

APRIL 2019 VOLUME 13, NUMBER 7





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Treating the Patient—and **Protecting Close Contacts-**When Pertussis Strikes

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Practice Management **Keep Patients** Coming Back by **Smoothing Out Their Financial Experience**



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URGENT PERSPECTIVES

Gimme a Break

■ JOSHUA RUSSELL, MD, MSC, FAAEM, FACEP

rediscovered the simple, profound power of taking breaks while battling through an episode of burnout. So striking was the transformation in how I felt about my clinical life that I was compelled to explore the science behind the value of taking breaks.

As providers, we have a paucity of natural break opportunities. There is always another patient to see, a note to finish, and an inbox of results to sift through. Additionally and importantly, we have an uphill battle should we have the audacity to actually take a break because there is an undeniable culture among clinicians to *simply push through*. Many clinicians bristle at the very notion of pausing, believing that a break will slow them down, keep patients waiting, and keep them at work longer.

However, abundant research in organizational psychology shows that our cognitive effectiveness is not fixed throughout the workday because mental vigilance wanes due to decision fatigue—the cumulative cognitive toll of the thousands of decisions, large and small, we make every shift. We become mentally drained, our mood worsens, and ultimately our decision-making faculties deteriorate. Multiple studies demonstrate that patients seen in the afternoon simply do worse: more unnecessary antibiotics in outpatient clinics, more adverse anesthesia events in operating rooms, and more missed polyps on colonoscopies.

We have an ethical obligation to mitigate the ill effects of decision fatigue. Fortunately, there is a simple solution. A few short breaks per day will do the trick.

This sounds simple enough, but the logistical challenges are many. Physical spaces conducive to pausing are not commonplace. In addition, taking time for breaks may make you stand out among your colleagues (like that sore thumb you're not taking care of right away while taking a breather). Rest assured, though, that taking breaks will make work less tedious and more enjoyable, actually improve our efficiency, and make us safer clinicians.



Joshua Russell, MD, MSc, FAAEM, FACEP practices emergency and urgent care medicine, and manages quality and provider education for Legacy/GoHealth Urgent Care. Follow him on Twitter: @UCPracticeTips.

Here are some tips for implementing breaks into your shifts: Realize that breaks needn't be long. A "microbreak" (1-2 minutes) every 2 hours is sufficient and much more practical than longer breaks.

Really unplug. Unfocused attention, or allowing the so-called "default mode network" to operate, is more restorative than logging into social media or checking email.

Rediscover nature. Getting some fresh air, even for a few minutes, has been shown to improve mood and reduce stress. Even looking out the window at the trees seems to confer similar benefits.

Talk to people (and not about work). Social interaction, which differs from goal-directed clinical interactions, is mentally restorative. Bonus: Getting to know your coworkers better improves team dynamics and effectiveness.

Meditate. Mindfulness practice improves what psychologists call "cognitive inhibition," which refers to our ability to tune out irrelevant stimuli. Get an app like One Minute Meditation, Headspace, or Calm. Close your eyes and just focus on your breath for several minutes.

Get a tea or coffee (and water). Change the scenery. Stay hydrated. Recaffeinate. What's not to love?

Get physical. There is an immediate boost in cognitive performance following short bursts of intense exercise. You can reap the benefits with simple calisthenics like push-ups, jumping jacks, and lunges. I go our staff locker room for 2 minutes every 2 hours. I meditate for 60 seconds, followed by 30 seconds each of jumping jacks and squats. Then, I take a big swig of water and head back out, always with renewed motivation and mental clarity.

After you begin to take breaks, you'll recognize when you're cognitively fatigued more readily and also have tools to address it. You will find the workday becomes transformed from one long slog to a series of manageable episodes, each with a fresh start boost.

For our sake and that of our patients, we need to change provider culture from the *push through it* mindset to one which acknowledges that we're human and need breaks to perform optimally. And you'll probably find, by taking a few breaks per shift, that you enjoy your job much more in the process.



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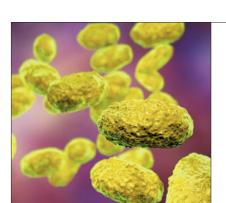


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CLINICAL

11 Suspected Pertussis in Infants and Adolescents—What to Do?

Patients presenting with signs of pertussis can be almost desperate for relief. Some even need emergent care. Quick recognition and management decisions—and knowing how to protect close contacts—are essential to positive outcomes.

Ellen Laves, MD

PRACTICE MANAGEMENT

Perfecting the Consumer Financial Experience in Your Urgent Care Center



Patients are more savvy about the financial aspects of healthcare these days and are becoming pickier consumers of healthcare as a result. Keeping pace with best practices in your urgent care operation is likely to pay off in the form of happy, loyal customers.

Alan A. Ayers, MBA, MAcc

CASE REPORT

A 44-Year-Old Man with Cough of Several Weeks' Duration



Clearly, lung cancer is outside of the range of services offered in urgent care. That doesn't mean undiagnosed patients experiencing early—or even advanced—symptoms won't be presenting, however (as this case proves). Jordan Miller, DO and Elise Ngalle, MD

HEALTH LAW AND COMPLIANCE

What Exactly Are Whistleblower Lawsuits—and How Can You Protect Your Urgent Care Operation?



Robust financial rewards are ample incentive for employees to blow the whistle on wrongdoing by their employer. In urgent care, claims most often concern straying beyond the bounds of the False Claims Act. Compliance is your best defense.

Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF JUCM

It's not uncommon for patients to present with heel pain of unknown origin. They haven't been pounding the pavement, running a marathon, or jumping off ladders. They just know they're in pain, and they want it to stop. You could just refer them to the podiatrist, but then they feel they've wasted their time coming to you, and in truth you really haven't done anything to help them. In many cases, you can keep those patients in-house and set them on their way to relief. In the May issue of JUCM, we will offer an original article on assessing patients with heel pain, focusing on the five most likely presentations you'll see.

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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 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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Address Changes

JUCM printed edition is published monthly except for August for \$50.00 by Braveheart Group LLC, 185 State Route 17, Mahwah, NJ 07430. Standard postage paid, permit no. 372, at Midland, MI, and at additional mailing offices. POSTMASTER: Send address changes to Braveheart Group LLC, 185 State Route 17, Mahwah, NJ 07430. Email: address.change@jucm.com



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o matter how consistently you inform new patients that your urgent care center is ready, willing, and able to meet their immunization needs there will always be those who don't have time, aren't sure what they need, or (worst) just don't believe in vaccinations. The problem is compounded by the fact that too many adults make that choice for their children. Add to that the fact that immunization can wane over time, and it's easy to see why some patients present with vaccine-preventable diseases.

One of them-pertussis, aka whooping cough-can be especially distressing and worrisome to parents because of the characteristic sound patients may make when they're coughing. The worries aren't only auditory, of course, as both the patient and their close contacts could face serious complications without the right management.

That's where our article Suspected Pertussis in Infants and Adolescents—What to Do? (page 11), comes in. The author, Ellen Laves, MD preaches familiarity with the immunization



schedule and explains why expertise in diagnosis and treatment should be well known to urgent care providers—for the good of their patients and the reputation of their practice.

Dr. Laves is assistant professor in Pediatrics at the University of California, San Francisco.

A patient presenting with a cough is at the center of this month's case report, too—though it's of a frighteningly different sort. In their article A 44-Year-Old Man with Cough of Several Weeks' Duration (page 27), Jordan Miller, DO and Elise Ngalle, MD relay the case of a middle-aged male who presents with a pesky cough that just won't go away. His visit to urgent care ended up being just the first step in a spiral that culminated with his demise, despite fast action on the part of the urgent care providers.

Drs. Miller and Dr. Ngalle are both with Adena Health System. Fortunately, relatively few patients presenting to urgent care confront that same fate. All have some degree of involvement with the financial aspect of seeking medical care in any setting, however. The urgent care operation that helps smooth that bumpy road can expect to have patients who are also very satisfied customers who will return as often as needed.

It's easier said than done, of course. Fortunately, though, Alan A. Ayers, MBA, MACC navigates us through this challenging issue in Perfecting the Consumer Financial Experience



in Your Urgent Care Center (page 17). In this new and original article, he discusses how changes in insurance plan design have resulted in greater financial exposure for patients—and how you can keep pace via financial systems and policies that align with emerging point-of-sale best practices.

Mr. Ayers is CEO of Velocity Urgent Care, LLC and is Practice Management Editor of The Journal of Urgent Care Medicine.

Mr. Ayers also lends his urgent care acumen to this month's Health Law and Compliance feature, on how to avoid finding yourself the subject of a "whistleblower" lawsuit. The short answer is, remain in compliance with applicable laws, especially the False Claims Act; that's a deceptively simple answer, however. To learn more about the nuances, your responsibilities, and your rights, read What Exactly Are Whistleblower Lawsuits—and How Can You Protect Your Urgent Care Operation?, starting on page 30.

In this month's Abstracts in Urgent Care (page 23), Joshua Russell, MD, MSc, FAAEM, FACEP looks at relevant literature concerning choice of antibiotics for cellulitis; increasing the cure rate



for cutaneous abscesses, treating children with minor abdomen trauma, and more. Dr. Russell practices emergency and urgent care medicine, and manages quality and provider education for Legacy/GoHealth Urgent Care.



(Dr. Russell also penned the latest Urgent Perspectives editorial—this one on the value of learning to take breaks in the interest of preventing burnout and maintaining your passion for prac-

ticing medicine. Flip back to page 1 to read it.)

And finally: One of the distinguishing characteristics of the 21st century urgent care center is the ability to offer x-rays on site. As technology evolves, however, so do methods of coding to ensure maximum reimbursement for the work you do. So, **David Stern, MD** explains how to apply to correct modifiers when coding for various modalities of x-rays. His Revenue Cycle Management column starts on page 43. Dr. Stern is CEO of Practice Velocity, LLC, NMN Consultants, and PV Billing

Thanks to Our Peer Reviewers

We rely on the urgent care professionals who volunteer to serve as peer reviewers to ensure we bring you relevant, unbiased articles every month. This month, we thank:

- Jason Amich, MBA, DHSc student
- Rob Estridge, BA, BS, MPAS, PA-C
- Toni Hogencamp, MD
- Janet Williams, MD, FACEP

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CONTINUING MEDICAL EDUCATION

Release Date: April 1, 2019 Expiration Date: March 31, 2020

Target Audience

This continuing medical education (CME) program is intended for urgent care physicians, primary-care physicians, resident physicians, nurse-practitioners, and physician assistants currently practicing, or seeking proficiency in, urgent care medicine.

Learning Objectives

- 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

Accreditation Statement



This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Urgent Care

Association and the Institute of Urgent Care Medicine. The Urgent Care Association is accredited by the ACCME to provide continuing medical education for physicians.

