

# JUCM™

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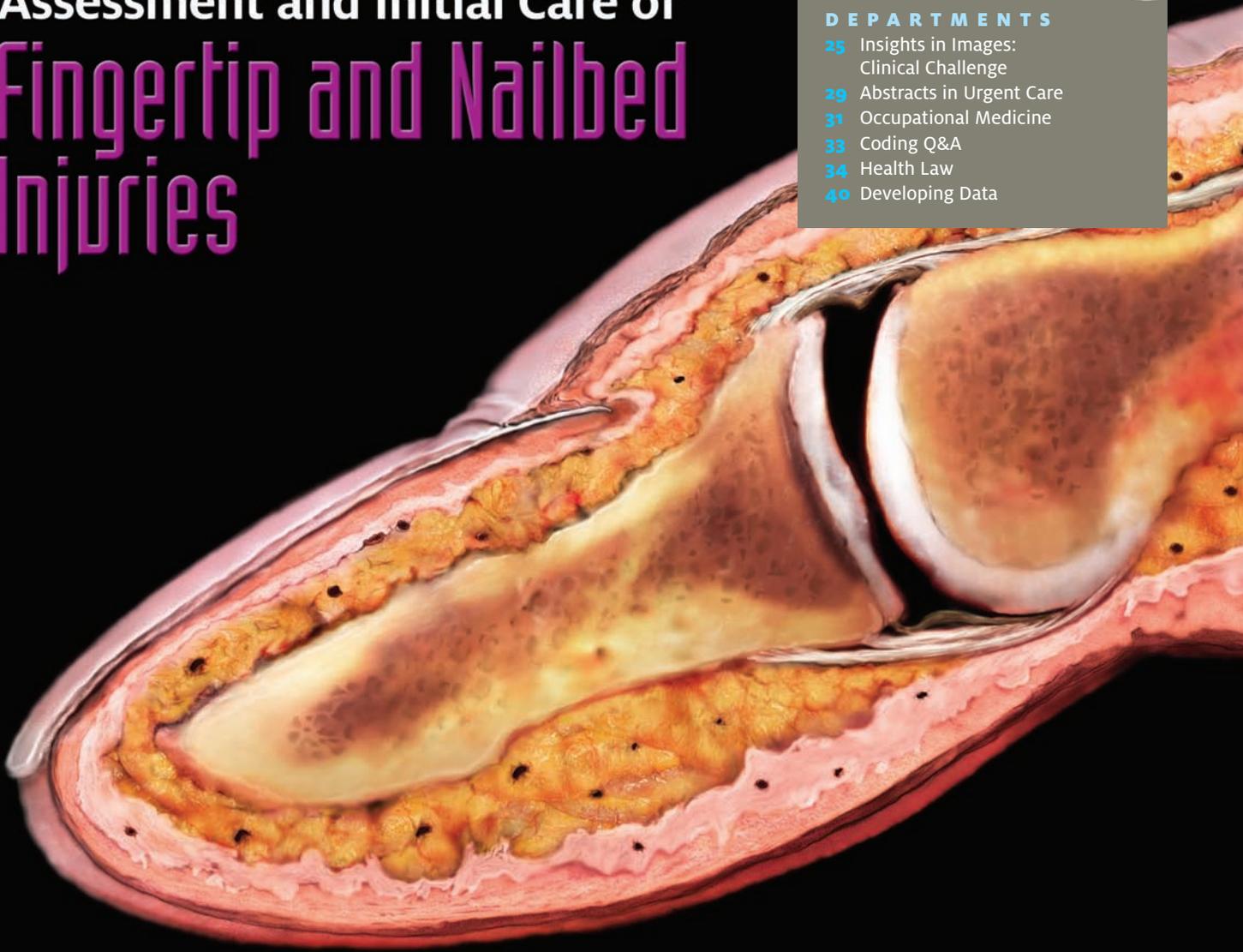
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## Assessment and Initial Care of Fingertip and Nailbed Injuries





## Get rid of the pink in a blink.\*

VIGAMOX® solution erases 99% of *Streptococcus pneumoniae* pathogens *in vitro* in as little as an hour.<sup>1\*†</sup>

†*In vitro* data are not always indicative of clinical success or microbiological eradication in a clinical setting.

**Vigamox®**  
(moxifloxacin HCl ophthalmic solution) 0.5% as base

\*The dosing of VIGAMOX® solution is one drop in the affected eye(s) 3 times daily for 7 days.

### IMPORTANT SAFETY INFORMATION

VIGAMOX® solution is indicated for the treatment of bacterial conjunctivitis caused by susceptible strains of the following organisms: *Corynebacterium species*<sup>†</sup>, *Micrococcus luteus*<sup>†</sup>, *Staphylococcus aureus*, *S. epidermidis*, *S. haemolyticus*, *S. hominis*, *S. warneri*<sup>†</sup>, *Streptococcus pneumoniae*, *Streptococcus viridans* group, *Acinetobacter lwoffii*<sup>†</sup>, *Haemophilus influenzae*, *Haemophilus parainfluenzae*<sup>†</sup>, *Chlamydia trachomatis* (†efficacy for this organism was studied in fewer than 10 infections). VIGAMOX® solution is contraindicated in patients with a history of hypersensitivity to moxifloxacin, to other fluoroquinolones, or to any of the components in this medication. NOT FOR INJECTION. VIGAMOX® solution should not be injected subconjunctivally, nor should it be introduced directly into the anterior chamber of the eye. In patients receiving systemically administered quinolones, including moxifloxacin, serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported, some following the first dose. As with other anti-infectives, prolonged use of VIGAMOX® solution may result in overgrowth of non-susceptible organisms, including fungi. The safety and effectiveness of VIGAMOX® solution in infants below 1 year of age have not been established. The most frequently reported ocular adverse events were conjunctivitis, decreased visual acuity, dry eye, keratitis, ocular discomfort, ocular hyperemia, ocular pain, ocular pruritus, subconjunctival hemorrhage, and tearing. These events occurred in approximately 1%–6% of patients.

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Please see brief summary of prescribing information on adjacent page.

## Vigamox®

(moxifloxacin hydrochloride ophthalmic solution) 0.5% as base

**DESCRIPTION:** VIGAMOX® (moxifloxacin HCl ophthalmic solution) 0.5% is a sterile ophthalmic solution. It is an 8-methoxy fluoroquinolone anti-infective for topical ophthalmic use.

### CLINICAL PHARMACOLOGY:

#### Microbiology:

The following *in vitro* data are also available, but their clinical significance in ophthalmic infections is unknown. The safety and effectiveness of VIGAMOX® solution in treating ophthalmological infections due to these microorganisms have not been established in adequate and well-controlled trials.

The following organisms are considered susceptible when evaluated using systemic breakpoints. However, a correlation between the *in vitro* systemic breakpoint and ophthalmological efficacy has not been established. The list of organisms is provided as guidance only in assessing the potential treatment of conjunctival infections. Moxifloxacin exhibits *in vitro* minimal inhibitory concentrations (MICs) of 2 µg/ml or less (systemic susceptible breakpoint) against most (≥ 90%) of strains of the following ocular pathogens.

#### Aerobic Gram-positive microorganisms:

*Listeria monocytogenes*  
*Staphylococcus saprophyticus*  
*Streptococcus agalactiae*  
*Streptococcus mitis*  
*Streptococcus pyogenes*  
*Streptococcus Group C, G and F*

#### Aerobic Gram-negative microorganisms:

*Acinetobacter baumannii*  
*Acinetobacter calcoaceticus*  
*Citrobacter freundii*  
*Citrobacter koseri*  
*Enterobacter aerogenes*  
*Enterobacter cloacae*  
*Escherichia coli*  
*Klebsiella oxytoca*  
*Klebsiella pneumoniae*  
*Moraxella catarrhalis*  
*Morganella morganii*  
*Neisseria gonorrhoeae*  
*Proteus mirabilis*  
*Proteus vulgaris*  
*Pseudomonas stutzeri*

#### Anaerobic microorganisms:

*Clostridium perfringens*  
*Fusobacterium species*  
*Prevotella species*  
*Propionibacterium acnes*

#### Other microorganisms:

*Chlamydia pneumoniae*  
*Legionella pneumophila*  
*Mycobacterium avium*  
*Mycobacterium marinum*  
*Mycoplasma pneumoniae*

#### Clinical Studies:

In two randomized, double-masked, multicenter, controlled clinical trials in which patients were dosed 3 times a day for 4 days, VIGAMOX® solution produced clinical cures on day 5-6 in 66% to 69% of patients treated for bacterial conjunctivitis. Microbiological success rates for the eradication of the baseline pathogens ranged from 84% to 94%. Please note that microbiologic eradication does not always correlate with clinical outcome in anti-infective trials.

**INDICATIONS AND USAGE:** VIGAMOX® solution is indicated for the treatment of bacterial conjunctivitis caused by susceptible strains of the following organisms:

#### Aerobic Gram-positive microorganisms:

*Corynebacterium species\**  
*Micrococcus luteus\**  
*Staphylococcus aureus*  
*Staphylococcus epidermidis*  
*Staphylococcus haemolyticus*  
*Staphylococcus hominis*  
*Staphylococcus warneri\**  
*Streptococcus pneumoniae*  
*Streptococcus viridans group*

#### Aerobic Gram-negative microorganisms:

*Acinetobacter lwoffii\**  
*Haemophilus influenzae*  
*Haemophilus parainfluenzae\**

#### Other microorganisms:

*Chlamydia trachomatis*

\*Efficacy for this organism was studied in fewer than 10 infections.

**CONTRAINDICATIONS:** VIGAMOX® solution is contraindicated in patients with a history of hypersensitivity to moxifloxacin, to other quinolones, or to any of the components in this medication.

#### WARNINGS:

NOT FOR INJECTION.

VIGAMOX® solution should not be injected subconjunctivally, nor should it be introduced directly into the anterior chamber of the eye.

In patients receiving systemically administered quinolones, including moxifloxacin, serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported, some following the first dose. Some reactions were accompanied by cardiovascular collapse, loss of consciousness, angioedema (including laryngeal, pharyngeal or facial edema), airway obstruction, dyspnea, urticaria, and itching. If an allergic reaction to moxifloxacin occurs, discontinue use of the drug. Serious acute hypersensitivity reactions may require immediate emergency treatment. Oxygen and airway management should be administered as clinically indicated.

#### PRECAUTIONS:

**General:** As with other anti-infectives, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. If superinfection occurs, discontinue use and institute alternative therapy. Whenever clinical judgment dictates, the patient should be examined with the aid of magnification, such as slit-lamp biomicroscopy,

and, where appropriate, fluorescein staining. Patients should be advised not to wear contact lenses if they have signs and symptoms of bacterial conjunctivitis.

**Information for Patients:** Avoid contaminating the applicator tip with material from the eye, fingers or other source.

Systemically administered quinolones including moxifloxacin have been associated with hypersensitivity reactions, even following a single dose. Discontinue use immediately and contact your physician at the first sign of a rash or allergic reaction.

**Drug Interactions:** Drug-drug interaction studies have not been conducted with VIGAMOX® solution. *In vitro* studies indicate that moxifloxacin does not inhibit CYP3A4, CYP2D6, CYP2C9, CYP2C19, or CYP1A2 indicating that moxifloxacin is unlikely to alter the pharmacokinetics of drugs metabolized by these cytochrome P450 isozymes.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Long term studies in animals to determine the carcinogenic potential of moxifloxacin have not been performed. However, in an accelerated study with initiators and promoters, moxifloxacin was not carcinogenic in rats following up to 38 weeks of oral dosing at 500 mg/kg/day (approximately 21,700 times the highest recommended total daily human ophthalmic dose for a 50 kg person, on a mg/kg basis).

