

JUCM[®]

THE JOURNAL OF **URGENT CARE** MEDICINE[®]

MAY 2019
VOLUME 13, NUMBER 8



www.jucm.com

The Official Publication of the UCA and CUCM

CLINICAL **cme**

Turning Heel Pain to Healed Pain in the Urgent Care Center

ALSO IN THIS ISSUE

- 19 Case Report**
Is the Mechanism of Injury Only the Tip of the Iceberg?
- 22 Health Law and Compliance**
Payroll Peril: Know When You're Legally Bound to Pay OT for NPs and PAs
- 40 Revenue Cycle Management**
If You're Not Up to Speed on the Updated CCI Edits, You're Losing Money



Practice Management **cme**
 Buying or Selling Your Urgent Care Business:
 Failure to Prepare is Preparing to Get a Bad Deal





Where **kids**
go out to **play**,
ticks lie in wait
to **prey**.



Sofia 2 Lyme FIA: **CLIA-waived**
Results in minutes, not days.

With the incidence of Lyme disease on the rise and children among those most commonly affected, parents want answers – fast. It doesn't help that current testing options may take hours or days for results. Not anymore! Sofia 2 Lyme FIA uses a finger-stick whole blood sample to provide accurate, objective and automated results in as few as 3 minutes, getting doctor and patient on a path to treatment much sooner.

Sofia 2 Lyme FIA is the only rapid, near-patient testing solution that provides IgM and IgG differentiated results in a single test. It has demonstrated accuracy comparable to laboratory testing – all with less than 1 minute hands-on-time. And with the power of Virena, you will have near real time prevalence data and incidence mapping for your area providing greater information and allowing for better healthcare decisions.

To find out how to get ready for Lyme Season with our **CLIA-waived**
Sofia 2 Lyme FIA, contact Quidel Inside Sales at 858.431.5814



Sofia²
Lyme FIA



Sofia2Lyme.com

AD20319400EN00 (02/19)



LETTER FROM THE EDITOR-IN-CHIEF

New Coding Rules: Triumph or Turmoil?



In July 2018, the Centers for Medicare and Medicaid Services made its first proposals to overhaul the primary payment methodology for outpatient services in over 20 years. In an attempt to simplify documentation, bill submission, and compliance requirements, CMS made a bold move that will materially change the way physicians and advanced-practice providers (APPs) manage their clinical work flows.

In essence, the recommendation was to eliminate the variable payments for the different Evaluation and Management levels (eg, 99202-05 and 99212-15), and instead pay one rate for all levels. The fixed fee proposal was combined with significant documentation requirement reductions intended to allow providers to spend more time with patients. Once implemented, clinicians would be able focus their documentation on what is relevant, rather than counting elements and points to ensure compliant and accurate coding. In the proposed model it was estimated that physicians would see an average reimbursement impact of +/- 1%, while gaining significant efficiencies, reduced administrative costs, and more time with patients. All in all, it sounded like a pretty big win for most physicians and it was slated to go into effect January 2019.

Through the second half of 2018, CMS solicited feedback and, predictably, there was pushback from some in the physician community. Particular concern was expressed by specialties that treat more complex patients, spend more time per visit, and code higher levels of service on average (eg, rheumatology and oncology). This prompted a pause and delay for the proposed changes, as well as an extension of the opportunity for public comment. The new proposal carves out Level 5 E&M codes for a separate level of reimbursement. And, for better or worse, the new proposal moves the implementation of the final rule to calendar year 2021.

So what does all this mean for the typical urgent care practice? According to the 2019 proposal, the typical family medicine physician would see no material reimbursement impact in the new rule. The impact with the Level 5 carveout is not expected to be materially different. Interestingly, nurse practitioners and physician assistants are predicted to see a 3%

increase in reimbursement, according to the CMS report; however, it is unclear whether this reflects changes to the rules for incident-to billing or merely lower coding habits of APPs.

More important, however, is the potential of the new rules to lower administrative burdens, improve efficiency, and reduce the anxiety associated with coding compliance. Consider that Level 2, 3, and 4 visits will only require documentation of a Level 2 code. Practitioners will be free to document clinically relevant information without the burden of documenting to support a code. The efficiencies gained could be significant and, with that, productivity should rise.

While not specifically assessed in the CMS report, any improvement in productivity will have a 100% return and could be very significant. In addition, the impact to administrative costs should not be overlooked. The need for certified coders and extensive audits could be dramatically reduced with the new rules, along with denial rates, while cash flow improves. This administrative and fiscal relief will directly hit the bottom line. In addition, the distracting burden of coding compliance and the anxiety it generates should improve professional satisfaction and eliminate a major factor in physician burnout. It should also be noted that private payers routinely follow the CMS lead on coding rules, so any change will quickly be universal.

While we now must wait until 2021 for full implementation, the proposed rule changes appear very favorable overall for the urgent care provider and practice owner. The progress made by CMS to reduce the clinically irrelevant burdens that plague modern day medicine is commendable and the quick response and openness to public comment signifies a serious commitment to these critical reforms. In all, I can confidently call it a "triumph" for urgent care providers and patients alike. ■

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

Nail it with one swab.

Syndromic respiratory infection testing now CLIA-waived

The BioFire® FilmArray® Respiratory Panel (RP) EZ uses a molecular syndromic approach to accurately detect and identify a wide range of pathogens—not just Flu A and B. As a healthcare provider, this means your patients can receive the right treatment the first time, potentially leading to higher patient satisfaction and lower costs. And as the name implies, it's easy and can be performed right in your office or clinic.¹ 1 test. 14 respiratory pathogens. All in about an hour.

biofiredx.com

BioFire RP EZ Pathogens

Viruses

Adenovirus
Coronavirus
Human Metapneumovirus
Human Rhinovirus/Enterovirus
Influenza A

Influenza A/H1

Influenza A/H1 -2009
Influenza A/H3
Influenza B
Parainfluenza Virus
Respiratory Syncytial Virus

Bacteria

Bordetella pertussis
Chlamydomphila pneumoniae
Mycoplasma pneumoniae



¹ CLIA Certificate of Waiver required to perform testing.

For more information contact
[+1 801-736-6354 ext. 1947](tel:+18017366354)



A BIOMÉRIEUX COMPANY

Syndromic Testing: The Right Test, The First Time.

BFDX-MKT-0234

JUCM[®]

The Official Publication of the UCA and CUCM

May 2019 | VOLUME 13, NUMBER 8



CLINICAL

11 Top 5 Causes—and Controversial Conducts—of Heel Pain in Urgent Care

By the time patients visit urgent care due to heel pain, they may have been living with it for a while. Understanding the history can help you narrow down the possible causes and start the patient on a treatment plan.

Katty Edmond Grandpierre, MD, CMSS, Frank Ida, BS, EMT-B, and Vincent D'Amore, MD, FACEP

CASE REPORT

19 An 11-Year-Old Girl with Back Pain and Chronic Poor Appetite



The presenting complaint isn't always indicative of the actual problem. Precipitating events might not always help narrow the possibilities down, either. A thorough history that looked beyond those factors informed an unusual diagnosis in this young patient.

Lavanya Boddu, MD, MBA

HEALTH LAW AND COMPLIANCE

22 Do Nurse Practitioners and Physician Assistants Qualify for Overtime in the Urgent Care Setting?



The answer to the question raised in the title of this article is...*that depends*. To understand your obligations, you have to look at several factors you might not even be aware of yet.

Alan A. Ayers, MBA, MAcc

PRACTICE MANAGEMENT

29 Practical Considerations for Buying/Selling Your Urgent Care Practice



Urgent care continues to be a hotbed of mergers and acquisitions. Despite how common such deals have become, the process is complex; understanding it will help ensure the best possible outcome for your business.

Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF JUCM

As the weather warms up, people all over the country may be responding to the call of the wild by heading outdoors on hiking expeditions, family camping adventures, fishing trips...all of which can be fraught with hazard. No matter where your practice is, you need to be prepared to see patients who may present with unusual complaints related to their exploits in the wilderness. Read how to ensure you're up to the challenge in the June issue of *JUCM*.

DEPARTMENTS

- 6 Continuing Medical Education
- 9 From the UCA
- 25 Abstracts in Urgent Care
- 33 Insights in Images
- 40 Revenue Cycle Management Q&A
- 44 Developing Data

CLASSIFIEDS

- 41 Career Opportunities

TO SUBMIT AN ARTICLE:

JUCM utilizes the content management platform Scholastica for article submissions and peer review. Please visit our website for instructions at <http://www.jucm.com/submit-an-article>



JUCM EDITOR-IN-CHIEF

Lee A. Resnick, MD, FAAFP

Chief Medical and Operating Officer,
WellStreet Urgent Care
Assistant Clinical Professor, Case Western
Reserve University,
Department of Family Medicine

JUCM EDITORIAL BOARD

Alan A. Ayers, MBA, MAcc

CEO, Velocity Urgent Care

Jasmeet Singh Bhogal, MD

Medical Director, VirtuaExpress Urgent Care
President, College of Urgent Care Medicine

Tom Charland

CEO, Merchant Medicine LLC

Jeffrey P. Collins, MD, MA

Chief Medical Officer,
MD Now Urgent Care
Part-Time Instructor, Harvard Medical School

Tracey Quail Davidoff, MD

Attending Physician
Rochester (NY) Regional Health
Immediate Care

Thomas E. Gibbons, MD, MBA, FACEP

Lexington Medical Center Urgent Care
President, Columbia Medical Society

William Gluckman, DO, MBA, FACEP, CPE, CPE, FCUCM

CEO, FastER Urgent Care

David Gollogly, MBChB, FCUCP (New Zealand)

Chair, Royal New Zealand College of
Urgent Care

Glenn Harnett, MD

Principal, No Resistance Consulting Group
Trustee, UCA Urgent Care Foundation

Toni Hogencamp, MD

Regional Medical Director, PM Pediatrics
Founding Member, Society for Pediatric Urgent
Care

Sean M. McNeeley, MD, MD, FCUCM

Network Medical Director, University
Hospitals Urgent Care
Clinical Instructor, Case Western Reserve
University School of Medicine
UCA President

Shailendra K. Saxena, MD, PhD

Professor, Creighton University
Medical School

Elisabeth L. Scheufele, MD, MS, FAAP

Physician, Massachusetts General Hospital
Chelsea Urgent Care
Physician Informaticist

Laurel Stoimenoff, PT, CHC

CEO, Urgent Care Association

Joseph Toscano, MD

Chief, Emergency Medicine
Medical Director, Occupational Medicine
San Ramon Regional Medical Center
Board Member, Board of Certification in
Urgent Care Medicine

Janet Williams, MD, FACEP

Medical Director, Rochester Regional Health
Immediate Care
Clinical Faculty, Rochester Institute of
Technology

JUCM ADVISORY BOARD

Kenneth V. Iseron, MD, MBA, FACEP, FAAEM

The University of Arizona

Peter Rosen, MD

Harvard Medical School

Martin A. Samuels, MD, DSc (hon), FAAN, MACP

Harvard Medical School

Kurt C. Stange, MD, PhD

Case Western Reserve University

Robin M. Weinick, PhD

RTI International

UCA BOARD OF DIRECTORS

Richard Park, MD

President

Sean McNeeley, MD

Immediate Past President

Shaun Ginter, MBA, FACHE

President-Elect

Mike Dalton, MBA, CPA

Treasurer

Lou Ellen Horwitz, MA

Secretary

Tom Charland

Director

Joe Chow, MD, MBA

Director

Lori Japp, PA

Director

Max Lebow, MD, MPH

Director

Damaris Medina, Esq

Director

Armando Samaniego, MD, MBA

Director

Jeanne Zucker

Director

Laurel Stoimenoff, PT, CHC

CEO

JUCM®

EDITOR-IN-CHIEF

Lee A. Resnick, MD, FAAFP

editor@jucm.com

MANAGING EDITOR

Harris Fleming

hfleming@jucm.com

ASSOCIATE EDITOR, PRACTICE MANAGEMENT

Alan A. Ayers, MBA, MAcc

ASSOCIATE EDITOR, CLINICAL

Michael B. Weinstock, MD

CONTRIBUTING EDITORS

Joshua Russell, MD, MSc, FAAEM, FACEP

David E. Stern, MD

ART DIRECTOR

Tom DePrenda

tdeprenda@jucm.com



185 State Route 17, Mahwah, NJ 07430

PUBLISHER AND ADVERTISING SALES

Stuart Williams

swilliams@jucm.com • (201) 529-4004

CLASSIFIED AND RECRUITMENT ADVERTISING

Samantha Rentz

samantha.rentz@communitybrands.com • (727) 497-6565 x3322

Mission Statement

JUCM The Journal of Urgent Care Medicine (ISSN 1938001) 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.

Publication Ethics & Allegations of Misconduct, Complaints, or Appeals

JUCM® expects authors, reviewers, and editors to uphold the highest ethical standards when conducting research, submitting papers, and throughout the peer-review process. *JUCM* supports the Committee on Publishing Ethics (COPE) and follows its recommendations on publication ethics and standards (please visit <http://publicationethics.org>). *JUCM* further draws upon the ethical guidelines set forth by the World Association of Medical Editors (WAME) on its website, www.wame.org. To report any allegations of editorial misconduct or complaints, or to appeal the decision regarding any article, email the Publisher, Stuart Williams, directly at swilliams@jucm.com.

Disclaimer

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

Advertising Policy

Advertising must be easily distinguishable from editorial content, relevant to our audience, and come from a verifiable and reputable source. The Publisher reserves the right to reject any advertising that is not in keeping with the publication's standards. Advertisers and advertising agencies recognize, accept, and assume liability for all content (including text, representations, illustrations, opinions, and facts) of advertisements printed, and assume responsibility for any claims made against the Publisher arising from or related to such advertisements. In the event that legal action or a claim is made against the Publisher arising from or related to such advertisements, advertiser and advertising agency agree to fully defend, indemnify, and hold harmless the Publisher and to pay any judgment, expenses, and legal fees incurred by the Publisher as a result of said legal action or claim.

Copyright and Licensing

© Copyright 2019 by Braveheart Group, LLC. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or any information storage and retrieval system, without written permission from the Publisher. For information on reprints or commercial licensing of content, please contact the Publisher.

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





JUCM CONTRIBUTORS

The human heel is something of an engineering marvel when it comes to loadbearing. It can absorb 110% of body weight when a person is walking around—and up to 200% if someone is running. Small wonder, then, that heel pain is the presenting complaint in around 2 million office visits every year. Potential causes are many, so having a good sense of how to work through the diagnostic process is essential.

This month's cover article should help. In Top 5 Common Causes—and Controversial Conducts—of Heel Pain in Urgent Care (page 11), authors **Katty Edmond Grandpierre, MD, CMSS**, **Frank Ida, BS, EMT-B** and **Vincent D'Amore, MD, FACEP** break down not only the more common diagnoses but also the distinct assessments, likely causes, and “next steps” for setting patients off in the direction of becoming pain-free.

Dr. Grandpierre practices with CityMD Urgent Care, where Mr. Ida is senior medical scribe and Dr. D'Amore is executive vice president.



The subject of this month's case report is a less common occurrence. The patient in question is a child who took a hard fall on the school playground a couple of weeks prior. Her symptoms run deeper than related pain at the site of impact, however. Looking beyond the information conveyed by the patient and her parent ensured the less-than-obvious diagnosis was correct, which facilitated treatment earlier than might have otherwise occurred—and a positive outcome. Read *An 11-Year-Old Girl with Back Pain and Chronic Poor Appetite*, by **Lavanya Boddu, MD, MBA** on page 19.

Dr. Boddu is an urgent care provider and the medical director at Memorial Express Care. She also serves as an emergency physician in the Memorial emergency department.

While there may seem to a natural ebb and flow to even relatively rare clinical presentations, nothing could be further from the truth on the business side of things. Consider the process of buying and selling an urgent care operation; it continues to change as the industry evolves. If you're thinking of selling or buying an urgent care business and want to ensure you get maximum value, you'll need to know what to expect—which makes *Practical Considerations for Buying/Selling Your Urgent Care Practice* (page 29) by **Alan A. Ayers, MBA, MAcc** required reading.

Mr. Ayers, chief executive officer of Velocity Urgent Care and practice management editor of *JUCM*, also addresses another topic that reflects a growing phenomenon in urgent care this



month. In *Do Nurse Practitioners and Physician Assistants Qualify for Overtime in the Urgent Care Setting?* (page 22), he explains that the role NPs and PAs play in urgent care, along with the state they practice in, has a lot to do with whether they're eligible to receive overtime pay. If advanced-practice providers play an important role in your operation, you'll benefit from giving it a look.

