JUCM™
THE JOURNAL OF URGENT CARE MEDICINE®
NOVEMBER 2013
VOLUME 8, NUMBER 2
Urgent Care Association of America
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The Official Publication of the UCAOA and UCCOP

Part 1

Urgent Care Management of Needlestick Injuries

Also in this issue

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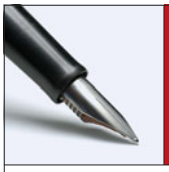
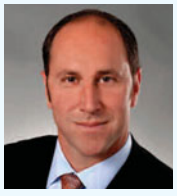


LETTER FROM THE EDITOR-IN-CHIEF

Urgent Care Under Fire: Is This a Trend?



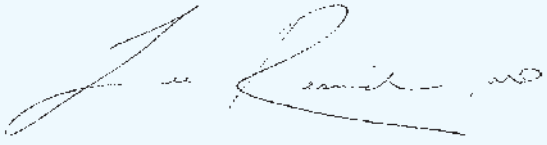
Well-meaning or not, government regulation of health care is always cause for concern among practicing physicians. No other profession is exposed to the layers of oversight that physicians endure—from OSHA to HIPAA, from Stark to Anti-kickback laws, the OIG and Medicare, just to name a few. Individual health care bills pile on to create a practice environment so mired in regulation that it would paralyze health care delivery to adequately follow each regulation to the letter of the law.

Urgent care is now increasingly the target of scrutiny, both governmental and otherwise. Urgent care has also become the target of powerful specialty interest groups that feel threatened by our very existence. While these interest groups often cite care quality and disruption of the medical home as their concerns, there exists no evidence that clinical quality suffers or that primary care relationships are impacted by the urgent care or retail clinic model. In fact, some UCAOA benchmarking data suggest that a significant number of *new* primary care referrals are born out of urgent care visits by patients that otherwise have no relationship with the health care system. Other data suggest that 25% to 50% of patients who seek care at urgent care and retail clinics do not have a relationship with primary care, a unique opportunity for collaboration that has largely been ignored.

The potential merger of specialty interest group fear with government scrutiny is not lost on me. The Texas Medical Association (TMA), under pressure from specialty interest groups, took aim at urgent care centers in 2009-2010. The TMA lumped urgent care centers and freestanding emergency departments in their demands for facility licensing rules. Urgent cares almost fell victim to the 163-page law, except for a last-minute plea by then-UCAOA president, Don Dillahunty. Despite having a scope of practice that is no different than a traditional family practice, it is hardly coincidental that urgent care was targeted. Burdensome regulation, after all, is the surest way to slow down the perceived urgent care threat to primary care and emergency medicine.

Now, New York State has launched a bill that mandates the study of urgent care centers and retail clinics. Included in the bill is evaluation of the scope and provision of services "not presently required to undergo the state Certificate of Need process nor required to obtain authorization to conduct office based surgery." I cannot make this stuff up. The bill is sponsored by State Senator Brad Hoylman, whose district saw the shuttering of St. Vincent's Hospital and their emergency department. He claims that his concern was piqued when his "constituents were bombarded with marketing for urgent care centers" after the closing of the hospital. I don't believe that this so-called marketing and proliferation of urgent care centers led a senator to believe this was responsible for the closing of a hospital in Manhattan and posed such a threat to the public and overall health care delivery system that a bill mandating examination of the need for regulation followed. There must be more to this story and I suspect that specialty interest groups are playing a role. Most of the large specialty groups have Political Action Committees (PACs), lobbyists and consultants whose sole job it is to represent the interests of their specialty. With no such army behind the discipline of urgent care, it is simply not a fair fight. Does it surprise you that State Senator Hoylman determined that there was urgent need for a targeted evaluation of urgent care without ever interviewing a leader, expert or other representative from the urgent care community? It not only doesn't surprise me, it hints at the underlying motivation.

The message to the New York State Commissioner of Health conducting the study of urgent care services is simple. Urgent care centers provide the exact same services, with similarly licensed and board-certified providers, under the same state medical board requirements as any primary care physician practice in the state, using the same code set for billing. The sole difference is extended office hours and walk-in availability at all times. We offer services that, while in the scope of practice and training of any family physician (e.g. laceration repair, minor fracture care), many choose not to provide, leading to unnecessary, cost-prohibitive care for minor conditions in the ED. We do not provide or advertise provision of emergency services, a distinction clearly stated on every urgent care website I have seen. A simple, straightforward "Certified Urgent Care™" process that defines basic urgent care services is available through the UCAOA. ■



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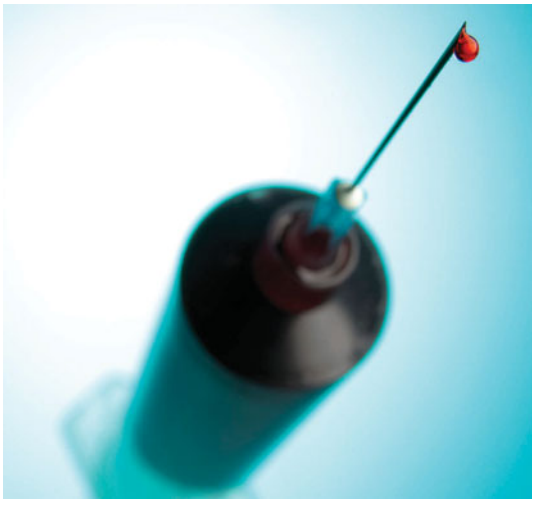
November 2013

VOLUME 8, NUMBER 2



CLINICAL

9 Urgent Care Management of Needlestick Injuries: Part 1

Needlestick injuries are common and require a prompt response based on an understanding of the latest USPHS guidelines and informed consent and counseling of the patient.

Maya Heck, MS-2, and John Shufeldt, MD, JD, MBA, FACEP

PRACTICE MANAGEMENT

18 Post-Visit Follow-up Calls: Improving Patient Satisfaction, Center Profitability and Clinical Outcomes

Call-backs within 24 to 48 hours of discharge can identify potential complications, ensure that instructions are followed, and reinforce a positive visit experience.

Alan A. Ayers, MBA, MAcc

CASE REPORT

23 Schamberg's Disease

No definitive treatment is available for this condition but diagnosis is important to reassure patients and avoid unnecessary care.

Shailendra K. Saxena, MD, PhD, Mikayla Spangler, PharmD, BCPS, and Archana Mikkilineni, MD

IN THE NEXT ISSUE OF *JUCM*

A police officer arrives at an urgent care center with a handcuffed, bloodied prisoner, who he says spit on him during an altercation. The suspect is an IV drug abuser and the officer wants a "blood test" to determine if the man is HIV-positive; if he is, the officer wants prophylaxis to prevent seroconversion. The suspect refuses the test. What should the urgent care provider do?

The answer to that question is the subject of our December cover story—Part 2 of our series on management of needlestick injuries. In Part 2, the authors review definitions of HIV transmission risk, HIV post-exposure prophylaxis, and appropriate steps to follow for managing needlestick injuries based on the recently updated US Public Health Service guidelines.

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

Affiliations
JUCM The Journal of Urgent Care Medicine (www.jucm.com) is published through a partnership between Braveheart Group, LLC (www.braveheart-group.com) and the Urgent Care Association of America (www.ucaoa.org).

Address Changes
JUCM (ISSN 1938-002X) printed edition is published monthly except for August for $50.00 by Braveheart Group LLC, 120 N. Central Avenue, Ste 1N, Ramsey NJ 07446. Periodical postage paid at Mahwah, NJ and at additional mailing offices. POSTMASTER: Send address changes to Braveheart Group LLC, 120 N. Central Avenue, Ste 1N, Ramsey, NJ 07446.

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More than 30 different pathogens are known to cause infection in health care workers or hospital personnel following exposure to blood or body fluids, the most serious of which are hepatitis B and C and HIV. Needlesticks are the subject of this month's cover story, the first of a two-part series by Maya Heck, MS-2 and John Shufeldt, MD, JD, MBA, FACEP. In this issue, the authors review the current CDC guidelines for body substance exposures that carry risk of hepatitis and HIV transmission, the definition and management of the "source patient," and pre-exposure prophylaxis and post-exposure management for hepatitis B and C. Part 2, in the December issue, will focus on HIV transmission risk definitions and HIV post-exposure prophylaxis.

Ms. Heck is a second-year medical student at Oregon Health & Sciences University in Portland, Oregon. Dr. Shufeldt is principal of Shufeldt Consulting and sits on the Editorial Board of *JUCM*.



Pinpoint petechiae with a brown or yellow base were the presenting symptom in the patient in this month's case report, a 42-year-old man with no other complaints. Although the lower-extremity rash was of 3 months' duration, the cause—Schamberg's disease—was benign. As authors Shailendra K. Saxena, MD, PhD, Mikayla Spangler, Pharm D, BCPS, and Archana Mikkilineni, MD, explain, making the correct diagnosis and offering a patient reassurance rather than unnecessary treatment are the keys to effective care for the urgent care provider who sees this chronic skin discoloration.

Dr. Saxena is an Associate Professor in the Department of Family Medicine at Creighton University School of Medicine in Omaha, NE. Dr. Spangler is an Assistant Professor at Creighton University School of Pharmacy and Health Professions and School of Medicine, Department of Family Medicine. Dr. Mikkilineni is Resident Physician, Creighton University School of Medicine, Department of Family Medicine, Omaha, NE

Does your urgent care center make it a practice to do patient call-backs 24 to 48 hours after discharge? Author Alan A. Ayers, MBA, MAcc, explains why every urgent care should in this month's practice management article, and the reasons are not only clinical. Follow-up calls, Mr. Ayers says, can identify potentially life-threatening complications and ensure that patients understand discharge instructions. They also make good business sense because the contact can increase patient satisfaction and spur repeat business and word of mouth.

Mr. Ayers is Content Advisor, Urgent Care Association of America, Associate Editor, *JUCM*, and Vice President, Concentra Urgent Care.

Also in this issue:

In Health Law this month, **John Shufeldt, MD, JD, MBA, FACEP**, discusses what every urgent care provider needs to know about engaging with or employing a mid-level provider or "physician extender."

Nahum Kovalski, BSc, MDCM, reviews new abstracts on literature germane to the urgent care clinician, including studies of survival after pneumonia, UTIs in men, and oral anticoagulants for VTE.

In Coding Q&A, **David Stern, MD, CPC**, discusses coding for intravenous infusions with hydration and medical decision making.

