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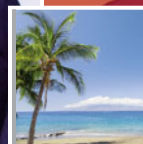
Identify the Right Source—
and Safest Treatment—
for Back Pain

ALSO IN THIS ISSUE

- 9 From the UCAOA CEO**
Connections Help Us Conquer the Future
- 24 Health Law and Compliance**
Inappropriate Giveaways Can Get You in Hot Water
- 33 Case Report**
Don't Let 'Simple' Abdominal Pain Fool You
- 43 Revenue Cycle Management**
Should You Be Worried About Lower Reimbursement for Modifier -25?

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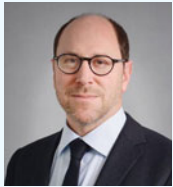
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LETTER FROM THE EDITOR-IN-CHIEF

Chasing Flu: Predictably Unpredictable



I have managed urgent cares for nearly 20 years and can officially say that predicting flu is for fools! Perhaps I should have known—after all, the CDC, WHO, ACIP and even Google all get it wrong, with spectacular consistency. Despite all the research, public and private money, and sophisticated analytics, we just can't seem to find a way to predict the behavior of a fairly banal collection of viral RNA wrapped in a host membrane and coated with docking proteins. Perhaps Bezos and Musk will put humans on Mars before we solve this riddle.

The flu season of 2017-18 was one for the ages, with its record-setting climb to its precipitous fall and downright disappearing act. Urgent care centers around the country scrambled to serve the flood of ill patients while our emergency medicine colleagues were popping up tents in parking lots. The understandable hysteria in response to healthy children dying and the media attention that followed added to the mess.

To make matters worse, our extraordinary efforts to get everyone vaccinated was punished with a paltry level of vaccine efficacy. Undoubtedly, this will fuel a public rejection of flu vaccine for next season. Our urgent care staff was stretched, stressed, and ultimately sick themselves, further burdening our effort to be open and available for our patients.

Meanwhile, the scientific community worked overtime to understand the virulence, persistence, and likelihood of a sustained season. The message they delivered was clear: H3N2 was the predominant strain of flu A in the early part of the season and contributed to a trifecta of early holiday peak, virulence, and poor vaccine coverage (this same strain was responsible for the last holiday flu crisis in 2014-15.) It was then predicted that the 2017-18 season would continue at high levels as flu B strains started to circulate in March and April (as is their routine). Only it didn't. In fact, flu just disappeared entirely, almost overnight, and there is no indication that it will peak again this season.

How is it that such an effective virus with little vaccine protection could disappear so quickly? I am no virologist, but this behavior is neither uncommon nor unique to influenza. In fact, it seems like all of the recent pandemic viral scares have exhibited similar behaviors, with one common theme: The

more virulent, deadly, and dramatic, the more rapidly and inexplicably these viruses disappear.

Ebola comes to mind. A terrifyingly effective killer with no treatment and hundreds of millions of vulnerable hosts living in conditions ripe for transmission. And then one day, it just disappeared. Rest assured it will come back, and there are still some burning embers in parts of Africa, but as dramatically as Ebola came on the scene, it seemed to just "burn out" in the end.

"Ebola was a terrifyingly effective killer with no treatment and millions of vulnerable hosts. Then, one day, it just disappeared."

There's limited research in this area, with the most accepted theory being that highly virulent viruses are so effective that they quickly run out of healthy hosts to infect. While this argument sounds plausible on the surface, you would think that the disappearance would occur more gradually. Yet, a nonscientific look at flu seasons since 2014 shows a surprisingly similar trend; 2014 and 2017 flu rose rapidly, peaked at dramatic levels, and then fell off the charts within a matter of days. Flu seasons in between had less dramatic entrances, peaked lower, lasted longer, and disappeared more gradually.

It's a fascinating storyline for an armchair epidemiologist to follow. One that seems destined to repeat itself for years to come. Until then, urgent care providers will plan and prepare in vain. ■

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

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CLINICAL

11 Management of Acute Exacerbation of Chronic Low Back Pain in the Urgent Care Setting

A systematic approach to evaluating, diagnosing, and treating low back pain in the urgent care center can help patients get on the right track to safe, effective treatment while reducing hospital utilization.

Ashley Clay, MS, PA-C

HEALTH LAW AND COMPLIANCE

24 New Rules for Beneficiary Inducements at Urgent Care Centers



Relatively low-cost items like gift cards are often offered to entice customers to try, or stay loyal to, retail businesses. That practice can be frowned on in healthcare, however. Know the laws in your area.

Alan A. Ayers, MBA, MAcc

PRACTICE MANAGEMENT

27 Thinking Differently About Paid Time Off



Remote access to work has led companies in other industries to experiment with unlimited time off for some workers. Would such a policy work in your urgent care center?

Alan A. Ayers, MBA, MAcc

CASE REPORT

33 An Uncommon Clinical Presentation of Ovarian Torsion



The differential diagnosis of abdominal pain can be a challenge, thanks to often nonspecific symptoms and signs. This is especially true with an uncommon presentation like the one detailed in this real-world case.

Fabrizia Faustinella, MD, PhD, FACP

IN THE NEXT ISSUE OF JUCM

Head injuries are among the most vexing presentations in the urgent care setting. Things can be even more complicated when the patient is a child. The knee-jerk reaction may be to send them to the emergency room without considering what you might be able to do for them on site—even though many patients, ultimately, leave the ED with nothing more than a list of precautions to watch out for. In the June issue of JUCM, we will bring you multiple articles that examine what approach makes the most sense when a patient with a minor head injury presents, including discussion of one urgent care center's educational initiative to improve the knowledge base of its providers.

DEPARTMENTS

- 6 Continuing Medical Education
- 9 From the UCAOA
- 20 Abstracts in Urgent Care
- 37 Insights in Images
- 43 Revenue Cycle Management Q&A
- 48 Developing Data

CLASSIFIEDS

- 45 Career Opportunities

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Mission Statement

JUCM The Journal of Urgent Care Medicine (ISSN 19380011) 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 College of Urgent Care Medicine, *JUCM* seeks to provide a forum for the exchange of ideas regarding the clinical and business best-practices for running an urgent care center.

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Sudden flare-ups of chronic back pain are among the more common complaints you're likely to hear—not just in urgent care, but in life. There's probably always going to be a relative, neighbor, or coworker who tells you from time to time that their back "is acting up again," possibly with the hope that you'll have some magical advice or prescription to make it go away on a moment's notice.

Unfortunately, that's not how it works. Equally unfortunately, at first glance it's impossible to tell the difference between everyday aches and pains and true medical emergencies. Further complicating matters is the outdated belief by too many patients, and even some providers, that opioid pain medications will help.

To sum up, it's not a simple problem to address. However, a systematic approach to evaluating, diagnosing, and treating low back pain in the urgent care setting can help reduce unnecessary hospital visits, identify red flag symptoms that warrant further evaluation, and help reduce opioid prescriptions. Such an approach is described in detail by **Ashley Clay, MS, PA-C** in her original article *Management of Acute Exacerbation of Chronic Low Back Pain in the Urgent Care Setting*, which starts on page 11.

Ms. Clay is an occupational health and wellness clinic coordinator/physician assistant with Medcor at Novartis (Alcon).



Abdominal pain is another complaint heard often in urgent care. As with so many other presentations, assuming the simplest, least ominous source is a luxury that urgent care providers (or their patients) cannot afford. Even so, some presentations are even more unusual than others. You can read about one that occurred in the real world in this issue. Our latest case report, *An Uncommon Clinical Presentation of Ovarian Torsion*, by **Fabrizia Faustinella, MD, PhD, FACP**, can be found on page 33.

Dr. Faustinella is an associate professor of medicine in the Department of Family and Community Medicine at Baylor College of Medicine.

On the nonclinical side, **Alan A. Ayers, MBA, MAcc** explains the rules regarding beneficiary inducements—incentives such as gift cards and the like—for urgent care centers looking to attract or maintain a patient base. Those rules may not be as straightforward as they seem in other industries, so this is a must-read. *New Rules for Beneficiary Inducements at Urgent Care Centers* starts on page 24.



Speaking of practices that are becoming more common in other industries, can you envision granting your staff, or even select members who fill specific functions in your operation, unlimited, paid time off? Believe it or not, that option is gaining traction in some fields. Mr. Ayers, who is chief executive officer of Velocity Urgent Care, LLC and practice management editor of *The Journal of Urgent Care Medicine*, addresses this topic in *Thinking Differently About Paid Time Off* (page 27).

Also in this issue:

Glenn Harnett, MD shares insights into newly published articles from across the medical landscape on what makes for efficiency (and inefficiency) in a clinical setting; a warning to keep an eye on the duration of antibiotic therapy; how the FDA is planning to make it easier for patients to quit smoking; concerns that steroids may be overused in acute respiratory tract infections, and more in *Abstracts in Urgent Care* (page 20). Dr. Harnett is principal of the No Resistance Consulting Group.

Finally, in *Revenue Cycle Management Q & A* (page 43), **David Stern, MD, CPC** answers questions about whether urgent care operators should be concerned about Anthem Blue Cross Blue Shield's proposed plan to lower reimbursement on evaluation and management services billed with modifier -25. In addition to being a true thought leader in urgent care, Dr. Stern is the CEO of Practice Velocity, LLC; Urgent Care Consultants; and PV Billing.

A Note of Thanks to Our Peer Reviewers

We appreciate the time and insights shared by the following urgent care leaders who accepted our invitation to review content for the May issue of *JUCM*:

- **Terence Chang, MD, FAAFP**
- **Sal D'Allura, DO, FAAFP**
- **Thomas Gibbons, MD, MBA, MAcc**

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CONTINUING MEDICAL EDUCATION

Release Date: May 1, 2018

Expiration Date: April 30, 2019

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Learning Objectives

1. To provide best practice recommendations for the diagnosis and treatment of common conditions seen in urgent care
2. To review clinical guidelines wherever applicable and discuss their relevancy and utility in the urgent care setting
3. To provide unbiased, expert advice regarding the management and operational success of urgent care practices
4. To support content and recommendations with evidence and literature references rather than personal opinion

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Member reported no financial interest relevant to this activity.

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CONTINUING MEDICAL EDUCATION

JUCM CME subscribers can submit responses for CME credit at www.jucm.com/cme/. Quiz questions are featured below for your convenience. This issue is approved for up to 3 AMA PRA Category 1 Credits™. Credits may be claimed for 1 year from the date of this issue.

Management of Acute Exacerbation of Chronic Low Back Pain in the Urgent Care Setting (p. 11)

1. How many vertebrae make up the lumbar section of the vertebral column?

- a. 6
- b. 5
- c. 7
- d. 3
- e. 4

2. What test is classically used to test L4, L5, and S1 nerve roots?

- a. Femoral stretch test
- b. Finkelstein test
- c. Straight leg raise
- d. Numerical rating scale
- e. Phalen's maneuver

3. Nonpharmacologic treatment options for low back pain include:

- a. Physical therapy
- b. Weight loss
- c. Smoking cessation
- d. Ergonomic adjustments
- e. All of the above

Thinking Differently About Paid Time Off (p. 27)

1. What does unlimited PTO mean?

- a. An employee can take off as much time he/she wants, at their whim
- b. Permission to take as much leave as needed while still balancing the needs of the business and colleagues
- c. The idea of staying "connected" to the office although not physically in the office
- d. None of the above
- e. b and c

2. What are the benefits of offering unlimited PTO?

- a. Helps recruit top talent
- b. Recharges and refreshes employees
- c. Saves the company money in accrued vacation time expense
- d. All of the above

3. When rethinking PTO, what are some things to take into consideration?

- a. A written policy for unlimited PTO
- b. Preparing for more absences in the work place, as more people will be taking PTO
- c. Evaluation of the vacation accruals on the books
- d. All of the above
- e. a & c

An Uncommon Clinical Presentation of Ovarian Torsion (p. 33)

1. Which of the following are risk factors for ovarian torsion?

- a. Hypermobility of the ovary
- b. Enlarged corpus luteum in pregnancy
- c. Ovarian masses/cysts
- d. All of the above

2. What is the imaging modality of choice in ovarian torsion?

- a. CT pelvis with IV contrast
- b. MRI
- c. KUB
- d. Ultrasound
- e. Laparoscopy

3. Ovarian torsion accounts for what percentage of gynecological emergencies?

- a. 15%
- b. 30%
- c. 3%
- d. 10%
- e. 0.5%



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Channeling Vince

■ LAUREL STOIMENOFF, PT, CHC

Vince Lombardi was an inspirational football coach. His intolerance of losing is legendary, but he also had an expectation for mindful preparedness that was evident when he said, “Winning isn’t everything, but wanting to win is.”

I’d like to go on record stating that I want to win. I want to win for those of you who show up at work during a horrific flu season knowing it’s going to be a day where you may not have time to eat, nor do you have any idea what time your shift will end. I want to win for all of those who support the moments leading up to and after the physician, PA, or NP walk into that room and the healing begins. And I want to win for the consumer who is ill, injured, or fearful who finds solace knowing that there is easy access to a competent and caring medical professional at a local urgent care center.

Our responsibility at UCAOA is to raise our heads up every day and think strategically on how we can ensure the ongoing success of urgent care medicine. That also means understanding our limitations. We are a staff of 18 passionate individuals armed with a vision that could easily command a team twice that size. The administrative team supports the advancement of not only the Urgent Care Association of America, but the strategic initiatives of the College of Urgent Care Medicine, the Urgent Care Foundation, and the newly formed Urgent Care Services Corporation.

Making Connections

Recognizing that we cannot accomplish our vision without collaboration, the UCAOA Board of Directors has stressed the importance of *connections* over the past year. We are forging relationships with other associations and stakeholders in the world of on-demand, consumer-driven healthcare and identifying areas of common interest. According to the Kaiser Family Foundation, as of October 2017, there were 456,389 professionally active primary care physicians in the U.S.¹ Assuming



Laurel Stoimenoff, PT, CHC, is Chief Executive Officer of the Urgent Care Association of America.

“The Annual Convention & Expo brings together thought leaders of the on-demand healthcare industry to celebrate our diversity and identify areas where we can capitalize on common ground.”

the association’s database of 8,223 urgent care centers each employed 2.5 physicians, urgent care’s voice would pale as a percentage. But we know we can amplify that voice through our connections and collaborative efforts.