The Urgent Care Association designates this journal-based CME activity for a maximum of 3 AMA PRA Category 1 CreditsTM. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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- Lee A. Resnick, MD, FAAFP
 - Member reported no financial interest relevant to this activity.
- Michael B. Weinstock, MD
 - Member reported no financial interest relevant to this activity.
- Alan A. Ayers, MBA, MAcc
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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.

Suspected Pertussis in Infants and Adolescents—What to Do? (p. 11)

- 1. Which of the following characterize the catarrhal phase of pertussis?
 - a. Cough, coryza, and a low-grade fever
 - b. Paroxysms of cough
 - c. Paroxysms of "whoop"
 - d. Gradual decrease in coughing frequency and severity
- 2. Booster doses of DTaP vaccine should be given at:
 - a. 4-6 years of age
 - b. 11-12 years of age
 - c. 15 years of age
 - d. Both a and b
 - e. All of the above
- 3. Which of the following household contacts *are not* among those who should be offered prophylaxis within 21 days of exposure to pertussis, if asymptomatic?
 - a. Infants <12 months of age
 - b. Women in their third trimester of pregnancy
 - c. Women in their first or second trimester of pregnancy
 - d. Those with preexisting health conditions that could be exacerbated by pertussis
 - e. All of these should be offered a course or prophylaxis

Perfecting the Consumer Financial Experience in Your Urgent Care Center (p. 17)

- Patients may be inclined to pay cash for an urgent care visit:
 - a. If they are uninsured
 - b. Due to increased cost sharing
 - c. Because of rising deductibles
 - d. All of the above
 - e. None of the above
- An urgent care center can force a patient to use their insurance:
 - a. If they know the patient has insurance by virtue of a recent visit
 - b. Within the first 3 months of a calendar year
 - c. Always; since the Affordable Care Act took effect everyone is insured
 - d. Never

3. Which of the following practices can be helpful in making a patient's financial experience positive and seamless?

- a. Price transparency
- b. Charging a flat fee, plus the cost of any ancillary services or lab work
- c. Declining to accept any insurance
- d. Billing the patient directly and having them sort out what their insurer will pay

A 44-Year-Old Man with Cough of Several Weeks' Duration (p. 27)

- 1. Which of the following are risk factors for lung cancer?
 - a. Arsenic in drinking water
 - b. Previous radiation therapy
 - c. Radon exposure
 - d. Asbestos exposure
 - e. All of the above are risk factors for lung cancer
- 2. Which of the following is the leading cause of death due to cancer?
 - a. Lung cancer
 - b. Osteosarcoma
 - c. Pancreatic carcinoma
 - d. Ovarian cancer
 - e. Uterine cancer
- 3. In patients with a lung nodule found on chest x-ray, it is important for follow-up instructions to be:
 - a. Time-specific
 - b. Action-specific
 - c. Both a and b
 - d. Given by an oncologist
 - e. General, so as not to worry the patient



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FROM THE UCA PRESIDENT

Our Secret Sauce: The Big Five

SEAN MCNEELEY, MD

very successful organization has a way to focus on its mission. Over the last 5 years, your UCA Board of Directors and staff Lhave been working to assure the organization and our members are able to face the challenges of an evolving medical system and maturing industry. We have reinvigorated the College of Urgent Care Medicine (CUCM) and the Urgent Care Foundation (UCF) and retooled UCA for the future. We have a comprehensive strategic plan, mission, vision statement, and values. Most of this is on the new website. What is not there is the "secret sauce." First described by our past president, Steve Sellars, the Big Five are a great way to look at our success as an organization. Today, I am sharing them with you along with recent accomplishments in each category:

Membership

Our biggest advancement last year was implementation of new membership software that will allow us to serve you better. Special thanks to Jami Kral and the rest of the UCA team for accomplishing this huge feat. With this, we have expanded our membership and made it possible to add a CUCM membership to a group membership for just \$95. We added to the number of votes for newer membership levels, and an assortment of new member benefits that are too numerous to mention here but can be found at www.ucaoa.org.

Education

We now host one all-encompassing, annual convention and expo. It was a difficult choice to sunset the fall conference, but we knew we could provide you with the best product ever if we focused on just one event per year. We have partnered with Hippo Education through CUCM to provide an urgent care bootcamp to help clinicians prepare for whatever comes through the door. The Certified Urgent Care Management Professional designation will keep our management teams on the cutting edge. The Urgent Caring Newsletter hit year three and will



Sean McNeeley, MD is Network Medical Director, University Hospitals Urgent Care and outgoing President of the Urgent Care Association

expand significantly in coming months.

Advocacy

As we have grown and matured, many outsiders have begun to pay more attention to our industry. UCA has been there for you when lawmakers debated legislation that could hinder our ability to provide patients the care and access they need. We partnered with great organizations such as the North East Regional Urgent Care Association in these matters. We have even started a PAC to make sure we are there for our patients now and into the future.

UCA, CUCM, and UCF have taken a stand on antibiotic stewardship and are actively working with the CDC and the Antibiotic Resistance Action Center at George Washington University to safeguard these important medications for when we need them.

Our Accreditation process is growing and provides a way for organizations to show their focus on quality and safety to outsiders such as insurance companies, regulators, and government officials. We don't require it but others do so we have provided a process with a strong urgent care emphasis.

Relationships

We have been seeking to partner with those who can help you, our members. Vendors, other organizations, and government agencies are just the beginning of those we have been working with. We also are constantly working to strengthen our relationship with you, our members.

Communication

Communication with our members, patients, insurers, other organizations, and governmental agencies is essential in assuring that our industry and its importance to our patients is understood, and that it continues to be a high-quality, low-cost, and convenient option for all those in need of urgent care.

By the time you read this, my time as UCA Board President will be over. I now move into the past president position and wish Dr. Richard Park all the best as I pass him the baton. Although this article is not about me, I want to thank those who made this year go smoothly including my fellow board members, the UCA staff, and particularly our CEO, Laurel Stoimenoff.

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Suspected Pertussis in Infants and Adolescents—What to Do?

Urgent message: Familiarity with the schedule for immunization against pertussis, as well as expertise in diagnosing and prescribing treatment, should be within the urgent care provider's capabilities—as should the ability to distinguish which patients require transfer to a higher-acuity setting.

ELLEN LAVES, MD

Case #1

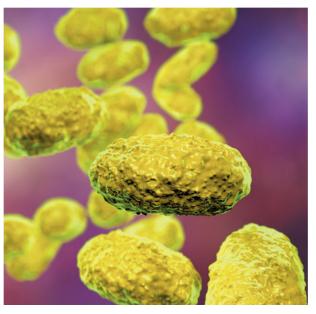
A 5-month-old ex-term, fully immunized otherwise healthy female infant presents with 5 days of cough, congestion, and a tactile fever; however, the mother is most concerned about the cough. She describes coughing "fits" which last approximately 30 seconds, during which the infant cannot catch her breath and turns a ruddy color. She denies emesis, apnea, or poor feeding. The infant is afebrile with a respiratory rate of 40 and heart rate of 120. She is well-appearing with nasal congestion and a benign lung exam. The provider suspects pertussis but is unsure about hospitalization, antibiotic therapy, and treatment of household contacts.

Case #2

A 17-year-old male presents to urgent care with 2 weeks of cough, congestion, and a low-grade fever. His congestion and fever have resolved; however, his cough has persisted and he has been unable to return to school or drive because of frequent coughing fits that last up to 60 seconds and are sometimes followed by vomiting. He received his Tdap booster at age 11 years and is otherwise fully immunized. On exam, he is well-appearing, with clear lungs, and has two witnessed episodes of coughing where he is unable to catch his breath. The provider suspects pertussis, but is unsure if this can be diagnosed in an immunized patient and if there is a role for diagnostic testing of an adolescent patient.

Microbiology and Immunity

pertussis is a toxin-mediated disease caused by the gram-negative coccobacillus *Bordetella pertussis*. Toxins produced by *B pertussis* impair ciliary clearance of pulmonary secretions through the paralysis of normally beating cilia.¹



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Childhood immunity to pertussis is conferred through the acellular pertussis vaccination, which comes in two forms: DTaP and Tdap. Children are immunized with DTaP at 2 months, 4 months, 6 months, and 15-18 months of age. A booster dose of DTaP is given at 4-6 years old, and a second booster dose of Tdap is given at 11-12 years of age.² The risk of acquiring pertussis increases six-fold after the fifth year following the initial 5-dose DTaP regimen.^{3,4} Similarly, vaccine effectiveness can wane to approximately 34% in the 2-4 years follow-

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Table 1. Risk Factors for Pertussis-Related Complications

- Infants <4 months old
- Unimmunized or underimmunized children
- Patients with <2 weeks of symptoms
- Prematurity; over half of infant fatalities occur in those born at <37 weeks

ing a dose of Tdap.5 Risk of pertussis is highest in infants, children who are not fully immunized, and older children with waning immunity.

Clinical Course

The clinical course of pertussis classically follows three stages: catarrhal, paroxysmal, convalescent. The catarrhal phase lasts approximately 1-2 weeks and is often mistaken as a viral upper respiratory infection, as it includes cough, coryza, and a low-grade fever. The paroxysmal phase can last up to 10 weeks and usually prompts the clinician to consider the diagnosis of pertussis. During the paroxysmal phase, the patient has paroxysms of cough followed by an inspiratory whoop and post-tussive emesis or gagging. The patient can have either a ruddy or cyanotic color change. The convalescent phase lasts 2-3 weeks and is characterized by a gradual decrease in coughing frequency and severity. 1,6

Pertussis in infants

Infants are most likely to have an atypical clinical course which is characterized by a short catarrhal phase and a more severe and atypical paroxysmal phase. Instead of paroxysms of cough with post-tussive emesis, infants may have gagging, gasping, bradycardia, and apneic events with the absence of the classic inspiratory whoop. 1,6,7 Infants are therefore at risk for severe complications associated with the apnea and bradycardia that may require hospitalization, especially when accompanied by hypoxemia or cyanosis. Infant pertussis can progress to pneumonia or death. 1,2,6,7 Infants < 2 months of age who are not eligible for their first DTaP are at the highest risk of death from pertussis.8

Pertussis in adolescents/adults

Pertussis presenting in older children and adults follows a typical course, with prolonged cough often accompanied by the classic inspiratory "whoop." Adolescents and adults who have been previously immunized may have milder illness with prolonged dry/harsh coughing fits in the absence of the classic "whoop."

History Pearls

When considering the diagnosis of pertussis, clinicians should consider the following questions:

Question 1: What is the likelihood that the patient has pertussis?

The diagnosis of pertussis can be made when a patient presents with classic clinical symptoms as described above. Laboratory testing is not required to initiate treatment, especially since early treatment during the catarrhal phase can improve the clinical course of the disease.⁶

Clinicians should discuss the nature of the cough with the family, specifically asking whether the cough comes in prolonged bursts and is followed by an inspiratory whoop and post-tussive emesis or gagging. The lack of inspiratory whoop or post-tussive emesis in young infants should not preclude the consideration of pertussis if the cough is paroxysmal. Infants presenting solely with apneic events should also prompt the consideration of pertussis and a transfer to the ED. Vaccination-conferred immunity wanes over time. Therefore, a fully immunized child can still be infected with *B pertussis*.³⁻⁵

The likelihood of pertussis also increases with known exposures to pertussis. Clinicians should therefore not only discuss the symptoms of the patient, but also ask about other members of the household who may have symptoms concerning for pertussis.