Our Developing Data end piece this month looks at the average time to payment receipt for urgent care centers. ■

To Submit an Article to *JUCM*

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

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

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

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The Value of Face-to-Face Meetings

P. JOANNE RAY

"Face-to-face communication is the broadest bandwidth communication you can have in professional life."
— Harvard Business Review

With limited budgets, distance, and busy schedules acting as barriers, it is challenging to prioritize in-person educational and networking endeavors. Despite these challenges, the 308 paid attendees and 76 exhibiting companies who attended last month's Urgent Care Fall Conference would surely concur with many business surveys that show in-person meetings are essential for developing new business and maintaining long-term business relationships and partnerships.

From skills learned and enhanced in the hands-on splinting and casting course to strategies learned from the speakers and each other regarding the role of internal marketing to improve patient experience to following the examples of how other centers are positioning themselves in the era of health care reform, these attendees were in the "right place." The time invested translated to hands-on, relevant, and practical learning opportunities.

UCAOA onsite conferences help you meet the daily challenges you face as an urgent care provider or supporting vendor, while enhancing your ability to achieve ever higher levels of performance. Observing the conference attendees, I was reminded of the importance and unmatched value face-to-face interaction brings to preparing us to deal with the day-to-day pressures and challenges of our individual and collective commitment to urgent care. The valuable exchange of ideas, the new contacts and shared experiences, the follow up months down the road to further brainstorm, and the growth you'll experience justify committing to a few days that will lead to personal and center improvement.

The 2009 *Harvard Business Review Report "Managing Across Distance in Today's Economic Climate"* surveyed 2,300 subscribers and the outcomes support unflappable evidence of the value of in-person meetings:

"UCAOA onsite conferences help you meet the daily challenges you face as an urgent care provider or supporting vendor, while enhancing your ability to achieve ever higher levels of performance."

- 69% said their companies had reduced their overall travel budgets. The average travel budget of executives surveyed shrank by 17%.
- Even with travel budgets being cut, 95% said face-to-face meetings are key to successful long-term relationships and to building strong relationships.
- 81% of executives surveyed said traveling to meet in person offers value beyond the meeting.
- Just 20% said they could achieve the same results with virtual meetings as they could with in-person meetings.

A 2009 Forbes Study provides a strong argument for the value of face-to-face meetings. It also supports my very own belief that in-person meetings go deeper than the "at your desk" webinars and virtual events. *(However, if you can't get to a face-to-face meeting, at least purchasing access to the archived sessions from a conference will help further your education.)* Web-based conferences were preferred only for data-oriented presentations (44%) and information dissemination (43%), although they held less than a 10% margin over face-to-face meeting in those two areas.

Your next face-to-face major urgent care-specific meeting opportunity is just 4 months away. Reserve the time and set aside your personal or center budget now to join your colleagues March 17 to 20 in Las Vegas for the Spring National Urgent Care Convention. You'll grow and create long-term relationships that will serve you for years to come. ■

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

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Urgent Care Management of Needlestick Injuries: Part 1

Urgent message: Needlestick injuries are common and require a prompt response based on an understanding of the latest USPHS guidelines and informed consent and counseling of the patient.

MAYA HECK, MS-2 and JOHN SHUFELDT, MD, JD, MBA, FACEP

Your center is fortunate to contract with a variety of different business to provide employee health services. A local homeless shelter is one of the clients to whom your center provides new hire physicals, drug screens and on the job injury care. A bright-eyed young volunteer arrives at your center from the shelter. While emptying the trash, she believes she poked herself with an exposed hypodermic needle. The hollow-bore needle went "all the way to my bone" before she pulled it out and doused her hand with rubbing alcohol. She is getting married in a month and wants to ensure she is "safe." How do you respond?

Needlestick accidents and exposure to bodily fluids in health care and civil service settings are more common than we'd like to think. As post-Affordable Care Act patient volumes increase, expect the number of needlesticks to increase as well as providers are more harried in their patient interactions. At the present time, according to the Centers for Disease Control and Prevention (CDC), about 385,000 sharps-related injuries occur annually among health care workers (health care workers) in hospitals.[1] These data suggest that nearly 1 of every 10 health care workers in the United States has a needlestick exposure each year.[2] It is speculated that even more go undocumented.

More than 30 different pathogens are known to cause infection following exposure to blood or body fluids in health care workers or hospital personnel.[3,4] The most important of these pathogens, which are considered to be transmitted through a blood or secretion exposure, are hepatitis B virus (HBV), hepatitis C virus (HCV), and HIV infection.

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In Part 1 of this two-part series, we'll review the current CDC guidelines, the pathogenicity of the viruses, the pre- and postexposure management of exposed health care workers, and pre-exposure prophylaxis and post-exposure management for hepatitis B and C. Part 2, in a subsequent issue, will review definitions of HIV transmission risk, HIV post-exposure prophylaxis, and the appropriate steps to follow for managing needlestick injuries.

Maya Heck is a second-year medical student at Oregon Health & Sciences University in Portland, Oregon. **John Shufeldt** is principal of Shufeldt Consulting and sits on the Editorial Board of *JUCM*.

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INDICATED FOR CHILDREN 6 MONTHS OF AGE AND OLDER[2]

- No Contraindications
- Sklice Lotion should be used in the context of an overall lice management program

IMPORTANT SAFETY INFORMATION FOR SKLICE LOTION

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

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- One tube. One time.
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PRODUCT APPLICATION[2]

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INDICATION

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

ADJUNCTIVE MEASURES

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

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

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

IMPORTANT SAFETY INFORMATION FOR SKLICE LOTION

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

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

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

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

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

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

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

Sklice® (ivermectin) Lotion, 0.5%

SANOFI PASTEUR

SKLICE® **Rx Only**
(ivermectin) Lotion, 0.5% for topical use

Brief Summary of Prescribing Information

1 INDICATIONS AND USAGE

1.1 Indication

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

1.2 Adjunctive Measures

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

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

2 DOSAGE AND ADMINISTRATION

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

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

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

Avoid contact with eyes.

4 CONTRAINDICATIONS

None.

5 WARNINGS AND PRECAUTIONS

5.1 Ingestion in Pediatric Patients

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

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

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

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

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category C

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

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

Human Data

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

Animal Data

Systemic embryofetal development studies were conducted in mice, rats and rabbits. Oral doses of 0.1, 0.2, 0.4, 0.8, and 1.6 mg/kg/day ivermectin were administered during the period of organogenesis (gestational days 6–15) to pregnant female mice. Maternal death occurred at 0.4 mg/kg/day and above. Cleft palate occurred in the fetuses from the 0.4, 0.8, and 1.6 mg/kg/day groups. Exencephaly was seen in the fetuses from the 0.8 mg/kg group. Oral doses of 2.5, 5, and 10 mg/kg/day ivermectin were administered during the period of organogenesis (gestational days 6–17) to pregnant female rats. Maternal death and pre-implantation loss occurred at 10 mg/kg/day. Cleft palate and wavy ribs were seen in fetuses from the 10 mg/kg/day group. Oral doses of 1.5, 3, and 6 mg/kg/day ivermectin were administered during the period of organogenesis (gestational days 6–18) to pregnant female rabbits. Maternal toxicity and abortion occurred at 6 mg/kg/day. Cleft palate and clubbed forepaws occurred in the fetuses from the 3 and 6 mg/kg groups. These teratogenic effects were found only at or near doses that were maternally toxic to the pregnant female. Therefore, ivermectin does not appear to be selectively fetotoxic to the developing fetus.

8.3 Nursing Mothers

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

8.4 Pediatric Use

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

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

8.5 Geriatric Use

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

10 OVERDOSAGE

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

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

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IVE-BPLR-SA-FEB12 Revised: February 2012

Table 1. Body Fluids That Do Not Pose Significant Risk of Blood-borne Pathogen Transmission Unless Visibly Contaminated With Blood

Urine	Stool
Saliva	Sweat
Non-purulent sputum	Emesis
Nasal Discharge	Tears

Overview of CDC Recommendations

The CDC defines exposure as contact with blood, tissue, or other body fluids that may place a health care worker at risk of HIV infection and therefore requires consideration of post-exposure prophylaxis (PEP) as[4]:

1. A percutaneous injury (eg, a needlestick or cut)
2. Contact of mucous membrane or nonintact skin (eg, exposed skin that is abraded, or afflicted with dermatitis)

Body fluids of concern include: semen, vaginal secretions, or other body fluids contaminated with visible blood that have been implicated in the transmission of HIV infection, and cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids, which have an undetermined risk for transmitting HIV. **Table 1** lists body fluids that do not pose a significant risk of blood-borne pathogen transmission unless visibly contaminated by blood.

Risk of infection is higher with exposure to: (1) a larger quantity of blood or other infectious fluid; (2) prolonged or extensive exposure of non-intact skin or mucous membrane to blood or other infectious fluid or concentrated virus in a laboratory setting; (3) exposure to the blood of a patient in an advanced disease stage or with a high viral load; (4) a deep percutaneous injury; or (5) an injury with a hollow-bore, blood-filled needle.

The CDC guidelines also mandate prompt evaluation for all potential exposures to blood or body fluids as defined previously. The name of the source, time/date of exposure, nature of exposure, body location and contact time with fluid, infective status of the source, and the description of injury should be obtained. In addition, obtaining a detailed history including dates of hepatitis B immunizations; previous testing for HIV, HBV, and HCV; tetanus immunization status; current medications; and current underlying medical conditions should be recorded for the health care worker.

Provided that consent is given, all source cases should be tested for HBsAg, HCV, and HIV, unless the source is known to be infectious because subsequent pre-exposure prophylaxis (PEP) is based upon the results of source tests. PEP is recommended when occupational exposures to HIV occur. PEP should be initiated as soon as possible after the exposure. The general guidelines described above should always precede the steps that are specific to each pathogen and described later in this article.

Table 2. FDA-Approved Rapid HIV Tests

- OraQuick® (and its newer version OraQuick® Advance)
- Rapid HIV-1/2 Antibody Test (OraSure Technologies, Inc., Bethlehem, PA)
- Reveal™ (and its newer version Reveal™ G2) Rapid HIV-1 Antibody Test (MedMira, Halifax, Nova Scotia)
- Uni-Gold Recombigen® HIV Test (Trinity BioTech, Bray, Ireland)
- Multispot HIV-1/HIV-2 Rapid Test (Bio-Rad Laboratories, Redmond, WA).

Positive tests should be confirmed with a Western Blot test and HBsAB status confirmed within 7 days.

If the source patient is known, test the source patient for hepatitis B surface antigen (HBsAg) and HCV and HIV antibodies. HIV viral load assessments for routine screening of source patients are NOT recommended. If available at the site of exposure, use a rapid HIV-antibody test on the source patient. In some institutions, results are available in under 30 minutes. Rapid HIV tests approved by the US Food and Drug Administration are listed in **Table 2**.

If the source patient is NOT infected with a blood-borne pathogen, baseline testing or further follow-up of the health care provider is not necessary. The ability to determine the status of the source patient is "center-dependent." If you are unable to determine the individual's status and the exposure occurs in a high-risk environment, consider using the two-drug PEP regimen as described in **Table 3**. State regulations related to informed consent and confidentiality also should be followed.

