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Management of Palpitations in Urgent Care

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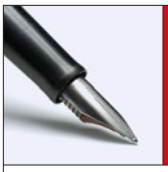
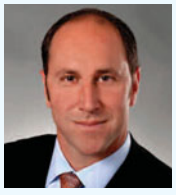


LETTER FROM THE EDITOR-IN-CHIEF

It Depends on What the Meaning of the Word 'Is' Is



Much has been written of late about use of emergency services by patients covered by Medicaid. For some time, consensus has been that Medicaid patients overuse emergency services for non-emergencies. The emergency department (ED), it was thought, served as the de facto primary care physician for this because of problems with access and lack of pricing pressures to deter use. Until recently, supportive data were lacking and the notion of overuse was based primarily on physician and hospital experience.

To better define actual usage rates, the Center for Studying Health System Change, with funding from the Robert Wood Johnson Foundation, set out to provide better definition for the data. Unfortunately, the study relied on pre-existing data from the 2008 National Hospital Ambulatory Medical Care Survey Emergency Department (NHAMCS-ED), leaving us with the same questions as before the study. The key trouble with these data is that they are far too interpretive to be of any use from a policy perspective.

In the report, ED visits are divided into five categories as determined by a triage nurse: (1) emergent—patient needs to be seen immediately or within 15 minutes of arrival; (2) urgent—15 to 60 minutes; (3) semi-urgent—1 to 2 hours; (4) nonurgent—2 to 24 hours; and (5) no triage or unknown. A full 75% of Medicaid patients received triage scores of 1 to 3. However, very little is written about how such a subjective yet definitive categorization will affect the interpretive impact of the findings. In fact, despite the utter lack of visibility behind the triage score and its misleading terminology, several policy groups and media outlets have carelessly presented the study findings as a statement of fact.

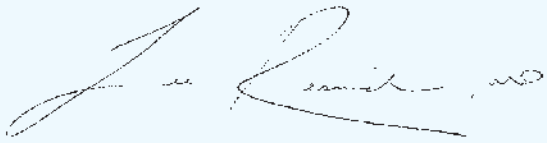
So, I have to ask, "Is this what the study *really* showed?" The authors are all really smart people with deep knowledge of statistics and knowledge, so they must be on to something....right? Just to be sure, I did some of my own investigative work and what it reveals is less than encouraging.

- The study uses common lay terms like "urgent" and "emergent" to define a very specific category with meaning only for purposes of this study. It is tempting but incorrect to assume that anyone who needed to be seen in 15 to 60 minutes had a "proper" ED visit. Much the same could be said about the 1- to 2-hour category. By that definition, at least 75% of all ED visits are "proper." However, closer inspection would reveal that a large percentage of such patients could be seen elsewhere. One also might make the reverse error and draw the conclusion that all the urgent, semi-urgent, and non-urgent visits are, by definition, "non-emergent" and therefore, could be interpreted as "appropriate for alternative care" settings such as urgent care clinics. By that definition, only 12% of all ED visits are true emergencies (a very different story indeed).
- The study's main defining data point is almost entirely subjective, dependent on the triage nurse's interpretation with very few objective components. Nowhere is it defined "how" the triage nurse determines the amount of time within which a patient needs medical attention.

Policy groups and the media made quick work of drawing broad conclusions about the definition of "routine" care. I'm not sure what that means, either. Regardless, the vast majority of complaints seen in the study were for non-emergencies like fever, sore throat, respiratory infections, headaches, rashes, minor injuries, and minor pain. The vast majority of these patients were "stable," and while their conditions required some level of urgent or semi-urgent evaluation, they were by no means emergencies.

Perhaps, then, the study's most glaring flaw is that it failed to ask the right question. That is, how many of the 75% to 90% so-visits called "non-emergent" could and/or should have taken place in an alternative setting such as an urgent care clinic? Until we focus our inquiry on the right question we will be left with nothing but literary fodder for pundits and interest groups.

In my next column, I will propose a method to quantify the potential impact of urgent care services on emergency department utilization. ■



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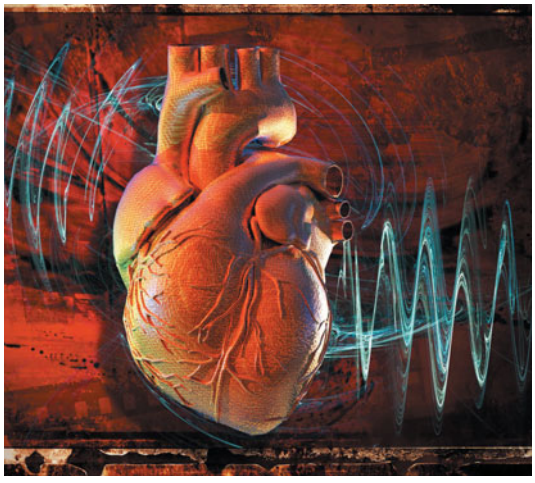

CLINICAL

7 Management of Palpitations in Urgent Care

Patients with palpitations often present to urgent care clinics. Making the correct diagnosis requires knowledge of underlying pathophysiology and thorough differential diagnosis.

Ebrahim Barkoudah, MD, and Jeffrey P. Collins, MD

PRACTICE MANAGEMENT

13 Five Federal Employment Regulations Urgent Care Operators Need to Know (Part 2)

The second article in a two-part series looks at USERRA, FMLA, and NLRA—three federal labor laws that urgent care operators are likely to encounter.

Alan A. Ayers, MBA, MAcc

CASE REPORT

20 Abdominal Pain of Unusual Origin in a Teen

Always be mindful of the 'zebra' in a stampede of 'horses' in the differential diagnosis.

Elisabeth L. Scheufele, MD, MS, FAAP

IN THE NEXT ISSUE OF *JUCM*

Estimates indicate that infants cry a total of 1 to 2 hours per day. Parents with "colicky" or irritable infants sometimes bring them to urgent care clinics out of concern about a medical problem or because they themselves are exhausted. Studies indicate that 5% to 60% of infants seen in emergency departments for excessive crying have a serious medical condition. Excessive crying in infants is the subject of next month's cover story. It reviews steps for a careful history and physical exam, conditions to consider in differential diagnosis, and diagnostic and therapeutic measures for specific conditions.

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JUCM *The Journal of Urgent Care Medicine* supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing 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.

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Palpitations—a sensation of pounding heartbeats—is an unpleasant feeling that leads many patients to present at urgent care clinics. In most cases, palpitations do not imply pathological arrhythmias, but urgent care providers need sufficient knowledge about palpitation etiology to identify patients in whom this symptom may be associated with a life-threatening condition. In our cover story this month, Ebrahim Barkoudah, MD, and Jeffrey P. Collins, MD, review causes of palpitations, presentation and initial evaluation, use of twelve-lead ECG and other forms of imaging and testing for palpitation diagnosis, and triage and patient management. Their article conveys the importance, in urgent care, of accurate diagnosis of palpitations and of having a protocol in place to address potentially fatal arrhythmias.

Dr. Barkoudah is associate physician at Brigham and Women's Hospital, clinical affiliate at Massachusetts General Hospital, and instructor in medicine at Harvard Medical School in Boston, MA. Dr. Collins is assistant in medicine at Massachusetts General Hospital, clinical instructor in medicine at Harvard Medical School in Boston, MA, and a member of the *JUCM* Editorial Board.

In this month's case report, Elisabeth L. Scheufele, MD, MS, FAAP presents the case of a teen with abdominal pain and a 4-day history of pain, shortness of breath and night sweats who recently started working at a job lifting heavy bags of food. The account underscores the need to consider unusual conditions in differential diagnosis because "zebras" do exist amidst the "horses."

Dr. Scheufele is an assistant in Internal Medicine and Pediatrics at Massachusetts General Hospital, Boston, MA, and a member of the *JUCM* Editorial Board.

In the second of a two-part practice management series, author Alan A. Ayers, MBA, MAcc presents a must-read article on five federal labor laws with which urgent care operators—as employers and managers of people—need to be aware. This installment covers the Uniformed Services Employment and Re-employment Rights Act, the Family Medical Leave Act, and the National Labor Relations Act.

Mr. Ayers is Vice President, Concentra Urgent Care and Content Advisor, Urgent Care Association of America. He is also the Associate Editor, Practice Management for *JUCM*.

Also in this issue:

John Shufeldt, MD, JD, MBA, FACEP, discusses DUI laws and the many reasons why physicians should not drink and drive.

Nahum Kovalski, BSc, MDCM, reviews news abstracts on literature germane to the urgent care clinician, including studies of age-based cutoffs for D-dimer levels and a WHO call for action to stop the spread of gonorrhea.

In Coding Q&A, **David Stern, MD, CPC**, discusses E/M coding for multiple visits, contracted case-rate billing, and comparing payor reimbursement policies.

Our Developing Data end piece this month looks at physician assistant staffing at 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.

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Management of Palpitations in Urgent Care

Urgent message: Patients with palpitations often present to urgent care clinics. Making the correct diagnosis requires knowledge of underlying pathophysiology and thorough differential diagnosis.

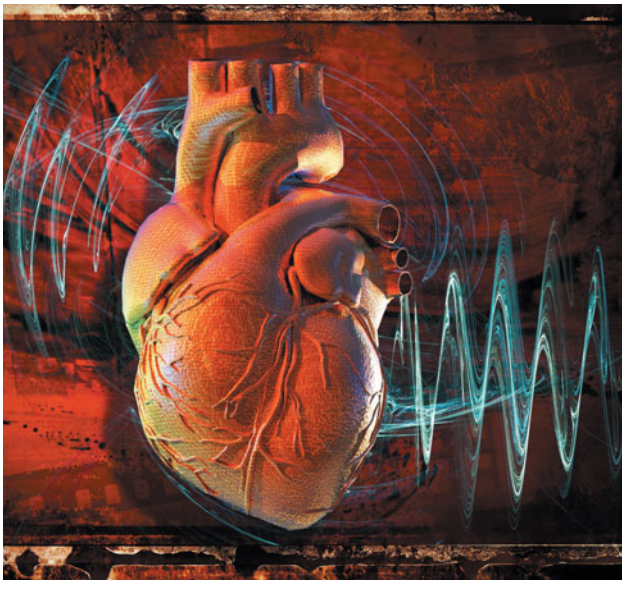
EBRAHIM BARKOUDAH, MD, and JEFFREY P. COLLINS, MD

Case Record

A 75-year-old woman with no prior history of cardiac disease complained of "palpitations" but neither lightheadedness nor syncope. She denied excess caffeine intake or use of illicit drugs and had no other significant past medical history on triage. The patient's initial blood pressure measurement was noted to be 105/74 mmHg and heart rate 190 BPM. An electrocardiogram (ECG) was obtained **(Figure 1)**. The patient was conversant but appeared uncomfortable. Her blood pressure was rechecked 3 minutes after the initial reading and remained in a similar range. The patient reported "tidiness in the chest."

Introduction

Palpitations are a common reason for urgent care visits. Aside from what the brain interprets as abnormal heartbeats, patients may complain of a sensation of rapid, pounding, skipped or irregular heartbeats. The causes of palpitations range from benign to serious and proper history-taking and thorough evaluation are warranted to explore underlying etiology in a patient and establish a management plan. Arguably most patients' palpitations are not explained by any serious cardiac condition, but an urgent care provider may want to explore cardiac causes for any such complaints. In some cases, further evaluation is of little use in explaining underlying etiology. Besides increasing medical costs, further testing may cause anxiety in patients and their families. Therefore, in urgent care, the decision whether to proceed with further evaluation and management should be guided by focused history and physical examination.



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Medical Literature on Palpitations

Palpitations—described as a sensation of pounding heartbeats—are an unpleasant feeling that leads patients to seek medical attention.[1-3] In most cases, palpitations

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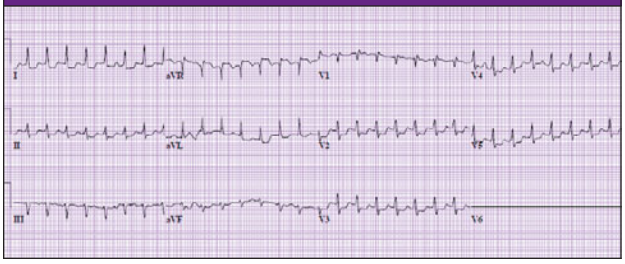
Figure 1. Initial ECG



do not imply pathological arrhythmias.[4] However, urgent care providers need enough knowledge about etiology to identify patients in whom palpitations may be associated with life-threatening etiology.