Likewise, *Abstracts in Urgent Care* (page 25) includes highlights of articles published throughout the medical journal landscape that will assist you in offering the best care possible. This month, **Joshua Russell, MD, MSc, FAAEM, FACEP** shares insights into how urgent care providers can mitigate legal risk by sharing the decision-making process with patients, when it is (or isn't) prudent to treat incidental high blood pressure findings, and more.

Finally, in *Revenue Cycle Management* (page 40), **David Stern, MD** explains what your coding personnel need to know about the Centers for Medicare and Medicaid Services' update of claim adjudication rules for National Correct Coding Initiative Procedure-to-Procedure edits.

Congratulations to ASHPE Award-Winning *JUCM* Contributors!

Every year, the American Society of Healthcare Publication Editors (ASHPE) puts out a call for medical journals to submit their best content for consideration to receive an ASHPE Award. It's a competitive field that includes publications produced by medical societies and healthcare publishers across the country. We're pleased to report that *JUCM* won two awards in this year's contest—our 16th and 17th since our first issue in 2006. We took home a Silver Award in the Best Case History category for *A Pregnant Mother Presenting to Urgent Care with Chickenpox* (*JUCM*, December 2018), by **Samrana Arefeen, MD** and **Khalid Aziz, MD** and a Bronze Award in Best Cover, Computer-Generated for Art Director **Tom DePrenda's** September 2018 design. Congratulations, and thank you, to them and to all who make *JUCM* essential reading.

Thanks to Our Peer Reviewers

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

- **Barbara Chambers**
- **Aldo C. Dumlao, MD**
- **Cesar Mora Jaramillo, MD**
- **Lo Fu Tan, MD, MS, FCFP**

If you'd like to support the journal—and your colleagues—by reviewing articles, please send an email with your CV to editor@jucm.com.



CONTINUING MEDICAL EDUCATION

Release Date: May 1, 2019

Expiration Date: April 30, 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

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

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 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Planning Committee

- **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**
Member reported no financial interest relevant to this activity.

Disclosure Statement

The policy of the Urgent Care Association CME Program (UCA CME) requires that the Activity Director, planning committee members, and all activity faculty (that is, anyone in a position to control the content of the educational activity) disclose to the activity participants all relevant financial relationships with commercial interests. Where disclosures have been made, conflicts of interest, real or apparent, must be resolved. Disclosure will be

made to activity participants prior to the commencement of the activity. UCA CME also requires that faculty make clinical recommendations based on the best available scientific evidence and that faculty identify any discussion of “off-label” or investigational use of pharmaceutical products or medical devices.

Instructions

To receive a statement of credit for up to 1.0 *AMA PRA Category 1 Credit™* per article, you must:

1. Review the information on this page.
2. Read the journal article.
3. Successfully answer all post-test questions.
4. Complete the evaluation.

Your credits will be recorded by the UCA CME Program and made a part of your cumulative transcript.

Estimated Time to Complete This Educational Activity

This activity is expected to take 3 hours to complete.

Fee

There is an annual subscription fee of \$145.00 for this program, which includes up to 33 *AMA PRA Category 1 Credits™*.

Email inquiries to info@jucmce.com

Medical Disclaimer

As new research and clinical experience broaden our knowledge, changes in treatment and drug therapy are required. The authors have checked with sources believed to be reliable in their efforts to provide information that is complete and generally in accord with the standards accepted at the time of publication.

Although every effort is made to ensure that this material is accurate and up-to-date, it is provided for the convenience of the user and should not be considered definitive. Since medicine is an ever-changing science, neither the authors nor the Urgent Care Association nor any other party who has been involved in the preparation or publication of this work warrants that the information contained herein is in every respect accurate or complete, and they are not responsible for any errors or omissions or for the results obtained from the use of such information.

Readers are encouraged to confirm the information contained herein with other sources. This information should not be construed as personal medical advice and is not intended to replace medical advice offered by physicians. The Urgent Care Association will not be liable for any direct, indirect, consequential, special, exemplary, or other damages arising therefrom.



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.

Top 5 Common Causes—and Controversial Conducts—of Heel Pain in Urgent Care (p. 11)

1. The most common cause of heel pain is:

- Plantar fasciitis
- Achilles tendinopathy
- Sever's disease
- Tarsal tunnel syndrome
- Peroneal tendon pathology

2. Which of the following are key historical questions to ask of patients presenting with heel pain?

- Does your heel pain start with the first few steps out of bed?
- Does your heel hurt when you're resting in bed or wake you up from sleep?
- Where in your heel does it hurt?
- All of the above

3. Referral to a specialist should be considered in heel pain patients:

- With pain over 3–6 months
- With pain over 3–6 weeks
- Whose heel pain may be work-related
- Who cannot pinpoint a causative event
- Who insist they need an opioid drug to manage their pain

An 11-Year-Old Girl with Back Pain and Chronic Poor Appetite (p. 19)

1. Differential diagnosis for back pain in an 11-year-old girl includes which of the following?

- Imperforate hymen
- Urinary tract infection/pyelonephritis
- Constipation
- Muscular strain
- All of the above

2. The development of the female genital tract begins at 3 weeks of gestation and continues until:

- First menses
- Pregnancy
- Second trimester of pregnancy
- Menopause
- This is unpredictable

3. Imperforate hymen and hematocolpos should be considered in menarche age-group girls with:

- Family history
- Delayed puberty
- Precocious puberty
- Recurrent abdominal pain and bowel problems
- All of the above

Practical Considerations for Buying/Selling Your Urgent Care Practice (p. 29)

1. Changes in the healthcare landscape may make it more difficult for independent practices to remain profitable. Such changes include:

- Increased pressure from the government, payers, and patients to provide improved services at lower cost
- Shifting reimbursements and a changing regulatory environment related to finance, billing, collections, and other considerations
- Irregularity in patient volumes, seasonality, and extended hours needed to serve patient needs
- All of the above
- Answers a and c

2. Which of the following is *not* considered one of the eight critical steps to selling your urgent care business?

- Clarifying end goals
- Marketing the operation with a business broker
- Conducting a background check of the potential buyers' investors
- Prequalifying potential buyers, which includes asking them to produce documents that may be confidential
- Each of the above is one of the eight essential steps

3. Professional guidance from a tax expert is advisable when doing IRS due diligence. This will focus on:

- Charitable purposes
- Retained rights
- Reasonable compensation/incentives
- All of the above
- None of the above



UCA
 URGENT CARE
 ASSOCIATION

MEMBER BENEFITS & RESOURCES

UCA - YOUR GATEWAY TO BETTER...



Industry News: complimentary subscriptions to *UCAccess* eNewsletter and 11 monthly issues of the *Journal of Urgent Care Medicine*.



Access Hundreds of Ready-to-Go Members-only Resources:

- Clinic Startup Toolkit
- Public Relations Toolkit
- Payer Relations Toolkit
- Practice Management Toolkit
- Clinical & Practice Management Sessions



Continuing Education: obtain CME/CU credit by participating in live webinars, annual convention, clinical workshops, and recorded/online sessions.



Networking Opportunities: share information and get your questions answered by participating in special sections, regional chapters, and live educational events.



Exclusive Member Discounts:

- Special members pricing on certification, accreditation, events, webinars, products, career center postings and more
- \$100 OFF the Urgent Care Bootcamp clinical training program through Hippo Education
- Discounted rate on the Merit-based Incentive Payment System (MIPS) qualified registry reporting option



Member & Vendor Directory: search and interact with other members, clinics, and businesses in your area.

UCA membership is open to Clinicians, Practice Managers, Urgent Care Centers, Large Organizations, Vendors, Business Partners, and Individual Business Professionals.

Learn more: ucaoa.org/benefits | 877-698-2262





FROM THE UCA CEO

Mission Accomplished

■ LAUREL STOIMENOFF, PT, CHC

UCA 2019 Oceans of Opportunity is in the books! In late 2018, the decision was made to move to one all-encompassing convention. UCA's 2019 Annual Convention & Expo is the inaugural year for creating this new experience. Colleagues, vendors, and healthcare leaders convened in West Palm Beach for 4+ days of action-packed education, networking, celebration, and thought leadership.

Specialty sections convened and boards met to refine and implement strategic initiatives. Chapter members gathered to address state and regional issues impacting the industry. We'd also like to welcome our newest state chapter, TexUCA, representing members in the great state of Texas!

The Foundation held its annual Awards Celebration recognizing exceptional individuals and organizations who have contributed to the industry, the association, and their communities. The event was truly a success, with money raised to support the Foundation's mission of advancing the urgent care industry through research, innovation, and philanthropy. During the event we also inducted four new Fellows into the College of Urgent Care Medicine. The opportunity to become a Fellow was previously something only physicians could pursue; but, we are excited that a nurse practitioner and a physician assistant have now earned the FCUCM distinction based on a new set of criteria.

What's New?

The Gateway2Better Network (G2B Network) was introduced as a member benefit with the goal of delivering patients to your door and disrupting traditional patient-access methodologies. An antibiotic stewardship symposium was held with industry stakeholders and representatives from the Centers for Disease Control and Prevention. Opportunities to distinguish your organization through Antibiotic Stewardship Commendation as a sole award or as an optional add-on distinction to UCA Accreditation were outlined. Certification is going *international*,



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



and the first organizations pursuing it were recognized.

The 2019 faculty was unprecedented, replete with clinical experts, industry leaders, healthcare visionaries, and regulatory prognosticators and raised the bar for future events.

Leadership & the Election

Our members chose their new Board. We look forward to the leadership provided by Tom Charland, Lou Ellen Horwitz, Lori Japp, and Shaun Ginter. And it's always good to look forward *and* look back. As UCA celebrated its *15-year anniversary*, we took time during opening ceremonies to celebrate all of our Past-Presidents who have volunteered their time, talent, and grit shepherding UCA to where it is today. Pictures of the opening ceremonies and many other event activities can be found in the UCA 2019 Convention & Expo photo album on www.facebook.com/ucaoa.

We want to thank our (now) Past-President, Sean McNeeley, MD, for his commitment to advancing the agenda and strategic objectives of UCA. Dr. McNeeley served us all tirelessly and with great industry insight this past year. The gavel was passed to Richard Park, MD during the closing general session. Other officers elected include Shaun Ginter, President-elect, Lou Ellen Horwitz, Secretary, and Mike Dalton, Treasurer.

We hope you start making plans to join us May 3-6, 2020 at the Paris Hotel in Las Vegas. Having a single major event in a year allows us more time to plan and prepare. We'll never stop trying to improve on the prior year, so our mission was accomplished, but we are already in pursuit of taking this to the next level. Save the date and *experience the future* at UCA2020! ■

LICENSED RADIOLOGISTS
IN ALL 50 STATES

QUALITY
RADIOLOGY REPORTS

Teleradiology Specialists is licensed to provide urgent care over reads in all 50 states. With our network of more than 90 board certified, U.S. based radiologists, 99.97% accuracy rate and industry leading turnaround times, you will receive an accurate diagnosis to serve your patients quickly.

If you're looking for a new teleradiology partner, we can have you up and running with training and cases tested in 7 days or less. Contact us today to get your free quote and to get started.



info.teleradiologyspecialists.com/covered | 888-779-9738



Top 5 Common Causes—and Controversial Conducts—of Heel Pain in Urgent Care

Urgent message: Nontraumatic heel pain is a common presenting complaint in urgent care. Knowing how to accurately diagnose and develop a treatment plan is important, as the course is typically prolonged.

KATTY EDMOND GRANDPIERRE, MD, CMSS, FRANK IDA, BS, EMT-B, and VINCENT D'AMORE, MD, FACEP

Introduction

The heel can absorb 110% of body weight while a person is walking and 200% of body weight during running.¹ While the most common cause is plantar fasciitis (PF), accounting for approximately 2 million office-based visits a year,² the causes and treatments are often confusing. It's a frustrating fact, for both patient and clinician, that there is no gold standard for treatment and the benefits of common treatments are questionable.

In assessing patients who present with heel pain, the urgent care provider must consider causes beyond PF. In this article, we present the "top 5" most likely culprits:

- Plantar fasciitis
- Achilles tendinopathy and bursitis
- Sever's disease
- Tarsal tunnel syndrome
- Peroneal tendon pathology

History

Three key historical questions to ask all patients with heel pain to guide your thoughts:

1. *Does your heel pain start with the first few steps out of bed?* (The most common cause of heel pain, PF, is specific for this complaint.)
2. *Does it hurt when you're resting in bed or wake you up from sleep?* (Musculoskeletal pain that is occurring at rest is concerning for fracture, osteomyelitis or malignancy. History including duration of symptoms and other associated complaints will direct



further workup.)

3. *Where in your heel does it hurt?* (The specific location of the pain and tenderness will often guide the clinician to the correct diagnosis. For example, tenderness at the point of insertion of the Achilles tendon (posterior heel) is specific for pathology at that site and strongly rules out PF as the cause.)

Katty Edmond Grandpierre, MD, CMSS, is a physician with CityMD Urgent Care. Frank Ida, BS, EMT-B is senior medical scribe at CityMD Urgent Care. Vincent D'Amore, MD, FACEP is executive vice president of CityMD. The authors have no relevant financial relationships with any commercial interests.

TOP 5 COMMON CAUSES—AND CONTROVERSIAL CONDUCTS—OF HEEL PAIN IN URGENT CARE

Condition	Diagnostic Pearls	Treatments
Plantar fasciitis	“First step” pain Inner medial tenderness of heel	Acute: (<6 weeks): PT (stretching and strengthening of involved anatomy), rest, foot/heel orthotics, steroid injection Chronic: Continued acute treatment; referral for “restorative therapy” (extracorporeal shock wave therapy [ECSW]), surgery
Achilles (calcaneal) tendinopathy calcaneal bursitis	Tenderness at posterior aspect of heel Pain increases with activity and passive dorsiflexion	Rest, PT, heel lift, NSAIDs
Sever’s disease (calcaneal apophysitis)	Heel pain in grade-school children Positive squeeze test	Rest, PT, heel lift, NSAIDs
Tarsal tunnel syndrome	Tenderness Possible <i>positive</i> Tinel test posterior to medial malleolus Positive dorsiflexion-eversion test Neuropathic symptoms unilaterally (may extend to toes)	Rest, PT, orthotics, referral for further testing
Peroneal tendinosis, tendinitis	Tenderness posterior to lateral malleolus Lateral foot pain Popping sound Apprehension with dorsiflexion and eversion	Non weightbearing status +/- walking boot, NSAIDs, acutely refer if persistent symptoms

Exam**General**

As with all patients, examination should include having the patient remove shoes and socks of both feet to check for symmetry as well as obvious signs of infection and inflammation (such as redness or swelling). Additionally, neurovascular status must be assessed and documented, and the joint “above” (knee and fibular head) and “below” (midfoot) the area of the patient’s complaint examined. The location of tenderness will guide the clinician to the correct cause of pain:

1. *Inner medial section of heel surface:* Most commonly, the tenderness will be present at the inner medial section of the heel in addition to possible tenderness along the sole of foot. This is consistent with a diagnosis of PF. If the clinician dorsiflexes the toes it will put tension on the plantar fascia and increase the pain of PF.
2. *Posterior aspect of heel:* The “back” of the heel is where the Achilles (calcaneal) tendon inserts, as well as the location of the retrocalcaneal bursa. Inflammation and injury to these structures will manifest here. In children with heel pain, the most common cause is calcaneal apophysitis (Sever’s disease), an inflammation of the growth plate of the calcaneus.

3. *Bottom of heel:* Tenderness to the middle of the heel pad implies an injury of the heel pad, such as contusion of the heel.
4. *Medial superior aspect of heel (posterior to medial malleolus):* The tibial nerve and flexor tendons pass through the tarsal tunnel, a groove along the inner medial calcaneal bone. In cases of prior injury to the foot, bone spurs or fragments can cause pressure on the tibial nerve. This can result in Tarsal tunnel syndrome.
5. *Lateral superior aspect of the heel (posterior to the lateral malleolus):* Posterior to the lateral malleolus are the tendons of the peroneus longus and brevis. Injuries consisting of both acute (tendinitis) and chronic (tendinosis) can occur.

Heel Pain Culprit #1: Plantar Fasciitis**General**

Thankfully, symptoms of this most common heel condition typically present classically. Upon sleeping or sitting for a prolonged period of time, a patient will have a painless heel suddenly and exquisitely hurt on the medial aspect of that heel upon ambulating the first few steps. This will somewhat resolve upon ambulating but return after periods of rest. The pain will lessen throughout the

day with activity but increase toward the end of the day, depending on the amount of weight the foot has borne.

