it going to stay a law? What was the Supreme Court going to do?

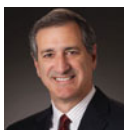
Then, who was going to win the election and would the law remain intact?

Now the ACA is a reality. How will its implementation affect our patient flow? Most experts feel that urgent care centers will see more footsteps in the door in 2014.

UCAOA is evaluating programs, tools, and resources that will help you navigate the changes going forward. We will offer educational opportunities to learn about new methods of reimbursement being discussed and piloted in some areas, new health information technology programs that can add efficiency to your centers and help drive business to your doors. Our educational resources will be focused to raise the level of understanding, be functional for practices of all sizes, and ultimately allow our members to have access to an up-to-date knowledge base from which they can make informed decisions that are important to their individual practices.

On the legislative front, we want to be at the table. We have contracted with Summit Health Care (SHC), a consulting firm located in Washington, D.C. SHC specializes in government relations and healthcare policy advocacy for professional healthcare associations. We have a voice — and we want to get in front of legislators and regulatory bodies that are looking for innovative and efficient healthcare delivery systems.

It is my honor and privilege to work with your UCAOA team. I look forward to serving you and moving UCAOA and urgent care front and center of all discussions of best-in-practice healthcare solutions for this country and internationally. ■



Nathan Newman is president of the Urgent Care Association of America. He may be contacted at info@ucaoa.org.

Nathan Newman, MD, FAAFP
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An Urgent Care Approach to Low Back Pain

Urgent message: To better evaluate and treat patients with low back pain, urgent care providers need a good understanding of the anatomy of the back and they must be vigilant for “red flags” that signal a potentially serious condition.

SHAILENDRA K. SAXENA, MD, PHD, MIKAYLA SPANGLER, PHARM D, BCPS, and SANJEEV K. SHARMA, MD, MBA

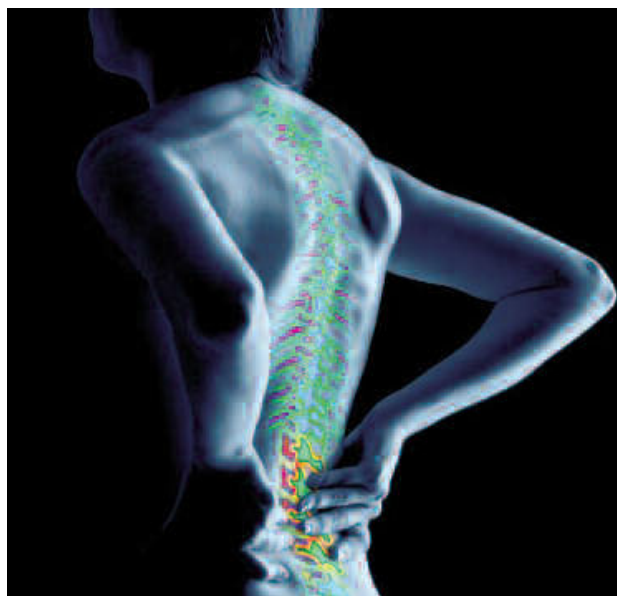
Introduction

Acute low back pain is a common condition often seen by urgent care providers. An episode of acute low back pain is usually of short duration and many patients will recover without any therapeutic intervention. The challenge for a provider is to manage low back pain effectively while limiting diagnostic evaluations and providing adequate conservative treatment. At the same time the provider needs to be vigilant about red flags associated with low back pain that may require further work up and referral to a spine specialist. This article is a comprehensive review of evaluation and treatment of low back pain and red flags associated with it. It should be noted that red flags may not necessarily indicate serious pathology, but providers should rely on a comprehensive clinical approach to evaluation of the condition.

Incidence and Anatomy of Low Back Pain

Lifetime prevalence of low back pain is as high as 84%, and it is reported to be the second most common reason for office visits in the United States.¹ Most patients are likely to experience one episode of low back pain

Shailendra K. Saxena is an Associate Professor in the Department of Family Medicine, Creighton University School of Medicine, Omaha, NE. **Mikayla Spangler** is an Assistant Professor in the Creighton University School of Pharmacy and Health Professions and School of Medicine, Department of Family Medicine. **Sanjeev K. Sharma** is an Associate Professor in the Department of Family Medicine at Creighton University School of Medicine.



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during their adult lives.² It can affect individuals at any age, but it is most often seen between ages 20 and 40, with an equal gender distribution.²

The anatomy of the back is complex. To understand the pathophysiology of low back pain, a thorough knowledge of the anatomy is necessary.

A typical vertebra consists of a vertebral body, a vertebral arch and seven processes (a spinous process, two transverse processes and four articular pillars).³ The

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

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INDICATION

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

ADJUNCTIVE MEASURES

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

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

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

IMPORTANT SAFETY INFORMATION FOR SKLICE LOTION

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

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

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

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

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

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

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

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Brief Summary of Prescribing Information

Rx Only

1 INDICATIONS AND USAGE

1.1 Indication

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

1.2 Adjunctive Measures

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

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

2 DOSAGE AND ADMINISTRATION

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

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

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

Avoid contact with eyes.

4 CONTRAINDICATIONS

None.

5 WARNINGS AND PRECAUTIONS

5.1 Ingestion in Pediatric Patients

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

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

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

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

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category C

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

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

Human Data

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

Animal Data

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

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

8.3 Nursing Mothers

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

8.4 Pediatric Use

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

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

8.5 Geriatric Use

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

10 OVERDOSAGE

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

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

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Sanofi Pasteur Inc.
Swiftwater, PA 18370

Manufactured by:
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129685

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

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Table 1 . Signs Associated with Systemic Disease

History of cancer
Age >50 years
Unexplained weight loss
Pain duration >1 month
Nighttime pain
Pain unresponsive to previous therapies
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Table 2. Social and Psychological Stresses Leading to Low Back Pain⁵

Anxiety
Depression
Job dissatisfaction
Somatization disorder
Low educational attainment
Psychologically strenuous work

Table 3. Red Flags to Recognize in Patients with Low Back Pain⁶

Recent trauma
Unexplained weight loss
Unexplained fever
Immunosuppression
History of cancer
IV drug use
Osteoporosis, prolonged use of glucocorticoids
Age >70 years
Focal neurologic deficit or disabling symptoms
Pain duration >6 weeks
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intervertebral disc is interposed between the vertebral bodies. The outer ring of the disc is fibrocartilage (annulus fibrosus) while the central core is fleshy (nucleus pulposus). Herniation or protrusion of the nucleus pulposus into or through the annulus fibrosus and compressing the nerve roots is a well-recognized cause of low back pain (Sciatica). The laminae of adjacent vertebral arches are joined by the yellow ligament, the ligamen-

tum flavum, which assists with straightening of the vertebral column after flexing. Hypertrophy of the ligamentum flavum is another common cause of low back pain (lumbar stenosis).

Several ligaments and extrinsic and intrinsic back muscles are attached to the spinous and transverse processes. They are necessary to support and move the vertebral column. Minor sprains of these ligaments and muscles are also a common cause of low back pain (muscle sprain). The spinal nerve roots of the lumbar and sacral spinal nerves are the longest and descend in the lumbar cisterns before exiting through the intervertebral foramina. Compression of these nerve roots may cause low back pain and saddle anesthesia in the perineum (Cauda Equina Syndrome).

Preparation for Clinical Evaluation

Acute low back pain often is non-specific but urgent care providers should nonetheless be prepared to take a detailed history aimed at identifying specific causes, especially those associated with systemic and anatomical pathology. They should look specifically for signs and symptoms associated with systemic diseases (Table 1), social and psychological stresses (Table 2), and risk factors that may be contributing to a patient's low back pain. In addition, red flags (Table 3) that may be indicative of a serious cause of low back pain also should be evaluated.

Evaluation of Symptoms and Correlation with Anatomy

Patient evaluation begins with characterization of the pain (Table 4) to establish the diagnosis. It should be noted that before presenting in the urgent care setting, many patients will have already tried non-steroidal anti-inflammatory (NSAID) medications and heat or cold packs. Patients often report pain radiating to the leg (radiculopathy) but pain radiating below the knee is a more important sign of true radiculopathy than that radiating to the thigh.⁷

Physical Examination

Physical examination of the back should be an important part in the evaluation of low back pain. Inspection of the back should be done to look for rash (Herpes Zoster), scoliosis or asymmetry of muscle mass and tone (muscle spasm). It may be possible to elicit point tenderness (compression fracture) or costovertebral angle tenderness (urinary tract infection/pyelonephritis). Most patients may be unable to perform movements of the spine. Attempts should be made, however, to check spinal movement

Table 4. Characterization of Low Back Pain

Is it gradual or sudden?
What is the duration of pain?
What is the severity of the pain?
Where does it hurt?
When does it hurt?
How does activity affect the pain?
Does the pain radiate?
What relieves the pain?
Is pain associated with a rash?