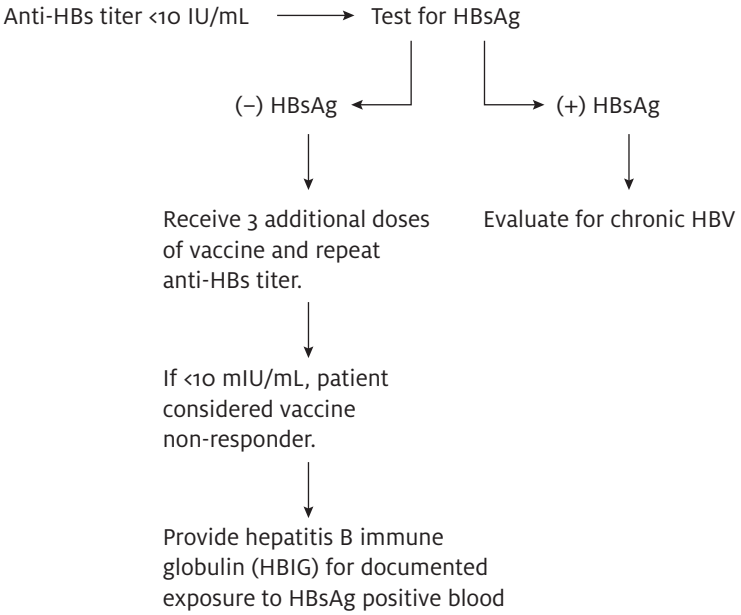
If the source patient is UNKNOWN, evaluate the likelihood of high-risk exposure. Consider the likelihood of blood-borne pathogen infection among patients in the exposure setting, that is, what is the community infection rate? Inquire about the setting in which the exposure occurred. Does the practice in which the needlestick or exposure occurred treat a large number of HIV-, HBV- or HCV-infected or at-risk patients? The general guidelines stated above should always precede the following information specific to each pathogen.

Table 3. Recommendations for PEP to Prevent HBV Infection

		Exposed health care worker		
		Unvaccinated	**Adequate* response to vaccine**	**Unknown response to vaccine**
Source	**HBsAg positive**	HBIG (within 24 hrs) and vaccine series	No treatment needed, consider booster dose of vaccine	Test exposed person for anti-HBs. If adequate* no treatment necessary. If inadequate, administer HBIG and vaccine booster
	HBsAg negative	Vaccine series	No treatment needed	No treatment needed
	Unknown HBsAg status	Vaccine series	No treatment needed, consider booster dose of vaccine	Test exposed person for anti-HBs. If adequate* no treatment necessary. If inadequate, administer vaccine booster and recheck titer in 1 month

* Adequate antibody response (>10 mIU/mL) documented after completion of an HBV vaccination series.

Figure 1. Follow-up Testing for Anti-HBs After Hepatitis B Vaccination



HBsAg = Hepatitis B surface antigen; HBV = Hepatitis B virus

Hepatitis B Virus

HBV is the most infectious of the three bloodborne viruses reviewed here for several reasons. Not only has HBV been transmitted by percutaneous and mucosal exposures, but also by fomites such as multi-dose medication vials, jet gun injectors, and endoscopes.[5] In addition, HBV can survive and remain infectious on countertops for up to 7 days.[6]

The virulence of HBV has been greatly minimized since the advent of the HepB vaccine and Occupational Safety and Health Administration's (OSHA) requirement that all health care workers with reasonably anticipated exposure to blood be offered the vaccine. Studies suggest that vaccination has been very successful, with a 95% decline in incidence of hepatitis B infection among health care workers between 1983 and 1995.[7]

Pre-exposure Prophylaxis. The Advisory Committee on Immunization Practices (APIC) and the Hospital Infections Control Practices Advisory Committee recommend that all health care workers with potential exposure to blood or blood products receive immunizations to protect against HBV.[8,9] The approved dosing schedules are as follows:

- Engerix-B (Smith-Kline) — 1.0 mL (20 mcg) at 0, 1, and 6 months or 0, 1, 2, 12 months; or,
- Recombivax-HB (Merck) — 1.0 mL (10 mcg) at 0, 1, 6 months.

The Engerix schedule including 12 months is intended for individuals who have or may have been exposed to HBV. In addition, follow-up testing for anti-HBs is required 1 to 2 months after the final vaccine dose, as

illustrated in **Figure 1**.

Despite the decline in detectable vaccine-induced antibodies over time, booster doses are not recommended for immunocompetent health care workers.[10] This is due to the protection provided against clinical hepatitis and chronic infection by the initial vaccine series even when their anti-HBs levels become low or undetectable.

Post-exposure prophylaxis. PEP with HBIG and/or administration of the vaccine should be used after percutaneous or mucous membrane exposure to blood known or suspected to be HBsAg positive (**Table 3**).[11]

Hepatitis C Virus

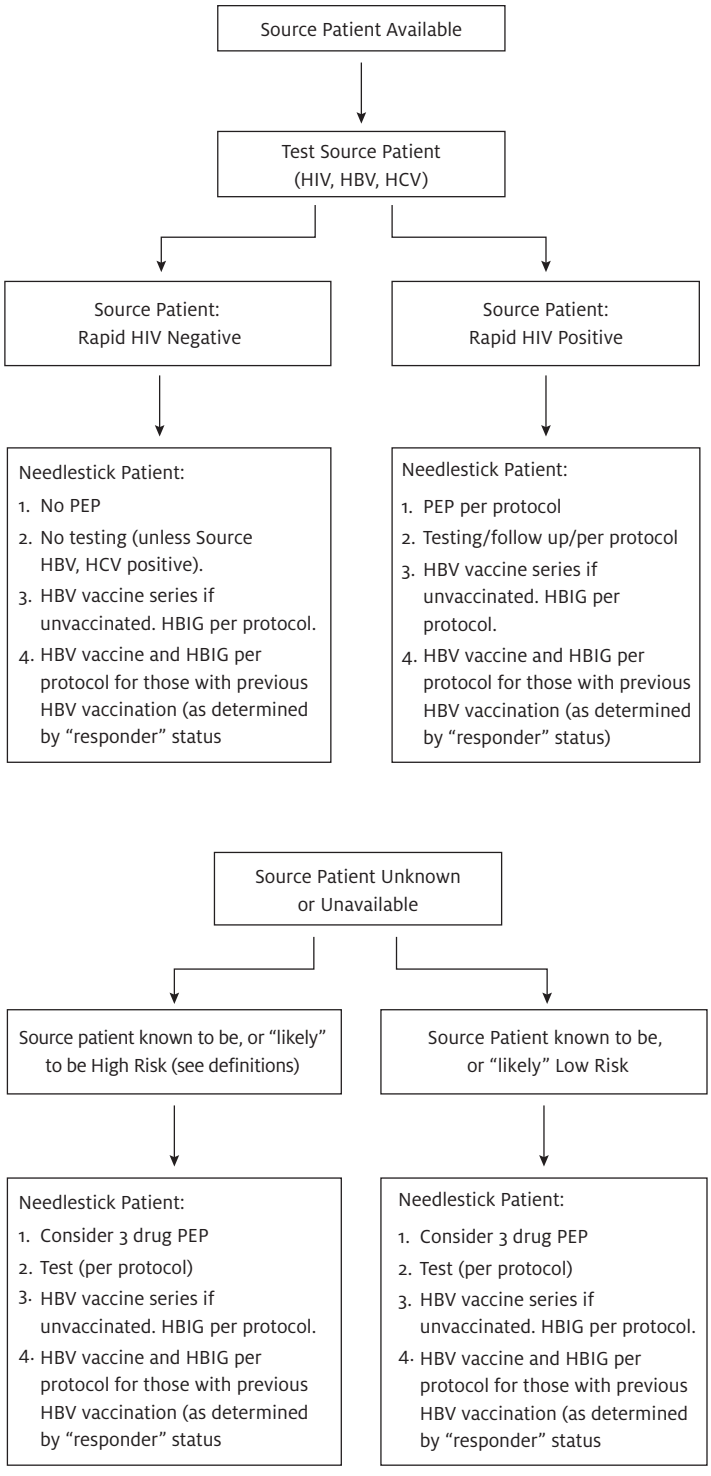
Despite the awareness of transfusion-related HCV, the virus still remains a large health care burden. The asymptomatic nature of the disease increases the frequency of viral transmission among the population. Although the spread through transfusion products has been a leading cause of transmission of HCV, due to improved screening, it is now more strongly associated with intravenous and percutaneous drug and needle use.[12] However, HCV is not transmitted easily through exposure of health care workers to blood; the average incidence of anti-HCV seroconversion after percutaneous exposure from an HCV-positive source is 1.8% (range: 0% – 7%).[12]

"HCV is not transmitted easily through exposure of health care workers to blood."

Pre-exposure Prophylaxis. Currently pre-exposure prophylaxis (PrEP) for HCV is not available.

Post-exposure Prophylaxis. The Advisory Committee on Immunization Practices (ACIP) has concluded that the use of immune globulin (IG) as post-exposure prophylaxis after exposure (PEPE) to prevent HCV was not supported.[13] Also, PEP use of interferon has not been

Figure 2. Management of Needlestick Injuries



"NIH recommends that exposed health care workers have a baseline immunoblot or HCV RNA assay."

demonstrated to reduce the rate of infection and in addition, interferon is associated with many side effects.[14,15]

The CDC recommends that individuals exposed to an HCV-positive source have the following baseline and follow-up testing[16]:

1) Baseline testing for anti-HCV, HCV RNA, and alanine aminotransferase (ALT)
2) Follow-up testing for HCV RNA 4 to 6 weeks after exposure
3) Follow-up testing for anti-HCV, HCV RNA, and ALT 4 to 6 months after exposure

The National Institutes of Health (NIH) recommends that exposed health care workers have a baseline immunoblot or HCV RNA assay.[17] Aside from avoiding donating blood, plasma, organs, tissue, or semen during the follow-up period, individuals exposed to HCV-infected blood do not need to take any special precautions to prevent secondary transmission.[18,19]

The algorithm in **Figure 2** provides an overview of management of needlestick injuries. The National Clinicians' Post-Exposure Prophylaxis Hotline is a 24/7 resource that offers advice on treatment and follow-up options. Call 1-888-448-4911 or visit http://www.ucsf.edu/hivcntr/PEPline.

The sidebar lists key points to remember when responding to a needlestick injury in a health care worker, so as to minimize the risk of legal liability.

Key Points in Response to a Needlestick in a Health Care Worker

1. Timely evaluation and treatment of the exposed worker is crucial.
2. Sources can only be tested after they have

given informed consent.