Whereas the diagnosis of PF is straightforward, the causes are multifactorial, and treatments confusing.

Anatomy and Presumed Causes

The plantar fascia is an aponeurosis of flattened tendons consisting of poorly vascularized connective tissue (type 1 collagen fibers) from the medial posterior calcaneus to the proximal phalanges.

Patients tend to have multiple concurrent factors, including anatomical and functional.

Functional causes of PF relate to problems that occur with modern life, such as sitting too long at both our careers and leisure. Accordingly, we develop tight hamstrings, calves, and iliopsoas muscles, causing positional changes in our trunk and lower extremities and resulting in foot pronation which subsequently increases stress on the plantar fascia.

It is easy to see how a 30-minute workout of jumping rope or running on a heavier-than-designed body can cause an injury to the plantar fascia.

Etiology—overuse

Tension and trauma that are too much and/or too sudden and that overwhelm the body's ability to adapt will cause injury of soft tissues and possibly bone. Running or jumping can cause micro tears at the insertion of the plantar fascia to the heel and cause pain.

A stress fracture of the calcaneus must also be considered if there is an acute significant overuse history, as this diagnosis can present in a similar fashion; consider MRI or bone scan with a concerning history.³

History and Physical

The classic patient with acute PF is a middle-aged, overweight, flat (pronated) footed patient who has recently been exercising more intensely than usual by a running and/or ballistic (bouncing) mechanism or has a career that forces them to stay on their feet for a large portion of the day. Pain follows the classic pattern of being worse on initial ambulation after having been off the foot (such as upon awakening after sleep), no pain while at rest, and tenderness to palpation of the medial inferior portion of the heel with toe dorsiflexion.

Diagnosis

Diagnosis is often made clinically if no concerning history or physical factors exist. Plain x-rays are not necessary to diagnose PF although there are suggestive signs

that can be seen on plain x-ray.

1. Thickness of the plantar fascia (on lateral films) over 5 mm within 5 mm of the calcaneus is a reliable measure of pathological thickening.
2. The triangular-shaped fat pad seen at the calcaneal origin of the plantar fascia may become distorted or absent in those with PF.
3. Finally, there may be cortical changes at the plantar fascia attachment site.

Note that bone spurs are not specific for PF and are often seen in asymptomatic patients.⁴ MRI findings include plantar fascia thickening, edema, and fat pad irregularities below the plantar fascia.

Treatments

Acute

Acute (within the first 6 weeks) treatments commonly prescribed, especially for an acute injury or pain, are rest, ice to the area, stretches, and possibly a short course of NSAIDs.

While a common course of practice adopted by many clinicians is to treat a painful musculoskeletal condition with anti-inflammatory medicines, there have not been strong data to support their use. A randomized, prospective, placebo-controlled study found no difference between celecoxib and placebo at 1, 2, or 6 months.⁵ Accordingly, the American College of Foot and Ankle Surgeons (ACFAS) does not recommend the routine use of NSAIDs in treating PF.⁶

Strengthening of intrinsic foot muscles and stretching of the plantar fascia and tight muscle groups such as calves, hamstrings and hip flexors should be encouraged. Specifically stretching the PF with a cold bottle rolled along sole of foot is an often-suggested treatment as it stretches the plantar fascia itself, applies the anti-inflammatory properties of ice, and may “break up” scar tissue.

Therapeutic taping of the foot decreases foot pronation and transfer force to the lateral aspect of foot while ambulating. The tape is often worn for 2–5 days and can be applied by the patient at home or by a physical therapist.

Orthotics and foot splints

Initial treatment often includes a foot orthotic, as an orthotic minimizes the stress placed on the plantar fascia with ambulation and often decreases pain by reducing foot pronation despite not addressing the underlying causes, such as tight calves. While some clinicians may suggest expensive custom orthotics, store-bought orthotics (Figure 1) are found to be as helpful as custom orthotics. It is a reasonable initial treatment but

should not be the only treatment.

Padded foot splints, which dorsiflex the ankle and stretch the calves, are also of some help and are often purchased over the counter but often their lack of comfort, they are generally worn while sleeping, limits their use.⁷

Physical therapy

Anatomical changes of muscle relationships that result in increased stress on the plantar fascia and weakening of supporting intrinsic muscle strength of the foot, as is often the case, must be addressed.

Muscle mobilization therapy

Forcefully rubbing the muscles of the calves and heel of the foot at the fascia insertion and sole by hand and/or with hard tools to induce a microtrauma and “break up” scar tissue is a common mobilization therapy. The Graston technique is a patented example of this type of treatment.

Local steroid injection

Although no definitive consensus as to when, or exactly how much and which steroid should be used, *at some point* if initial treatments do not help, referral for local corticosteroid injection should be considered. There are multiple approaches that may, or may not, include sonographic guidance, which theoretically will decrease the likelihood of puncturing the plantar fascia with the needle. There is often short-term benefit, which has been shown to decrease one month after injection when compared to placebo.⁸ There is no definitive consensus as to how many steroid injections can be given safely.

Multiple injections are given judiciously as they may predispose to heel pad atrophy and/or PF rupture.

These “conservative” options are standard treatment and usually effective in treating the condition effectively in 90% of patients.

Extracorporeal shock wave therapy

The presumed mechanism for this minimally invasive, well-tolerated treatment is that the local shock waves will disrupt scar tissue and induce revascularization and thus enhance intrinsic healing. There are currently no definitive treatment protocols which may influence the reported results of this treatment which has shown a short term (3–6 months) improvement over placebo and suggested benefit over placebo for up to a year.⁹

Surgery

Conservative treatments are effective in 90% of patients, making surgery unusual.

Heel Pain Culprit #2: Achilles (Calcaneal) Tendinopathy And Bursitis

General

Pain at the back of the heel is commonly the result of pathology to the Achilles tendon at the insertion to the calcaneus. Injury at the insertion site is termed *enthesopathy*. Additionally, bursae exist at the insertion site of the calcaneus that can also become inflamed. The gastrocnemius and soleus muscle together form the calcaneal, or Achilles, tendon. That, as well as the peroneus longus and brevis, allows for plantar flexion of the ankle.

Although not technically the heel, it is imperative to consider and rule out calcaneal tendon rupture, as this may require surgical treatment.

Injury, as well as rupture, of the tendon tends to occur at an area that has less blood flow to the tendon, roughly 2–6 cm proximal to the insertion at the calcaneus. As with other tendon pathologies, it is presumed this area may have more prior micro injuries that have not healed, resulting in abnormal fibroblastic growth that is vulnerable to acute tear from a shearing stress on activity.

This injury is more common among those who regularly forcefully flex their calves, such as runners and competitive athletes. Age is also a factor, especially as people continue to compete longer.

Historically, the patient will present with an acute pain upon forceful plantar flexion, unlike a sprain, a common incorrect diagnosis, which occurs with trauma. Physical exam for the integrity of the tendon is done by performing a Thompson’s test. The patient lies prone, and squeezing of the calf muscle elicits plantar flexion. This test has been found to be very accurate in diagnosing rupture with a sensitivity and specificity of 96% and 93% respectively.¹⁰

Management

All ruptures or potential ruptures should be referred to orthopedic surgery for further testing, treatment, and possible surgical repair (although there is no definitive study demonstrating the superiority of surgical to non-surgical treatment).

Nonsurgical treatments also vary specifically but attempt to maintain contact between both ends of the injured tendon.

Splinting the patient in plantar flexion will help maintain contact. Weightbearing status will change as the injury heals “when ankle mobility allows it.”¹¹

Assuming that tendon rupture has been ruled out, the clinician can focus on the area in question.

Enthesopathy, or injury, at the posterior section of the

calcaneus is the specific location of pain and discomfort felt by patients. The mechanism commonly is a direct pulling of tendon fibers from the bony periosteum. This results in an inflammatory reaction acutely.

As can be expected, those who endure more forceful contractions and tension at this anatomical site are prone to more injuries. Runners, especially if competitive, male, and older, are prone to this entity.

Occasionally an exostosis, or bony outgrowth, of the posterosuperior of the calcaneus will occur. Currently this outgrowth, Haglund's deformity, is felt to be due to chronic high stress of the calcaneal tendon. It is more common in women and is termed a "pump bump," as certain shoes will repeatedly cause pressure to the area.

Located at the insertion site both superior and inferior to the tendon are two calcaneal bursa that can also become inflamed by the same mechanisms.

History and Physical

Patients will present with pain and tenderness at the back of the heel. Often it will be the result of increased activity overwhelming the body's ability to repair itself, as is the case of many acute presentations of heel pain. Furthermore, patients will also be older and active, as is the case with other causes of heel pain as well.

Physical exam will reveal tenderness at the posterior heel. There may be signs of inflammation, such as redness and swelling of the site.

It is difficult to definitively differentiate the specific source of pain. Insertional tenderness is usually greatest in the middle of the calcaneus while bursitis tenderness is usually just superior to the bone. Bursitis pain usually is not elicited by only palpating the tendon itself

Diagnosis

The diagnosis is typically clinical with both palpation at the insertion of the Achilles tendon and performing the Thompson test to rule out a tendon rupture as mentioned previously.

Radiological imaging has not been found to be very accurate in diagnosis of tendinopathy.

Ultrasound may help differentiate between bursae or tendon pathology and can see localized inflammation demonstrate fluid in inflamed bursae.

MRI can additionally show tears in the calcaneal tendon and evaluate specifically for stress fractures as well as infection.¹²

Treatment

A common course of treatment initiated to these

Figure 1. Sever's disease



Source: Noffsinger MA. Calcaneal apophysitis (Sever disease) workup. Medscape. September 7, 2016.

patients is one of avoidance of likely precipitating factors. Additionally, ice to the area as well as a heel lift to decrease tension at the insertional site is often provided. Many will consider a short course of NSAIDs to help acutely.

If symptoms persist, patients are often sent to PT which will concentrate on strengthening both in concentric and eccentric fashion which is felt to normalize tendon function. Symptoms may be prolonged and it may be 3-12 months before full strength and function is restored.¹³

Heel Pain Culprit #3 (A School-Age Problem): Sever's Disease

General

In children with heel pain, the most common cause is calcaneal apophysitis (Sever's disease), an inflammation of the growth plate, or apophysis, of the calcaneus. It usually occurs in active grade school children.

The growth plate of the calcaneus starts to close around 8 years of age and by 14 years is usually fused. There is increased metabolic activity of the apophysis during periods of rapid growth which may make it more susceptible to injury.

It is felt that repetitive injury from activity causes micro trauma and pain to the area. Additionally, both the tibial tendon as well as the plantar fascia insert into the apophysis. Tight muscles may contribute to the pathology as well.

History and Physical

The pain is insidious at onset and worse with activity, especially running and jumping. This can be thought of as Osgood-Schlatter disease of the foot by mechanism, too much stress on a nonfused growth plate, which should resolve as the child ages.

An exam technique that can differentiate this from other causes of heel pathology is the squeeze test. Grasping both sides of the calcaneus avoids the potential anatomical causes of pain of PF as well as tendon pathology. Pain elicited is specific for calcaneal source of pain.

Diagnosis

X-rays are usually not indicated unless symptoms are prolonged or if concern of other pathology exists. MRI imaging can show inflammation within the apophysis as well as exclude other pathology such as stress fracture

Treatment

Treatment consists of rest, calf stretches and strengthening of eccentric calf contraction that will soften landing forces on heel, padding to the heel, ice to affected area and a short course of NSAIDs if pain is severe. NSAIDs should not be given before athletic event as they can mask pain and allow more micro trauma to occur.

Heel Pain Culprit #4: Tarsal Tunnel Syndrome**General**

Posterior to the medial malleolus is the tarsal tunnel, which encompasses multiple flexor tendons as well as the posterior tibial artery and nerve that pass through this tunnel bordered by bone on the inside and the flexor retinaculum on the outside. Increased pressure in this canal, often from anatomical causes, will cause pressure on the nerve. Commonly, prior injuries that result in bony fragments or overgrowth, scar tissue, nerve ganglion, etc. can cause this uncommon peripheral neuropathic syndrome.

History and Physical

Patients complain of pain along the nerve path from the inner heel to the sole of the foot. Additionally, a patient can feel tingling and burning “shooting” along the inner sole of the foot. In more pronounced cases, a Tinel’s sign will be present on tapping of the tibial nerve posterior to the malleolus. Often there will have been a prior injury to the talus or medial malleolus that will result in scar formation, bone spurs or cartilage fragments compressing the anatomical canal.

Diagnosis

History of pain posterior to the medial malleolus radiating to the inner sole of the foot is suggestive of this entity.

On physical exam, two tests are helpful:

1. The Tinel test, which consists of tapping the nerve to elicit symptoms, is somewhat helpful as sensitivity ranges from 25%-75% and specificity 70%-90%.¹⁴
2. The dorsiflexion-eversion test stretches the canal and possibly compress the nerve. It is performed by passive dorsiflexion and eversion of the ankle as much as comfortably tolerated for 10 seconds. This test is positive in 82% of those patients with tarsal tunnel syndrome.¹⁴
3. Radiologic imaging is not typically necessary with short duration of symptoms.
4. X-rays can evaluate for bony abnormalities. MRI can evaluate the tarsal tunnel itself to assess for space occupying lesions.

Treatment

As with any nerve compression injury, if left untreated irreversible nerve damage may result. While a short course of NSAIDs and rest is reasonable, referral for further diagnostic testing such as MRI and nerve conduction studies is suggested if symptoms persist. Surgery releasing the nerve may be necessary in severe cases. If the neurological complaints were bilateral, one would consider neuropathy as a cause, especially if the patient were diabetic.

Heel Pain Culprit #5: Peroneal Tendon Pathology**General**

Peroneal tendon pathology is an underappreciated condition of those with chronic lateral ankle pain. The peroneus longus and brevis run along the lateral portion of the lower leg. They help in stabilization of the ankle, as well as plantar flexion and eversion. A few centimeters proximal to the lateral malleolus they are surrounded by a sheath that courses posterior to the lateral malleolus to the lateral foot. The tendons are kept from subluxing at the lateral malleolus by the superficial peroneal retinaculum.

Pathology of this area is often of an overuse mechanism with injury to the tendon and/or the retinaculum.

Pain can be felt along the outer heel into the tendon insertions on the lateral aspect of the foot, medial cuneiform, and first metatarsal bone and base of the fifth metatarsal, respectively. This is often seen in athletes who run or are required to make sharp cutting movements while running. Lateral wear on the heel of their shoes may imply additional stress and stretching

on those tendons.

An easy-to-make mistake is to simply diagnose a lateral ankle ligament sprain when in fact the ligaments, which are located inferior to the lateral malleolus, are not involved. As the treatment is different, a high index of suspicion should exist.

In one chart review, only 60% of those with peroneal disorders were correctly diagnosed on initial examination.¹⁵

History and Physical

Patients will often complain of post-activity lateral ankle pain that resolves with rest. Additionally, and specifically, they may complain of a “popping” or slipping feeling in their ankle. That complaint alone may cause an alert clinician to refer to specialty care.

On physical exam, swelling and thickening of the tendons may be appreciated.

Dorsiflexion and eversion of the ankle may worsen symptoms.

Diagnosis

If a fracture is expected, radiograph imaging needs to be performed; however, that will not show soft tissue injuries.

Ultrasound has emerged as a quick and accurate testing tool for peroneal tendon abnormalities. Tendon pathology is evident if one sees thickening, hypoechoic (darker) swelling, and damage to the tendon fibers. Additionally, abnormal tendon movement may be visible if the retinaculum is damaged. The ability to do contralateral ankle comparison and perform dynamic testing differentiates it from MRI and is commonly performed.

One study using operative results as the gold standard stated ultrasound had a sensitivity and specificity of 90% and 94%, respectively, while MRI only had a sensitivity of 23% although a 100% specificity and accuracy of 66%.¹⁶

However, MRI still continues to be an accurate imaging modality as it can “see” tendon pathology (as well as osteochondral lesions, if present) not as easily seen on ultrasound.

Treatment

Acute injuries are often treated as is expected with rest, ice, and immobilization. When the peroneal tendons are acutely injured, many will include a period of non weight-bearing, often in a walking boot; this is not the common treatment for the misdiagnosis of ankle sprain the patients often are given.

If the injury or pain is significant for a severely torn

or stretched tendon, or instability from a retinaculum tear, surgery is recommended to tighten, repair, and stabilize the ankle.