Table 5. Differential Diagnosis as per Pain History

<ul style="list-style-type: none"> Dull or sharp shooting lower back pain Symptoms worsen when patient sits or stands for extended periods Pain increases with coughing or sneezing Pain radiates down the leg Pain increases with forward flexion of the spine Leg pain is greater than back pain Usually unilateral 	Herniated Disc
<ul style="list-style-type: none"> Dull, aching lower back pain Pain increases with standing and walking Pain improves with rest and forward flexion of spine Pain may be unilateral or bilateral 	Spinal stenosis
<ul style="list-style-type: none"> Diffuse back pain with or without buttock pain Pain increases with movement Pain improves with rest Pain does not radiate to leg 	Lumbar strain/sprain (muscular)
<ul style="list-style-type: none"> Diffuse lower back pain Bladder or bowel incontinence Urinary retention Saddle anesthesia Progressive motor or sensory loss 	Cauda Equina Syndrome
<ul style="list-style-type: none"> History of trauma or osteoporosis Point tenderness Pain increases with flexion of spine Pain increases with change in posture from supine to sitting or from sitting to standing position 	Compression fracture
<ul style="list-style-type: none"> Gradual onset of low back pain in early adolescents Pain located at the center of the spine Pain increases with backward bending (extension) and remits with rest Pain may extend into the buttocks and posterior thigh 	Spondylolisthesis/spondylolysis/spondylosis

(whatever possible) to determine whether pain is related to vertebral discs (pain in forward movement), spinal stenosis (pain in backward movement) or related to mus-

Table 6. Signs and Symptoms of Nerve Root Compression

L3 and L4	<ul style="list-style-type: none"> Decreased strength in quadriceps (unable to perform extension at the knee) Unable to squat and rise Diminished knee jerk Numbness (dysesthesias) over thigh/knee
L5	<ul style="list-style-type: none"> Decreased strength in extensor hallucis longus muscle Inability to do heel walking Inability to do dorsiflexion of great toe and foot Numbness over big toe and medial foot
S1	<ul style="list-style-type: none"> Decreased strength in toe flexors Inability to do plantar flexion of great toe and foot Inability to walk on toes Numbness over fifth toe and lateral foot Diminished ankle jerk
S2-S4 (Cauda Equina)	<ul style="list-style-type: none"> Progressive motor or sensory deficit New onset bowel and bladder dysfunction Numbness over perineum (saddle dysesthesia) Loss of anal sphincter tone

Table 7. Laboratory Tests to Consider in Evaluation of Low Back Pain*

Erythrocyte sedimentation rate
C-reactive protein
White blood cell count*
*Use these blood tests only when the history and physical exam indicate the potential for an infectious, autoimmune, or systemic cause.

cle spasm (pain in all movements).

A straight-leg raise (SLR) test—also known as Lasegue's sign/test—should be performed to determine whether disc herniation is the cause of low back pain. With the patient supine position on the table and the uninvolved knee bent to 45°, the provider should hold the involved leg straight, hold the heel with the other hand in the dorsiflexed position, and gently raise the leg. The SLR test is positive if the patient has pain in the distal leg with leg elevation between 30° and 70°. A crossed SLR also should be performed. The test is positive when the physician lifts the unaffected leg and the patient has pain that radiates below the knee in the affected leg.² All efforts should be made to determine the site of nerve root compression in the lumbar area (Table 6). However, it should be noted that the value of these tests declines with advancing age.

Laboratory and Radiographic Testing

Patients with low back pain of less than 6 weeks' duration should be treated conservatively unless red flags are present.⁶ Imaging is not warranted for most patients with acute

low back pain. Without signs and symptoms indicating a serious underlying condition, imaging does not improve clinical outcomes in these patients. For even patients with a few of the weaker red flags, 4 to 6 weeks of treatment is appropriate before imaging studies are considered. Several laboratory studies and radiographic tests, however, can be used to evaluate low back pain. Tables 7 and 8 list these studies and tests but urgent care providers are advised to consult published guidelines to determine when they are appropriate for a particular patient.^{8,9}

Management

Numerous treatments have been recommended for acute low back pain. Each has its own merits and demerits. It is, however, good news for urgent care providers to know that the prognosis for acute low back pain is excellent and up to 90% of patients will improve on their own.⁹ Treatment protocols for acute low back pain are summarized in Table 9.

Discussion

Acute low back pain that is uncomplicated (i.e., no red flags)

Table 8. Considerations for Radiographic Testing in Low Back Pain

Plain x-rays	<ul style="list-style-type: none"> Used to evaluate for fracture, malignancy, degenerative changes, disc space narrowing and prior surgery Usually has little diagnostic value because of its low sensitivity and specificity
Magnetic resonance imaging (MRI)	<ul style="list-style-type: none"> Without contrast is recommended Used to evaluate disc herniation, spinal stenosis, osteomyelitis, spinal epidural abscess, bone metastases and neural tube defects Clinical correlation of MRI findings is essential because the likelihood of false-positive results increases with age
Computed tomography (CT) scan	<ul style="list-style-type: none"> CT is superior to MRI for detection of bony abnormalities, fractures, abnormal facet joints, degenerative changes, and congenital abnormalities CT is also superior to plain x-rays to detect changes in sacroiliac joints of ankylosing spondylitis
Myelogram	<ul style="list-style-type: none"> Not routinely recommended Used to evaluate multiple disc abnormalities, multilevel radiculopathies or previous lumbar surgery

is a self-limiting condition that does not require imaging or laboratory studies. In our opinion, urgent care providers



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 - Easy application process
 - Risk Mgmt/Educational support
 - Fast turnaround on policy changes
 - Rapid response claim service

Table 9. Treatment of Acute Low Back Pain

Bed rest and modification of physical activities	<ul style="list-style-type: none"> • Bed rest used to be the standard of care for acute low back pain. Early ambulation, modification of physical activities, and return to normal activities are now known to produce better outcomes.¹⁰ • Return to work recommendations should be individualized.¹⁰
NSAIDs	<ul style="list-style-type: none"> • Symptoms of low back pain were improved with NSAIDs compared to placebo after 1 week.¹¹ • Recommended for 2-4 weeks • Physicians should be aware of the nephrotoxicity and GI toxicity associated with NSAIDs¹¹
Muscle relaxants	<ul style="list-style-type: none"> • Muscle relaxants are more effective than placebo.¹² • A combination of a muscle relaxant and an NSAID provides effective symptom control • Muscle relaxants are associated with dizziness and sedation.¹² • Muscle relaxants may be abused.
Opioids	<ul style="list-style-type: none"> • Misuse and abuse are common with opiates.¹³ • Use should be short term and based on clinical judgment. • Opioids may only be used at bedtime to limit side effects.
Glucocorticoids	<ul style="list-style-type: none"> • A short course of oral corticosteroids has not been shown to benefit patients with radicular leg pain.¹⁴ • A bolus dose of intravenous methylprednisolone has shown transient pain reduction with radicular leg pain.¹⁵ • The American College of Physicians and the American Pain Society do not recommend the use of systemic glucocorticoids because of the lack of significant benefit over placebo.¹⁶
Exercise and physical therapy	<ul style="list-style-type: none"> • Results are conflicting regarding the significance of early physical therapy.¹⁷ • Exercise and physical therapy may help to prevent recurrence of low back pain.
Cold and heat	<ul style="list-style-type: none"> • There is no evidence that cold or heat benefits low back pain¹⁸
Patient education	<ul style="list-style-type: none"> • Patient education is necessary and important in improving outcomes.

need a good understanding of the anatomy of the back to better evaluate and treat patients with acute low back pain. They should also be vigilant to note red flags associated with a patient's low back pain.

Besides the treatments mentioned in table 10, many other strategies have been recommended for acute low back pain. These include spinal manipulation, massage and yoga, acupuncture, traction, and braces.¹⁹ Unfortunately, none of these has been shown to improve back pain significantly over placebo. Epidural steroid injections also have been used to treat low back pain but. However, they have only been shown to improve symptoms for a short duration and have not been shown to be more effective than systemic corticosteroids.^{20,21} In conclusion, it appears that short-term treatment with nonsteroidal anti-inflammatory drugs with or without muscle relaxants and patient education are key in the management of acute low back pain in urgent care. ■

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Practice Management

Establishing Your Online Presence: Website Basics for Urgent Care Operators

Urgent message: Establishing a practice website takes careful planning and execution but it can enhance traditional marketing efforts by providing a central repository of relevant information for prospective patients.

ALAN A. AYERS, MBA, MACC

When consumers experience a minor illness or injury, numerous questions arise, such as “What do these symptoms mean?” “Can I do something about this myself?” and “What kind of help do I need, where do I get it, and how much will it cost?” Increasingly, people are turning to the Internet for answers. In fact, with so many consumers “connected” via smart phones and tablets, utilization of the Yellow Pages and other traditional media has waned. The Internet can instantly point prospective patients to relief and your urgent care center should be part of their consideration.

If your urgent care center doesn’t have a website that appears in major search engines, you could be missing out on potential patients. Even awareness that comes from seeing an urgent care center’s sign, participating in a community event, or hearing positive word of mouth must be reinforced at a time of need in order to spur utilization. The following steps will support your marketing efforts by demonstrating how to build a website from start to finish while also raising awareness of your website and online presence.

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Purchasing a Domain Name and Website Hosting

1. Brainstorm Potential Website Address (Domain Name) Choices

The first step in building a website for your urgent care center is to determine what your website’s address (also known as a URL or domain name) will be. A domain name is an address for the Internet and it helps potential patients discover your website. If you

haven't determined the name of your urgent care center yet, researching available website addresses beforehand is a good idea. Law governing trade names does not necessarily prevent someone from registering your business name as a domain, so if this has occurred, your website address may end up being different than the name of your center.

An initial brainstorming session will help you come up with potential options. Here are some best practices for a domain name to keep in mind when considering website address choices:

- Ideally the domain name should be the same as your urgent care center's name so that a consumer can easily "guess" the URL. For instance, if the name of your center is "Provo Urgent Care," use www.provourgentcare.com as your domain.
- Make the domain name memorable yet relevant. It should reflect the nature of walk-in services offered at your center.
- Keep the domain name as short and simple as possible. Shorter domain names are easier for people to remember and to share, and there is less chance of users mistyping.
- A domain name can consist of letters, numbers, and hyphens (although use of only letters is recommended because numbers and hyphens can be confusing when sharing your website address with people). Spaces or other symbols are not allowed.
- Create a list of all of your ideas, starting with your first choice, second choice, and so on.