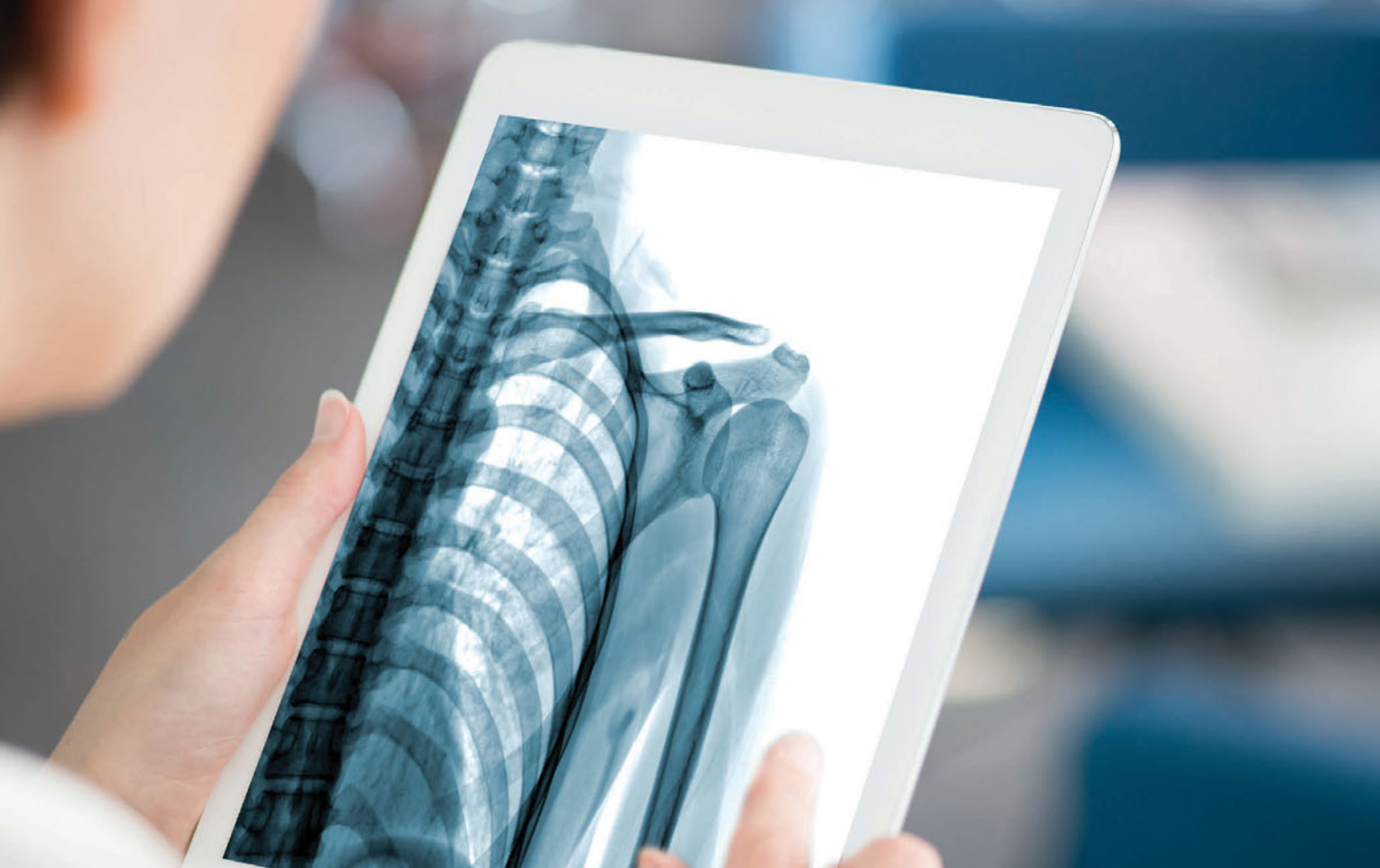
Our Annual Convention & Expo brings together thought leaders from other sectors of the on-demand healthcare industry to celebrate our diversity and identify those areas where we can capitalize on our common ground. While our dialogue is in its nascent stages, it is apparent that the strategic direction of these organizations is also about inclusiveness and outreach. And just as the annual Convention & Expo acts as a connector between a diverse group of clinicians, operators, vendors, and speakers, the association strives to make connections on behalf of our members through online resources, specialty sections, advocacy efforts, education, and networking opportunities.

Vince Lombardi also said, “In all my years of coaching, I have never been successful using somebody else’s play.” The wisdom there is not to simply replicate what someone else has done, but improve upon it. I’m confident Vince studied the plays of others, but subsequently reinvented them. And then those who followed studied what Vince did, and the game was better because of it.

We will continue to build upon the burgeoning platform of consumer-driven healthcare. There will be challenges along the road to success, but we don’t *get bitter*. We will use them to *get better*. And win. You deserve that. ■

Reference

1. Kaiser Family Foundation. Professionally active physicians. Available at: <https://www.kff.org/other/state-indicator/total-active-physicians>. Accessed March 26, 2018.



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Management of Acute Exacerbation of Chronic Low Back Pain in the Urgent Care Setting

Urgent message: A systematic approach to evaluating, diagnosing, and treating low back pain in the urgent care setting reduces unnecessary hospital visits, identifies red flag symptoms that warrant further diagnostic or neurosurgical evaluation, promotes returning to work quicker, and helps to reduce the number of opioid prescriptions that are prescribed for episodic exacerbation and/or chronic conditions.

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Introduction

Up to 80% of the United States population experiences back pain at some point; however, most complaints resolve within 1-4 weeks without any additional treatment aside from the initial history and physical examination.¹

Statistics

In the late 1990s, chronic conditions such as back pain and arthritis were being treated by opioid prescriptions; this resulted in increases in dosage and frequency. National opioid prescription rates began escalating in 2006, hitting a peak of 255 million in 2012²; retail opioid prescriptions increased to 81.3 per 100 persons.² In 2016, more than 42,000 people lost their lives to opioid overdoses; of those deaths, 40% were from prescriptions.³ According to the CDC, taking even low doses of opioid medication for more than 3 months increases the risk of addiction 15 times.²

Anatomy

The vertebral column, whose essential functions are support, protection, and ambulation, is a flexible network of fibrocartilaginous discs and 33 vertebrae. It can be broken down into five sections:⁴

- Cervical (seven vertebrae)



- Thoracic (12 vertebrae)
- Lumbar (five vertebrae)
- Sacral (five vertebrae, which fuse in adults to form the sacrum)

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- Coccygeal (four vertebrae, which fuse to form the coccyx after roughly 30 years)

The C7 vertebra serves as a landmark for determining the end of the cervical spine and the beginning of the thoracic region. It has the longest spinous process, is easily palpated when the neck is flexed, and results in a bony structure that protrudes out further than the others.⁴

The lumbar region has the largest moveable vertebrae, L5. L4-5 and L5-S1 represent the location where >90% of herniated discs occur.⁵ Locating the spinous processes of L4 and L5 may prove more difficult, as these are shorter than other lumbar processes.

Common Disorders

Mechanical origins constitute the most common causes of low back pain and typically involve problems with muscles, tendons, ligaments, and discs.⁵ Several common disorders can affect the lumbar region, including: lumbosacral strain, postural backache, lumbar degenerative disc disease (LDD), herniated disc, and spinal stenosis. Differentiation among these etiologies can be difficult with physical exam alone; however, understanding the presenting symptoms can be of value.

- **Lumbar strain** is often caused by strenuous work and presents as a sudden, localized pain in individuals aged 20-50 years.⁵ Pain is experienced during motion, but not straining or coughing. This is frequently associated with occupational twisting and lifting. On physical exam, the straight leg raise (SLR) will cause back but not leg pain; diagnostic imaging is generally not warranted.
- **Postural backache** is common in obese individuals and produces vague complaints that increase as the day progresses. Typically, on physical exam the patient will present neurologically intact, SLR will result in back but not leg pain, and anterior/posterior range of motion is commonly limited.⁵
- **Degenerative changes** commonly affect individuals over 50 years of age and are commonly encountered when arthritis is present in other joints.⁵ The pain is axial in nature, of gradual onset, worse in the morning, and does not generally radiate. X-ray evidence reveals spurring and narrowing of the disc spaces. Evidenced by autopsy reports, 80% to 90% of individuals show signs of degenerative disc disease (DDD) by age 50, and DDD is considered the most common cause of disability in those under 45 years of age.⁵

- Typically, **herniated discs** affect males more than females and cause sudden, radiating pain that may involve the buttock and leg. Pain typically radiates in the posterolateral aspect of the leg with some weakness of leg muscles. Coughing, sneezing, and hyperextension of the lumbar spine can exacerbate symptoms. Physical findings may include: asymmetrical limitation of motion, tenderness over the sciatic notch, restricted SLR, and neurologic manifestations of the lower limbs.⁵ When sciatica accompanies the LBP, this is often associated with a herniated disc, spinal stenosis, and chronic low back pain.
- **Lumbar spinal stenosis (LSS)** generally affects elderly patients and causes gradual LBP that is worse with extension due to a progressive narrowing of the spinal canal. Neurogenic claudication (pain with ambulation that is relieved with sitting) is the hallmark symptom of LSS; this pain will slowly improve following the cessation of walking.¹ A distinguishing characteristic of spinal stenosis is that flexion often alleviates pain; therefore, exercises such as bicycling, which results in spinal flexion, are tolerated well by those suffering from LSS. Pain will slowly improve after cessation of walking.⁵

Presentation and Evaluation

Complaints of back pain warrant a review of the patient's medical, personal, occupational, and sexual histories. During the interview, special attention should be given to any chronic back pain complaints and treatments that have previously been attempted, noting any medications, prescribing provider, and confirming opioid prescriptions by accessing the prescription drug monitoring program database.

Signs and symptoms

History should include the onset (activity performed when pain began), location (specifically addressing any radiating complaints), duration, aggravating/alleviating activities, and the character (sharp, dull, throbbing). Attention should be given to any exaggerated pain mannerisms or discrepancies on the prescription drug monitoring records to identify individuals with secondary gains and/or drug-seeking behavior.

Social and psychological histories are important aspects to obtain. Concurrent diagnoses of depression and/or chronic pain may cause variations in reported severity and findings on physical exam.⁵ Resolution of pain is found to be more challenging in those with concurrent mental disorders such as depression or a history

of substance abuse.⁶ Identifying conversion disorder, depression, or psychosis as a root cause for psychogenic pain disorders often directs treatment at the source of pain and may differ from nonpsychogenic management.

Occupational history is beneficial in identifying secondary gain issues, occupational risks, and potential causes of complaints such as strenuous or heavy lifting jobs. If a work-related injury is suspected, additional documentation should include: whether complaint is new or an exacerbation, date/time of incident, witnesses to injury, action being performed, if place of employment was notified, Worker's Compensation claim number (if available), job satisfaction rating, if personal protection equipment was utilized/available, and if focus is placed on ergonomics and job rotation.

During a thorough history and physical exam, certain findings differentiate the source of complaints. For instance, infectious processes are unlikely if the pain complaints are related to posture, activity, trauma, or if episodic presentation is relieved by rest.⁵

Physical examination

In addition to inspection and palpation of the back, evaluate for range of motion (cervical/lumbar spine, hip joint, upper and lower extremities), gait, reflexes, strength, sensation of light touch, peripheral pulses, and nerve root testing. Nonorganic, psychogenic causes of LBP should be suspected if physical examination is out of proportion to findings. Waddell's tests are a group of five categories that can be quickly assessed and used to identify those with underlying psychosomatic disease. If three signs are positive, follow-up is warranted.⁷ Positive findings do not rule out organic cause, but help identify symptom magnification and/or malingering. Waddell's signs include:

- tenderness to light touch that is nonspecific and diffuse
- simulation tests with unexpected results
- distraction tests resulting in contradictory results
- discrepancies when testing strength and sensory
- overreaction of facial expressions^{7,17} (it is noted that overreaction can cause observer bias and it should be treated carefully)

The SLR is classically used to test L4, L5, and S1 nerve roots (sciatic nerve irritation) by stretching the dura. The test is performed sitting or standing by raising the leg with the knee extended to 30°–35°. When the dural attachments are inflamed, stretching of the sciatic nerve causes pain experienced in the lower leg, foot, and ankle. The SLR is considered positive when the radicular

complaints are reproduced. If the patient experiences only back pain during the test, this would be considered negative. Observation of gait, heel, and toe walking proves beneficial to assess foot drop as well as motor function. Sensory, motor strength, and reflex testing help to reinforce the suspected diagnosis.

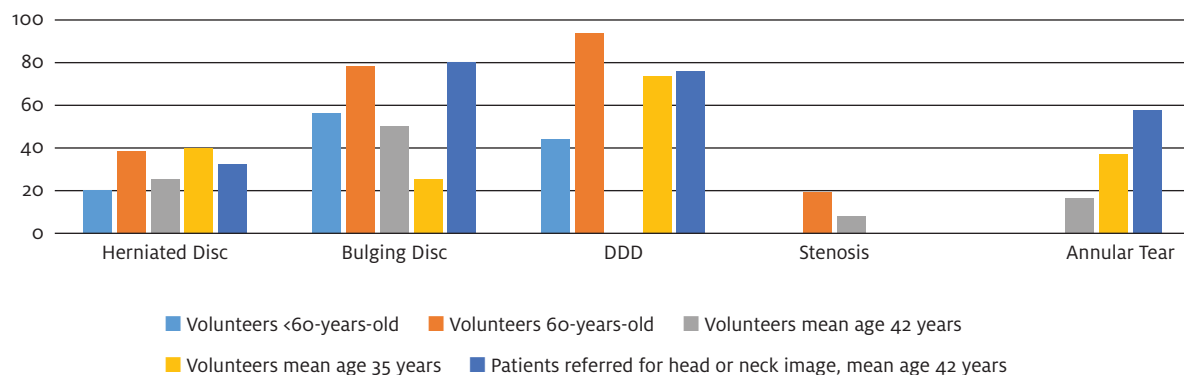
Diagnostic studies

The American College of Radiology recommends no imaging studies within the first 6 weeks unless red flag symptoms are present.¹ As a general rule, imaging studies are not used to make a diagnosis but to confirm one already made based on history and physical examination findings; this is likely due, in part, to the fact that approximately 80% of LBP cases resolve within 2 weeks and 90% resolve within 6 weeks.¹ For an acute presentation, plain radiographs are generally not helpful for the evaluation of nontraumatic back pain in otherwise healthy individuals between 20 and 50 years of age as discs, muscles, and ligaments are not readily visualized by radiographs. Exceptions include suspicion of infection or neoplasia.