Moxifloxacin was not mutagenic in four bacterial strains used in the Ames *Salmonella* reversion assay. As with other quinolones, the positive response observed with moxifloxacin in strain TA 102 using the same assay may be due to the inhibition of DNA gyrase. Moxifloxacin was not mutagenic in the CHO/HGPRT mammalian cell gene mutation assay. An equimolar result was obtained in the same assay when v79 cells were used. Moxifloxacin was clastogenic in the v79 chromosome aberration assay, but it did not induce unscheduled DNA synthesis in cultured rat hepatocytes. There was no evidence of genotoxicity *in vivo* in a micronucleus test or a dominant lethal test in mice.

Moxifloxacin had no effect on fertility in male and female rats at oral doses as high as 500 mg/kg/day, approximately 21,700 times the highest recommended total daily human ophthalmic dose. At 500 mg/kg orally there were slight effects on sperm morphology (head-tail separation) in male rats and on the estrous cycle in female rats.

#### Pregnancy: Teratogenic Effects.

**Pregnancy Category C:** Moxifloxacin was not teratogenic when administered to pregnant rats during organogenesis at oral doses as high as 500 mg/kg/day (approximately 21,700 times the highest recommended total daily human ophthalmic dose); however, decreased fetal body weights and slightly delayed fetal skeletal development were observed. There was no evidence of teratogenicity when pregnant Cynomolgus monkeys were given oral doses as high as 100 mg/kg/day (approximately 4,300 times the highest recommended total daily human ophthalmic dose). An increased incidence of smaller fetuses was observed at 100 mg/kg/day.

Since there are no adequate and well-controlled studies in pregnant women, VIGAMOX® solution should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** Moxifloxacin has not been measured in human milk, although it can be presumed to be excreted in human milk. Caution should be exercised when VIGAMOX® solution is administered to a nursing mother.

**Pediatric Use:** The safety and effectiveness of VIGAMOX® solution in infants below 1 year of age have not been established.

There is no evidence that the ophthalmic administration of VIGAMOX® solution has any effect on weight bearing joints, even though oral administration of some quinolones has been shown to cause arthropathy in immature animals.

**Geriatric Use:** No overall differences in safety and effectiveness have been observed between elderly and younger patients.

#### ADVERSE REACTIONS:

The most frequently reported ocular adverse events were conjunctivitis, decreased visual acuity, dry eye, keratitis, ocular discomfort, ocular hyperemia, ocular pain, ocular pruritus, subconjunctival hemorrhage, and tearing. These events occurred in approximately 1-6% of patients.

Nonocular adverse events reported at a rate of 1-4% were fever, increased cough, infection, otitis media, pharyngitis, rash, and rhinitis.

#### Rx Only

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#### Reference:

1. Data on file. Alcon Laboratories, Inc.

# Call for Articles

**JUCM**, the Official Publication of the Urgent Care Association of America, is looking for a few good authors.

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

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

Please e-mail your idea to

JUCM Editor-in-Chief

Lee Resnick, MD at

[editor@jucom.com](mailto:editor@jucom.com).

He will be happy to discuss it with you.





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# A Recipe for Medical Decision Making



No other specialty requires more expertise in medical decision making than urgent care medicine. We specialize in the evaluation and management of the “undifferentiated patient,” with limited access to diagnostic and consultative resources.

Our scope of care is one of the broadest in medicine, requiring breadth of knowledge across disciplines. Our patients are almost entirely new to us, giving us limited clinical and personal insight into their presentations.

Finally, constraints on our time with the patient mandate an ability to quickly sift through relevant—and, often, irrelevant—information in light of widely variable patient agendas, cultural differences, and education levels.

These challenges combine to require the most honed medical decision-making skills in all of medicine.

How can we perfect our craft? Of course, there is no one formula, but there are some basic ingredients:

### Fund of Knowledge

Comprehensive understanding of the pathophysiology of disease forms the underpinnings of any evaluation.

### History and Physical

Oh yeah, that little thing they taught me in med school.

Medical decision making begins with a systematic approach to the history and physical. It is, perhaps, the most obvious and underappreciated part of the evaluation. It is by far the most important tool we have in the evaluation of the undifferentiated patient.

I advise you to go back to your notes from med school and appreciate the importance of a complete and sound H & P. The vast majority of medical decisions can be made with a simple H & P, and the vast majority of errors can be avoided. A good H & P will guide appropriate utilization and will have a profound impact on patient trust and satisfaction.

Spending time here will save you time in the long run. Do *not* make productivity demands your excuse for not taking a systematic approach to the history and physical.

### Patient Agendas

If you do not understand what brought the patient in to seek care in the first place, you simply cannot make accurate medical decisions. Patient agendas color every encounter, and can derail an evaluation if not adequately assessed.

### Judgments and Assumptions

I have discussed in previous columns how making judgments and assumptions about patients can lead to inaccurate decision making, so I will not elaborate here. Suffice to say that resisting the urge to judge your patients facilitates gaining their trust, which in turn enhances your ability to elicit the important information necessary to ensure the best outcomes.

### References

Referring to the medical literature through texts, online tools, and algorithms is a regular part of the decision-making process.

### Diagnostics

Their importance has been overstated in the era of defensive medicine, but they still have an important place in decision making. (Notice, however, this is one of the last ingredients.)

### Consultation

Relying on expert opinion, when appropriate, has always been central to the decision-making process.

Mix these ingredients together, throw them in the oven, and 15 minutes later, hopefully your cake will rise! ■

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

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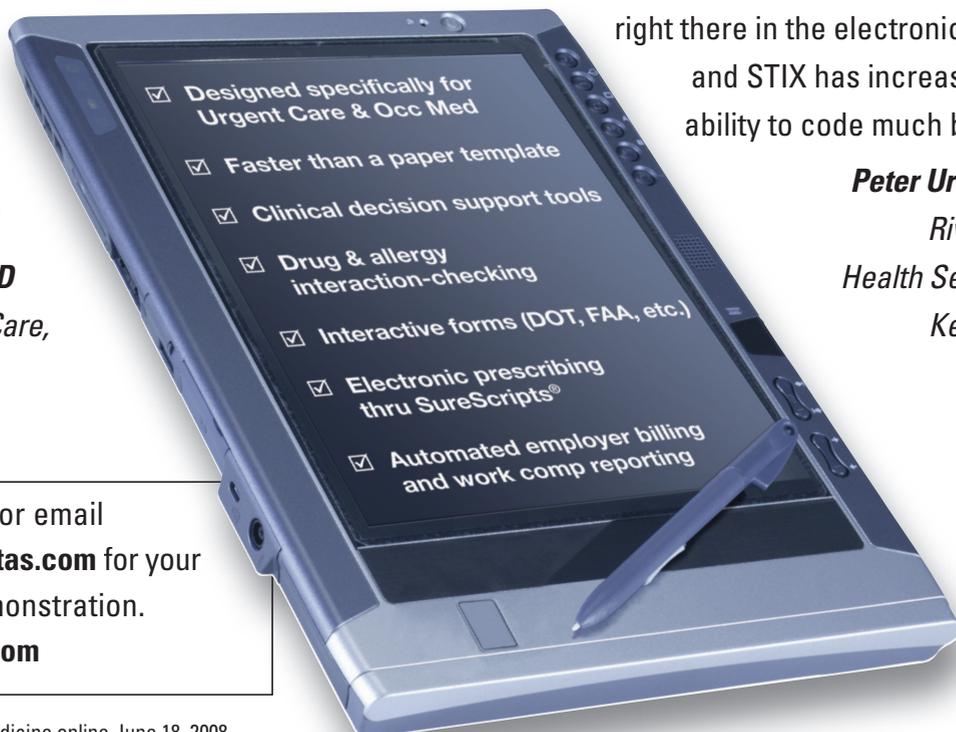
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\*New England Journal of Medicine online June 18, 2008.



### CLINICAL

## 11 Assessment and Initial Care of Fingertip and Nailbed Injuries

Injuries to the fingertip and nailbed may be the result of a crushing blow or sloppy handling of saws or other power tools. Understanding the relevant anatomy is the first step toward proper initial care and long-term positive outcomes.

By Scott M. Zimmer, MD

### PRACTICE MANAGEMENT

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Front office personnel affect a patient's perception of your practice and can support—or hinder—your quest to build a healthy business. Hiring a good manager and assembling the right team can be a make-or-break factor.

By Alan A. Ayers, MBA, MAcc



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From the UCAOA Executive Director

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**In the next issue of JUCM:** Acute foot injuries often send patients to urgent care—though sometimes weeks or months after the onset of pain. How should your approach differ for injuries that occurred an hour ago vs. a month ago? The first of a two-part series.

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## Mission Statement

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

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

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## FROM THE EXECUTIVE DIRECTOR

# UCAOA Has a New Home(page)

■ LOU ELLEN HORWITZ, MA

You've probably noticed that UCAOA has an entirely new website at [www.ucaoa.org](http://www.ucaoa.org)! Since we've moved some things around and added a lot of new content, we want to make sure you're able to find what you're looking for when you visit us.

### Overall Hints

There are two main "navigation" areas on every page—the tabs on the top and on the left side of your screen.

The tabs at the top of the screen take you to the five main areas of the site; you can click on the tab itself for an overview, or "roll over" it for subheadings.

- **Membership**—Information about UCAOA, why you should be a member, and the secrets of the Members Only portion of the site.
- **Get Involved**—How you can be a speaker, get published, participate, exhibit, or sponsor.
- **Education**—All of our education options (face-to-face, online, in *JUCM*, and fellowships).
- **Resources**—Articles, vendors, statistics, and the ever-growing JobBank.
- **Accreditation**—Simple information on how to become accredited.

Use the quick links on the left side of the screen to get to the details of a section; once you're in one of the five main areas, *these are probably the fastest way to get to what you want*. The links that are available on every page (such as Members Only, Contact Us, Join Now, and Vendors Click Here) allow you to jump to those pages from wherever you are on the site.

### The Home Page

The home page ([www.ucaoa.org](http://www.ucaoa.org)) has its own special links on the left that jump to our most popular pages, as well as four sections running down the middle of the screen, to help you get where you're going with as few clicks as possible.



**Lou Ellen Horwitz** is executive director of the Urgent Care Association of America. She may be contacted at [lorwitz@ucaoa.org](mailto:lorwitz@ucaoa.org).

The content running down the center of the homepage is organized as follows:

- *What's New* will change almost weekly to keep up with what's going on in urgent care and at UCAOA.
- *Conferences* has information about the next upcoming conference, along with links to more detailed information.
- *Forums* links directly to the online discussion forums.
- *Journal* previews the content in the current issue of *JUCM* and offers a link directly to the online version of that issue.

The UCAOA home page also has links to our Platinum Sponsors, and a few spots for advertising, so you may see centers for sale or other ads on the right side of the page.

### New Website Features and Content

- **JobBank**—UCAOA is now part of a national job network; this gives you the option to post or search for new positions.
- **Resources by category**—A listing of everything we have, plus links to clinical guidelines relevant to urgent care.
- **Getting Started**—If you're new to urgent care, we set aside resources specifically to help you hit the ground running.
- **Self-study**—Our new online library has 55 urgent care lectures and counting, available for immediate download and access for one year (either by lecture or as a whole). Access this by rolling over the Education tab along the top of the screen.

### Members Only

If you're not a member and have wondered what's in Members Only, we now offer a sneak preview. In the Resources sections, we include reference to all of the resources that are only available to members so you can get a hint of what's beyond those "velvet ropes." Come join us and see!