2. Check Domain Name Availability & Purchase Domain Name

Once you have a list of all the potential domain names for your urgent care center's website address, the next step is to check if the domain name is available for purchase. There are many websites that you can use to check domain availability including www.networksolutions.com, www.godaddy.com, www.1and1.com, and www.hostgator.com. Many of these sites will ask if you want a domain name ending with a .com, .org, .net, .info, and other extensions. A website ending in .com (which stands for "commercial") is the most common for business and is what you'll want to purchase for your center. Using the .org, .net, etc. extensions will likely confuse consumers who presume your website is a "dot-com" and mistype, ending up on someone else's webpage.

To check the availability of a domain, enter the desired domain name into the search box of the web-

sites previously and hit "search." If your potential domain names aren't available, it's time to get a little creative to come up with unique alternatives. You can try:

- Rearranging the word order
- Using abbreviations
- Adding location-specific words
- Adding a prefix
- Adding a suffix (urgentcarecentral.com)

For some ideas on prefixes and suffixes, visit: www.daillyblogtips.com/200-prefixes-and-suffixes-for-domain-names.

Once you've found an available domain name that you like, you can purchase a license to use the domain. The minimum subscription is typically 1 year, but discounts are offered for longer periods of time.

3. Purchase Website Hosting

After securing your domain name, you'll next need to purchase website hosting. Web hosts are companies that provide space on their servers for use by many different customers who choose to not make the substantial investment of buying and maintaining their own web servers. If the domain name can be likened to an "address" directing people to your website, hosting provides the online "space" for all of your web pages, including files, images, videos, and other media associated with your website.

Typically the same companies that license domain names also offer website hosting. Vendors typically bundle hosting with tools and resources to help build, enhance, and manage your website including easy-to-use website builders, a free email address for your domain, transaction processing, and more. When you purchase your domain name, usually the vendor will proceed to ask if you want to purchase hosting as well. For simple websites, usually the basic package will meet your center's needs. Also, discounts usually are available if you purchase hosting services for a long time period.

Designing Your Website

1. Planning the Website Content

Remember the main reason for having a website is for current and new patients to come across your center when searching the Internet. Patients may be searching for a particular piece of information, whether it's your center's hours, phone number, physicians at your facility, insurance accepted, or conditions treated. So you'll want to plan your website pages accordingly.

The best way to think of a website is as a place to put



*When I started my Urgent Care Center,
2 bucks a visit for my EMR & billing seemed great.
But now that we've grown so much,
they're eating my profits.*

EMR fees pinching *your* profits?

Give us a call for a cost comparison!

- Our fees are user-based and predictable.
- Our EMR sprints.
- Our service excels.



Cut time, boost profits!

all information related to your center that may be subject to change. As your center grows, you may add providers, extend hours, or expand your service mix—you'd hate to place printed marketing materials in consumers' hands (sometimes tucked away for years) with incorrect information. Include the basics—center name, address, phone, and core services—in your printed materials along with your website address and consumers who want additional information will always be able to find it by visiting your website.

Before jumping right in, though, take some time to visit the websites of local competitors and larger multi-location providers to start gathering ideas on what you like and dislike about their websites. Some items to take note of:

- What type of information does the website include?
- How is the content organized?
- How many pages do they have?
- What types of visual images or multimedia assets are used?
- What type of additional features did you like or dislike?
- What are your thoughts on the colors, fonts, etc...?
- How quickly did the website load and did it function correctly?

Spending time studying “best-in-class” websites will give you plenty of ideas and a head start on planning your own website.

2. Create Mockup Website

Regardless of whether you decide to build your website on your own or hire a third party, you'll need to have a good idea of the design and content. Remember that a website is a collection of related information organized in a user-friendly way. The homepage is the starting point for visitors to get to know your urgent care and “link through” to related pages for additional information.

A few ways to create a mockup website include:

- Using “old-fashioned” paper and pencil. Many people like to sketch out their website by hand and draw each piece of the page.
- Using Microsoft Word or other word processing programs. These programs can be used to create a mockup of each web page by using the insert and draw options to create text boxes, insert images, insert shapes, and other useful tools.
- Using Microsoft Publisher, Adobe Photoshop, or other layout publishing programs. If you want to get more

creative and detailed, you can use these advanced publishing programs, which have more functionality, to take your website design even further.

- Using tools tailored to create mockup websites, such as www.balsamiq.com, www.gomockingbird.com, and www.mockupbuilder.com. These tools make it simple to drag, drop, create, and reposition website elements to create a prototype.

Building Your Website

Now that you have an initial website design plan, it's time to construct or “code” your website—either on your own or utilizing a third party.

1. Building Your Website on Your Own

There are three typical ways to build your website on your own: 1) Use your web host's online website builder; 2) Use website development software; or 3) Use a content management system.

Website Builder from Web Host: Most web host vendors include free website building tools when you purchase their hosting services. These tools usually incorporate an easy drag-and-drop interface to add items to the page. The interface is called WYSIWYG which stands for “what you see is what you get.” So, whatever shows on the page you are designing will be how your website will look. No technical programming skills are necessary. The issue is that these tools are for very basic websites—using them for a business may result in a website that looks amateurish or unprofessional.

Website Development Software: There are many different software programs you can use specifically to build a website. Most of these also include a WYSIWYG user interface and go even further to include the ability to switch to HTML code to create your website. Hypertext Markup Language (HTML) is the coding language used for creating web pages and other information that can be displayed in a web browser. Using HTML gives web developers more flexibility, functionality, and control in designing a website. Website development software includes:

- CoffeeCup Visual Site Designer:
www.coffeecup.com/designer
- Adobe Dreamweaver:
www.adobe.com/products/dreamweaver.html
- WebStudio: www.webstudio.com
- Microsoft Webmatrix:
www.microsoft.com/web/webmatrix

Content Management System (CMS): A CMS is a program that allows publishing, editing, and modification of

content from a central interface, usually through a user-friendly system accessed online (or in the cloud). The most popular CMS system is WordPress. WordPress is a platform with various features to build your website while making your website more robust, such as website themes, functionality add-ons, and more. No technical coding is necessary to build your site, although a little technology knowledge in general is helpful. WordPress usually is free and it can be installed through your web host. Contact your webhost for installation details.

2. Hiring a Contractor or a Third Party to Build Your Website

Unless you've had formal training in HTML programming or are already highly skilled in desktop publishing, the technical intricacies of building a website may be overwhelming. In addition, because a website reflects your "brand," an amateurish-appearing or error-filled website will turn off prospective patients and defeat the purpose of your online presence.

If you decide not to build your website yourself, you can hire a contractor or a third-party company to do it. Most local advertising and marketing agencies—who can develop a more comprehensive campaign for your center including your logo, printed collateral such as brochures and flyers, and mass advertising including newspapers, billboards and radio—can also assist you in building an online presence. If your center is already established and you're approaching your website as a one-off project, there are also various websites you can use to find someone to help you. Some websites to consider using include:

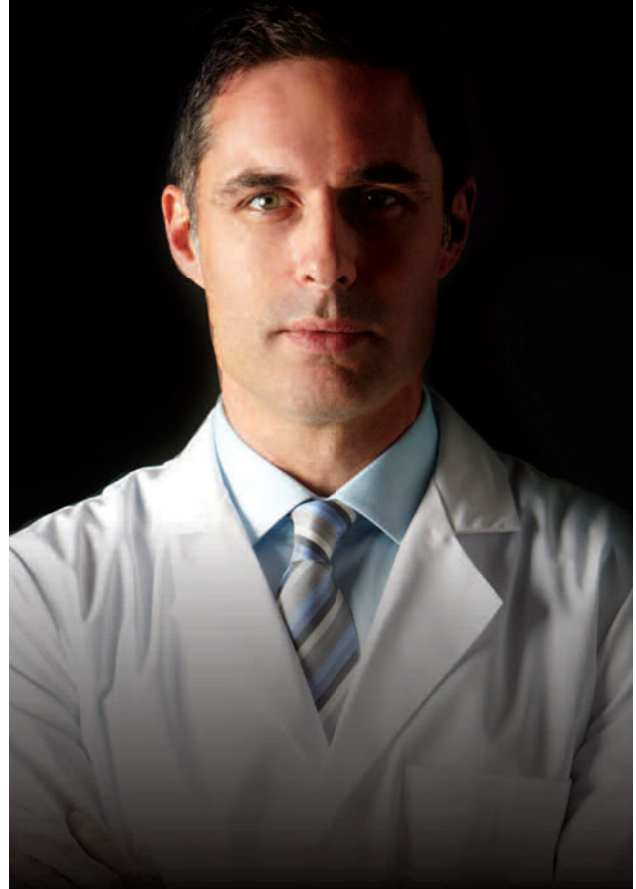
- Elance www.elance.com
- Freelancer www.freelancer.com
- Desk www.odesk.com
- Craigslist www.craigslist.com

When working with a freelance website developer or third-party marketing firm, you'll want to provide as much detail as possible to ensure that your website turns out as you expect it to. Up front, provide the designer with your website mockups and any additional ideas you have about the project. It can also help to provide samples of websites you think are particularly appealing. When looking for someone or a company to work with, ask for references and/or work samples—it's important that a developer be credible, reliable, knowledgeable, and communicate well. Expect a few conversations either by phone or email to ensure



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that the developer understands the project, require the opportunity to review drafts, and verify that the website meets your requirements before making payment.

The best way to have your website listed in search results is to actually submit your website address to the main search engines.

business (example myurgentcare@gmail.com). If you don't have a Gmail account, you can sign up for one by clicking on the red "Sign Up" button in the top right corner.

