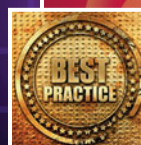


CLINICAL **cme**

Musculoskeletal Pain Is Keeping Your Patients Down— Help Them, or Watch Them Falter

ALSO IN THIS ISSUE

- cme** 35 **Case Report**
A Common Diagnosis in an Unexpected Patient: Could You Catch It?
- 42 **Health Law and Compliance**
Keep Your Practice Afloat When a Provider Jumps Ship Without Notice
- 45 **Revenue Cycle Management**
Claim Denied! How to Recover What's Rightfully Yours



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LETTER FROM THE EDITOR-IN-CHIEF

Virtual Urgent Care: Boom or Bust?



Telemedicine remains a hot topic of debate in urgent care circles. In fact, it seems like every urgent care conference I attend lately has a telemedicine track or expert panel. *JUCM* recently featured a point-counterpoint discussion between two industry leaders, Stanford Coleman, MD, MBA, FAAP and William Gluckman, DO, MBA, FACEP—whose opinions on the topic are as well-reasoned as they are divergent.

So, let me add my two cents.

The discussions and analyses I've been privy to leave me with many of the questions I have always had: Will I be too early with a telemedicine offering or too late? Do "tele-urgent care" services meet quality standards? How can I get consistently reimbursed for telemedicine? Do I use "down-time" in the clinic to have providers do telemedicine visits? Do I partner with a telehealth provider to offer this service or do I provide the service myself? Why hasn't telemedicine taken off? Will it ever?

It is no secret that I have been personally skeptical of telemedicine for urgent care. I am concerned that tele-urgent care will become an antibiotic vending machine without proper guidelines or testing to ensure stewardship. I am concerned that negative price pressure from large payers and national vendors is creating a race to the bottom from a reimbursement standpoint. And I am concerned that urgent care operators will unnecessarily cannibalize their face-to-face business with low-margin virtual care. In no way do I feel that telemedicine has no place in healthcare; nor do I claim to have a crystal ball to see what the future will hold. But I am confident that telemedicine has limitations, especially for urgent care services, and that adoption of a virtual access point will not have a market-changing impact on urgent care, at least for the foreseeable future.

While telemedicine is not new, broad adoption has been slow. And despite the conviction that millennials would flock to virtual healthcare, this has not been realized as expected. Why not? I have two theories: 1) Even millennials value in-person care, especially for new, undiagnosed conditions. 2) The limited menu of services available via telehealth decreases confidence that comprehensive care can be provided.

Regarding the second point, we saw this quite a bit with the

retail pharmacy clinics. These clinics threatened to erode the urgent care patient base for years, but it never really materialized. I think there are a couple of reasons for this. First, getting conclusive care is very valuable to time-crunched patients, and thus, the frequent referrals to urgent care centers for x-rays and procedures erodes consumer confidence. Second, the psychology of healthcare decisions is underappreciated, especially for illness and injury which require an impulse decision on where to access care. The fact that retail clinics are not the primary service offering at pharmacies may play a role in why patients choose urgent care despite its higher cost. While these theories have never been tested, it stands to reason that there is some ill-defined value that has made urgent care centers more resilient than most predicted.

Quality of care is another area of concern when it comes to virtual urgent care, especially antibiotic stewardship. Three of the top presenting telemedicine complaints include sore throat, earache, and urinary tract symptoms. Well-established guidelines exist for all of these, and yet each requires a level of testing not readily available during a virtual visit. The under- or overprescribing of antibiotics for these conditions is an undeniable concern that has yet to be adequately addressed by most virtual urgent care providers. And while urgent care providers have their own work to do in this regard, there are some additional challenges confronting telemedicine that have yet to be fully resolved.

All said, the virtual medicine revolution has hardly been seismic, despite billions of dollars invested. Nonetheless, I do not count out the power and promise of technology to solve many of the issues confronting the industry. Exactly when it will disrupt traditional urgent care is far less certain. ■

Lee A. Resnick, MD, FACP

Editor-in-Chief, *JUCM*, *The Journal of Urgent Care Medicine*

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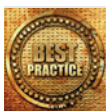
11 Repetitive Motion Injuries: Urgent Diagnosis, Patient-Centered Management

Performing the same motion over and over (and over) again takes its toll on the body, often in the form of musculoskeletal disorders like carpal tunnel syndrome and rotator cuff tendinopathy. Many times, the first stop for patients suffering that fate is often an urgent care center. The question is, what then?

Ashley Clay, MSPAS, PA-C

PRACTICE MANAGEMENT

29 Creating the 'Ideal' Urgent Care Experience



The healthcare landscape is more competitive than ever before. It's not just urgent care vs other practice settings, however. It's urgent care vs urgent care. If you want to be the first choice, you need to know what patients want—and ensure you can offer it.

Alan A. Ayers, MBA, MAcc

CASE REPORT

35 Abdominal Pain in the Younger Adult: Let's Not Forget Acute Diverticulitis



When a patient says they're having stomach pain, your thoughts might gravitate toward the most likely causes, given that patient's overall condition, any chronic health conditions, dietary concerns, age.... Be aware that could knock you off the right track, though.

Fabrizia Faustinella, MD, PhD, FACP and L. Alexandre Frigini, MD

HEALTH LAW AND COMPLIANCE

42 The Consequences of a Medical Provider Quitting Without Notice



If a provider quits spontaneously, with no notice, you've got more problems than simply trying to fill their spot on the schedule. There could be legal ramifications if their sudden absence constitutes patient abandonment.

Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF JUCM

As has been our custom in years past, this midsummer issue of JUCM is dated July–August. As such, you can look forward to receiving the next issue in September. In the meantime, here's a sampling of the original, urgent care-specific topics we'll be covering for you during the remainder of 2019:

- Conjunctivitis
- #MeToo in urgent care
- Toddler fractures
- Venous sinus thrombosis
- Earlobe laceration
- Chronic subdural hematomas
- Working for a Millennial boss

Between now and then, watch your inbox for more fresh content from JUCM News!