In their systematic review, Thavendiranathan et al concluded that a known history of cardiovascular disease increases likelihood of malignant arrhythmia and life-threatening events in the setting of palpitations.[4] Similarly, data from the Netherlands showed that patient characteristics play an important role in predicting cardiac arrhythmias in those who present with palpitations to their general practitioners.[2,5]

Position papers from multiple medical societies recommend a structured workup, based on findings from a detailed history and physical examination, along with utilization of less expensive surveillance tools, such as ECG. [6] The universal recommendation is to use the least expensive diagnostic tool before proceeding to further cardiac monitoring, metabolic and endocrine workup, or advanced imaging.[7] The exception is in the case of clear evidence that a patient suffers from a cardiac arrhythmia and a life-threatening risk is imminent.[8]

Causes of Palpitations

A variety of conditions may be responsible for causing palpitations. Data on these causes in an urgent care setting are not readily, but the differential diagnosis should include cardiac and non-cardiac conditions. Cardiac causes of palpitations include electrical pulse abnormalities, such as increased automaticity of the cardiac conduction at any level of the system pathway or reentry phenomena via accessory pathway and structural cardiac diseases that can precipitate arrhythmias. Patients with malfunctioning pacemakers and implantable cardioverter defibrillators also can present with complaints of palpitations. In these specific situations, the possible etiologies consist of hardware failure or pacemaker-mediated tachycardia (PMT) caused when a device senses an atrial pulse and generates ventricular stimulation.

Stimulant substances and many medications can result in cardiac conduction excitation and subsequently lead to palpitations. In addition, many of the most commonly used medications—specifically neuroleptics and antiemetics—can lead to QT Interval prolongation as a causal pathway to Torsades de Pointes ventricular tachycardia. Hence, urgent care providers should be well-informed about the adverse effects of such treatment and know how to address secondary palpitations in these patients.

Moreover, neuropsychiatric disorders, endocrine gland diseases (both hyposecretion and hypersecretion states) increase heart rate. In addition, physiological responses to increased body temperature, decreased intravascular volume, and electrolyte imbalance should be considered as reversible causes of palpitations.

Presentation and Initial Evaluation

Initial evaluation and testing of patients with palpitations should be guided by the likelihood of a cardiac etiology, based on patient history and physical examination **(Table 1)**. Further urgent management should be contingent upon a patient's concomitant presentation and hemodynamic profile. A wide variety of concomitant symptoms can accompany a non-specific complaint of palpitations, which could determine further evaluation. For example, dizziness or syncope in the setting of palpitations is a concerning presentation for cardiac arrhythmias. Patient demographics—specifically age and past medical history—also are helpful in determining the possible cause and further risk stratification. In adolescents, for instance, palpitations usually are benign and often explained by hormonal changes in this population. In rare adolescents, a true presentation of arrhythmia is concerning for structural congenital heart disease or hereditary cardiac conduction disorders. Conversely, in adults with cardiac disease, the presentation of dizziness and palpitations may be indicative of ventricular arrhythmia. We suggest that initial evaluation of palpitations include ECG and basic laboratory testing (if available in the urgent care center) and outpatient cardiac event monitoring when a patient is hemodynamically stable.

ECG Evaluation

Twelve-lead ECG is the cornerstone of arrhythmia diagnosis in the setting of palpitations and a necessity for documentation and treatment. Although single-lead monitors alone are inadequate and can be misleading, debated exists about use of ECG as a first-line surveillance tool. Recommendations from professional medical soci-

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Table 1: Triage and Management of Palpitations in Urgent Care

Initial Rapid Assessment and Triage
- Any tachycardia should be taken seriously, and to a lesser degree for sinus tachycardia in anxiety, dehydration, etc.
- Vital signs determine the severity index for rapid triage
- Rapid triage should focus on medical history highlights

Provider History and Exam
- Concurrent clinical history: chest pain, SOB, Syncope, etc.
- Exam: focus on neurologic, cardiac, pulmonary findings

Initial Diagnostic Approach
- ECG
- Electrolytes
- TSH
- Cardiac enzymes
- BNP or NT-proBNP
- Digoxin level when applicable
- Urine drug screen
- Imaging: Chest x-ray
- Continuous closed-loop, Holter and trans-telephonic event recording monitors

Management
- Place patient in acute bed with cardiac monitor and DC pads
- Obtain IV access
- Initiate CAB protocol if hemodynamic profile becomes unstable.

Management of Unstable Palpitations
- Establish CAB protocol
- Convert or not convert if arrhythmia affected the stability of vital signs
  - Clinical decision: Explore coexisting etiologies (ACS, PE, CVA, etc.)
  - Dependent on stability of the case
  - Temporary solution
- Alert ED/cardiac unit
- Secure transfer to facility

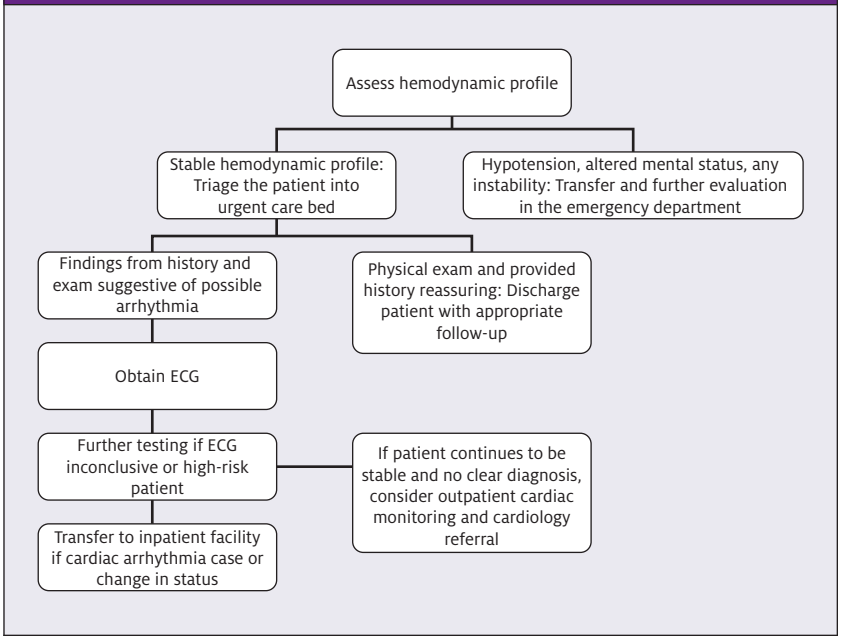
ACS = acute coronary syndrome; BNP = brain natriuretic peptide; CAB = chest compressions, airway, breathing; CVA = cardiovascular accident; ECG = electrocardiogram; ED = emergency department; IV = intravenous; NT-proBNP= N-terminal prohormone brain natriuretic peptide; PE = pulmonary embolism; SOB = shortness of breath; TSH = thyroid stimulating hormone

eties acknowledge that a patient's clinical picture and presentation will determine the indication for ECG.[9] Routine testing at the time of the complaint carries only 30% to 60% variability in determining the diagnosis.[10]

The key to accurate diagnosis and subsequent treatment is having a reasonable knowledge of ECG along with relevant clinical presentation and laboratory findings.[11] Recommendations from the American College of Cardiology (ACC) and the American Heart Association (AHA) emphasize that ECG should be done for validation of arrhythmia when a patient's clinical presentation suggests a cardiac cause.[9,11]

Automated readings in ECG machines use built-in software that does not always provide an accurate diagnosis. Specific arrhythmias may be over-read or not accurately diagnosed. In clinical practice, there is an accumulated body of evidence that outpatient ECGs should be stored or transmitted to a central station for diagnosis confirmation and future documentation.

Figure 2. Suggested Workflow for Palpitation Triage and Evaluation



Laboratory and Imaging Approach After Initial Evaluation and ECG

Guided by the available triage data, an urgent care provider may consider further testing to explore the cause of a patient's palpitations. The general initial approach can include a basic metabolic panel and complete blood count to investigate electrolyte abnormalities or anemia and screening for thyroid disease with measurement of thyroid-stimulating hormone. If a cardiac condition such as myocardial infarction or congestive heart failure is suspected, adding serum cardiac biomarkers and measuring digoxin level (when available) may be critical when triage of a patient and transfer to a hospital are needed. Chest x-ray is highly specific but has low sensitivity for screening tool for cardiopulmonary diseases. Urine drug screen can guide diagnosis in patients in whom illicit drug use is suspected. In such cases, true arrhythmias, and specifically ventricular tachycardia, are in the differential diagnosis.

In patients with complaints of persistent palpitations complaint who remain stable, Holter and closed-loop event monitoring can be considered.[12] This approach should follow the initial evaluation and probably ECG to rule out structural and valvular heart disease. Referral to a cardiac electrophysiological clinic should be considered for test interpretation and further management.

It is important to note that in some patients, extensive workup will not yield a definite diagnosis, even when complaints of palpitations are recurrent and require multiple urgent care visits. Further evaluation should be guided by a patient's clinical data and presence or absence of true cardiac arrhythmia, particularly in the current environment of value-based medicine and cost-effective approaches.

Triage of Palpitation and Further Management

Patients with hemodynamic instability require urgent transfer to a hospital **(Figure 2)**. Transfer also is required when cardiac arrhythmia is documented on ECG or even suspected and accompanied by altered mental status or chest pain in patients with known coronary artery disease. Successful risk stratification of patients with palpitations on initial evaluation in an urgent care clinic will expedite triage and facilitate initiation of an appropriate protocol.

Once a patient is stable, further testing can be considered while he or she is observed in the urgent care clinic. Referral to outpatient cardiology consultation for data review and advance assessment may be helpful in patients with intermittent but benign arrhythmias.

Clinical Case Course

For our patient, a vagal maneuver was attempted (in this case, it was carotid massage, but a valsalva maneuver, orbital pressure, and ice on the face are other options). After the maneuver failed, adenosine was given (0.1 mg/kg IV push followed by 10-mL saline flush). The patient returned to sinus rhythm and was transferred to a hospital for further evaluation and consultation by the cardiology service.

Case Record Discussion

Our patient presented with supraventricular tachycardia (SVT), a common cause of palpitations in younger indi-

viduals that carries a favorable prognosis. SVT is commonly known as AV re-entrant tachycardia (AVRT), but it is also caused by increased automaticity in the atrium. The differential diagnosis includes a wide variety of rhythms that trigger the electrical pulse above the ventricular conduction system, but without ventricular involvement. Examples include AV nodal re-entrant tachycardia (AVNRT) in which a secondary pathway is present. Other AVRT anomalies include Wolf-Parkinson-White syndrome, in which AV blockers can stimulate the conduction and cause ventricular activation.

Conclusion

Palpitations represent a nonspecific presentation of cardiac and noncardiac conditions. Triage, urgent care management, and further disposition of a patient with palpitations depends on the patient's history, physical examination, and clinical presentation. In an urgent care clinic, cardiac monitoring and ECG may help provide an accurate diagnosis while a patient is waiting for further work-up or transfer to a tertiary care facility. Having a protocol in place to address all potential fatal arrhythmias in an urgent care setting is important. ■

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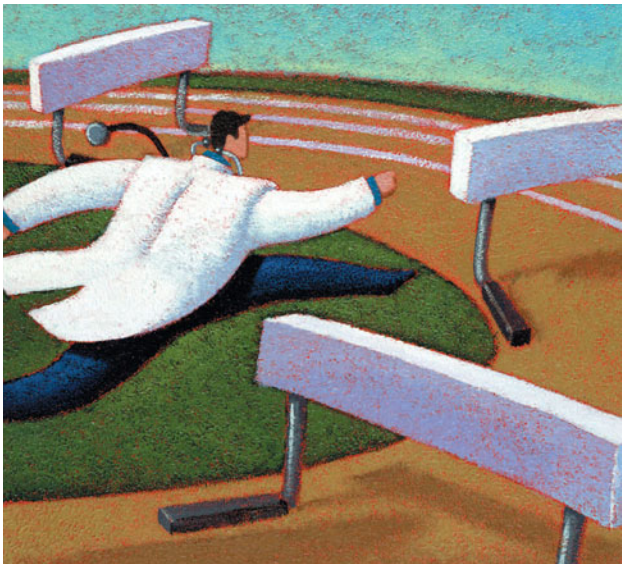
Five Federal Employment Regulations Urgent Care Operators Need to Know (Part 2)

Urgent message: The second article in a two-part series looks at USERRA, FMLA, and NLRA—three federal labor laws that urgent care operators are likely to encounter.

ALAN A. AYERS, MBA, MAcc

Urgent care centers are subject to a multitude of federal employment regulations and failure to comply with any of them could result in civil litigation or criminal penalties. Laws prohibiting discrimination, regulating wages and hours, permitting leave for military service and family or personal health issues, and affecting collective bargaining are commonly misunderstood, and as a result, violated by urgent care operators. The best protections are detailed human resources policies and an operating culture of integrity and compliance. As a start, managers and supervisors should be educated on the basics. This article is the second in a two-part series that offers specific cases illustrating five of the most significant federal employment regulations. The first part, published in July/August 2012, covered anti-discrimination laws and the Fair Labor Standards Ac.