Clinical Pearls

- Many diagnoses are clinical and can be made at the bedside in the urgent care office.
- For many acute injuries, a conservative approach of rest, ice, and consideration of a short course of NSAIDs, if there are no contraindications, is a reasonable approach for many of the most common diagnoses. An additional consideration of peroneal tendon injury should exist for all “common” ankle sprains as the treatment is more conservative: a walking boot over the usual *weight-bearing as tolerated* precautions.
- Clinicians should have a low threshold to send patients to physical therapy.
- For patients with pain over 3-6 months, consider specialist referral for definitive diagnosis and consideration of steroid injections and possibly “restorative therapy” treatments. ■

References

1. Jozsa LG, Kannus P. Human tendon: anatomy, physiology and pathology. Champaign, IL; Human Kinetics Publisher 1997.
2. Tu P, Bytowski JR. Diagnosis of heel pain. *Am Fam Physician*. 2011;84(8):909-916.
3. Mayer SW, Joyner PW, Almekinders LC, Parekh SG. Stress fractures of the foot and ankle in athletes. *Sports Health*. 2014;6(6):481-491.
4. Draghi F, Gitto S, Bortolotto C, et al. Imaging of plantar fascia disorders: findings on plain radiography, ultrasound and magnetic resonance imaging. *Insights Imaging*. 2017;8(1):69-78. [Epub December 12, 2016.]
5. Donley BG, Moore T, Sferra J, et al. The efficacy of oral nonsteroidal anti-inflammatory medication (NSAID) in the treatment of plantar fasciitis: a randomized, prospective, placebo-controlled study. *Foot Ankle Int*. 2007;28(1):20-23.
6. Schneider HP, Baca JM, Carpenber BB, et al. American College of Foot and Ankle Surgeons Clinical Consensus Statement: Diagnosis and treatment of Adult Acquired Infracalcaneal Heel Pain. *J Foot Ankle Surg*. 2018;57(2):370-381.
7. Lewis RD, Wright P, McCarthy LH. Orthotics compared to conventional therapy and other non-surgical treatments for plantar fasciitis. *J Okla State Med Assoc*. 2015;108(12):596-598.
8. Crawford F, Atkins D, Young P, Edwards J. Steroid injection for heel pain: evidence of short-term effectiveness. A randomized controlled trial. *Rheumatology (Oxford)*. 1999;38(10):974-977.
9. Aqil A, Siddiqui MR, Solan M, et al. Extracorporeal shock wave therapy is effective in treating chronic plantar fasciitis: a meta-analysis of RCTs. *Clin Orthop Relat Res*. 2013;471(11):3645-3652.
10. Maffulli N. The clinical diagnosis of subcutaneous tear of the Achilles tendon. A prospective study in 174 patients. *Am J Sports Med*. 1998;26(2):266-270.
11. Gulati V, Jaggard M, Al-Nammari SS, et al. Management of Achilles tendon injury: a current concepts systematic review. *World J Orthop*. 2015;18(6):380-386.
12. Shah MT, Wong BS. Clinics in diagnostic imaging (170). *Singapore Med J*. 2016;57(9):517-522.
13. Kedia M, Williams M, Jain L, et al. The effects of conventional physical therapy and eccentric strengthening for insertional Achilles tendinopathy. *Int J Sports Phys Ther*. 2014;9(4):488-497.
14. Kiel J, Kaiser K. Tarsal tunnel syndrome. StatPerls (Internet). Available at: <https://www.ncbi.nlm.nih.gov/books/NBK513273/>. Accessed April 15, 2019.
15. Dombek MF, Lamm BM, Saltrick K, et al. Peroneal tendon tears: a retrospective review. *J Foot Ankle Surg*. 2003;42(5):250-258.
16. Rockett MS, Waitches G, Sudakoff G, Brage M. Use of ultrasonography versus magnetic resonance imaging for tendon abnormalities around the ankle. *Foot Ankle Int*. 1998;19(6):604-612.

FASTER ANSWERS.
EARLIER TREATMENT.



Introducing The
Sysmex® XW™-100



**CLIA
WAIVED**

CBC tests that once required a central lab can now be performed at the point-of-care with the Sysmex XW-100 — benefiting both patients and providers through faster results.

- Expedite diagnosis and treatment
- Improve patient satisfaction
- Streamline workflow

Sysmex, the global leader in hematology analyzers, has developed the first FDA-cleared, CLIA-waived CBC analyzer that provides reliable, convenient, and often, same-visit CBC results. If you are looking to increase practice efficiencies and patient satisfaction, the same visit CBC offers unprecedented possibilities.

For more information, visit CBCin3.com



Case Report

CME: This article is offered for AMA PRA Category 1 Credit.[™] See **CME Quiz Questions** on page 7.



An 11-Year-Old Girl with Back Pain and Chronic Poor Appetite

Urgent message: Patients with recurrent symptoms should have an expanded history—including a genitourinary history in premenarchal girls.

LAVANYA BODDU, MD, MBA

Presentation

The patient is an 11-year-old female brought by her mother to urgent care, with a chief complaint of back pain. The patient was pushed down at school about 2 weeks ago playing ball, landed on her buttocks, and is complaining of back pain radiating to BL hips. She is still able to walk and carry out her regular activities with some pain. No fever, recent illnesses, abdominal pain, nausea, or vomiting. No dysuria, increased frequency or urgency, but at times she has to push on the pelvic area to urinate and have bowel movements.

- Past medical history: Neg
- Allergies: None
- Meds: None
- FH: Not significant
- Surgical history: None

Social

Lives with parents. Nothing has changed at home. She does not eat well, is not gaining weight, and misses school quite a bit, stays in bed with pain some days—more in the past year. Patient has been to her primary care for these issues many times in this last year; all tests were normal.

She also had GI referral, labs done—abdominal panel, gluten, urine—all of which were negative. She was referred to psychiatry secondary to recurrent abdominal pain in light of normal labs and missing school quite a bit.

Physical Exam

- Vital signs normal except for tachycardia, with HR of 115.



©Fotolia.com

- Appearance: Thin build. Uncomfortable, appears in pain, trying to rest her buttocks very lightly on the end of the examination table, frequently raising the buttocks up as if it hurts by putting pressure on hands
- CVS: Tachycardia, regular rhythm
- Lungs: Clear
- Abdominal exam: NT/ND, BS+. Soft, abdomen. No HSM. No BL CVA tenderness
- MS: Tenderness on L spine and BL paralumbar spinal areas, radiating to sacrum, BL hips and BL greater trochanteric area. No tenderness to palpa-

Lavanya Boddu, MD, MBA serves as physician and medical director at Memorial Express Cares, Memorial Medical Center in Springfield, IL. The author has no relevant financial relationships with any commercial interests.



AN 11-YEAR-OLD GIRL WITH BACK PAIN AND CHRONIC POOR APPETITE



tion in the buttock region

- Gait: Widespread legs, hunched-over gait, taking wide slow steps
- Neurologically: CN 2-12 intact
- Psych: A/O x 3. Tearful secondary to moderate pain in back

Labs

- UA: neg
- X-ray: L spine and BI hips normal

Differential Diagnosis

- Trauma: Consider x-ray for fracture, though the time span of 2 weeks makes this less likely musculoskeletal pain. If imaging is negative, consider musculoskeletal pain for a strain or sprain; however, that does not explain patient's out-of-proportion pain or the wide-based abnormal gait 2 weeks after her injury.
- UTI: UTI symptoms are not always typical. Some

patients present with back pain, abdominal pain, dizziness, weakness, or even, in the elderly, hallucinations. Our patient complains of having to "push" on the abdomen to get urine out. She may have an epidural compression/cauda equina syndrome and should have bedside evaluation including strength, sensation, and straight leg raise testing.

- Constipation: It is very common in this age group and remains on the differential diagnosis, but more serious things need to be considered first.
- Abdominal pathology: Abdominal pathology like appendicitis must be considered; note that it can present with or without fever, abdominal pain, decreased appetite, nausea, vomiting. Thought gastroenteritis is common, our patient does not fit this diagnosis.
- GERD can present with early satiety, nausea, abdominal pain. *H pylori* infection would be unusual in this age group.
- Attention-seeking: Should be a diagnosis of exclusion; should be considered with questions about home and school situation and relation of abdominal pain to social stressors.

Summary

None of our patient's symptoms are typical of the differential above. Her problem list includes:

- Low back pain
- Musculoskeletal injury
- Abnormal gait
- Tachycardia

An MRI L spine is ordered to look for musculoskeletal or soft tissue abnormalities. The patient is sent home from the urgent care center with recommendation for OTC symptomatic analgesics.

Diagnosis

Hematocolpos
Imperforate hymen

Outcome

After MRI results showed distended vaginal area, tugging on the back in lumbosacral region, filled with blood/fluid (Figure 1), patient was referred to the ED, with OB/GYN consulted. Gynecological exam revealed normal labia but a small bluish mass (about 3 cm) pushing out through the vagina. Patient was transferred to the children's hospital. Patient evaluated by pediatric GYN specialist, taken to surgery. Patient underwent hymenotomy and drained

approximately 350 cc of old blood that had accumulated due to retrograde menses in the past year.

Discussion

Diagnosis and Management of Congenital Anomalies of the Vagina

Embryology

The development of the female genital tract begins at 3 weeks of gestation and continues into the second trimester of pregnancy.¹⁻³

Hymen

The vaginal lumen is separated from the urogenital sinus by the hymenal membrane. The hymen usually ruptures before birth due to degeneration of the central epithelial cells. However, a thin fold of mucous membrane persists around the vaginal introitus.³

Anomalies of the Hymen

The hymenal membrane consists of fibrous connective tissue attached to the vaginal wall. Hymenal anomalies are derived from incomplete degeneration of the central portion of the hymen.

Imperforate Hymen

An imperforate hymen is one of the most common obstructive lesions of the female genital tract. At birth, infants may have a bulging introitus due to mucocolpos from vaginal secretions stimulated by maternal estradiol.^{1,4-6} If the diagnosis is not made in the newborn period and the hymen remains imperforate, the mucus will be reabsorbed and the child usually remains asymptomatic until menarche. At that time, the adolescent girl may present with a history of cyclic abdominal or pelvic pain and hematocolpos, which may give the hymenal membrane a bluish discoloration. Marked distension of the vagina may also result in back pain, pain with defecation, or difficulties with urination.^{7,8}

Differential diagnosis includes imperforate hymen, agenesis of lower vagina, or a low transverse vaginal septum.

Treatment

Repair of the hymen can be performed at any age, but is ideal in the newborn, postpubertal, or premenarchal time periods.^{4,7,8}

“Differential diagnosis includes imperforate hymen, agenesis of lower vagina, or a low transverse vaginal septum.”

Incomplete Hymenal Fenestration

Incomplete fenestration of the hymenal opening (microperforate, septate, or cribriform) is often asymptomatic. Patients may seek gynecologic evaluation because of inability to insert tampons, douches, or vaginal creams, or because of difficulty with coitus.⁹ In addition, women with microperforate hymens may present with postmenstrual spotting or malodorous discharge due to partial obstruction and

poor drainage. If menstrual products are not fully evacuated from the vagina, the retained blood may become infected and lead to tubo-ovarian abscesses.¹⁰

Treatment of microperforate, septate, and cribriform hymens involves resection of the excess hymenal tissue to create a functional hymenal ring, as described above. The excess hymenal tissue is excised with the use of electrocautery and interrupted sutures are placed to reapproximate the tissue.

Conclusion

- Include a menstrual history in adolescent girls, keeping in mind age of menarche may occur as early as 8 years.
- A GU exam may make the diagnosis.
- In menarche age-group girls with chronic recurrent abdominal pain, back pain, bowel problems, and bladder problems, consider imperforate hymen and hematocolpos. ■

References

1. The American Fertility Society classifications of adnexal adhesions, distal tubal occlusion, tubal occlusion secondary to tubal ligation, tubal pregnancies, müllerian anomalies and intrauterine adhesions. *Fertil Steril*. 1988;49(6):944-955.
2. Garcia RF. Z-plasty for correction of congenital HYPERLINK "file:///C:/contents/diagnosis-and-management-of-congenital-anomalies-of-the-vagina/abstract/6" transverse-HYPERLINK "file:///C:/contents/diagnosis-and-management-of-congenital-anomalies-of-the-vagina/abstract/6" vaginal septum. *Am J Obstet Gynecol*. 1967;99(8):1164-1165.
3. Jenny C, Kuhns ML, Arakawa F. Hymens in newborn female infants. *Pediatrics*. 1987;80(3):399-400.
4. Saxena AK. Pediatric Imperforate hymen treatment & management. *Medscape*. Available at: <https://emedicine.medscape.com/article/954252-treatment>. Accessed April 10, 2019.
5. MacLaughlin DT, Donahoe PK. Sex determination and differentiation. *N Engl J Med*. 2004;350(4):367-378.
6. Berenson A, Hager A, Andrews S. Appearance of the hymen in newborns. *Pediatrics*. 1991;87(4):458-465.
7. Vainio S, Heikkilä M, Kispert A, et al. Female development in mammals is regulated by Wnt-4 signalling. *Nature*. 1999;397(6718):405-409.
8. BIASON-LAUBER A, KONRAD D, NAVRATIL F, SCHOENLE EJ. A WNT4 mutation associated with müllerian-duct regression and virilization in a 46,XX woman. *N Engl J Med*. 2004;351(8):792-798.
9. Tardieu SC, Appelbaum H. Microperforate hymen and pyocolpos: a case report and review of the literature. *J Pediatr Adolesc Gynecol*. 2018;31(2):140-142.
10. Evans TN, Poland ML, Boving RL. Vaginal malformations. *Am J Obstet Gynecol*. 1981;141(8):910-920.



HEALTH LAW AND COMPLIANCE

Do Nurse Practitioners and Physician Assistants Qualify for Overtime in the Urgent Care Setting?

Urgent message: Physician assistants and nurse practitioners perform many of the same tasks as physicians in urgent care settings, but ambiguity as to the nature of their practice means additional consideration must be given in how their pay is structured.

■ ALAN A. AYERS, MBA, MAcc

The federal Fair Labor Standards Act¹ (FLSA) states that all “nonexempt” employees must receive overtime pay not less than 1½ times their regular rate of pay for every hour over 40 hours worked during a work week.^{2,3} Of concern to urgent care owners is whether their nurse practitioner (NP) and physician assistant (PA) employees, known collectively as advanced-practice providers (APPs), qualify for overtime. While much of the evidence supports a conclusion that they are exempt from overtime under the FLSA, some claim that the rules are ambiguous and open for debate.

Discussion

APPs in urgent care facilities are increasingly asked to work independently to care directly for patients. Doing so includes taking a history and physical, evaluating symptoms and consulting medical literature, making a diagnosis, performing many procedures, prescribing medication, and making referrals—the same day-to-day work as a physician.

In some states, APPs are able to now practice independently

without physician supervision. And where physician supervision is required, it frequently takes the form of on-call availability and chart reviews rather than direct physical supervision. Our national physician shortage has created a call for PAs and NPs to staff urgent care facilities on their own and for extended hours.

MDs, DOs, and APPs have typically been paid on an hourly basis in urgent cares. This is because of scheduling, as an urgent care center may be open 12-14 hours per day; it’s more practical to pay these healthcare professionals based on hours worked instead of a flat salary. The schedule for urgent care can be unpredictable.

Physicians—even when “hourly exempt”—don’t qualify for overtime; however, the FLSA has been interpreted in more than one way that supports some urgent care centers paying hourly overtime to APPs.

White-Collar Exemption

Those employees who are in a “bona fide executive, administrative or professional capacity”⁴—commonly referred to as a “white-collar” job—are exempt from the overtime requirements of the FLSA. As a result, an employer isn’t required to pay these employees overtime.⁵

The term “employee employed in a bona fide professional capacity” means “[a]ny employee who’s the holder of a valid license or certificate permitting the practice of law or medicine or any of their branches and is *actually engaged in the practice thereof*...”⁶



Alan A. Ayers, MBA, MAcc is Chief Executive Officer of Velocity Urgent Care and is Practice Management Editor of *The Journal of Urgent Care Medicine*.

HARD EARNED MONEY
CHILDREN'S FUTURE
RETIREMENT
FAMILY STABILITY

With so much at risk,

SUCCESS

is your only option.