DEPARTMENTS

- 6 Continuing Medical Education
- 9 From the UCA
- 21 Insights in Images
- 39 Abstracts in Urgent Care
- 45 Revenue Cycle Management Q&A
- 49 Developing Data

CLASSIFIEDS

- 47 Career Opportunities

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JUCM The Journal of Urgent Care Medicine (ISSN 19380011) supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing healthcare marketplace. As the Official Publication of the Urgent Care Association and the College of Urgent Care Medicine, *JUCM* seeks to provide a forum for the exchange of ideas regarding the clinical and business best-practices for running an urgent care center.

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Musculoskeletal disorders (MSDs) have an impact far deeper than “achy joints” or other nonspecific complaints patients may express. Sometimes, especially when the root cause is overuse or repetitive motions, they affect a patient so greatly that they can’t work. Some people even retire earlier than they’d planned because the pain and disability are so great that they just can’t function.

In other words, MSDs are a big, painful, expensive problem not just for the patient but for the entire U.S. healthcare system and economy.

Since an urgent care center is often the first stop for patients struggling with persistent MSDs, it behooves the provider to know what to look for, but also to be able to forecast the implications outside of direct treatment. In *Repetitive Motion Injuries: Urgent Diagnosis, Patient-Centered Management*, **Ashley Clay, MSPAS, PA-C** addresses how to do that, starting from the first visit.

As an occupational health and wellness clinic coordinator and certified physician assistant working at Medcor, Inc. this is a topic she’s highly qualified to address. You can read her article starting on page 11.



“Abdominal pain” is another complaint urgent care providers hear a lot. The potential causes are myriad—and some of them can turn

deadly, so zeroing in on the right one (and, more to the point, beginning the right treatment) as soon as possible is essential. Unfortunately, a typical complaint isn’t necessarily indicative of a typical diagnosis, or at least the one you’d expect in a patient given certain demographic characteristics. In *Abdominal Pain in the Younger Adult: Let’s Not Forget Acute Diverticulitis* (page 35), **Fabrizia Faustinella, MD, PhD, FACP** and **L. Alexandre Frigini, MD** present a real-world case in which the ability to look past the likeliest possibilities got a patient moving in the right direction before serious consequences could take hold.

Dr. Faustinella is associate professor of medicine in the Department of Family and Community Medicine at Baylor College of Medicine, where Dr. Frigini is associate professor of diagnostic radiology.

Of course, every patient expects a positive outcome. That’s obviously not possible, even when the care provided is spot-on. What *is* possible, however, is striving to perfect and standardize the overall patient experience. What does that even look like, though? Whose *ideal* is actually the ideal? **Alan Ayers, MBA, MAcc** walks us through the process of figuring that out and



offers a game plan for maintaining operational excellence over the long haul. His article, *Creating the ‘Ideal’ Urgent Care Experience*, starts on page 29. Mr. Ayers is chief executive officer of Velocity Urgent Care, LLC and practice management editor of *JUCM*.

Surely one of the “ideals” for management is a stable workforce at every level. Like all ideals, though, that doesn’t always pan out. One event that could be potentially catastrophic for an urgent care location is when a provider quits spontaneously—as in, today they’re managing their regular shift and tomorrow you find out they’re gone for good. In doing so, they’re leaving not just you but also their colleagues and patients in the lurch. To learn how to handle it, including what your legal concerns could be, read *The Consequences of a Medical Provider Quitting Without Notice*, also by Mr. Ayers, on page 42.

Also in This Issue

There’s a lot to keep up with when it comes to medical literature. We do our best to keep you up to speed on current practices in urgent care medicine, but there’s a whole other world out there, and nobody can read everything. So, in *Abstracts in Urgent Care* (page 39), **Joshua Russell, MD, MSc, FAAEM, FACEP** presents the most salient, urgent care-relevant points from articles in other publications every month. In this issue, he presents reviews of articles on the relative “urgency” of stress tests, current approaches to urinary tract infections in very young patients, whether cholecystectomy is really necessary in biliary colic, and more.

Finally we’re indebted to **David Stern, MD** for continuing to share his invaluable insights into the often-perplexing world of revenue cycle management. In this month’s column (page 45), Dr. Stern offers advice on the best ways to deal with claims denials.

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:

- **Suzanne Alton DNP, FNP-BC, RN**
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CONTINUING MEDICAL EDUCATION

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Repetitive Motion Injuries: Urgent Diagnosis, Patient-Centered Management (page 11)

1. All of the following are true of the exam for de Quervain tendinopathy, except:
 - a. Radial-sided wrist pain
 - b. Pain exacerbated by resisted radial deviation, grasping, or gripping
 - c. Tenderness with/without swelling over the first dorsal compartment
 - d. Ulnar-sided wrist pain
2. Which of the following personal medical factors increase risk of development of carpal tunnel syndrome?
 - a. Diabetes
 - b. Obesity
 - c. Pregnancy
 - d. Hypothyroidism
 - e. All of the above
3. Musculoskeletal diseases are most prevalent in which of the following age groups?
 - a. Under 18
 - b. 19-44
 - c. 45-64
 - d. 65 and over

Creating the “Ideal” Urgent Care Experience (p. 29)

1. Which of the following is not considered one of the three foundational pillars in the modern-day urgent care playbook?
 - a. Operational excellence
 - b. Patient experience
 - c. Staff buy-in to established key performance indicators (KPIs)
 - d. An engaged, empowered employee culture

2. If patients who reserved a spot online have to wait before being led to an exam room, they should receive updates:

- a. Every half hour
- b. No less than every 10 minutes
- c. When front office staff observe that they appear impatient
- d. When they ask for an update