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Uniformed Services Employment and Re-employment Rights Act (USERRA)

The Uniformed Services Employment and Re-employment Rights Act (USERRA) provides employment and reemployment rights for members of the uniformed services, including veterans and members of the Reserve and National Guard. The Act applies to all employers regardless of size.

Under USERRA, service members who leave their civilian jobs for military obligations can serve with the knowledge that they will be able to return to their previous jobs with the same pay, benefits, and status they would have attained if they had not been away on duty. If seniority is a factor, an employee's military service must be computed as if he or she had served the entire time with the employer. The Act also prohibits employers from discriminating on the basis of an individual's military service.[1]

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Re-employment Rights

Employees have the right to re-employment with the same employer when returning from a period of service, provided they meet the following conditions:

- The employee provides reasonable advance notice of service. However, if prior notice was impossible due to military necessity, this requirement does not apply. The military commander makes the determination of whether prior notice was impossible or unreasonable, and the determination cannot be challenged by the employer.[2]
- The employee gives written or verbal notice that leave is required. If verbal notice is given, the employer cannot require the employee to produce written orders. However, upon reinstatement if the leave is greater than 31 days, the employer can seek proof that includes discharge statements, earnings statements, or the employer can call the command post for verification.
- The employee has 5 years or less of cumulative—not necessarily consecutive—service with that employer. However, required drills, annual training, and service performed in times of war, national emergency, or in support of critical missions *do not* count towards the 5-year allotment.[3] Service with a previous employer likewise does not count toward the 5-year allotment.
- The employee returns to work or applies for re-employment in a timely manner after returning from leave.
- The employee has not been separated from service with a disqualifying or dishonorable discharge.

In addition to current employees, USERRA also affects the hiring process. For example, a prospective employee discloses in an interview that he or she has applied for the National Guard. The employer—to avoid accommodation of his/her leave or training should he/she be accepted—decides to offer the position to someone else. The employer may be liable for discrimination because USERRA protects individuals who "have applied for membership" in the uniformed service.

Family Medical Leave Act (FMLA)

The Family Medical Leave Act provides employees with up to 12 weeks of unpaid leave in a 12-month period for specified medical or family reasons. Employers with 50 or more workers for at least 20 weeks in the current or previous year are covered by the Act, as are all public agencies, regardless of size.

The Family Medical Leave Act provides employees with up to 12 weeks of unpaid leave in a 12-month period for specified medical or family reasons.

The Act provides that an employer must maintain health benefits for the individual during the leave period, in the same manner as if the employee had continued to work. If necessary, the employer will also need to make arrangements for employees to pay their share of health benefits while out on leave.

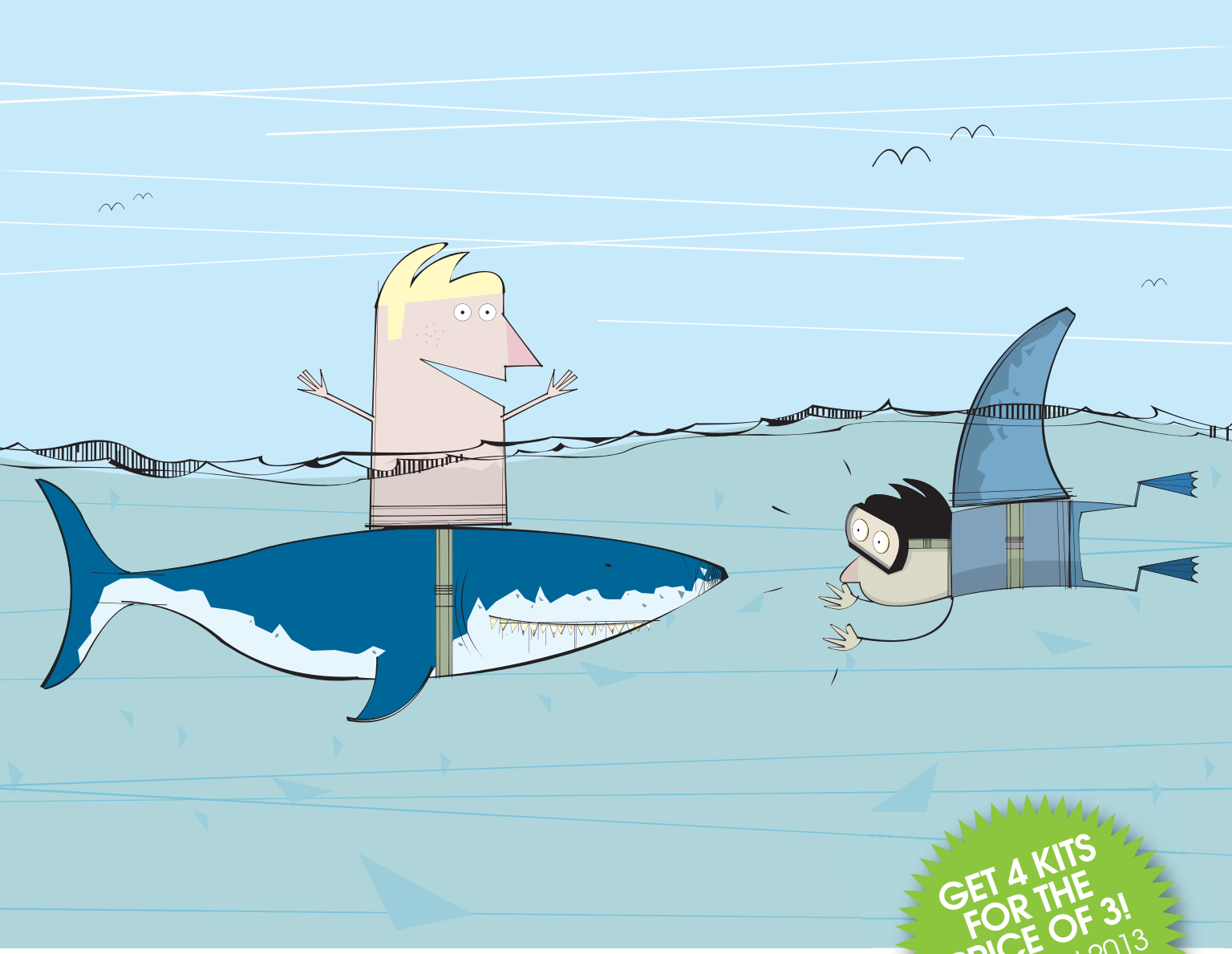
The U.S. Department of Labor emphasizes that an employee returning from FMLA leave must "be restored to the employee's original job, or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment."[4]

An employer cannot discriminate against an employee for taking Family Medical Leave. Use of leave must not "result in the loss of any employment benefit that the employee earned or was entitled to before using FMLA leave, nor be counted against the employee under a 'no fault' attendance policy." If, however, a bonus or other payment is based on the achievement of a specified goal such as hours worked, products sold, or perfect attendance, and the employee has not met the goal due to FMLA leave, payment may be denied unless it is paid to an employee on equivalent leave status for a reason that does not qualify as FMLA leave."[4]

Eligibility Criteria

An employee who works for a covered employer is eligible to apply for Family Medical Leave if he/she:

- Has worked for the employer for a *cumulative total of 12 months*. While the time does not need to be consecutive, employment prior to a break of 7 years or more does not have to be counted unless the employee was protected by USERRA during the time away.
- Has worked *1,250 hours in the previous 12-month period*.
- Is based at a location in the United States or U.S. territory that employs at least 50 employees within a 75-mile radius.



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*Theocharis, George. Vouloumanou, Evridiki et al."Evaluation of a direct test for seasonal influenza in outpatients", *European Journal of Internal Medicine*, Vol.21 (2010) 434-438

Table 1. FMLA Limitations

Issue	Limitation
Spouses who both work for the same employer	Spouses are only entitled to a combined total of 12 weeks of family leave for birth, adoption or foster care, or care of a parent. Spouses are limited to a combined 26 weeks to care for a covered service member.
Intermittent leave for birth, adoption or foster care	The leave is subject to the employer's approval. The employer can request that the employee schedule the leave to better suit the employer's operational needs.
Substitution of paid leave	An employer can require the employee to use paid leave (sick, or vacation, for example) concurrent with FMLA leave.
Scheduling time off	Reasonable efforts must be made to minimize the impact on the employer's operations

Qualifying Reasons

Twelve weeks of leave may be granted for any one—or a combination of—the following reasons:

- Birth and care of a newborn, newly adopted or fostered child within 12 months of the birth or placement;
- Care for a spouse, son, daughter, or parent with a serious health condition;
- Employee's own serious health condition; or
- Military exigencies arising from the call to active duty, such as:
  - Short-notice deployment
  - Arranging child-care and school activities
  - Post-deployment activities
  - Financial and legal arrangements
  - Military events and related activities

A "serious health condition" is defined as a condition involving inpatient care, continuing treatment from a healthcare provider—which includes at least 3 days of incapacity, a visit to a provider and an ongoing regimen of treatment—or a chronic health condition.

FMLA leave allotment is *per year, not per incident*. Regardless of the number of qualifying events, the employee is only entitled to a combined total of 12 weeks in a 12-month period. The exception is if the employee is a spouse, son, daughter, parent or next of kin of a current member of the Armed Services, National Guard or Reserves with a serious injury or illness—in which case the employee is entitled up to 26 weeks of unpaid leave during the 12-month period to provide care for the service member.

The definition of "child" has been expanded by the U.S. Department of Labor (DOL) Wage and Hour Division Administrator's Interpretation No. 2010-3. This interpretation clarified that either day-to-day care or financial support may establish a loco parentis relationship. Employees without biological or legal relationships with a child, but who assume these parental responsibilities, will qualify for leave for that child under the same circumstances as a biological parent. The interpretation also recognizes non-traditional family arrangements—including adopted children of same-sex partners—and states that an employee who will share equally in the raising of a child with the child's biological parent is also entitled to leave for the child's birth.

An employee may take continuous leave, intermittent leave, or a combination of the two. Intermittent leave allows an employee to take short blocks of leave over the course of the 12-month period, not to exceed the 12-week allocation, for a chronic condition, for example.

Requesting Leave

An employee is required to provide 30 days' notice of the need for leave, when the leave is foreseeable, such as for a scheduled surgery. If the leave is not foreseeable, the employee must provide notice "as soon as practicable." The employee is responsible for providing sufficient information to enable the employer to determine FMLA is required. *An employee does not have to specifically mention the FMLA to have met her burden to provide initial notice under the Act.*

Whether sufficient notice is given can vary based on the condition. For example, an employee requests intermittent leave because she has migraines. The employer doesn't want to grant leave because the short notice of the migraines negatively impacts schedule coverage, and consequently, the quality of patient care. Does the employee qualify for leave

under FMLA? Yes—because migraines qualify as a "chronic condition" under the Act. However, another employee requests leave for a bad headache. He was out of work for the required 3 days and saw a doctor on the first day. The doctor told him to take over-the-counter medicine if needed. Although he was out for 3 days, and saw a health care provider, he was not under ongoing care or a regimen of treatment, so his condition does not qualify for FMLA protection.

The NLRB applies to hospitals and other health care facilities (including doctors offices) that have a gross annual volume of business of at least $250,000.

An employer is generally responsible for posting a notice of employee FMLA rights. When an employer discovers that a specific employee may be eligible for FMLA leave, the employer is responsible for providing that employee with notification of eligibility, informing the employee of his or her rights and responsibilities, and—if the employer has enough information to make the determination—telling the worker that the leave has been designated as FMLA leave and will be counted toward the 12-week entitlement.

Employers are entitled to seek certification from a health care provider regarding the request for leave. If clarification is required, the following employees can contact the doctor:

- HR Professional
- Leave Administrator
- Management Official

However, the employee's direct supervisor *cannot* contact the doctor to seek clarification.

Regulations do limit leave rights in some very specific circumstances, as illustrated in **Table 1**.

National Labor Relations Act (NLRA)

The National Labor Relations Act (NLRA) provides that employees have the right to protected, concerted activity. The Act does not distinguish based on the number of employees a company has. Instead, the National Labor Relations Board (NLRB) sets standards for jurisdiction. If an employer falls under NLRB jurisdiction, it's subject to the provisions of the NLRA.

In general, the NLRB covers most non-government employers in the United States, including employee-owned businesses, non-profits, non-union businesses, and employers in "right to work" states. The NLRB applies to hospitals and other health care facilities (including doctors offices) that have a gross annual volume of business of at least $250,000. That means most employees of urgent care centers have rights under the act—even if the center employs only three people.