3. Providing accurate, written informed consent information to the patient is important and, if done appropriately, will prevent the claim of "loss of a chance" if the patient sero-converts.

Conclusion

Although the treatment of patients who were exposed to a needlestick is nuance-driven, it is fairly straightforward if you simply follow the evidenced-base guidelines. Every time a patient who has been exposed presents to an urgent care clinic, pull out the guidelines, get informed consent from the patient, provide written material, and treat the patient. In Part 2 of this article next month, we will discuss post-exposure guidelines for evaluation and treatment of HIV. ■

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Post-Visit Follow-up Calls: Improving Patient Satisfaction, Center Profitability and Clinical Outcomes

Urgent message: Call-backs within 24 to 48 hours of discharge can identify potential complications, ensure that instructions are followed, and reinforce a positive visit experience.

ALAN A. AYERS, MBA, MAcc

Introduction

Urgent care centers provide immediate medical attention to patients who feel their symptoms are too pressing to wait for an appointment with their primary care physician, but not serious enough to warrant a visit to the emergency room (ER). With extended night/weekend hours, high-visibility locations, and on-demand service via a walk-in model,urgent care is also a retail delivery channel for health care. As a result, urgent care centers must have adequate training, procedures, and equipment to assess, diagnose, stabilize or treat conditions ranging from cuts and sprains to back pain, fever, skin conditions, sinus congestion, stomach discomfort, and breathing difficulties—among others.

For many patients, urgent care is a provider of "first resort"—their entry point to the health care system—so what may be described as the *therapeutic journey* begins in the center and has to be put on the right path upon discharge when the patient is no longer under a provider's observation. "Clinical quality" includes timely follow-up of findings and tests and, when appropriate, referral to a higher-acuity facility, a qualified specialist or a primary care physician for longitudinal care.

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Anticipating Failure in Patient Communication

When an urgent care provider explains to the patient his or her observations, diagnosis, proposed treatment and follow-up requirements, the supposition is that the patient has understood those remarks and will comply

accordingly. Medical professionals, however, have learned through experience that even when patients "hear" what the doctor has said in simple words, a large percentage will still fail to comprehend the details of the physician's discharge instructions. A patient's failure to understand next steps can result in adverse outcomes.

It is not acceptable for a patient to put a prescription in his or her pocket, wave good-bye to the receptionist and walk out the door. This may be convenient and time-saving but it's neither a good nor safe practice. Before a patient leaves the center, a knowledgeable and responsible provider should:

- determine that the patient truly understands the clinical findings and the instructions for follow-up or self-care, *and* intends to follow them;
- assess whether, if the patient received a prescription, he or she intends to get it filled whether the cost of the drug is affordable;
- arrange for follow-up with a specialist or primary care provider if necessary, including forwarding the chart to the patient's personal physician (verify it's the same one named by the patient at registration); and
- detail where the patient should go if his or her condition worsens, including back to the urgent care center or straight to the hospital ER.

In addition, the patient should be told upon discharge that it is the center's procedure to telephone a day or two after the visit to determine all is going well with the therapeutic journey:

- the patient should be told that the center *will* call to follow up;
- the patient should be asked *what number and what time* to call;
- but never asked *whether* the center should call.

Making the Case for Follow-up Telephone Calls

Although many physicians insist theirs is a profession and not a business, if money is received in exchange for a service, then a business transaction has taken place. It can be a well- or an ill-conducted business, but a business it is. Profitability in urgent care is driven by volume, therefore,

Table 1: Patient Callback Guidelines

- Patients are generally called 2 days after their visit. The next day is often "too soon" because the patient's course of treatment may not have had time to take effect, resulting in too many unnecessary rechecks to the provider.
- Who should be called, when and by whom:
  - Patients who have been referred for further acute care. — Next day by provider.
  - When labs or x-ray reports come back and patient is not scheduled to review during a recheck. — 2 days by provider.
  - Everyone else. — 2 days by Nurse, Medical Assistant, or Well-Trained Front Office Staff
- The charts of any patients with labs pending are kept in a "labs pending area" and are not filed away until labs are received and called on, with systems in place to make sure any expected outside labs or tests don't fall through the cracks. Typically a nurse or technician checks each chart against the lab log daily to ensure that everything is up to date.
- If follow-up calls are made by the front desk staff, any hint of a problem or question must be referred to the nurse or provider. If the problem is urgent, then the nurse or provider takes the call immediately. Otherwise the nurse or provider calls the patient back within 2 hours.
- Caller should verify that:
  - Patient is stable or improving
  - Taking his or her meds as prescribed
  - Referral or recheck visit has been scheduled
- Caller should advise every patient to call or come back to the center if they're not progressing as expected—sometimes patients don't realize they're welcome to follow up with the center.
- Remember that this is an *urgent care* facility—if a condition was "urgent" on Tuesday it likely has not faded into nothingness by Wednesday. If an urgent care center deals with individuals who are injured, have a fever, or are in pain—then the sense of urgency those patients have often remains until the condition resolves.
- Charts are not filed away until the callback occurs, and follow-up is documented on a progress note.

to capture repeat patient visits and spur positive word of mouth, urgent care centers need to ensure that patients are satisfied with their experience and outcomes.

Patient satisfaction is not merely a "smile and be nice" set of behaviors. It's a philosophy that is founded in the concept that the patient's experience of care is important and ultimately translates into greater compliance with the provider's instructions. The follow-up steps[1] are thus:

- Important: a follow-up (unexpected or not) is evidence of a patient-centered practice.
- Effective: when an unexpected follow-up occurs, it's impressive and reinforces a positive patient experience.
- Engaging: a follow-up demonstrates a connection and a continuing concern and reinforces patient compliance with medical instructions.
- Revealing: a follow-up opens communications in both directions.
- Differentiating: a follow-up puts a center ahead of its competition, especially when competitors are too busy to "care."
- Inexpensive: most follow-up steps are relatively simple and don't have a big price tag attached. Satisfied patients return, they refer and they are bonded to the practice through an established relationship.

The fact that urgent care is a business does not take "care" out of the picture. So although patients will be pleased that the clinic appears to be concerned for their welfare when it calls, the caller should, in fact, "care" that the patient is or is not improving. Calling and feigning "care" is worse than not calling at all.

Murphy's Law

The cliché is that if something *can* go wrong, sooner or later it *will* go wrong. Wise urgent care operators do not fool themselves into believing that Murphy's Law does not apply to their centers—instead, they set up damage control mechanisms for the inevitable. Often, providers are rushed to see patients and errors in diagnosis, treatment, medication, and documentation can result. Diagnostic errors are a leading cause of malpractice claims against outpatient facilities such as urgent care centers.[2] The follow-up call is the damage control mechanism for

a diagnosis of a severe condition that was not recognized at the time of the visit. Unless the patient is checked again by phone, he or she may not seek further care.

As a risk reduction strategy, follow-up phone calls[3]:

- Promptly recognize a change in patient condition
- Uncover patients' concerns before formal complaints occur
- Give the center's staff prompt feedback on their performance
- Minimize complaints, claims, lawsuits, and payouts

Because the calls provide accurate and timely patient satisfaction data, they can be used to improve the center's patient satisfaction scores, provide a roadmap for improving center performance, and enhance the center's reputation in the community.

Policies and Procedures for Follow-up Calls

As **Table 1** illustrates, follow-up calls are generally made 2 days after the patient visit, with the exception of patients who have been referred for acute care. The treating provider should set the timeframe for callbacks by indicating in the chart at discharge: "how many days to f/u." Any patients with a potential for misdiagnosis or for complication should be called the next day, or possibly even later the same day. And so should the mother of a child with a fever. But a sutured finger or a mild flu can wait 2 or 3 days because the condition may not immediately improve, resulting in premature complaints regarding outcome and an unnecessary return trip to the center if a call to the patient is made the next day.

Generally follow-up calls are made by a nurse, medical assistant, or well-trained member of the office staff—except in cases of referral or when lab/test results need to be reviewed by the medical provider. Engaging the staff in callbacks works well when providers work "shifts" and are not present in the center every day. Although a patient may be flattered if he or she receives the personal attention of the doctor,[4] that is not always possible although undeniably a call from the provider is preferable to that of a member of staff. Because most urgent care centers experience ebb and flow in patient volume, callbacks are something that can keep the center team productive during slow periods (typically mid-afternoon in most centers).

A patient follow-up call is not a social visit over the phone. Yes, it must be conducted in a pleasant manner and leave the patient feeling that he or she has a friend in the clinic. But the caller must be a knowledgeable person, attuned to hints of all not being quite as "rosy" as the patient bravely states, fully conversant with all the potential complications of the condition, and knowing always that the diagnosis may be incorrect.

During a patient callback, the caller might review the patient's discharge instructions, ensure the patient is taking his or her medication as prescribed, inquire about pain control, and inquire whether the patient has received or scheduled follow-up care. Often, in addition to reviewing instructions, the caller asks the patient to describe the care and medication the patient has received since dis-

Table 2: Sample Post-Visit Follow-up Form

Patient Name:	Date of Service:
Date/Time of Call:	Patient Phone:
Caller Name:	☐ Spoke with Legal Guardian
☐ Message Left	Name:

Initial Call:
☐ Patient States Condition Improving
☐ Patient States Condition Remains the Same
☐ Patient States Condition Declining
☐ Patient Would Like to Speak with a Clinician
☐ Recheck Scheduled: Date/Time: _____
☐ Patient Seeking Follow-up w/ PCP or ER (Clinician to Review Chart)
Notes:

Clinician Follow-up Call: Date/Time of Call: _____
☐ Recheck Scheduled: Date/Time: _____
☐ Patient Seeking Follow-up w/ PCP or ER (Clinician to Review Chart)
☐ Other
Notes:

charge. The caller may also schedule a follow-up exam and encourage the patient to make a list of questions to ask upon returning to the center.[5]

The patient's chart should not be restored to filing until the follow-up call has been made. If the clinic is "paperless," then a program must be devised within the electronic medical record system to ensure no call is neglected.

Documenting Follow-up Calls

Among lawyers' many axioms is, "If it wasn't written down – it didn't happen." Ludicrous as that may seem to non-lawyers, there will be little support in court for the doctor who says, "I know I called him, but I forgot to make a note of it."

Any medical advice provided to a patient by telephone is entered in the patient's record and appropriately signed or initialed, including medical advice provided and the names of individuals who provided such instructions. The method of record will depend on the office system, essentially to what extent it is "paperless." But there must be a record of every phone call, and it is as well to have a checklist, as illustrated in **Table 2.**

At a minimum, the checklist should have a date and time stamp (always preferable to a potentially forged entry); name of person making the call; name of person responding if not the patient; a statement about the patient's progress; a statement about future intentions; a statement about advice given; and duration of call (or time signed off).