3. The guiding theme of each of the pillars of the ideal urgent care experience should be:

- a. Transparency is king
- b. The patient is always right
- c. No wait, no waste, no hassle
- d. No shirt, no shoes, no service

Abdominal Pain in the Younger Adult: Let’s Not Forget Acute Diverticulitis (p. 35)

1. Differential diagnosis of abdominal pain is challenging because:
 - a. Many symptoms and signs are nonspecific
 - b. Patients may have concomitant medical issues that cause abdominal pain
 - c. Patients tend to use nonspecific language in describing pain
 - d. All of the above
2. What percent of hospital admissions for acute diverticulitis are in patients under 45 years of age?
 - a. 2%
 - b. 16%
 - c. 33%
 - d. Over 50%
3. Diverticulitis usually presents with all of the following except:
 - a. Left lower quadrant pain
 - b. Fever
 - c. Nausea
 - d. Changes in bowel habits
 - e. Hematuria

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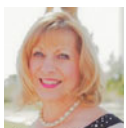
■ LAUREL STOIMENOFF, PT, CHC

The 24 Hours of Le Mans is an endurance sports car race. This prestigious event has been taking place in France since 1923. A driver once surmised that his success in the race occurred when conditions caused drivers to slow. He'd quickly evaluate the risks and, when able, seize that moment by accelerating instead of slowing.

Patient volume dips during the summer months in most urgent care centers. It's easy to use that time to take a summer vacation, exhale, and relish the relative absence of chaos. Alternatively, though, we can get a leg up on the competition and push down on the accelerator.

A former mentor of mine encouraged me to lift my head up from the day-to-day business activities and take time to *think and act* strategically while also preparing for the future. He told me there had to be a disciplined approach to going from being a "down and in" to an "up and out" thinker. So, if you're not lucky enough to be in a place where there is an uptick in seasonal summer volume, we have some suggestions of *up and out* things to do on your summer break.

- 1. Boost your volume with new business through the Department of Veterans Affairs.** Reach out to TriWest Healthcare Alliance to care for our nation's eligible veterans covered through the VA in partnership with TriWest. The Urgent Care Association (UCA) has been advocating for this benefit and we are pleased to announce that veterans can now access urgent care services nationwide without pre-authorization.
- 2. Attend one of the UCA Accreditation Workshops** in Warrenville, IL (a Chicago suburb), August 7-8, or November 5-6 directly following the NERUCA conference in Springfield,



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MA. Whether maintaining or pursuing UCA accreditation, or simply interested in benchmarking your own internal quality and safety standards, this workshop provides hands-on opportunities and tools to succeed, including a mock survey. Consistent application of policy saves money, and attention to quality grows and differentiates your business. For more information, go to www.ucaoa.org/workshop.

- 3. Create opportunities for new patients by signing up to be part of the UCA Gateway2Better Network.** This is truly a case of "chicken and egg." UCA is consistently contacted by organizations seeking regional or nationwide access to urgent care centers. This occurs so frequently that we elected to create a national network of member centers. Your organization may opt in or opt out of any new business opportunity we bring you, so signing up is risk-free. We need to build the network to fully market it and ultimately deliver patients to your door. Take a few moments to join the G2B Network at www.ucaoa.org/G2BN or call (331) 472-3745 to learn more.
- 4. Use downtime to attend summer school via UCA's robust library of online education.** Whether signing up to pursue your Certified Urgent Care Management Professional (CUCMP) designation, honing your clinical skills, adding a new service, or seeking opportunities to run a better business, we've got you covered. Check out www.ucaoa.org/summerschool for details.
- 5. Surf UCA Link for the best pricing on services and products.** Membership matters, and we've negotiated great pricing on behalf of our members with UCA vendor members. They're offering savings you've never seen before on products and services designed to enhance your practice. UCA is focused on member success, and these are just a few suggestions available in our portfolio. The UCA team stands ready to assist you and customize the best use of your summer vacation. So, step on the gas and gear up for a great fall! ■

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Repetitive Motion Injuries: Urgent Diagnosis, Patient-Centered Management

Urgent message: Musculoskeletal disorders result in costly, disabling outcomes for Americans—causing significant economic impact (work-related injuries, early retirement, days away from work) and representing a leading cause of chronic diseases nationwide. Frequently, the initial treating facility, which determines if the injured/ill patient is capable of returning to work or needs time away from work or modified duty, is an urgent care center.

ASHLEY CLAY, MSPAS, PA-C

Introduction

An estimated one in two adults older than 18 years of age, or 126.6 million Americans, are affected by musculoskeletal disorders (MSDs),¹ exceeding the percentage of adults with pulmonary and cardiovascular disease.¹ In 2012–2014, the United States Bone and Joint Initiative estimated that \$322 billion were spent treating MSDs.¹ Factors contributing to cost include an aging population, overutilization of diagnostic studies, inappropriate visits to emergency departments, poor understanding of work functions, bodily requirements, and ergonomic design.

Overview of MSDs

The likelihood of developing musculoskeletal complaints is multifactorial²; see **Table 1** for categorization of occupational vs nonoccupational risks.

History and physical examination

The approach to the musculoskeletal exam begins with a detailed history and establishing symptom parameters. These include:

- Location/radiation
- Onset, timing
- Duration
- Aggravating/alleviating factors



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Table 1. Occupational vs Nonoccupational Risk for Musculoskeletal Complaints²

Occupational Risks	Nonoccupational Risks
<ul style="list-style-type: none"> • Job satisfaction • Ergonomic factors <ul style="list-style-type: none"> – Repetition – Force – Non-neutral posture – Vibration – Lighting – Temperature • Inadequate rest cycles • Lack of task variability • Pace 	<ul style="list-style-type: none"> • Age • Sex • Obesity • Smoking • Deconditioned status • Comorbidities

- Quality
- Context, mechanism of injury
 - Trauma, leisure or work-related, previous injury
- Other associated symptoms

The urgent care provider is responsible for understanding work duties, identifying exposure risk, and determining return-to-work status. Consideration may be given to restrictive duties, such as decreased or temporarily avoiding certain movements, repetitions, awkward postures, and enforcing weight limits; however, lost time for certain conditions may be unavoidable. Maintaining functional capacity and limiting muscle loss is paramount for the patient and practitioner.