Question 2: Is the patient at risk for complications?

Complications include apnea, bradycardia, pneumonia, and death. There are no existing clinical decision rules to assess risk; however, studies point to certain groups who are at highest risk for severe complications as seen here and in Table 1.

- Infants (<4 months old): Infants demonstrate decreasing rates of complications with increasing age.^{6,9} Infants <4 months old are at highest rates of severe complications.^{3,9,10}
- Unimmunized or underimmunized children: While vaccination does not prevent pertussis infection, it can attenuate the severity of the disease.⁸⁻¹⁴ Even a single dose of DTaP can impact infant mortality, and the odds of complicated pertussis decreases with increasing doses of DTaP.^{8,9,11}
- Short disease duration: Patients with <2 weeks of symptoms are at higher risk of severe pertussis complications, including ICU hospitalization, assisted ventilation, and death.8,9
- Prematurity: Premature infants have demonstrated increased risk for mortality, with 51% of fatal infant

cases occurring in infants born at <37 weeks and 29% occurring in infants born at <35 weeks gestational age. It is unclear what corrected gestational age mitigates this risk.

Question 3: Are the close household contacts at risk?

The clinician should query the family regarding ages of any household contacts and pregnancy status, and whether household members have contact with infants/children, pregnant women, or elderly persons. Finally, the clinician should ask about the immunization status of the household members and whether they currently have pertussis-like symptoms.

Exam Pearls

The clinician's exam should focus primarily on the pulmonary exam, specifically focusing on evidence of respiratory distress, hypoxia, or focality on auscultation. The clinician should also pay special note to the patient's hydration status, as infants are prone to have feeding difficulties.

Testing and Management

Testing

Laboratory options include pertussis culture or pertussis PCR, both of which can be collected via a nasopharyngeal swab or aspirate.² Pertussis culture has high specificity but relies on live bacterium and therefore is less sensitive later in disease course and in the setting of prior antibiotic use. Pertussis PCR has higher sensitivity as it does not rely on live bacterium, but individual tests can vary in specificity. The CDC recommends that culture be used within the first 2 weeks of cough onset and PCR within the first 4 weeks of illness.²

Antibiotic therapy

Regardless of age, antibiotic therapy should be initiated prior to or in the absence of testing for any child who has a clinical picture that is strongly suggestive of pertussis, or for a child at high risk of pertussis-related complications. Early antimicrobial therapy may attenuate the severity of the disease, especially if it is administered during the catarrhal phase when live bacterium are still present, ^{1,6} and will help curtail spread of disease. As the disease is toxin-mediated, treatment initiation later in the disease may have little impact on symptoms, but is still worthwhile as it decreases the risk of transmission.

Antibiotic options are outlined in **Table 3**. Azithromycin is the first-line medication recommended for both treatment and prophylaxis of pertussis, especially

Table 2. Management Dilemmas in Patients with Suspected Pertussis

Infants

- When to hospitalize
- When and how to treat
- When to treat or provide prophylactic treatment to household contacts

Adolescents

- When and how to treat
- Role of antibiotic treatment
- Symptom relief
- When to return to school or work

in young infants who may be at risk for complications with other agents, including kernicterus and idiopathic hypertrophic pyloric stenosis.²

Admission

The decision of whether to admit will be based on the clinical exam and the patient's overall risk for developing severe pertussis. Symptoms such as respiratory distress, hypoxemia, apnea, cyanosis, or dehydration would suggest a need for hospitalization or prolonged observation. Infants who require admission for management of apnea or bradycardia should be admitted to an institution with pediatric expertise, and preferably a pediatric intensive care unit. High risk factors for pertussis complications include infants less than 4-monthsold, infants with history of premature birth, and immunocompromised patients.

Management of close contacts

Even if we are not caring for other family members during the encounter, it is important to curtail the spread of disease and manage close contacts. Household contacts should be offered a course of prophylaxis within 21 days of exposure if asymptomatic, and treatment if symptomatic,² especially if underimmunized. Prophylaxis should also be considered in nonhousehold, close contact exposures who meet high-risk criteria, including:

- infants <12-months-old
- pregnant women in their third trimester of pregnancy
- preexisting health conditions that could be exacerbated by pertussis
- close contact (spread potential) with other highrisk individuals (eg, physicians, daycare attendants, nursing home workers, etc.)

Reporting

Clinicians should complete the appropriate reporting forms to their state department of public health when initiating treatment for pertussis.

Patient age	Primary (preferred) options		Secondary options	
	Azithromycin	Erythromycin*	Clarithromycin	TMP/SMX [†]
<1 month	Recommended agent for infants <1 month of age; 10 mg/kg per day in a single dose x 5 days	40-50 mg/kg per day in 4 divided doses x 14 days	Not recommended	Contraindicated in infants <2 months of age (risk for kernicterus)
1-5 months	10 mg/kg per day in a single dose x 5 days	See above	15 mg/kg per day in 2 divided doses x 7 days	Contraindicated in infants <2 months of age (risk for kernicterus)
				• For infants ≥2 months TMP 8 mg/kg per day; SMX 40 mg/kg per day in 2 divided doses x 14 days
≥6 months	10 mg/kg as a single dose on day 1 (maximum 500 mg); then 5 mg/kg per day as a single dose on days 2-5 (maximum 250 mg/day)	40 mg/kg per day in 4 divided doses for 7-14 days (maximum 1-2 g per day)	See above (maximum 1 g/day)	See above
Adolescents and adults	500 mg as a single dose on day 1 then 250 mg as a single dose on days 2-5	2 g/day in 4 divided doses x 14 days	1 g/day in 2 divided doses x 7 days	TMP 32 mg/day, SMX 1600 mg/day in 2 divided doses x 14 days

Symptom relief

As pertussis is a toxin-mediated disease, the cough may last for a significant amount of time after the bacterium is cleared. The cough can be debilitating and impact the quality of life for the child and their family. As the cough is a reaction to the damaged cilia, there are very few remedies that will impact the patient's symptomatology. Importantly, the FDA recommends against the use of codeine or hydrocodone in all children and does not recommend using any over-the-counter cough or cold medications in children less than 2 years of age. 12

Back to school, work, or daycare

Patients may return to school following completion of 5 days of antimicrobial therapy and if their symptoms are reasonably managed. Patients who do not receive therapy should be excluded from school until 21 days after the onset of symptoms. $^6 \blacksquare$

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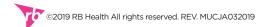
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¹Cepacol* is the #1 Recommended product in the Sore Throat Lozenges category in the US among the Universe of Physicians (IQVIA, ProVoice Survey). Period from June 1, 2017 to May 31, 2018.

⁹MUCINEX* Children's is the #1 Pediatrician Recommended non-antihistamine, multi-symptom brand in the Children's Cough/Cold category among the Universe of Pediatricians (IQVIA ProVoice Survey). MAT 52 weeks through February 2018.





Perfecting the Consumer Financial Experience in Your Urgent Care Center

Urgent message: Changes to insurance plan design are resulting in increased financial exposure for patients, with urgent care providers scrambling to adapt to the associated rise in patient consumerism. It therefore behooves the urgent care provider to evolve their financial systems and policies such that they align with emerging point-of-sale best practices in order to meet patient expectations, enhance the revenue cycle, and cultivate patient loyalty.

ALAN A. AYERS, MBA, MACC

As the number of healthcare patients with highdeductible health plans (HDHPs) has grown tremendously over the past decade, patient consumerism has grown right along with it. Responsible for larger and larger portions of their healthcare bill, patient expectations have definitely shifted. No longer passive recipients of their healthcare, today's patients demand competitive pricing and all the other hallmarks of a traditional consumer marketplace: convenience, access, high quality, and a frictionless financial transaction.

In addition to burgeoning consumerism, a secondary (and correlated) consequence of proliferating HDHPs is the creation of a larger class of patients who are underinsured. These "underinsured" patients (ie, having coverage plans with low monthly premiums but high deductibles) face high out-of-pocket costs relative to their incomes, causing them to weigh their point-of-care decisions carefully. And when they decide a medical visit or procedure doesn't make sense for them financially, they'll react in one of several ways: delay or forgo care, not pay their share of the bill, self-diagnose and/or treat with over-the-counter medications, or bypass their HDHP and pay out-of-pocket.

How Underinsured Urgent Care Patients Behave

Underscoring the issue, a frequent observation in urgent care centers is an increase in the number of patients with



insurance who choose to pay cash instead. Front-office staffers consistently see patients who are listed with one insurance in the system come into the clinic, tell the receptionist they're uninsured, and request to pay cash.

Cash-pay used to be for the uninsured but, again, the landscape has shifted. Since enactment of the Affordable

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Care Act, technically, nobody should really be "uninsured," but increased cost sharing and rising deductibles can make healthcare cost-prohibitive. As such, this encourages some covered patients to behave as if they're uninsured regardless. For the urgent care operation's part, when servicing a patient who's insured by an in-network carrier, they're required by the insurance contract to take the patient's copay and bill the insurance. An urgent care center cannot, however, force a patient to use their insurance.

"Policies must be implemented to elevate the financial experience, bring these patients back into the fold, and engender long-term loyalty to the provider."

These "covered but cash pay" patients are savvy consumers who understand they have an HDHP—making them responsible for the cost of their entire visit—and that their total cost will likely be lower if they go ahead and pay out-of-pocket at the time of service. In effect, they're playing the financial long game. But the urgent care "charge master" of prices typically isn't disclosed to the public, so how are patients determining that an outof-pocket cash payment would ultimately be less expensive? Through either experience, or an understanding of the way their coverage works.

When an urgent care operator bills insurance, for instance, it is common to charge an elevated rate (typically, 200%-300% of Medicare), knowing that the insurance company will adjust the bill down to the contracted amount. If an insurance contract pays, say, \$165, the urgent care may bill insurance \$200 to assure it receives the highest allowable reimbursement and no money gets left on the table. Any amount not reimbursed by insurance can be written off. Additionally, some urgent care centers add billable codes correlated to night/weekend or walk-in availability, which may or may not be reimbursed by insurance and frequently get written off.

So, if the patient wound up responsible for the bill, they could be charged the entire billable amount or the insurance-contracted amount, either of which might be higher than if the patient had paid cash. Smart patients with HDHPs that leave them underinsured understand this and are increasingly opting to pay cash at the time of service.

The Revenue Cycle and the Patient Financial Journey In short, the proliferation of HDHPs has helped create

a significant number of both underinsured cash-pay patients, and financially distressed patients who forgo care altogether. While the two can often overlap, when taken together they present both a challenge and an opportunity for healthcare providers.