Conclusion

Calling patients within 24 to 48 hours of discharge allows the urgent care provider to follow-up on how they are doing. Not only can callbacks identify potentially life-threatening complications that require immediate medical attention, they can also ensure that patients understand the discharge instructions they were given, seek care with the appropriate referral providers, and have an opportunity to ask any questions. From a business perspective, follow-up calls increase patient satisfaction, reinforce a positive visit experience, and spur repeat business and word of mouth. Overall, callbacks are an inexpensive but high-impact way that urgent care centers ensure safe, quality care for their patients. ■

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Case Report

Schamberg's Disease

Urgent message: No definitive treatment is available for this condition but diagnosis is important to reassure patients and avoid unnecessary care.

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Rashes are a common reason for patients to present to the urgent care clinic. Many require treatment but some do not. Schamberg's disease is one such rash.

Case Presentation

A 42-year-old male presented to our clinic with a chief complaint of bilateral lower extremity rash, which he had been experiencing for the past 3 months. The rash was erythematous, mildly pruritic, hyperpigmented and associated with pinpoint yellowish discoloration of the skin (**Figure 1**). There was no associated edema or stasis dermatitis of the skin. The patient did not have any other associated symptoms including fever, excoriation, blistering, or sharp pain around the site.

Definition

Schamberg's disease was named after Jay Frank Schamberg, who first described it in 1901.[1] It is also commonly known as "progressive pigmentary dermatosis of Schamberg," "purpura pigmentosa progressiva," or "Schamberg's purpura."[1] It is characterized by chronic discoloration of the skin and is seen predominantly in the lower extremities. Although Schamberg's disease is more common in males, it can present across all age groups, including both adult and pediatric patients.[2, 3]

Pathogenesis

Schamberg's disease is caused by extravasation of red blood cells from the blood vessels near the surface of the skin.[2] These cells penetrate through the capillary membrane and deposit in the skin and subcutaneous tissue. Degradation of hemoglobin to hemosiderin is responsible for the yellow-brown, pinpoint rash-like appearance.[2] The causes of this type of capillaritis include medications, food-additive allergies, viral infections and exercise.[2]

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Medications associated with Schamberg's disease

There is no definitive medication-related cause of Schamberg's disease. However, there have been case reports detailing possible causative medications. Nishoika and colleagues[4] identified many potential agents that could be responsible for the development of the condition, including vitamin B3 and chlordiazepoxide. In these cases, removal of the offending agent usually resulted in an improvement in the appearance of the skin.[4] Although medications are not commonly the cause of Schamberg's disease, providers should rule

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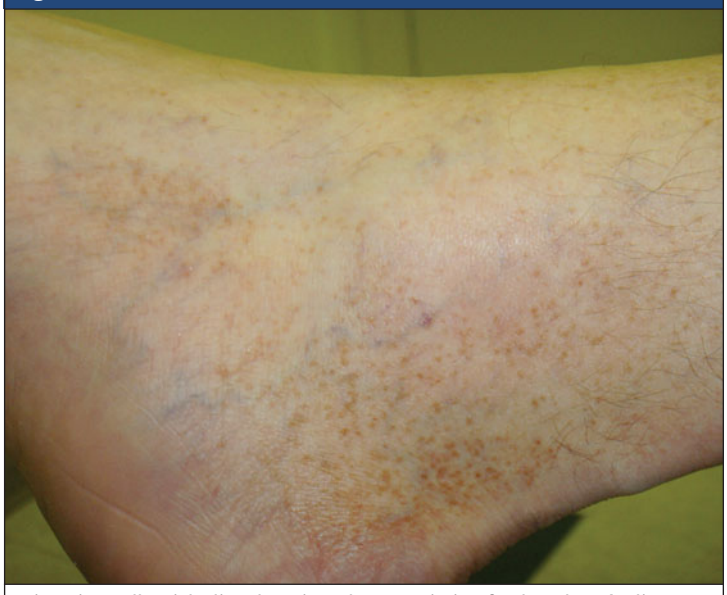
Figure 1.



Pinpoint yellowish discoloration characteristic of Schamberg's disease.

out medication-related instances by implementing a drug holiday.

Symptoms

The symptoms of Schamberg's disease include irregular yellow-brown, rust-colored flat patches on the skin, with reddish pinpoint lesions along the border of the discoloration, which are often described as Cayenne pepper spots.[1] New spots appear within and along the edges of old lesions. These lesions are usually present on the lower extremities (around the ankles), but can be seen on any part of the body, including the hands. The patches are usually not bothersome, but can occasionally cause some pruritis. The eruption can persist for many years, although the pattern of eruption can change with slow extension and clearing of lesions.[5]

Differential diagnosis

Differential diagnoses of Schamberg's disease include purpura annularis telangiectodes (Majocci's Disease),[5] which is characterized by annular telangiectasias along with Cayenne pepper spots. Pigmented purpuric dermatosis of Gougerot and Blum is another possible diagnosis and is characterized by lichenoid papules.[1] Diagnosis of Schamberg's disease is made when microscopic examination of a skin biopsy shows perivascular lymphocytic superficial dermal infiltrate with mild hemorrhage and hemosiderin deposition. The biopsy may also show red cell extravasation, endothelial cell swelling, and hemosiderin-laden macrophages.[1]

Treatment

There is no known definitive treatment for Schamberg's disease. Cosmetic imperfections, rather than heath-related issues, are the main concern for patients with this disease. The discoloration of the flat, smooth patches resembling Cayenne pepper may be cause for embarrassment. Various strategies for controlling the rash include discontinuing or changing the offending medication, avoiding food preservatives and artificial coloring agents, and wearing support stockings to counteract abnormal vein function. Taking vitamins such as vitamin C has helped individuals in some cases. Topical steroids, such as cortisone, may be used if there is an itching component to the rash, but this rarely cures the capillaritis, which is the predominant cause of the disease. Some patients have reported successful treatment with pentoxifylline, but that does not work in every case.[6] Laser therapy is being considered as a treatment option, but further research must be performed before it can be considered as a definitive treatment option.[6]

Discussion

Schamberg's disease is usually characterized by pinpoint petechiae with a brown or yellow base. This distinct rash is easy to recognize in clinical practice but other diagnoses should also be considered, including Pigmented purpuric dermatosis of Gougerot and Blum,[1] drug-induced eruptions,[3] Majocci's Disease,[5] and leukocytoclastic vasculitis.[7] The purpura is usually harmless. However, localized lichinifications, scaling, and atrophy may present with rash.[1] The treatment of Schamberg's disease has not been well established. Making a correct diagnosis is imperative to reassure patients and to avoid further costly referrals and unnecessary treatment. ■

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Using Physician Extenders

JOHN SHUFELDT, MD, JD, MBA, FACEP

You breathe a deep sigh of relief after learning that you were not the treating provider of a patient who came into your urgent care center and had an unexpected bad outcome. The patient was seen by your mid-level provider who works on opposite days from you in your center.

As documented in the medical record, the patient sounds benign: a 28-year-old female who presented with continued sinus symptoms after failing one course of amoxicillin. She was afebrile, had a slight headache, and complained that her vision was a bit "off." No rash was evident and her neurologic exam was written as WNL. Your only criticism was that visual acuity and a fundoscopic exam were not documented. According to her significant other who came to pick up her medical records, she started taking the new prescription the very same day of her visit with the physician extender yet continued to decline. Two days later, she presented to the emergency department with altered mental status and was ultimately diagnosed with cavernous vein thrombosis.

Although you feel badly for the patient and her family, you know you won't be held liable for her bad outcome because you were not actually the one who treated her. Consequently, you are completely shocked when you are named in the medical malpractice suit and cited by your medical board for failure to supervise your mid-level provider.

The number of physician assistants (PAs) and nurse practitioners (NPs) has grown tremendously over the last decade. These physician extenders (PEs) provide an incredibly valuable service treating millions of patients who likely would have had to wait extended periods to be seen by a physician. Most analysts agree that under the Affordable Care Act, at least 30 million more Americans will be eligible for health insurance. Thus, given the additional number of patients, the use of mid-level providers will be even more prevalent and necessary than today.

Currently there are more than 85,000 trained and certified PAs in the United States and more than 155,000 practicing NPs. PAs can prescribe in all 50 states but they can only work under the supervision of a licensed physician. In 18 states plus the District of Columbia, NPs can work independently but they may need a formal collaborating agreement with a medical doctor.

"Generally speaking, when a mid-level provider is sued, so too will the physician be named for a claim of negligent supervision. Physicians ought to remember the legal truism that 'although you can delegate responsibility, you cannot, under the law, delegate liability.'"

Before engaging with or employing a mid-level provider, it's important to review your state supervision statutes and to notify your medical malpractice carrier to ensure that you are covered for claims of negligent supervision. Generally speaking, when a mid-level provider is sued, so too will the physician be named for a claim of negligent supervision. Physicians ought to remember the legal truism that "although you can delegate responsibility, you cannot, under the law, delegate liability."

The good news is that PAs and NPs are less likely to get sued than are their physician counterparts. These data come from a 2009 study by the Federation of State medical boards, which looked at claims data from 1991 through 2007. During that period there was, on average, 1 payment for every 2.7 physicians

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as compared with 1 for every 32.5 certified PAs and 1 in every 65.8 NP.[1] However, in a review of closed claims by the Physician Insurers Association of America, the average unadjusted to present value indemnity payment was $174,871 for physician-extender suits that also named a physician. This amount was greater than the amount when only a physician was named.

Causes of Action with Physician Extenders

Generally, in order to successfully file a lawsuit, the patient and physician must have established a prior physician-patient relationship. However, many states have expanded the nature of this relationship in order to capture the negligent acts of on-call and attending physicians while supervising medical students, residents, and physician extenders.

Vicarious Liability: Under this cause of action, the physician is responsible for the negligent acts of employees or contractors under his or her control. This is also called *respondeat superior* or let the master answer. The bright line test is whether or not the employer directs and controls the actions and performance of the employee. The Maryland appellate court in 1957 established the following criteria for determining whether a master servant relationship exists:

1. Did the employer select and hire the employee?
2. Does the employer pay the employees' wages?
3. Does the employer have the power to terminate the employee?
4. Does the employer control the employee's conduct?
5. Is the work of the employee part of the regular business of the employer?

Negligent Supervision/Hiring: Liability on the part of the physician can also be imputed under a negligent supervision or negligent hiring cause of action. Even if the physician extender is not found to be negligent, the supervising physician can retain liability for negligent hiring and negligent supervision.