Radiography would be useful to aid in diagnosis of compression fractures, cancer, Paget's disease, or multiple myeloma. Magnetic resonance imaging (MRI) is the most comprehensive way to evaluate degenerative changes, detection of tumors, and the most sensitive for herniated discs, but should be delayed in lieu of conservative treatment for nonemergent presentations. In comparison, computed tomographic (CT) scans are valuable in location of herniation or tumor⁵ and would be acutely warranted for concerns such as compression. Lab studies such as erythrocyte sedimentation rate (ESR) and alkaline phosphate (ALP) levels should be obtained if uncommon causes of LBP are suspected.⁵ CT or MRI studies are warranted for any patient with worsening neurological state or suspicion of a systemic illness.⁶

One indication for radiographs is, following a trauma, AP and lateral views should be obtained. Lumbosacral radiographs cause 20 times the dose of radiation of a chest radiograph.¹ Electromyography (EMG) studies are also out of the scope of an urgent care setting; such testing should be deferred to the clinician managing chronic pain in those presenting with radiculopathy or peripheral neuropathy complaints. MRI should be reserved for those considering surgical intervention or who have evidence of a systemic disease.¹

An MRI is the diagnostic study of choice for anyone presenting with symptoms consistent with cauda equina syndrome, tumor, or epidural mass. An MRI

Figure 1. Prevalence of Findings on MRI Studies in Asymptomatic Adults

Adapted from Deyo RA, et al. *N Engl J Med*. 2001;344:363-370.

should not be ordered for those believed to have a routine disc herniation, as most will improve over 4–6 weeks with conservative treatment.¹

Figure 1 summarizes the prevalence of findings on MRIs in asymptomatic patients. The studies concluded that MRI findings were routinely discovered even in the absence of symptoms.⁸

Another study found that 25% of asymptomatic individuals younger than 60 years of age and 33% older than 60 had MRI evidence of herniated discs.⁶ Asymptomatic pathology does not warrant treatment, reinforcing that MRI should be reserved for the appropriate patient. Potential issues adapted from The Agency for Health Care Policy and Research that warrant an MRI are outlined in **Table 1**.¹

Unless certain risk factors are present suggesting infection or tumor, MRIs should be reserved for those refrac-

tory to conservative measures. Indications for emergent MRI include:

- signs and symptoms consistent with cauda equina syndrome, including loss of sphincter tone, incontinence, saddle anesthesia, urinary retention, and impotence
- fever accompanied by immunosuppression
- unexplained weight loss
- history of IV drug use with concern for epidural abscess
- concern for metastatic disease, including advanced age or back pain unrelieved by rest⁵

Warning signs/red flag symptoms

Evaluating for “red flag” symptoms is imperative in eliminating serious etiologies such as cancer, infection, cauda equina syndrome, aneurysm, and fracture. Such symptoms include bowel and bladder dysfunction, impotency issues, loss of sphincter tone, fever, pain described as “tearing,” saddle anesthesia, progressive motor weakness, unexplained weight loss, and pain not improved with rest. Any history of intravenous drug abuse must be documented.⁵

Cancer and/or infection should be suspected in anyone presenting with unexplained weight loss, immunosuppression, history of IV drug abuse, age >50 years, febrile illness, or no improvement of LBP complaints with rest.

Cauda equina syndrome is a rare surgical emergency that presents with rapid progression; patients should undergo surgical intervention within 48 hours for the best outcome. Typical signs and symptoms of acute cauda equina syndrome include bowel or bladder incon-

Table 1. Potential Issues Warranting MRI

Possible fracture	<ul style="list-style-type: none"> • Major trauma • Minor trauma in those <50-years • Long-term corticosteroid use • Osteoporosis • >70 years
Possible tumor/infection	<ul style="list-style-type: none"> • >50 years • <20 years • History of cancer • Constitutional symptoms • Recent bacterial infection • Injection drug use • Immunosuppression • Supine or nocturnal pain

tinence, saddle anesthesia, weakness of the lower extremities, or acute paraplegia.

Ruptured abdominal aneurysm is another medical emergency that must be ruled out. Dizziness, “tearing” pain, or a pulsatile mass in the abdominal area may be present.⁹ Acute medical emergencies must be identified during the physical examination and completion of the medical history as prompt care dictates patient outcomes.

Management

Initial presentations of acute or chronic low back pain exacerbation in an urgent care setting should focus on conservative approaches unless physical examination and history suggest a serious, red flag etiology. A conservative treatment protocol should be followed for up to 6 weeks when a patient under 50 years of age presents without progressive weakness or acute constitutional symptoms. Patient education should focus on preventing re-injury, nonpharmacologic treatment options, avoidance of opioid analgesics, ergonomic discussions, management of patient expectations, and treatment of underlying psychosocial issues.

From July 2015 until August of 2016, a randomized clinical trial followed 416 patients 21 to 60 years of age who presented to the emergency department with acute lower extremity pain and were given a single dose of oral analgesics in order to compare opioid and nonopioid treatment outcomes. No clinically significant reduction in pain occurred at 2 hours among groups given three different opioid and acetaminophen combinations when compared with groups given only ibuprofen and acetaminophen combinations.¹⁰ This study supports the use of ibuprofen and acetaminophen combinations in lieu of opioid analgesics for acute pain in the ED setting.

Nonpharmacologic

Nonpharmacologic options include aqua therapy, physical therapy (PT), stretching exercises, cold/hot therapy, massage, weight loss, smoking cessation, ergonomic adjustments, trigger point injections, and controlled physical activity. Cold therapy initiated within 48 hours of acute injury reduces pain and swelling while promoting peripheral vasoconstriction, resulting in increased blood flow to deeper vessels and tissues. Over time, some recommended first-line treatment modalities have been found to have little or no benefit. For example, traction is no longer recommended for lumbar radiculopathy. In the past, bed rest (controlling physical activity) would last much longer than the now 0 to 2-day recommendations. Studies confirm that prolonged bed

Table 2. Effective Treatment Options vs Those to Be Avoided

Conservative treatment options to utilize	Treatment options with little to no value that should be avoided
<ul style="list-style-type: none"> • NSAID therapy • Multimodal treatment strategy • Nonpharmacologic options • Patient education • Avoidance of opioid analgesics • Ergonomic management • Expectation management • Avoid diagnostic studies unless trauma or “red flag” symptomology 	<ul style="list-style-type: none"> • Opioid analgesic as first-line • Single modality strategy • Radiographs/diagnostic studies for nontraumatic, nonemergent • Prolonged bedrest

Adapted from Chang AK, et al. *JAMA*. 2017;318(17):1661-1667.

rest results in deconditioning and muscle weakness.

A study of five healthy men found that 3 weeks of bed rest caused a decline in cardiovascular and work capacity greater than that of aging 30 years.⁶ The main principle behind a shortened course of bed rest is that quicker recovery is achieved by avoiding deconditioning.⁶ Encourage activities that do not exacerbate pain, promote maintaining function, and returning to work quickly.

Pharmacologic

The mainstay, first-line treatment for acute low back pain is nonsteroidal anti-inflammatory medications (NSAIDs) for 2-4 weeks, pending no contraindications. Any patient at risk for peptic ulcer disease should be provided gastrointestinal prophylactic medication and instruction on use.⁶ Cardiovascular and renal functionality should be reviewed and risks discussed prior to initiating NSAID therapy. Acetaminophen is an alternative for those who cannot tolerate NSAIDs. If NSAIDs fail to achieve adequate pain relief, a short course of systemic steroids gradually tapered may improve LBP and associated radicular symptoms.

Other pharmacologic treatment options for acute back pain include muscle relaxers and analgesics, both opioid and non-opioid types. Opioids are reserved for severe, intractable pain and treatment duration should be very short as they have a very limited role.¹ Per the CDC’s 2016 recommendations, only in rare circumstances should acute pain situations require a supply of opioids >7 days; if warranted, the duration should gen-

Table 3. Nonpharmacologic vs Pharmacologic Options

Nonpharmacologic options	<ul style="list-style-type: none"> • Aqua or physical therapy • Ice/heat therapy • Massage therapy, trigger point injections, TENS unit application • Stretching, ergonomic discussions, limited bed rest (modified activity) • Weight loss, smoking cessation • Address psychosocial issues, patient expectations
Pharmacologic options	<ul style="list-style-type: none"> • NSAIDs • Muscle relaxants • Systemic steroids • Anticonvulsants • SSNRIs vs TCAs

erally not exceed 3 days.¹¹

A study by Friedman, et al compared the efficacy of pain control and functional outcomes at 1 week in patients with nontraumatic, nonradicular acute pain by utilizing common treatment options, including naproxen, cyclobenzaprine, oxycodone/acetaminophen, or placebo. This randomized, double-blinded, three-group study was conducted in an emergency department setting on patients with pain <2 weeks duration and found no difference between those treated with naproxen alone and those treated with naproxen and oxycodone/acetaminophen.¹²

Muscle relaxant use is often limited secondary to sedating properties. Anticonvulsants (gabapentin or pregabalin), serotonin and norepinephrine reuptake inhibitors (SNRIs) (duloxetine and venlafaxine), and tricyclic antidepressants (TCAs) (nortriptyline and desipramine) have been recommended by several guidelines as first-line medications for neuropathic pain.^{1,11} Other medications that may be helpful include capsaicin cream, tramadol, tapentadol, lidocaine patch, and medical cannabis strains with high levels of cannabidiol (CBD).^{1,15} A risk-benefit analysis should be determined with these modalities, as well, specifically in patients with history of depression or concurrent treatment for depression and the elderly population. Anticonvulsants may cause dizziness, confusion, and weight gain. All black-box warnings and assessment of suicidal ideation and serotonin syndrome need to be reviewed when initializing an antidepressant for the treatment of pain.

Multimodal therapies are superior in reducing pain and improving function when compared with single modalities.⁸ Nonopioid pharmacologic treatments are

generally not associated with substance-use disorders or fatal overdoses and are regarded as safer alternatives than opioid options.¹²

Treatment of an acute exacerbation in the urgent care setting should focus on ruling out serious causes and education to follow up with a provider managing chronic pain or primary care for referral. If considering an opioid prescription in this population, it is imperative to document the board of pharmacy results, listing the last prescription filled by chronic pain; perform a pill count of those medications that are provided by their chronic management team; and send office notes to the pain management provider so they are aware the patient is seeking treatment for pain complaints outside of their practice. If they have opioid prescriptions available, consider not providing additional medication and reinforce that they should only take their medication as prescribed.

Emergent surgical referral is warranted for a presentation consistent with cauda equina syndrome. Routine referral for surgical intervention is warranted if progressive neurologic deficit is present along with back pain that is equal to leg pain, positive SLR, evidence of a surgically amendable lesion that correlates to symptomology, and if unresponsive to conservative measures.

Chronic Low Back Pain

Pain is considered chronic when the duration is >12 weeks.⁶ Once the pain duration has reached the chronic classification, consider referring to a chronic pain specialist. Ideally, referral to a pain management specialist would occur at the primary care level. This allows appropriate documents to accompany the referral, including previous treatments; PT or attempts at other conservative measures; urine drug screening results; and diagnostics when available. Continuity of care is a crucial factor in management; chronic pain specialists continually review prescription monitoring programs and urine drug screens prior to and during treatment to ensure patient compliance.

Chronic pain specialists may provide management options that include lumbar epidural steroid injections (ESI) for LBP with radicular features extending below the knee (sciatica), facet joint injections for those presenting with axial spine pain accompanied with primarily radiation to the buttocks generally not past the knee, radiofrequency nerve block/ablation for facet arthropathy, trigger point injections for myofascial pain syndromes, medications (NSAIDs, APAP, tricyclic antidepressants, anticonvulsants, muscle relaxers), cognitive

behavioral therapy, and implantable devices for refractory pain.

ESIs are considered after failure of more conservative approaches with NSAIDs, activity modification, and muscle relaxers. Typically, these are fluoroscopically guided transforaminal corticosteroid injections. A caudal approach may provide greater relief and easier access for the clinician in a patient with a history of lumbar spinal surgery. The usual precautions regarding steroid use should be followed, and these should be limited to three per year, generally given a few months apart. Typically, ESIs are scheduled in a series allowing 1 month between each if undergoing for the first time. If benefit is appreciated, the ESI may then be repeated and given as a “booster” injection approximately every 4 months. Benefit is variable among patients; some will have complete resolution of radicular symptoms after only 1 injection, while others may not have benefit until the series is complete, and some may experience no relief.⁶

Interestingly, double-blinded studies have not found repeated injections to be superior to a single injection and that relief of sciatica is short term and provides no functional improvement.¹ Others argue that epidural injections have proved to be 40% effective in alleviating leg pain and may need to be repeated two times allowing 4–6 weeks to lapse before determining efficacy.⁶ Injection therapy remains controversial for the treatment of spinal complaints, but does appear to be a valid option for those suffering chronic LBP with radiculopathy who have failed more conservative approaches.

Surgical intervention is considered the last line of therapy for nonemergent LBP complaints and is reserved for failure of conservative modalities. It should be noted that only a small number of individuals presenting with a herniated disc require surgery. Indications for surgery vary. The most dramatic presentation of acute disc herniation resulting in surgery is cauda equina compression syndrome, and may present as loss of all neurologic function. If continued progressive neurological deficit is appreciated, it warrants close observation and early surgical intervention to reduce the risk of further impairments. Radicular features, not axial spine pain, are most often relieved by surgery. Prior to surgical

“With some states legalizing medical and recreational marijuana use, urgent care providers must be aware of this treatment option, and knowledgeable to discuss risk-benefit.”

consultation, discuss with the patient that while many do not experience relief of spinal pain, relief of leg symptoms can be achieved or reduced.

If surgery is not an option, or after failure of conservative and/or surgical treatments, individuals suffering from intractable pain may be candidates for implantable devices such as spinal cord stimulators (SCS) or intrathecal (IT) drug delivery systems. In the United States, 10% to 40% of patients suffer from persistent pain following lum-

bosacral surgery.¹³ A randomized cross-over study conducted at John Hopkin’s hospital found that SCS was superior to reoperation in the treatment of ongoing radiculopathy with or without concurrent low back pain in those with surgically amendable causes.¹³

Spinal cord stimulation remains controversial; however, the advancement of programmable options and precise epidural placement continue to support implantation. Advancements in stimulator technology have made relief of back pain achievable. Previous relief postimplantation was primarily targeted to the lower extremities. Both SCS and IT systems are trialed prior to surgical implantation,^{13,14} allowing patients to experience the degree of relief that could potentially be obtained with placement.