### Feedback

We want to know what you think about the website—what's still missing, if you're having trouble navigating or finding what you're looking for, and what you like about it. Your feedback will help us develop the site into a tool you'll use every day.

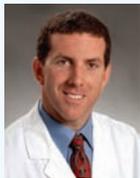
(PS—Early registration for the 2009 Annual Convention is now open. Visit [www.ucaoa.org](http://www.ucaoa.org) to learn more!) ■



# JUCM CONTRIBUTORS

It's a rare (and very lucky) person who hasn't experienced the pain of slamming a fingertip in a door or bashing it with a hammer or other blunt object. Likewise, few things get patients to an urgent care center faster, especially when the mishap occurs outside of their physician's normal office hours.

With winter fast upon us and fuel costs still high, fingertip and nailbed injuries may become more common as more folks cut and stack wood to heat their homes. Of course, an errant swing of an ax or slip of a chain saw isn't the only way injuries of this nature occur, but how you respond to them could mean the difference between an injury that will heal and a digit that may permanently lose sensation or, worse, need to be amputated.



In our cover story, Assessment and Initial Care of Fingertip and Nailbed Injuries (page 11), **Scott M. Zimmer, MD** reviews what to look for in the initial evaluation of a patient in distress and discusses the various techniques and treatments for these often-serious injuries. Dr. Zimmer is director of hand and upper extremity surgery for University Hospitals Medical Practices and director of the UH Geauga Hand and Upper Extremity Center in Cleveland.

This month's issue also features a practice management article from an expert who's familiar to loyal *JUCM* readers, **Alan A. Ayers, MBA, MAcc**. In *The Front Office: Window to Your Practice* (page 18), he discusses the critical role of the manager and front desk



staff to the success of an urgent care center. Surround yourself with good employees and you'll free yourself up to do what you do best: practice sound medicine.

### Also in this issue:

**Nahum Kovalski, BSc, MDCM** reviews abstracts of new articles on the San Francisco Syncope Rule, antibiotics in treating pyelonephritis, and the role of multidetector computed tomography (MDCT) in diagnosing appendicitis.

**Frank Leone, MBA, MPH** examines the ins and outs of launching a marketing campaign for your urgent care center. Hint: The approach will be much different if you live in New York City versus a tiny hamlet in the Adirondacks.

**John Shufeldt, MD, JD, MBA, FACEP** discusses how to not only survive, but prosper in the wake of current turbulence in the economy.

**David Stern, MD, CPC** reveals changes in the ICD-9 coding system that could impact your bottom line.

As always, we'd like to hear from you. If you have a thought about an article you read here—be it a challenge to one of our author's conclusions, a general reaction to how we're doing, or an idea for a future article—please send an e-mail to our editor-in-chief, **Lee A. Resnick, MD**, at [editor@jucm.com](mailto:editor@jucm.com).

And, if our cover story hasn't issued enough of a warning already, be careful gathering that wood this season. ■

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*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.

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## Assessment and Initial Care of Fingertip and Nailbed Injuries

**Urgent message:** Whether required due to a crushing blow or close contact with a sharp surface, proper initial care for fingertip and nailbed injuries is essential to good outcomes and can often be administered in the urgent care setting.

Scott M. Zimmer, MD

### Introduction

Fingertip injuries are one of the most common conditions seen in urgent care and emergency room settings. From door crush to table saw injuries, the proper initial care is vital in the long-term result.

The goal is a fingertip that has minimal pain, good sensation, and adequate soft tissue coverage. Treatments range from simple cleansing with healing by secondary intention to bone-shortening and primary closure.

The goals of this article will be to foster understanding of fingertip and nailbed anatomy, common injury patterns, and proper initial care.

### Anatomy

A simple understanding of the anatomy is necessary for



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proper initial treatment. In addition, it allows the urgent care physician to convey the nature and severity of the injury to the hand specialist. This communication is key to long-term success because, often, the urgent care physician will simply need to provide wound care and proper follow-up.

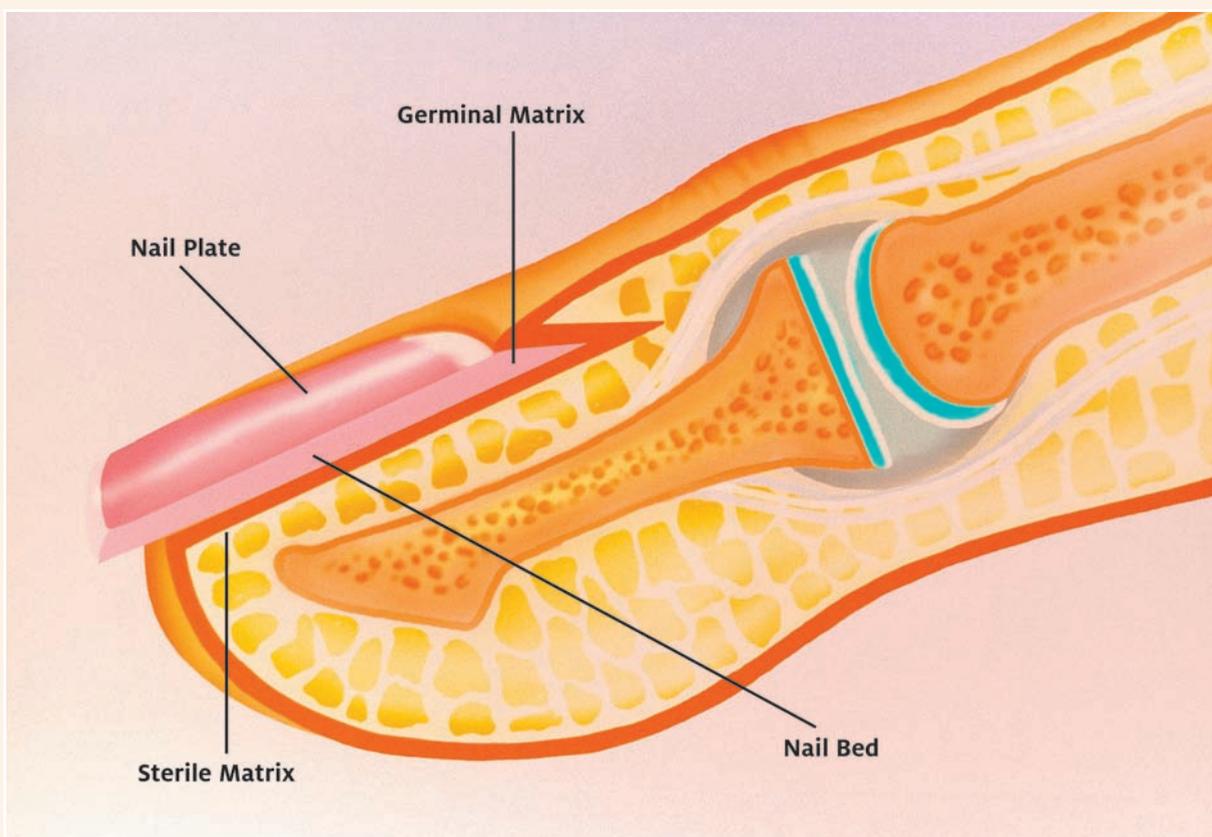
The pulp at the end of a digit is highly specialized tissue and consists of fibrous and fatty tissue that has septa extending from the skin to the distal phalanx.

The nail unit is made up of the nail plate and the

nailbed (**Figure 1**). Beneath the nail plate, the nail bed is divided into the sterile matrix and the germinal matrix.

The germinal matrix is the proximal region of the matrix demarcated by the crescent-shaped region seen at the

Figure 1.



© BSIP / Photo Researchers, Inc.

nail base called the lunula. The germinal matrix produces over 90% of the nail but does not adhere to the nail plate.

The sterile matrix is distal to the lunula and is responsible for nail adherence. An important anatomical relation is the nail plate's relation to the dorsal and ventral nail fold. Common injuries involve nail plate avulsion from this location. A mistake can be made by suturing the nail plate in place without replacing it in this anatomic location, causing pain and deformity with subsequent nail growth.

The terms *hyponychium*, *paronychium*, and *eponychium* refer to the regions of skin distal, on either side, and proximal to the matrix, respectively.

### Initial Evaluation

Most fingertip injuries occur in children and young adults, which can make initial evaluation difficult.<sup>1</sup> The history allows the physician to determine the forces involved and the degree of contamination. Young chil-

dren with near amputations of the pulp with a small amount of nail should be considered for simple reattachment, since many times the nail acts as a composite graft and gives a desirable result.

Radiographs allow the determination of fracture, which often suggests a nail matrix laceration even if the nail plate is intact.

Digital block is often necessary to properly evaluate and cleanse the wound. Various techniques for the block have been described, but all can be a challenge in the young patient. One technique described by Chiu<sup>2</sup> allows one injection into the flexor sheath as if giving a trigger injection and uses much less volume of anesthetic than circumferentially infiltrating the digit. A simple soak in a sterile normal saline and 4% povidone iodine or chlorhexidine bath (dilution at least 5:1) is an effective cleansing treatment and is often followed simply by a non-adherent dressing of bacitracin, petroleum gauze, and 2x2s.

A short course of cephalexin or clindamycin is appropriate. However, detailed discussion of this recommendation is beyond the scope of this article.

This type of initial treatment is effective even in severe fingertip injuries, as long as follow-up to a hand specialist is arranged within a few days.

The remaining sections of this article will detail treatment for various fingertip and nailbed injuries.

### **Nailbed Injuries**

Controversy exists as to what constitutes a significant subungual hematoma. Traditional teaching states that a 50% or greater subungual hematoma warrants nail plate removal and inspection and possible matrix repair.

A 1999 study<sup>3</sup> revealed similar outcomes in children treated with and without nail plate removal and matrix repair regardless of the presence of fracture, size of subungual hematoma, or injury mechanism. In these patients, the nail plate was intact.

A lacerated nail plate almost always signifies a nail matrix laceration and the nail plate must be removed and the matrix repaired with 6-0 absorbable suture. A simple soak, dressing, and antibiotic with a timely referral to a hand specialist is needed unless the physician has experience with this type of repair.

Subungual hematoma release is indicated for a significant hematoma greater than 25% to 50% that is associated with pain. No study has demonstrated a better outcome after evacuation (nail trephination), but it does decrease pain. This is performed by a twisting motion with an 11 blade scalpel or an 18 gauge needle piercing the nail plate over the hematoma.

Nailbed injuries with an associated displaced fracture represent a more difficult challenge. In the acute setting, simple care as described above still is sufficient if a quick referral is obtained, but digital block and fracture reduction with or without nailbed repair may be performed.



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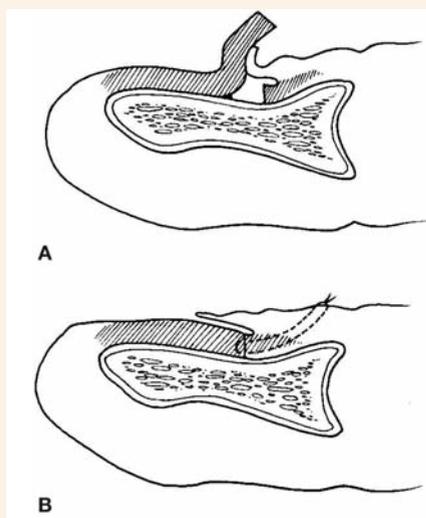
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**Figure 2.**

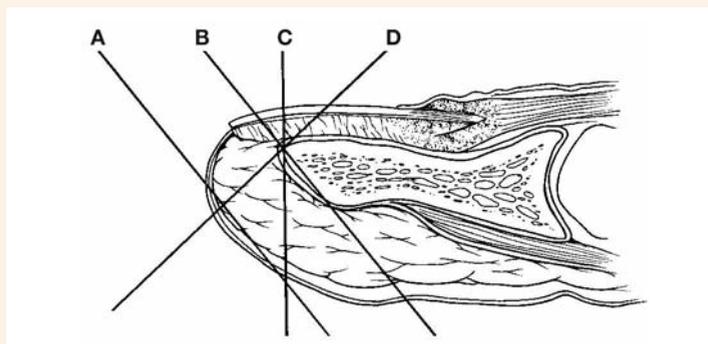


**Figure 2A.** Proximal detachment of the germinal matrix.

**Figure 2B.** Replacement into nailfold and repair with horizontal mattress sutures.

Source: Fassler PR. Fingertip injuries: Evaluation and treatment. *J Am Acad Orthop Surg.* 1996;4:84-92. Copyright 1996 by the American Academy of Orthopaedic Surgeons.