For the cash-pay patient steeped in the tenets of health care consumerism, convenience is king. As they shoulder a greater share of their healthcare financial burden, they demand easy access, financial transparency, and a frictionless financial transaction—and have

demonstrated the willingness to shop providers until they find one that delivers.

For those who forgo care due to perceiving it to be unaffordable, patient advocacy and financial counseling become paramount. When this patient fully understands their bill, their financial obligations, and their payment options, and their questions and fears are addressed at each juncture, their loyalty and resulting healthcare spend can be recaptured. Even patients with adequate insurance coverage are empowered in this consumerism-driven era, and demand similar levels of improved quality, value, transparency, and convenient financial transactions.

As mentioned, these patient groups can be one and the same; instead of a clear line of delineation between them, they frequently overlap depending on the situation. Regardless, the urgent care revenue cycle, particularly at the point of sale, must be better optimized to serve patients at each point of their financial journey. From preregistration through billing and payment, postvisit, and collections, payment mechanisms, technology, and policies must be implemented to elevate the financial experience, bring these patients back into the fold, and engender longterm loyalty to the provider.

With that in mind, the following sections will spotlight current best practices in the areas of convenience, access, transparency, and ease of the financial transaction, and offer suggestions and strategies for carrying them out in your urgent care center. We'll also take a brief look at the Portland, OR-based Zoom+Care urgent care operation, and how its systems and policies are allowing the chain to flourish in a consumer-driven healthcare market.

Convenience/Access

Today's consumer has grown accustomed to leveraging technology and tools to access products and services when they need them, where they need them. They reserve restaurant seats, order meals ahead of time, request grocery delivery, and arrange transportation (eg, Uber, Lyft) through apps on their phone. In short, they interact with these service providers on their own terms, in ways that fit their schedule and lifestyle. And as healthcare patients who embrace consumerism, they expect providers to deliver the same level of access and convenience. Hence, an urgent care center that seeks to capitalize on patients' desire for convenience

should implement the following technologies:

- Online queueing system This technology allows patients to "reserve" their spot online, and shift their waiting location from in the clinic lobby to their car while they run errands, or even the comfort of their own home. Patients would be able to reserve their spot from any web-enabled device and receive text alerts for time estimates for when it's their turn to see the physician, or if any unexpected delays occur. While this convenience isn't the same as an actual appointment, it does allow the patient to wait on their own terms the same way they do with restaurant call-ahead seating and other services.
- E-registration/preregistration system After reserving their spot online, patients should also have an option to register their demographics and medical/social history online. This feature saves them the inconvenience of having to fill out a clipboard or tablet in the lobby or exam room, which allows them to speed up their visit. It also gives the patient an opportunity to look over their information to ensure that it's accurate ahead of the visit, avoiding potential delays and registration errors that could lead to a claim denial.
- Online patient portal Urgent care centers should invest in full-featured online patient portal technology to afford patients' around-the-clock remote access to their personal health information. This technology also serves to shift some administrative tasks away from front office staffers, freeing up valu-

"Urgent care providers must closely examine their patient-facing revenue cycle operations and strive to put systems and mechanisms in place toward making the financial experience positive and seamless."

able time to focus on in-person patient care. A secure passwordprotected portal should provide the following features and access to patients:

- Two-way private messaging with the provider and/or urgent care staff for health questions and concerns
- The ability to view personal and private health records, patient history, and view/print their chart
- Labs, test results, and their medication list
- Refill requests
- Follow-up appointment scheduling and upcoming appointment
- Email and text notifications
- Marketing-focused push notifications (eg, sports physical promotions, flu shots)
- Online patient bill pay Today's patient should have an easy, convenient way to pay their medical bills from their mobile device, either in-clinic or at home. Investing in an online payment solution where patients can access their account balance information and submit a secure credit card payment helps to streamline the payment process and significantly bolster collections.

Point-of-Sale Financial Best Practices

The financial behaviors of the growing pool of HDHP patients can negatively affect financial outcomes of providers across the healthcare landscape. As noted earlier, cash-strapped patients concerned that they can't afford treatment may forgo it altogether, whereas other patients who are confused about their financial obligations, face surprise charges, or experience frustrations about how and when to pay are likely to experience high levels of dissatisfaction. Urgent care providers, therefore, must closely examine their patient-facing revenue cycle operations and strive to put systems and mechanisms in place toward making the financial experience positive and seamless, which patients are increasingly demanding. These include:

■ **Price transparency** – The first principle in elevating the financial experience is eliminating price uncertainty. Consider: What other competitive service industry has the kind of baked-in price uncertainty

Zoom+Care: A Brief Look at a Thriving, Consumerism-Based Urgent Care Model



Dating all the way back to 2006, the Zoom+Care urgent care operation in Portland, OR has been at the forefront insofar as meeting the demands of patient consumerism. Implementation of mobile technology throughout the platform, online scheduling, telemedicine, and flat and transparent pricing are among the patient-centered features that has allowed Zoom+Care to thrive and serve as an exemplary example of the kind of "outside the box" innovation that's possible in the urgent care space. Here, we take a brief look at the way the model leverages technology, policies, and payment mechanisms toward excellent patient service.

Zoom+Care (35 locations) breaks the day down into 15 minute "appointments" which patients book online. A credit card is required to schedule one of these appointments, and if a patient cancels with less than a 1-hour notice, their card gets charged \$99. Because of this practice, Zoom+Care does not accept Medicare, Medicaid, or Tricare. The advantage of this practice is it smooths the ebb and flow of a walk-in clinic by pacing

arrivals in 15-minute increments. It also optimizes productivity of the providers and staff and facilitates diversion to nearby locations if a clinic is particularly busy. Patients who know exactly when the provider will be available to see them have greater control over their wait, vs being "stuck" in a waiting room.

Additionally, Zoom+Care has a "safety net" payment policy: If your insurance company isn't able to verify your benefits, the clinic collects the total cost at the time of your visit and issues a refund once they receive payment from your insurance company (typically, within 30 to 45 business days). This policy saves the company money, as it's far less expensive to issue refunds on credit card charges than to pursue unpaid accounts through collections, which often results in write-offs.

Additionally, Zoom+Care has a comprehensive price list posted in-clinic and online, with one flat cash price of \$165 for an injury or illness visit (medications and lab tests extra).

Unlike urgent care centers who sometimes try to "jury-rig" an insurance fee schedule for cash patients (including offering 25%–35% prompt-pay discounts on rates that are not transparent to patients), there are no surprises for Zoom+Care patients. Zoom+Care's pricing is also consistent with the trend toward insurance "case rate" or flat-fee payment from insurance, regardless of services performed. The downside is they may be leaving money on the table for higher-reimbursing procedures (such as suturing or ortho cases, for example).

Lastly, Zoom+Care does not accept cash or checks. A debit or credit card is required to make a reservation and payment. Going cashless greatly helps operationally as Zoom+Care staff don't have to worry about the hassles associated with cash handling, safes, change kitty, daily bank runs... and it's a trend that more and more retail businesses seem to be embracing.

that has plagued healthcare for decades? Few, if any. Urgent care providers who lag here must therefore move to ensure that their clinic features full price transparency for all services and procedures, which can then be compared by the patient with other urgent care providers. To that end, there should be a large menu board with posted pricing in the lobby, and price listings on your website, social media channels, and any other viable touchpoints. Additionally, there should never be any surprise charges after the visit.

■ Frictionless financial transaction – The point-ofsale urgent care financial transaction must evolve from its current state, with several fragmented processes, to an integrated, comprehensive system that eliminates friction and results in a seamless financial transaction, ending with payment for service being collected. In urgent care, the financial transaction entails confirming the patient's information, verifying insurance, identifying any deductibles/copays/co-insurance or other patient responsibility, notifying the patient of prospective balances due, and collecting payment. The point-of-sale financial process should also entail registration quality assurance. This would involve staff members verifying that the information entered on each other's computer systems is correct; this can be performed during lulls or slow periods. Such a redundant system of

checks and balances to ensure that patient information is correct up front can prevent hassles and payment delay errors on the back end.

- Financial counseling/advocacy – The role of the front desk today has become much more complex than simply "medical receptionist." Indeed, the front desk function must now include financial counseling, which is crucial for helping patients understand the benefits provided by their employer or the government, what services they can afford through either their insurance
 - or out-of-pocket, and the options they have for paying their bill.
- Credit card preauthorization When a patient's financial obligation cannot be definitively ascertained at the time of service, the practice of credit card preauthorization can be an effective safety net. The process begins with the urgent care operation swiping the patient's credit card, then placing an authorization on the account for the anticipated charge of the visit. Once the patient signs off to approve the authorization, the medical visit proceeds after which the patient is notified by email of the calculated charges. Finally, the patient's card is either charged within 7 days, or the authorization is released when insurance is verified.
- Clear, consolidated billing Rather than create separate bills for imaging, labs, etc. there should be one consolidated bill for all services during the visit. Additionally, the billing statement should be created in a way that makes it easy for the patient to understand the charges and to pay it in a single transaction. Financial counseling should be available at any point where there is confusion about a charge or service, or an explanation of insurer benefits is necessary. It cannot be understated how important a touchpoint the billing and collections process is in cultivating patient satisfaction and loyalty. Frustrated and confused patients will look for another provider, while happy patients will return.

Conclusion

As patients increasingly bear the brunt of financial respon-

"When a patient's financial obligation cannot be definitively ascertained at the time of service, the practice of credit card preauthorization can be an effective safety net."

sibility for their own healthcare costs, they'll continue to embrace the tenets of consumerism. This puts the onus on healthcare providers to adapt their service models such that convenience, access, and frictionless financial transactions are no longer regarded as a perk, but rather an integral part of the business model. Today's patients—accustomed to high quality and value through their other service providers—demand nothing less and are voting with their pocketbooks to prove it.

Urgent care, therefore, must grasp the enormous revenue opportunity in aligning with policies, procedures, and mechanisms

that elevate the patient financial experience, and embrace them wholeheartedly at every point in the patient's financial journey. Doing so will allow urgent care providers to better compete in an ever-growing market, meet consumer demands, and capture longterm patient loyalty. ■

Summary

- · Rising deductibles and use of cost-sharing increase financial burden even on insured patients, leading some to behave as if they are uninsured. While an urgent care operator is required by insurers to collect copays and bill insurers for services rendered, they cannot force patients to use their insurance.
- Proliferation of high-deductible health plans has helped create a significant number of both underinsured cashpay patients and financially distressed patients who forgo care altogether.
- As healthcare "consumerism" increases, patients become more inclined to demand easy access, financial transparency, and a frictionless financial transaction. Some may even "shop providers" until they find one that delivers on their expectations.
- Urgent care centers seeking to capitalize on patients' desire for convenience should implement the following technologies:
- Online queueing system
- E-registration/preregistration system
- Online patient portals
- Online patient bill pay

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ABSTRACTS IN URGENT CARE

- Oral or IV Antibiotics for Cellulitis?
- Increasing the Cure Rate for Cutaneous Abscesses
- Children with Minor Abdomen
 Trauma
- JOSHUA RUSSELL, MD, MSC, FAAEM, FACEP

- Think Twice Before Skipping a Pelvic Exam
- Rebound Nasal Congestion

Rethinking IV Antibiotics for Cellulitis

Key point: Oral antibiotics are noninferior to parenteral antibiotics for uncomplicated cellulitis. Erythema of cellulitis commonly expands somewhat, even if treated with appropriate antibiotics, for the first 1-2 days after starting treatment. Citation: Aboltins CA, Hutchinson AF, Sinnappu RN, et al. Oral versus parenteral antimicrobials for the treatment of cellulitis: a randomized non-inferiority trial. J Antimicrob Chemother. 2015;70(2):581-586.