After an appropriate history, the physical examination consists of a stepwise approach:

- Inspection (comparing contralateral side)
 - Erythema
 - Edema
 - Previous surgical scarring
 - Discoloration
 - Bruising
 - Muscle atrophy, tone
 - Symmetry
- Palpation
 - Crepitus
 - Tenderness
 - Warmth
- Range of motion (ROM)
 - Active and passive
- Neurological testing
 - Sensory
 - Reflexes
 - Strength assessment
- Peripheral pulses

Clinical tests specific to the suspected diagnosis may also be required.³ All red flag symptomology should be ruled out and any signs of malingering documented. Secondary gain concerns may be involved with a reported work-related injury, and a detailed description of job duties is warranted. If the urgent care provider is encountering reported work-related injuries frequently, it may be helpful to tour the job site in order to better understand the working environment and accommodation process.

Repetitive motion injuries commonly seen in the urgent care setting include:

- Rotator cuff tendinopathy
- Carpal tunnel syndrome
- de Quervain tendinopathy
- Lateral and medial epicondylitis
- Trigger finger or thumb

Rotator Cuff Tendinopathy

Overview

Rotator cuff (RC) tendinopathy results in painful motion associated with inflammation and friction of muscles, tendons, and bursa related to multiple causes. RC tendinopathy falls into the spectrum of shoulder impingement syndrome.³ The RC is primarily responsible for internal/external rotation, shoulder abduction, and stabilization—composed of four muscles (the supraspinatus, infraspinatus, teres minor, and subscapularis) and corresponding musculotendinous attachments. Shoulder pain is a common presenting complaint in the urgent care setting, estimated to account for 16% to 34% of complaints, with rotator cuff pathology as the most common reason patients seek treatment.⁴

Stress to the rotator cuff, specifically the supraspinatus muscle, occurs when the arm is in an elevated position.

History/Clinical Presentation

- Complaints of pain with overhead activities
 - Lateral deltoid area
 - Daily activities such as putting on a shirt or brushing hair cause pain
 - Vocational vs recreational history involving repetitive shoulder motion or working with hands over head
- Difficulty sleeping, more pronounced when lying on affected side
- Pain is gradual, nonradiating, and exacerbated by external rotation and elevation

Physical examination

- Tenderness of the supraspinatus, infraspinatus,

and subacromial aspect

- Supraspinatus tendon—most frequently injured
- Crepitus (grating, cracking sound)
- Atrophy of supraspinatus and infraspinatus muscle
 - Indicates longstanding disease
 - Sunken appearance of scapular fossa

Testing

Exclusion of other etiologies (cervical spine issues, acute coronary ischemia, osteoarthritis) is important. Rotator cuff tendinitis is clinically diagnosed; many consider musculoskeletal ultrasound as the gold standard for initial evaluation of tendon disorders⁵; however, this is not routinely completed in the urgent care setting. Physical exam signs suggestive of rotator cuff pathology include:

- Painful arc test—Shoulder pain between 60° and 120° abduction
 - Most useful when used in conjunction with Neer and Hawkins-Kennedy testing
- Neer—Pronate, passively forward flex affected arm
 - Pain is a positive result
- Hawkins-Kennedy—Elevate the arm, flex shoulder and elbow to 90° and internally rotate
 - Pain is a positive result³
- “Empty can” test
 - Straighten arm, 90° of abduction and 30° forward flexion, internally rotate
 - Relative isolation of the supraspinatus tendon
 - Many consider this the “gold standard” for evaluation of supraspinatus function
 - Clinician then attempts to adduct arm against resistance
 - Tendinopathy—pain *without* weakness
 - Tear—pain *with* weakness
 - Lidocaine injection test—distinguishes between tendinopathy and tear
 - More accurate assessment of strength
 - Tendinopathy—normal strength
 - Tear—weakness

Diagnosis

Obtaining radiographs of the shoulders for nontraumatic shoulder pain is generally not warranted and provides little diagnostic benefit.⁶ Overutilization of x-rays is common; a chart review of 312 patients presenting to the ED with complaints of shoulder pain found that only 20% of the 185 patients for whom x-rays were

Table 2. An Approach to Assessing Musculoskeletal Complaints

History	Inspection	Palpation	Range of motion
<ul style="list-style-type: none"> • Parameters of the symptoms • Inquire about trauma, leisure, or work activities • Monitor for malingering 	<ul style="list-style-type: none"> • Palpation • Edema • Erythema • Surgical scarring • Discoloration • Bruising 	<ul style="list-style-type: none"> • Crepitus • Tenderness • Warmth 	<ul style="list-style-type: none"> • Active • Passive • Flexion, extension • Adduction, abduction • Internal, external rotation

ordered had a condition resulting in specific treatment; 0% of x-rays in patients in the absence of a fall or deformity provided diagnostic benefit resulting in treatment.⁷

MRI is recommended after failure of conservative measures or when suspicious for an RC tear. Electromyography (EMG) and nerve conduction velocity studies (NCVs) may be useful to rule out neurological involvement.