Testing Your Website

Once your website has been built, you'll want to test it to make sure everything looks and works the way you expect it to. You wouldn't want a prospective patient to get the wrong impression if your website contains errors or does not function properly. Some common problems you should test for are:

- Do all of the hyperlinks work?
- Is all of the information there?
- Is all the information correct?
- Is the website free of misspellings and grammatical errors?
- Do all of the images show?
- Do the videos and other multimedia assets work?
- Does your website work in different web browsers (Internet Explorer, Google Chrome, Mozilla Firefox, and Apple Safari)?

If you have outsourced your project to a third party, a professional web developer should thoroughly test the website prior to delivery. Also having multiple people review the website can better catch errors and generate suggestions for improvement.

Submit Website To Search Engines

Now that your website is built, you'll want to ensure that people are able to discover your new website using search engines such as Google and Bing, which account for a majority of web searches. The best way to have your website listed in search results is to actually submit your website address to these main search engines so they can "index" or "crawl" your site to discover all of your new web pages. This process may take a few weeks to sometimes even months. Let's go through the steps on submitting your website to Google and Bing. You can also easily search how to submit your website on various search engines other than these main ones, but it's good to start out with these two first.

1. Submit Website to Google

1. Go to the website: www.google.com/submityourcontent/business-owner
2. Select the "Add your URL" link.
3. Sign into the Gmail account associated with your

4. Enter your URL into the box.
5. Enter the re-CAPTCHA code.
6. Select the "Submit Request" button when finished.

2. Submit Website to Bing

1. Go to the website: www.bing.com/toolbox/submit-site-url
2. Enter your URL into the box.
3. Enter the characters from the picture in the text box.
4. Select the "Submit" button when finished

Because Google functions like an online Yellow Pages, you'll also want to make sure your physical business is in its listings. "Google Places for Business" will ensure that your center comes up on a map with other businesses when prospective patients search. Google Places matches the user's physical location with businesses meeting their search description. What's nice is that adding your business to Google Places is free.

Submit Business to Google Places

1. Go to the website: www.google.com/placesforbusiness
2. Sign into the Gmail account associated with your business (example myurgentcare@gmail.com). If you don't have a Gmail account, you can sign up for one by clicking on the red "Sign Up" button in the top right corner.
3. Enter your main business phone number.
4. Select the "Find Business Information" button. Google will search to see if information related to your business is already available to help fill out your business listing.
5. If your business isn't found, go ahead and enter your business information manually. This includes business name, phone number, address, website address, operating hours, and other relevant information.
6. Select the "Submit" button when finished.

Improving Your Website Ranking with Search Engine Optimization (SEO)

Do you ever wonder why some websites are listed on the first page of Google or other search engines when you type in certain keywords to search for? Search engines have a complex way to determine which web-

sites are most relevant to the keywords or phrases a person is searching for. If your website is listed on the first page for keywords, chances are better that a person will visit your website. Some studies state that 85% of people never look beyond the first page of the results.

Luckily, there are many tactics to help your website achieve a higher ranking based on keywords for which people search. This is called Search Engine Optimization (SEO). SEO is the process of improving the visibility of your website or webpage in a search engine's "natural" or unpaid "organic" search results. SEO might sound complicated, and it can be, but there are simple and basic SEO tactics your center can implement on your website that will help improve your webpage rankings. These include:

1. Researching keywords that potential visitors are using to search for urgent care centers. It would be easy if everyone typed in something as precise as "urgent care centers in Denver" but patients are more likely to search for specific conditions or needs, such as "flu," "travel vaccinations," or "walk-in doctor." Consider incorporating some of the keywords in Table 1. You can also use Google's Keyword Tool to see what the average search volumes are for keywords and see related terms that you might not have thought of.
2. Integrating these keywords into the content of your website. Your website should contain all the terms that an individual might search for information related to your operation. You can include the keywords in:
 - a. The title of your webpage
 - b. Any headers on your webpage
 - c. Throughout the text in the body of your webpage
3. Integrate social media accounts to enhance your online presence by linking to your social media accounts from your website and linking from your social media accounts back to your website.

SEO doesn't just happen on your website, though, it also happens outside of it, too. One major factor by which search engines determine the ranking of your webpages is the number of websites that link back to yours. Each link back to your site is like a "vote" for your site. So, it's important to consider efforts to broaden the online reach of your website, whether it's through obtaining positive press online, getting listed in directories, being mentioned in blogs, or other methods. Be

sure to include your website's address in anything you do or post online.

For more details about SEO, visit www.seomoz.org/beginners-guide-to-seo

Maintaining Your Website

Once your website is built, it's important to keep it updated with the latest information about your center. This is especially helpful if there are changes in hours of operations, staff, or any other essential information patients are often looking for on your website. You want a good plan for maintaining your website, including who will update it and how often, and what information will need to be updated.

How you will maintain your website should also be a consideration when determining how to design and build your online presence. If you hire an expert to build a sleek, high-performing website and you have no skills to update it, you'll need to rely on other professionals to make changes. This is why establishing a relationship with a web developer or integrated marketing agency may be preferable to treating the website as a one-off endeavor.

Updating Marketing Materials to Include Your New Website Address

Your website is a great way to market your business to potential clients. Make sure you include your website address on printed marketing materials such as business cards, advertisements, flyers, and brochures. Because you can't print every detail of your operation in your marketing materials, your website will serve as a reference for individuals who want to learn more about your center.

Integrating Social Media to Enhance Online Presence

Most likely you've heard of or even used a social media site but have you thought about how social media can drive business to your center's website? Social media is an interactive platform where individuals and communities create and share user-generated content. Connecting with your target audience through social media is a great way to improve your online presence by improving your reach and engagement through social platforms that are being used every day to communicate. Social media channels allow real-time sharing of information, whether it is news, photos, videos, or other multimedia content. Many urgent care centers have found that social media increase exposure, improve traffic, generate leads, and develop loyal patients.

Table 1: Urgent Care Keywords

Consumers typically search online for medical symptoms or problems—for which urgent care can be a solution. To ensure that your center's website is recognized by major Internet search engines like Google, Yahoo and Bing, be sure to include throughout your website the keywords for which potential patients may be searching. You can add to or subtract from the words listed here, depending on your service offering, patient mix, and acuity.

Adult Illnesses	Common Illnesses		Diagnostic Tests	Gynecological Conditions	Skin Conditions	Vaccinations
Allergic reactions	Acid Reflux	Frozen Shoulder	Arthritis Panel	Menopausal Complications	Acne	dtap
Anemia	Acne	Heart Burn	Cultures	Menstrual Irregularities	Athlete's Foot	Flu
Anxiety	Allergies	Heat Stroke	Full Lab Panels	Pregnancy Diagnosis	Burns Rashes	Hepatitis a
Arthritis	Amenorrhea	Hemorrhoids Hemoglobin	Hematocrit	Sexually Transmitted Diseases	Cold Sores	Hepatitis b
Asthma	Bee Stings	Influenza	Hepatitis	Vaginal Bleeding	Ear Piercing	hib
Colitis	Bladder Infections	Insect Bee Stings	HIV		Eczema Dry Skin	ipv
Diabetes	Bronchitis	Interstitial Nephritis	Influenza	Trauma	Impetigo	meningitis
Diverticulitis	Chicken Pox	Laryngitis	Kidney Liver	Acute Fracture	Poison Ivy Poison Oak	mmr
Gallstones	Colds	Pink Eye	Microscopy	Auto Accident Whiplash	Psoriasis	pneumonia
Gastritis Indigestion	Cuts Lacerations	Sinus Infections	Mononucleosis	Complex Lacerations	Ringworm	td
Gout	Dehydration	Splinter Removal	Prostate PSA	Crush Injuries	Skin Infections	varicella
Headaches Migraine	Diarrhea	Sprains	Pregnancy Test	Falls	Skin Lesion Removal	Other
Hypertension	Ear Infections	Stomach Flu	STD Cultures	Insurance	Sunburn	School Physicals
Kidney Stones	Ear Wax Removal	Strep Sore Throat	Strep	Blue Cross Blue Shield	Swimmer's Itch	Sports Camp Physicals
Sleep Disorders	Fever	Swimmer's Ear	Therapeutic Blood Levels	Cigna Aetna Humana	Wart Removal	Pediatrics Children
Urine and Bladder Problems	Fingernail Toenail Injuries	Swine Flu	Thyroid Screens	United HealthCare UHC	Wound Care	Walk-in Center Clinic

Basic Tactics on Using Social Media to Enhance Your Website

- Have social media accounts link **BACK** to your website. Many of the social media accounts allow you to provide information about the business, including your business website address. This will help increase exposure and traffic back to your site.
- Have your website link **OUT** to social media accounts. Connecting your website to your social media pages will encourage website visitors to connect with you.

There are various social media platforms for you to consider using, such as Facebook, Twitter, LinkedIn, and others. Let's take a brief look at how to setup these accounts.

Facebook is the most popular social networking site. Facebook can be used to share the latest news, stories, or other relevant content that your target audience will be interested in. The first step in using Facebook is to set up a business page for your center by following the instructions at www.facebook.com/pages/create.php.

Twitter is known for instant updates with a limit of 140 characters for each tweet (or message). Twitter can

be used to send out short reminders or messages to your target audience. To set up a twitter account, visit <https://twitter.com/signup>.

LinkedIn is a business-oriented social networking site where you can create a company page for your business. A company page can tell your story, highlight your services, engage your followers, share career opportunities, and drive word-of-mouth marketing. To find out more about setting up a LinkedIn company page visit http://help.linkedin.com/app/answers/detail/a_id/1561.

Conclusion

As more consumers begin their search for health information on the Internet, establishing your center's website and online presence are essential steps in reaching these prospective patients. A website will enhance your traditional marketing efforts by providing a central location for the latest relevant information about your center that patients can easily find and reference. Establishing an online presence takes careful planning and execution and with the knowledge you've gained after reading this information, you are now better prepared to take the next steps on the journey to build a successful website for your center. ■

Case Report

A Slowly Healing Leg Wound

Urgent message: Clinical suspicion of CA-MRSA should be high for any skin wound or soft tissue infection with delayed healing, abscess, or persistent cellulitis.