Patients with cellulitis are often referred from urgent care to the emergency department for "IV antibiotics." This practice is based on the common belief, dogma even, that IV antibiotics are somehow more potent and effective. The investigators in this study wanted to assess the validity of this assumption. Their results are compelling and cast serious doubts on this line of thinking.

The researchers randomized 47 patients referred to an Australian ED for extremity cellulitis to receive either IV (cefazolin) or PO (cephalexin) antibiotics. Importantly, they included patients with fever and diabetes. Patients with concerns for *severe* sepsis and/or necrotizing fasciitis were excluded. The outcome of interest was time to cessation of advancement of cellulitis. Rates of pain at 7 and 28 days post initiation of treatment and treatment failures were also measured.

Both groups showed progression of erythema for 1-2 days after initiation of treatment. The mean time required for erythema to stop spreading was 1.29 days in the oral antibiotic group vs 1.78 days in the IV antibiotic group. Treatment failure



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was relatively rare (<25%) in both groups. A higher rate of treatment failure actually was observed in the IV antibiotic group; however, this difference was not statistically significant.

While patients with significant cellulitis are commonly sent from urgent care to the ED, and often even admitted to the hospital for IV antibiotics, this practice probably doesn't improve patient-centered outcomes and certainly adds to cost and risk for iatrogenesis. Cellulitis certainly can look scary. However, in reliable patients who can follow up or return if clinically declining and who do not appear to have necrotizing fasciitis or sepsis with extremity cellulitis, starting with a trial of oral antibiotics, even in severe cases, is a reasonable, safe, and effective treatment strategy.

The Latest on PO vs IV Antibiotics and Cellulitis

Key point: Presence of tachypnea, chronic skin ulcers, history of MRSA infection, and prior cellulitis in the preceding year were associated with failure of oral antibiotics for cellulitis. Patients with these features should be warned they may require more aggressive therapy.

Citation: Yadav K, Suh KN, Eagles D, et al. Predictors of oral antibiotic treatment failure for nonpurulent skin and soft tissue infections in the emergency department. *Acad Emerg Med*. 2019;26(1):51-59.

The vast majority of patients with cellulitis can be diagnosed clinically and treated adequately with oral antibiotics. Occasionally, however, patients may fail to improve as quickly as desired with PO antibiotics alone.

In this retrospective chart review of 288 Canadian ED patients receiving oral antibiotics, the researchers explored which features of patients' histories and presentation were associated with failure of PO therapy. Treatment failure was defined as

ABSTRACTS I N URGENT CARE

"Even when available, CT imaging is undesirable in children without apparent serious injury due to the associated high dose of ionizing radiation."

admission or antibiotic change >48 hours after the initial visit. In this study population, treatment failure occurred in 29.5% of patients. This is likely partially attributable to a sicker group of patients than we commonly see in urgent care because this was an ED-based study. The finding most predictive of failure of PO antibiotics was tachypnea at triage (odds ratio [OR] 6.31), followed by presence of chronic ulcers (OR 4.9), and history of MRSA (OR 4.83). History of cellulitis in the preceding year was also slightly predictive of PO antibiotic failure (OR 2.23).

Importantly, failing oral antibiotics was not associated with major adverse outcomes, but rather requiring a change in antibiotic and/or hospitalization. The odds ratios are relatively low for each identified risk factor for treatment failure, implying that many patients even with chronic skin ulcers, for example, will still respond well to PO antibiotics. However, the urgent care clinician should take a moment to warn patients about the slightly higher probability of needing more aggressive therapy if they have cellulitis and these risk factors for treatment failure.

Is Getting the Pus Out Enough?

Key point: Treatment with antibiotics in addition to incision and drainage increased the cure rate in patients with cutaneous abscesses.

Citation: Gottlieb M, DeMott JM, Hallock M, Peksa GD. Systemic antibiotics for the treatment of skin and soft tissue abscesses: a systematic review and meta-analysis. Ann Emerg Med. 2019;73(1):8-16.

Antibiotics for abscesses: Should we or shouldn't we? The pendulum has swung back and forth on this issue with alarming frequency. In their 2014 guidelines, the Infectious Disease Society of America (IDSA) recommended I&D strongly for virtually all purulent skin infections, but systemic antibiotics only in select cases.

In this meta-analysis, the authors analyzed an impressive 2,406 patients with skin abscesses across four randomized controlled trials of I&D plus antibiotics or placebo. What they found was noteworthy. Patients treated with systemic antibiotics were 8.4% more likely to achieve clinical cure compared with I&D alone (NNT = 14). Patients treated with antibiotics were also less likely to develop new purulent skin infections (NNT = 10). There was, however, a 4.4% increase in risk of adverse events in the antibiotic treatment group, as would be expected. Most adverse reactions were minor.

Finally, it is worth acknowledging that 49% of infections were due to MRSA, providing further evidence to support the practice of empirically covering for MRSA when choosing to use antibiotics for purulent skin infections. These data allow urgent providers to have a more informed risk/benefit discussion about the use of antibiotics after I&D in cases of cutaneous abscesses.

Clearing the Belly in Kids with Blunt Trauma

Key point: Use of the PECARN clinical decision rule can safely identify children at very low risk of clinically important intraabdominal injuries (CIIAI) after blunt trauma.

Citation: Springer E, Frazier SB, Arnold DH, Vukovic AA. External validation of a clinical prediction rule for very low risk pediatric blunt abdominal trauma. Am J Emerg Med. 2018; S0735-6757(18)30943-30944.

Children with minor trauma to the abdomen commonly present to urgent care centers. The caregivers of injured children generally seek reassurance that their child isn't seriously hurt. Previously, this reassurance has been difficult for clinicians to provide without obtaining labs and advanced imaging studies. However, the study of choice to exclude traumatic intraabdominal pathology is a CT scan, which is often not immediately available in the urgent care setting. Even when available, CT imaging is undesirable in children without apparent serious injury due to the associated high dose of ionizing radiation.

These investigators from the PECARN group sought to externally validate a previously derived rule which aimed to identify pediatric patients with blunt trauma at very low risk of clinically significant injury. They reviewed over 5,000 cases of children with blunt abdominal injury, among whom 133 had CIIAI (defined as death or needing operative intervention or transfusion). Impressively, the decision rule correctly identified all but one case of CIIAI, giving the rule a sensitivity of 99%.

The rule is likely to be of highest clinical utility in the urgent care patient population among patients who generally present after low-mechanism injuries and without significant pain or distress. In order for a patient to be considered very low risk they must have:

- GCS >13
- No evidence of abdominal wall trauma or "seatbelt sign"
- No abdominal tenderness
- No evidence of thoracic wall trauma
- No vomiting
- No decrease in breath sounds
- No spontaneous complaints of abdominal pain In such patients, urgent care clinicians can now feel confi-

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dent in offering reassurance to parents, without labs or imaging, that the likelihood of a serious abdominal injury is vanishingly small.

Skip the Pelvic Exam? Not so Fast

Key point: Addition of a pelvic exam did not improve the sensitivity, compared with history alone, in the evaluation of cervicitis and pelvic inflammatory disease (PID) in adolescent females. However, exam findings during pelvic exam altered management in a significant number of patients.

Citation: Farrukh S, Sivitz AB, Onogul B, et al. The additive value of pelvic examinations to history in predicting sexually transmitted infections for young female patients with suspected cervicitis or pelvic inflammatory disease. Ann Emerg Med. 2018;72(6):703-712.

For a variety of reasons, there are few exams that are feared and avoided with as much fervor by patients and clinicians alike as the female pelvic exam, especially in the urgent care setting. Pelvic exams take time. Patients have to get undressed and positioned. You need to find a chaperone. Patients are anxious. Providers commonly try to talk themselves out of the necessity of doing a pelvic exam for these reasons. And now in the era of PCR and other DNA detection methods, there is further fodder for skepticism regarding the utility of pelvic exams.

Within this modern context, this group of researchers asked the question: What is the current utility and value of the pelvic exam? This was a single-site, prospective, observational study conducted in an academic pediatric emergency department on approximately 300 adolescent female patients presenting with vaginal discharge or lower abdominal pain. The providers (which were a mix of residents, fellows, attendings, and advanced practice providers) collected a history from each patient and estimated the likelihood of cervicitis and PID. The same providers then performed a pelvic exam and gave a second estimate of the likelihood of STI. The results were compared with urine testing for GC, chlamydia, and trichomonas.

Among this group of clinicians, the authors found that history alone had a sensitivity of 54% and specificity of 60% compared with history plus pelvic exam, which had a sensitivity and specificity of 48% and 61%, respectively. The rate of any STI in this population was 27%. Based on these results, they conclude that the routine performance of pelvic exam "should be reconsidered."

This conclusion, however, should be taken with a large grain of salt. First, the gold standard for the presence of STI was based on urine testing, which has significantly lower sensitivity for the detection of sexually transmitted pathogens compared with vaginal and endocervical samples. Additionally, patients included in the study were only those complaining of lower abdominal pain and/or vaginal discharge. But patients with GC, chlamydia, and/or trichomonas may present with primarily

dysuria, abnormal bleeding, or no symptoms whatsoever. Finally, and most importantly, the authors note that findings on pelvic exam changed management in a whopping 25% of cases-far from useless.

This study does indeed highlight that pelvic exam findings alone do not add much to the sensitivity or specificity of a thorough history in the evaluation for cervicitis or PID. But it also demonstrates that examining the area of concern often changes clinical management. Unless there is a compelling reason to skip the pelvic (eg, absolute patient refusal), pelvic exam remains a clinically useful part of the evaluation of urogenital complaints, especially in sexually active young women.

Greatest Hit of the Month: Just in Time for Allergy Season: A Simple Fix for Rebound Nasal Congestion Associated with Afrin?

Key point: Short course fluticasone (Flonase) nasal spray appears to mitigate rebound nasal congestion associated with prolonged use of oxymetazoline (Afrin) nasal spray.

Citations: Vaidyanathan S, Williamson P, Clearie K, Lipworth B. Fluticasone reverses oxymetazoline-induced tachyphylaxis of response and rebound congestion. Am J Respir Crit Care Med. 2010;182(1):19-24.