Treatment

RC tendinopathy is initially treated with conservative measures for 3-6 weeks:

- Patient education
 - ROM exercises to prevent adhesive capsulitis
 - Diabetes increases the risk of adhesive capsulitis
 - Avoid aggravating activities (work restrictions may be of value)
 - **Work restrictions:** Avoid prolonged, repetitive tasks requiring shoulder abduction, flexion especially above 60° (commonly written as “no overhead work”); avoid heavy lifting and vibration exposure
 - In order to facilitate recovery, ergonomic redesign of the workplace may be recommended to the employer, focusing on force, shoulder flexion, duration, and posturing
 - Support return-to-work and daily activities within limitations of pain
 - Based on ROM, strength, and function
 - Prior to resuming full duty status, the patient should be able to perform work-activities without return or exacerbation of symptoms
- Physical therapy

- An exercise approach for the treatment of RC tendinopathy has been found to have the same patient outcomes as surgical intervention, even in the presence of partial and full-thickness RC tears³
- OTC NSAIDs for 7-10 days
- Self-application of ice or heat
 - Ice believed to reduce acute inflammation
 - Heat believed to accelerate healing by way of increased blood supply
- Follow-up appointment scheduled 1-2 weeks after initial assessment
 - Assess work limitations and adjustments to activity modifications
- Subacromial glucocorticosteroid injection
 - Considered if more conservative approaches (including PT) fail after several weeks
 - Initially, a single injection is scheduled; if adequate response, a second should be attempted after waiting at least 2 weeks

“Electrodiagnostic tests help confirm diagnosis; however, electromyography is only indicated to rule out other pathology or determination of severity when contemplating surgical intervention.”

- Lateral vs posterior approach
 - Lateral approach significantly reduces risk of injecting into RC tendons
- Locate lateral edge of acromion; entry point of needle is 1 to 1.5 inches below
 - Needle inserted parallel to acromial angle
 - Depth dependent on body habitus of patient
 - Inject local anesthetic
 - Deltoid muscle (1 mL)
 - Deep deltoid fascia (0.5 mL)
 - “Popping” sensation appreciated = in appropriate place (subacromial bursa)
 - 1 to 2 mL of anesthetic
 - Needle left inserted
 - Retest strength; if the following conditions are met, inject shoulder with 1 mL methylprednisolone (Depo Medrol) (80 mg/mL)
 - 50% reduction in pain

- 75%-80% strength (abduction, external rotation) is 75%-80% of unaffected side
- Absent any “red flag” symptoms or actual diagnosis of an RC tear (in which case referral should be made earlier), refer to orthopedist after 6-9 months of conservative treatment or if suspicion of RC tear

Carpal Tunnel Syndrome (CTS)

Overview

CTS may be acute or idiopathic in nature, resulting from compression of the median nerve causing pain and numbness in the hand. The median nerve passes through the carpal tunnel (formed by the carpal bones and the flexor retinaculum).

Characteristics of CTS include:

- Female predominance
- Personal medical factors increase risk of development³
 - Diabetes
 - Obesity
 - Pregnancy
 - Hypothyroidism
 - Rheumatoid arthritis
 - Anatomic

In addition to personal risk factors, repetition, vibration, awkward postures, forceful exertion, dominant hand overuse, and prolonged task duration are suspected contributing factors.³

History/Clinical Presentation

Pain and numbness occur along the distribution of the median nerve:

- Thumb
- Index and middle fingers
- Radial aspect of fourth finger
- Complaints progress over time
 - Frequently dropping items
 - Weakness, decreased dexterity, and tingling/numbness in the wrist and palm
 - Report feeling the need to “shake out” hands to alleviate symptoms
 - Difficulty with sustained grasping (eg, holding a steering wheel)
- Often with increased symptoms while in bed

Physical examination

- **Strength:** Weakness with thumb opposition and abduction may be appreciated
- **Muscle loss:** Thenar atrophy may be present in long-standing cases

- **Sensory:** Fixed sensory loss over the median nerve distribution (not appreciated over the thenar eminence) is another late characterization³

Testing

- Tinel's sign (percussing lightly over the median nerve)
- Phalen's test (request the patient hold the dorsal aspect of their flexed wrists together for 60 seconds)
 - These are considered positive if a tingling sensation occurs along the distribution of the median nerve
 - Phalen's has both greater sensitivity and specificity than Tinel's sign³
- Other pertinent clinical testing include:
 - Monofilament, vibration, hand elevation test, and carpal compression

Electrodiagnostic tests help confirm the diagnosis; however, electromyography (EMG) is only indicated to rule out other pathology or determination of severity when contemplating surgical intervention. Patients with high clinical suspicion for CTS can undergo injections without having an EMG/NCS completed.

Diagnosis

CTS is a clinical diagnosis, highly suspicious when signs and symptoms are present over the median nerve with characteristic factors providing diagnostic value. If a patient presents with classic symptoms of CTS, confirmed by nerve conduction studies (NCS), and does not wish to undergo surgical decompression, EMG is not warranted or needed for diagnosis.

Treatment

Nonsurgical treatment may provide relief.

- Activity modification and exercise⁸
 - **Work restrictions:** Not always warranted, consider avoiding high force combined with repetitive gripping or pinching and handheld tools that vibrate
- Night splinting⁸
- Oral corticosteroids³
 - For patients who *do not* want to undergo injection therapy
 - Dosing recommendations vary; consider prednisolone 20 mg daily for 10 to 14 days⁸
 - Studies note short-term benefit
- Corticosteroid injections³
 - Superior to oral forms

- Used if unresponsive to nocturnal splinting with symptoms lasting > 3 weeks
- **Technique:** A minimum dose of methylprednisolone 40 mg using a 25- or 27-gauge needle at a 45° angle entering the skin near the distal crease⁸
- No more than once every 6 months per wrist
- Recurrent symptoms after two injections warrant additional adjunct treatment or surgical evaluation
- Lidocaine patches
 - Recommended for select cases of acute, subacute and chronic CTS⁸
- Phonophoresis (ultrasound utilized to deliver topical medications, glucocorticosteroids or NSAIDs via electrical current)⁸
 - Splints and/or injection are generally attempted first as those are believed to provide greater relief⁸
- NSAIDs
 - Not as primary treatment unless thought to have an inflammatory component⁸

Surgical intervention is considered if nonoperative measures fail; temporary relief following an injection represents a favorable prognostic factor in terms of surgical outcome.