Intrathecal drug delivery systems allow for a continuous infusion of medication,¹⁴ often morphine or hydromorphone (Dilaudid). Microdosing of medication results in a lower side-effect profile and greater tolerability. After (or at times prior to) implantation, the goal is to wean from all oral opioid medication. An intrathecal catheter is connected to a reservoir typically located in the lower quadrant of the abdomen, storing and delivering medication.¹⁴ IT pumps are programmable, and dosing frequency can determine how often a pump refill is required,¹⁴ thus decreasing time between office visits. IT pumps can also provide predetermined bolus dosing delivered by the patient when exacerbation of pain is experienced. Patient education focusing on expectation management and overall quality of life should be addressed in conjunction with a psychological evaluation prior to implanting these devices. Patients or family members may mistakenly associate an IT drug delivery system as an end-of-life treatment and reassurance of rational is often warranted.

Lastly, cannabis has been utilized for medicinal purposes across the world for centuries. Now with several states legalizing both medical and recreational use, it is imperative the urgent care provider is aware of this treatment option and is knowledgeable to discuss risk-benefit. Patients will likely present questioning if medical marijuana could effectively treat their conditions. States have varying approved medical conditions (eg, multiple sclerosis, chronic pain, cancer, HIV/AIDS, neuro-pathic pain, spinal cord injury) and various methods of delivery (vaporization, dry leaf, ointment, patches, and so forth) for medical marijuana use.¹⁵ The endocannabinoid system regulates many biologic functions such as pain and appetite. Cannabis (marijuana) produces (exogenous) cannabinoids which mimic endogenous cannabinoids that aid in altering pain signals by suppressing sensitization and inflammation.¹⁵

As of February 2018, 29 states, the District of Columbia, Guam, and Puerto Rico allow some form of cannabis use.¹⁶ Proponents for medical cannabis in the treatment of chronic pain often cite the opioid epidemic, escalating opioid doses to achieve pain control, and resultant opioid-induced hyperalgesia (increased pain secondary to central sensitization) as a main focus for considering cannabinoid pharmacotherapy.¹⁵ Epidemiologists cite reduction in opioid prescription need with increased availability of medical cannabis programs.¹⁵

Multiple controlled studies have found cannabis to be effective for pain¹⁵; however, research to reflect long-term analgesic effect and potential adverse events is lacking. With the introduction of recreational and medical marijuana policies and programs across the country, longitudinal studies to evaluate cognitive effects with acute and chronic use, success rates of substitutability and/or supplementation from prescription opioids, and management of symptoms will become available and valuable.

Conclusion

Management of an acute or chronic exacerbation of low back pain can be challenging for the urgent care provider. It is essential to define the parameters of the symptoms, establish baseline chronic pain complaints vs variations

“It is essential for urgent care providers to define the parameters of symptoms, establish baseline chronic complaints vs variations of acute exacerbation, and identify red flags that warrant further evaluation.”

of an acute exacerbation, list failures of previous treatment modalities, identify diversion tactics, refer chronic management to a pain provider, appropriately manage common causes of LBP, be knowledgeable of available treatment modalities, and identify any red flag symptoms that warrant further diagnostic evaluation and work-up.

Treatment recommendations have continued to evolve, and understanding current pharmacologic and nonpharmacologic options, avoiding opioid analgesics when possible, facilitating appropriate referrals, and man-

aging expectations via patient education can promote better outcomes for this common complaint while aiding in the fight against the opioid epidemic that is occurring nationwide. ■

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ABSTRACTS IN URGENT CARE

- Efficiency and Inefficiency in the ED
- Duration of Antibiotic Therapy
- Reducing Nicotine in Cigarettes
- Steroids in Acute Respiratory Tract Infection
- Detecting HIV During Routine Screening
- Are Saturated Fats Really So Bad?
- Boosting Immunization Rates
- Procalcitonin Testing and Antibiotic Use

■ GLENN HARNETT, MD

Each month the College of Urgent Care Medicine (CUCM) provides a handful of abstracts from or related to urgent care practices or practitioners. Glenn Harnett, MD leads this effort.

Factors Influencing Provider Efficiency—or Inefficiency—in the ED

Key point: *Emergency department study on provider efficiency has relevance to urgent care.*

Citation: Bobb MR, Ahmed A, Van Heukelom P, et al. Which practices make for efficient emergency department providers? *Acad Emerg Med*. December 18, 2017. [Epub ahead of print]

This mixed-methods study published in *Academic Emergency Medicine* identified five practices/behaviors that increased provider efficiency in the emergency room and two practices that did not. What makes some ED providers more efficient than others is not always clear. The investigators' goal was to better identify particular practices associated with provider efficiency, a topic with scant published research. Methods included interviewing medical directors, providers, and nurses in order to generate a list of practices/behaviors presumed to be associated with provider efficiency. They then observed providers in four community EDs and calculated the time each provider spent on each practice/behavior. Then they determined the association between each practice and provider efficiency (as measured by relative value units/hour). They included carrying a higher patient load, using team member's names, having conversations with the team, visiting patient rooms, and "running the board" (systematically reviewing the status of current patients on an

electronic or handwritten tracker board). The two practices associated with significantly decreased provider efficiency included performing tasks (whether work-related or personal) not pertinent to current clinical load and failing to complete required documentation prior to patient discharge. Although both these efficient and inefficient practices may seem obvious to most, urgent care medical directors would be wise to share these data with their providers. ■

Keep an Eye on Duration of Antibiotic Prescriptions

Key point: *Even when appropriately prescribed, the duration of many antibiotic prescriptions for sinusitis exceeds IDSA guidelines.*
Citation: King LM, Sanchez GV, Bartoces M, et al. Antibiotic therapy duration in US adults with sinusitis. *JAMA Intern Med*. March 26, 2018. [Epub ahead of print]

JAMA Internal Medicine published a research letter detailing that even when antibiotics are appropriately prescribed for sinusitis, most courses exceeded the duration recommended by national guidelines. The Infectious Diseases Society of America (IDSA) currently recommends 5–7 days of treatment for sinusitis, when antibiotics are indicated, in patients who have a favorable response to initial therapy. This current research examined data from 3.7 million office visits in 2016 revealing that more than two-thirds of antibiotic courses and 91% of non-azithromycin antibiotic courses prescribed for the treatment of acute sinusitis in adults were ≥ 10 days. Prior research has shown that shorter durations (3–7 days) of antibiotic therapy for sinusitis have been associated with similar outcomes and fewer drug-related adverse events compared with longer durations. Also, $>20\%$ of



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“Use of corticosteroids for patients with acute respiratory tract infections likely represents high-cost, potentially harmful care.”

the total prescriptions were for 5 days of azithromycin, despite the fact that the IDSA explicitly recommends against the use of azithromycin for the treatment of sinusitis because of its known association with the development of drug resistance. Due to the high and persistent concentrations of azithromycin in tissue, a 5-day course of azithromycin approximates a 10-day course of erythromycin; this means that a 5-day course of

azithromycin does not actually involve a shorter duration of antibiotic exposure. These data present another opportunity for urgent care providers to reduce the unnecessary use of antibiotics even when therapy with antibiotics is indicated. ■

FDA Plan for Reducing Nicotine in Cigarettes

Key Point: *Nicotine may not cause most cigarette-related disease, but it makes it harder to quit smoking.*

Citation: Apelberg BJ, Feirman SP, Salazar E, et al. Potential public health effects of reducing nicotine levels in cigarettes in the United States. *N Engl J Med*. March 15, 2018. [Epub ahead of print]

Tobacco is addictive, primarily because of the presence of nicotine. Although nicotine itself is not the direct cause of most smoking-related diseases, addiction to nicotine in tobacco is recognized as the proximate cause of these diseases because it sustains smoking behavior. On July 28, 2017 the FDA announced a new comprehensive plan that places nicotine, and the issue of addiction, at the center of the agency's tobacco



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regulation efforts. By enacting a policy to lower nicotine in cigarettes to a minimally or nonaddictive level, the FDA hopes to decrease the likelihood that future generations become addicted to cigarettes and allow more who are currently addicted smokers to quit. This paper, published in *The New England Journal of Medicine*, used a simulation model with inputs derived from empirical evidence and expert opinion to estimate the effect of such a policy on the prevalence of tobacco use. According to their models, smoking prevalence would decline from a median of 12.8% in the baseline scenario to a median of 10.8% in the policy scenario within a year after the implementation of the policy. They estimated that approximately 5 million additional smokers would quit smoking within a year after implementation of the hypothetical policy, a number that would increase to a total of 13 million additional former smokers within 5 years. In subsequent years, the difference in smoking prevalence would continue to grow because of sustained increases in cessation and decreases in initiation in the policy scenario. They estimate that by 2060, smoking prevalence would drop from 7.9% in the baseline scenario to 1.4% in the policy scenario, leading to a substantial reduction in tobacco-related mortality. ■

Steroids May Be Overused in Acute Respiratory Tract Infection

Key point: Steroids continue to be commonly used for acute respiratory tract infections (eg, otitis, URI, sinusitis, bronchitis, allergic rhinitis, influenza, and pneumonia) despite the lack of demonstrated clinical efficacy.

Citation: Dvorin EL, Lamb MC, Monlezun DJ, et al. High frequency of systemic corticosteroid use for acute respiratory tract illnesses in ambulatory settings. *JAMA Intern Med*. February 26, 2018. [Epub ahead of print]

Clinical practice guidelines, based on best available evidence, do not recommend systemic steroids in the treatment of acute respiratory tract infections (ARTIs). While some studies have shown earlier symptom resolution with steroids given for pharyngitis, clinical trials show no efficacy of systemic steroids for sinusitis and bronchitis. Despite this fact, patients presenting with ARTIs are still commonly treated with systemic corticosteroids. This research letter published in *JAMA Internal Medicine* examined nearly 40,000 adults with an outpatient diagnosis of ARTI across the U.S. The retrospective observational study revealed significant regional variation in prescribing steroids for ARTI diagnoses, ranging from a prevalence of 13.6% in the South to 8.3% in the Midwest. In Louisiana, 23% of adult primary care encounters for ARTI included steroid injections. They found significantly higher odds for steroid prescriptions among individuals with a medical history of COPD or asthma, visit diagnosis of bronchitis, and an encounter with a nurse practitioner

“HIV screening in urgent care centers could be of public health benefit, considering that 15% of people infected in the U.S. are unaware of their infection.”

or physician assistant. One commenter, Dr. Matthew J. Thompson from the University of Washington, told Reuters Health, “Inappropriate use of not only steroids, but also antibiotics, seems ‘the norm’ for acute bronchitis/acute respiratory tract infections. There can be few conditions in healthcare where the mismatch between what is done in clinical practice versus what the evidence shows is so stark.” The authors of this study concluded that future research is needed to further explore regional and national trends in use of corticosteroids for patients with ARTIs, as it likely represents high-cost, potentially harmful care. ■

New Tests Improve Chance for Earlier Detection of HIV

Key point: New “4th generation” HIV antigen-antibody tests lead to higher rates of HIV detection in an emergency department setting.

Citation: White DAE, Giordano TP, Pasalar S, et al. Acute HIV discovered during routine HIV screening with HIV antigen-antibody combination tests in 9 US emergency departments. *Ann Emerg Med*. January 5, 2018. [Epub ahead of print]

Newer “4th generation” HIV tests are able to detect not only HIV antibodies but also the HIV-1 p24 antigen, which is present in the blood before antibodies, making these tests able to detect infection earlier than ever before. The CDC recommends nontargeted screening (ie, screening everyone, not just those with risk factors) for HIV infection in the ED setting when the diagnosis rate is at least 0.1% of patients tested. This retrospective study published in the *Annals of Emergency Medicine* included data from nine EDs in six U.S. cities over a 3-year period. In total, 214,524 patients were screened for HIV and 839 (0.4%) received a new diagnosis, of which 122 (14.5%) were acute HIV infection and 717 (85.5%) were established HIV infection. Some of these new diagnoses likely would have been missed by older HIV tests. Compared with patients with established HIV infection, patients with acute HIV infection were younger and had higher RNA and CD4 counts. They were also more likely to have symptoms of viral syndrome (41.8% vs 6.5%) or fever (14.3% vs 3.4%) as their reason for visit. HIV screening in some urgent care centers could be of public health

benefit, especially considering the fact that 15% of people infected with HIV in the U.S. are unaware of their infection. ■

Reconsidering the Dangers of Saturated Fats

Key point: *Saturated fat consumption has no association with all-cause mortality, coronary artery disease, stroke, or type 2 diabetes.*
Citation: Malhotra A, Redberg RF, Meier P. Saturated fat does not clog the arteries: Coronary heart disease is a chronic inflammatory condition, the risk of which can be effectively reduced from healthy lifestyle interventions. *Br J Sports Med.* 2017;51(15):1111-1112.

Dietary guidelines recommend that saturated fats should be limited to <10% (5%–6% for those who would benefit from lowering of LDL cholesterol), and trans fats to <1% of energy or as low as possible, primarily to reduce risk of ischemic heart disease and stroke. The authors of this paper published in the *British Journal of Sports Medicine* review a recent landmark systematic review and meta-analysis of observational studies that showed little to no association between saturated fat consumption and all-cause mortality, coronary heart disease, CHD mortality, ischemic stroke, or type 2 diabetes in healthy adults. They also noted that in the secondary prevention of CHD there is no benefit from reduced fat, including saturated fat, on myocardial infarction, or cardiovascular or all-cause mortality. In contrast, industrial or commercial trans-fats were associated with increased CHD and mortality. Ruminant trans-fats were not associated with increased CHD or mortality; in fact, ruminant trans-oleic acid was inversely associated with type 2 diabetes incidence. The authors suggest that despite popular belief among doctors and the public, the conceptual model of dietary saturated fat clogging arteries is flawed. ■

Reminders of Any Kind Boost Immunization Rates

Key point: *Texting and even good old fashioned “snail mail” patient reminders can improve vaccination rates.*
Citation: Jacobson Vann JC, Jacobson RM, Coyne-Beasley T, et al. Patient reminder and recall interventions to improve immunization rates. *Cochrane Database Syst Rev.* 2018 Jan 18;1:CD003941.