TIME
REPUTATION

When it comes to your urgent care endeavor, success is the only option. Why risk that success when you can partner with Urgent Care Consultants for all of your startup or enhancement needs? #WhyRiskIt

**Urgent Care
ConsultantsSM**

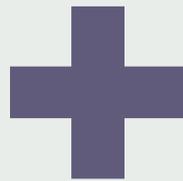
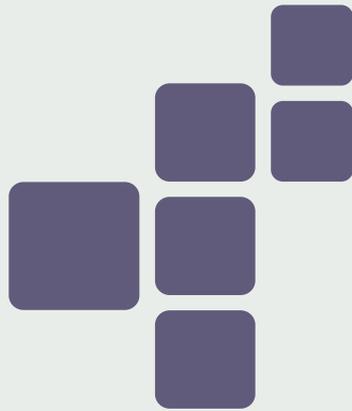
888-779-0543 | urgentcareconsultants.com/whyriskit

This happened at UCA.

DocuTAP & Practice Velocity have agreed to merge. In partnership with urgent care centers throughout the country, DocuTAP and Practice Velocity have shaped the industry. As one company, we will help our clients grow, thrive, and evolve through innovation and a commitment to patient-centered care—it's what (still) drives us.*

To learn more, visit docutap.com or practicevelocity.com.

*Regulatory approval pending.
Until closing, PV & DT will continue to operate as separate companies.



**PENDING
REGULATORY
APPROVAL**

Our Solutions

YOUR SUCCESS

**Direct access to
the urgent care
credentialing
experts.**

Why risk your reimbursements when we have access to an in-house contracting and credentialing team who can anticipate any barriers you may face obtaining contracts? We have solutions for all your startup or enhancement needs. #WhyRiskIt

**Urgent Care
ConsultantsSM**

888-779-0543 | urgentcareconsultants.com/whyriskit

H E A L T H L A W A N D C O M P L I A N C E

An employee is considered paid on a salary basis if “under his employment agreement he regularly receives each pay period on a weekly, or less frequent basis, a predetermined amount constituting all or part of his compensation.”⁷ However, section 541.3(e) provides that the salary-basis test doesn’t apply to bona fide professionals.⁸

Belt v Emcare, Inc.

In a 2006 Fifth Circuit case, PAs and NPs sued their employers, seeking back wages and liquidated damages for alleged violations of the FLSA.⁸ The PAs and NPs provided healthcare services and were paid hourly at a flat rate for all hours worked, including overtime. They alleged that the employers violated the FLSA by failing to pay time-and-a-half compensation for overtime, however. The employers argued that the PAs and NPs qualified for the exemption as bona fide professionals under 29 C.F.R. § 541.3(e) because they unambiguously practiced medicine or a branch of medicine within the meaning of the regulation. The only issue was whether NPs and PAs hold a license permitting, and actually engage in, “the practice of...medicine or any of [its] branches.”⁸

The Court said if the NPs and PAs “practice medicine” within the meaning of § 541.3(e), they didn’t need to satisfy the salary-basis test to qualify for the exemption. As such, the employer could deny additional overtime pay. But if the PAs and NPs don’t practice medicine under § 541.3(e), they *are* subject to the salary-basis test, they *don’t* fall within the exemption, and they *are* eligible for time-and-a-half compensation.

The Fifth Circuit held that the employers’ ambiguity argument was preserved for appeal because a finding that § 541.3 was ambiguous was necessary to the district court’s ultimate conclusion. The Court also determined that § 541.3(e) was ambiguous as to whether PAs and NPs practiced medicine or any of its branches. As a result, the Fifth Circuit gave controlling weight to the Department of Labor’s opinion letter, the Bureau of Labor Statistics’ Occupational Outlook Handbook, and amicus brief, which gave credence to the interpretation that PAs and NPs needed to be paid on a salary basis to be exempt from the FLSA. Thus, PAs and NPs did not fall within the professional exemption.⁸

Physician Assistants

The U.S. Department of Labor (DOL) has stated that the white-collar exemption for medical professions extends to certified physician assistants with 4 years of preprofessional and professional study, and who are graduates from an accredited PA program.⁹

An alternative interpretation of the FLSA endorsed by the American Academy of Physician Assistants (AAPA) contends that urgent care owners may *choose* to pay PAs as hourly wage earners. If an employer chooses to pay PAs hourly, then they don’t fall into any exempt category. As a result, the urgent care owner must, by law, pay them at least time-and-one-half for

“Urgent care owners should use caution and consult with experienced legal counsel with expertise in employment law when developing an overtime policy that impacts PAs and NPs. Besides (arguably unclear) federal legislation, there may be state laws to consider.”

any hours over 40 worked in a week.^{10,11}

A question arises as to whether there’s a distinction between a PA or NP who is working as the sole provider on a shift and one who is “helping” as the second provider when a physician is also on duty. While this argument may have some merit, some states have closed off this line by enacting legislation. For example, in Pennsylvania, a PA “practices medicine with physician supervision,” and “shall be considered the agent of the supervising physician in the performance of all practice-related activities.”¹²

In New York, a federal district court has also heard this argument.¹³ The Court said that, in most cases, “the practitioners who are expressly included within or have been held to fall within § 541.304 are required to hold doctoral-level medical degrees.”¹³ Again, the Court emphasized its role of construing the FLSA’s exemption provisions narrowly.¹³

Nurse Practitioners

In *Hager v Claiborne Cty. Med. Ctr.*,¹⁴ a nurse practitioner alleged that he was an employee of the defendant and was paid on an hourly basis, and that he worked over 40 hours a week. The NP claimed that the hospital paid him at the regular rate for every hour worked over 40 in any given work week, rather than at time and half.

The Court found that the NP was paid on an hourly basis, so he didn’t satisfy the salary-basis test.¹⁴ But the Court noted if the NP holds “a valid license or certificate permitting the practice of...medicine or any of [its] branches and...[was] actually engaged in the practice thereof,” he may qualify for the “salary-basis exception” and, therefore, be subject to the professional exemption.¹⁴ Nonetheless, the Court reiterated that the Fifth Circuit has deferred to the DOL’s opinion that NPs must be paid on a salary basis to be exempt from the FLSA.¹⁴ In light of this,

HEALTH LAW AND COMPLIANCE

the Court found that the NP wasn't paid on a salary basis, and therefore, wasn't subject to the professional exemption.¹⁴

Learned Professional Exemption

The federal rules also provide an exception for "learned professional employees." To qualify for the exemption, an employee's primary duty must be "the performance of work requiring advanced knowledge in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction."¹⁵ The test includes three elements:

- The employee must perform work requiring advanced knowledge.
- The advanced knowledge must be in a field of science or learning.
- The advanced knowledge must be customarily acquired by a prolonged course of specialized intellectual instruction.¹⁵

The AAPA argues that "[T]his does not mean that PAs must be classified as learned professionals."¹⁶ The organization argues that to be considered a "learned professional," an individual has to meet *all* of the criteria—which PAs do not do. In their view, PAs are learned professionals and are not protected by federal overtime requirements if the employer chooses to pay them a salary.¹⁶

Analysis

The Fifth Circuit's 2006 decision has not been overruled or distinguished by the U.S. Supreme Court. As a consequence, that Court's deference to the DOL and the Bureau of Labor Statistics appears sound.

That Court in *Belt* explained that, in addition to creating the salary-basis test under 29 C.F.R. § 541.3 (1973), the DOL also issued regulations interpreting the salary-basis test.¹⁷ The Court noted that the DOL has also issued an opinion letter that addresses the application of the salary-basis test to PAs. Further, a DOL handbook also interprets the salary-basis test as it applies to PAs.¹⁷ The Court found that "[t]hese interpretations will be controlling unless they are clearly erroneous." The regulations define and delimit the substance of the overtime exception for those employed in an executive, administrative, or professional capacity.¹⁸

A Pennsylvania court noted that the DOL "has consistently interpreted the regulations set forth in § 541 to require a PA to satisfy both the duties test and the salary-basis test, as set forth in § 541.300(a)(1)-(2), in order to qualify for an exemption from the FLSA's overtime requirements."¹⁹ It explained that the DOL has refused to extend § 541.304's exception to the salary-basis requirement beyond actual physicians and has "consistently taken the position that the salary-basis exception does not apply to PAs."¹⁹

More recently, a New York District Court recognized that "[a]lthough there is limited case law interpreting § 541.304 or

its predecessor provision, courts have determined that Nurse Practitioners and Physician's [sic] Assistants are not within the exception because, despite the similarity of their duties to those of general practitioners, the Department of Labor considers them to 'service the medical profession.'"²⁰

Courts since that time have rejected attempts to broaden the application and scope of the FLSA exemptions.^{21,22} Given the current sense of stability and acceptance of this rule, the more prudent approach would be to not treat PAs and NPs as being within the overtime exception.

Takeaway

Only a handful of federal courts have looked at this issue. Notably, the *Belt* case from the Fifth Circuit (encompassing the Eastern District of Louisiana, the Middle District and Western District of Louisiana, the Northern District and Southern District of Mississippi, and the Eastern District, Northern District, Southern District, and Western District of Texas) has thoroughly examined the issue of overtime for APPs. Those courts that have heard the issue have chosen not to disregard or distinguish the *Belt* decision.

With that said, urgent care owners should use caution and consult with experienced legal counsel with expertise in employment law when developing an overtime policy that impacts PAs and NPs. In addition to this arguably unclear federal legislation, there also may be state laws to consider. ■

References

1. 29 U.S.C. § 201, *et seq.*
2. 29 U.S.C. § 207(e)(6).
3. Duran A. Employers: understand how to manage overtime regulations in the health-care industry. *SwipeClock*. May 8, 2018. Available at: <https://www3.swipeclock.com/blog/employers-understand-how-to-manage-overtime-regulations-in-the-health-care-industry/>. Accessed March 28, 2019.
4. 29 U.S.C. § 213(a)(1).
5. *Donovan v Nektan, Inc.*, 703 F.2d 1148, 1151 (9th Cir. 1983).
6. 29 C.F.R. § 541.304(a)(1) (emphasis added).
7. 29 C.F.R. § 541.118(a).
8. *Belt v Emcare, Inc.*, 444 F.3d 403, 407 (5th Cir. 2006).
9. 29 C.F.R. § 541.301(e)(4).
10. American Academy of PAs. PAs and the Fair Labor Standards Act. December 2016. Available at: <https://www.aapa.org/advocacy-central/federal-advocacy/pas-and-the-fair-labor-standards-act/>. Accessed March 28, 2019.
11. *Cuttic v Crozer-Chester Med. Ctr.*, 760 F. Supp. 2d 513, 519 (E.D. Pa. 2011).
12. 49 Pa. Code § 18.151(a).
13. *Luo v L&S Acupuncture, P.C.*, 2015 U.S. Dist. LEXIS 33102, at *13-14 (E.D.N.Y. Jan. 23, 2015).
14. *Hager v Claiborne Cty. Med. Ctr.*, No. 5:14-CV-106-KS-MTP, 2016 U.S. Dist. LEXIS 5419, at *1 (S.D. Miss. Jan. 15, 2016).
15. 29 C.F.R. § 541.301(a).
16. United States Department of Labor. Wage and Hour Division. Fact Sheet #17D: Exemption for Professional Employees Under the Fair Labor Standards Act (FLSA). Revised July 2008. Available at: https://www.dol.gov/whd/overtime/fs17d_professional.htm. Accessed March 28, 2019.
17. *Belt v Emcare Inc.*, at 627 n.2, citing 29 C.F.R. § 541.99-602 (1973).
18. 29 C.F.R. §§ 541.0-541.52.
19. *Cuttic v Crozer-Chester Med. Ctr.*, 760 F. Supp. 2d 513, 518-19 (E.D. Pa. 2011).
20. *Luo v L&S Acupuncture, P.C.*, 2015 U.S. Dist. LEXIS 33102, at *11 (E.D.N.Y. Jan. 23, 2015) (Citing *Belt*).
21. See *Cuttic v Crozer-Chester Med. Ctr.*, 806 F. Supp. 2d 796, 799 (E.D. Pa. 2011).
22. *Lucas v Noypi, Inc.*, No. H-11-1940, 2012 U.S. Dist. LEXIS 143889, at *8-9 n.20 (S.D. Tex. Oct. 3, 2012).



ABSTRACTS IN URGENT CARE

- Sharing Decisions → Mitigating Legal Risk
- Incidental High BP Findings: to Treat or Not to Treat
- A Fresh Look at Ondansetron in Pregnancy
- Steroids and the Wheezy Child
- Cleaning Before a Urine Dipstick Test
- Patients Overestimate Penicillin Allergies

■ JOSHUA RUSSELL, MD, MSC, FAAEM, FACEP

Mitigating Risk Through Shared Decision-Making

Key point: Shared decision-making appears to mitigate the risk to clinicians of patient complaints and lawsuits in the event of a bad outcome.

Citation: Schoenfeld EM, Mader S, Houghton C, et al. The effect of shared decisionmaking on patients' likelihood of filing a complaint or lawsuit: a simulation study. *Ann Emerg Med.* January 3, 2019. [Epub ahead of print]

Missed and delayed diagnoses of dangerous conditions are unavoidable in urgent care. The deck is simply stacked against us. We are forced to see high volumes of undifferentiated patients with whom we have no prior relationship and diagnose and treat them with minimal access to diagnostic testing. Additionally, for most patients presenting to urgent care, there isn't one "right" course of action, but rather, multiple courses of action which could be reasonable. For example, should a young patient with atypical chest pain and a normal ECG go to the emergency room immediately, be monitored in clinic for an hour, or go home and follow-up with a primary care doctor the next day? The "right" answer really depends on the patient's preferences and risk tolerance.

Shared decision-making (SDM), as the name implies, involves including the patient in the thought process behind determining the course of testing and/or treatment. In so doing, patients understandably will generally feel greater autonomy and responsibility for whatever outcome arises. In other words, we'd expect

that the young patient with chest pain would be less likely to blame the clinician if they actually did have a PE or MI, if they were offered an ED referral but chose to go home.

These authors sought to answer this question specifically. Using an online survey of a hypothetical scenario surrounding a missed diagnosis of appendicitis, 812 respondents were randomized to receive either no-SDM, brief SDM, or extensive SDM when determining whether or not to get a CT scan. The respondents were then asked how likely they were to file a complaint or seek litigation against the clinician. The results were striking: 41% of the respondents in the no-SDM group reported they were likely to seek damages for the misdiagnosis vs 12% and 11% in the brief SDM and extensive SDM group, respectively.

These findings offer a unique perspective on how we may rethink the notion of practicing defensively. Rather than ordering a battery of labs and imaging studies, it seems the most defensible practice is actually much cheaper and more rational: simply involve the patient in the decisions about their care when multiple courses of action would be reasonable. Furthermore, remarkably, there was no difference between the groups who received brief SDM vs extensive SDM. So we needn't fear that SDM requires a lengthy discussion to allow patients to feel a sense of autonomy and responsibility for their outcome. ■

Should We Just Let That High Blood Pressure Ride?

Key point: Treating mild hypertension in patients at low risk for cardiovascular disease may do more harm than good.

Citation: Sheppard JP, Stevens S, Stevens R, et al. Benefits and harms of antihypertensive treatment in low-risk patients with mild hypertension. *JAMA Intern Med.* 2018;178(12):1626–1634.

We see it all the time. Blood pressures of 140 or 150 systolic in otherwise healthy patients. Sure, it could be pain, stress, or anxiety.



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.

ABSTRACTS IN URGENT CARE

So we repeat the blood pressure when our patient is more comfortable, but we get the same value. For years, the conventional wisdom and teaching has been to recommend the patient follow-up with a PCP for blood pressure control. Some urgent care providers may even start an antihypertensive medication in these instances for patients with poor access to follow-up care, believing, understandably, that they are helping to prevent MI and stroke.

This paper, however, casts some doubt on that traditional thinking. In this paper, British researchers performed a retrospective cohort study of nearly 40,000 patients with mild hypertension (defined as 140-160/90-100 measured on three occasions over 12 months). Half of the patients were treated with antihypertensive medication and half were not. Only low-risk patients, (ie, those with no history of heart, kidney, or vascular disease) were included. Patients were followed for a median duration of 5.8 years.

During the period of follow-up, there was no increase in mortality or adverse cardiovascular events detected in those whose hypertension was not treated. There was, however, a significantly higher rate of adverse outcomes among the group taking antihypertensive medications—predominantly electrolyte disturbance, hypotension, and kidney injury. Based on these data, it is reasonable to pump the brakes on lower-risk patients presenting with incidentally identified hypertension in urgent care. Initiation of medication in such patients may have little or no benefit and, therefore, not be worth the risks. In light of these data, allowing such patients to monitor their blood pressure and have a more nuanced discussion with a PCP is likely a more sensible approach for the urgent care provider. ■

Can We Finally Use Ondansetron Again in Pregnancy? Almost

Key point: Use of ondansetron (Zofran) in early pregnancy does not appear to increase risk of cardiac malformations, but may slightly increase the risk of cleft palate.