Treatments *not* recommended include:

- Gabapentin
- Opioids
- Magnets
- Pulsed magnetic field therapy
- Acupuncture

de Quervain Tendinopathy

Overview

de Quervain tendinopathy is a noninflammatory thickening of the extensor retinaculum, resulting in tendon entrapment of the abductor pollicis longus and extensor pollicis brevis (housed in the first dorsal compartment). As the overlying retinaculum thickens, pain develops over the radial aspect of the wrist.⁹ It is a common condition, affecting 1.3% of women and 0.5% of men worldwide.¹⁰ The etiology is not well-understood; however, suggestive causative factors include:

- Repetitive motion (overuse)
- Awkward postures (thumb held in extension and abduction)
- Postpartum period
- Diabetes
- Advanced age
- Increased BMI⁹



History/Clinical Presentation

- Gradual onset of pain over the radial styloid
- Atraumatic history
- Difficulty with gripping objects
- Common in mothers of infants
 - Thought to be related to repetitive lifting of the baby⁹

Physical examination

- Radial sided wrist pain/pain at base of thumb with wrist or thumb motion
- Exacerbated by resisted radial deviation, grasping or gripping
- Tenderness with/without swelling over the first dorsal compartment

Testing

Radiographs do not improve clinical diagnosis but can assist in ruling out other suspected pathology.⁹

Diagnosis

A classic diagnostic maneuver, Finkelstein's test, is considered positive if pain is reproduced when the patient has thumb flexed, fingers wrapped around it and the examiner deviates the hand towards the ulna.⁹

Treatment

- Rest
- Ice

- NSAIDs
- Splinting (thumb spica)
- Follow-up visits are generally required every 1-2 weeks
 - Allows determination of treatment benefit vs relief of symptoms
- Work restrictions may require restricted lifting, gripping, and twisting of affected hand; can also consider limiting repetitive wrist flexion and ulnar deviation
 - Ergonomic recommendations provided to employer may include identification of localized pressure from sharp objects and forceful use of digits

Refractory cases may require an injection of corticosteroid into the sheath of the first dorsal compartment to reduce tendon thickening, inflammation.⁹ Researchers continually advocate for conservative approaches. Earp, et al demonstrated that a single injection abated symptoms in 82% of participants at 6 weeks, and 52% were estimated to remain symptom-free at 6 and 12 months postinjection.¹⁰ If injection therapy fails, surgical release of the first dorsal compartment relieves the entrapment; this intervention is completed on an outpatient basis⁹.

Lateral/Medial Epicondylitis

Overview

The term *epicondylitis* is a misnomer by name as it suggests “inflammation” of either the medial or lateral aspects of the elbow; however, microscopic analysis of the tendon does not reveal inflammation. Epicondylitis, an overuse condition, is a constellation of micro-tears, collagen distortion, and angiofibroblastic degeneration¹¹ resulting in tendinosis.

- Annually affects 1%-3% of the population¹¹
- Women and men are affected equally
- Average onset between the ages of 40 and 60 years¹¹
- **Lateral epicondylitis**—Injury to the extensor carpi radialis brevis muscle (ECRB)
 - Effects wrist extension
 - Referred to as “tennis elbow”
- **Medial epicondylitis**—Injury to the pronator teres and flexor carpi radialis muscles
 - Effects wrist flexion
 - Referred to as “golfers’ elbow”

History/Clinical Presentation

Patients will likely present with pain around the lateral or medial aspects of the epicondyle (dominant hand)

and subjective complaints with gripping activities. Causative factors include:

- Forceful use (managing loads > 44 pounds)
- Repetition, especially for more than 2 hours per day¹¹
- Smoking
- Obesity

Physical examination

- Tenderness along respective epicondyle
 - 1-2 cm distal to ECRB
 - Pain is commonly elicited with resisted pronation of the forearm¹²
- **Lateral epicondylitis**—Pain with wrist extension
- **Medial epicondylitis**—Pain with wrist flexion
- Full ROM
- Rarely associated numbness or tingling
 - Suggests additional ulnar or radial neuropathy

Testing

Diagnostic studies are rarely warranted or useful during the initial workup; however, if complaints persist following 4 weeks of treatment, plain radiographs should be considered; if there is concern for C-6 radiculopathy, MRI may be of value. It should be noted that ultrasound can be employed to characterize the areas of tendinosis and may assist in treatment modalities.¹¹

Diagnosis

Typically clinical and based on history and physical examination findings.

Treatment

Treatment recommendations are similar for both medial and lateral presentations. The cornerstone of therapy includes:

- Rest, ice, compression, elevation (RICE therapy)
 - **Work restrictions:** Avoid vibrating hand tools, high-force gripping or pinching¹³
 - As this is not a progressively worsening condition, no basis for permanent restrictive duty
- NSAIDs
 - Oral vs topical
- Acetaminophen
- Counterforce bracing—circumferential forearm band
 - Applied 10 cm distal to elbow joint¹¹
- Stretching, strengthening¹²
 - A 2012 study of 297 patients found that struc-

tured physical therapy provided greater pain relief than corticosteroid injections or NSAIDs

- Patients treated with PT also found to have lower recurrence rate¹¹
- Corticosteroid injection
 - Provides acute relief; however, long-term outcomes remain unchanged for both conditions^{11,12}

Trigger Finger/Thumb

Overview

Entrapment (thickening, stenosis) of the flexor tendons at the level of the A1 pulley system results in trigger finger (TF).