Under the NLRA, employees have the right to:

- Organize a union to negotiate with the employer concerning wages, hours, and other terms and conditions of employment.
- Form, join or assist a union.
- Bargain collectively through representatives of employees' own choosing for a contract setting wages, benefits, hours, and other working conditions.
- Discuss terms and conditions of employment or union organizing with co-workers or a union.
- Take action with one or more co-workers to improve working conditions by raising work-related complaints and seeking help from a union.
- Strike and picket, depending on the purpose or means of the strike or the picketing.
- Choose not to do any of these activities.[5]

An employer is prohibited from:

- Forbidding employees from soliciting for a union during non-work time.
- Discouraging union support or activities.
- Taking adverse action against an employee for concerted activity
- Threatening to close a workplace if a union represents employees
- Promising promotions or other benefits to discourage—or encourage—union support.
- Prohibiting employees from wearing union hats, buttons, t-shirts, and pins in the workplace except under special circumstances.
- Spying on or videotaping peaceful union activities and gatherings or pretending to do so.

The union also has restrictions under the Act, and may not:

- Threaten employees that they will lose their job unless they support the union.
- Refuse to process a grievance because the employee criticized union officials or is not a member of the union.
- Use or maintain discriminatory standards/procedures in making job referrals from a hiring hall.

- Cause or attempt to cause an employer to discriminate against employees because of union-related activity.
- Take adverse action against an employee based on whether he or she has joined or supports the union.

Employers must be conscious of the appearance of "union-busting" activity. Managers shouldn't question employees about whether they have signed a union card, whether they support the organizing activity or if they plan to vote in favor of the union. Other examples of union-busting activity are promising benefits if the union is not elected, threatening reprisals against employees who form or join a union, threatening to close the facility if it becomes unionized, and discouraging employees from communicating about union-related matters.

Employers must carefully monitor communications policies in the workplace, because if the company permits break room posters or flyers promoting other non-employer organizations—such as advertising a Weight Watcher's program—it cannot subsequently refuse similar posters or flyers encouraging employees to join a union. However, NLRB did rule in 2007 that employers could distinguish between charitable causes (such as United Way solicitations) or individual employee solicitations (such as selling Girl Scout cookies) while still restricting commercial and union solicitations.[6,7] Evidence of union-busting activity is viewed unfavorably by the Board and may result in certification of the union.

Evolving case law could also prohibit an employer from censoring an employee who uses social media—such as Facebook and Twitter—to criticize or collaborate with co-workers on issues such as pay, benefits, and working conditions. In one recent case, the NLRB found that an employee's complaints about the stale buns and cheap hot dogs served at a BMW dealership event constituted protected concerted activity.[8] An employer should be cautious about disciplining or terminating an employee who complains about that employer online.

Employee Free Choice Act

In 2009, the Employee Free Choice Act (EFCA) was proposed to amend the NLRA. The bill would have eliminated the right of the employer to conduct a ballot, allowing a union to be certified if union officials collected the signatures of a majority of workers. In addition, the EFCA would have required employers and unions to enter binding arbitration to produce a collective agreement no later than 120 days after the union was recognized, and it would have increased penalties on employers who discriminate against workers for union involvement, among other things.

While Congress did not pass the EFCA, employers should be prepared for changes in union organizing tactics and procedural requirements and make sure their human resources policies are up to date on union issues. Federal agencies, including the National Labor Relations Board (NLRB), have been attempting to adopt through administrative rulemaking many of the reforms sought in

the failed EFCA legislation.

In 2011, for example, the NLRB proposed various rules that support unionization, including rules that would lead to significantly speedier union elections, and a requirement that all employers should post a notification informing employees of their rights under the NLRA. This notification requirement was challenged by the National Federation of Independent Business (NFIB), which states that the NLRB has overreached its authority. The NFIB states that the posting rule will affect over 6 million businesses, even those that have never committed a violation. According to the NFIB, "small businesses are particularly vulnerable to accidental violations because the regulatory compliance burden most often falls on the small business owner and because small businesses do not have dedicated compliance staff."

Although the notification requirement was originally supposed to take effect on November 14, 2011, it was delayed to January 31, 2012 due to a legal challenge of the requirements. Most recently, the date has been delayed again and is pending appellate court review. While the Final Rule associated with the notice posting requirement is being formally challenged, employers must stay informed of the issue to ensure compliance**.** Employers should also stay abreast of upcoming social media guidance from NLRA decisions related to employee speech and concerted activity.

How Can Employers Stay in Compliance?

Although the breadth of federal employment regulations may seem overwhelming to an urgent care operator, employers can stay up to date with the most recent rules by visiting the U.S. Department of Labor's website and using associated resources. Have a qualified human resources professional periodically review all your employment policies and procedures with an eye towards compliance. State and municipal departments—such as the Department of Industrial Relations, the Department of Fair Employment and Housing, or the local EEOC office—all can answer questions about specific state and local regulations and how they impact federal compliance. If you're ever in doubt about your compliance, you can also check your practices with an employment law attorney. ■

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Case Report

Abdominal Pain of Unusual Origin in a Teen

Urgent message: Always be mindful of the 'zebra' in a stampede of 'horses' in the differential diagnosis.

ELISABETH L. SCHEUFELE, MD, MS, FAAP

Young adults often present to urgent care clinics with abdominal pain. In most cases, this symptom is secondary to a virus or assorted other issues in the gut. However, the broader differential includes a whole host of additional conditions, a few of which may catch an urgent care practitioner a little off guard.

Case Presentation

J.H. is a 19-year-old Hispanic male presenting with abdominal pain and shortness of breath for the last 4 days. He had visited the urgent care clinic about 2 days before with similar symptoms and was discharged with a diagnosis of muscle strain. J.H. returned with persistent symptoms and he indicates that the pain is mostly along the left upper quadrant. It is not associated with eating or drinking, and his urine output and bowel movements are normal (no black or bloody discoloration).

The patient also denies nausea, vomiting or diarrhea, fever, chest pain, or rash. He reports shortness of breath, but believes it's related to trouble inhaling deeply because of the abdominal pain. Of note, J.H. reports night sweats over the last 4 to 5 days, but no weight loss. He has taken acetaminophen or ibuprofen for the pain without much relief, and denies alcohol or drug use. Three weeks before presentation, he started working at a job where he lifts very heavy bags of food. The note from the previous visit also documents recent recovery from upper respiratory symptoms.

Elisabeth L. Scheufele is an assistant in Internal Medicine and Pediatrics at Massachusetts General Hospital, Boston Mass.

Observations and Findings

Physical exam

Evaluation of the patient revealed the following:
Temp: 99 °F
BP: 140/76
HR: 93
RR: 20
O_2 Sat: 100%
General: Well-nourished, well-developed male in no acute distress
Chest: CTAB, no RRW
CVS: RRR, no mrg
ABD: NABS, soft, with tenderness to palpation along left

upper quadrant and mild guarding, no rebound or rigidity, non-distended, no masses and no appreciable organomegaly on exam.

Laboratory Results
J.H. presented to the urgent care clinic during hours when the laboratory was closed and imaging services other than for plain films were unavailable. Labs were drawn for the main hospital to run, and an ultrasound (U/S) of the abdomen was set up for the following morning.

The results were as follows:
Chemistries were within normal limits except for AST (SGPT) of 64 U/L
Monospot: negative
CBC: WBC 14.8 th/cmm; HCT: 41.5%;
Hgb: 14.8 gm/dL; Plt: 35 th/cumm

Man Diff:
Poly: 5%
Band: 9%
Lymph: 8%
Mono:3%
Eos: 0%
Baso: 1%
Blasts: 73%
Myelos: 1%

Peripheral smear revealed a monomorphic population of medium-sized leukocytes with scant cytoplasm, notched to irregular nuclei, finely dispersed to slightly clumped chromatin, and conspicuous nucleoli, consistent with blasts. Rare blasts showed azurophilic granules and cytoplasmic vacuoles, but Auer rods were not seen. Also noted were mature neutrophils and lymphocytes as well as circulating myeloid precursors and occasional nucleated red blood cells. There was also marked thrombocytopenia. The findings were those of acute leukemia with morphology most consistent with acute lymphoblastic leukemia (ALL).

Ultrasound: Hepatosplenomegaly

Diagnosis

B-cell ALL

Course and Treatment

From the urgent care clinic where he had the U/S performed, J.H. was sent to the main hospital for urgent evaluation of hepatosplenomegaly in light of the smear findings of blasts. He was urgently admitted to the pediatric oncology service for further work up and management, which elucidated the ALL diagnosis.

As urgent care physicians, we must be vigilant in care for our patients and always be on the look out for those zebras even though we are often working in a stampede of horses.

Discussion

The differential diagnosis for abdominal pain is expansive and includes, at a minimum, a myriad of gastrointestinal (GI) causes, conditions with visceral organ involvement, and conditions with soft-tissue involvement. Lacking any other GI symptoms or association with food, conditions that are fairly self-contained to the stomach and intestines—such as gastritis, reflux, ulcers, and gastroenteritis—fall low on the differential. Guarding on exam is more concerning for a differential consistent with visceral organ involvement (such as conditions that result in splenomegaly, hepatomegaly, or pancreatitis) or conditions with transmural effects on the intestines (such as diverticulitis or advancing tumor). Soft-tissue involvement, such as muscle sprain or spasm, is also of concern, particularly secondary to the patient's new employment that requires significant physical exertion. However, the patient also complained of several days of night sweats, which would be more in line with an infectious or inflammatory cause, such as mononucleosis, cancer, or abscess. Mononucleosis also was at the top of the differential, given the patient's age and symptoms. Therefore, we were a bit more than surprised when the U/S demonstrated hepatosplenomegaly, and the CBC returned with such low platelets and atypical lymphocytes.

Acute Lymphocytic Leukemia: A brief review

Precursor B-cell ALL is the cause of about 2% of the lymphoid cancers diagnosed in the United States. Although it is seen most often in children, it does occur in adults. The median age of presentation in adults is about 39. Frequency is slightly higher in males than females, and Hispanics have the highest incidence of any ethnic group.

Presentation can be acute or more gradual, and most symptoms are secondary to anemia, neutropenia, or thrombocytopenia. Symptoms on presentation can include fatigue, easy or spontaneous bruising, infections and the B symptoms of fever: night sweats or unintentional weight loss. As many as half of these patients also may present with hepatomegaly, splenomegaly or lymphadenopathy.

Diagnosis is made based on examination of bone marrow aspirate with or without biopsy, and results of flow cytometric and cytogenetic evaluation. B-cell lineage is distinguished from T-cell by expression of B-cell antigens (such as CD19 and CD22) and lack of T-cell antigens (such as CD3). Leukemia (precursor B-cell ALL) is differentiated from lymphoma (precursor B-cell lymphoblastic lymphoma) by the presence of more than 25% bone marrow blasts.

Prognosis for patients with ALL is generally dependent on age and genomic factors. It is better for children in general, and particularly children with hyperdiploidy and t(12;21) translocation (85% to 90% long-term survival rates). On the other hand, prognosis is poorer for infants younger than age 1 year and adults, as well as those with hypodiploidy and Ikaros mutations. In adults, t(9;22) and t(v11q23) abnormalities are associated with poor prognosis.

Conclusion

The distinguishing and concerning features in this patient presentation were repeat presentation within a couple days, night sweats for several days, and tenderness to palpation and mild guarding on abdominal exam. Together, those features could add up to something with a fairly innocuous course, such as mononucleosis, or something much more serious, such as ALL. As urgent care physicians, we must be vigilant in care for our patients and always be on the look out for those zebras even though we are often working in a stampede of horses. ■

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DUI: Rules of the Road

JOHN SHUFELDT, MD, JD, MBA, FACEP

Oh crap! The flashing red lights illuminating the interior of Eric's car snapped him back to reality. He had lived through a tough year—passed his family medicine boards, finished residency, separated from his wife and ultimately went through a contentious divorce. Eric's first post-graduate job ended poorly after he was caught up in owner infighting and left as the practice he joined dissolved.

Suffice it say, Eric needed a drink or two. To celebrate a new start, he and a few friends from his residency program hit the town for a mellow night of dinner and a few drinks. When he was sufficiently relaxed and refreshed, he bid his friends goodnight and headed home. His new job was in an urgent care center and he wanted to make sure he was well rested before his 12-hour shift.

While Eric was driving home, he texted his ex-wife to simply say goodnight and that he was sorry for the way everything transpired. While texting, his car swerved a bit into the next lane. Fortunately, he realized his mistake and immediately put his phone down. About two blocks from Eric's apartment, the road he was traveling on ended at a "T" intersection. It was a quiet night and no traffic was approaching from his left, so after double checking, he rolled slowly through the stop sign, made a quick right turn, and headed into the parking lot surrounding his complex.