RALPH S. BOVARD, MD, MPH, and ANNE REINER, MD, MPH

Introduction

Caregivers need to remain vigilant and challenge diagnoses to avoid complacency in the treatment of “common” problems. We all need to foster the habit of systematic and meticulous clinical evaluation. As Goethe said: “We see what we know.”

Case Presentation

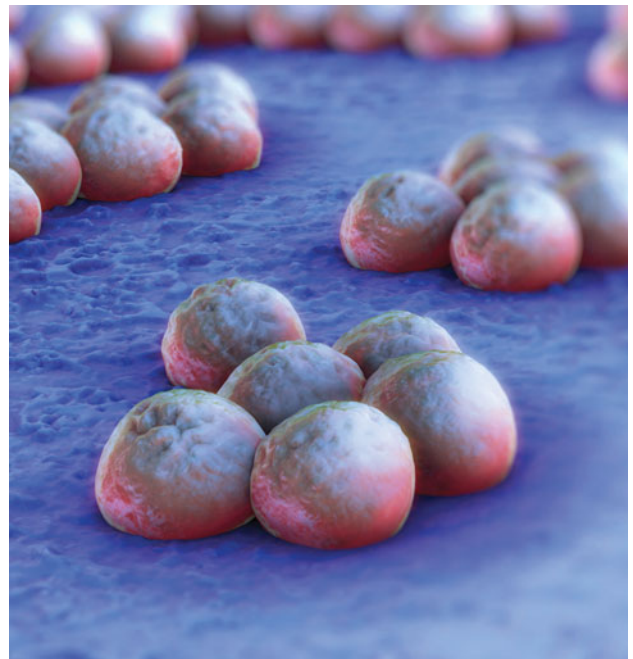
The patient was a 48-year-old male who presented to the Occupational Medicine (OM) clinic approximately 2 weeks following an injury to his posterior lower leg. While at work as a janitor for the local school district, he had leaned a folding table on its side against the wall. As he turned it fell, scraping and abrading the posterior aspect of his left lower leg for about 4 inches to just above the heel. He was able to walk to the workplace first aid station where it was treated as a superficial wound not requiring sutures.

Four days later, he noticed swelling of the posterior ankle and went to the local emergency room. X-rays were obtained which did not show evidence of a fracture (Figures 1 and 2). He was diagnosed with a superficial wound infection and started on cephalexin 500 mg po QID x 7 days. He was seen in our clinic 2 weeks post-injury for a return-to-work letter after having completed the cephalexin. The wound was reported as “improved” with less discomfort and swelling.

Pertinent History

The patient had no known allergies and did not take any

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medications on a regular basis. He was a pack-a-day smoker and had gained 30 to 40 lb in the past 3 years. He denied a history of type II diabetes and reported a normal fasting blood sugar test the previous year.

Follow-up Evaluation

Two weeks later (1 month after the initial injury) he returned to the OM clinic with a complaint of persistent swelling, redness, and drainage from the wound that had now increased in size. He was unable to get his foot into his work boot because of pain and swelling and thus was unable to work.

Figure 1. Lateral view of left heel and foot

No subcutaneous emphysema or significant soft-tissue swelling in the region of the left posterior lower leg.

Physical Exam (1 month post-injury)

Height 6'2". Weight 240 lb. On inspection there was a 7 cm x 1 cm curvilinear wound on the posterior left lower leg extending to just above the heel (Figure 3). The wound overlay the Achilles tendon, but the tendon was not visible beneath the wound. Thompson test was negative (normal). The wound showed some evidence of granulation but with yellowish, mucopurulent drainage. Range of motion at the ankle was 10 degrees DF and 45 degrees PF. There was some swelling extending to the lateral ankle but no focal tenderness over either malleoli. No signs of ligamentous injury.

Course and Treatment

Wound culture was performed and sent to the laboratory for analysis. We started the patient on Augmentin 875 mg po BID x 10 days and initiated twice-daily dressing changes with a non-adherent gauze, sterile bandages, and silver sulfadiazine 1% cream. He was to keep the wound clean and dry. He was placed on light duty work status.

Diagnostic Studies

On laboratory analysis the gram stain showed many gram-positive cocci and gram-positive cocci in clusters. The wound culture showed many *Staphylococcus aureus* organisms resistant to Oxacillin.

WBC: 9.2k/uL

HGB: 14.6g/dL

HCT: 42.8%

PLTS: 207k/uL.

Electrolytes: Normal except for fasting glucose 123 mg/dL.

Figure 2. Normal X-ray

An AP view of the left heel and os calcis.

GFR: Normal at >60 mL/min/1.73m²

CRP: <0.5 mg/dL

Cholesterol: 133 mg/dL; TRIG: 153 mg/dL (H), HDL 39 mg/dL (L).

Diagnosis

Community-Acquired (CA)-Methicillin Resistant *Staphylococcus Aureus* (MRSA) wound infection

Revised Treatment Plan

Our infectious disease service was consulted. The patient's antibiotic coverage was changed, based on culture sensitivities, to sulfamethoxazole-trimethoprim 800 to 160 mg po BID x 14 days. He was instructed in proper wound care management and disposal of MRSA contaminated bandage material. He was referred to a nutritionist and to his primary care physician for type II diabetes management. He was seen for follow-up in the OM clinic at 1-week intervals over the ensuing month with improvement of symptoms and gradual healing of the ankle wound. He failed his final follow-up visit.

Discussion

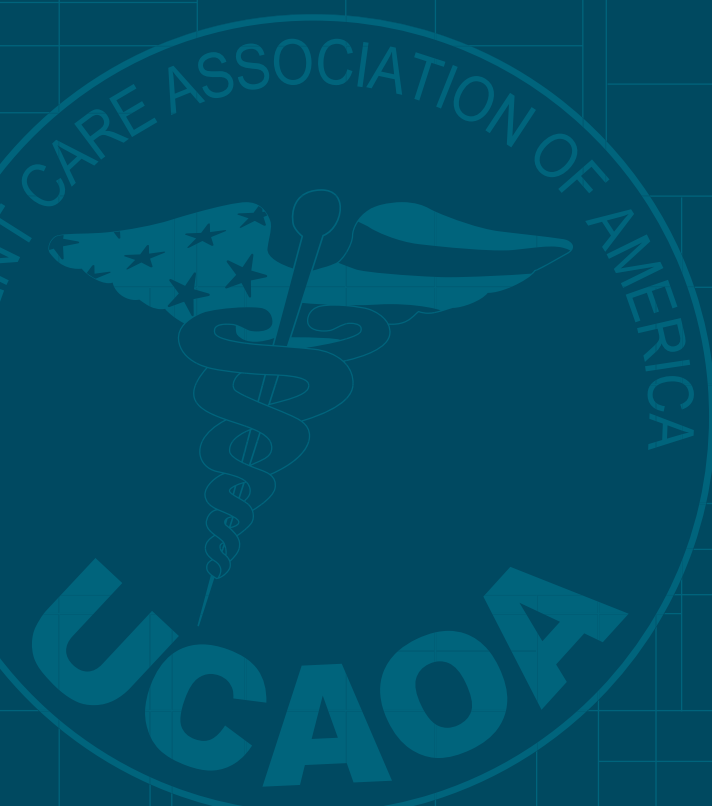
When MRSA first emerged in the 1990s it was largely associated with hospitals and nursing homes. In recent years, it has emerged as an increasingly common cause of skin



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infections in otherwise healthy individuals. The proportion of *staphylococcus* infections attributable to MRSA is reported to have increased from 40% in 1999 to approximately 60% in 2005. MRSA is generally divided into community acquired (CA) and hospital acquired (HA) forms. CA-MRSA, first identified in 1998, is currently estimated to account for 14% of all MRSA cases reported. Groups at risk for CA-MRSA include members of the military, children in daycare, people who have gotten tattoos, athletes with frequent skin contact or who may share towels or razors, those who inject illegal drugs, and individuals with compromised immune systems (individuals with metabolic disorders such as type II diabetes mellitus may fall in this risk pool). Risk factors associated with HA-MRSA include recent hospitalization, surgery, residence in a long-term care facility, dialysis, or the presence of invasive medical devices.

The Agency for Healthcare Research and Quality (AHRQ) estimated that there were upwards of 390,000 cases of MRSA in the United States in 2005.¹ Kleven, et al estimated 94,000 invasive MRSA infections requiring hospitalization and upwards of 19,000 deaths in 2005.² The excess cost of treating a MRSA infection (versus a methicillin-sensitive *S. aureus* infection) ranges from \$3,000 to \$35,000 per case; this resulted in total costs to the health care system of \$830 million to \$9.7 billion in 2005.³ Patient education is important to limit the further spread of this disease to close contacts. Clean dry bandages, careful hygiene, proper disposal of dirty bandages, consistent use of gloves, hand washing, and alcohol or antiseptic gels are important modalities in limiting the further spread of MRSA.⁴ Nasal colonization has been identified as a potential risk factor for infection. Increasingly it is a pre-surgical consideration, especially in total joint procedures to test for nasal colonization. While 25% to 30% of individuals are colonized with *staphylococcus*, fewer than 2% are colonized with MRSA.⁵ Decolonization using topical and systemic antimicrobials and antiseptic body washes such as chlorhexidine are increasingly used as control interventions.