An updated Cochrane review revealed that patient reminders or recall interventions, including telephone and auto-dialer calls, letters, postcards, text messages, combination of mail or telephone (such as postcards and text messages) improve vaccination rates. As immunization schedules become increasingly complex and demands on primary care providers grow, it is more important than ever to understand and promote interventions that increase immunization coverage in acute care settings. This review included data from 75 studies on

reminders sent to primary care patients. The evidence showed that postcards, text messages, and automated phone calls each improved vaccination rates with high certainty as compared with no reminders. There was moderate-certainty evidence that nonautomated phone calls and letters to patients increased immunizations. The evidence was strongest for childhood and adolescent vaccinations, but benefits were also shown for adult vaccination rates. Patient reminders were not shown to be as effective in increasing rates of child and adult influenza infections. Overall, reminders increased vaccination rates by about 8 percentage points. ■

Procalcitonin Testing May Help Optimize Antibiotic Use

Key point: *JAMA provides evidence synopsis on procalcitonin testing to guide antibiotic therapy for respiratory infections.*
Citation: Schuetz P, Wirz Y, Mueller B. Procalcitonin testing to guide antibiotic therapy in acute upper and lower respiratory tract infections. *JAMA.* 2018;319(9):925-926.

In February 2017, the U.S. Food and Drug Administration approved procalcitonin to guide clinical decisions regarding antibiotic use for patients with respiratory tract infections who are hospitalized or treated in the emergency department. In acute upper and lower respiratory tract infections, a low procalcitonin level is associated with a lower likelihood of bacterial infection and may help identify patients who do not need antibiotics. In patients prescribed antibiotics, a decline in procalcitonin levels over time may help guide decisions about stopping antibiotic therapy, thereby reducing antibiotic exposure. This *JAMA* Clinical Evidence Synopsis summarizes a Cochrane review of 27 RCTs that assessed clinical outcomes associated with procalcitonin testing for patients with acute upper and lower respiratory tract infections. Procalcitonin testing was associated with a shorter duration of antibiotic exposure (from a median of 7 days to 5 days), shorter mean duration of infection (2.4 days), and a 25% reduction in antibiotic-related adverse effects (16.3% with procalcitonin testing vs 22.1% with controls). Procalcitonin testing was associated with lower 30-day mortality (patients with procalcitonin testing [8.6%] vs controls [10%]). Procalcitonin testing for antibiotic guidance was associated with lower rates of antibiotic use, fewer antibiotic-related adverse effects, and improved overall survival. This favorable association was similar for distinct types of respiratory infections (ie, community-acquired pneumonia, exacerbation of chronic obstructive pulmonary disease, bronchitis, upper respiratory infections) and across subgroups by clinical setting (emergency department, medical ward, intensive care). Currently, the procalcitonin test is only approved by the FDA for use in the hospital or ED, and further research is needed in primary care using rapid point-of-care procalcitonin tests. ■



New Rules for Beneficiary Inducements at Urgent Care Centers

■ ALAN A. AYERS, MBA, MAcc

Urgent message: Unlike other retail businesses, which commonly provide gift cards and other incentives in marketing or as remediation for unsatisfactory service, urgent care operators must be aware of various statutes prohibiting “inducements” to patients.

People in the U.S. love the idea of getting something for nothing. Businesses across the spectrum leverage this to promote their products, attract new customers, and increase sales.¹

This tactic is also common among urgent care centers. For example, an urgent care operator in Massachusetts recently announced that new patients would receive a \$10 CVS e-gift card.² As one might imagine, a single \$10 gift card most likely wouldn’t cause trouble. However, there are rules about giving gifts to patients and prospects. Using giveaways in urgent cares can be effective in marketing to new patients to draw them to try the center’s services; however, owners should be aware of the rules concerning remuneration and beneficial inducements.

Under §1128A(a)(5) of the Social Security Act, enacted as part of HIPAA,³ “a person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary’s selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services may be liable for civil monetary penalties (CMPs) of up to \$10,000 for each wrongful act.”⁴



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Pitfalls of Inducements

Federal statutes stipulate that any remuneration which “promotes access to care and poses a low risk of harm to patients and federal healthcare programs” doesn’t constitute “remuneration” under the beneficiary inducement federal civil monetary penalty statute.⁴ However, as mentioned above, such payments may run afoul of payer contracts prohibiting discounting of copays, as well as statutes on federal health programs.

The beneficiary-inducement statute prohibits providing free or discounted items or services to a Medicare or Medicaid beneficiary that are apt to influence the beneficiary to seek such reimbursable services from a particular provider. For these federal and other state healthcare programs, there is a concern that a gift card is an inducement to use services that are billed to the government—thus adding to the nation’s healthcare costs. Specifically, the statute prohibits offering or transferring remuneration to a beneficiary of Medicare or a state healthcare program (including Medicaid) when that person “knows or should know is likely to influence” the patient to order or receive a service from a particular provider, practitioner, or supplier.⁴

For urgent care owners, it’s critical to note that the objective standard includes what the provider *should have* known vs only what they *actually* knew, creating a broader canvas for non-compliance.

Exceptions

Several regulatory exceptions to the beneficiary inducement statute drafted by the HHS Office of the Inspector General (OIG) went into effect in January 2017.⁵

It’s essential to understand that the new “access to care” exception protects the provision of remuneration that promotes access to care and *poses a low risk of harm* to patients and federal healthcare programs.⁶ Remuneration would pose a low risk of harm to Medicare and Medicaid beneficiaries and the programs by:

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“The fact that urgent care operators are complying with an exception to the beneficiary-inducement provisions doesn’t guarantee the arrangement will be protected from prosecution.”

- being unlikely to interfere with, or skew, clinical decision-making
- being unlikely to increase costs to federal healthcare programs or beneficiaries through overutilization or inappropriate utilization
- not raising patient safety or quality-of-care concerns⁷

The Civil Money Penalties statute states that “remuneration” doesn’t include the offer or transfer of items or services for free, or less than fair market value, if:

- the items or services consist of coupons, rebates, or other rewards from a retailer
- the items or services are offered or transferred on equal terms available to the general public, regardless of health insurance status
- the offer or transfer of the items or services is not tied to the provision of other items or services reimbursed in whole or in part by the program under Title XVIII or a state healthcare program⁷

The OIG has specified that items potentially covered by this exception include free or discounted medications, supplies, or devices; food vouchers; and coupons or rebates.⁸ The OIG went on to state that “[t]he concept of ‘other reward’ is broad: if the item or service meets the three criteria listed in the regulation, it can be protected.”⁸ However, the reward can’t be in the form of a copayment waiver, as these do not meet the third criterion of the exception.⁸

While this exception appears to be quite broad, the OIG warned that it may be challenging to satisfy the “low risk of harm” requirement if a more applicable exception or one of the safe harbors to the federal Anti-Kickback Statute (AKS)⁹—which also may be leveraged to protect arrangements implicating the beneficiary-inducement statute—was available and not utilized.¹⁰

Promoting Access to Service

The OIG also explained that providing incentives in return for

receiving care or for complying with a treatment plan would not qualify for this exception; these incentives would be considered a *reward* for accessing care rather than *promoting* access to care.¹¹ Thus, remuneration that may entice a beneficiary to receive care wouldn’t qualify for the exception; however, items that make it possible for the beneficiary to access care will qualify for protection under this safe harbor.

An urgent care owner is wise to structure any offerings in a way that *facilitates* care rather than *rewarding* treatment adherence.

Monetary Limits Revised

In addition to the exceptions for promoting access to care, the OIG reexamined the monetary limits it had previously implemented on the provision of beneficiary inducements “of nominal value.” These inducements do not violate the beneficiary inducement statute.

The OIG increased the limit for individual items from \$10 to \$15, and the annual aggregate limit per patient from \$50 to \$75.¹²

However, cash or cash equivalents wouldn’t be considered low risk.⁸ The OIG defines “cash equivalents” as items that can be converted to cash—such as checks—or that are used like cash—like general-purpose debit cards. The OIG would not consider “gift cards that can be redeemed only at certain stores for a certain purpose, like a gasoline gift card” as cash or cash equivalents.⁸

Thus, the \$10 CVS e-gift card offered by the urgent care facility in Massachusetts wouldn’t be deemed cash or a cash equivalent because it can only be redeemed at that retailer and is of nominal value.

Analysis

The OIG noted that one of its objectives in soliciting comments on its interpretations of the beneficiary-inducement CMP exceptions was to “ensure that we protect low-risk, beneficial arrangements without opening the door to abusive practices that increase costs or compromise patient choice or quality of care.”⁸ As one observer wrote, the fact that the OIG, in most cases, merely codified the existing statutory exceptions without adding any clarification or guidance evidences “how difficult it is to balance the broad prohibitions in the law with actual business practices and the particular needs of patients.”¹¹

Hence, urgent care providers who create and implement patient incentive programs should understand that the fact that they are complying with an exception to the beneficiary-inducement provisions of the CMP doesn’t guarantee that the arrangement will be protected from prosecution under the Anti-Kickback Statute. This may serve as a potential Catch-22 for urgent care providers; by offering a beneficiary inducement that promotes a patient’s access to medical services that arguably poses low risk of harm to the patient and federal healthcare



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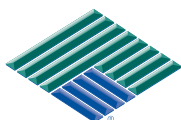
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“By offering a beneficiary inducement that promotes a patient’s access to medical services that arguably poses low risk of harm to the patient and federal healthcare programs, an operator could be violating the rules on kickbacks.”

programs, an operator could be violating the rules on kickbacks.

The OIG said that it would “continue to monitor the changing landscape and could consider new or revised safe harbors in the future.” Until then, urgent care owners should stay abreast of OIG actions that give further insight on the safe-harbor exceptions to the beneficiary-inducement prohibitions as they impact the Anti-Kickback Statute and perform a separate review of any proposed programs for compliance with both the AKS and CMP statutes. ■

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Thinking Differently About Paid Time Off

Urgent message: As 24/7 connectedness becomes the norm in the modern workplace, innovative technology companies have begun exploring unlimited paid time off (PTO) policies as a way to promote better work/life balance. Could unlimited PTO also become a trend in a healthcare industry that is likewise becoming increasingly 24/7 connected and still struggling with the issue of employee burnout?

ALAN A. AYERS, MBA, MACC

The concept of unlimited paid time off (PTO) has gotten quite a bit of buzz lately. Companies with innovative cultures, following in the footsteps of highly reported firms like Netflix and Virgin Group, are exploring the concept of removing their conventional 2-week PTO ceilings and affording employees the latitude to take an “unlimited” amount of paid time off.

Of course, the concept of unlimited PTO sounds far more intriguing in theory than it does in practice, given that workplaces need their employees mostly present for the proper functioning of the business. Still, unlimited PTO and its purported ability to facilitate work-life balance has piqued the interest of employers and workers alike, and while it's not yet caused a stampede toward it, it's at least triggered some spirited debates. For example:

- How does a workplace prevent employees from abusing such a policy?
- Does the policy kick in on the first day of work, or must the employee wait a specific time—90 days, a year?

An urgent care center cannot function without a sufficient number of providers and staff on site during all open hours to serve patient demand. Discussions about innovative PTO may therefore, realistically, be limited to larger operations with a “bench” of available labor and/or management and administrative functions.



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- Can unlimited PTO be denied due to, or tied to performance?
- How to reconcile granting unlimited PTO with staffing shortages and coverage issues?
- How to handle employees who have accrued significant “paid” vacation time ahead of the policy, and were expecting to “cash out” at some point?

And for an urgent care operation specifically: Can an unlimited PTO policy “work” in an industry largely predicated on being present and accounted for at the point of service, which is necessary to drive patient throughput? And does the urgent care concept itself

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support a workplace culture that encourages employees to take unlimited PTO?

A Closer Look at Unlimited PTO

Despite the name, unlimited PTO doesn't mean an employee can take off as much time as they want, at their whim. Rather, it's a concept that essentially says, "As a company, we're no longer going to place arbitrary ceilings on the amount of paid time off we allow." In effect, it grants employees permission to take as much leave as needed—within reason—while still balancing the needs of the business and their colleagues. Depending on the business model and job function, employees would have the freedom to take the time off they need when they need it, so long as the vacation time is sorted out with their supervisor in advance.

More importantly, the time away shouldn't place undue strain on the operation, as there should be a plan in place for how the workload will be handled in the employee's absence.

Unlimited PTO does mean the employee will still stay "connected" to the workplace or work remotely—which many proponents of unlimited PTO insist flies in the face of a policy meant to allow employees to unplug and stave off burnout. This arrangement is indeed a necessity for many job functions, however, as employees will still need to complete their tasks and projects, albeit away from the office. In other cases, employees may want to step away from their jobs completely for a period to pursue, say, a passion, extended vacation, or charitable cause, which requires them to fully unplug. In the examples of PTO we've seen, the policy can be adapted to each of those cases.

Paid time off is a concept that originated with industrial assembly lines that required an employee be present at all times the line was operational, but expected nothing of employees when away from the factory. While an urgent care center has similar "production" requirements of providers and front-line staff, non-provider management functions are necessarily connected 24/7 due to the urgency of decision-making in a healthcare environment so there is really never any "stepping away."

Why Unlimited PTO Is Impractical for Urgent Care Providers and Staff

In the aforementioned examples of unlimited PTO for

Netflix and Virgin Group employees, it should be noted that those job functions are compatible with the unlimited PTO concept. Indeed, many of those positions are either administrative, managerial, or executive, meaning that those tasks could be handed off to another employee, or completed remotely. Additionally, for high-level executives or operations managers who are never really "off" work anyway, the "off" part of PTO is really a misnomer. Indeed, for leadership posts that are responsible for overseeing large staffs or complex operations, there are always pressing issues and time-sensitive projects that need to be tended to in real time—regardless of whether it is in person or remotely. In healthcare, critical decisions need to be made in real time. For these leaders, being totally "unplugged" for, say, a week or two is simply not an option.

Is it really paid time off if an administrator works 40-50 hours in 4 days in order to take a Friday off? Or, is it really PTO if an administrator is away on vacation yet is still tied to a mobile device because critical decisions still need to be made?

Similarly, the front-line staff of an urgent care center—including the providers—must be present and accounted for during their scheduled shifts. Being adequately staffed here directly impacts patient flow, thus the concept of unlimited PTO is a poor fit in these functions. In fact, when providers and front-line staff miss time unexpectedly, the center is forced to employ temporary labor, pay overtime to present staff, or suffer the customer service impact of prolonged wait times. These negative consequences certainly underscore why unlimited PTO is not viable here and has the potential to hurt the operation in numerous ways. Additionally, a case can be made that a provider working, say, back-to-back 12-hour shifts followed by 2-3 consecutive days off shouldn't need any PTO at all, as there is adequate time between shifts to recharge and tend to personal matters (especially when the schedule can be coordinated to give that provider 7 or more consecutive days "off" without impacting patient care).