Eric's car was bathed in stark white light as an officer walked up to him while he was attempting to get out of his car. The officer politely said, "Sir, since you are already out of the car, please keep your hands where I can see them. Do you know why I stopped you?" After waiting a few moments, the office continued, "I stopped you because you crossed into the lane next to you and then proceeded to roll through the stop sign." As Eric attempted to explain, the officer raised his hand as if to say "halt" and then said, "Sir, have you been drinking?"

Eric responded honestly that he had 3 beers with his friends. At that point, the officer proceeded to ask him pointed questions about his alcohol consumption during the evening. Eric concluded his final answer with, "Oh, by the way, I'm a doctor." To which the officer responded, "Help me understand how that is relevant? Are you telling me this because you are on your way to an emergency?"

The interaction went downhill from there. Next, the officer requested that Eric perform a Horizontal Gaze Nystagmus (HGN) test and then a Field Sobriety Test (FST). According to the officer, Eric flunked both. Next, the officer performed an intoxilyzer (breath alcohol test), which demonstrated a blood alcohol level of .07—slightly below the limit in Eric's state. Despite the fact that his level was below the cutoff, Eric was handcuffed, read his Miranda rights, placed in the back of the squad car, and driven down to the police station to be booked.

Most states have enacted very tough DUI laws and Eric's state was no exception. He ultimately worked through all the issues, but not before spending thousands on an attorney's fees, fines, and alcohol counseling through a medical board-mandated program. He now has to list the DUI on every malpractice insurance form, state medical board, and medical staff privilege form he completes.

Learning from Eric's mistakes

In retrospect, how should Eric have altered his actions? The obvious answer is "don't drink and drive."

If a situation like Eric's happened to you, here are a few things to consider. First, if you are a medical provider, most states have mandatory reporting requirements. In other words you must notify the medical board. If the board learns of the citation, and you have not notified them, you will be dealt with more severely.

Many physicians believe that a DUI charge will not impinge on their medical license because it relates to behavior in their personal life, not their professional practice. The reality is that the Board is permitted to regulate a physician's "personal life" conduct, at least to a certain extent.

Courts have held that the Medical Board has the authority to discipline physicians for illegal activity not directly associ-

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Table 1. A Quick Guide to BAC by Weight in Pounds and Number of Drinks.

Men	80 lbs	100 lbs	120 lbs	140 lbs	160 lbs	180 lbs	200 lbs	220 lbs
1 drink	0.05	0.04	0.03	0.03	0.02	0.02	0.02	0.02
2 drinks	0.06	0.08	0.06	0.06	0.05	0.04	0.04	0.04
3 drinks	0.15	0.12	0.10	0.08	0.07	0.06	0.06	0.05
4 drinks	0.19	0.16	0.13	0.11	0.10	0.09	0.08	0.07
5 drinks	0.24	0.19	0.16	0.13	0.12	0.11	0.10	0.09

Women	80 lbs	100 lbs	120 lbs	140 lbs	160 lbs	180 lbs	200 lbs	220 lbs
1 drink	0.06	0.05	0.04	0.03	0.03	0.03	0.02	0.02
2 drinks	0.12	0.09	0.08	0.07	0.06	0.05	0.05	0.04
3 drinks	0.18	0.14	0.12	0.10	0.09	0.08	0.07	0.07
4 drinks	0.24	0.19	0.16	0.14	0.12	0.11	0.10	0.09
5 drinks	0.30	0.24	0.20	0.17	0.15	0.13	0.12	0.11

ated with the quality of their medical care, on the theory that those activities relate to the professional qualifications inherent in holding a medical license. Essentially, courts have justified this practice on the theory that activities outside the practice of medicine reflect on a physician's ability to practice medicine.

Please check the laws in your state for specific reporting requirements.

To give you an example of penalties under state law, here are the fines in Arizona for first-time DUI offenses:

- **Standard DUI: Blood alcohol content (BAC) over *0.08* (three drinks for most men and two drinks for most women [Table 1])**
  - Mandatory jail time of 10 days - No plea bargaining (second offense - 30 to 90 days)
  - Mandatory suspension of driver's license for 90 days (second offense - 1 year)
  - Mandatory installation of ignition interlock device in car for 1 year (Cost: $1,000 plus $100 per month)
  - Court fees - $1,500 (second offense - $3,000), points, increased insurance, attorney fees, etc.

- **Extreme DUI: BAC over *0.15***
  - Mandatory jail time of 30 days - No plea bargaining (second offense - 60 to 120 days)
  - Mandatory suspension of driver's license for 90 days (second offense - 1 year)
  - Mandatory installation of ignition interlock device in car for 1 year (Cost: $1,000 plus $100 per month)
  - Mandatory alcohol monitoring - 30 days (second offense - 90 days plus 30 days of community service)
  - Mandatory vehicle impoundment - 30 days
  - Court fees - $2,500 (second offense - $5,000), points, increased insurance, attorney fees, etc.

- **Super Extreme DUI: BAC over *0.20***
  - Mandatory jail time of 45 days - No plea bargaining (second offense - 180 days)
  - Mandatory suspension of driver's license for 90 days (second offense - 1 year)
  - Mandatory installation of ignition interlock device in car for 18 to 24 months (Cost: $1,000 plus $100 per month)
  - Mandatory alcohol monitoring - 30 days (second offense - 90 days plus 30 days of community service)
  - Mandatory vehicle impoundment - 30 days
  - Probation - 0 to 1 year (second offense - 0 to 5 years)
  - Court fees - $3,000 (second offense - $6,000), points, increased insurance, attorney fees, etc.

- **Felony DUI - 0.08 or above but *with a MINOR in the car less than 16 years old***
  - Felony charge
  - Mandatory jail time of 30 days - No plea bargaining
  - Suspended driver's license for *3 years*
  - Ignition interlock device - Installed in car for 18 months *or possible loss of car* ($1,000 plus $100 per month)
  - Fees (*up to $150,000*), points, increased insurance, attorney fees, etc.
  - Possible probation for up to 5 years

Anyone under age 21 who is pulled over in Arizona and has had ANY alcohol (even the day before they turn 21) is subject to the above rules plus loss of their driver's license for a minimum of 2 years with no plea bargain available and a record for 7 years.

Here are some other things to consider:

- Depending on the police department, you have about an

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85% chance that the encounter with a police officer is being videotaped and recorded.

- The BAC is not affected by whether a person can handle alcohol. It is a chemical formula based on your blood content, not how you act.
- If you have a BAC lower than 0.08 but fail the field sobriety test, you can be charged with a DUI.
- The BAC is at its highest 2 hours after the last drink is taken. The BAC will not start going down until 2 hours after the last drink (that means stalling at the police station will probably not help).
- The most common infraction for which people are pulled over, especially at night, is a wide left or right turn.
- When the police department has a DUI task force in place in an area, they will basically pull over everyone who is driving through that area, regardless of whether they have done something wrong.

If you are ever pulled over and the officer asks you to get out of the car, there is a good chance you will be arrested unless you have had absolutely nothing to drink. The premise is he or she would not have asked you to get out of the car unless he suspected you were impaired. The main purpose of the field sobriety test and the questioning (every question) is designed to gain evidence that you were "even slightly impaired."

For example, you could fail the FST, go to the substation and blow a 0.06 and still get a DUI because they have proven that you were slightly impaired. The field sobriety test is very, very difficult to pass even stone cold sober. It is also a subjective test and no one—except the police officer and you—know what really happened.

Here is what Eric should have said (if he was sure he had only one or two drinks) when the officer asked why he was pulled over: "I do not know." (People will occasionally respond, "I rolled through the stop sign." That statement is admissible in court).

If you are stopped and an officer inquires about alcohol consumption and you have been drinking, you can politely say, "I had a couple of drinks." Give the officer your driver's license, registration and proof of insurance. If the officer then asks you to take an FST, you can politely tell the officer that you do not want to answer any more questions nor do the FST or HGN until you have talked with a lawyer. When asked why you can say, "I have been told by my lawyer that these are things you look at to see if I am impaired. I am not impaired, so if you are asking me to do these, I want to speak to my lawyer before consenting." The officer may get upset and continue to ask you questions. Stay polite and firm (your right to not speaking is protected by the Constitution and the fact that you did not speak cannot be used against you in court). You will likely be handcuffed and taken to the police station for a blood test. When you get to the police substation, they will take away your cell phone and put you into a room with a phone and a telephone directory. Do not take a breath, blood or urine test until you have talked with a lawyer.

If you don't have a lawyer, you should then find a "24-hour lawyer" from the telephone directory. You will probably get an answering service which will tell you that the lawyer will call you back shortly. You should tell the police officer that fact. You should then follow the lawyer's advice, which will probably be to take the blood test but not answer any questions or do any agility tests. Ask to be released to obtain an independent blood test at a hospital. It probably will not help your defense, but at least you may not spend that night in jail.

Take-home points

- Although you will probably never need one, carry the name of a criminal defense attorney and a 24-hour phone number with you.
- If you are stopped, follow the advice above.
- Check your state's reporting requirements for the medical or nursing boards. Chances are that your state has reporting requirements.
- Always, always, always be very polite and keep your hands very visible. (I work with police officers and they have a thankless job none of us would want). They are used to dealing with individuals who are less than thrilled by their presence. Don't joke around and don't be overly defensive.
- You can admit to having consumed alcohol, just don't admit to a quantity. If you don't admit to drinking at all, and the police officer smells it on your breath, you are a "liar" in the officer's mind and will give him/her a reason to dig deeper.
- Have your license, insurance card, and registration easily reachable. Officers are trained to observe for manual dexterity.
- If an officer asks you to step out of the car, he or she will be watching your balance and to see if you are holding onto the door to steady yourself. Police officers have the right to demand that you step out of the vehicle.
- Don't let passengers interject. Your passengers should be quiet and very observational. If the passengers are obnoxious, they will destroy their credibility as your character witnesses.
- It is not illegal to "drink and drive." It is illegal to drive while impaired. Most individuals who are stopped are not arrested. Do not give an officer grounds to investigate further.
- I would not say things like, "I'm a doctor, etc." Generally speaking, no good will come from that statement.
- If you are planning on drinking while you are out, take a cab. You have worked too hard to risk your career over a few bad choices. ■

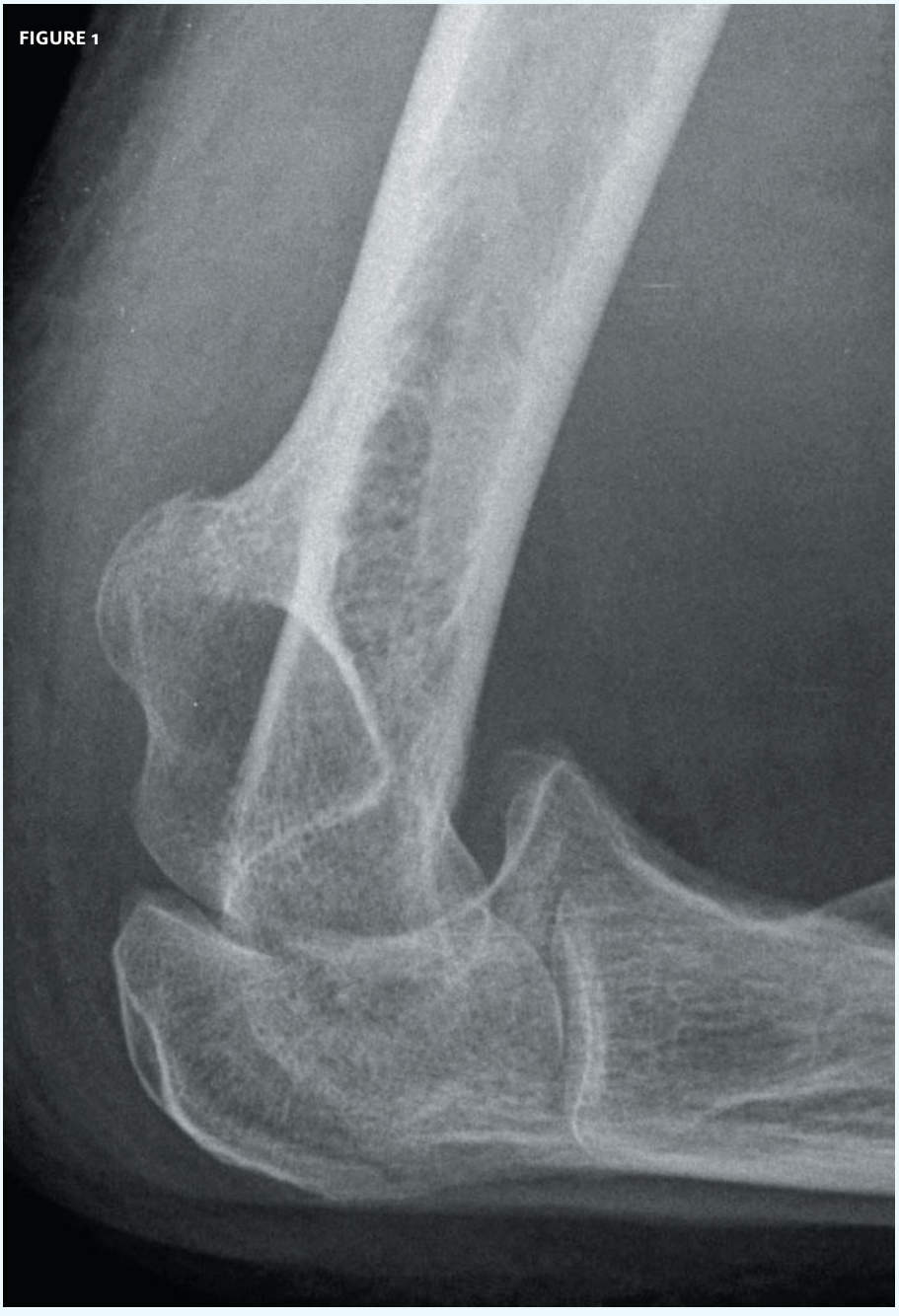
INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 1

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

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

FIGURE 1



The patient, a 72-year-old male, had local swelling in his right elbow. He had no history of trauma but he did suffer from dementia.