- One of the most common upper limb issues evaluated in orthopedic practice¹⁴
 - Occurs 20 times more often than de Quervain's¹⁰
- Female predominance
- More common between the ages of 52 and 62¹⁴
- Associated with

“Efficient, cost-effective management of MSDs is well within the field of expertise for urgent care providers.”

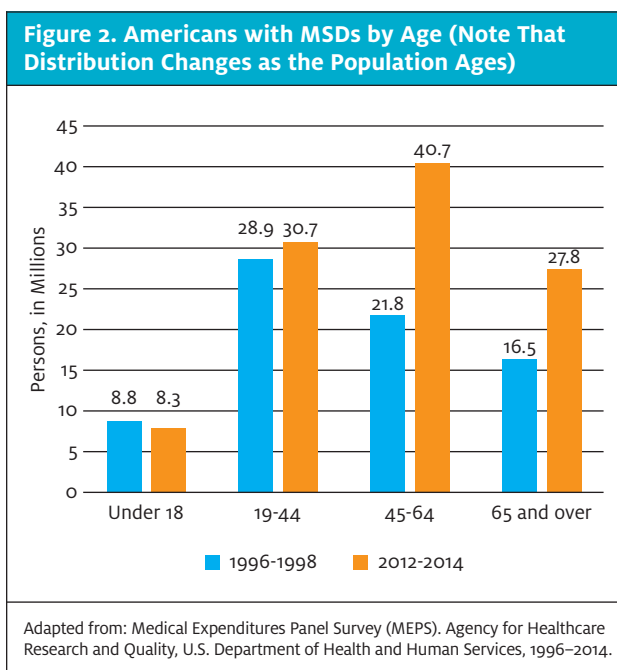
- Diabetes
- Connective tissue disorders
- Nontraumatic events
- Occupations with repetitive tasks requiring force and grip; exposure to vibration

History/Clinical Presentation

This condition results in the finger or thumb feeling “stuck” or causing a sensation of “catching” during flexion (bending) or extension (straightening) of the digit.¹² Initially, patients complain of joint stiffness or pain over the palmar aspect radiating along the digit.

Physical examination

- Palpable snapping sensation or crepitus over the A1 pulley system (overlying the MCP joint) with associated tenderness
- Nodule may be present distal to the metacarpophalangeal (MCP) joint¹⁴
- Puckering of the skin is common
- Thickening of palmar fascia decreases ROM



Testing

No routine lab or imaging tests are required if other diagnoses have been ruled out. X-rays can be utilized if there is concern for joint abnormalities or inflammatory arthritis exists, but are not required if presentation supports a clinical diagnosis.

Diagnosis

Clinically diagnosed, locking or clicking observed as patient opens and closes hand.

Treatment

- Corticosteroid injection into the tendon sheath
 - First-line treatment
 - Injections are reported to be 64%-93% successful in nondiabetic patients¹⁵
- Surgical intervention is generally considered after failing two or three injections
- Ice
- NSAIDs
- Splinting
 - Often affects dexterity and mobility, resulting in noncompliance
 - Shown to resolve in 55% of manual labor population if splinted early¹⁶
- **Work restrictions:** Avoid repetitive activities that aggravate complaints; consider padded gloves

Urgent Care Impact

Responsibilities of the urgent care provider often encompass occupational health roles, especially in rural areas, as preferred provider networks within Worker's Compensation are limited; urgent care clinicians provide initial medical management for musculoskeletal complaints and reported work-related injuries.

Appropriate referrals to specialists, coordination of care, determination of work-relatedness, and management of the return-to-work (RTW) process are aspects of these visits. Utilization of ambulatory centers for the treatment of MSDs (work and non-work-related) continue to increase; according to the Bone and Joint Initiative, 85% of individuals with MSDs will have at least one ambulatory care visit annually, averaging slightly below six office visits per year.¹⁷

As the population ages, it is reasonable to expect an increase in healthcare utilization for MSDs. The U.S. Census Bureau projects that by the year 2060, one-quarter of the population will be 65 years and over (nearly doubling in size from 2017 to 2060).¹⁸ Efficient, cost-effective management of MSDs is well within the field of expertise for urgent care providers.

A 12-month retrospective review of 12,722 patients treated at a physician-owned urgent care facility specializing in orthopedics found that access to care for ambulatory conditions in an urgent care setting improved patient care and decreased overall health costs for the patients and the facility. The average wait time to be seen by a provider was 17 minutes at the UC, compared with 45 minutes in the hospital ED; time to follow-up with an orthopedist was 1.2 days post UC compared with 3.4 days post ED; overall cost per visit was \$461 (UC) and \$8,150 (ED).¹⁹

Work-Related Musculoskeletal Disorders

Clinicians can incorporate basic screening tools with a detailed understanding of workplace responsibilities to establish causation and potential need for work restrictions. Occupational history should include:

- Job satisfaction
- Employment length
- Rotation schedule
- Reported cause
- Job description
 1. Subjective employee description
 2. Employer-provided description vs job site survey
- Occupational risk factors, exposure duration
- Exertional demands

According to the American College of Occupational

Table 3. Considerations for Anticipated Functional Status in Select MSDs	
Rotator cuff tendinitis	<ul style="list-style-type: none"> • Encourage participation in work activities within limitations of pain • Assess for issues with abduction, forward flexion • Limit heavy lifting, avoid or limit activities with hand above shoulder, “no overhead use”; rarely permanent • Maximum medical improvement (MMI) expected in 30-60 days once symptoms improving and no surgical intervention
Carpal tunnel syndrome	<ul style="list-style-type: none"> • No evidence to suggest restrictions are required • Most activities can safely be performed; however, consider need for limitation of forceful grip, repetition • If significant impairment in hand sensation, restrictions may be of value for those working with hot, sharp, or breakable objects • Perform ergonomic evaluations to analysis duration, frequency, reach, pinch force, hand postures, etc. • MMI status post surgical intervention: 60-90 days • Continued improvement s/p surgery is possible over 18 months
de Quervain tendinopathy	<ul style="list-style-type: none"> • Ergonomic recommendations to reduce exposure recommended • Consider advising to avoid awkward hand postures, thumb pinching • MMI: 30-45 days status post surgery
Epicondylitis	<ul style="list-style-type: none"> • Limit loss of muscle mass, maintain functional capacity • Severe cases with dominant hand involvement may affect writing, typing, fine motor skills • Temporarily limit lifting, carrying heavy objects • Use of straps or splints may affect dexterity
Trigger finger/thumb	<ul style="list-style-type: none"> • Reduce repetitive motions, forceful gripping • Ability to perform tasks such as writing, typing may be limited • Conduct job analysis to evaluate contact stress and forceful finger use • Need for restrictive duty rarely extends beyond 6 weeks with effective treatment
Adapted from the American College of Occupational and Environmental Medicine.	