In either case, reliability and predictability form the bedrock of an optimally functioning urgent care clinical staffing model; thus, unlimited PTO would necessarily be reserved for urgent care professionals on the administrative/management/ leadership side of the operation, where onsite presence is not always a critical factor.

The Benefits of Unlimited PTO for Employers

Up to this point, the discussion of unlimited PTO has centered around the benefits it affords employees. But the promise of unlimited PTO goes well beyond being a nice job perk to offer. Employers stand to benefit greatly as well in several of the following ways:

- **It acts as an attractive perk in recruiting top talent** – The ability to offer unlimited PTO as an extra perk was frequently cited as a top reason for firms adopting the program. In many of the tech markets where unlimited PTO began springing up, recruiting and retaining top talent is not merely a luxury; it's a vital component to growing the business and remaining competitive. The market for qualified tech workers is highly competitive. Thus, the ability to offer unlimited PTO is an attractive perk to add to the overall compensation package. Additionally, high achievers and top performers tend to be driven, career-oriented and self-motivated, and thus less likely to abuse such a policy and more likely to require brief hiatuses from the workplace to refresh and recharge. In short, the policy would be appealing to in-demand talents who work hard and play hard.
- **Saves the company money in accrued vacation time expense** – Project Time Off, a research initiative conducted by the U.S. Travel Association, cited that each year there is *\$224 billion dollars* in liability carried by American companies due to unused vacation. This figure represents an enormous business liability residing on the balance sheets of American companies in the form of accrued vacation expense. Hence, adopting unlimited PTO policies, the same report asserts, can result in savings as high as \$1,898 per employee.
- **Less administrative time spent tracking vacation time** – E-business Ask.com reported that when their company shifted to an unlimited vacation policy, it freed up roughly 52 administrative hours a year that would have been otherwise allocated to tracking and managing vacation time. Ask.com now allocates the newfound time to recruiting and retention, which has shown measurable positive results for the company.
- **Recharged, refreshed employees perform at a higher level** – It's no secret that well-rested employees are healthier and happier. This makes another compelling business case for unlimited vacation, as it supports improved wellness in workers and their families. This greater wellness also has the demon-

strable added benefit of indirectly lowering the usage of disability insurance and health insurance, which naturally improves the company bottom line. Armed with the freedom and latitude to easily take time off for dentist/doctor appointments and other self-care activities, employees are thus less likely to call in sick, resulting in improved productivity levels companywide.

Because PTO is considered part of the overall compensation package, there is an inherent unfairness when the demands of the business limit an employee's ability to use it—particularly when the employee is forced to forfeit unused vacation time. Unlimited PTO doesn't enable people to shirk their responsibilities, but it removes PTO from the compensation equation.

- **No year-end scramble to use unused vacation** – Since there is no accrued vacation time with unlimited PTO, there's no more mad dash to “use it or lose it” at the end of the year. As an added bonus, the unlimited PTO policy also encourages “office warriors” and other workaholic types to take days off more frequently during the year, since they know they can still take additional vacation during the holidays.
- **The implicit trust and ownership increases employee engagement** – Allowing employees, especially high performers, to manage their own vacation time conveys a sense of deep trust that has been shown to bolster engagement and cultivate an ownership mentality. Affording your staff the freedom to manage their tasks and projects as they see fit also grants much valued autonomy, which encourages employees to think like owners who consider what's best for the company first.
- **Unlimited PTO can be used as an incentive for employees to adopt healthy behaviors** – Pīala, a marketing firm in Japan, offers an interesting example as to how a health-and-wellness-based initiative tied to extra vacation time can motivate workers to adopt healthy desired behaviors. The initiative began when an employee complained that smokers unfairly get more breaks than their nonsmoking counterparts. The employee also asserted that productivity declined because of the frequent breaks. The solution Pīala reached was to incentivize,

Kronos: A Case Study in Rethinking PTO

Kronos, a workplace management software firm, took an interesting and insightful foray into the unlimited PTO arena in 2016, as documented by CEO Aron Ain. According to Ain, who worked his way up from entry-level college graduate in 1979 to CEO today, “unlimited PTO” (although it wasn’t called that back then) was always the standard for top executives, as people in senior roles were required to “work” 24/7 regardless. In fact, nights and weekends were par for the course for top-level leaders, such that tracking vacation time simply didn’t make sense for them. Rank-and-file employees started off at 2 weeks’ vacation as is the workplace standard, with an additional day earned with each yearly anniversary with the company.

When Kronos struggled to fill key positions in 2015 due to their inability to entice top talent with their standard compensation package, Ain and the leadership team decided to shift to unlimited paid vacation for all employees. They concluded that due to pervasive 24/7 connectedness, workers at every level are answering emails or otherwise doing office work well past traditional business hours. With so much of the staff “plugged in” at all hours, the line between being at-work- and off-work was becoming increasingly blurred, making official office policies on vacation time seem out of touch and antiquated.

Meanwhile, while most of Kronos’ employees were delighted by the policy rollout, some were predictably disgruntled. The angry employees fell into three general categories:

- Employees who stood to lose all their accrued vacation time and the cash value associated with it
- Tenured employees who felt those with less seniority shouldn’t enjoy equal amounts of vacation time
- Managers who were concerned that the new policy would create new logistical headaches as far as deciding when to approve or deny unlimited PTO requests, and dealing with prolonged employee vacations

These objections were met and addressed individually, to mostly positive resolutions. Where Kronos needed to be flexible and accommodating in handling individual complaints, they were. Kronos also tracked several key metrics around the unlimited PTO policy to measure the results and came away very happy with the findings: The company saved big in eliminating accrued vacation expenses (which were reinvested in employee initiatives) and had a banner year in terms of financial performance and overall employee engagement. Notably, however, employee vacation time usage crept up only slightly. So why did the new policy have such an overall positive effect despite employees only slightly increasing their overall PTO usage? Ain and the rest of the Kronos leadership concluded that the flexibility, trust, and autonomy ensuing from the new policy was behind their stellar year; hence, they vowed to continue the unlimited PTO policy moving forward.

(Adapted from Ain A. *Harvard Business Review*. Available at: <https://hbr.org/2017/11/the-ceo-of-kronos-on-launching-an-unlimited-vacation-policy>.)

“One issue that has derailed attempted unlimited PTO rollouts is angered employees who feel the company is trying to ‘steal’ their hard-earned vacation accruals and the cash value they hold.”

rather than penalize, abstinence from smoking. The reward for not smoking was now 6 extra days of vacation, eligible to all employees. The results were overwhelmingly positive, as 42 employees kicked the habit to earn the extra vacation time. Predictably, productivity increased while healthcare expenditures decreased.

Considerations for Rethinking PTO in Your Organization

Drawing from data, anecdote, and consensus conclusions from unlimited PTO rollouts across industries, keep these tips in mind when considering unlimited PTO for your urgent care operation:

- **Craft a written policy** – As an unlimited PTO rollout can be confusing for employees accustomed to the standard 2-week vacation structure, you should craft a written policy. The policy should cover such things as the policy structure, eligibility, how to request PTO, and any other necessary guidelines. It’s also important that all requests must be approved by management, and that the policy clearly states that abuse will not be tolerated.
- **Carefully evaluate the vacation accruals on the books** – The one issue that has derailed a number of attempted unlimited PTO rollouts we’ve seen is angered employees who feel the company is trying to “steal” their hard-earned vacation accruals and the cash value they hold. Address each case indi-

vidually and make every attempt to accommodate tenured employees who have longevity with the company. Inform employees well in advance of the impending policy, with the option to use their accrued vacation time, or in some cases, cash it out at a percentage. Never give long-term, loyal employees the impression that the company is trying to cheat them out of what they've earned over years of dedicated service.

- **Track and encourage use of PTO** – Ironically, some companies have reported that their unlimited PTO policies have resulted in *fewer* employees taking vacation time for fear of abusing the policy. Therefore, you'll need to track unlimited PTO usage closely, ensure that managers are setting an example by taking days off, and encourage employees to feel free to take advantage of the work-life balance benefits the policy was intended for.
- **Be prepared to manage issues of perceived favoritism** – In a large company with multiple divisions that employ both exempt and nonexempt employees, it's only natural that the jobs requiring predictability of presence would be ineligible for the unlimited PTO that other, more flexible functions can readily accommodate. Thus, HR and management will need to address any perceptions of favoritism to reduce tension, and seek out creative ways to give different perks to the non-unlimited PTO-eligible workers.
- **Consider time off related to the Family Medical Leave Act (FMLA), Americans with Disabilities Act (ADA), pregnancy and paid sick leave, and other forms of time off** – If PTO is not coordinated with other authorized forms of leave, including federal and state/local sick-leave laws, there may be unintended consequences. For instance, employees may take more time than needed for FMLA leave if they can utilize unlimited PTO benefits to assure a paycheck. Experts recommend clear verbiage that excludes various other forms of legal leave from the unlimited PTO benefit.

“Unlimited PTO is untenable in ‘production’ environments such as call centers, hotels, retail outlets, and the customer-facing side of an urgent care operation.”

Conclusion

Despite the buzz surrounding unlimited PTO, the Society for Human Resources Management states that fewer than 1%-2% of companies offer such a policy—meaning it's hardly a growing trend. This begs the question: Is there an inherent limit to how widespread unlimited PTO can be implemented? For sure, the policy is appropriate for 24/7 leaders, and innovative employee cultures that need to offer

attractive perks to lure top talent. But the reality is, for employees who aren't technologically connected to the workplace after business hours, it's likely a poor fit.

Simply put, unlimited PTO is untenable in “production” environments such as call centers, hotels, retail outlets, and definitely the customer-facing side of an urgent care operation. The reality is that there are some job functions where people have to be predictably at their posts for the operation to run. So, the concept may ultimately see situational implementation in certain industries, rather than mass adoption. Urgent care leaders, executives, and upper management—defined by their positions and never more than an email, call, or text away from being “at work”—are among those who would do well to take advantage of the many work-life balance advantages unlimited PTO affords, while extending it to their teams where appropriate and applicable. ■

Summary

- Paid time off policies should always be in writing.
- Benefits of an unlimited PTO policy include bolstering recruitment of top talent; encouraging employees to recharge and refresh—which is likely to help them perform at a higher level; and saving the company money in both accrued vacation time expense and the time it takes staff to track vacation time.
- Consideration of implementing an unlimited PTO policy include preparing for more absences in the workplace and evaluation of vacation accruals already on the books.
- Offering unlimited PTO demonstrates that ownership trusts the staff to consider the needs of the business, and that employees will not abuse the policy.
- There are some job functions for which unlimited PTO will not be feasible.



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An Uncommon Clinical Presentation of Ovarian Torsion

Urgent message: Abdominal pain is an extremely common complaint in the urgent care setting. The differential diagnosis of abdominal pain is often a challenge, however, because many symptoms and signs are nonspecific. Ovarian torsion usually presents with sudden onset of severe, unilateral lower abdominal pain, associated with nausea and vomiting; however, in a small percentage of cases, the clinical course is prolonged, as the torsion can be intermittent. While failure to consider ovarian torsion in the differential diagnosis is not uncommon, given its relatively low occurrence, timely diagnosis is of paramount importance to prevent necrosis and preserve ovarian viability.

FABRIZIA FAUSTINELLA, MD, PhD, FACP

Introduction

Gynecological causes account for about 4% of all abdominal pain complaints seen in emergency departments. Of those, 3% of cases are attributed to ovarian torsion. Also referred to as *adnexal torsion* or *tubo-ovarian torsion*, ovarian torsion is the partial or complete rotation of the ovary and portion of the fallopian tube on the vascular and ligamentous structures, which results in limitation or complete cutoff of the blood supply to the ovary. The incidence of ovarian torsion is higher in younger women (15-30 years) and postmenopausal women. Approximately 20% of the cases occur during pregnancy. Risk factors for ovarian torsion include hypermobility of the ovary due to increased length of ovarian ligaments (<50%); enlarged corpus luteum in pregnancy; and the presence of ovarian masses/cysts (50%-60%), with masses between 5 and 10 cm causing the highest risk for torsion.¹⁻⁴

Presentation

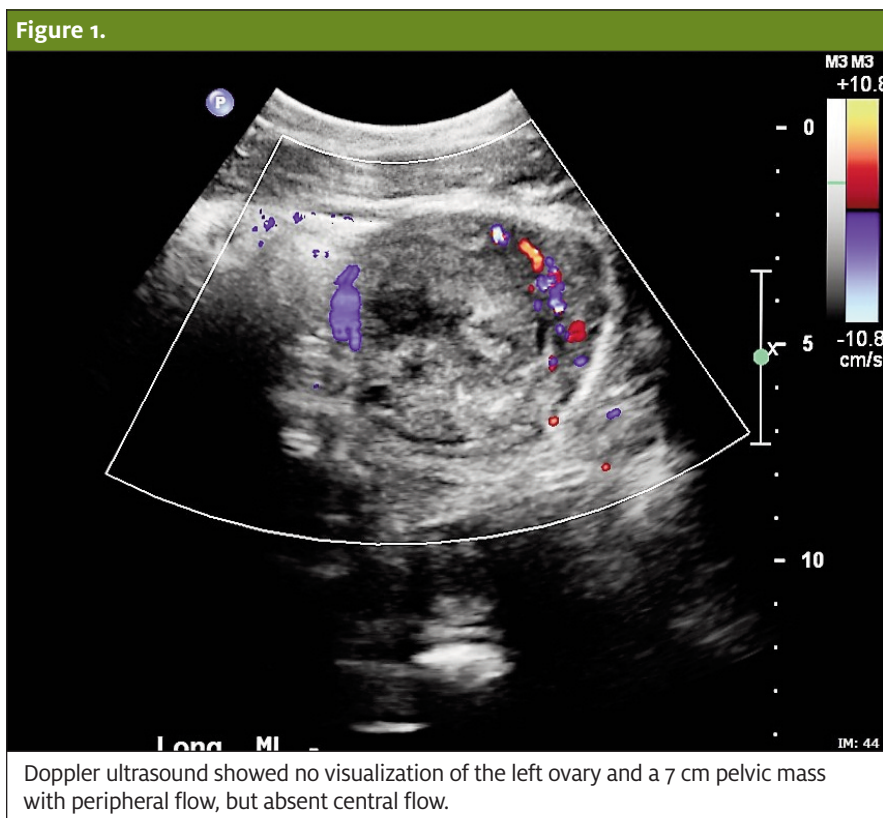
A 32-year-old woman presented to our walk-in clinic with intermittent, progressively worsening left lower abdominal pain for 3 days. The patient stated that she had self-medicated at home with PCP and cocaine without relief



of pain. Patient reported occasional episodes of nausea and vomiting; no diarrhea, constipation, fever/chills, dysuria/urinary frequency. The patient stated that it was becoming difficult for her to walk and stand up straight due to worsening pain in the left lower quadrant.