**Figure 3. Angles and Levels of Amputation**



- A. Volar oblique with no exposed bone.
- B. Volar oblique with exposed bone.
- C. Transverse with exposed bone.
- D. Dorsal oblique with no exposed bone.

Source: Fassler PR. Fingertip injuries: Evaluation and treatment. *J Am Acad Orthop Surg.* 1996;4:84-92. Copyright 1996 by the American Academy of Orthopaedic Surgeons.

The nail plate is the best structure to place back over the matrix after repair, and even after partial avulsion. It has the best contour and often does not even need to be sutured in place. A new nail will begin to grow and push the replaced nail out in a few weeks.

The physician does not need to replace the nail plate if the dorsal and ventral nail fold region is not damaged. If the physician does not feel comfortable replacing the

nail plate, then a simple dressing with abundant bacitracin/Neosporin will suffice. The matrix will dry out after a few days and become non-tender. It is better to leave the nail plate off if there is a laceration of the matrix and the physician is referring it for repair.

It is also important for the physician to align lacerations of the eponychium, hyponychium, and paronychium. These can be repaired with 4-O or 5-O nylon or Prolene and is necessary to guide the new growing nail in proper alignment.

One practical point is the technique for nail plate removal. Avoid using sharp scissors, as this may damage the matrix. A mosquito hemostat or a freer-elevator works well to slide under the nail plate and lift it off the matrix with minimal damage. The ability to remove the nail plate quickly with minimal trauma is needed not only in injury, but is necessary in acute paronychia infections where the region needs to be decompressed.

The germinal matrix may also become avulsed from its base and flip out in front of the eponychium (**Figure 2**). It is important to recognize this occurrence and replace it in its anatomic location. Again, the key is recognition of different patterns of injury and the ability to convey the nature of the injury to a hand specialist.

### Fingertip Amputations

Amputations can range from small pulp injuries to total amputation of the finger through the nail. In the majority of cases, the small amputated remnant is not able to be replanted. An exception is a small child in which case the tip can simply be sutured back in place if there is no significant contamination or tip destruction.

In any adult or child, if there is any skin bridge connecting the amputated part, simple suture closure may lead to unexpectedly excellent results. This treatment is certainly acceptable in an acute setting, especially if it is the nailbed that is still connected since this is a highly vascular structure.

Treatment of any amputation begins with determining the level of amputation and its obliquity (**Figure 3**).

A main determinant is the amount of exposed bone.

A misconception is that no exposed bone is allowed and that the bone must be shortened at the initial evaluation. Fingertip amputations with a small amount of exposed bone can be treated open by healing with secondary intention, with excellent results.<sup>4-8</sup>

In the urgent care or emergency room setting, the physician does not need to feel that he or she must shorten the bone and get primary closure. Appropriate care would consist, again, of soak, bacitracin/Neosporin, and dressing with referral in two to three days. **Figure 4** demonstrates an amputation of the nail plate and nailbed with a small amount of exposed bone five days after injury. The wound will be allowed to simply heal in by secondary intention with daily dressing changes.

An important point to understand is the role of the distal phalanx in supporting the nailbed. If there is no bone supporting the nail matrix, then the nail will "hook" over the end of the digit. Bone should only be trimmed back to the edge of the nail matrix to prevent this deformity.

The decision to perform an immediate revision amputation in the urgent care or emergency department setting is discouraged unless the physician has considerable training in this area. In many rural settings, there may be a need to perform this procedure acutely, but several key points need to be addressed. An amputation just distal to the distal interphalangeal joint will be used as an example.

A common mistake would be to trim back the bone far enough to get closure. Two important factors must be considered.

First, the closer one gets to the joint, the greater the chance that the distal insertions of the extensor and flexor tendons may be disrupted. If only a small amount of distal phalanx is left, then removal of this small remaining fragment may be best. The flexor and extensor tendons should never be repaired to the ends of the bone because this will alter function at the metacarpophalangeal and proximal interphalangeal joints. Simply pull on the tendon and cut it, then allow it to retract into the wound.

The more common problem seen is that a good portion of the germinal matrix is left at the nail base. The nail must be completely ablated by excising the entire matrix prior to end closure. If the matrix is left, a painful nail cyst will develop. Care must be taken not to release the terminal extensor tendon when excising the matrix.

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Figure 4.



Amputation in a 15-year-old from a log splitter injury.

Source: Scott M. Zimmer, MD.

### Summary

Fingertip and nailbed injuries are among the most common injuries seen in urgent care and emergency department settings. The following summary points may serve as guidelines in directing care in the acute setting:

- Initial evaluation with radiographs and exam will allow the physician to determine appropriate care and convey the injury to the hand specialist.
- Acute cleansing for all fingertip injuries can be a soak of diluted 4% povidone iodine/chlorhexidine and saline solution, followed by bacitracin/Neosporin nonadherent dressing with splint or bulky wrap.
- A three-day course of cephalexin or clindamycin is appropriate.
- The majority of partial amputations can heal by secondary intention.
- A nail plate laceration is indicative of a matrix injury, and repair is needed.
- Definitive treatment is rarely needed in the urgent care setting, and quick referral within three

days is usually acceptable. This will be dependent on the practices and expectations of the local hand surgeon. ■

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## The Front Office: Window to Your Practice

**Urgent message:** Patients will return again and again—and tell their friends, too—if your center’s manager and employees are unfailingly courteous, competent, and thorough.

Alan A. Ayers, MBA, MAcc

If you’re planning to own and operate an urgent care center, you’re probably not thinking about managing an administrative office. Instead, you envision yourself hurrying between exam rooms, suturing cuts, setting fractures, and dispensing orders. Digging your way out of paperwork, refereeing staff disputes, tracking down cash, and assuring supply cabinets are stocked are probably not in your dreams.

The front office of an urgent care center isn’t only the first and last place patients interact with the practice: It’s critical to assuring that the center gets paid for every visit and has all the resources it needs to run smoothly.

But despite its importance, all too often the front of-



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office is the least funded and most neglected part of the urgent care operation. By focusing on the management, staff, processes, and physical environment of the front office, an urgent care center operator can potentially improve the performance and morale of the entire facility.

### **Your Key Employee: The Center Manager**

Most urgent care centers employ a full-time manager, although the scope of his or her duties may vary depending on daily patient volume, owner-

ship structure, and the extent of external billing and operations support. In a freestanding, independent urgent care center, the manager is typically a “jack of all trades” who oversees day-to-day operations, imple-

ments marketing programs, provides financial reports, and supports the delivery of urgent care services. In a multicenter network, tasks like marketing, accounting, training, and billing may be consolidated into a centralized structure that supports each individual center. In these networks, the managers function in more of an administrative role.

As you'll see in **Table 1**, an urgent care center manager has a full plate of responsibilities. In many centers, the manager is trained in all support functions and fills in as a medical assistant or front desk attendant as needed.

The ownership and volume of the practice will also determine the skills and experience required of an urgent care center manager. This person's background may range from a Registered Nurse or MBA graduate, to a technologist or medical assistant with on-the-job training. As with any position, it's important to assure that the center manager has the knowledge, skills, and experience to be effective and take the facility to the next level. This position requires someone with extensive experience in human resources, clinical operations, billing, customer service, and physician relations. Many centers choose to promote from within, which can be a good practice, but it should be done with consistency and based on merit—job qualifications must be met as if hiring someone from the outside. When a center manager's duties are administrative in nature and this person lacks the experience, authority, or management training to make operational decisions, his or her impact on the overall business may be greatly diminished.

Whether promoting from within or hiring externally, qualifications for center managers typically include:

- Associates/bachelors degree
- Health care experience (3-5 years)
- Supervisory/management experience (1-2 years)
- Human resources experience
- Strong work history/references from previous employers
- Customer service experience
- Professional presentation

Center managers must be able to perform with min-

**Table 1. Day-to-Day Responsibilities of the Urgent Care Center Manager**

- Interview, hire, orient, train, and develop staff and assure all HR policies are followed.
- Develop staff schedules, review time cards, and compile payroll.
- Hold staff meetings, recognize staff achievements, and address staff concerns.
- Conduct performance appraisals and provide mentoring/coaching to staff.
- Review daily balance sheets, reconcile the cash drawer, and make bank deposits.
- Review invoices and prepare accounts payable packages.
- Manage medical and office supply inventory; place, check, and stock orders.
- Assure chart documentation is complete and submit charges for billing.
- Research billing issues, identify causes of errors, and adjust or re-bill accounts.
- Assure medical and clerical equipment is maintained and in working order.
- Assure facility is clean, maintained, and all systems are functioning properly.
- Check alarm system, security cameras, and videos.
- Review center logs, including lab, x-ray, narcotics, reportable incidents, and daily duties.
- Respond to patient feedback and resolve customer service issues.
- Assure compliance with all operating standards, policies and procedures, and laws/regulations.
- Identify, organize, and participate in grassroots marketing activities.

imal supervision and understand that “contributing” means doing more than their assigned tasks—it means having a measurable impact on the company's bottom line by putting the right team members in place, maintaining quality standards, meeting patient needs, and controlling costs.

Productive, happy employees generally feel they're making unique contributions that provide a sense of personal pride. If a center manager has the necessary resources, he or she should be able to work independently—anyone who has worked under a dreaded micro-manager understands the motivating power of a leader's trust. When the center manager makes decisions, urgent care providers and the center's owners shouldn't interfere. This doesn't mean to abandon accountability—such as weekly update meetings and

**Table 2. Front Desk Processes**

**Patient Greeting:** Patients should be greeted in a welcoming and professional manner as they enter the facility. When there's a wait, the front desk should ask the patient his or her first name and write it on the waiting list, along with the arrival time. Check-in time should be the time the patient arrives, not when he approaches the front desk to complete registration.

**Registration:** Front desk staff should explain each form and its purpose to ensure understanding and to limit the patient's time spent filling out the forms. Patients are typically given a registration package that includes demographic/insurance information, medical history, HIPAA acknowledgment, and the center's financial policies. Information on secondary insurance and any guarantor should be obtained from all patients. For existing patients, the staff should review information in the computer system—such as address and insurance plan/group numbers—to assure nothing has changed. Asking the patient if anything changed since his last visit is insufficient because he may not know what information is already in the system.

**Insurance Verification:** Insurance verification should occur prior to every physician encounter. This crucial step can be facilitated by providing links to insurance websites on the registration PC desktop, a list of verification phone numbers, or by subscribing to an online verification portal. Staff should verify plan participation, urgent care co-pays, and any unmet deductible.

**Payment Collection:** Staff should collect either the deductible portion or co-pay at the time of service. Payments are typically collected prior to the visit for co-pays and outstanding balances. For past balances, the registration staff should be versed in the reasons insurance companies deny claims. For deductibles and self-pay patients, patients are typically escorted by the clinical staff to the discharge counter where charges can be calculated and the correct amount collected after the visit.