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

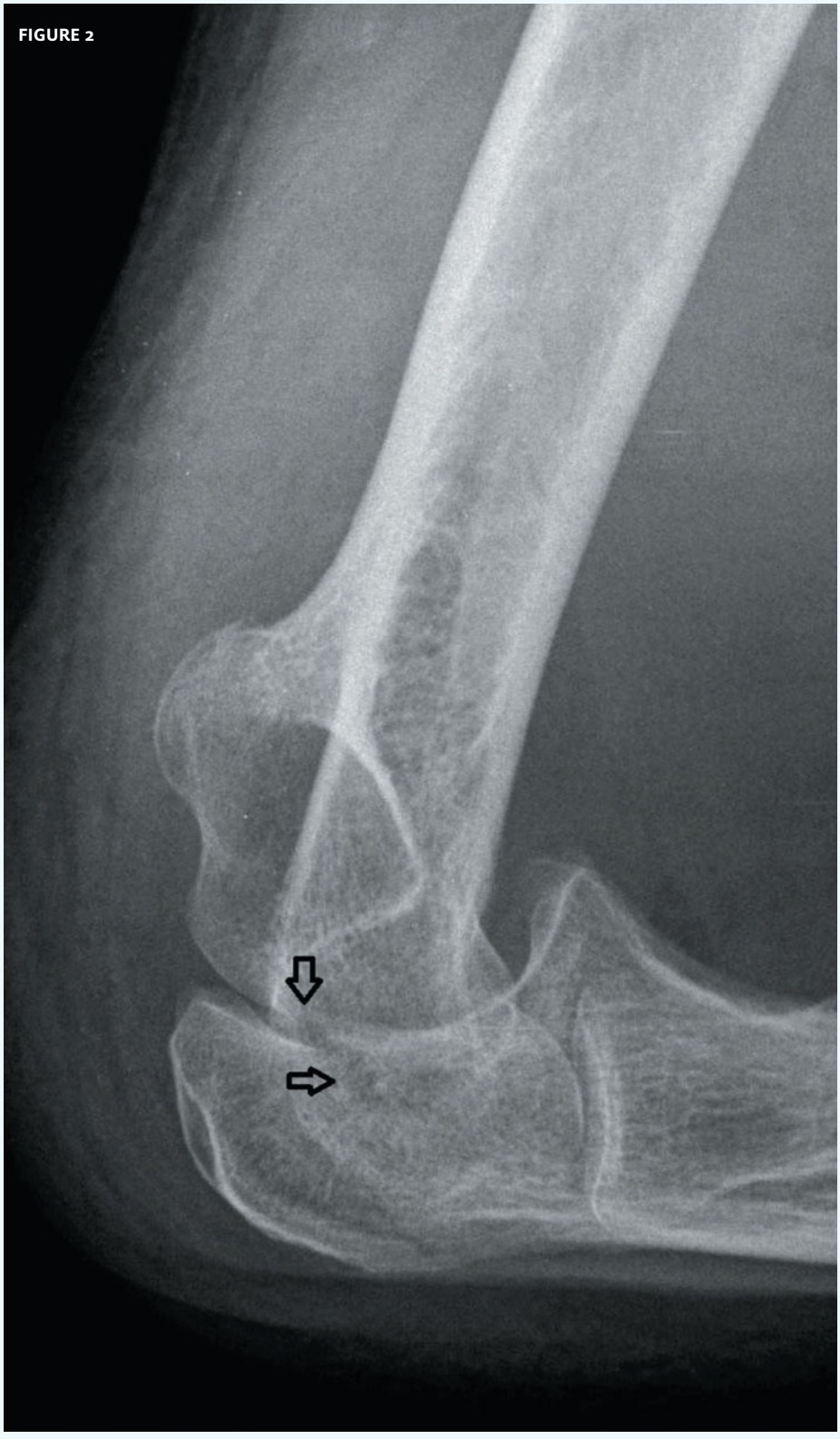


FIGURE 2

Diagnosis: The x-ray reveals a fracture of the olecranon. In a patient with dementia and this type of fracture, there may not be a history of a fall or trauma. A cast splint at 90 degrees at the elbow 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.

INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 2

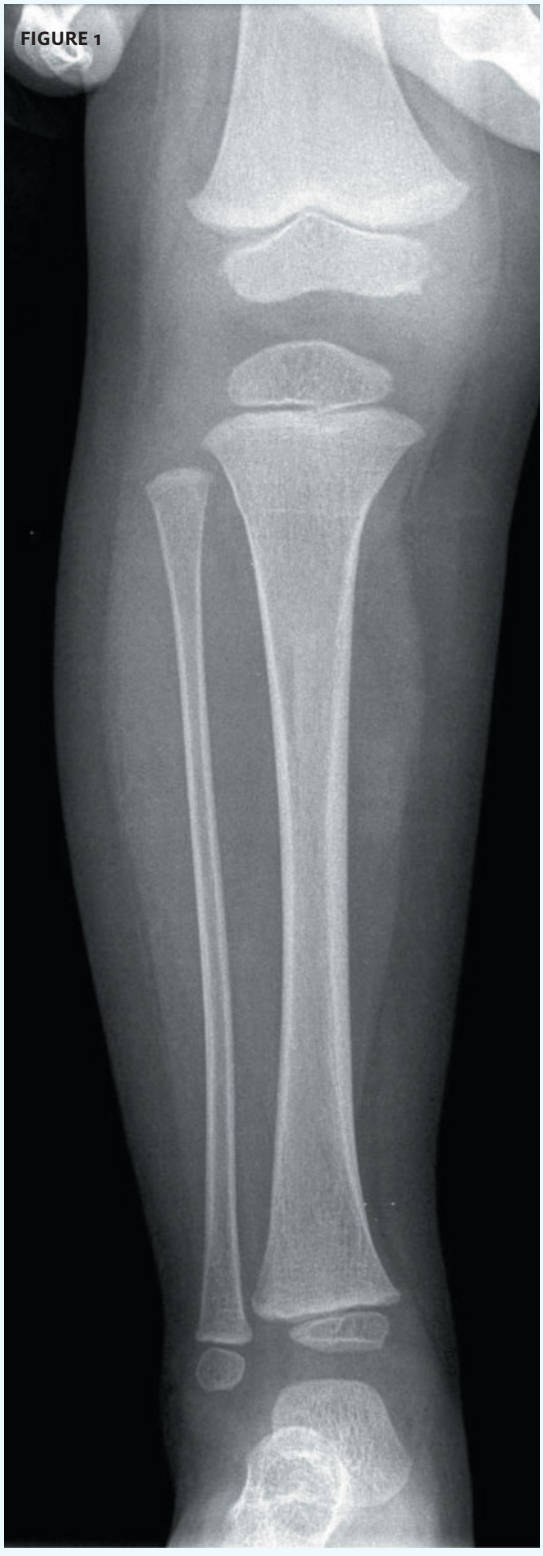


FIGURE 1

The patient, a 2-year-old girl, suffered a blow to her right knee and could not bear weight on her right leg.

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

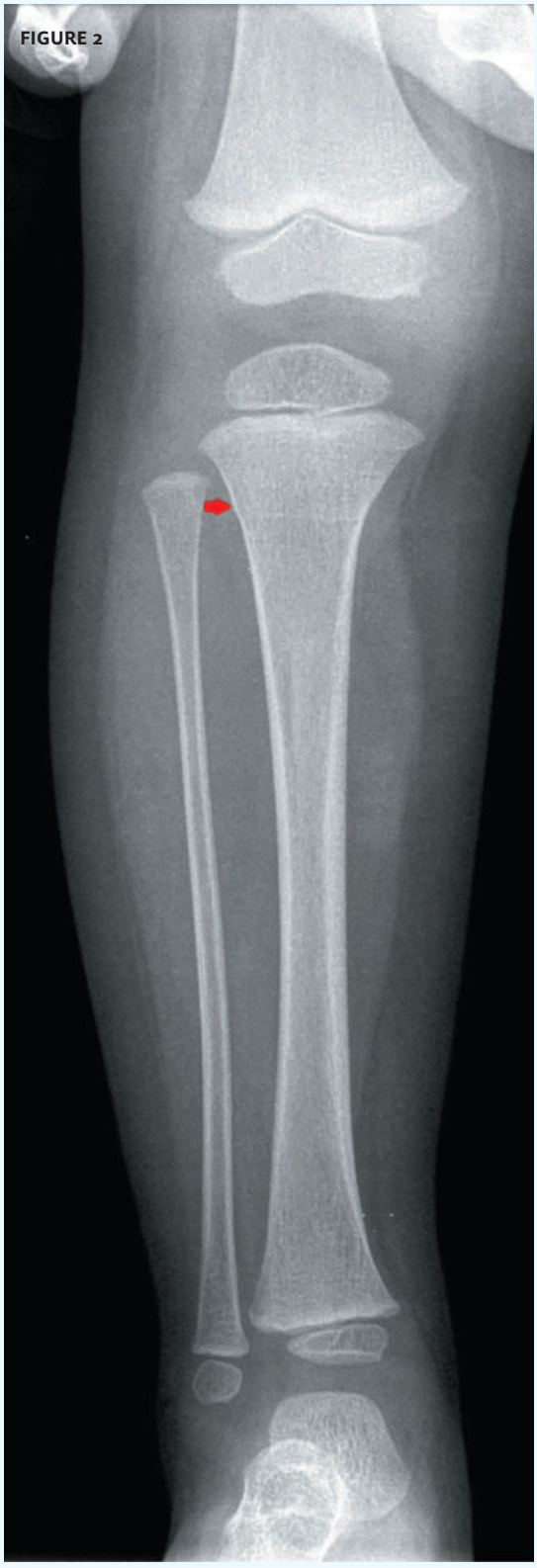


FIGURE 2

Diagnosis: The x-ray reveals a greenstick fracture of the tibia (arrow). A long leg cast splint 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.

ABSTRACTS IN URGENT CARE

- Age-based cutoffs for D-dimer levels
- WHO plan for gonorrhea
- Childhood CT scans and cancer
- Cephalosporins in penicillin-allergic patients
- CT scans in older patients with minor head trauma
- Risk factors for death at 30 days in discharged syncope patients
- Lactobacilli vs TMP/SMX to prevent recurrent UTI
- Normal WBC count does not rule out bacteremia
- Antibiotics overprescribed for acute bronchitis

■ 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.

Age-based cutoffs for D-dimer levels

Key point: Age-based cutoffs for D-dimer levels can more accurately rule out deep venous thrombosis than the conventional cutoff level.

Citation: Schouten HJ, Koek HL, Oudega R, et al. *BMJ*. 2012;344:e2985.

Researchers measured D-dimer values in some 650 patients suspected of having deep venous thrombosis but who had a low clinical probability according to their Wells score. Compression ultrasonography was used to confirm the diagnosis. Various cutoff levels were evaluated:

- The conventional cutoff level (500 g/L) was able to exclude 42.0%;
- A cutoff based on age (age in years x 10 g/L) could exclude 47.8%;
- Using a cutoff of 750 g/L in those aged 60 and older could exclude 47.4%; and
- False-negatives were roughly 0.3% in all approaches.

The age-related cutoffs proved more efficient with increasing age, reaching about 45% (versus 30% with the conventional cutoff) in those between 70 and 80.