Mitigating Your Risk

Before hiring a physician-extender, the employer should ensure that the candidate has the appropriate level of training and certification necessary to perform the required duties. If an employer fails to exercise reasonable care in the hiring process, a cause of action for negligent hiring may ensue. The following eight areas should be addressed before employing a physician extender:

1. Review and application of the relevant state statutes
2. Delegation of responsibilities and duties as supervising physician
3. Review of the education and training of the physician extender
4. Determination of the appropriate setting in which the physician extender works
5. Confirmation of skills and knowledge during a mandatory proctoring process
6. Understanding of the collaborative nature of physician extender and physician interactions
7. Delineation of scope of practice and methods of communication
8. Signatures of both the physician and the physician extender on documents outlining the nature of their relationship

Many physician extenders are reluctant to call the supervising physician when they have questions or concerns. Therefore, establishing specific and well delineated medical protocols removes this common barrier and can help minimize risk.

Physician extenders should always address themselves using the title PA or NP. Nametags should also clearly delineate the title and role of the medical provider and under no circumstances should patients be led to believe that they have been seen by a physician when they are actually being seen by a physician extender.

Conclusion

It is imperative that physicians and physician extenders check their state statutes regarding supervision and collaboration requirements. Lawsuits involving physician extenders will likely increase as their scope of practice expands and as more and more patients receive primary, urgent and emergent care from highly trained PAs and NPs. ■

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Key Points

- Before hiring, ensure that your practice is knowledgeable about the reporting and supervising requirements.
- Understand the three causes of action: Respondeat Superior, Negligent Supervision, and Negligent Hiring.
- Draft clear guidelines for the appropriate use of physician extenders.
- Check training, prior experience, and work history on all physician extenders.
- Ensure that the supervising physician is meeting state-mandated supervising duties.
- Have clear titles (PA, NP) on name badges and while making introductions. Do not let patients believe that they are being seen by a physician when an extender is the treating provider.

ABSTRACTS IN URGENT CARE

- Survival after pneumonia
- Speed bumps and appendicitis
- UTIs in men
- Oral anticoagulants and VTE
- Sugar for infant pain
- Pediatric pain and emergency care
- Flucelvax
- Probiotics for diarrhea prophylaxis

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.

Long-term Survival Following Pneumococcal Pneumonia

***Key point:** Pneumococcal pneumonia foretold considerably higher 10-year mortality than the expected rate.*

Citation: Sandvall B, Rueda AM, Musher DM. Long-term survival following pneumococcal pneumonia. *Clin Infect Dis.* 2013;56(8):1145-1146.

Before antibiotics, pneumonia was called "the old man's friend" for carrying the old and infirm to a swift and relatively painless death. Now that short-term survival after pneumonia is the rule, does the disease provide any long-term prognostic information?

Veterans Administration researchers reviewed medical records of 392 patients in whom bacteriologically confirmed pneumococcal pneumonia was diagnosed at a single hospital during 10 years. Almost all patients were men (mean age, 63), and 48 (12%) died within 1 month of diagnosis. Among the remaining patients, the overall 10-year survival rate was <70%, which was substantially lower than the >95% expected rate for 63-year-old American men. When patients were stratified by severity of pneumonia according to a standard scoring system, 10-year mortality significantly increased with increasing severity scores, but even the mildest disease was associated with higher-than-normal long-term mortality. Bacteremic disease was associated with lower 10-year survival than was nonbacteremic disease.

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

Published in *J Watch General Med* April 16, 2013 — Abigail Zuger, MD ■

Pain Over Speed Bumps in Diagnosis of Acute Appendicitis: Diagnostic Accuracy Study

***Key point:** Pain over speed bumps has a negative predictive value of 90%.*

Citation: Ashdown HF, D'Souza ND, Karim D, Stevens RJ, Huang A, Harnden A. Pain over speed bumps in diagnosis of acute appendicitis: diagnostic accuracy study. *BMJ.* 2012;345 doi: http://dx.doi.org/10.1136/bmj.e8012

To assess the diagnostic accuracy of pain on travelling over speed bumps for the diagnosis of acute appendicitis, a prospective questionnaire-based diagnostic accuracy study was done in a secondary care surgical assessment unit at a district general hospital in the United Kingdom. One hundred one patients aged 17 to 76 years, referred to the on-call surgical team for assessment of possible appendicitis, participated.

The analysis included 64 participants who had travelled over speed bumps on their journey to hospital. Of these, 34 had a confirmed histological diagnosis of appendicitis, 33 of whom reported increased pain over speed bumps. The sensitivity was 97% (95% confidence interval 85% to 100%), and the specificity was 30% (15% to 49%). The positive predictive value was 61% (47% to 74%), and the negative predictive value was 90% (56% to 100%). The likelihood ratios were 1.4 (1.1 to 1.8) for a positive test result and 0.1 (0.0 to 0.7) for a negative result. Speed bumps had a better sensitivity and negative likelihood ratio than did other clinical features assessed, including migration of pain and rebound tenderness.

Presence of pain while travelling over speed bumps was as-

sociated with an increased likelihood of acute appendicitis. As a diagnostic variable, it compared favorably with other features commonly used in clinical assessment. Asking about speed bumps may contribute to clinical assessment and could be useful in telephone assessment of patients. ■

Two Studies on UTIs in Men

Key point: Longer Treatment Offers No Advantage in Male UTIs; Routine Pre-Op Urine Cultures Useless.

Citations: Drekonja DM, Rector TS, Cutting A, Johnson JR. Urinary Tract Infection in Male Veterans Treatment Patterns and Outcomes *Arch Intern Med.* 2012;():1-7. doi:10.1001/2013.jamainternmed.829,and Drekonja DM, Zarmbinski BA, Johnson JR. Preoperative Urine Cultures at a Veterans Affairs Medical Center. *Arch Intern Med.* 2012;():1-2. doi:10.1001/2013.jamainternmed.834.

One study followed outcomes in some 33,000 outpatients with urinary tract infections, two thirds of whom received treatment for longer than 7 days. Over 12 months' follow-up, longer therapy (more than 7 days) was not associated with a reduction in early or late recurrence. The risk of *Clostridium difficile* infection was significantly higher with longer therapy.

Another study at a veterans' medical center found that preoperative urinary cultures were ordered inconsistently and were associated with higher rates of surgical-site infection, diarrhea, and *C. difficile*. The presence of bacteriuria, however, was not associated with surgical-site infection.

A commentator recommends "a culture shift in antibiotic prescribing practices for men with bacteriuria from 'more is better' to 'less is more.'" ■

Novel Oral Anticoagulants Are as Effective as Vitamin K Antagonists for Patients with Acute VTE

Key point: Rivaroxaban was associated with 1/2 the risk of major bleeding.

Citation: Foix BD, Kahn SR, Langleben D, Eisenberg MJ, Shimony A. Efficacy and safety of novel oral anticoagulants for treatment of acute venous thromboembolism: Direct and adjusted indirect meta-analysis of randomised controlled trials. *BMJ.* 2012;345:e7498.

Novel oral anticoagulants are promising alternatives to vitamin K antagonists for treating patients with acute venous thromboembolism (VTE). In a meta-analysis of nine randomized, controlled trials that involved >16,000 patients, investigators compared the effectiveness of novel oral anticoagulants (factor Xa inhibitors, rivaroxaban [Xarelto] and apixaban, and direct thrombin inhibitors, dabigatran [Pradaxa] and ximelagatran) and conventional oral vitamin K antagonists (e.g., warfarin). Vitamin K antagonists always were preceded by initial heparin therapy, whereas pretreatment with heparin was variable before the novel agents.

For recurrent acute VTE and all-cause mortality, no significant differences were found among any of the novel anticoagulants or conventional vitamin K antagonists. Rivaroxaban was associated with significantly lower risk for major bleeding (relative risk, 0.57).

Published in *J Watch Gen Med* December 4, 2012 — Paul S. Mueller, MD, MPH, FACP. ■

A Little Sugar and Less Pain

Key point: A small amount of oral sucrose is widely recommended for routine use during painful procedures in young infants.

Citation: Harrison D, Beggs S, Stevens B. Sucrose for procedural pain management in infants. *J Watch Pediatr Adolesc Med* 2012;130(5):918-925.

The Prophet Mohammed seemed aware of the calming effect of oral sugar when he started the custom of giving newborns a well-chewed date in 632 AD (http://www.islamicvoice.com/april.2001/quran.htm). The first report in the pediatric medical literature documented a significant nonsedating calming effect of oral sucrose in infants (*Pediatrics* 1991 Feb; 87:215). Medical progress moves slowly as the effect of sucrose in infants continues to be studied (*J Watch Pediatr Adolesc Med* Sep 29 2010). A recent review on oral sucrose for procedural pain management examines existing evidence and practice recommendations.

Sucrose is sweeter and more effective than glucose or lactose. Evidence of the calming and analgesic effect of sucrose is limited to infants younger than 12 months. Most studies have examined a 24% sucrose solution in small amounts (0.2–0.5 mL/kg). In a meta-analysis of 44 randomized, controlled trials in infants, oral sucrose reduced behavioral responses to pain (e.g., cry duration and facial actions) and composite pain scores during painful procedures (e.g., heel stick and circumcision) compared with placebo, no treatment, or a less-sweet solution (e.g., breast milk). Administering oral sucrose throughout a painful procedure provides a sustained analgesic effect, and the effect is enhanced when combined with nonnutritive sucking. Evidence is limited on the use of oral sucrose in preterm and sick infants.

The mechanism of the effect of oral sucrose appears to be the release of β-endorphin in response to the sweet substance. This theory is based on evidence that oral sucrose was not effective in infants who were exposed to antenatal methadone (a substance that depresses endogenous opioids).

Recommendations for the use of oral sucrose include the following:

- Use small volumes for painful procedures only.
- Avoid use for calming irritable infants who are not undergoing painful procedures.

- Administer sucrose in small amounts throughout the duration of the procedure.
- Use in combination with other effective strategies (e.g., nonnutritive sucking, breastfeeding).

Published in *J Watch Pediatr Adolesc Med*. December 5, 2012 — Martin T. Stein, MD. ■

Reducing Pediatric Pain and Anxiety During Emergency Care

Key point: Recommendations include pediatric-specific provider education, pain assessment, and new techniques for reducing pain and anxiety.

Citation: Fein JA, Zempsky WT, Cravero JP; Committee on Pediatric Emergency Medicine and Section on Anesthesiology and Pain Medicine; American Academy of Pediatrics. Relief of pain and anxiety in pediatric patients in emergency medical systems. *Pediatrics*. 2012;130(5):e1391-1405.