Morris S, Eccles R, Martez SJ, et al. An evaluation of nasal response following different treatment regimens of oxymetazoline with reference to rebound congestion. Am J Rhinol. 1997;11(2):109-115.

Ok, so admittedly this was a small study on healthy subjects, but the results are compelling enough to share. Oxymetazoline is among the most commonly used over-the-counter treatments for nasal congestion. Prior studies have shown that, while effective for immediate relief of congestion, rebound rhinitis symptoms commonly occur with prolonged use.

In this 2010 randomized, double blind, placebo-controlled crossover trial, 19 healthy volunteers received oxymetazoline nasal spray three times daily for 2 weeks. In all subjects, some degree of increase in nasal congestion at day 14 was observed compared with baseline. After 2 weeks of oxymetazoline use, participants were given fluticasone nasal spray (2 squirts in each nostril, twice daily) for an additional 3 days. Resistance to nasal airflow was measured before and after the additional 3 days of nasal steroid use.

Participants were found to have significant improvement in nasal airflow after the use of fluticasone, in most cases completely reversing the apparent rebound congestion caused by oxymetazoline. In patients using (and especially overusing) oxymetazoline for allergic rhinitis, consider adding a short course of fluticasone to minimize this side effect. Given the sheer quantity of patients we see in urgent care with seasonal allergy related complaints this time of year, this slight tweak could be a game changer.

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A 44-Year-Old Man with Cough of Several Weeks' Duration

Urgent message: Lung cancer—the leading cause of cancer-related deaths in the United States—may first present with relatively benign symptoms and findings, such as those seen in urgent care. A pulmonary nodule may be the first manifestation of lung cancer in tobacco users. Early diagnosis and intervention, as well as ensuring a patient has appropriate and timely access to follow-up, is a critical measure in decreasing mortality.

JORDAN MILLER, DO and ELISE NGALLE, MD

Introduction

ung cancer is the second most common cancer in both females and males, and is the leading cause of Ldeath due to cancer, with an average age of diagnosis of 70-years-old; the likelihood for a man to develop lung cancer is 1 in 15, while for a woman it is 1 in 17.1 Risk factors include:

- tobacco smoking
- asbestosis exposure
- radon exposure
- air pollution
- previous radiation therapy
- family or personal history of lung cancer
- arsenic in drinking water

Screening for lung cancer is recommended for adults age 55 to 80 who have a 30-pack-year smoking history and are current smokers or have quit in the last 15 years.² Nodules on chest x-ray should be closely followed as Fleischner guidelines, especially in individuals who smoke tobacco. The reported incidence of malignancy in a solitary pulmonary nodule, defined as a single round or oval opacity in the pulmonary parenchyma measuring <3 cm in diameter and surrounded by pleura, is 3% to 6% in the general population.³

Case Presentation

A 44-year-old male presented to urgent clinic for a cough that had been increasing in frequency over a few weeks. He denies any associated hemoptysis, weight changes,



night sweats, or chills. He denied any past medical history. His father died from a Pancoast tumor that invaded the spine. The patient was a one pack-per-day smoker since he was a teenager. Physical exam revealed a well-nourished, well-developed male in no acute distress. He had a benign physical exam, including during auscultation of the lungs. Due to the patient's timeline of cough and risk factors, the decision was made to proceed with a

Jordan Miller, DO and Elise Ngalle, MD are both in practice with Adena Health System. The authors have no relevant financial relationships with any commercial interests.

Table 1. Acute vs Chronic Cough Presenting to Urgent Care			
Classification of cough	Concerning for		
Acute cough (<3 weeks)	 Upper respiratory infection Lower respiratory infection Pulmonary embolism Pneumonia Exacerbation of chronic issues (eg, COPD or CHF) 		
Chronic cough (>8 weeks)	 Asthma Gastroesophageal reflux Postnasal drip in addition to ACE inhibitor use, GERD, eosinophilic esophagitis, and asthma 		

RED FLAGS

- Systemic symptoms (ie, fever, chills, night sweats)
- · Weight loss
- Tobacco use
- Personal or family history of cancer, radon exposure, or previous radiation therapy

"Giving an outpatient a follow-up appointment at the time of discharge increases follow-up compliance compared with solely being given discharge instructions."

chest radiograph, which noted a small nodule. He was counseled on the findings and was told to follow up with pulmonology for further evaluation given his risk factors. The patient had multiple no-shows and cancellations at the pulmonology office.

Lung Cancer

For patients under the age of 45, it is unlikely that a pulmonary nodule will be a harbinger of cancer. One study showed that patients diagnosed under the age of 40 years old constituted about 5% of lung cancers. ^{4,5} General rules for following up on pulmonary nodules are with Fleischner guidelines. Depending on the size and number of nodules, recommendations are outlined for how many months later a patient with a solitary pulmonary nodule should come back for another evaluation. ⁶

Cough

The first step in the evaluation of cough is to determine

the duration.⁷ If a patient has had a cough for less than 3 weeks, it is acute; subacute is 3 to 8 weeks and chronic is more than 8 weeks. Acute coughs include upper/lower respiratory infections, pulmonary embolism, pneumonia, and exacerbation of chronic issues such as COPD or CHF.

Chronic cough may be due to asthma, gastroe-sophageal reflux, or postnasal drip in addition to ACE-I use, GERD, eosinophilic esophagitis, and asthma. Red flags include systemic symptoms (ie, fevers, chills, night sweats), weight loss, tobacco abuse, a personal history or family history of cancer, radon exposure, or previous radiation therapy.⁷

Indications for Chest X-ray in the Urgent Care Setting

Indications for chest radiographs include chest trauma, acute respiratory or cardiac disease in a patient with no recent/available radiographs, hemoptysis, suspected pneumonia or pleural effusion, positive TB skin test, or suspected mass. The following are not normally indications for radiographs: URI, uncomplicated COPD exacerbation, and screening for lung cancer.⁸ Although the patient did present with a cough and had risk factors that made lung cancer higher on the differential, a chest radiograph wasn't necessarily indicated in this patient.

Follow-up

Ensuring patients understand the potential for more serious illness and diagnostic uncertainty is important for their motivation to follow up. For example, providing a mechanism for making appointments 24/7 can increase follow-up. One study showed that web-based appointment systems reduced the average wait time from 98 minutes to 7 minutes, which improves satisfaction and thus decreases no-show rates. 10 Another way to encourage follow-up is for healthcare workers to address what occurred during the urgent care visit, such as providing the patient mentioned above with information about the meaning of his radiograph findings. One study showed that giving an outpatient a follow-up appointment at the time of discharge increases follow-up compliance compared with solely being given discharge instructions.^{9,11} Although the patient described in this case study was given an appointment, he had multiple no shows and may not have known that the appointment had been made.

Resolution of the Case

A year after his initial visit to urgent care, the patient re-

presented as a transfer for multifocal pneumonia and large lung mass. He was found to have multiple intracranial metastases, as well as necrotic adenopathy in the right neck. He was now experiencing symptoms including increasing productive cough, neck pain, and sputum production. On initial evaluation during this hospital visit the patient had extensive lymphadenopathy of the supraclavicular and subauricular area. He underwent CTguided biopsy of the right clavicular mass, which showed poorly differentiated non-small-cell carcinoma consistent with metastatic pulmonary adenocarcinoma. CT scan of the chest showed extensive supraclavicular, mediastinal, hilar, and axillary lymphadenopathy. Lytic lesions were noted in the cervical spine. Large masses were noted in the bilateral upper lungs. The patient was discharged and followed up with hematology-oncology for palliative chemotherapy and radiation.

Two months after diagnosis the patient re-presented with increasing shortness of breath with complete occlusion of the right middle lobe and right lower lobe bronchi with complete collapse of the right middle and lower lobes on CT, and a large pericardial effusion on ECHO. He was provided comfort care and ultimately passed away.

Discussion

Findings of metastatic lung cancer include persistent cough, shortness of breath, sudden weight loss, and hemoptysis. Paraneoplastic syndrome also can occur. Syndrome of inappropriate antidiuretic hormone secretion, also known as SIADH, can cause patients to have hyponatremia, leading to confusion. Hormones can cause hypercalcemia in squamous cell carcinoma. Bone pain, nail clubbing, and increasing skin pigmentation can also occur.

Though our patient did not have these symptoms when he initially presented, integrating some of these questions, such as regarding weight loss, hemoptysis, or family history of cancer into the initial history may help with diagnosis of subtle cases. Early diagnosis and routine follow-up are vital for patient safety.

Summary Points

- Lung cancer is the most common cause of cancerrelated death in America, with over 149,000 predicted deaths for the year 2019.¹
- Follow-up of abnormal urgent care test results is important for patient safety, as well as risk manage-
- Patients under the age of 45 are very unlikely to have lung cancer; however, those with risk factors and pul-

Table 2. When Should a Chest X-ray Be Performed in the Urgent Care Center?

X-ray is indicated in patients:

- · with chest trauma
- with acute respiratory or cardiac disease with no recent/available radiographs
- with hemoptysis, suspected pneumonia, or pleural effusion
- who have had a positive TB skin test
- who have a suspected mass

X-ray is not typically indicated in patients:

- diagnosed with upper respiratory infection
- with uncomplicated COPD exacerbation
- as screening for lung cancer

"Integrating certain questions, such as regarding weight loss, hemoptysis, or family history of cancer into the initial history may help with diagnosis of subtle cases. Early diagnosis and routine follow-up are vital for patient safety."

monary nodules need to have follow-up according to the guidelines.

■ Patient follow-up instructions should be action- and time-specific.

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HEALTH LAW AND COMPLIANCE

What Exactly Are Whistleblower Lawsuits—and How Can You Protect Your Urgent Care Operation?

Urgent message: The increasing visibility of "whistleblower cases," in which employees share in any fines from reporting their employer's malfeasance to federal and state authorities, calls for urgent care center owners to understand the False Claims Act and the whistleblower lawsuit process.

ALAN A. AYERS, MBA, MACC

"whistleblower" is an employee who makes complaints about a company's misconduct. This includes complaints about health and safety code violations, financial fraud, discrimination, or other illegal activities.1

Whistleblower claims are not uncommon in the urgent care industry. Perhaps most visible is the \$10 million penalty assessed a large Arizona-based urgent care operator in 2012.2 In that case, prosecutors alleged that the company submitted false claims to Medicare, TRICARE, and the Federal Employees Health Benefits Program, along with the Medicaid programs of several states. The urgent care company billed for unnecessary allergy, H1N1 virus, and respiratory panel testing. The federal government also alleged that it inflated billings for urgent care medical services—a practice known as upcoding.2

According to testimony, the former CEO threatened to fire managers who didn't hit a quota for giving allergy tests to patients who didn't need them and billing Medicare and Medicaid for the unneeded tests.3



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Recent Urgent Care Violations

In May 2018, another major urgent care company that at the time operated 88 urgent care centers in the New York City area was ordered to pay \$6.6 million to settle False Claims Act (FCA) allegations in a whistleblower lawsuit. Federal prosecutors alleged that the company billed Medicare for services that physicians failed to perform and billed Medicare for more expensive and complex services than were actually provided to their urgent care patients.⁴ Then just a month later, the company paid New York State \$883,000 to settle false-claims allegations involving inappropriate facilities fees charged to the state's Empire Plan health insurance program for government workers and their families.5

As you can see, urgent care centers have run afoul of the False Claims Act and whistleblower lawsuits for many years. And whistleblower activity in healthcare continues to gain momentum. In the first half of 2018 alone, the Department of Justice announced roughly \$600 million in FCA settlements.