The authors call for further validation before advocating widespread clinical use. ■

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.

WHO Calls for 'Urgent Action' to Stop Spread of Drug-Resistant Gonorrhea

Key point: Drug-resistant Gonorrhea is spreading and requires aggressive identification and treatment protocols.

Citation: ***http://www.who.int/mediacentre/news/notes/2012/gonorrhoea_20120606/en/index.html***

The World Health Organization (WHO) is calling for "urgent action" to limit the spread and impact of drug-resistant *Neisseria gonorrhoeae* infection, citing reports of emerging resistance to cephalosporin antibiotics — the last-line treatment in gonococcal infection.

The WHO's action plan emphasizes the following points:

- The importance of prompt diagnosis and treatment, ideally with single-dose therapy to ensure adherence, treatment of partners (patients may deliver treatment to their partners) education and prevention, with special attention to high-risk groups such as sex workers and men who have sex with men, and better surveillance and reporting of drug-resistant cases.

The document also includes flow charts on how to manage cephalosporin treatment failure in both symptomatic and asymptomatic patients. ■

Radiation from Childhood CT Scans Increases Risks of Leukemias, Brain Tumors

Key point: Childhood CT scans carry a distinct — if very small — risk for leukemias and brain tumors.

Citation: Pearce MS, Salotti JA, McHugh K, et al. Radiation ex-

posure from CT scans in childhood and subsequent risk of leukaemia and brain tumours: a retrospective cohort study. *Lancet*. Doi:10.1016/S0140-6736(12)60815-0

Researchers used national radiology and healthcare databases in Great Britain to track the correlation between estimated radiation dosages from computed tomography (CT) and incidence of leukemia or brain tumors during a follow-up of about 10 years. The cohort included some 180,000 patients without previous malignant disease.

The authors estimate that the radiation dosage from two to three head CTs in children younger than age 15 could triple the risk of brain tumors. Five to 10 CTs would result in a similar increase in risk of leukemia.

Noting that the absolute risk is small (one excess leukemia and one excess brain tumor per 10,000 head CTs before age 10), both the authors and a commentator nonetheless urge clinicians to have solid justification for every scan performed. ■

The Use of Cephalosporins in Penicillin-allergic Patients

Key point: For penicillin-allergic patients, the use of third- or fourth-generation cephalosporins or cephalosporins with dissimilar side chains than the offending penicillin carries a negligible risk of cross allergy.

Citation: Campagna JD, Bond MC, Schabelman e, Hayes BD. The use of cephalosporins in penicillin-allergic patients. *J Emerg Med*. 2012;42(5):612-620.

The practice of avoiding cephalosporin administration to penicillin-allergic patients persists despite the low rate of cross-reactions between both groups of antibiotics. The purpose of this literature review is to evaluate the published evidence regarding the commonly held belief that patients with a history of an allergic reaction to penicillin have a significantly increased risk of an allergic reaction to cephalosporins.

Penicillins have a cross-allergy with first-generation cephalosporins (odds ratio 4.8; confidence interval 3.7–6.2) and a negligible cross-allergy with second-generation cephalosporins (odds ratio 1.1; CI 0.6–2.1). Laboratory and cohort studies confirm that the R1 side chain is responsible for this cross-reactivity. Overall cross-reactivity between penicillins and cephalosporins is lower than previously reported, though there is a strong association between amoxicillin and ampicillin with first- and second-generation cephalosporins that share a similar R1 side chain.

Although a myth persists that approximately 10% of patients with a history of penicillin allergy will have an allergic reaction if given a cephalosporin, the overall cross-reactivity rate is approximately 1% when using first-generation cephalosporins or cephalosporins with similar R1 side chains. However, a single study reported the prevalence of cross-reactivity with cefadroxil as high as 27%. For penicillin-allergic patients, the use of third- or fourth-generation cephalosporins or cephalosporins with dissimilar side chains than the offending penicillin carries a negligible risk of cross allergy. ■

High Rate of Positive CT Scans in Older Patients with Minor Head Trauma

Key point: Head computed tomography was positive in two-thirds of patients aged >65 with Glasgow Coma Scale scores of 15 and no loss of consciousness.

Citation: Moore MM, Pasquale MD, Badellino M. Impact of age and anticoagulation: Need for neurosurgical intervention in trauma patients with mild traumatic brain injury. *J Trauma*. 2012;73(1):126-130.

Whether to perform head computed tomography (CT) on patients with minor traumatic brain injury (TBI) remains a dilemma. This study assessed whether age and use of anticoagulant or antiplatelet therapy is associated with need for neurosurgical intervention in such patients. Researchers retrospectively reviewed charts of all patients aged >14 years who were admitted to a level I trauma center in Pennsylvania with Glasgow Coma Scale (GCS) scores of 14 or 15 and underwent neurosurgery from 2007 through 2009.

Of 7,678 patients who presented with GCS scores >13, 101 (1.3%) underwent surgery. Rates of neurosurgical intervention were significantly higher in patients aged ≥65 than in younger patients (3.3% vs. 0.6%), as was mortality (15% vs. 0.02%). All 10 patients aged ≥65 who died were taking anticoagulants. Neurosurgical interventions included trephination or Burr hole placement, craniotomy or craniectomy, and ventriculostomy catheter placement. was positive in 66% of 65 patients aged ≥65 who presented with GCS score of 15 and no history of loss of consciousness. Mortality was higher in patients on anticoagulant or antiplatelet therapy (warfarin, aspirin, clopidogrel, or a combination) than in those not on such therapy (24% vs. 1%). Among 5 patients (13%) in the younger group and 36 (55%) in the older group who were taking anticoagulants or antiplatelets (warfarin, aspirin, clopidogrel, or a combination), mortality was 0% and 28%.

Published in *J Watch Emerg Med*. June 15, 2012 — Kristi L. Koenig, MD, FACEP. ■

Risk Factors for Death at 30 Days in Discharged Syncope Patients

Key point: Age ≥80 and history of congestive heart failure were strongly associated with short-term death.

Citation: Derose SF, Gabayan GZ, Chiu VY, Sun BC. Patterns and preexisting risk factors of 30-day mortality after a pri-

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Bellmore, NY

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Gulf Shore, Gulf Shores, AL

Temple ReadyCare
Philadelphia, PA

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Paramus, NJ

The Doctors Office of West
Caldwell, West Caldwell, NJ

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mary discharge diagnosis of syncope or near syncope. *Acad Emerg Med.* 2012;19(5):488-496.

To determine risk factors for short-term death in patients discharged from the emergency department (ED) with syncope, researchers reviewed data from Kaiser Permanente Southern California during a 5-year period. Of 22,189 patients with primary ED discharge diagnoses of syncope or near syncope, 321 died within 30 days.

In regression analysis, increasing age was strongly associated with risk of death; hazard ratios were 6.59 for ages 60 to 79 and 11.73 for age ≥80, compared with ages 18 to 59. History of congestive heart failure was also associated with increased risk, and the association varied with age; hazard ratios were 14.30 for ages 18 to 59, 3.09 for ages 60 to 79, and 2.34 for age ≥80. Male sex, recent visit for syncope or near syncope, and history of diabetes, seizure, or dementia were all associated with slightly increased risk for death (HRs ranging from 1.36 to 1.86).

Published in *J Watch Emerg Med*. June 22, 2012 — Diane M. Birnbaumer, MD, FACEP. ■

Lactobacilli vs. TMP/SMX to Prevent Recurrent Urinary Tract Infections

Key point: Effectiveness was similar to trimethoprim-sulfamethoxazole, and Lactobacilli did not cause antibiotic resistance.

Citation: Beerepoot MJ, ter Riet G, Nys S, et al. Lactobacilli vs antibiotics to prevent urinary tract infections: A randomized, double-blind, noninferiority trial in postmenopausal women. *Arch Intern Med.* 2012;172(9):704-712.

Lactobacilli use can restore normal vaginal flora and thwart colonization by pathogenic bacteria. To assess its value in preventing urinary tract infections (UTIs), Dutch researchers conducted a randomized placebo-controlled trial that involved 252 postmenopausal women with histories of at least three symptomatic UTIs in the previous year; the women received either nightly trimethoprim-sulfamethoxazole (TMP-SMX; 80 mg/400 mg) or standard doses of *Lactobacillus rhamnosus* GR-1 and *L. reuteri* RC-14 twice daily.

During the next 12 months, the mean numbers of symptomatic UTIs were 2.9 in the TMP-SMX group and 3.3 in the *Lactobacilli* group (compared with roughly 7 UTIs in the preceding year for both groups); the difference was not statistically significant, but *Lactobacilli* treatment did not meet prespecified criteria for noninferiority. After the first month of treatment, TMP-SMX resistance rose from about 20% to 80% in the antibiotic group and climbed to 100% by the end of the study. On sensitivity testing, bacterial isolates in the TMP-SMX group also showed increased resistance to amoxicillin. No increase in resistance to any antibiotic was noted in the *Lactobacilli* group. Adverse events were similar between groups.

Published in *J Watch Gen Med.* May 22, 2012 — Thomas L. Schwenk, MD. ■

Normal White Blood Cell Count Does Not Rule Out Bacteremia

Key point: Of 289 patients with bacteremia, 52% had normal WBC count and 17% had neither WBC elevation nor fever.

Citation: Seigel TA, Cocchi MN, Salciccioli J, et al. Inadequacy of temperature and white blood cell count in predicting bacteremia in patients with suspected infection. *J Emerg Med.* 2012;42(3): 254-259.

Despite multiple studies showing that a normal white blood cell (WBC) count does not exclude serious disease, physicians in all specialties continue to behave as if it did. To assess whether a normal WBC count or absence of fever reliably excludes bacteremia in patients with suspected infection, investigators conducted a secondary analysis of data from a prospective study of 3563 adults who had blood cultures at a single emergency department.

Among 289 patients (8%) with positive blood cultures, 77% had fever and 48% had elevated WBC count on initial measurement. Neither fever nor an elevated WBC count was noted in 17% of bacteremic patients.

Published in *J Watch Emerg Med.* May 11, 2012 — Daniel J. Pallin, MD, MPH. ■

Antibiotics Are Overprescribed for Acute Bronchitis

Key point: Antibiotics were prescribed to too many patients and bronchodilators to too few at two emergency departments in San Diego.

Citation: Kroening-Roche JC, Soroudi A, Castillo EM, Vilke GM. Antibiotic and bronchodilator prescribing for acute bronchitis in the emergency department. *J Emerg Med.* 2012; published online 20 February 2012.

There is ample evidence that acute bronchitis should not be treated with antibiotics, except in patients with pertussis or significant underlying pulmonary disease. Investigators conducted a chart review to characterize acute bronchitis treatment at two academic emergency departments in in 2008. Of 836 patients with a diagnosis of acute bronchitis, 74% were prescribed antibiotics. Antibiotics were prescribed to 87% of patients with HIV, AIDS, or other immunosuppression; 81% with COPD; 76% with asthma; 77% with diabetes; 74% with more than one comorbid condition; and 72% with no comorbid condition noted. Among patients without asthma, 50% were prescribed a bronchodilator.

Published in *J Watch Emerg Med.* May 11, 2012 — Daniel J. Pallin, MD, MPH. ■

CODING Q&A

E/M Coding for Multiple Visits, Contracted Case-rate Billing, Comparing Payor Reimbursement Policies

DAVID STERN, MD, CPC

Q. We sometimes have patients who require two visits to clear impacted cerumen in their ears. In some cases, this procedure requires a 24-hour regimen to soften the cerumen prior to flushing the ear. How do we bill for the second visit and does it change how we bill if we find a second diagnosis after we clear the cerumen?

A. For the second visit, you may code for all services rendered as if the first visit did not happen. A new diagnosis should not change the CPT coding for the visit. ■

Q. What are the guidelines for billing two E/M codes on the same day? The patient was seen in the morning and then returned again in the evening.

A. Only one E/M code is allowed per patient per day. You will need to combine all of the data from both visits and bill it as a single E/M code visit. ■

Q. When a patient returns to our center for suture removal, are we allowed to collect another co-payment and bill for the return visit?

A. You can bill a second E/M code visit for follow up of a *simple* wound repair (not intermediate or complex wound repair.) This is true even if the follow-up visit for suture removal is within the first 10 days after the original procedure. You can bill a case-rate code for each return visit regardless of any procedures performed because procedures are not typically recognized with this type of contract. You would generally also collect a co-payment for the return visit. ■

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

Q. I am a biller for an urgent care clinic in Texas. I have been receiving denials from a payor for CPT Code 99213 as "services enclosed in encounter rate." What is meant by this phrase and what do I need to do to get reimbursement for our clinic?