The American Academy of Pediatrics Committee on Pediatric Emergency Medicine and Section on Anesthesiology and Pain Medicine provide comprehensive recommendations for reducing pediatric pain and anxiety in the emergency department and during out-of-hospital emergency transport. Emphasizing provider education, appropriate pain assessment, and pediatric-specific pain and anxiety-reduction techniques, the authors endorse the following:

- A dedicated child-friendly, calming environment
- Pediatric-specific visual pain scales modified for the developmentally delayed
- A toolbox of pediatric distraction equipment for minimizing anxiety
- Child life specialists to coach and calm children using age-appropriate techniques
- Family presence during painful procedures
- Use of intranasal, mucosal, oral, transdermal, or inhaled analgesia in place of intravenous or intramuscular routes
- Use of vibrating devices applied over cold packs or topical anesthetics to reduce pain associated with necessary needle sticks
- Breastfeeding or giving 12% to 25% oral sucrose solution for infants <6 months undergoing minor procedures
- Topical anesthetics for minor laceration repair, lumbar puncture, and abscess drainage
- Warmed, buffered lidocaine injected slowly with a small-gauge needle for deeper-tissue analgesia
- Tissue adhesives or steri-strips for low-tension wounds
- Absorbable sutures for higher-tension lacerations
- A quality improvement program for reviewing pediatric pain management practices

Published in *J Watch Emerg Med*. December 7, 2012 — Katherine Bakes, MD. ■

Flucelvax

Key point: The FDA has approved a seasonal influenza vaccine manufactured using mammalian cell culture.

Citation: FDA approves first seasonal influenza vaccine manufactured using cell culture technology [press release]. *Silver Spring, MD: U.S. Food and Drug Administration* ; Nov 20 , 2012. http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm328982.htm.

On November 20, 2012, the FDA announced the approval of Flucelvax, an inactivated seasonal influenza vaccine indicated for patients aged ≥18 years. The vaccine is produced using cultured animal cells rather than fertilized chicken eggs. Although mammalian cell culture has long been used for production of other vaccines, Flucelvax is the first seasonal influenza vaccine manufactured by this method to be approved in the United States.

In a randomized, placebo-controlled trial involving 7,700 people aged 18 to 49, Flucelvax was 84% effective in preventing influenza. In a separate study involving about 1,700 individuals aged >49, immunogenicity was similar to that of an egg-based vaccine. Safety evaluations revealed injection-site and general reactions typical of current influenza vaccines. The efficacy of Flucelvax compared with other seasonal influenza vaccines has not been evaluated.

Published in *J Watch Infec Dis*. December 12, 2012 — Lynn L. Estes, PharmD. ■

Probiotics Prevent *Clostridium difficile*–Associated Diarrhea

Key point: In a meta-analysis of 20 randomized, controlled trials, probiotics reduced risk by 66%.

Citation: Johnston BC, Ma SSY, Goldenberg JZ, et al. Probiotics for the prevention of Clostridium difficile–associated diarrhea: A systematic review and meta-analysis. *Ann Intern Med*. 2012;157(12):878-888.

Clostridium difficile–associated diarrhea (CDAD) is increasing in incidence and severity in North America and Europe. Some studies have suggested that probiotics taken in combination with antibiotics can reduce the risk for antibiotic-induced CDAD.

The current meta-analysis identified 20 eligible trials including 3818 patients. The investigators were interested in the protective effect of any probiotic at any dose. Probiotic species included were *Bifidobacterium*, *Lactobacillus*, *Streptococcus*, and *Saccharomyces*. The pooled relative risk for CDAD in patients receiving probiotics was 0.34 (95% confidence interval, 0.24–0.49). Probiotic use was not associated with increased risk for adverse events and was effective in both adults and children. The risk reduction was greater in trials that used multiple species (relative risk, 0.25).

Published in *J Watch Gastro*. December 7, 2012 — Douglas K. Rex, MD. ■

INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 1

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

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

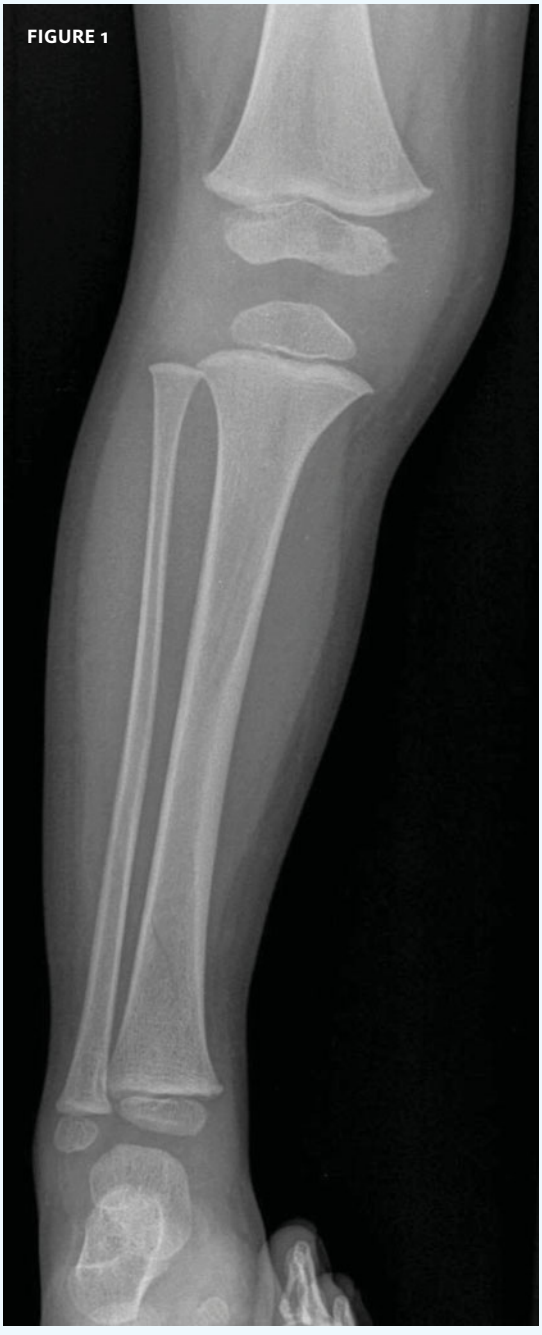

FIGURE 1

The patient, an 18-month-old boy, presented after twisting his left leg. He was unable to bear weight on it.

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

Resolution of the case is described on the next page.

THE RESOLUTION

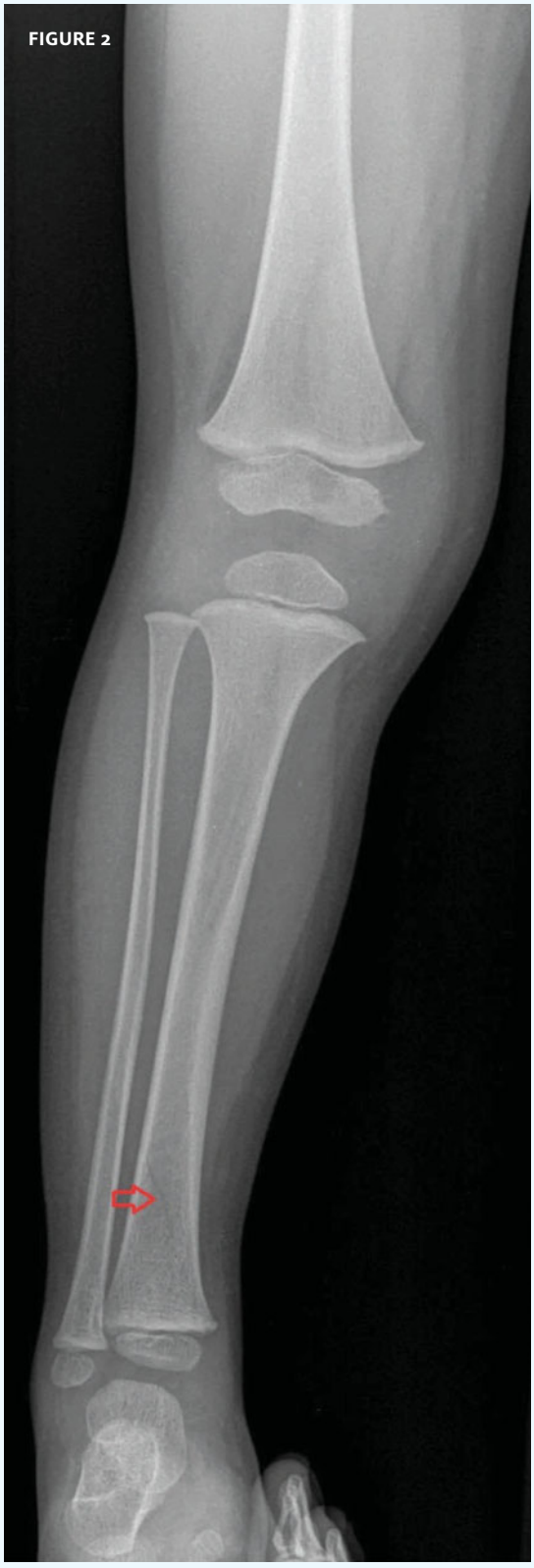

FIGURE 2

Diagnosis: The x-ray reveals an oblique/spiral low-energy fracture of the mid to distal tibial shaft (arrow) in a walking toddler. A cast splint (foot to knee) and follow up with an orthopedist are appropriate for this patient.

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

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Coding Intravenous Infusions with Hydration; Medical Decision Making

DAVID STERN, MD, CPC

Q. We perform a lot of IV infusions in our urgent care facility. Sometimes we also perform IV pushes and hydration at the same time as the infusion. We have been billing CPT codes 36000, 96365 -59, 96360 -59, and 96374 -59. Medicare pays for these codes when we append the -59 modifier but I am concerned that this may not be the correct way to bill after reviewing some articles on the CMS website. What is the proper way to code IV infusions with hydration?

A. If an IV infusion and IV push are performed concurrently in the same IV site, you should only bill one "initial" code. According to CPT guidelines, only one "initial" service code should be reported for a given date, unless protocol requires that two separate IV sites must be used. When these codes are performed in the physician office, the "initial" code billed is the code that best describes the primary reason for the encounter and should always be reported irrespective of the order in which the infusions or injections occur.

Certain procedures and supplies are included and not reported separately if performed to facilitate the infusion or injection:

- Use of local anesthesia
- IV start
- Access to indwelling IV, subcutaneous catheter or port
- Flush at conclusion of infusion
- Standard tubing, syringes, and supplies

For example, a patient is diagnosed with dehydration (276.51) and the provider orders an infusion of 1000 cc of normal saline to rehydrate the patient. Based on the documentation, the key reason for the visit is dehydration. The hydration infusion is started at 3:00 p.m. The patient becomes nauseated 10 minutes later and the provider orders 25 mg of Phenergan to be pushed at the same access site, which is performed at 3:13 p.m. The infusion is completed at 4:00 p.m. and the IV disconnected. The proper coding for the procedure is 96360, "Intravenous infusion, hydration; initial, 31 minutes to 1 hour," J7030, "Infusion, normal saline solution, 1000 cc," and J2550, "Injection, promethazine HCl, up to 50 mg."