MRSA infections are classically resistant to beta-lactams (penicillins and cephalosporins), macrolides/azalides (erythromycin, clarithromycin, and azithromycin), and quinolones (levofloxacin). CA-MRSA has typically been responsive to gentamicin, tetracycline, doxycycline, clindamycin, and trimethoprim/sulfamethoxazole. HA-MRSA is often resistant to multiple classes of antimicrobial agents. Clinical suspicion of CA-MRSA should be high for any skin wound or soft tissue infection with delayed healing, abscesses, or a persistent cellulitis. CA-

Figure 3. Left posterior lower leg



One month post-injury the wound showed some evidence of granulation but had eroded with weepy, yellowish, muco-purulent drainage.

MRSA may be confused with tissue necrosis associated with spider bites (rare). The severity of MRSA skin infections may vary from mild superficial infections to deeply invading soft tissue processes requiring hospital admission, surgical excision, and parenteral antibiotics. It is essential to obtain wound cultures in order to determine antibiotic sensitivities.⁶ Timely referral to infectious disease and specialty surgical services is indicated. ■

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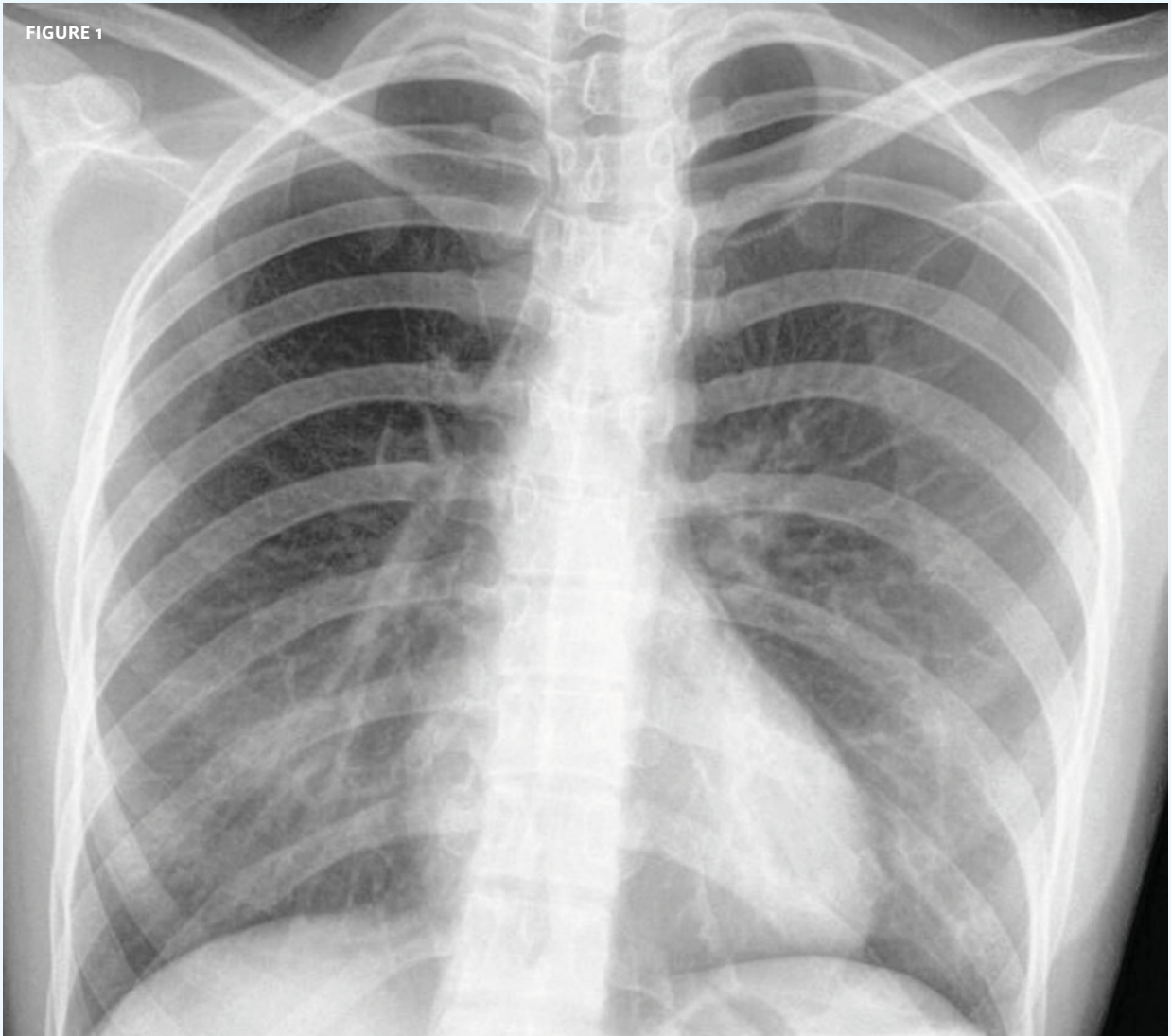
INSIGHTS IN IMAGES

CLINICAL CHALLENGE

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

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

FIGURE 1

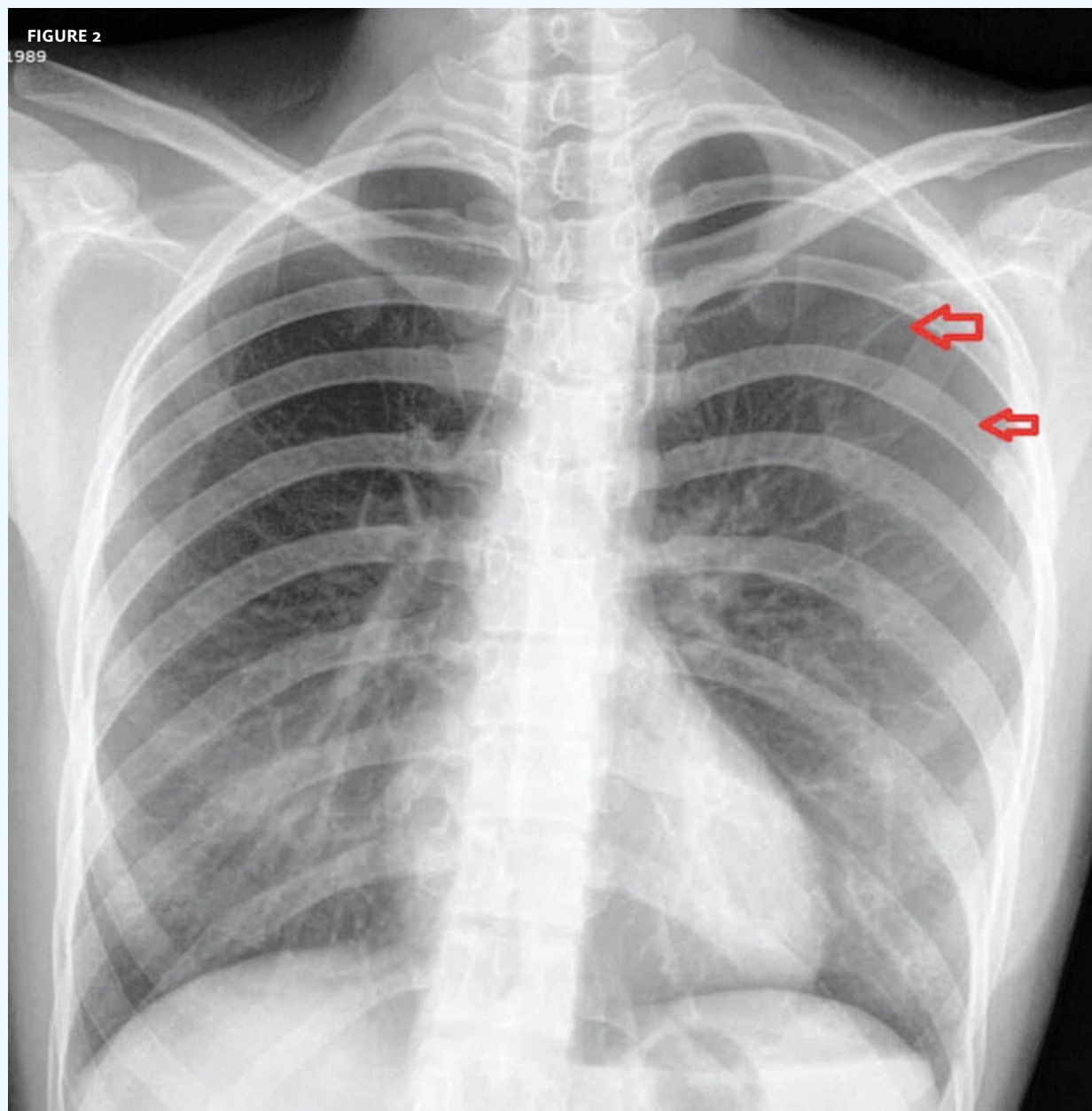


The patient, a 22-year-old woman, presented with a complaint of chest pain.

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



Diagnosis: The x-ray reveals pneumothorax (arrows). Referral to a hospital is appropriate for this patient.

Acknowledgement: Case reprinted with permission from the Logical Images digital medical image library. For more information, visit <http://www.logicalimages.com>



ABSTRACTS IN URGENT CARE

Ondansetron safety during pregnancy and the link between NSAIDs and kidney injury in dehydrated kids

■ 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.

Ondansetron Safe During Pregnancy

Key point: No significant association between the antiemetic ondansetron and adverse pregnancy outcomes.

Citation: Pasternak B, Svanstrom H, Hviid A. Ondansetron in pregnancy and risk of adverse fetal outcomes. *N Engl J Med* 2013;368:814-823.

In this retrospective cohort study, ondansetron had been prescribed for nausea and vomiting in almost 2000 of some 600,000 pregnancies. Ondansetron users were no more likely than nonusers to experience spontaneous abortion or stillbirth, or to have preterm delivery, a small-for-gestational-age infant, or an infant with a major birth defect. ■

NSAIDs Linked to Acute Kidney Injury in Dehydrated Kids

Key point: Commonly used NSAIDs can lead to acute kidney injury in pediatric patients, particularly those suffering from dehydration.