A. It sounds as though the urgent care provider has signed a contract with the payor for case-rate billing. Under this arrangement, visits are usually coded with S9083 instead of using other CPT codes. The visit will be reimbursed at the same contracted rate regardless if the patient has a hangnail or a heart attack. You should check the contract to see whether this is the correct billing method for this urgent care clinic. ■

Q. When I billed a wound repair to a diabetic patient's insurance company, the office visit was denied and the wound repair charge was applied to the patient's deductible. One of our diabetic neighbors with a different insurance company went to a different urgent care with a <1 cm laceration. The urgent care clinic was paid for visit code 99205, charges for a wound repair, charges for dressing and charges for medicine. Nothing was done in terms of his diabetes because it is well controlled. How can I make sure I also get paid like that other urgent care clinic?

A. Unfortunately, every payor has different reimbursement policies. Thus, what you are really asking is not to be reimbursed in the same way as a different urgent care center, but rather, for the patient's insurance company to process claims the same way that your neighbor's insurance company processes claims. This is not a realistic expectation. In addition, it may be a good idea to investigate whether mistakes in coding or modifiers may be leading to denials. ■

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kkernagh@phs.org
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Velocity Care has several opportunities for a Board Certified Urgent Care, Emergency Medicine or Family Practice Physician. We are expanding in the Shreveport/Bossier area in Louisiana and opening a new facility in Little Rock, Arkansas.

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Contact Krista Diehl: kdiehl@lutheran-hosp.com
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2) Urgent Care physician needed to work in the Urgent Care Zone of the ER. The McLeod ER is a 60 bed Level II trauma center and this position is for a Family Medicine Physician to work in the Urgent Care Zone located at the front of the ER.

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Please check us on the web at www.mcleodhealth.org OR ww.mcleodphysicianrecruiting.org. If you are interested in Outpatient Urgent Care work, please call Angela Stukes at 843-777-7046 or email at astukes@mcleodhealth.org.

Urgent Care Opportunities Available in Berks County, PA

The Reading Hospital Medical Group is seeking BC/BE Family Medicine Physicians for Urgent Care openings throughout scenic Berks County, PA.

If you are looking for an urgent care practice setting with no call requirements, our QuickCare locations are the perfect choice for you. We are currently seeking physicians for full- and part-time opportunities in our Leesport and Wyomissing locations.

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The Reading Hospital Medical Group (TRHMG) is a non-profit affiliate of The Reading Hospital and Medical Center, a financially stable, 700+ bed facility on a scenic, 36-acre campus. TRHMG is a network of 100+ physicians, including BC and Fellowship Trained physicians in IM, FM, Sports Medicine, OBGyn and Pediatrics. THRMG provides outstanding medical care to our growing community of approximately 420,000 in more than 30 practice sites.

Berks County maintains a perfect balance of urban, rural and suburban settings. Our community offers diverse outdoor and cultural activities, an outstanding quality of live and easy accessibility to shore points, airports and major metro areas, like Philadelphia, Washington, DC and New York City.

For immediate consideration, email your CV to Bob Carper at robert.carper@trhmg.org.

The Reading Hospital Medical Group

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CAREERS

SHARP REES-STEALY MEDICAL GROUP, a 400+ physician multi-specialty group in San Diego, is seeking full-time BC/BE Family Medicine or Emergency Medicine physicians to join our Urgent Care staff. We offer a competitive compensation package, excellent benefits, and shareholder opportunity after two years. Please send CV to: SRSMG, Physician Services, 2001 Fourth Avenue, San Diego, CA 92101. Fax: (619) 233-4730. E-mail: Lori.Miller@sharp.com.

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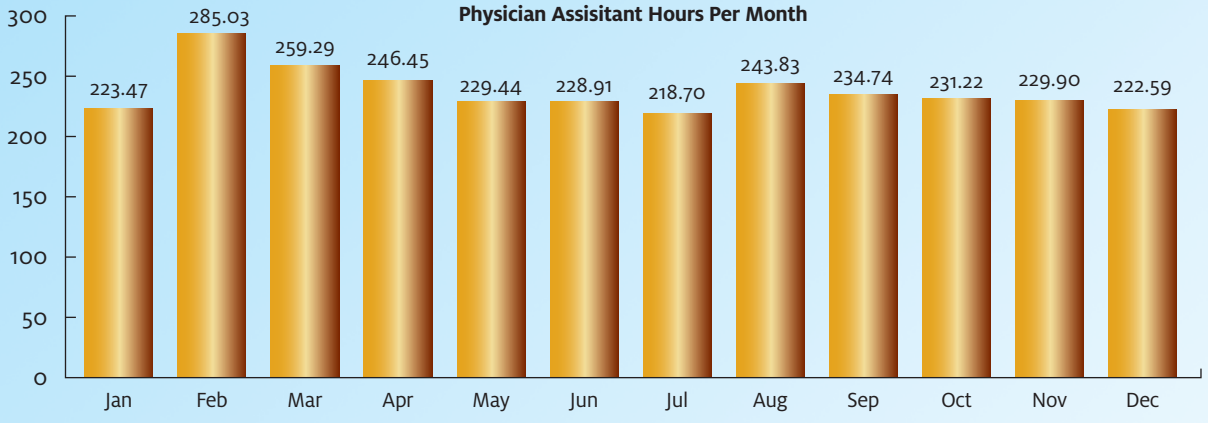
DEVELOPING DATA

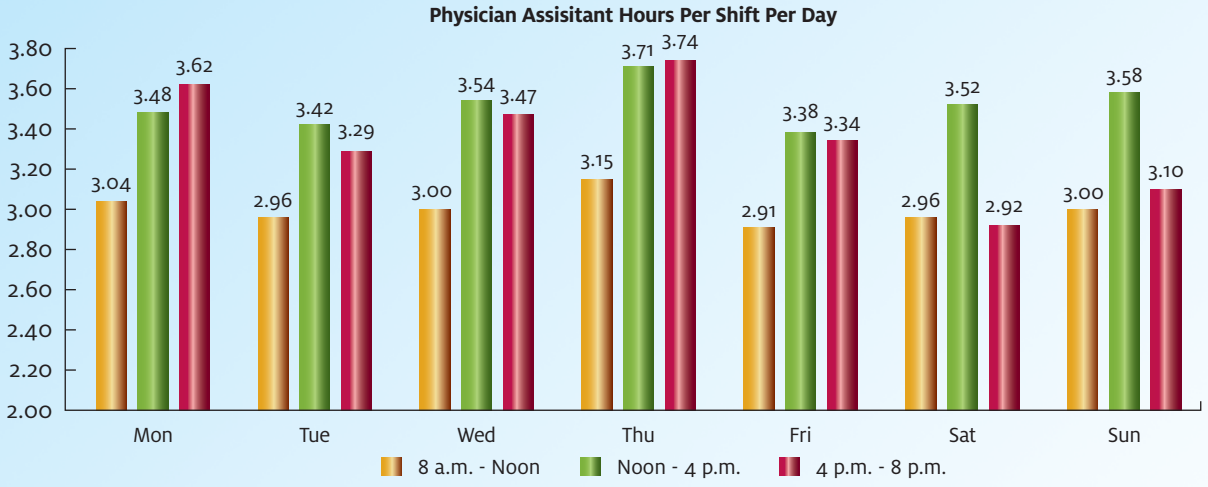
These data from the 2010 Urgent Care Benchmarking Survey are based on responses of 1,691 US urgent care centers; 32% were UCAOA members. The survey was limited to "full-fledged urgent care centers" accepting walk-ins during all hours of operation; having a licensed provider and x-ray and lab equipment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

In this issue: How many hours are physician assistants working in your center?

PHYSICIAN ASSISTANT STAFFING

The 2008 survey looked generally at numbers of professionals on staff, as well as at patient volume per provider, qualifications of physicians, and physician benefits. The 2010 survey delved into these aspects much more in depth and in some new areas. From January to December 2009, 47.4% of all centers reported at least one physician assistant working. Among these centers, the following results apply:





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

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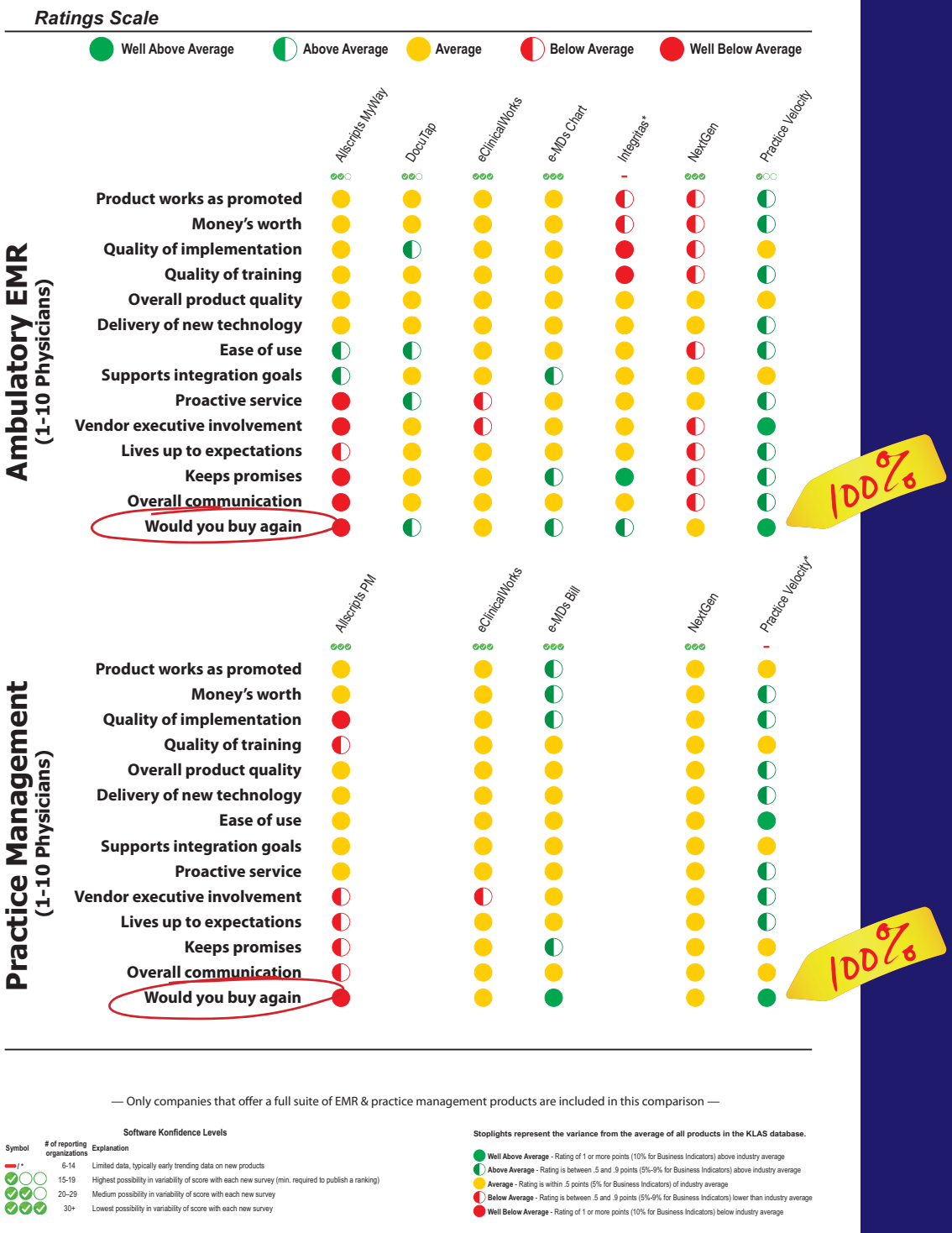
www.ucaoa.org/fall

Urgent Care Association of America and Urgent Care College of Physicians

Which EMR Would You Choose?

Overall Vendor Performance Comparison

Prepared by KLAS — April 13, 2012



— Only companies that offer a full suite of EMR & practice management products are included in this comparison —

Software Konfidence Levels

Symbol	# of reporting organizations	Explanation
/ *	6-14	Limited data, typically early trending data on new products
	15-19	Highest possibility in variability of score with each new survey (min. required to publish a ranking)
	20–29	Medium possibility in variability of score with each new survey
	30+	Lowest possibility in variability of score with each new survey

Stoplights represent the variance from the average of all products in the KLAS database.

- **Well Above Average** - Rating of 1 or more points (10% for Business Indicators) above industry average
- **Above Average** - Rating is between .5 and .9 points (5%-9% for Business Indicators) above industry average
- **Average** - Rating is within .5 points (5% for Business Indicators) of industry average
- **Below Average** - Rating is between .5 and .9 points (5%-9% for Business Indicators) lower than industry average
- **Well Below Average** - Rating of 1 or more points (10% for Business Indicators) below industry average