**Charge Entry/Coding:** Depending on the practice management system in place and whether the urgent care center performs its own billing or out-sources to a third party, the front desk may code charts and calculate charges. Physicians generally complete documentation for the visit, including entering ICD-9 and CPT codes. The front desk should be aware of ICD-9 and CPT incompatibilities, which can create delays in getting claims out on a timely basis.

written status reports—or to withhold guidance on critical decisions. While each center manager will have a unique style, personality, and talents, the owners still set the overall tone and direction of the practice.

The manager's office is typically located near the front desk to oversee the registration staff, answer questions, and resolve customer service issues as they arise. Center managers typically work a 40-hour week, during daytime hours, although they may occasionally fill in for absent staff members on nights and

weekends. Larger urgent care centers may employ multiple managers who oversee administrative functions and coordinate clinical support, as well as shift supervisors who have management responsibility when the center manager is away.

### **Greeting the Patient: Registration Staff**

Like the center manager, patient registration staff must juggle a variety of tasks while assuring patient needs are met. The front desk is the patient's first interaction when entering the urgent care center and sets the tone for the entire visit and experience. To assure a positive experience, the front desk staff must act as:

- Diplomat—Handle difficult situations and patients with tact.
- Listener—Pick up on unspoken messages.
- Problem Solver—Handle each patient and situation efficiently and courteously.
- Crisis Counselor—Calm troubled or angry patients with compassion and reassurance.
- Time Saver—Reduce the number of unnecessary questions or issues for staff and physicians to deal with.
- Public Relations Expert—Present the most positive image of the center.

But the role of the front desk doesn't stop with great customer service. The staff has to be knowledgeable and comfortable with insurance benefits and how they're administered, acting in the following capacities:

- Investigator—Decipher information from an insurance card, website, or telephone call.
- Validator—Access, obtain, and understand information about insurance and benefits eligibility.
- Enforcer—Collect patient balances in a professional, yet "forceful" manner.

In short, the front office staff needs to be trained well enough to understand insurance terminology and explain it competently to patients. Moreover, if patients don't understand their benefits, the front desk staff must be willing and able to help.

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TUSSIONEX® is indicated for the relief of cough and upper respiratory symptoms associated with allergy or a cold in adults and children 6 years of age and older. Each 5 mL of TUSSIONEX® contains hydrocodone polistirex equivalent to 10 mg hydrocodone bitartrate and chlorpheniramine polistirex equivalent to 8 mg chlorpheniramine maleate.

TUSSIONEX® is contraindicated in children less than 6 years of age due to the risk of fatal respiratory depression, and in the presence of known allergy or sensitivity to hydrocodone or chlorpheniramine. The most common adverse reactions associated with TUSSIONEX® are sedation, drowsiness, and mental clouding, which may impair the mental and/or physical abilities required for potentially hazardous tasks such as driving or operating machinery. TUSSIONEX® should not be taken with alcohol or other CNS depressants. TUSSIONEX® is dosed at 5 mL every 12 hours in patients 12 years of age and older, and at 2.5 mL every 12 hours in patients 6-11 years of age. Overdose with TUSSIONEX® has been associated with fatal respiratory depression. Patients should be advised to measure TUSSIONEX® with an accurate measuring device. A household teaspoon is not an accurate measuring device. As with any other drugs in this class, the possibility of tolerance and/or dependence, particularly in patients with a history of drug dependence, should be considered.

Please see full Prescribing Information on reverse.

Reference: 1. US Food and Drug Administration. FDA takes action to stop marketing of unapproved hydrocodone products [press release]. Available at: <http://www.fda.gov>. Accessed June 6, 2008.

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

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 **Tussionex®**   
Pennkinetic®  
(hydrocodone polistirex/  
chlorpheniramine polistirex)  
Extended-Release Suspension

**Cough relieved. Rest assured.™**

# Tussionex<sup>®</sup> Pennkinetic<sup>®</sup>

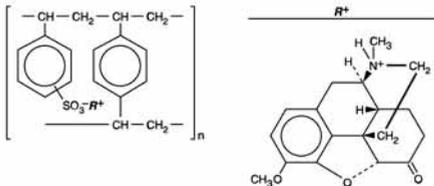
(hydrocodone polistirex and chlorpheniramine polistirex)  
Extended-Release Suspension

Rx Only

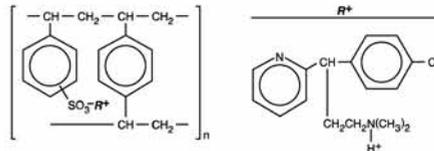
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**DESCRIPTION:** Each teaspoonful (5 mL) of TUSSIONEX Pennkinetic Extended-Release Suspension contains hydrocodone polistirex equivalent to 10 mg of hydrocodone bitartrate and chlorpheniramine polistirex equivalent to 8 mg of chlorpheniramine maleate.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

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



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



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

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

Chlorpheniramine is an antihistamine drug (H<sub>1</sub> receptor antagonist) that also possesses anticholinergic and sedative activity. It prevents released histamine from dilating capillaries and causing edema of the respiratory mucosa.

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

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

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

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

The use of TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in children less than 6 years of age due to the risk of fatal respiratory depression.

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

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

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

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

**Pediatric Use:** The use of TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in children less than 6 years of age (see CONTRAINDICATIONS).

In pediatric patients, as well as adults, the respiratory center is sensitive to the depressant action of narcotic cough suppressants in a dose-dependent manner. Caution should be exercised when administering TUSSIONEX Pennkinetic Extended-Release Suspension to pediatric patients 6 years of age and older. Overdose or concomitant administration of TUSSIONEX Pennkinetic Extended-Release Suspension with other respiratory depressants may increase the risk of respiratory depression in pediatric patients. Benefit to risk ratio should be carefully considered, especially in pediatric patients with respiratory embarrassment (e.g., croup) (see PRECAUTIONS).

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

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

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

Patients should be advised to measure TUSSIONEX Pennkinetic Extended-Release Suspension with an accurate measuring device. A household teaspoon is not an accurate measuring device and could lead to overdose, especially when a half a teaspoon is measured. A pharmacist can recommend an appropriate measuring device and can provide instructions for measuring the correct dose.

Shake well before using.

Keep out of the reach of children.

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

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

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

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

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

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

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

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

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

**Pediatric Use:** The use of TUSSIONEX Pennkinetic Extended-Release Suspension is contraindicated in children less than 6 years of age (see CONTRAINDICATIONS and ADVERSE REACTIONS, Respiratory, Thoracic and Mediastinal Disorders).

TUSSIONEX Pennkinetic Extended-Release Suspension should be used with caution in pediatric patients 6 years of age and older (see WARNINGS, Pediatric Use).

**Geriatric Use:** Clinical studies of TUSSIONEX did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

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

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

**General Disorders and Administration Site Conditions:** Death

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

**Renal and Urinary Disorders:** Ureteral spasm, spasm of vesical sphincters, and urinary retention have been reported with opiates.

**Respiratory, Thoracic and Mediastinal Disorders:** Dryness of the pharynx, occasional tightness of the chest, and respiratory depression (see CONTRAINDICATIONS).

TUSSIONEX Pennkinetic Extended-Release Suspension may produce dose-related respiratory depression by acting directly on brain stem respiratory centers (see OVERDOSAGE). Use of TUSSIONEX Pennkinetic Extended-Release Suspension in children less than 6 years of age has been associated with fatal respiratory depression. Overdose with TUSSIONEX Pennkinetic Extended-Release Suspension in children 6 years of age and older, in adolescents, and in adults has been associated with fatal respiratory depression.

**Skin and Subcutaneous Tissue Disorders:** Rash, pruritus.

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

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

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

**DOSAGE AND ADMINISTRATION:** It is important that TUSSIONEX is measured with an accurate measuring device (see PRECAUTIONS, Information for Patients). A household teaspoon is not an accurate measuring device and could lead to overdose, especially when half a teaspoon is to be measured. It is strongly recommended that an accurate measuring device be used. A pharmacist can provide an appropriate measuring device and can provide instructions for measuring the correct dose.

Shake well before using.

**Adults and Children 12 Years and Older:** 5 mL (1 teaspoonful) every 12 hours; do not exceed 10 mL (2 teaspoonfuls) in 24 hours.

**Children 6-11 Years of Age:** 2.5 mL (1/2 teaspoonful) every 12 hours; do not exceed 5 mL (1 teaspoonful) in 24 hours.

This medicine is contraindicated in children under 6 years of age (see CONTRAINDICATIONS).

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

NDC 53014-548-67 473 mL bottle

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

**Storage:** Shake well. Dispense in a well-closed container.

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

TUSSIONEX Pennkinetic Extended-Release Suspension

Manufactured for:

UCB, Inc.  
Smyrna, GA 30080



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Salaries and benefits are an urgent care center's biggest costs, so the extent to which the center manager can schedule front office staff without compromising service will have an immediate impact on the bottom line. Consideration should be given to seasonal and daily volume trends. For instance, if a center sees most of its patients between 9:00 am and noon, and again between 4:00 pm and closing, there may be times in the afternoon when the registration staff is underutilized. It's the center manager's responsibility to assure time isn't wasted, by delegating tasks such as cleaning, filing, marketing, or patient follow-up during any slow periods. Some centers hire part-time front office staff in the mornings and evenings and then utilize back office staff for patient registration in the afternoon.

Typically, a front office staff member is hired as an entry-level employee who receives on-the-job training and meets the following qualifications:

- Previous health care experience or training.
- Completing and passing of a hiring assessment tool.
- Strong and positive feedback from professional references.
- Professional appearance and positive attitude.

Center managers must understand that hiring for the front office is much more than filling openings—it's identifying and meeting the center's operating needs. Front office staff typically has the highest turnover of any position in an urgent care center. Even if there's a desperate need to get a position filled, hiring out of panic or desperation almost always leads to regret. The costs associated with hiring the "wrong" individuals for front-line positions is more than the time, money, and effort of recruiting, interviewing, and training—it's also measured by future business that may be lost when that employee interacts with customers, the costs of billing and collections errors, and pressures on other employees who must pick up the slack created by underperformers.

It's therefore vital to take time to find the "right" personality and skills for front office staff. The capacity and desire for further growth are essential traits—no point in hiring someone who is as "good as they're going to get" or someone who has great potential but no desire to grow in the job. Effective front office staff provides a reliable pipeline for future center managers.

### Setting the Front Desk in Motion

Once a manager and front office staff have been se-

lected, the real work begins. People are only effective insofar as good policies, procedures, and processes have been defined, implemented, and consistently executed. In short, staff members who know exactly what they're supposed to do in every patient encounter experience less stress and work more efficiently than those who face their jobs unprepared.

Critical front office processes include greeting and registering patients, verifying insurance, calculating charges, and collecting payment. Staff must be confident in the duties they're assigned, as highlighted in **Table 2**.

Whenever the front office staff seems ineffective, the center manager should watch closely to determine whether it's a "people" or "process" issue. If burdensome documentation and difficult-to-navigate computer systems cause the front desk to get behind and focus more on "processing" than "serving" patients, then an examination of front desk systems might be in order.

If processes are sound but the front office staff isn't motivated to perform, implementing employee incentive programs can help the center achieve its goals. Sample incentives include:

- Lowest number of cancellations in a month (% of hours scheduled).
- Greatest cash collections (% of amount owed).
- Lowest number of registration errors (% of patients registered).
- Highest patient satisfaction (% of patients seen).
- Lowest number of billing errors (% of transactions).

Staff performance can also be improved by focusing on the work environment.