Citation: Misurac JM, Knoderer CA, Leiser JD, et al. Nonsteroidal anti-inflammatory drugs are an important cause of acute kidney injury in children. *J Ped*. 2013; doi:10.1016/j.jpeds. 2012.11.069

Reviewing charts for 1015 cases of pediatric acute kidney injury (AKI) treated at the Riley Hospital for Children in Indianapolis, the authors found that 27 cases (2.7%) were linked to preadmission use nonsteroidal anti-inflammatory drugs (NSAIDs), in-

cluding 21 instances of acute tubular necrosis and 6 instances of acute interstitial nephritis.

Symptoms on presentation pointing to dehydration included vomiting (74%), decreased urine output (56%), and diarrhea (26%).

The majority of patients (78%) had been using NSAIDs for less than 7 days, and many used ibuprofen (67%), naproxen (11%), or ketorolac (7%). Data available for 75% of patients showed that most had received an appropriate dose (75%).

Although none of the youngsters died or developed permanent kidney failure, 30% had evidence of mild chronic kidney damage persisting after recovery from the acute episode.

NSAIDs are perhaps the most common avoidable AKI risk to which children are regularly exposed, suggesting that renal function be evaluated before NSAID administration.

Although the majority of patients were teenagers (median age, 14.7 years; range, 6 months-17.7 years), AKI effects were particularly severe among children younger than 5 years. Younger patients were more likely than their older counterparts to require peritoneal dialysis (100% vs 0%; $P<.001$) and intensive care unit admission (75% vs 9%; $P=.013$), resulting in a longer hospital stay (median, 10 vs 7 days; $P=.037$).

Although the reason remains unknown, the authors surmise that young children may have an increased susceptibility to NSAID-related nephrotoxicity.

The study was limited by its retrospective nature, which hindered the researchers' ability to draw conclusions regarding the temporal connection between NSAID exposure and AKI onset. In addition, the majority of children included in the study had been otherwise healthy, and few serum creatinine levels had been previously drawn. The very presence of an acute illness causing dehydration is also a confounding factor in the development of AKI. ■



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



The Game Part 1

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

In the movie *The Game*, Nicholas Van Orton (played by Michael Douglas) is a very wealthy and successful businessman. Unfortunately, his successes come at the cost of his family life and close, personal relationships. His brother, Conrad (played by Sean Penn), gives him a gift on his 48th birthday. The gift is enrollment into a live-action game where Nicholas is the principal player. This game initially consumes then seemingly destroys his life. Conrad, remarks, “They won’t leave me alone! I’m a goddam human piñata!” The movie plot takes Van Orton through many twists and turns and just when he believes he has it figured out, he is thrown a new set of facts and plot twists. At the end of the movie, after nearly killing himself by jumping off a building, he realizes it is really just a game.

Many providers feel like a human piñata when they go through their first encounter with the legal system if the encounter relates to defending a medical malpractice suit. Malpractice suits have been known to initially consume and sometimes destroy well-meaning medical providers who find out too late that in the eyes of some of the participants, it is just a game.

This is the first of two articles in which I will provide an overview of the twists and turns one encounters while going through a medical malpractice suit. Understanding this process will allow the uninitiated to better understand the game in which they were thrust.

The game begins

When you are accused of medical negligence it does not feel anything like a game. It feels like you are thrown into an abyss the end of which is nowhere in sight. Many providers hope that by doing nothing, a lawsuit will simply go away, which rarely happens. Typically the legal process can take years to completely resolve the issues in dispute.

The resolution is often in the hands of others, thus leaving providers feeling powerless over the outcome. As a medical

“You can be sued in another state if you treated the patient in that state, regularly practice in that state, live in the state, or maintain an office within or solicit patients to your practice from that state.”

provider, you are by no means powerless. In fact, there are many things you can do to significantly improve your chances of a favorable outcome. One of the most important things you can do is remain positive, forward thinking, and not reactionary. Everyone involved—from your attorney to the insurance claims adjuster to the plaintiff’s attorney—is simply doing their job the best they know how. And by way of full disclosure, there are many things you can do to negatively impact your chances for a favorable outcome.

Jurisdiction

Suits involving medical malpractice are civil. They are heard, adjudicated, and resolved in civil court which is governed by substantive and statutorily-based laws and rules. Your case will be heard in one of three courts: your own state court, the federal court, or in the court of another state. The case can be heard in federal court if a plaintiff is a citizen of one state and the medical provider is a citizen of another state. The same is true if the medical provider is not a US citizen and none of the co-defendants (if any exist) are citizens of the state where the defendant practices. Finally, if the suit involves a federal question or it is against a federal employee, it can wind up in federal court. Conversely you can be sued in another state if you treated the patient in that state, regularly practice in that state, live in the state, or maintain an office within or solicit patients to your practice from that state.

Generally speaking, the plaintiff’s attorney will file a case in



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the jurisdiction in which he/she believes the plaintiff is most likely to prevail.

Elements of a Medical Malpractice Case

There are four elements of a medical malpractice case and all must be proven to the extent it is more likely true than not.

Duty. The provider must have had a duty to take care of the patient. This duty is established as a result of the doctor-patient relationship. Some providers mistakenly believe that if someone at the front desk person sends the patient to another facility, no doctor-patient relationship exists. That can be argued, but the claim may simply be that the front office person was negligible and that the practice or provider on site had a duty to supervise that individual's actions. As a general rule, I would have the provider see and document information about every patient who enters the center. If an untoward event happens and you have no documentation, you are left somewhat defenseless. If, however, you have recorded a patient's vital signs and chief complaint and done a cursory exam, you can argue based upon performing to the standard of care.

Breach. The plaintiff's attorney must prove that the provider failed to exercise a reasonable degree of care, skill, and learning that a reasonably prudent health care provider of the same or similar specialty in similar circumstances would have undertaken. This is called the standard of care. The jury will be aided in the standard-of-care determination by expert witnesses who are called upon to opine upon the facts of the case.

Proximate cause. The plaintiff must demonstrate that your failure to perform within the standard of care was a proximate cause of the plaintiff's injury. This does not mean that the provider's negligence was necessarily the only cause or even the major cause of the damage. It simply means that the provider's actions or inactions were a contributing factor to the ultimate injury.

Injury As a result of the breach of the standard of care, the patient had to have suffered an injury. His injury can be physical, emotional, financial or any combination of the three. In addition, a spouse or parent can claim a type of noneconomic injury called loss of consortium i.e. loss of companionship and services.

The process. There are distinct phases of the civil process

The complaint. Different states have different requirements about what is contained in the complaint, which sets out the allegations of what the provider did wrong. These allegations can be very general or very specific and may or may not set forth a dollar amount of damages. Your attorney will respond to this complaint in the form of an answer.

The plaintiff's attorney files this complaint with the clerk of the court. At this point, the lawsuit is initiated. The provider is then notified that the complaint has been filed by means of a summons attached to the complaint. The summons can be

served by a process server, sheriff's officer or via registered mail. The summons will order you to appear in court in a certain time on a certain date. You do not need to appear personally; the defense attorney assigned by your malpractice carrier will appear on your behalf.

The process of being served with a summons can be a frightening and shocking experience. I have known more than a few providers who have refused to open their door, run away, hidden, or become extremely belligerent when served. No good comes from this behavior. The process server is simply doing his or her job, so accept the summons.

The complaint will often accuse the provider of incredibly heinous and serious accusations, which are typically things you did not and would not ever do. Complaints are generally written before the plaintiff's attorney has all the facts and thus are extremely broad to cover every base and eventuality.

These complaints are largely boilerplate in nature with the facts filled in amidst the legal jargon. When you receive the complaint and/or summons it is important that you notify your medical malpractice carrier immediately. There is a relatively narrow window of time that your attorney has to answer the complaint. Lack of timely response can actually forfeit your right to respond to a medical malpractice complaint and a default judgment can be entered against you. Moreover, some malpractice carriers will not cover you in the event of a default judgment secondary to improper or untimely notification.

The experience of being served with the summons need not be as traumatic as you may imagine. You should educate your front desk that from time to time all medical practices and medical providers are the subject of a malpractice suit. You should also educate your staff that when the practice is served with a summons, they need to notify you immediately and be polite and professional to the person serving the summons. Most importantly you need to educate the staff that they are not to discuss anything related to the medical malpractice complaint with any other staff members or with anyone outside the practice other than your defense counsel.

The important points during this phase of the legal process are:

1. Notify your carrier immediately.
2. Review your malpractice defense policy to fully understand your rights.
3. Do not talk to the plaintiff, his or her attorney or any family representatives. Do not talk to your staff members or other physicians in the practice or community unless under the protection of peer review.
4. Do not alter the medical record. This means do not attempt to clarify, expound upon, or reconstruct any aspect of the medical record. If your practice uses an electronic health record (HER), a competent plaintiff's attorney will subpoena the metadata that runs continuously in the



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Congratulations New UCAOA Board Members

The membership of
The Urgent Care Association of
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We also congratulate newly
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**Alan Ayers, MBA, MAcc and
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Alan Ayers is also *JUCM's*
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Laurel Stoimenoff is a member of
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HEALTH LAW

background of the EHR. This metafile records all key-strokes and all changes in all areas of the medical record.

5. Review the patient's medical records.
6. Make two separate files:
 - a. The patient's original chart should be placed in a secure location.
 - b. Start a litigation file that includes a copy of the patient's medical record, correspondence from your attorney and any information, articles or data you collect.
7. Develop good lines of communication and a good working relationship with your appointed attorney.
8. If there are codefendants in the case, the plaintiff's attorney may attempt to divide and conquer. Generally speaking, the strongest defense is a unified defense. Your attorney will work with you to develop the best course of action to protect your interest.