Citation: Huybrechts KF, Hernández-Díaz S, Straub L, et al. Association of maternal first-trimester ondansetron use with cardiac malformations and oral clefts in offspring. *JAMA*. 2018;320(23):2429-2437.

Nausea, as a symptom, approaches ubiquity during the first trimester of pregnancy. For some women, it can be debilitating, making adequate nutrition and hydration a challenge. Ondansetron, among antiemetics, has a generally favorable side-effect profile, and dosing is especially convenient in cases of severe nausea with the oral dissolving tablet formulation.

Over recent years, several observational studies have shown some signal of association between ondansetron use in early pregnancy and fetal malformations of various types, including cardiac, leading to a questionably rational fear among clinicians and patients alike surrounding the use of this medication. This

study, again observational and retrospective, sought to determine whether these concerns are justified.

The investigators reviewed nearly 2 million pregnancies from a Medicaid database where the patient was prescribed ondansetron in the first trimester. The primary outcome of interest was cardiac malformations, with secondary outcomes of interest including other congenital malformations diagnosed in the first 3 months of life. Among this very large sample, there was no apparent increased risk in cardiac malformations or other classes of congenital anomalies associated with ondansetron risk in the first trimester. However, there was a small increase in the risk of the less concerning, but nontrivial, cleft palate (risk difference of 2.7 cases per 10,000 births).

Practically speaking, ondansetron is probably safe in early pregnancy, especially when considering a single dose for symptom relief in urgent care. However, consider a trial of first-line agents recommended by the American College of Obstetricians and Gynecologists (eg, ginger, vitamin B6, doxylamine) before prescribing ondansetron in pregnancy. The concerns for fetal harms are probably still worth mentioning if prescribing ondansetron, so your patients know that you've heard the news and aren't intending to harm their baby, but rather support them through a very difficult phase of pregnancy. ■

Will Steroids Help This Wheezy Toddler?

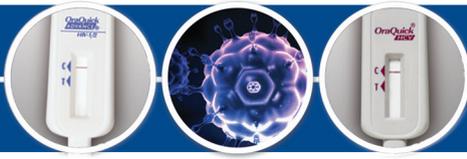
Key point: Most toddlers and preschool-age children with wheezing will not improve more rapidly with oral corticosteroids. Children most likely to see benefit from steroids are those with multiple prior episodes of wheezing, family history of asthma, and/or history of other atopic features.

Citation: Abrams EM, Becker AB, Szeffler SJ. Use of oral corticosteroids in the wheezy toddler. *J Pediatrics*. October 2018. [Epub ahead of print]

Most toddlers will have wheezing with a viral illness at some point. However, the majority of these children will not develop asthma. We know that systemic corticosteroids help reduce severity and duration of wheezing in children with asthma, but evidence is less clear in younger children with wheezing.

These authors review the available evidence surrounding the use of oral steroids in toddlers with wheezing. There have been multiple RCTs examining the use of steroids, generally prednisolone vs placebo, often initiated by the parent at home. These studies have all failed to show any acceleration in symptom resolution with steroid use.

A single emergency department study showed some improvement in length of stay (LOS) in the ED in wheezy toddlers treated with prednisolone over placebo. However, this difference in LOS, while statistically significant, is not clinically relevant, as the difference was only about 2.5 hours. Additionally, this study included a large number (>60%) of children with



Identify your patients today
and link them to care

OraQuick® Rapid
Antibody
Test
HCV

OraQuick® Rapid
Antibody
Test
ADVANCE® **HIV-1/2**

Simple

Rapid antibody test results in 20 minutes

Accurate

- HCV: >98% accuracy; clinical performance equivalent to lab EIA
- HIV: >99% sensitivity and specificity

Versatile

Ideal for clinical and non-clinical settings



OraQuick® HCV Rapid Antibody Test

Description	Item No.
25/Box	1001-0181
100/Box	1001-0180
Control	1001-0182

OraQuick ADVANCE® HIV-1/2
Rapid Antibody Test

Description	Item No.
25/Box	1001-0079
100/Box	1001-0078
Control	1001-0077



OraSure Technologies

220 East First Street
Bethlehem, PA 18015
1-800-672-7873
www.OraSure.com

IFD0054 (rev. 03/17) © 2017-2011 OraSure Technologies, Inc.
OraQuick® and OraQuick ADVANCE® are registered trademarks of OraSure Technologies, Inc.

For more information, contact your distributor sales representative
or customer service at 1-800-672-7873

ABSTRACTS IN URGENT CARE

history of prior wheezing and/or atopy.

Finally, the authors remind us of the adverse reactions to steroids, including behavioral and sleep disturbance and increased risk of infection. Specifically, in one study, ~1% more of children in the prednisolone group were found to have clinically significant infections after a short course of steroids, including three cases of varicella requiring ICU admission.

Prednisolone tastes terrible, has significant risks, and seems to offer little benefit in children without history of asthma and/or atopy who present with wheezing in the setting of a viral URI. ■

Cleaning Up the 'Clean Catch' in Kids

Key point: Gently cleaning the genital area of young children significantly reduces the likelihood of a false positive urine dip stick. This is of greatest value in girls and uncircumcised boys with nonretractable foreskin.

Citation: Marzuillo P, Guarino S, Furlan D, et al. Cleaning the genitalia with plain water improves accuracy of urine dipstick in childhood. *Eur J Pediatr.* 2018;177(10):1573-1579.

The urine dipstick is among the most ubiquitous tests available in urgent care. When considering UTI, a catheterized specimen is preferred but often not available for infants and small children in the urgent care setting because of lack of supplies and adequately trained staff. In the pre potty-trained child, contamination (especially if using bag urine collection) is common, leading to many false positive urine dips.

The investigators in this study sought to determine the impact of gently cleansing the genitals of children with water (using gauze for girls and syringe irrigation for boys) on the likelihood of false positive urine dips. They enrolled over 600 consecutive children presenting to a pediatric urology clinic; 69% of the children were toilet trained and 58% were male. Interestingly, in this European pediatric population, all males were uncircumcised.

Consecutive urine samples were collected from each child before and after cleaning the genital area with "plain water" (presumably meaning tap water, but not clearly defined in the study) and analyzed on urine dipstick. Thus, each child served as their own control. The researchers found that 25% of the positive tests normalized after cleaning. The risk of false positive was highest among females and males with nonretractable foreskin.

While the urine dipstick is far from a perfect test, we do base a large number of clinical decisions on the dip results while awaiting cultures. Using tap water to clean the genital area of young children prior to collection is a safe, no-cost method of improving the clinical utility of urine dip test results at the point-of-care. ■

'I'm Allergic to Penicillin!' But Are You Really?

Key point: Most patients who report allergy to penicillins will not

Tips on Twitter: Obesity and Back Pain

Sure, it's awkward to address the elephant in the room, but obesity is undeniably associated with acute and chronic low back pain and patients with acute pain need to be made aware that losing weight will help prevent them from developing the same pain *chronically*. (Follow Dr. Russell on Twitter: @UCPracticeTips.)

have a true hypersensitivity reaction. In patients reporting a low-risk history of allergy, an oral amoxicillin challenge in clinic is safe and can minimize unnecessary harms of treating with second line antibiotics. Cephalosporin cross-reactivity seems to be much lower than previously believed.

Citation: Shenoy ES, Macy E, Rowe T, Blumenthal KG. Evaluation and management of penicillin allergy: a review. *JAMA.* 2019;321(2):188-199.

Patient safety alert! jolts onto your screen. You've just diagnosed a child with bilateral otitis media and as you click to prescribe amoxicillin, your EHR stops you cold. The patient has a "penicillin allergy." I doubt many urgent care providers have gone a single shift without this exact experience.

Penicillins are a highly effective and affordable treatment option for many common infections we see in urgent care. Allergies to these antibiotics are reported by ~10% of Americans; however, >95% of patients who claim to be penicillin-allergic are actually able to tolerate penicillins safely. This is because most "allergies" are either non-IgE mediated rashes or nonallergic adverse reactions, such as GI upset.

In this review, a multidisciplinary writing group consisting of allergy & immunology, infectious disease, and epidemiology physicians and researchers produce evidence-based guidelines for the management of patients identifying as penicillin-allergic based on a review of the literature. They conclude that patients with a low-risk history of true penicillin allergy (ie, no history of rash/urticaria or anaphylaxis or unknown reaction >10 years previously) can safely undergo an observed trial of amoxicillin in clinic. Absence of any reaction within 1 hour of administration of 250-500 mg of amoxicillin indicates no risk for IgE-mediated hypersensitivity reaction (ie, anaphylaxis). Reassure your patient and update their allergy list.

Also worth noting, this writing group concluded, based on their literature review, that cephalosporin cross-reactivity is much lower than previously thought and occurs in only 2% of cases. Cephalosporins can safely be administered in patients with low-risk penicillin histories and/or patients who have not reacted during a 1-hour amoxicillin challenge. [For a useful patient reference about penicillin allergy, see Blumenthal KG, Shenoy ES. Am I allergic to penicillin? *JAMA.* 2019;321(2):216.] ■



Practical Considerations for Buying/Selling Your Urgent Care Practice

Urgent message: As urgent care remains a hotbed of merger, acquisition, and transactional activity, owners and operators may see a prime opportunity to sell their practices at maximum market value. The complexities of selling (or buying) an urgent care practice can make it a daunting undertaking, however, and thus requires careful planning, expert counsel, and due diligence to pull off successfully.

ALAN A. AYERS, MBA, MACC

Urgent care could be said to be in the *maturity* phase of the typical industry life cycle. The healthcare delivery model has gained widespread acceptance, growth has been steady, and transactional activity continues to ramp up. And while the private equity, market consolidators, and health system/payer “buyer classes” remain active in the urgent care space, competitive markets and oversaturation have resulted in a shift in overall investment strategy. That is, rather than open new clinics to fuel expansion, market participants looking to expand their footprint are increasingly relying on acquisitions and consolidations of existing urgent care practices/chains.

A trend we’re seeing is hospitals and PE groups approaching urgent care centers to gauge their interest in merging or selling outright. This prolific acquisition/consolidation activity presents the individual urgent care operator a viable exit strategy, and an opportunity to sell their urgent care business to growth-focused buyers likely to place a higher valuation on their practice. Hence, depending on the circumstances of the individual urgent care operator, this may be a perfect time to sell.

Time to Sell?

Indeed, the existing healthcare landscape has shifted such that it makes it more challenging for independent practices to remain profitable, including:

- Increased pressure from the government, payers,



and patients to provide improved services at a reduced cost.

- A shifting reimbursement landscape, and an ever-changing regulatory environment related to finance, billing, collections, EMR, HIPPA, etc.
- The irregularity in patient volumes, extreme sea-

Alan A. Ayers, MBA, MACC is Chief Executive Officer of Velocity Urgent Care, LLC and is Practice Management Editor of *The Journal of Urgent Care Medicine*. The author has no relevant financial relationships with any commercial interests.

sonality, and the extended hours necessary to service patients.

And while health concerns and burnout are the most common reasons owner-operators sell, a generation of baby boomer owner/entrepreneurs are headed toward retirement in the coming decade—meaning their businesses will be changing hands sooner rather than later. And as the best time to sell is when ample growth opportunity meets a seller's market, some urgent care operators may opt to strike while the iron is hot. Alternatively, the current climate also makes it an ideal time to buy into urgent care, and not just for PE groups and health systems/payors. With that in mind, the following sections will briefly examine the critical steps necessary to successfully sell your urgent care operation, along with important considerations to make if you're on the buyer's side of the transaction.

Eight Critical Steps to Selling Your Urgent Care Business

As many urgent care operators have built their operations from the ground up, the time, energy, and sweat equity they've invested in their businesses can make the selling process an emotional challenge. Their business has become their personal and professional identity in most cases, which is a hard thing to let go of. As such, owners may struggle to view their practices through an objective lens, leaving them with clouded judgement about its real versus perceived value from the perspective of potential buyers. Being a highly competent clinician, after all, hardly means they're prepared to navigate the complexities of prepping for and selling a medical practice by themselves. Indeed, an urgent care owner who has decided to sell requires a clear roadmap, and an experienced transition team to provide expert counsel along the way. With that in mind, here are eight critical steps* an owner should take, when they've decided to sell their urgent care.

1. Clarify your end goals. What outcome are you looking to achieve with the sale of your urgent care? Do you want a clean exit from the business? Do you want to stay on as part of a larger merger, or perhaps take on a short-term advisory role post-sale? Are you looking to sell to a colleague wherein price is not the overriding factor, or are you selling to a PE firm where getting top dollar is paramount? In cases where you're after a maximum return, you should enlist the services of an experienced business valuator—especially one experienced in urgent care valuations. Getting an objective valuation from a business valuator can help mitigate emo-

tional decision-making, create realistic expectations for how involved and detailed the sale process really is, and allow the seller to see the transaction from the end buyer's point of view.

- 2. Preparation is key.** Unless the seller is facing a health concern that necessitates an immediate sale, there should be no rush to sell. Instead, begin earnest preparations and expect the full process to last one to two years. This gives you ample prep time to get all of your business documentation in order. In fact, you should proceed as if you're preparing to perform an internal audit: start with year-to-date financial statements, at least three years of tax returns, and billing, payroll, and collections reports. You should also begin preparations to clear out bloated inventory, clean up outstanding debt and expenses, resolve any outstanding litigation, and protect intellectual property. Not to mention performing maintenance, clean up, updating, and repair on the physical plant.
- 3. Enlist the services of experienced advisors.** As an urgent care operator involved with the day-to-day operations, you likely lack the time or expertise to delve into the often-complicated financial documents mentioned previously, which is why you need a team of advisors to help you through the transition. Your team might include a healthcare mergers and acquisitions professional, a lawyer, a financial advisor, an accountant, and a business valuator who together can help you get organized, explain in clear terms the financial implications of your particular situation, and provide a steady hand in an often-overwhelming situation featuring plenty of moving parts. Additional legal documents that a team of experienced advisors will help you navigate would include articles of incorporation, employee benefits, risk management, and shareholder agreements. Your team should also help document and catalogue your physical inventory, including medical equipment, computer equipment, and office furniture, electronics, and fixtures.
- 4. Market your urgent care with a business broker.** There are numerous effective channels for marketing your urgent care to potential buyers. BizBuySell, for example, is an online business marketplace that lists 45,000 for-sale businesses while doubling as the largest broker directory in North America. And even though word-of-mouth and urgent care industry channels are viable options, adding a business broker to your team gives you the best chance of selling quickly and

at a higher price than you could negotiate on your own. A business broker typically charges a commission of 5%-10% of the sale price and can either perform the business valuation or connect you with an urgent care valuation expert if you don't currently have one. A business broker will also list your urgent care on the appropriate marketplaces, network with a large pool of potential buyers, work to get the highest price possible for your practice, and even help arrange financing sources for potential buyers.

5. **Prequalify potential buyers.** An often-necessary weeding-out process will take place at this stage, as most potential buyers will not be qualified—either they don't have the funds or can't secure the necessary financing. You can typically weed out the pretenders from the serious buyers with a firm asking price and a request that they produce confidential documents that verify proof of funds or access to financing.
6. **Craft a selling memorandum.** A selling memorandum acts as an advertisement of sorts for a company and should cast the urgent care in a positive light. It should be inspiring yet truthful and should add enough value to the company that it entices potential buyers to take a more in-depth look. An effective selling memorandum might include an executive summary, company history, analysis of strengths and weaknesses, market data, updated financial performance and projections, a rationale for the asking price, top management, and key employees and vendors. The size and scope of the operation will determine the depth and complexity of the selling memorandum, but it's only intended to give a broad overview to qualified buyers.
7. **Letter of intent.** When a buyer presents a letter of intent, it catapults the situation from a keen interest level all the way to serious negotiations. The document takes the urgent care off the market and lends a potential buyer negotiating exclusivity. While the necessary due diligence on both the buyer and seller's side has been performed to a degree, it ramps up at this stage. The prospective buyer will want to know everything about the urgent care operation down to the nuts and bolts, including confidential matters such as

“Individual entrepreneurs... feel that with upgrades in marketing, processes, industry knowhow, and branding they can boost performance and turn a for-sale clinic into a profitable endeavor.”

intellectual property, current contracts and liabilities, growth and profitability projections, in-house procedures, and staffing. Documents will be more closely examined by the potential buyer's own team of advisors, and an on-site inspection of the physical plant is typical. Noteworthy at this stage is that this is where many deals can collapse due to sellers becoming overwhelmed by sheer volume of requests and inquiries, negotiating sticking points,

intensive buyer scrutiny of the fine print, or a perceived lack of transparency on one or both sides. This is also the stage where the seller's role after the sale will be finalized, and the structure of deal (ie, payment structure, financing, stock vs asset sale) is decided.