### Put Yourself in the Patient's Shoes

Although creating a comfortable atmosphere at the front desk may seem more daunting than providing excellent clinical care, it's really not that difficult—just look at the experience from the patient's perspective. Patients want reassurance that they're going to be treated well and a front desk that's organized, efficient, friendly, and aesthetically pleasing provides cues as to the medical care that can be expected in the back.

First off, watch your signage. Entering a practice where the reception window has multiple pieces of paper taped around it—either handwritten and photocopied notices—projects neither an inviting or professional air. Moreover, signs that communicate what patients can't do (or what they *must* do) often convey a very negative and distrusting tone. The best patient

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### Table 3. Front Office Setup and Layout

What does your front office look like? Does it contain a clean and neat reception area that communicates that your center cares enough about its patients to keep its environment pleasant? The following goals should be considered when evaluating your front office:

- This is a professional office, not a home.
- We care that you're comfortable.
- Clutter and chaos do not belong here.
- This is a joyful place for both men and women to work.
- We have planned our office décor.

These goals can be met by avoiding the following:

- Photocopied and handwritten notices to patients.
- Signage that conveys a negative tone.
- Bulletin boards overflowing with announcements and memos.
- Cluttered desks and countertops, making the staff appear disorganized.
- Piles of supplies, giving the appearance of a storage closet.
- Beanie babies, lace doilies, and cheap trinkets.
- Grungy, soiled carpeting and worn furnishings.
- Dead/dying plants or dust-laden fake plants.

communication is face-to-face, so limit signage unless it's absolutely necessary. When signage can't be avoided, it should be professionally made and carefully phrased.

You'll find additional suggestions on front office setup and layout in **Table 3**.

### Bringing It All Together

As mentioned earlier, the front office sets the tone for the patient's experience with the urgent care center. To make sure the experience is a patient-centered one, it's necessary to assure the right people, processes, and environment are in place for excellent service. A top-notch front office will not only impress upon patients that the urgent care center is a well-run medical practice, but it's the key to generating positive word of mouth and bottom-line growth.

If you want to sharpen the appearance of your front office, walk into the lobby of an upscale hotel or financial institution and look at its walls, counters, and desks. What impressions do you get? Your urgent care visits are giving an impression, too—make sure it's a positive one. ■



## INSIGHTS IN IMAGES

# CLINICAL CHALLENGE

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

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

FIGURE 1



The patient is a 23-year-old male who presents with a complaint of pain in the heel area after slipping down four steps. He is limping but able to bear weight.

On exam, you note local tenderness and swelling over the area of the Achilles tendon. Other findings are unremarkable.

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

## THE RESOLUTION

FIGURE 2



The x-ray shows minimally displaced fractures of the posterior process of the talus. The patient was placed in a short cast at the urgent care site, with advice to avoid putting weight on the affected limb and to follow up with an orthopedist within three days.

Typically, such injuries are treated with a short leg cast for four to six weeks, with some suggesting 15 degrees of plantar flexion.<sup>1</sup>

Two processes—the lateral and the posterior—project from the body of the talus. Either process may be fractured, either as an isolated injury or in conjunction with other ankle/talar injuries.

Differential diagnoses of posterior ankle pain include the following:

- Fracture of the lateral tubercle of the posterior process (also known as Sheppard's fracture). This is characterized by inversion of the ankle, which may avulse the tubercle, leaving the posterior talofibular ligament intact. It may also occur when the ankle is forced into extreme equinus. Patients may present with ankle-sprain-like symptoms; posterolateral ankle tenderness may be elicited, with decreased and painful motion of the ankle and subtalar joints. In addition, active flexion of the great toe may produce pain as the flexor hallucis longus (FHL) moves over the fracture site between the medial and lateral tubercles. The lateral tubercle has an articular surface; fracture through this tubercle is often associated with arthrosis.
- Fracture of the medial tubercle. Look for tenderness and, perhaps, a mass just posterior to the medial malleolus, as well as pain with motion of the great toe—the latter due to motion of the FHL. Treatment may involve excision of the fragment.<sup>1</sup>

#### Reference

1. Fractures of Posterior Process of Talus. *Wheeless' Textbook of Orthopaedics*. Available at: [www.wheelessonline.com/ortho/fractures\\_of\\_posterior\\_process\\_of\\_talus](http://www.wheelessonline.com/ortho/fractures_of_posterior_process_of_talus).

*Acknowledgment: Case presented by Nahum Kovalski, BSc, MDCM; the patient was treated by Dr. Eliyahu Sheleg.*



*H.C. Chin, MD  
Anshin Medical Healthcare  
New York, NY*

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## On the San Francisco Syncope Rule, Antibiotics in Pyelonephritis, and the Accuracy of Helical CTs

■ 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.

### San Francisco Syncope Rule: Less Sensitive Than Previously Reported

**Key point:** An independent validation study demonstrated a sensitivity of only 74% for predicting serious outcomes.

**Citation:** Birnbaum A, Esses D, Bijur P, et al. Failure to validate the San Francisco Syncope Rule in an independent emergency department population. *Ann Emerg Med.* 2008;52(2):151-159.

Most patients who present with syncope have benign etiologies, but, for some, syncope is caused by a potentially life-threatening condition. Differentiating between the two etiologies is often difficult in an emergency department; as a result, many patients who might not require inpatient workup are admitted.

The San Francisco Syncope Rule was developed to identify low-risk syncope, and the original study reported 96% sensitivity for detection of short-term (seven-day) serious outcomes, defined as death, myocardial infarction, arrhythmia, pulmonary embolism, stroke, subarachnoid hemorrhage, significant hemorrhage, or any condition causing or likely to cause a return ED visit and hospitalization for a related event.

The rule categorizes patients as high risk for serious outcomes if they have any of the following features (remembered by the mnemonic CHESS):

history of congestive heart failure

- hematocrit <30%
- abnormal electrocardiogram
- shortness of breath
- systolic blood pressure <90 mm Hg

In a prospective, observational cohort validation study, researchers applied the rule to 713 adult patients who presented to a university hospital ED with acute syncope or near syncope and followed the patients at 7 days to detect serious outcomes. Of 61 patients (9%) with serious outcomes, 16 (26%) had not been identified as high risk by the rule. Sensitivity of the rule to predict serious outcomes was 74%, specificity was 57%, negative likelihood ratio was 0.5, and positive likelihood ratio was 1.7.

[Published in *J Watch Emerg Med*, September 19, 2008—Richard D. Zane, MD, FAAEM.] ■

### Early Antibiotic Treatment of Pyelonephritis

**Key point:** Early antibiotic treatment did not affect the rate of renal scarring compared with delayed treatment.

**Citation:** Hewitt IK, Zucchetto P, Rigon L, et al. Early treatment of acute pyelonephritis in children fails to reduce renal scarring: Data from the Italian Renal Infection Study Trials. *Pediatrics.* 2008;122(3):486-490.

Many experts believe that early antibiotic treatment of pyelonephritis in children might prevent the development of renal scars. As part of a randomized clinical trial in which 287 children (age range, 1 month to 7 years) with pyelonephritis (confirmed by dimercaptosuccinic acid [DMSA] scan) received different



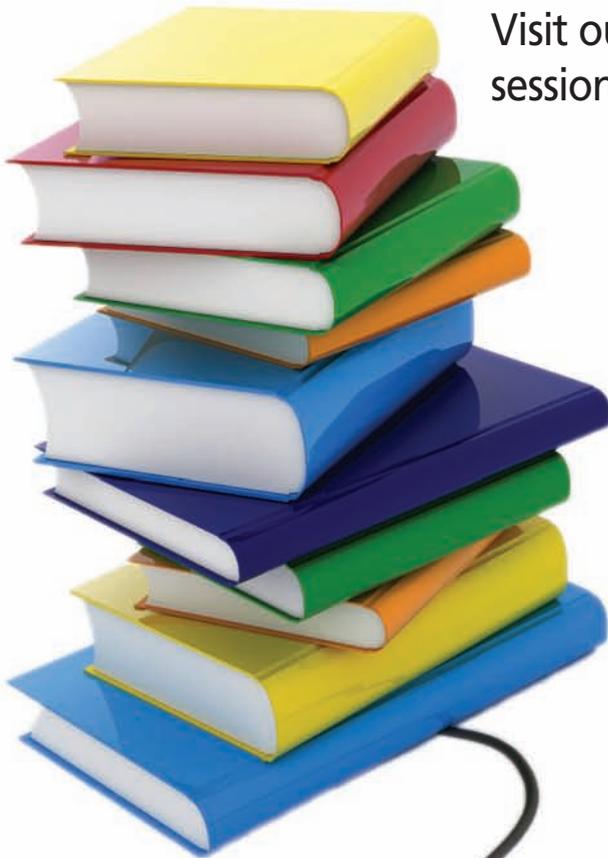
**Nahum Kovalski** is an urgent care practitioner and assistant medical director/CIO at Terem Immediate Medical Care in Jerusalem, Israel.

Continued on page 32

The Urgent Care Association of America presents its

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## Hedging Your Bets: The Art of Market Segmentation

■ FRANK H. LEONE, MBA, MPH

If you have more than one child or grew up with at least one sibling, you have probably experienced “segmentation.” That is, you have most likely used different tactics and strategies in dealing with each of your children or you were treated somewhat differently than your siblings.

Segmentation within the urgent care occupational health market follows the same principle; a communication technique that is effective with one audience may not work as well with another.

### Market Differentiation

Any clinic launching a marketing campaign should explore the question of whether its market has different segments that require different sales and marketing strategies. Usually, the answer is “Yes.”

Consider a national political campaign: A candidate’s core message in California is likely to be considerably different than the message he would emphasize in Georgia or Iowa.

Market segments for an occupational health initiative are limited only by one’s imagination and are likely to vary by region. However, three variables are virtually universal in occupational health: employer size, industry type, and proximity (i.e., distance from your core delivery locale).

### Employer Size

A clinic’s basic instinct is to market to mid-sized employers. However, such an emphasis ignores the largest and smaller employers in a market, thus ceding volume potential to competitors. A more fruitful strategy is to market continu-

### Table 1. Three Steps to Market Segmentation

1. Is anything unique about your market? Does a particular industry type dominate? Do you wish to reach outlying markets? Are there an inordinately large number of big (or small) companies?
2. Does your clinic offer services that are relevant to one or more of these segments? For example, do you offer executive health services to your white-collar employer segment?
3. What unique marketing tactics might be applicable to a segment and/or a product geared to a given segment?

*“Small employers are largely overlooked, although they can produce significant volumes for an occupational health program.”*

ally to all segments: large, mid-sized, and small. Each of these segments requires different stimuli in order for your clinic to be most effective with each group.

*Large employers* tend to be low-probability/high-reward prospects. Breakthroughs with large employers are more likely to occur when a team, including physicians and/or clinic managers, is periodically involved in the sales process.

For example, your clinic might schedule a weekly group sales call at a set day/hour that is devoted to “large employers.” With such a commitment, your urgent care clinic will cultivate approximately 50 large employers a year.

*Small employers* are largely overlooked as well, although in the aggregate they can produce significant volumes for an occupational health program. When it comes to market-



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

**Table 2. Tailoring Your Approach to Segment and Customer Variables**

	Segment A	Segment B	Segment C
<b>Employer type</b>	<b>Large (&gt;400)</b> Group meetings Creative services	<b>Mid-sized</b> Traditional outreach	<b>Small (&lt;50)</b> E-mail/direct mail Marketing by phone
<b>Industry type</b>	<b>Gaming</b> Guest services Addiction medicine	<b>White Collar</b> Executive health Travel medicine Background checks	<b>All Others</b> Traditional outreach
<b>Proximity</b>	<b>Close (&lt;5 miles)</b> Stress ease of access	<b>Mid-distance</b> Traditional outreach	<b>Distant (&gt;15 miles)</b> On-site services Mobile services

ing to smaller employers, emphasize multiple contacts through various modalities (e-mail, voice mail, letters) that reiterate a constant message and continually reinforce your clinic’s name.