There will be a point in the process when your attorney will talk to you about your options. The carrier and your attorney will want to know how committed you are to the care you provided and your willingness to see this case all the way to the trial and verdict.

This process can take an emotional toll on a defendant and many will elect not to vigorously defend and would prefer to settle the case and move on with their lives. Some insurance policies contain a clause stipulating that if you choose not to settle against the advice of your carrier and attorney, that you are liable for the monetary difference between what the case would have settled for and the ultimate damage award if it exceeds the proposed settlement amount. This is called a *hammer clause* and your attorney should discuss its implications in detail.

You should also be aware that if you do elect to settle the case, the federal law requires reporting of the settlement to the National Practitioner Data Bank (NPDB). Information reported to the NPDB includes your name and address (including your home address); name of your medical or professional school and date of graduation; field of professional license and license number; DEA number(s); names of the hospital or institutions with which you are affiliated; lawsuit name and case number; dates of the acts or omissions that gave rise to the lawsuit; the date of the settlement; the amount of the settlement; any other terms of the settlement; and a description of the actual omissions and injuries upon which the lawsuit was based.

After the NPDB receives notification, you will receive a copy from them and will be given the opportunity submit your own comments. In some states, notification of the state medical board is also mandatory.

In the next issue, we will discuss the disclosure and discovery segment, the comprehensive pretrial conference, depositions, the settlement conference, the trial, and the aftermath. ■



Mid-level Providers, Resident Providers, Non-payment for S9088, Non-payment for E/M 99205, POS -20 for Family Practice

■ DAVID STERN, MD, CPC

Q. Our urgent care is staffed by nurse practitioners (NP) 6 days per week and all of the billing is processed under the medical director for all insurance companies. I have three separate questions:

1. Is it legal for a new Medicare patient entering the urgent care setting to be billed under the medical director if he is not on site and has never seen the patient?
2. Is it better for the NP to be covered under the entire urgent care malpractice policy for Individual Professional Liability which includes all providers, or to be covered as an add-on under coverage B, which includes Partnership Liability?
3. How do we protect a Medicare patient that needs a tetanus vaccination per recommended guidelines after an injury if Medicare does not pay for it? Our billing staff states that the providers can no longer order/give vaccinations to Medicare patients.

A. It is considered fraudulent billing to bill a new Medicare patient under a provider who has never seen the patient. Medicare requires individual credentialing for providers as well as mid-level providers, including NP.

Regarding malpractice coverage, the answer depends on your state laws and the specific policy involved. I would recommend reviewing this issue with a healthcare attorney.

Tetanus vaccination can be provided in a network provider's office. In this situation, however, the patient should pay for the vaccine costs up front and then submit the claim to receive reimbursement from the Medicare Part D plan. The beneficiary

should contact his/her Medicare Part D plan in advance for detailed instructions on reimbursement for Tetanus vaccination. ■

Q. Absent any express guidance in the applicable managed care contracts between an urgent care facility and commercial payors, will commercial payors reimburse urgent care facilities for services provided by moonlighting residents who are licensed with the state and enrolled in Medicare, but not credentialed with the commercial payors?

A. You are unlikely to find any express guidance for moonlighting residents in commercial payor contracts. You would need to contact each payor because payors have many different policies, such as:

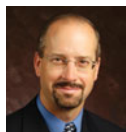
- Allowing billing for services rendered by resident physicians without credentialing;
- Requiring credentialing of resident physicians; and
- Refusing to credential or allow billing for services rendered by physicians who are not board eligible.

If you bill in these situations without confirming the payor's policy, a payor may:

- Deny all claims;
- Pay but do "take-backs" if they discover it was done; or
- Pay but cancel contracts if they discover it was done. ■

Q. We used S9088 and 99204 to bill for an urgent care service. The insurance only paid for 99204. In speaking with the insurance company, they stated that we need to add a modifier to either S9088 or 99204 in order to be reimbursed. What modifier do we use for either S9088 or 99204?

A. Since S9088 ("Services provided to an urgent care center - list in addition to code for service") is considered an add-on code, you would not typically need a modifier. The request for the modifier is uncommon, so you will want to review your contract with the payor regarding payment of this code or



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

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CODING Q & A

contact your provider relations representative and ask what specifically is required. There could be several reasons the payor denied S9088. A few of them are:

- The practice is not specifically contracted as an urgent care center.
- The payor will not pay unless reimbursement for the code is specified in your contract.
- The payor has made a blanket decision to no longer pay for the code. ■

Q. We used E/M 99205 and CPT code 10060 for an incision and drainage procedure, however, the insurance only paid CPT code 10060 without paying E/M 99205. The payor stated that we needed to add a modifier to code 99205 in order to receive reimbursement. What modifier do we add to 99205?

A. When performing a significant, separate procedure in addition to the E/M, you should append modifier -25, ("Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service") to the E/M code. Therefore, if the documentation supports both the E/M code and the procedure in your specific example, you would bill 99205-25 and 10060. The procedure notes should be separate from the notes for the E/M portion of the visit. ■

Q. Our family practice office offers urgent care from 8 a.m. to 8 p.m., 365 days a year. We also have a group of physicians who keep their family medicine patients on their regular, non-urgent schedule. We are offering urgent care services but do not have an urgent taxonomy, only family physician and DME taxonomies. What are the steps to add urgent care onto our list of taxonomies so that we can bill our urgent care visits under the urgent care taxonomy? Will we need to apply and go through credentialing like we did with DME?

A. You can simply use POS -20 for Medicare. It will make no difference in reimbursement and no registration is needed.

For non-government payors, you typically need to contract (generally under a separate TIN for the urgent care) with the payors for urgent care. Payors will rarely allow the same TIN to have contracts for both primary care and urgent care. However, some payors still use POS -11 for their urgent care contracts. ■

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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.

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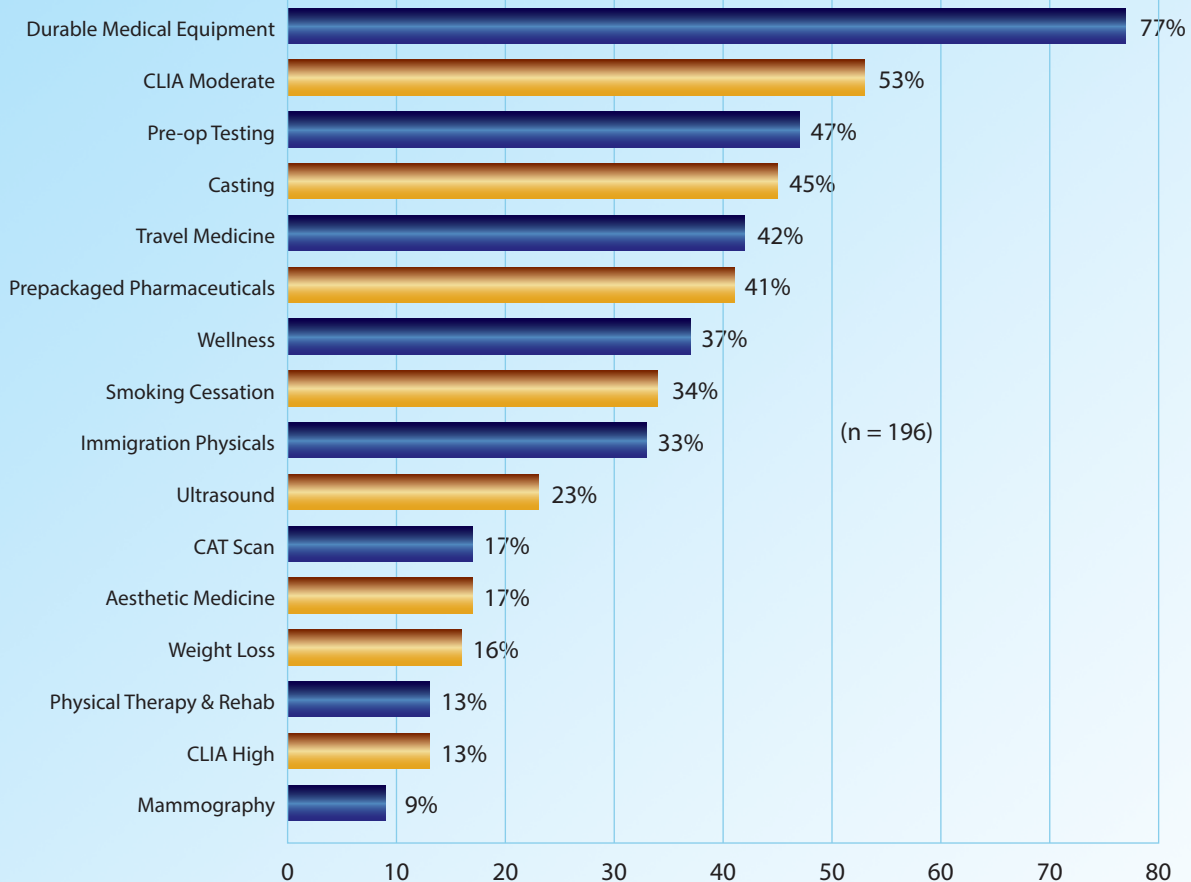
DEVELOPING DATA

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

In this issue: What General Clinical Services Are Urgent Care Centers Providing?

SERVICES PROVIDED

In addition to the usual services provided in an urgent care center, the 2012 survey examined more complex and “voluntary” services that centers could choose to provide, depending upon the needs of their communities, expertise of providers, and equipment available. While services such as high-end imaging and cosmetic medicine remain relatively rare, urgent care centers appear to be making efforts to further expand the “one stop shop” nature of their clinics.



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

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