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Figure 1.



On physical exam, the patient looked in mild to moderate distress. In addition, we found:

- BP 178/100
- HR 100
- RR 18
- Temp 99.8° F
- Chest: clear to auscultation bilaterally
- Heart: tachycardic, regular rhythm, no rub/gallop/murmur
- Abdomen: BS +; significant LLQ tenderness to palpation; + rebound tenderness; no rigidity

The patient was transferred to the emergency department where a CT abdomen and pelvis with contrast was immediately requested for further evaluation. Per the examining physician's notes, the CT scan was read as: "Heterogeneous 6.9 cm round mass superior to the uterus. Given lack of visualization of the left ovary and reported acute onset of abdominal pain, primary consideration is ovarian torsion with edematous left ovary. Additional consideration is a torsed pedunculated fibroid. Tubo-ovarian abscess remains in the differential consideration in the appropriate clinical setting. Recommend STAT gynecologic evaluation and pelvic ultrasound with

Doppler for further evaluation." A pelvic ultrasound with Doppler was requested and showed "No left ovary visualized with 7 cm pelvic mass which contains peripheral flow, but absent central flow. Given the reported history of acute onset abdominal pain, findings remain highly concerning for ovarian torsion."

Gynecology was consulted, and patient underwent a diagnostic laparoscopy. She was found to have a 7 x 6 x 6 cm left pelvic mass with ovarian torsion. A left salpingo-oophorectomy was performed. Later, the pathology reports showed an ovarian granulosa-theca cell tumor, adult type. Patient underwent a TAH/RSO and initiated chemotherapy.

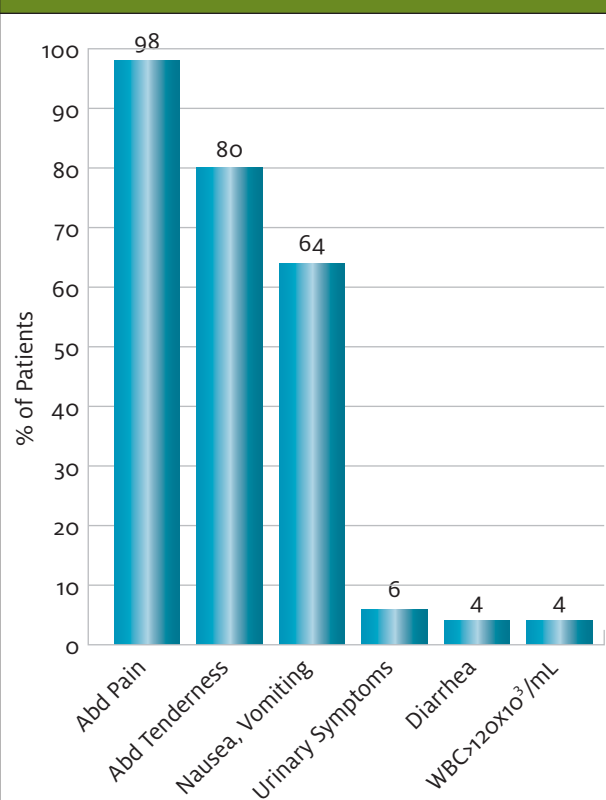
Discussion

The vast majority of patients with ovarian torsion present with sudden onset, unilateral, severe, persistent lower abdominal pain and

pelvic pain, often associated with nausea and vomiting. About 25% of patients experience bilateral lower quadrant pain, which is usually described as sharp and stabbing. Patients with intermittent ovarian torsion have a more prolonged time course. They typically experience pain intermittently and present for evaluation 1 to 3 days after onset of symptoms, resulting in delayed diagnosis.⁵⁻⁷

Our case is an example of the latter clinical scenario. Unilateral adnexal tenderness is a common physical finding but is nonspecific. Typically, the right ovary is more likely to develop torsion, possibly because the presence of the sigmoid colon on the left side has a stabilizing effect. In our particular case, the torsion occurred in the left ovary.

Our patient initially underwent a CT abdomen and pelvis with contrast, which raised the suspicion for ovarian torsion due to lack of visualization of the left ovary and the presence of a large mass. In the workup of ovarian torsion, pelvic ultrasound is the imaging modality of choice.⁸ Ultrasonography with color Doppler analysis can help in determining whether blood flow is impaired, but it's important to remember that Doppler flow is not always absent in torsion.^{9,10} Subsequently, a Doppler ultrasound showed no visualization of the left

Figure 2. Most Common Characteristics in Women with Ovarian Torsion

Adapted from: Ashwal E, Hirsch L, Krissi H, et al. *Obstet Gynecol.* 2015;126(3):514-420.

“A patient with a history and physical examination findings suggestive of ovarian torsion should still be evaluated by a gynecologist and possibly undergo laparoscopy.”

ovary and a 7 cm pelvic mass with peripheral flow, but absent central flow (Figure 1).

Our patient was admitted to the hospital and underwent a diagnostic laparoscopy with left salpingo-oophorectomy.

Our patient was diagnosed with adult-type granulosa-theca cell tumor, which belongs to the category of sex cord-stromal tumor. Granulosa-theca cell tumors are also known as granulosa cell tumors (GCTs) and include tumors composed of granulosa cells, theca cells, and fibroblasts in varying degrees of combinations. GCTs

Summary

- Intermittent ovarian torsion is uncommon and represents a diagnostic challenge.
- Risk factors for ovarian torsion include the following:
 - hypermobility of the ovary due to increased length of ovarian ligaments
 - enlarged corpus luteum in pregnancy
 - presence of ovarian masses/cysts, with masses 5–10 cm causing the highest risk for torsion
- Most patients with ovarian torsion present with sudden onset, unilateral, severe, persistent lower abdominal pain and pelvic pain, often associated with nausea and vomiting.
- Ovarian tumors, both benign and malignant, are implicated in 50%–60% of cases of torsion.
- Patients typically experience pain intermittently and present for evaluation 1–3 days after onset of symptoms, resulting in delayed diagnosis.
- Pelvic ultrasound is the imaging modality of choice in the workup of ovarian torsion.
- History and physical examination suggestive of ovarian torsion should prompt evaluation by a gynecologist, even if radiologic studies are normal.
- Pelvic ultrasound is the imaging modality of choice, but Doppler flow is not always absent in torsion.

account for approximately 2% of all ovarian tumors and can be divided into adult (95%) and juvenile (5%) types based on histologic findings.¹¹

Regardless of whether the radiologic studies yield normal results, a patient with a history and physical examination findings suggestive of ovarian torsion should still be evaluated by a gynecologist and possibly undergo laparoscopy. ■

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A 51-Year-Old Male with a Persistent Cough



Figure 1.

Case

The patient is a 51-year-old man who presents to urgent care complaining of a persistent cough. He reports it started “about a month ago,” but his wife, who is with him, insists it’s been at least 6 weeks.

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

THE RESOLUTION

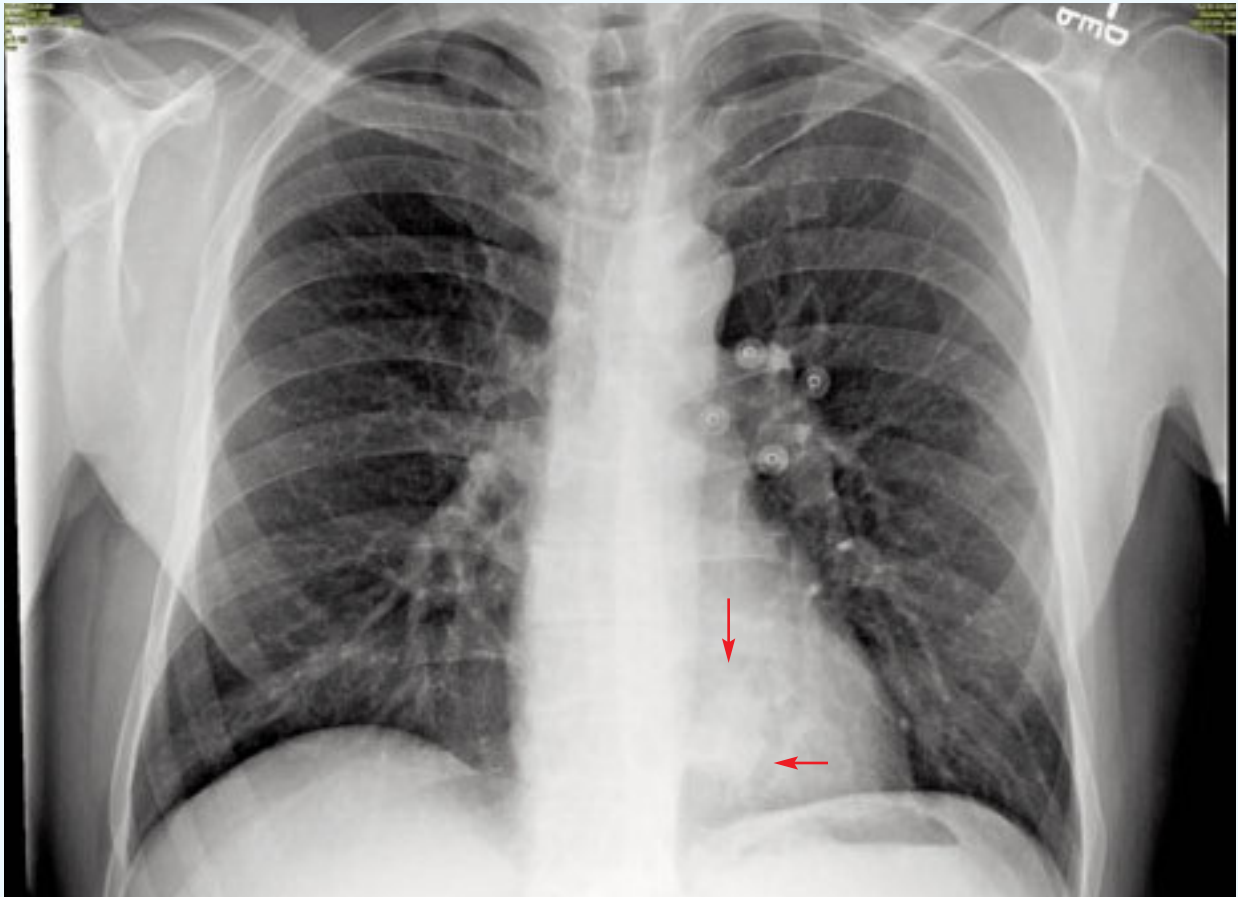


Figure 2.

Differential Diagnosis

- Fungal pneumonia
- Lung abscess
- Lung mass
- Pulmonary pseudotumor

Diagnosis

The x-ray reveals a left lower lobe lung mass; see the oval-shaped density in the medial aspect of the left lower lobe, visible in the retro cardiac region.

Learnings

- Search pattern on chest x-ray should always include the “hidden areas,” such as the retro cardiac region, lung apices, and hilar regions
- Any increased density in the retro cardiac region or loss of clearly defined left heart border should raise concern for mass or infiltrate

Pearls for Urgent Care Management and Consideration for Transfer

With this presentation and radiographic findings, the patient needs outpatient referral for advanced imaging and management



A 45-Year-Old Woman with Acute Chest Pain

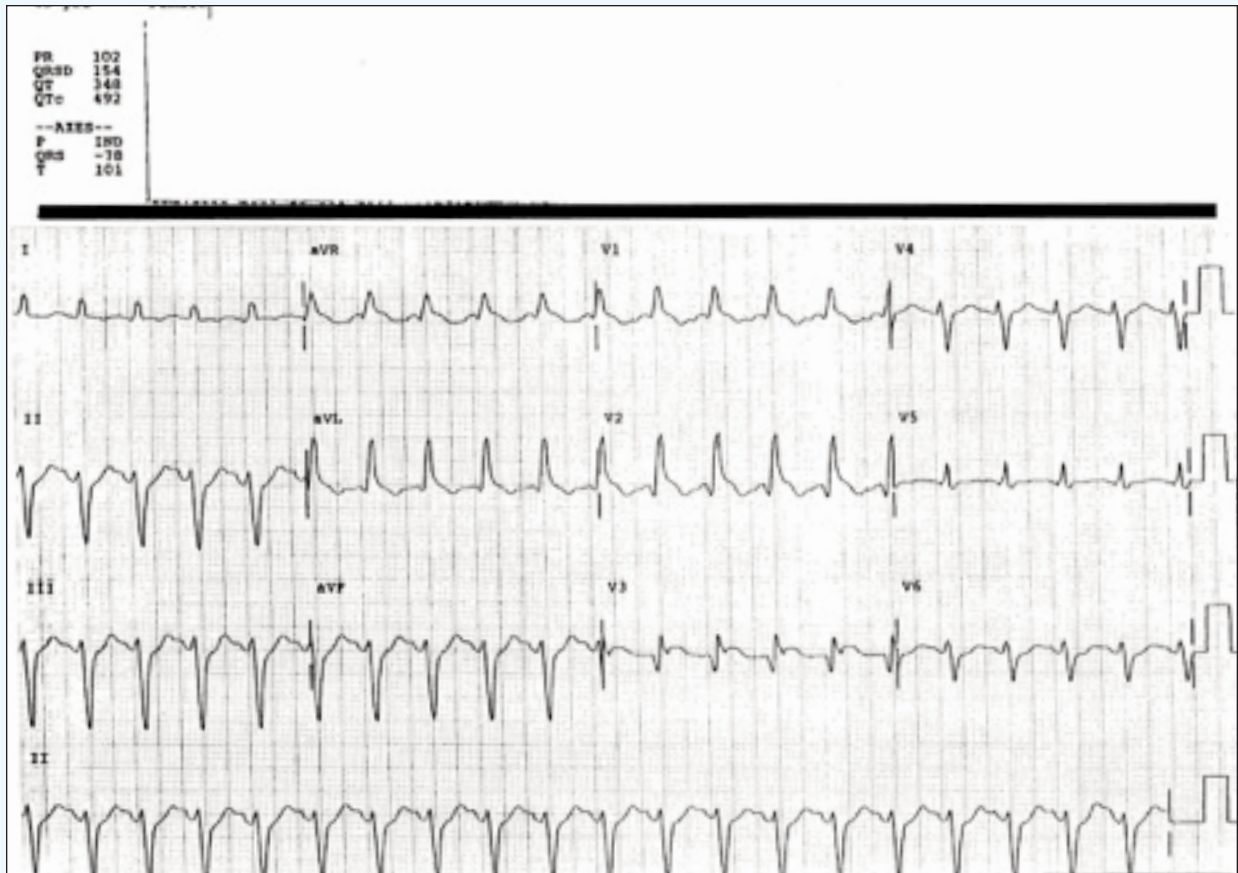


Figure 1.