How does a clinic define a large, medium, or small employer prospect? It depends on the market. The definition of employer size will vary markedly from Chicago, where a “large” employer might have more than 1,000 employees to Cullman, Alabama, where a large employer might be defined as any company with more than 50 employees.

**Industry Type**

Some markets may be perfectly heterogeneous, with an employer mix that reflects American industry as a whole. Others may have prominent niches, such as Las Vegas, resort communities, and/or markets with an agricultural or white-collar emphasis. Should a unique employer segment be identified, your clinic must determine specific outreach tactics and/or appropriate product niches.

**Proximity**

Different strategies and an emphasis on different products may apply to employers based at various distances from your urgent care clinic(s).

Your clinic should showcase its convenience, for example, to employers most proximate to your locale. Alternatively, a clinic can emphasize possible on-site and mobile services to employers located at the periphery of your market area.

The Chicago-Cullman continuum applies to this segment as well: a “distant employer” in Chicago may be simply more than a 15-minute drive away, while those in Cullman might be 30 or more miles away from the clinic. ■

antibiotic regimens, Italian investigators assessed response to therapy and the association between duration of fever before treatment and renal scarring 12 months after treatment.

No relation was found between scars on DMSA scan at 12 months and the number of days of fever (from <1 day to ≥5 days) before the start of antibiotic treatment (about 30% of children had scars, regardless of duration of fever).

Duration of fever after initiation of antibiotic treatment also was not associated with renal scarring.

The results were the same in analysis restricted to the 227 children aged 1 month to 2 years. In addition, no relation was found between duration of fever before treatment and four indices of inflammation: height of fever at presentation, white blood cell count, neutrophil count, and C-reactive protein level.

These results suggest that urgent treatment of children with pyelonephritis does not seem to affect the development of renal scars compared with delayed treatment. Children should be treated promptly, but after appropriate laboratory studies have been performed and a presumptive diagnosis has been made.

[Published in *J Watch Pediatr and Adolesc Med*, September 17, 2008—Howard Bauchner, MD.] ■

**Helical CT is More Accurate Than Clinical Judgment for Diagnosing Appendicitis**

*Key point: Even in cases of clinically apparent appendicitis, CT is more accurate.*

**Citation:** Kim K, Rhee JE, Lee CC, et al. Impact of helical computed tomography in clinically evident appendicitis. *Emerg Med J*. 2008;25:477-481.

The role of multidetector computed tomography (MDCT) scanning in the diagnosis of appendicitis is evolving as technology and resolution improve. Researchers in Korea compared the diagnostic accuracy of 16-detector MDCT scanning and clinical impression in 157 consecutive patients who presented to two emergency departments with signs or symptoms that raised concern for possible appendicitis.

All patients were evaluated by emergency physicians and senior residents who determined whether the clinical diagnosis was appendicitis. All patients then underwent MDCT with intravenous contrast only. MDCT scans were read by two radiologists who specialized in CT interpretation. The final diagnosis of appendicitis was based on surgical pathology or clinical follow-up.

The positive predictive value of the examining physician’s clinical impression was 73%, and the negative predictive value was 56%. Corresponding values for MDCT were 97% and 97%.

These findings suggest that MDCT scanning is more accurate than clinical judgment for diagnosing appendicitis, even in cases that are considered to be “clinically apparent.”

[Published in *J Watch Emerg Med*, September 5, 2008—Diane M. Birnbaumer, MD, FACEP.] ■



## ICD-9 Changes in 2008

■ DAVID STERN, MD, CPC

**Q.** I noticed that I am getting rejections for the code for fever (780.6). Do I need to add another diagnosis code to get paid?

**A.** There are numerous separate issues related to this code:

- First, every year ICD-9 updates go into effect on October 1. This year was no exception. This code is now sub-categorized as follows:
  - 780.60 Fever, unspecified
  - 780.61 Fever presenting with conditions classified elsewhere
  - 780.62 Postprocedural fever
  - 780.63 Postvaccination fever
  - 780.64 Chills (without fever)
  - 780.65 Hypothermia not associated with low environmental temperature
- Second, 780.60 is a specific code that can be used to specify a diagnosis.
- Third, this code now requires five digits, so most payors will reject the old code for fever (780.6) if you do not add a fifth digit.
- Fourth, you should not use these fever codes along with a diagnosis of a “confirmed infection” that is causing a fever. Thus, it would *not* be appropriate to diagnose fever (780.60 or even 780.61) along with streptococcal pharyngitis (034.0) for the same patient visit.
- Fifth, do *not* use this code set for the following:
  - heat stroke and sunstroke (992.0)
  - heat syncope (992.1)
  - heat cramps (992.2)
  - heat exhaustion (992.3, 992.4 or 992.5)
  - or other conditions related to environmental heat (992.6-992.9)



**David E. Stern, MD, CPC**, is a certified professional coder. He is a partner in Physicians Immediate Care, operating 12 urgent care centers in Oklahoma and Illinois. Stern serves on the Board of Directors of the Urgent Care Association of America and speaks frequently at urgent care conferences. He is CEO of Practice Velocity ([www.practicevelocity.com](http://www.practicevelocity.com)), providing urgent care software solutions to more than 500 urgent care centers. He welcomes your questions about coding in urgent care.

**Q.** Are there other important ICD-9 changes that are commonly used in the urgent care setting?

**A.** The short answer is “yes.” There are a number of changes to codes commonly encountered in urgent care. Let’s break them down and expand on them:

### *Hematuria*

The code for hematuria (formerly 599.7) now requires five digits and is subdivided into the following:

- 599.70 Hematuria, unspecified
- 599.71 Gross hematuria
- 599.72 Microscopic hematuria

### *Dehiscence of Traumatic Wound Repair*

Previously, no code was available to specify the dehiscence of a traumatic wound repair, as the codes available (998.31 and 998.32) referred only to dehiscence of an operative wound. Physicians may now use either:

- 998.30 Disruption of wound, unspecified
- 998.33 Disruption of traumatic wound repair

### *Vulvar Pain or Inflammation*

New codes now exist for vulvar pain or inflammation:

- 625.70 Vulvodynia, unspecified
- 625.71 Vulvar vestibulitis
- 625.79 Other vulvodynia

For additional ICD-9 changes highly relevant to urgent care, refer to Coding Q & A at [www.jucm.com](http://www.jucm.com). ■

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## Managing Through Change

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

The urgent care sector in particular, and healthcare in general, is undergoing a sea change—a phrase that has its origins in Shakespeare’s *The Tempest*:

*Full fathom five thy father lies  
Of his bones are coral made  
Those are pearls that were his eyes  
Nothing of him that doth fade  
But doth suffer a sea-change  
Into something rich and strange.*

Shakespeare was referring to the corpse of Ferdinand’s father being changed by the sea. Over the years, *sea change* has come to denote a profound transformation. During the last few weeks, I have received calls and e-mails about centers closing and going out of business because of the profound transformation of our capital markets and the resultant tightening of the debt market.

Fortunately, however, most urgent care physicians and owners thrive on change. As our place in the healthcare milieu becomes more clearly defined, we react by changing our practice to meet the demands of our customers. The following suggestions might help your practice sail through this perfect storm of market forces:

**Review your lending covenants.** Ensure that your practice is in compliance with your banking covenants. Banks use these covenants to protect against the risk of the debtor’s inability to pay down the debt. Typically, these covenants are very black-and-white ratios or clear terms defining the amount of cash needed in the account. If you are within your covenants, now would be a good time to negotiate some better terms as a hedge against future market changes. If you are not within the lending covenants, work to quickly get in compliance.



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

**Review staffing metrics.** Right-staffing is the “holy grail” of on-demand healthcare. Having too many people on staff ruins your bottom line; have too few and your customer service goes out the window. In our current market condition, I would err on being slightly *understaffed*. If able, hire individuals on a contract basis, with a specific job description to complete prior to bringing them on full time.

**Review your exit strategy.** This may be as easy as letting your lease run out, or subleasing to an alternative practice or business. Conversely, your exit strategy may be to round up your competitors and attempt to sell the entire area, en masse. Whatever it is, now is the time to reassess.

**Improve efficiencies.** Improving patient throughput will enable you to staff more effectively. Saving even a few minutes per patient will reduce the amount of full-time equivalents needed. The easiest way to accomplish this task is to use the “fresh set of eyes” perspective. Pretend you are a newcomer to the industry and study your patient care process. You will amaze yourself at the amount of wasted time inherent in your system. Now is the perfect opportunity to fix it!

**Review your collection practices.** As our economy declines, so too will people’s ability to pay in a timely manner. Unless you are diligent, your days in accounts receivable (AR) will begin a slow march in the wrong direction. These fractional changes may not seem like much, but in the aggregate, may be enough to throw you out of your covenants.

If your billing is outsourced, review the contract to ensure your incentives are aligned regarding days in AR and cash collection goals. Simply paying on a percentage of collections sounds like it should align incentives, however, it simply encourages the billing company to go after the low-hanging fruit.

Change is inevitable. As such, it should be welcomed. If it were not for changes in the healthcare arena, urgent care would not have a place. As Darwin said, “It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change.” ■

# Career Opportunities

**URGENT CARE IN LAKELAND, FLORIDA SEES** BE/BC physician. Must be comfortable with pediatrics and minor adult care. Excellent salary, benefit package, and bonuses. Future partnership available. Fax CV to (863) 666-6089.

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**URGENT CARE ARNP OR PA - WESTERN WASHINGTON** full-time opening for a nurse practitioner or physician assistant to provide quality healthcare to patients of all ages in one of our urgent care centers located within 40 minutes of downtown Seattle. Experience in urgent care and family practice is preferred. Candidates must be qualified for licensure and certification in Washington State as a PA or NP. You will enjoy excellent compensation and benefits, flexible shifts and system-wide support, while practicing your own patient care values. You'll live the northwest lifestyle and experience the best of northwest living, from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. For more information regarding this opportunity, contact Provider Services at (800) 621-0301 or send your CV to blazenewtrails@multicare.org. Refer to opportunity ID#734-910.

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# Career Opportunities



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The Fox Cities (Appleton, Neenah/Menasha, Oshkosh) offer a unique quality of life, combining a family centered, university community with all season recreation, a nationally acclaimed educational system, and a diverse and growing economy and population. Once here, we're sure you will agree that this is one of the best places in the U.S. to call home.

Enjoy an industry leading salary and benefit package. For more information, please contact or send your CV to: Cookie Fielkow, Physician Recruitment, Affinity Medical Group, 1570 Midway Place, Menasha, WI 54952; Fax: 920-720-1791; Phone: 800-722-9989; E-mail: cfielkow@affinityhealth.org Visit our website at [www.affinityhealth.org](http://www.affinityhealth.org) Not a J-1 opportunity. EOE. A partnership of Ministry Health Care and Wheaton Franciscan Healthcare.




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[koonsa@reidhosp.com](mailto:koonsa@reidhosp.com)  
800-755-3104



### JANESVILLE, WISCONSIN

Dean Health System is a large physician-owned multi-specialty group, headquartered in Madison, Wisconsin. We are looking for two Urgent Care physicians for our clinic in Janesville, 35 miles south of Madison.