In light of this, it's critical for urgent care center owners to understand the False Claims Act and the whistleblower lawsuit process.

The False Claims Act

The FCA is a federal law that makes it a criminal offense for any individual or organization to knowingly make a false record or file a false claim for any federal healthcare program. This includes any plan or program that provides health benefits

whether directly, through insurance, or otherwise, and which is funded directly, in whole or in part, by the U.S. government or any state healthcare system.6

The term knowingly includes having actual knowledge that a claim is false or acting with reckless disregard as to whether a claim is false. 6 This federal law covers fraud involving any federally funded contract or program, such as Medicare or Medicaid. The significant activities that may constitute violations under the False Claims Act include:

- Knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for pay-
- Knowingly using (or causing to be used) a false record or statement to have a claim paid by the federal government
- Conspiring with others to have a false or fraudulent claim paid by the federal government
- Knowingly using (or causing to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the federal government.7

Some common examples of potential false claims include knowingly billing Medicare for services that weren't provided,

"The laws protect employees and whistleblowers so they can stop, report, or testify about employer actions that are illegal, unhealthy, or violate specific public policies."

billing for provided medical services that weren't medically necessary, submitting fraudulent claims for actual services provided, and making false statements to obtain payment for services.8

Whistleblowers

Any individual or organization that has evidence of fraud against federal programs or contracts may file a qui tam lawsuit.9 The law provides whistleblowers with incentives that reward them for coming forward. Under the False Claims Act, whistleblowers receive between 15% and 30% of the monies the government recovers when these civil fraud cases are resolved by settlement or trial.10 For example, an employee of one of the companies described previously who was fired shortly before the filing her

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Case Example: Whistleblower Allegations of Upcoding Result in \$1.2 Million Settlement

In March 2018, the United States Department of Justice announced a \$1.2 million settlement with an urgent care company that operates more than 160 walk-in medical clinics. A whistleblower who brought the case received approximately \$204,000, according to The United States Department of Justice.

According to allegations, the company engaged in a practice known as upcoding, or billing the government for a higher level of service than what was actually performed. Medicare billing protocol allows a provider to bill for doctor visits by selecting the appropriate Evaluation and Management (E/M) code. The codes are divided into Levels 1 through 5, with Level 1 providing the lowest reimbursement and Level 5 the highest.

According to Medicare, a Level 5 visit may involve either a new or established patient and must include all three of the following: (i) a comprehensive review of the patient's medical history; (ii) a comprehensive medical exam, and; (iii) highly complex medical decision-making. Allegedly, this company was routinely billing for Level 5 visits where such visits did not actually occur.

The settlement resolved a civil lawsuit filed by a former employee under the whistleblower provisions of the False Claims Act, which permits private parties to file suit on behalf of the government and obtain a portion of the government's recovery.

(Adapted from Justice News. Department of Justice Office of Public Affairs. March 18,

claim shared an award of roughly \$1.6 million with another whistleblower who filed a similar lawsuit a year later.10

The False Claims Act is an extremely persuasive tool to thwart fraud on the government. The legislation generates more than \$15 in recoveries to the taxpayers for every \$1 spent on healthcare fraud enforcement.11

Violators of the FCA are liable for three times the dollar amount that the government is defrauded and civil penalties of \$5,000 to \$10,000 for each false claim.7

When a whistleblower files a qui tam lawsuit, it is placed "under seal" for 60 days. The government keeps the claim secreted from the accused employer. In the hands of the Justice Department, the claim is investigated. These federal whistleblower investigations can take months or years to resolve. As a result, the court may extend its seal order numerous times to allow the government additional time to investigate.12 During this time, the government will examine the whistleblower's evidence to determine whether to get involved or "intervene" in the case.12 Government involvement occurs in just a fraction of the qui tam cases—those that are most likely to be successful. Many

"One way that owners can reduce the risk of a whistleblower lawsuit is to be certain that their urgent care center compliance programs are up-to-date and comprehensive. These programs should be disseminated in writing to all employees."

qui tam cases settle, and to assist in that process, the government may request the seal to be lifted to discuss settlement negotiations.9

Whistleblower Protections

The laws protect employees and whistleblowers so they can stop, report, or testify about employer actions that are illegal, unhealthy, or violate specific public policies.¹³

The whistleblower statutes protect employees from retaliation.¹⁴ Further, the Patient Protection and Affordable Care Act¹⁵ broadened the government's reach under the False Claims Act with requirements aimed at enhancing fraud-fighting and increasing penalties for submitting false claims. Beginning in 2012, physicians are required to return known overpayments to the government within 60 days of discovering an error.16

However, a significant weakness in many statutory whistleblower protection laws is the brief statute of limitations, which is often exploited by entities accused of FCA violations. The clock on a case usually is deemed to start when the employee learns that she will be retaliated against, rather than her last day of employment.13

Takeaways for Urgent Care Owners and Operators

Urgent care center owners and operators should be aware that one of the most litigated issues in whistleblower law is the precise definition of protected whistleblower activity.^{13,17-19} Note that some states have very narrow definitions of what constitutes whistleblower activity, and others have definitions that are much broader.²⁰ Consult with your legal counsel for the specific parameters in your state.

One way that owners can reduce the risk of a whistleblower lawsuit is be certain that their urgent care center compliance programs are up-to-date and comprehensive. These programs should be disseminated in writing to all employees.

Urgent care centers should also have a process for reporting compliance issues to a compliance officer. This gives employees the opportunity to report any issues—and urgent care centers are given the responsibility of investigating and addressing these concerns without retaliating against employees for re-

HEALTH LAW AND COMPLIANCE

porting any perceived unlawful activity.21

Finally, urgent care centers should document the investigation, keep the whistleblower apprised of the investigation, and report the conclusions. Another best practice is to consider engaging a neutral third-party to investigate the claim.²¹

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A 40-Year-Old Female with Progressively Worse Cough and Fever





The patient is a 40-year-old woman who presents with cough and fever that has been getting worse "for a few days." She is a former smoker, and has diabetes mellitus.

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

INSIGHTS IN IMAGES: CLINICAL CHALLENGE

THE RESOLUTION





Differential Diagnosis

- Lung abscess
- Pulmonary gangrene
- Necrotizing pneumonia
- Necrotizing pulmonary malignancy

Diagnosis

This patient was diagnosed with necrotizing pneumonia. Examination of the images shows the cardiomediastinal silhouette is within normal limits. Patchy infiltrate is noted in the right lower lobe, concerning for pneumonia. This infiltrate demonstrates a focal area of low density in its lateral inferior aspect, concerning for possible area of either incomplete consolidation or cavitation. An area of cavitation would be concerning for necrotizing pneumonia. No pleural effusions are seen. There is no evidence of pneumothorax. The soft tissue and osseous structures appear unremarkable.

Learnings/What to Look for

- Necrotizing pneumonia is a rare complication of bacterial lung infection due to either the virulence of the microorganism or a predisposing factor of the host
- Complications include diffuse pulmonary inflammation, septic shock, and respiratory failure

Pearls for Urgent Care Management and **Considerations for Transfer**

- Intravenous broad-spectrum antibiotics are indicated, and should target pathogens that commonly cause necrotizing changes (most commonly such as Staphylococcus aureus, Staphylococcus pneumoniae, and Klebsiella pneumoniae)
- Sometimes pulmonary resection is necessary

Acknowledgment: Images and case provided by Teleradiology Specialists, www.teleradiologyspecialists.com.



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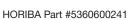
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A 57-Year-Old Man with a Chief Complaint of Syncope 3 Hours Ago



Figure 1.

Case

The patients is a 57-year-old man with a complaint of syncope 3 hours before arrival. He states he was sitting on the couch and the next thing he knew he was waking up. No preceding dizziness. No seizure activity, biting of the tongue, blood in the mouth, or post ictal symptoms. No cp, sob, leg pain, head pain, or back pain. He drank 2 glasses of water and felt better, but was encouraged to seek urgent care by his family.

Upon exam, you find:

General: Sitting on the cart, pink, skin dry, breathing comfortably and speaking normally

- Lungs: Clear bilaterally
- Cardiovascular: Regular rhythm, without m,r,g
- **Abdomen:** Soft and NT, no distention, without r/r/g, no pulsatile mass
- Ext: No edema or asymmetry, pulses are 2+ and equal in all extremities, no LE pain

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

INSIGHTS IN IMAGES: CLINICAL CHALLENGE

THE RESOLUTION



Figure 2. ST elevation with incomplete right bundle branch block (red arrows)

Differential Diagnosis

- First-degree AV block
- Wolff-Parkinson-White syndrome (WPW)
- Anterior STEMI
- Brugada syndrome
- Third-degree heart block

Diagnosis

This patient has Brugada syndrome. The syncope patient who is now "normal" is the classic urgent care encounter; typically all that is needed is a good history and physical and an ECG, looking for:

- 1. Wolff-Parkinson-White
- 2. Prolonged QT syndrome
- 3. Brugada syndrome
- 4. Hypertrophic cardiomyopathy
- 5. Ischemia or arrhythmia

Regarding the "differential diagnosis" for the ECG above, the normal PR interval is 120-200 ms, with first-degree AV block being a duration longer than 200 ms, not present on this ECG. WPW is defined by a short PR, a delta wave, and a wide QRS complex—again, not present here. Could this be an anterior STEMI? Possibly...but the morphology of the ST segments is different than typically seen with a STEMI; plus, the leads with ST elevation are curious—anterior STEMI generally involves leads V3 and V4, not V1-3, and...in a patient without chest pain, shortness of breath or sweating, this would be a very unusual presentation indeed! The final possibility presented is third-degree heart block, where there is no conduction of the p waves to generate a QRS complex. Third-degree (complete) heart block will have a P wave rate unrelated to the rate of the QRS complexes. This ECG has p waves conducted and related to the QRS complexes; this ECG is not complete heart block. This ECG shows Brugada syndrome defined by a symptomatic patient with right bundle branch block (RBBB) or incomplete RBBB in leads V1 and V2 with concurrent ST segment elevation.