However, let's say the same patient from our example above returns to the clinic later the same evening still nauseated. The patient is then diagnosed with nausea (787.02) and the provider orders an IV push of 25 mg of Phenergan. The IV is started, the Phenergan is administered from 7:05 p.m. to 7:10 p.m., and the IV is disconnected. In that case, you would bill CPT code 96374, "Intravenous push, single or initial substance/drug" with modifier -59 because the incident is separate from the first visit and another IV placement had to be performed.

Another example is a patient who has come in for a therapeutic infusion of "Antibiotic A," which is started at 1:00 p.m. using the same access site; a bag of 1000 cc of normal saline is hung at 1:02 p.m. to facilitate the infusion. The provider then orders a push of 60 mg Toradol to help with the discomfort. The push is performed from 1:10 p.m. to 1:13 p.m., again in the same access site. At 1:22, "Antibiotic B" is administered as a push per direction of the provider using the same access site and completed at 1:25 p.m. The IV is disconnected at 2:00 p.m.

To code, you need to first establish the primary reason for the encounter. In this case, that would be the infusion of the antibiotic, so your "initial" code is 96365, "Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, put to 1 hour." You would bill codes 96365, J7030, J1885, "Injection, ketorolac tromethamine, per 15 mg" (4 units), and the HCPCS codes for both of the antibiotics administered.

You will want to make sure that your documentation and coding are very accurate in case of an audit. Time is a factor in all hydration and infusion codes. Therefore, we recommend that start and stop times for each individual procedure be clearly documented. ■

David E. Stern, MD is a certified professional coder and board certified in Internal Medicine. He was a Director on the founding Board of UCAOA and has received the organization's Lifetime Membership Award. He is CEO of Practice Velocity, LLC (www.practicevelocity.com), PV Billing and NMN Consulting, providers of software, billing and urgent care consulting services. Dr. Stern welcomes your questions about urgent care in general and about coding issues in particular.

CODING Q & A

"Time is a factor in all hydration and infusion codes."

Q. An established patient presented with sore throat, fever, and pain on swallowing. The provider did a full History of Present Illness (HPI) (5 elements), full Review of Systems (ROS), and full Past Family and Social History (PFSH.) Eight systems were documented for the Physical Exam (PE). The rapid strep test was negative. Could this be billed with 99214 or would the Medical Decision Making (MDM) be too low?

A. Actually, if you were just counting the elements as noted in the 1995 E/M guidelines, the algorithm for the documentation noted would produce a 99215. According to CPT guidelines using the case you present above, the history component would be deemed comprehensive, the PE deemed comprehensive, and the MDM straightforward. The final code should result from meeting at least two of the three key components (Hx, Px, CMDM) for an established patient visit. Thus, you drop the lowest component and then code results from the lowest remaining component. However, many providers routinely bill a lower code, even if the documentation might support a higher code.

According to the *Medicare Internet-Only Manual*, pub. 100-4, chapter 12, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed."

It is up to the provider to determine what information is medically necessary to evaluate the patient and document accordingly.

If this was an otherwise healthy patient with a sore throat, the question for you to answer is this: "Was it medically necessary to perform a comprehensive history and exam?" This is a provider decision, but in many cases in urgent care, the provider is not very well acquainted with the patient (even if officially an "established" patient), so doing a more thorough history and physical exam is often quite appropriate in the urgent care setting. ■

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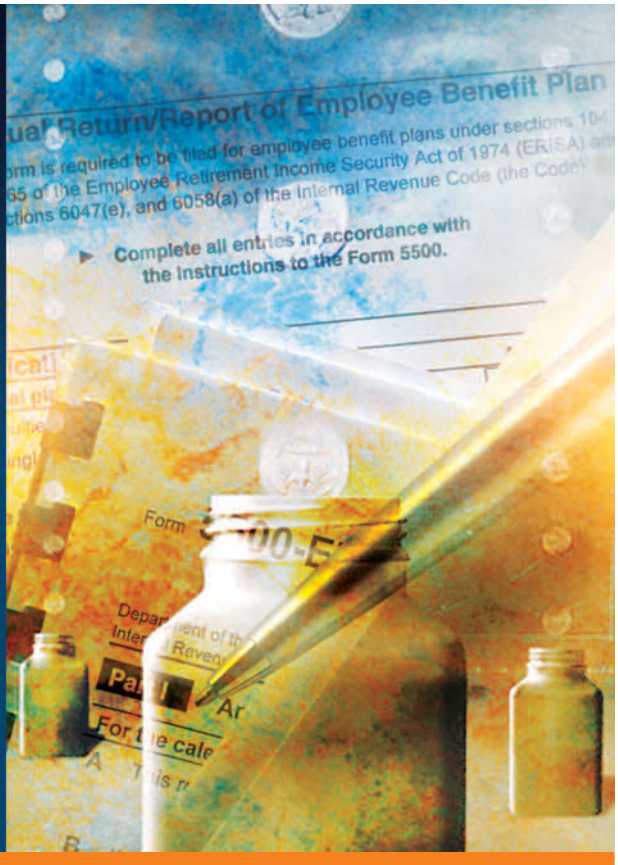

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DEVELOPING DATA

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

In this issue: What is the Average Time to Payment Receipt?

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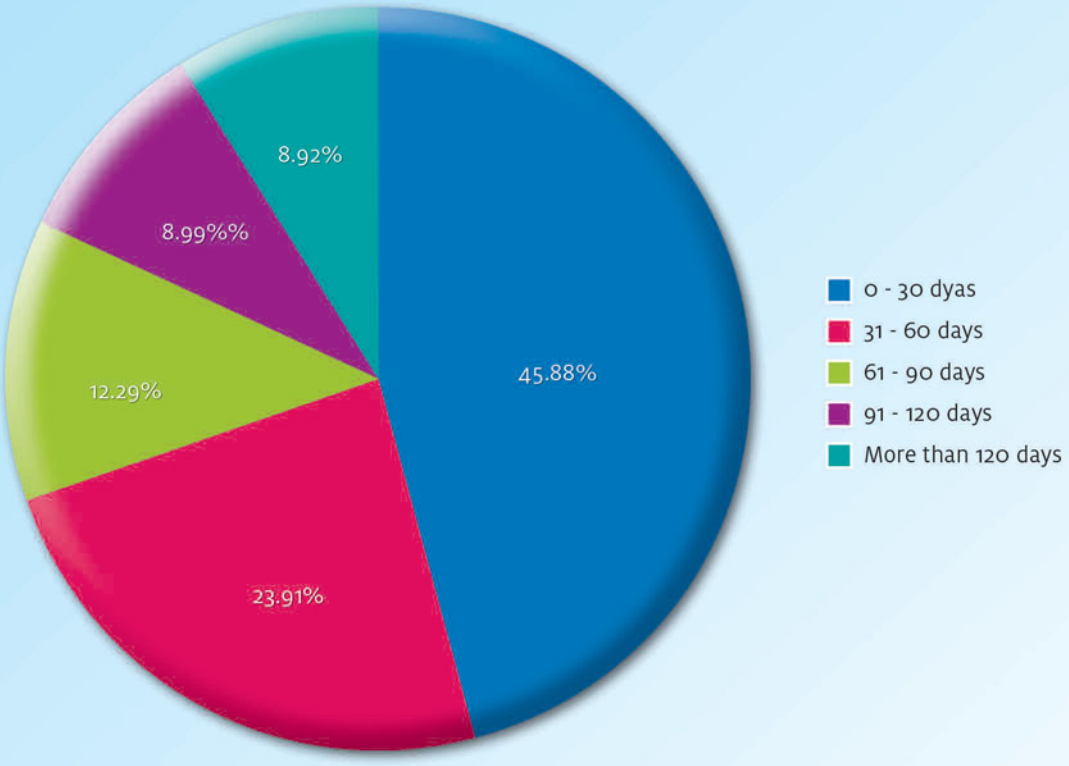

Delays in payments significantly influence an urgent care center's ability to manage its organizational resources successfully. With 30% of receivables outstanding for more than 2 months, centers must manage their cash flow and expenses carefully. Improvement in this area is a focus for many centers (n=105).

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

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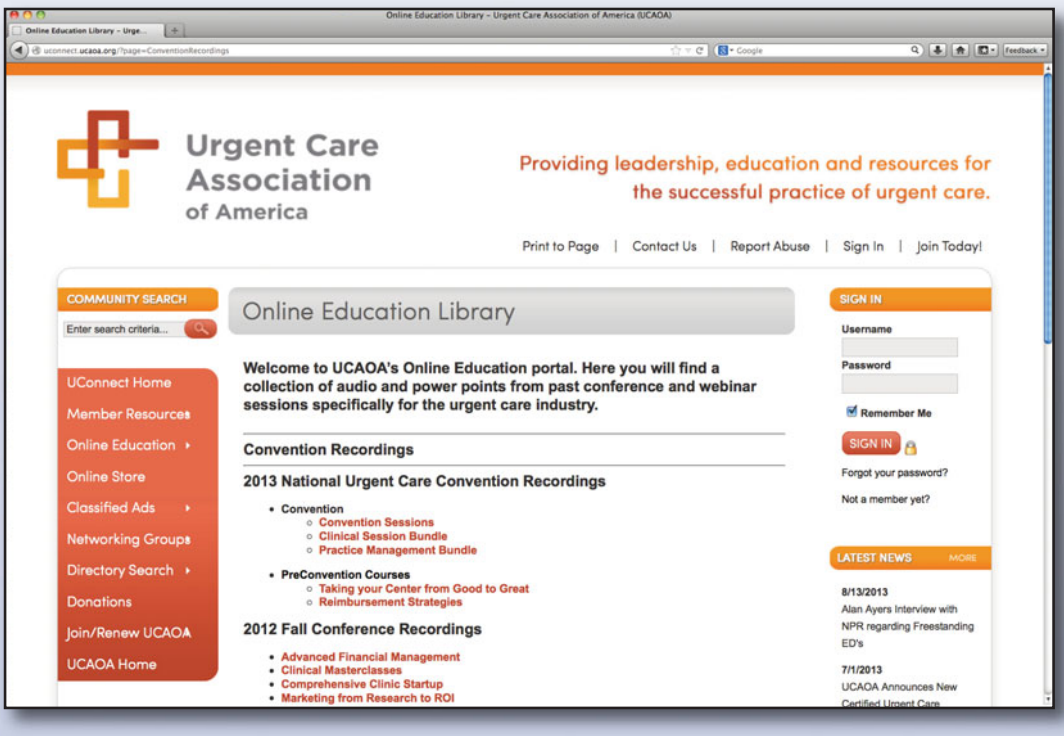

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