8. **Final negotiations and closings.** At this stage the sale price is finalized, the terms and conditions are ironed out, and the purchase and sale agreement is completed. The agreement is typically a document of 25-50 pages, and will include exhibits like non-compete covenants, employee agreements, and asset listings. The entire process can last from six months to a year from start to finish. In most cases, the purchase and sale agreement will stipulate that the seller will remain affiliated with the urgent care in some advisory capacity to facilitate the transition, and help maintain relationships with employees, vendors, and patients.

* Adapted from Meyer H. Closing the deal: eight essential steps for selling your business. Available at: <http://www.costcoconnection.com/connection/201208?pm=2&pg=25#pg25>. Accessed April 2, 2019.

As outlined above, the selling of a medical practice like an urgent care center is a long and involved process. Hence, it is prudent for owner-operators to seek out the help of advisors and expert counsel toward completing the sale successfully and getting a maximum return. Depending on your state and its *corporate practice of medicine* doctrine, you may have to vet your buyer to ensure that they have the legal right (eg, a licensed physician or professional medical corporation) to own a medical practice. Another legal consideration pertaining to the sale of an urgent care is whether it's operating as a hospital outpatient unit or a private medical practice. In the latter case, there must exist a clear separation between the administrative and management function of, say, a managed service organization, and the clinical operation involving the actual practice of medicine.

Considerations for Buying an Urgent Care Operation

Private equity and health systems/payers each have long-term strategies driving their urgent care acquisitions. PE portfolios can sell larger urgent care companies at higher EBITDA multiples, while health systems can increase patient access points. Both leverage the pre-existing platforms to facilitate expansion, benefit from economies of scale and reduce costs.

Individual entrepreneurs may also see opportunities to get involved in an urgent care acquisition. These potential buyers look at clinics that they perceive as having profitability potential—given the right strategy, philosophical approach, and capital investments—and make offers to purchase. They don't go in thinking they need to re-invent the wheel. Rather, they feel that with upgrades in marketing, processes, industry know-how, and branding they can boost performance and turn a for-sale clinic into a profitable endeavor after a change of ownership. To that end, we've put together a brief "acquisition checklist" that a potential buyer could follow to help them navigate through a complex purchasing process:

■ **Creating an Acquisition Roadmap**

- *Develop a realistic timeline* – An urgent care acquisition is a lengthy process, so expect a minimum six months to a year for the final closing.
- *Determine acquisition structure* – Will it be an asset sale or a stock sale? In general, sellers prefer stock sales given the lower tax rate on capital gains, whereas buyers prefer asset sales since the liabilities remain with the seller.
- *Properly value the acquisition target* – Enlist a valuation expert; determine profitability, payer mix, reimbursements, growth potential, staffing costs, patient volumes, location and visibility, etc.
- *Conduct due diligence* – Request documents to validate all representations and details included in the selling memorandum about the practice. Inspect the facility; cross all I's and dot all T's.
- *After-closing integration* – In what capacity does the seller stay on? Advisor, mentor, or ambassador?

■ **Considerations for a Potential Urgent Care Purchase**

- *Assets acquired* – Intellectual property, medical equipment, computer equipment, electronics, furniture, fixtures
- *Liabilities assumed* – Product liability, employee lawsuits, contract disputes, etc.
- *Existing market footprint* – Number of locations,

market share

- Compliance history – HIPAA, notifying patients of change in ownership, clear separation of the clinical practice and any MSO, etc.
- Valuation issues – Earnings, reimbursements, goodwill, tangible assets, etc.

■ **Things to Request in Due Diligence**

- Licenses and certifications (physician and practice)
- Third-party contracts (payers, management, etc.)
- Medicare billing (CHOW requirements)
- Healthcare compliance (HIPAA, HITECH act)
- Insurance compliance
- Medical malpractice claims
- Investigations (federal and state)
- Covenants not to compete
- Identify antikickback/Stark concerns

■ **Hire Professional Guidance (Tax Expert) for IRS Due Diligence**

- Timely valuation of assets
- FMV price/retained goodwill
- Retained rights
- Reasonable compensation/incentives
- Charitable purposes

Similar to the urgent care seller, a potential buyer will want to hire a team of advisors to provide expert guidance and counsel through the buying process. Whereas the buyer requires a high-level picture of the details surrounding the acquisition, the advisors will deal with the minutiae, specifics, and fine print.

Conclusion

There's a lot that goes into selling a medical practice like an urgent care clinic. Aside from the life-changing emotional impact of selling a business you strongly identify with, the sheer number of complexities associated with executing a sale from start to finish can make it a difficult, stressful, and time-consuming undertaking. Many of those same challenges exist from the buyer's perspective, as performing a proper due diligence on a potential acquisition involves a significant time and financial commitment.

Therefore, for an urgent care buy-sell situation to be successful for both parties, experts, advisors, and specialists must be enlisted to facilitate the process and take the reins. Done earnestly with cooperation and transparency, the buyer and seller can both achieve their objectives, and walk away satisfied with the outcome. ■



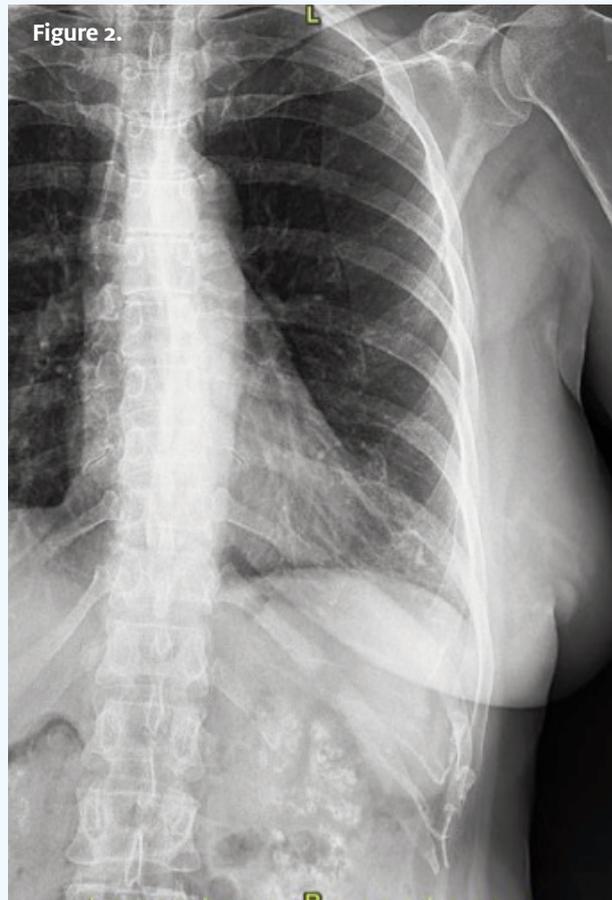
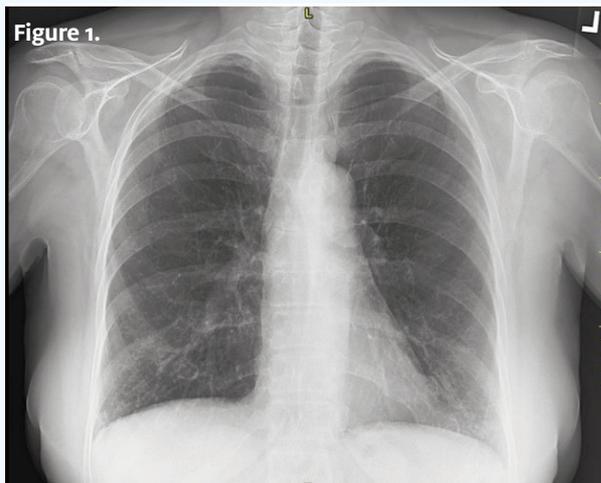
INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 1

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

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

A 70-Year-Old Female with ‘Bony’ Pain in Her Chest



Case

The patient is a 70-year-old female who presents with gradual onset of constant pain in her left lower chest and back. She is unsure when she first noticed the pain, but reports that it has worsened since she experienced a fall several days ago. She denies shortness of breath, diaphoresis, or an exertional component.

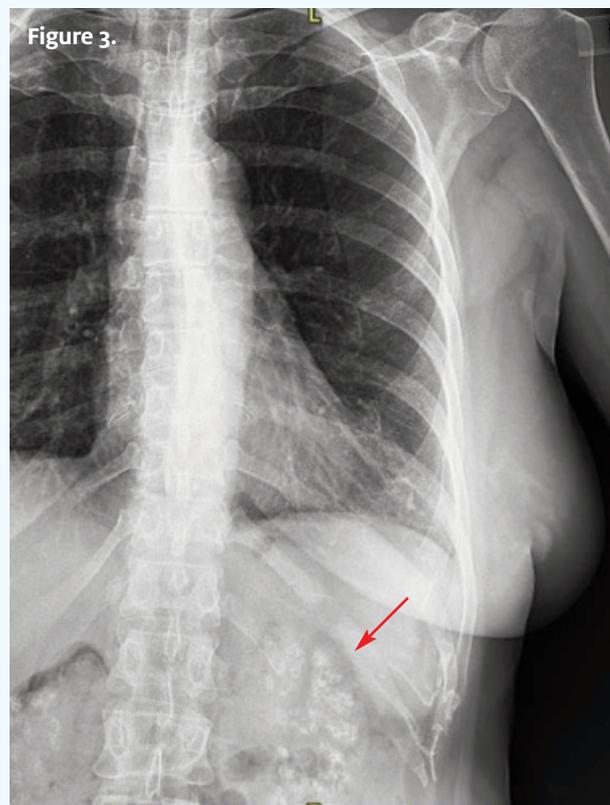
View the images taken and consider what the diagnosis and next steps would be. Resolution of the case is described on the next page.



INSIGHTS IN IMAGES: CLINICAL CHALLENGE

THE RESOLUTION

Figure 1.



Differential Diagnosis

- Bartter syndrome
- Dent's disease
- Hyperoxaluria
- Renal manifestation of primary mitochondrial disorders
- Renal nephrocalcinosis

Diagnosis

The images show bilateral, extensive renal medullary parenchymal calcifications, which led to a diagnosis of renal nephrocalcinosis—by definition, abnormal deposition of calcium phosphate and calcium oxalate crystals in the medullary segments of the kidneys. This is not a primary disease, but a secondary manifestation of a variety of diseases, many causing hypercalcemia. Common primary conditions causing nephrocalcinosis include hyperparathyroidism, hypoparathyroidism, hypervitaminosis D, multiple myeloma, prolonged immobilization, sarcoidosis, hyper oxaluria, renal tubular acidosis, Alpert syndrome, Bartter syndrome, sarcoidosis, and other less common causes.

Learnings/What to Look for

- Renal calculus disease often is concomitantly present and may be the presenting feature

- Renal nephrocalcinosis is often asymptomatic but can cause renal failure
- Radiographic findings on plain x-rays reveal abnormal fine granular calcium deposits in the medullary segment of the kidneys, usually bilateral
- Dense deposits can outline the medullary pyramids
- There may be accompanying renal calculus disease
- CT findings are more impressive revealing abnormally dense and calcified medullary segment of the renal parenchyma. Ultrasound usually reveals abnormally hyper-echoic medullary renal pyramids

Pearls for Urgent Care Management and Considerations for Transfer

- Treatment for nephrocalcinosis is aimed at alleviating symptoms and lowering the risk for further build-up of calcium, and includes for the primary disease. General management includes proper hydration, thiazide diuretic and citrate therapy

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





INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 2

An 18-Year-Old Female with Sudden Sharp Chest Pain



Figure 1.

Case

The patient is an 18-year-old female who presents to urgent care with 1–2 hours of “sharp” chest pain that worsens with range of motion. She reports it began suddenly while lifting boxes at work. Pain is not improved with acetaminophen. She denies exertional discomfort, pleuritic pain, and use of hormone therapy. There is no leg swelling, shortness of breath, or sweating.

Physical exam reveals:

- **General:** Sitting comfortably on the cart, breathing normally

- **Lungs:** Clear bilaterally
 - **Cardiovascular:** Regular rhythm, without m,r,g
 - **Chest:** There is point tenderness over the left lower sternal border
 - **Abdomen:** Soft and NT, no distention, without r/r/g
 - **Ext:** No edema or asymmetry, pulses are 2+ and equal in all extremities, no pain with palpation
- View the ECG 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**

- First-degree AV block
- Wolff-Parkinson-White syndrome (WPW)
- Anterior ischemia
- Posterior MI
- Persistent juvenile T wave pattern

Diagnosis

- This ECG shows normal sinus rhythm with a rate around 80. Regarding the possibilities listed in our differential diagnosis 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, which is not present here.
- Could this be an anterior ischemia? There is T wave inversion anteriorly, but this does not make sense with the clinical picture. Additionally, there is no ST elevation.
- How about a posterior MI? There is no ST depression in leads V1-3, as well as no clinical story consistent with ischemia or infarction.
- The correct diagnosis is persistent juvenile T wave pattern, which is a normal variant.

Learnings/What to Look for

- T wave inversions can be present with ischemia, but management of the patient needs to be based on a clinical history as well as the ECG reading
- Juvenile T wave inversions are present with T wave inversion in leads V1-3 which are asymmetric and less than 3 mm in depth
- Present commonly in young women of Afro-Caribbean descent

Pearls for Initial Management and Considerations for Transfer

- Perform an ECG in patients suspected of ischemia, syncope, and concern for arrhythmia, but not in young patients with an obvious musculoskeletal etiology
- Compare to an old ECG, if possible
- Young patients can have ischemia, so inquire about exertional pain, vomiting, diaphoresis, and dyspnea as well as risk factors
- If the T waves are over 3 mm in depth or extend to V4 or further, consider ischemia
- Consider pulmonary embolism in young patients with chest pain
- If there is a question about ischemia, err on the side of caution and phone consult with cardiology or transfer

Acknowledgment: Case adapted from Academic Emergency Medicine Education Masters. MedEDMasters. Persistent juvenile T-waves. Available at: <http://www.mededmasters.com/persistent-juvenile-twi.html>. Accessed April 10, 2019.



INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 3

A 28-Year-Old Man with Fever, Diaphoresis, and Nausea

Figure 1.

**Case**

The patient is a 28-year-old man who presents to urgent care with a single annular ecchymosis lesion on his leg the morning after returning home from a trip to visit his family's cabin in the mountains of North Carolina. He "thought" he noticed a small insect bite in the vicinity. The lesion has become increasingly painful.

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

Figure 2.

**Differential Diagnosis**

- CA-MRSA skin infection
- Brown recluse spider envenomation
- Centipede envenoming
- Coumadin necrosis

Diagnosis

The correct diagnosis is brown recluse spider envenomation. The brown spiders (*Loxosceles* species) are found in temperate and tropical latitudes around the world. They live and build nests in dark areas, either indoors or outdoors.

Learnings

- Symptoms of brown recluse spider envenomation include reddened skin that may be followed by a blister at the site of the bite

- Short of capture or definitive identification, the diagnosis is clinical
- The North American brown recluse (*L. reclusa*) is the most common species responsible for human injury in the U.S., but deaths are rare

Pearls for Urgent Care Management and Considerations for Transfer

- The wound site should be cleaned with soap and water, following by application of a topical antibiotic
- Ice may reduce pain and swelling
- Over-the-counter pain relievers may provide further relief
- If necrosis develops, patients can later follow up with plastic surgery

Acknowledgment: Images courtesy of VisualDx.



VisualDx is your
trusted second opinion.

Features include:

- Fast access to insights from the best specialists
- Handle complex cases directly
- Engage patients with our handouts

20% OFF
for JUCM
readers

visualdx.com/jucm

Made by health care professionals
for health care professionals.



REVENUE CYCLE MANAGEMENT Q&A

Be Aware: The CCI Edits, They Are a Changin’

■ DAVID E. STERN, MD, CPC

The Centers for Medicare and Medicaid Services [announce](#) an update to claim adjudication rules for National Correct Coding (CCI) Initiative Procedure-to-Procedure (PTP) edits to allow bypass of an edit if modifiers 59, XE, XS, XP, or SU are appended to either the column 1 or column 2 code.