Learnings/What to Look for

- Age of manifestation of Brugada syndrome is typically 30-40 years; it occurs in families
- Most patients are asymptomatic
- ECG will show incomplete RBBB in V1/V2 with ST segment elevation—saddle or cove type. These findings may be transient
- Brugada may be the culprit in up to 4% 5% of cardiac arrests
- Mortality is high without placement of an ICD, as there is a high risk of sudden cardiac death

Pearls for Initial Management and Considerations for Transfer:

- Perform an ECG in all syncope patients
- Many ECG machines are not programmed to read Brugada syndrome
- In the syncopal patient, look at the ECG specifically for Brugada syndrome, as well as for WPW, prolonged QT, HCM, and other serious arrhythmias, as well as ischemia
- Patients who have had a syncopal episode from Brugada are by definition symptomatic and either should be transferred to the ED by EMS or a plan determined after phone consultation with an electrophysiology cardiologist before the patient leaves the urgent care center

Acknowledgment: Image provided by Amal Mattu, MD.

Correction: In the February 2019 issue of JUCM, we presented the case of a 55-year-old male with 3 hours of epigastric pain. Ultimately, he was diagnosed with an inferior STEMI. We would like to clarify that the ECG in question shows inferior STEMI with a rhythm being sinus with 2:1 block. These patients are at higher risk of arrhythmia including heart block; EMS should be activated immediately and the patient monitored until arrival.



A 37-Year-Old Man with Multiple Symptoms Following a Trip to Japan



Case

The patient is a 37-year-old man who presents to urgent care complaining of fever, nausea, and abdominal pain. He had attributed these symptoms to a recent trip to Japan, where he ate lots of new foods along with old favorites like sushi. However, he became concerned when a pruritic, serpiginous lesion appeared on his flank.

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

INSIGHTS IN IMAGES: CLINICAL CHALLENGE

THE RESOLUTION



Differential Diagnosis

- Cutaneous larva migrans
- Gnathostomiasis
- Loiasis
- Strongyloidiasis

Diagnosis

This patient was diagnosed with gnathostomiasis, a helminth infection contracted after ingesting raw fish, frog, chicken, or pork infected with Gnathostoma spinigerum and other minor Gnathostoma spp.

Learnings

- Gnathostomiasis is endemic to parts of Asia and South/ Central America
- Symptoms are thought to relate to the movement of the parasite through the body
 - Constitutional symptoms may occur when it moves through the wall of the stomach (2 days to 2 weeks after ingestion), and skin manifestations when it moves under the skin (3 to 4 weeks after ingestion)

- Cutaneous manifestations are not unlike loiasis, in which the patient complains of migratory cutaneous and subcutaneous swellings which may be amorphous or resemble cutaneous larva migrans (serpiginous)
- Patients may complain of pruritus, arthralgias and myalgias, fever, nausea, and abdominal pain. However, larvae can migrate through any organ and, therefore, nearly any physical symptom is possible (eg, right-upper-quadrant pain and transaminitis may occur as the larvae migrate through the liver)

Pearls for Urgent Care Management and **Considerations for Transfer**

- Albendazole and ivermectin have been shown to be curative for cutaneous symptoms
- Recurrence requiring retreatment is not uncommon

Acknowledgment: Images courtesy of VisualDx.



REVENUE CYCLE MANAGEMENT Q&A

Correct Modifiers Make All the Difference When Coding for X-ray Services

DAVID E. STERN, MD, CPC

During a recent internal audit of claims where xrays were being billed, it was brought to my attention that we were not using the appropriate modifiers since we use computed radiography (CR) x-ray machines. What are those modifiers and will using them affect my reimbursement?

As outlined in the Consolidated Appropriation Act of • 2016, the Centers for Medicare and Medicaid Services (CMS) imposed reimbursement cuts to the technical component for x-rays performed on older technology beginning in 2017 with increased cuts in 2018 and 2023. (See Table 1.)

In order to track the usage of these x-ray technologies, CMS introduced modifier FX in 2017 to indicate an x-ray was taken using film, and modifier FY was introduced in 2018 to indicate an x-ray was taken using computed radiography. No modifier is required if an x-ray is taken using digital radiography.

Computed radiography (CR) uses a cassette-based system like analog film to create a digital image, and is considered to be a bridge between classic radiography and digital radiography (DR). CMS rationalizes incentivizing the use of digital radiography as it is the latest advancement to the radiography field, has higher efficiency, and offers high-volume capabilities for larger or busier clinics. However, since both CR and DR produce equivalent electronic images that can be easily stored and transmitted electronically, a skeptic might interpret the difference in payment between CR and DR could simply be seen as a cost-saving method for CMS.

You will want to check with your regional and commercial



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Table 1. Reimbursement Reductions for Older X-ray Technology					
X-ray Technology	Year Implemented	Reimbursement Reduction			
Analog	2017	20%			
Computed radiography	2018	7%			
	2023	10%			
Digital radiography	None	None			

"Until you decide to upgrade from computed radiography, advise your billing team to add modifier –FY to x-ray codes that are taken using the computed radiography machines."

payers to see if they are expecting these modifiers as well, especially for their Medicare products. For example, beginning in 2018, Blue Cross Blue Shield of Tennessee announced the requirement of the use of modifier -FY on all x-rays taken using CR, as well as the intention to impose the payment reduction rate introduced by Medicare on all of their Medicare Advantage plans.

If your practice is using CR machines, what is the impact of the reimbursement cut on just chest x-rays? According to the Medicare Physician Fee Schedule (MPFS), the national average reimbursement for the technical component of a plain film radiograph is \$20.90. CMS will impose a 7% rate cut, or approximately \$1.46 per x-ray. The cuts could add up, depending on how many you perform in a day.

REVENUE CYCLE MANAGEMENT Q & A

Study	Code	TC (\$)	Computed radiography 7% reduction (current)	Computed radiography 10% reduction (2023)	Analog radiography 20% reduction
Chest, 2 views	71046	\$20.90	\$1.46	\$2.09	\$4.18
Foot, 3 views	73630	\$23.07	\$1.61	\$2.31	\$4.61
Ankle, 3 views	73610	\$24.87	\$1.74	\$2.49	\$4.97
Knee, 3 views	73562	\$28.11	\$1.97	\$2.81	\$5.62
Shoulder, 2 views	73030	\$20.90	\$1.46	\$2.09	\$4.18
Ribs w/PA, chest, 3 views	71101	\$25.95	\$1.82	\$2.60	\$5.19
Elbow, 3 views	73080	\$21.26	\$1.49	\$2.13	\$4.25
Wrist, 3 views	73110	\$28.11	\$1.97	\$2.81	\$5.62
Hand, 3 views	73130	\$24.87	\$1.74	\$2.49	\$4.97
Finger(s), 2 views	73140	\$27.03	\$1.89	\$2.70	\$5.41
Average		\$24.51	\$1.72	\$2.45	\$4.90

Table 2. Comparison				
Computed Radiography X-ray	Direct Digital X-ray			
Lower initial investment	More expensive initial investment			
Can be retrofitted to existing installations	All new setup necessary			
Lower dose than analog and higher than digital	Flat panel detectors allow low dose			
Labor-intensive due to need for cassette transfer to plate reader	Completely digitized set-up			
Image can be digitized	Easy availability also in the cloud for quality control and research			
Similar to quality of DR at high-dose levels and can degrade in the time it takes to process the cassette	Better image quality with respect to contrast and detail detectability			
Final image viewing is 5 to 7 minutes	Rapid image viewing within 1 minute			
Digitized image storage is more space efficient than film	Easy storage and instant access to archived images			
Less costly to replace	More costly parts, requires protection from dropping or rough handling			
Easier to damage and needs more maintenance	Online or remote servicing possible			

A typical urgent care bills less than 200 x-rays to Medicare per year. At 200 x-rays billed to Medicare in one year, the annual loss in reimbursement for using CR would be approximately \$344 currently and \$490 by 2023.

Is switching from CR to DR right for you at this time? You will want to consider the number of x-rays performed in your facility(ies), the staffing and space you have available, as well as the upfront cost when deciding whether to purchase different x-ray equipment.

Each method offers its own attributes (**Table 2**).

From a purely financial perspective, however, the above

grid is a fairly pedantic exercise for urgent care centers. Even if the center's actual loss is three times the estimated average loss at \$1,500 per year, the high cost of transitioning to DR will not produce a return on investment within any reasonable timeframe. Thus, this change in reimbursement should not be the major factor in any decision to switch to DR.

Until you decide to upgrade from computed radiography, advise your billing team to add modifier -FY to x-ray codes that are taken using the computed radiography machines. Add modifier -FX for plain film x-rays for compliant coding and to avoid possible penalties. ■

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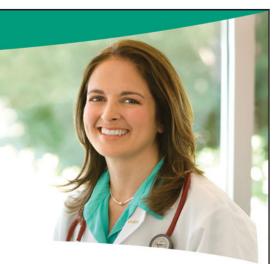
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For more information or to apply, visit www.phs.org/careers.



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NZLocums is a New Zealandbased not-for-profit ecruitment organisation.

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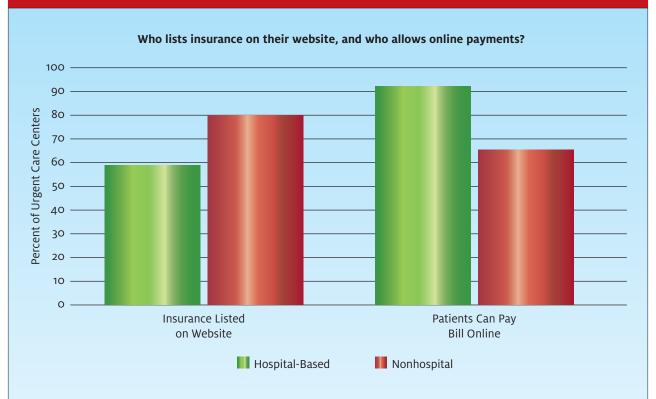
DEVELOPING DATA

Does Your Website Show Patients How Much Financial Flexibility You Offer?

his month's Practice Management feature article, Perfecting the Consumer Financial Experience in Your Urgent Care Center (page 17), reveals that with increasing flexibility in accessing healthcare, patients also want more flexibility when it comes to paying their bill. Their insurance status comes into play, as do methods of payment. It's been suggested that such details may even play a part in choosing where they go when they need to see a provider.

As such, it could be to your advantage to let them know this type of information before they walk through your door. Making it easy for them to pay can help with collections, as well, according to the Urgent Care Association's 2018 Benchmarking Report. Interestingly, as you can see below, hospital-based urgent care operators are more likely to allow patients to pay their bill online, while more nonhospital urgent care centers tend to list insurance details compared with their counterparts.

INSURANCE TRANSPARENCY AND ONLINE PAY POLICIES VARY BY URGENT CARE SETTING



Source: Urgent Care Association 2018 Benchmarking Report, based on Merchant Medicine analysis. For more information, visit https://www.ucaoa.org/Resources/Industry-Reports/Benchmarking.

I power extraordinary

A single mom of three was worried about affording her medical bills...

She called in over the weekend, and we discovered insurance was denying her claims due to a data entry error. When I corrected the error and rebilled the claims, you could hear in her voice how relieved she was. It felt great to take that pressure off someone who really needed it.

- Donte, Medical Biller



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