Case

The patient is a 45-year-old woman who presents after experiencing chest pain for the past 2 hours. She has some minimal dyspnea, but no diaphoresis. She takes birth control pills and is a smoker. She denies family history of cardiac disease.

Upon exam, you find:

General: Alert and oriented

Lungs: CTAB

Cardiovascular: RRR without murmur, rub, or gallop

Abdomen: Soft and NT without r/r/g

Ext: No peripheral edema or calf pain, pulses 2+ and equal in all extremities

View the ECG taken and consider what the diagnosis and next steps would be. Resolution of the case is described on the next page.

THE RESOLUTION

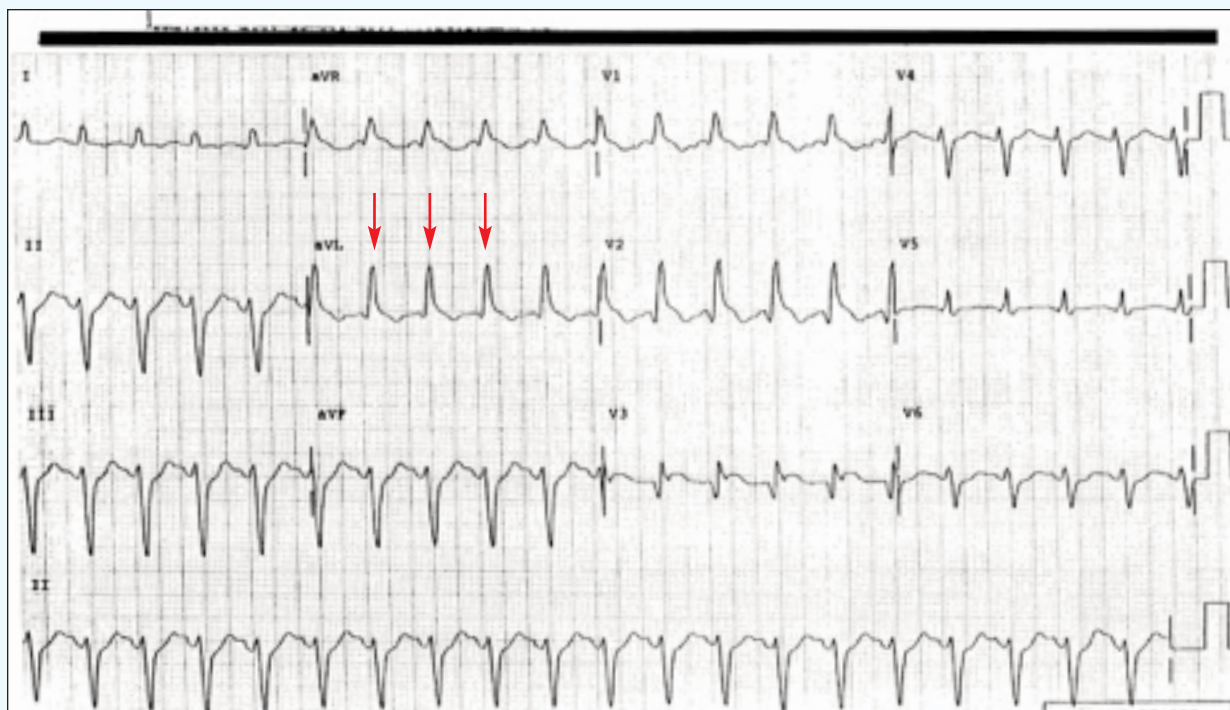


Figure 2.

Differential Diagnosis

- Lateral STEMI
- Wolff-Parkinson-White (WPW)
- Sinus tachycardia
- Brugada syndrome
- First-degree AV block

Diagnosis

- The ECG reveals a sinus tachycardia with a rate of 120
- The QRS is widened, and although a wide complex tachycardia should be evaluated for ventricular tachycardia, there are P waves before each QRS complex, so this is not V tach
- WPW can also cause a wide complex tachycardia with a short PR interval, but would show presence of the “upsloping” delta wave
- Brugada is an incomplete RBBB with ST elevation seen in leads V1 and 2, not present on this ECG. Normal PR interval is 0.12-0.20 and is not prolonged
- Other aspects of the ECG include bifascicular block as well as q waves anteriorly, likely indicating an old anterior MI
- There is ST elevation in leads V2 and V3; comparison to a previous ECG will help to determine if this is acute from a STEMI or chronic

Learnings/What to Look for

- Normal heart rate is 60-100 beats per minute
- Unexplained tachycardia, even in well-appearing patients, may indicate a more serious underlying process such as ischemia, myocarditis, aortic dissection, pneumothorax, pericardial tamponade, bleeding, or sepsis
- If the q waves and BBB are present on a previous ECG, this will help with the disposition decision by decreasing our concern; however, the tachycardia remains troubling for serious underlying pathology
- A smoker on oral contraceptive therapy over the age of 35 is at high risk for a thrombotic event such as pulmonary embolism (PE) or acute coronary syndrome (ACS)

Pearls for Initial Management and Considerations for Transfer

- A chief complaint of chest pain should prompt consideration of ACS, PE, and aortic dissection. Stratify risk based on the history of present illness and risk factors
- The presence of q waves in the above ECG is concerning for a previous MI. Though not 100% diagnostic, in the context of this presentation this should prompt consideration for emergent transfer
- Ongoing chest pain with an HPI concerning for ACS or PE should prompt emergent transfer, regardless of the ECG findings



A 40-Year-Old Veterinarian with Scaly Lesions

Figure 1.



Case

The patient is a 40-year-old man who presents with annular, scaly lesions on his arm which appeared over the past week. The patient is a veterinarian, and was diagnosed with type 2 diabetes last year.

View the photo and consider what your diagnosis and next steps would be. Resolution of the case is described on the next page.

THE RESOLUTION

Figure 2.

**Differential Diagnosis**

- Granuloma annulare
- Nummular dermatitis
- Psoriasis
- Tinea corporis

Diagnosis

This patient was diagnosed with tinea corporis—sometimes termed “ring worm.” It represents a skin infection by a dermatophyte species of fungus (either *Trichophyton*, *Microsporum*, or *Epidermophyton*).

Learnings

- Fungal organisms are transmitted to humans by direct contact with animals (which likely occurred in this case) or other people, or through fomites
- Tinea corporis usually appears as annular, erythematous, scaling plaques
- Infection may be pruritic or asymptomatic
- Disseminated tinea corporis may be seen in patients with diabetes, Cushing syndrome, malignancy, old age, or who are immunocompromised

Pearls for Urgent Care Management and Considerations for Transfer

- Treatment is tailored toward the fungal infection, underlying predisposing factors, and keeping the intertriginous areas as dry as possible
- Initial treatment could be a 7–14-day course of a topical antifungal cream, such as miconazole or clotrimazole
- Resistant cases may require oral antifungal agents, such as ketoconazole 22 mg/day or fluconazole 100 mg/day for 4–6 weeks
- Drying agents, such as cornstarch, talcum powder, or antifungal powders may be helpful in minimizing skin fold moisture



Reduction in Reimbursements for Modifier -25

■ DAVID E. STERN, MD, CPC

Q. Last fall, Anthem Blue Cross Blue Shield sent a notice to physicians in several states regarding their intent to reduce reimbursement rates on any evaluation and management (E/M) services billed with modifier -25, “significant, separately identifiable E/M,” by 50% effective January 1, 2018. What are the implications for urgent care?

A. This announcement initially spurred action from the California Medical Association (CMA), to coordinate with the American Medical Association (AMA), as well as other state medical and dermatology societies, to squelch the effort. Based on that feedback, Anthem then stated in early January 2018 that they would reduce the reimbursement by only 25% effective March 1, 2018. However, after more pushback from the CMA, AMA, and numerous other physician groups, Anthem rescinded its decision entirely and will not cut the reimbursement rate at this time.

Anthem Blue Cross Blue Shield previously sent letters to California providers warning them that they were closely monitoring these types of claims for possible overpayments. According to the March 9, 2018, issue of *Part B News*, Anthem says they are still “confident that duplication of payment for fixed/indirect practice expenses exists when physicians bill an E/M service appended with modifier -25 along with a minor surgical procedure performed the same day,” so look for future efforts from the payer on this front. With reimbursement rates topping \$2.5 billion in 2015 according to a *Part B News* analysis of Medicare claims data, it’s no surprise that these types of claims are a target for rate adjustment.

In order to protect your reimbursement for services performed and billed with an E/M code with modifier -25, you need to make sure you are documenting E/M services sepa-

“With reimbursement rates topping \$2.5 billion...according to a Part B News analysis of Medicare claims data, it’s no surprise that these types of claims are a target for rate adjustment.”

rately from the services included with the procedure. This could be a separate page, template, or dictation for each E/M and each procedure note.

These are some situations in which modifier -25 would be appropriately billed with the E/M service:

- When an E/M and a procedure are billed together and the diagnoses for each is the same.
 - Example: A patient comes into the urgent care center with an injured right hand, including an open wound. The provider is not familiar with the patient’s history, so they perform a full history. This should include potential issues that may indicate the risk of complications such as a history of diabetes, heart valve issues, medications such as immunosuppressant and/or anticoagulant medications, history of frequent infections, etc. The provider also may perform a full physical exam to evaluate for any indications of chronic conditions that could be unknown to the patient, the status of any of these conditions, and the ability of the patient to comply with instructions. Before repairing the laceration, the provider examines the hand, checks its mobility, and determines whether the wound has impacted any deeper structures such as tendons, joint capsules, or blood vessels, discusses the repair and potential complications with the patient, and then repairs the wound with sutures.

For this example, the provider billed a level 3 E/M service, or 99213, with a diagnosis of S61.411A, “Laceration without foreign body of right hand, initial en-



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counter.” The repair to the hand was 3.0 cm, so the provider also billed Current Procedural Terminology (CPT) code 12002, “Simple repair of superficial wounds of scalp, neck, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm” with the same diagnosis code. Because the provider did significant work before he started the actual procedure, an office visit may be billed along with the procedure. Modifier -25 would be appended to the E/M service code 99213.

- E/M and a procedure billed together with a different diagnosis for each:
 - Example: A patient is scheduled to see the provider in the urgent care center for a follow-up on a single laceration repair. The repair was simple, so there was no global period. The visit is documented and billed with the appropriate level of service for the E/M with modifier -25 appended and linked to the diagnosis

“Because the provider did significant work before he started the actual procedure, an office visit may be billed along with the procedure. Modifier -25 would be appended to the E/M service code.”

code for the laceration. While the patient is talking with the provider, he complains of severe wax build-up in his ears. A separate assessment confirms there is impacted wax in the right ear, so the provider would document the findings and service on a separate page or template and bill CPT code 69210, “Removal impacted cerumen requiring instrumentation, unilateral” with modifier -RT to indicate the service was performed on the right ear and use diagnosis code H61.21, “Impacted cerumen of right ear.” ■

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When is On-Demand Care Most In-Demand?

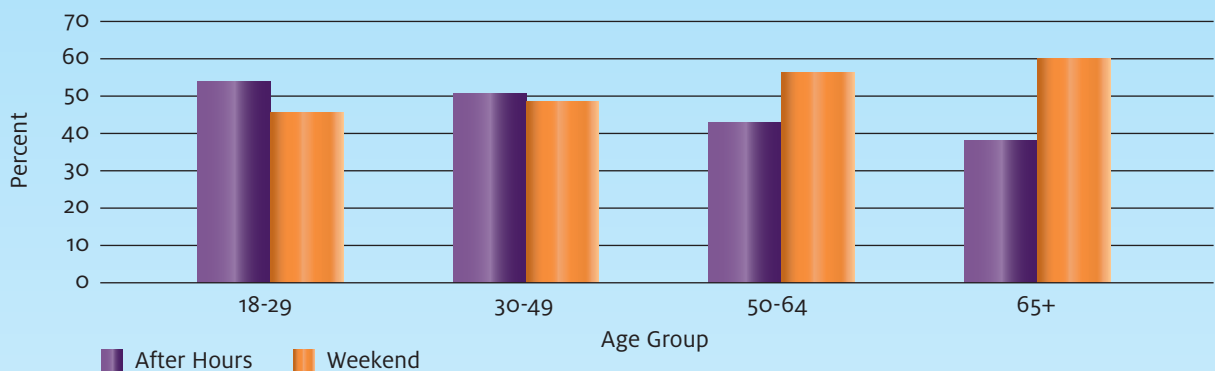
The combination of convenience and quality is the hallmark of the urgent care industry. As time goes on and patients have an increasing array of options, however, “convenience” may be a relative term (for example, virtual care is becoming more appealing to consumers and payers).

Urgent care has taken notice and continues to expand its offerings, from the foundational walk-in visits for a sore

throat to school physicals, return-to-work clearance, and support for cancer-related problems.

Many patient preferences are quantifiable by age. The most basic being, when is on-demand care most in-demand—and what matters most to those patients? The answers can be invaluable when it comes to scheduling staff and resources. We offer a few key insights below.

PATIENT PREFERENCES FOR VISITS OUTSIDE 'NORMAL' OFFICE HOURS



Data source: Advisory Board Market Innovation Center

In addition, each age group is influenced by its own set of decision factors that would be most likely to guide their choice of care site:

Age group	Influences
18-29	<ul style="list-style-type: none">• Online reviews• Comparison shoppers• Cost
30-49	<ul style="list-style-type: none">• Cost• Most open to virtual visits• Decision makers for both their own children and aging parents
50-64	<ul style="list-style-type: none">• Personal wellness• Multiple chronic conditions
65+	<ul style="list-style-type: none">• Hospital affiliation• Loyal to providers they like• Prefer providers close to home



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