The ideal candidates will be Family Physicians. The physicians generally work four 8-hour days per week, which includes every third weekend. EMR is in place. Starting salary is \$85 per hour, which bumps up in the 2<sup>nd</sup> year and again in the 3<sup>rd</sup> year. Outstanding fringe benefits package.

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For more information, contact:  
Christopher Kashnig  
608-250-1474 or email  
[christopher.kashnig@deancare.com](mailto:christopher.kashnig@deancare.com).

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### **Urgent Care - Peoria, IL**

Seeking physicians for employment in modern urgent care facilities operated by OSF Saint Francis Medical Center. Broad based diagnostic skills and experience are essential for practice at our facilities. On-site radiographic imaging and CLIA waived diagnostics available. Full-time position offered with opportunity to work extra shifts if desired.

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OSF Physician Recruitment  
Call: (309) 683-8354  
or (800) 232-3129 press 8  
Fax: (309) 683-8353  
stacey.e.doolittle@osfhealthcare.org  
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### **Occupational Medicine – Urgent Care Los Angeles, California**

Exciting opportunity for an experienced, outgoing, and motivated urgent care/occupational physician to join our rapidly growing practice. Located near Los Angeles International Airport, you will see patients from around the world. A truly unique opportunity.

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## Allegiance HEALTH

### **South Central Michigan**

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**For more information contact:**  
Michelle Spielberg at  
(800) 547-1451  
Email: [mspielberg@sourceonestl.com](mailto:m Spielberg@sourceonestl.com)



# JUCM

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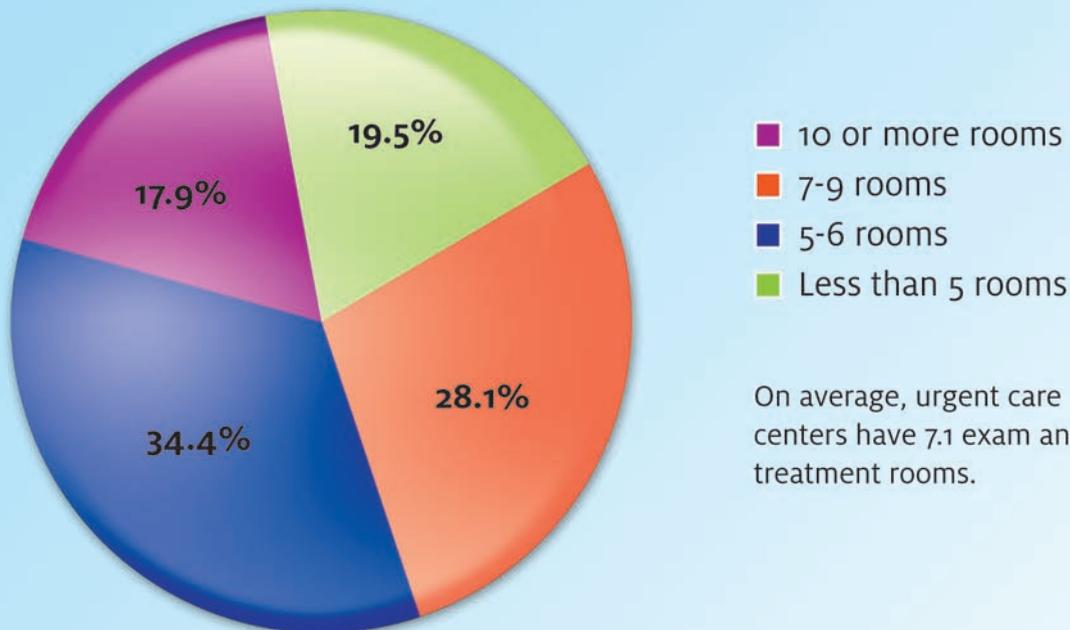
## DEVELOPING DATA

In early 2008, UCAOA revamped its annual survey in conjunction with researchers at Massachusetts General Hospital and Harvard University with the goal of assuring that the UCAOA Benchmarking Committee's efforts produced a scientifically valid report.

Over the coming months in *Developing Data*, *JUCM* will present some of the findings from this landmark survey, to which 436 urgent care centers responded.

*In this issue:* How large are urgent care centers?

### NUMBER OF EXAM AND TREATMENT ROOMS



Percent of Urgent Care Centers

On average, urgent care centers have 7.1 exam and treatment rooms.

It is important to note that many dimensions are important when describing the size of urgent care centers, and the number of exam and treatment rooms captures only one aspect.

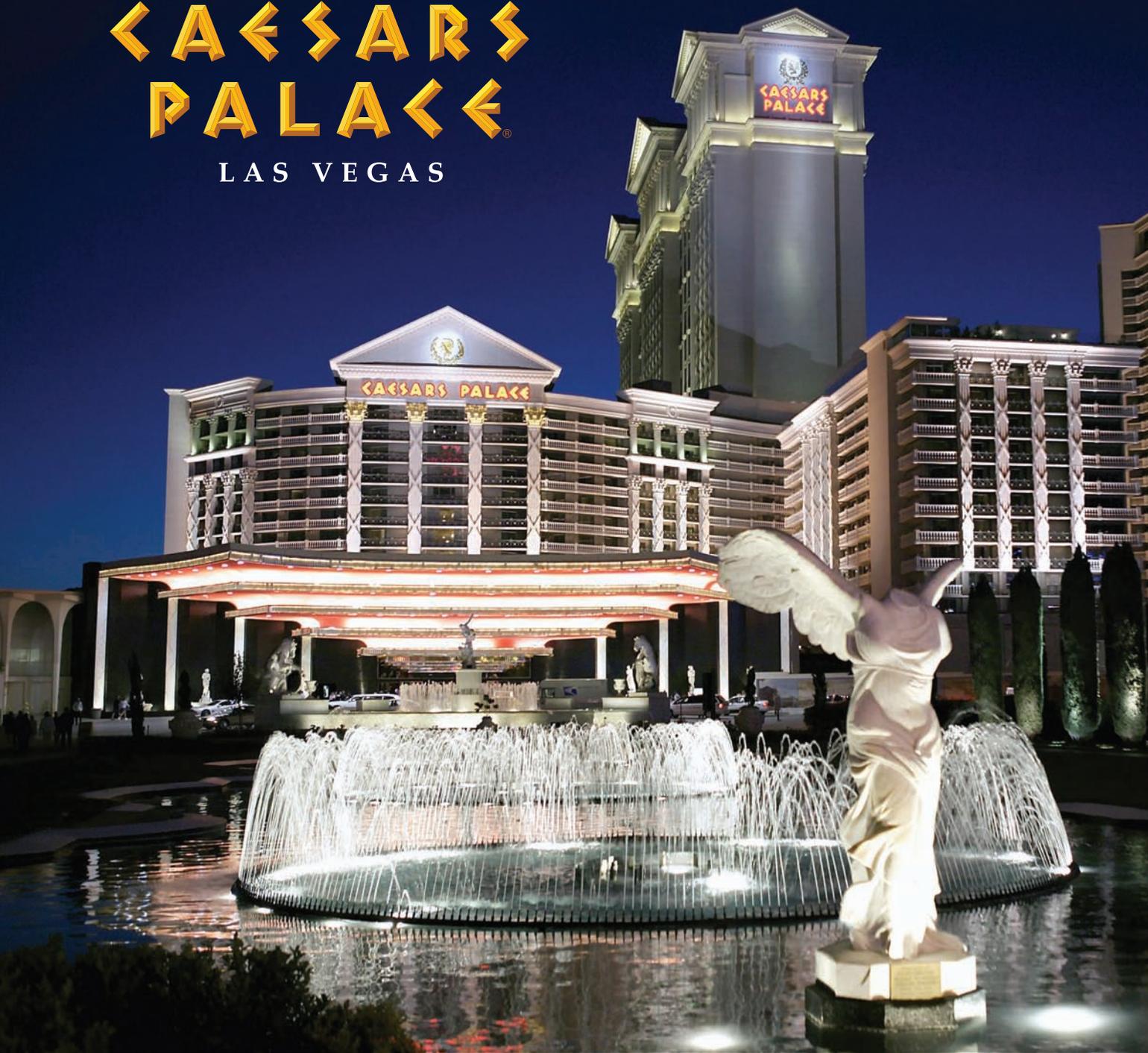
Acknowledgment: Data submitted by Robin M. Weinick, PhD, assistant professor, Harvard Medical School and senior scientist, Institute for Health Policy, Massachusetts General Hospital. Dr. Weinick is also a member of the *JUCM* Advisory Board.

**Next month in *Developing Data*:** How many physicians work in urgent care centers, and what are their specialties?

If you are aware of new data that you've found useful in your practice, let us know via e-mail to [editor@jucm.com](mailto:editor@jucm.com). We'll share your discovery with your colleagues in an upcoming issue of *JUCM*.

# CAESARS PALACE

LAS VEGAS

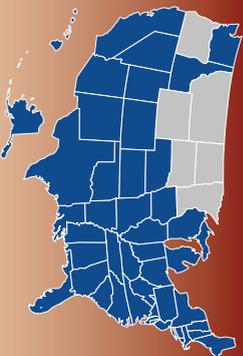


## URGENT CARE ASSOCIATION OF AMERICA **2009 National Convention**

**April 20: PreConvention • April 21-23: Main Convention**

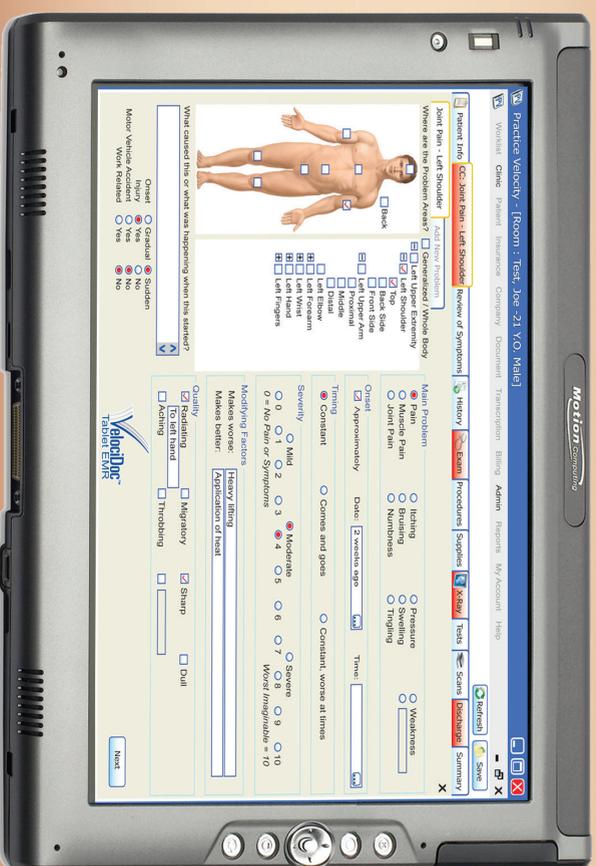
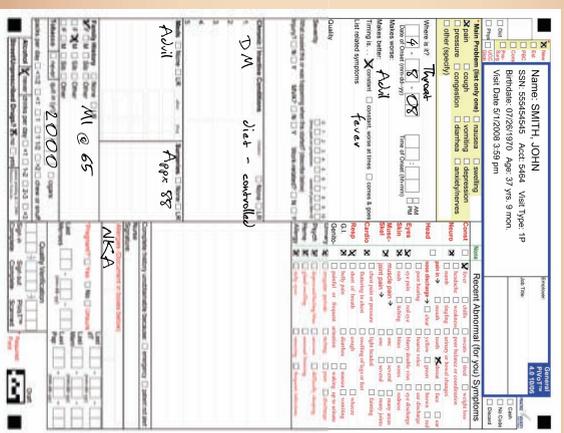
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