In 2015, the Centers for Medicare and Medicaid Services (CMS) introduced the following modifiers, referred to as X{EPSU} and intended to provide more information in scenarios where modifier -59, “Distinct procedural service,” would be appropriate:

- XE, “Separate encounter, a service that is distinct because it occurred during a separate encounter”
- XS, “Separate structure, a service that is distinct because it was performed on a separate organ/structure”
- XP, “Separate practitioner, a service that is distinct because it was performed by a different practitioner”
- XU, “Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service”

Later in 2015, CMS stated that additional guidance and education on the appropriate use of the new X modifiers would be introduced, and that modifier -59 could still be used. That additional guidance is still pending and little has been mentioned regarding the X modifiers—until recently.

This past February, CMS issued a change to the claims processing logic for CMS carriers effective July 1, 2019, involving Modifier -59, and included the X modifiers in the transmittal.

Currently, when one of the aforementioned modifiers is appended to override an edit, the CCI requires the modifier to be placed on the column 2 code of the CCI PTP edit pair for the edit to be bypassed.¹

This means that if the modifier is mistakenly placed on the column

1 code, a corrected claim needs to be resubmitted, which causes additional cost to both your practice and the payer. For example, when performing a 3.0 cm simple laceration repair to the finger that does not include the fingernail, you also performed an evacuation of a subungual hematoma. You want to be paid for performing both of those services since they were not related to each other, so you refer to the CCI edits to make sure it is billed properly.

In this case, Current Procedural Terminology (CPT) code 12002 (simple laceration repair) is in column 1 and CPT code 11740 is in column 2. Modifier -59 or modifier XS would be appended to CPT code 11740 because it is in column 2.

In July 2019, Medicare will allow a more billing-friendly approach when utilizing modifiers -59, XE, XU, XS, and XP. In the scenario above, the modifier can go on either code and it will bypass the edit.

Keep in mind that you will still want to append the modifier to the procedures with the lower reimbursement on the Medicare fee schedule; that is the one that will be reduced in reimbursement. Using our scenario above, per the Medicare Physician Fee Schedule,² the reimbursement for CPT code 11740 is \$52.62, and the reimbursement for CPT code 12002 is \$111. Thus, you would want to append the modifier to CPT code 11740 since the reimbursement is lower.

This change affects CMS carriers only, and does not apply to Medicare managed care payers, Medicaid, or commercial payers. Contact those payers to see if they have limitations regarding these modifiers when it comes to the column 1 and column 2 codes. During the survey, this would also be a good time to see if those payers recognize modifiers XE, XU, XS, and XP, and what guidelines may apply.

This change is the first fresh CMS reference to X modifiers in quite some time; we should look forward to an upcoming MedLearn Matters article with more detail in the future.

References

1. CMS. PTP Coding Edits. Available at: <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html>. Accessed April 17, 2019.
2. CMS. License for Use of Current Procedural Terminology, Fourth Edition (“CPT”). Available at: <https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx>. Accessed April 17, 2019.



David E. Stern, MD, is board-certified in internal medicine. He was a director on the founding board of UCAOA and has received the organization’s Lifetime Membership Award. He is CEO of Practice Velocity, LLC (www.practicevelocity.com), NMN Consultants (www.urgentcareconsultants.com), and PV Billing (www.practicevelocity.com/urgent-care-billing/), providers of software, billing, and urgent care consulting services. Dr. Stern welcomes your questions about urgent care in general and about coding issues in particular.

CAREERS

PHYSICIANS WANTED

Urgent Care Physicians

HEAL. TEACH. LEAD.

At HealthPartners, we are focused on health as it could be, affordability as it must be, and relationships built on trust. Recognized once again in Minnesota Physician Publishing's *100 Influential Health Care Leaders*, we are proud of our extraordinary physicians and their contribution to the care and service of the people of the Minneapolis/St. Paul area and beyond.

As an Urgent Care Physician with HealthPartners, you'll enjoy:

- Being part of a large, integrated organization that includes many specialties; if you have a question, simply pick up the phone and speak directly with a specialty physician
- Flexibility to suit your lifestyle that includes expanded day and evening hours, full day options providing more hours for FTE and less days on service
- An updated competitive salary and benefits package, including paid malpractice

HealthPartners Medical Group continues to receive nationally recognized clinical performance and quality awards. Find an exciting, rewarding practice to complement all the passions in your life. Apply online at healthpartners.com/careers or contact Diane at 952-883-5453 or diane.m.collins@healthpartners.com. EOE



Now Hiring for 24/7 Urgent and Emergency Care Centers

In summer 2019, Presbyterian Healthcare Services is opening New Mexico's first combined, 24/7 emergency and urgent care clinics in Albuquerque. Locally owned and not-for-profit, Presbyterian has been part of New Mexico's history since the beginning, and we are continuously growing and innovating the way we deliver care.

Emergency Medicine Physician Practice Highlights:

- Full-time position including day-one benefits through our employed provider group, Presbyterian Medical Group
- High-level support staff including nurses, EMTs, scribes, radiology, lab services, registration and administration
- Projected volume is 60 to 80 patients per day (60 percent urgent care, 40 percent emergency care)

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



AA/EEO/VET/DISABLED/NMhra. PHS is committed to ensuring a drug-free workplace.

Advertise Your Urgent Care Opportunity With Us

Get your urgent care job opportunity in front of the most qualified candidates in the industry.



727-497-6565 x3328
JUCMprint@CommunityBrands.com

Advertise Your Urgent Care Opportunity With Us

Get your urgent care job opportunity in front of the most qualified candidates in the industry.

727-497-6565 x3328
JUCMprint@CommunityBrands.com

PHYSICIANS WANTED

Urgent Care Physicians in Hampton Roads, Virginia \$20K Sign-on Bonus and Relocation

Velocity Urgent Care is seeking a board certified/board eligible physician trained in IM, FM or EM. We manage a wide variety of acute medical conditions as well as a robust Occupational Medicine practice. The successful candidate will work a minimum of 35 hours per week and have the opportunity for administrative and supervisory roles if desired.

Benefits to working at Velocity Urgent Care:

- Competitive hourly rate with a generous monthly production bonus
- Eligible for \$20,000 sign-on bonus with up to \$10,000 in relocation paid
- 12-hour shifts allowing more time off during the week
- Stipend for supervising Nurse Practitioners and Physician Assistants
- Generous benefits including medical, dental, vision and 401k retirement
- Paid time off and CME allowance

Come live where you work and play!

We are close to Washington, DC,
Williamsburg, Virginia Beach and the Outer Banks.

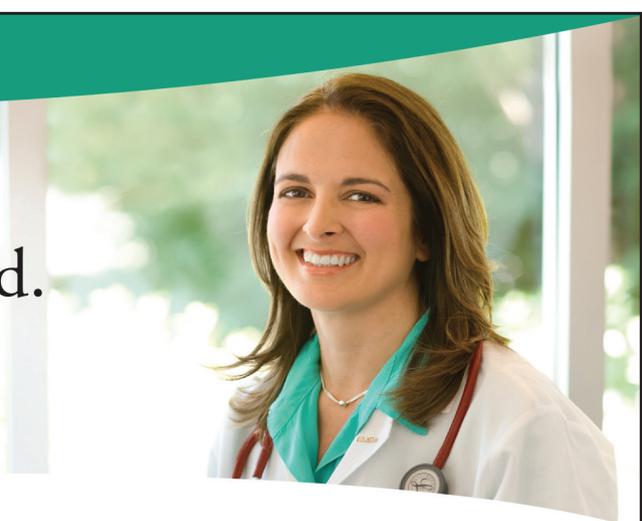
Apply Online at
www.velocityuc.com/careers



Patient First

Physician Founded.
Patient Focused.

With an outstanding staff, Patient First supports you in providing excellent care.



We are looking for full- and part-time physicians.

With over 70 locations throughout greater Washington, D.C., Maryland, Virginia, Pennsylvania, and New Jersey, Patient First physicians have been providing urgent and primary care for over 35 years. In addition to flexible schedules and career advancement opportunities, we offer a comprehensive compensation package that includes:

- Excellent salary
- Loan assistance
- Licensure and certification assistance and reimbursement
- Relocation package
- Outstanding malpractice insurance
- Health, dental, vision, life, and disability insurance, plus more.

To learn more, contact
Recruitment Coordinator Eleanor Hertzler
at 804-822-4478 or eleanor.hertzler@patientfirst.com,
or visit www.patientfirst.com/PatientFirstCareers

PHYSICIANS WANTED

WATSON CLINIC_{LLP}
Between Tampa & Orlando, Florida

Urgent Care Opportunity



We are seeking a BE/BC physician in Family Medicine or IM/Pediatrics to join our high-volume Urgent Care Department.

Contact Us:
www.watsonclinic.com
E: wcpphysicians@watsonclinic.com
P: 800-854-7786

NO STATE INCOME TAX!



JUCM
THE JOURNAL OF URGENT CARE MEDICINE

CAREERCENTER

FIND THE RIGHT JOB
www.UrgentCareCareerCenter.com

MARKET PLACE

MEDICAL EQUIPMENT/SUPPLIES



BlueRidge X-Ray
COMPANY

X-Ray Systems – *new or used*
Economy CR/DR options
Nationwide Installation

imaging solutions for your clinic & budget

CALL FOR MORE INFO!
1.800.727.7290 x1209
BlueRidgeXray.com

Advertise Your Urgent Care Opportunity With Us

Get your urgent care job opportunity in front of the most qualified candidates in the industry.

JUCM
THE JOURNAL OF URGENT CARE MEDICINE

CAREERCENTER

727-497-6565 x3328
JUCMprint@CommunityBrands.com



DEVELOPING DATA

New Data Show Urgent Care Outpacing Retail and ED

Urgent care started as something akin to the California Gold Rush; if a physician had the resources, the inclination, and the chutzpah to do so, they could stake a claim in the great wilderness of this new way of practicing medicine. The more reticent (some would have said *prudent* at the time) stayed in their lanes to continue practicing traditional family medicine, or pediatrics, or take shifts in the emergency room. Competition was scarce.

That didn't last long, of course—to the extent that urgent care

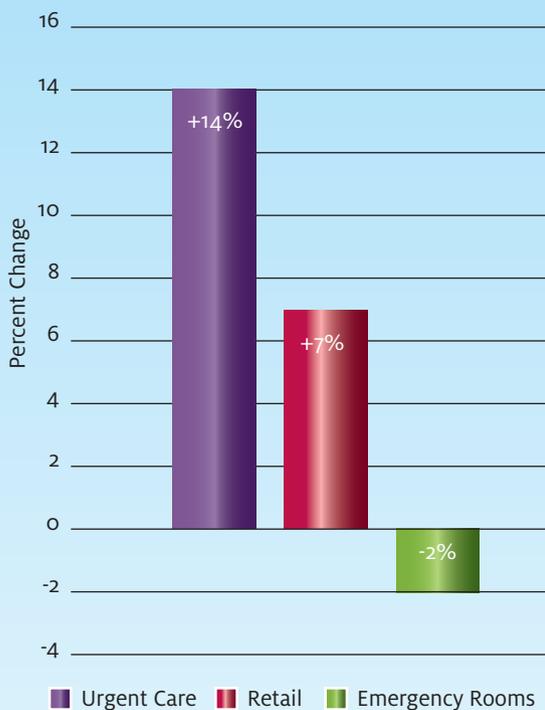
operators are not just competing with each other these days, but also taking on charges from health system-based newcomers and alternative settings. Retail, for example, has been getting a lot of press and has seen several major mergers in the past year (as urgent care has). But how is it all shaking out, really?

According to data revealed in a new white paper from FAIR Health, urgent care is not only holding its own but still growing at a faster rate than either retail or the ED setting.

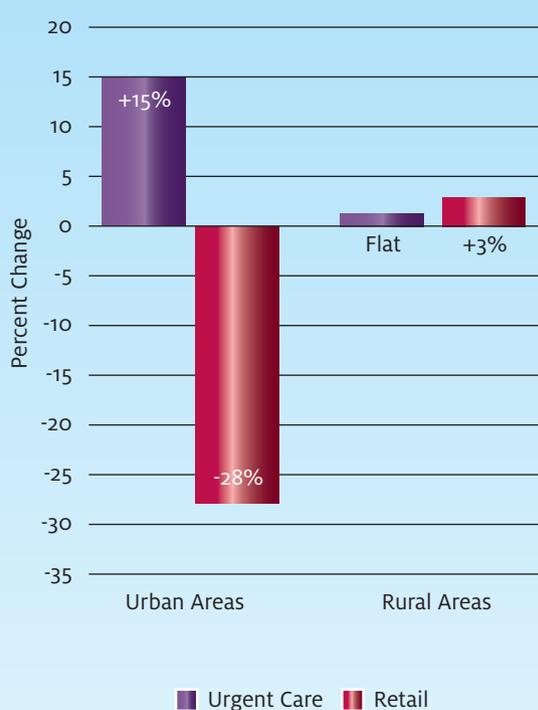
For highlights, see the graphs below. ■

URGENT CARE CLAIMS COMPARED WITH RETAIL AND THE ED

Urgent Care and Retail Up, ED Visits Down, 2016-2017



Urgent Care vs Retail by Area Type, 2016-2017



Adapted from: FH Healthcare Indicators and FH Medical Price Index 2019. An Annual View of Place of Service Trends and Medical Pricing. FAIR Health, Inc. New York, NY; 2019.





Announcing the Certified Urgent Care Management Professional (CUCMP) Program

The Certified Urgent Care Management Professional (CUCMP) certification is a **vital designation** for any professional seeking to advance their knowledge within the urgent care industry. This designation differs from other programs in that applicants must demonstrate **one of the following**:

1. A clinical degree + 1 year of supervisory experience in ambulatory care medicine; **OR**
2. 2 years of supervisory experience in ambulatory care medicine; **OR**
3. A Certificate in Urgent Care Management (UCMC) from UCA + 1 year of supervisory experience

Candidates will need 62 credits followed by an examination at the conclusion to achieve the CUCMP designation.

Expand Your Professional Education on Your Time

The CUCMP bundles are just a few of the resources available in UCA's newly expanded Online Education Library. You can now explore hundreds of urgent care topics anytime, anywhere, on any device.

- Powerful tools to help you develop and measure your critical learning skills
- Manage your learning progress, educational content and CMEs/CEs
- Intuitive user experience with suggested content

Learn more about CUCMP and Online Education: ucaoa.org | (877) 698-2262

7 Education Domains, 62 Credits

Earn Credits Online + In Person

3 Years to Complete Coursework

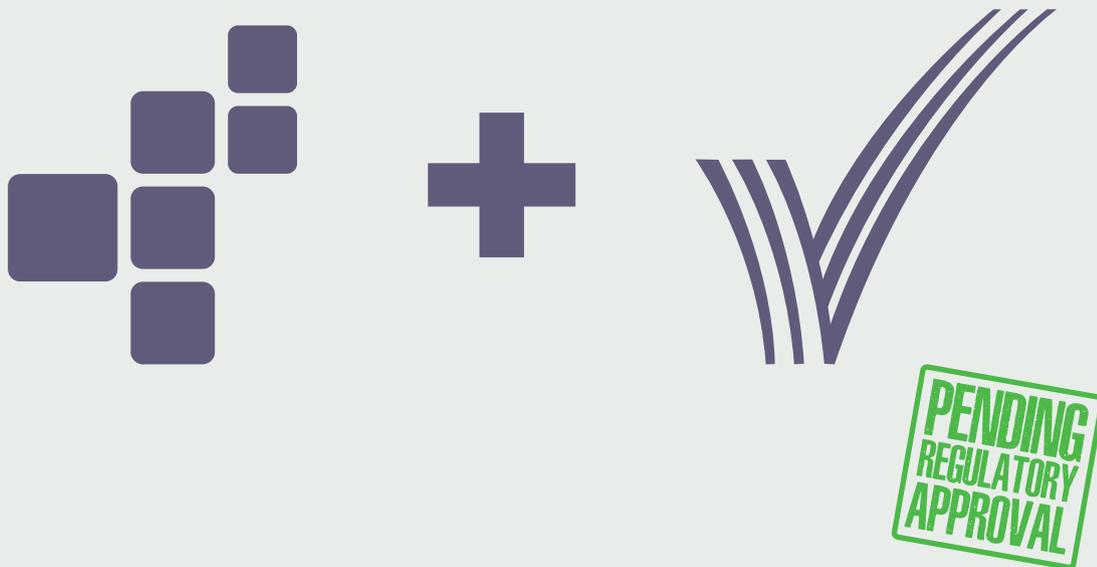


URGENT CARE
ASSOCIATION

Your gateway to betterSM



This happened at UCA.



DocuTAP & Practice Velocity have agreed to merge.

To learn more, see our ad inside.

*Regulatory approval pending. Until closing, PV & DT will continue to operate as separate companies.