and Environmental Medicine (ACOEM), medical causation refers to a causal link between an injury, illness, disease, or disorder and a known risk factor.²⁰ MSDs can be attributed to both work and non-work-related activities. Work relation is suspected when an event or exposure during work results in a bodily reaction.

MSDs are considered work-related musculoskeletal disorders (WMSD) if the following conditions are met: 1) The work environment and work duties contributed significantly to the disease and/or 2) the injury or illness is exacerbated or persists longer, secondary to work conditions.

Nearly one-third of injuries and illnesses reported in 2017 resulted in days away from work.²¹ Major events resulting in injuries included:²¹

- Bodily reaction
 - Sprains, strains, tears
- Overexertion
 - Pushing, pulling, lifting, carrying

The U.S. Bureau of Labor Statistics (BLS) reported that approximately 2.8 million nonfatal workplace injuries and illnesses occurred in 2017, at a rate of 2.8 cases per

100 full-time employees.²¹ Of those cases, tendinitis resulted in 33 median days away from work; carpal tunnel syndrome resulted in 30; and sprains/strains/tears accounting for 11 median days.²¹

In addition to having familiarity with epidemiological evidence supporting direct correlation with accepted risk factors,¹⁸ the urgent care clinician must fully understand the work environment and duties. MSDs are associated with high costs to employers secondary to absenteeism, lost productivity, increased healthcare premiums, disability, and Workers' Compensation.

Determining Work Relationship

Urgent care providers may need to determine work-relatedness based on presenting symptoms and work exposure—causation of MSDs is not always easily identified and nonacute subjective symptoms can progressively worsen and manifest as a multifactorial consequence. Often, cause-effect relationships between clinical diagnosis and occupational exposure are difficult to ascertain.

The initial assessment of a reported work injury often occurs at the urgent care level; causality findings during initial evaluation are often preliminary, and the provider should communicate the level of uncertainty to the patient, employer, and Workers' Compensation.²⁰ Objectives during the initial evaluation include:²¹

- Determine diagnosis
 - Accounting for subjective complaints, clinical signs, and objective diagnostic findings
 - Review previous medical records
 - Including pre-existing symptoms, diagnoses, previous injury or trauma
 - Results of medical surveillance and preplacement testing
 - Consideration of other contributing factors
 - Document any signs of malingering or concerns for secondary gain
- Workplace exposure (as detailed previously)
- Data review
 - Supports or refutes an occupational relationship
 - Literature, studies, case reports

Determining causation should account for occupational/nonoccupational risk, socioeconomic, and psychological factors.²⁰ Causation must be evidenced-based.

Incorrectly correlating the injury to the occupation or failing to associate job hazards with reported complaints may negatively impact multiple stakeholders, including Workers' Compensation carriers, employers, personal health insurance companies, and the employee.

Returning to Work/Modified Duty vs Lost Time

The initial treating facility—often an urgent care center—determines if the injured/ill patient is capable of returning to work, requires time away from work, or may return with restricted/modified duties. The American Medical Association strongly recommends that providers return patients to their usual duties as soon as possible. Strong evidence links positive benefits of mental and physical health to re-employment. The longer an injured worker is placed off work, the more likely they will remain off work.

Navigating the RTW process requires that the clinician understand tolerance, capacity, associated risks, work environment, and bodily requirements of a full return to duty. Assess if the employer accommodates modified duty status; many have progressive, robust RTW programs. The ACOEM offers guidance in terms

of anticipated functional status based on a variety of MSDs; see **Table 3**.

Conclusion

The ever-changing medical climate requires the urgent care provider be cognizant of economic impact and implications of cost burden and care. MSDs are costly, potentially disabling diagnoses requiring complex diagnostic and therapeutic approaches that encompass facilitation of care, understanding dynamic work environments, promoting total health, and improved functional status for work and non work-related conditions. ■

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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 2-Year-Old Girl with Leg Pain After Jumping on a Trampoline

Figure 1.



Figure 2.



Case

The patient is a 2-year-old girl who is brought to your urgent care center by her parents several hours after jumping on a trampoline with her friend. Her parents say she “seemed fine” when the mother picked her up to come home.

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

THE RESOLUTION

Figure 1.

**Differential Diagnosis**

- Acute transverse fracture of the proximal tibial metaphysis
- Hairline spiral fractures of the tibial diaphysis (ie, a toddler fracture)
- Irritable hip
- Subacute osteomyelitis

Diagnosis

The x-ray shows an acute transverse fracture of the proximal tibial metaphysis—an acute Salter type II “trampoline fracture” of the proximal tibia.

Learnings/What to Look for

- Trampoline fractures typically occur in children 2 to 5 years of age while jumping on a trampoline (or other jumping surface) with another, heavier individual

- The upwards bending/recoil of the jumping surface after the heavier partner’s jump exerts excessive axial load on the tibia of the younger lighter child concomitantly descending on the trampoline with extended knees. Immature bones of the children are soft and less resistant to the kinetic energy of the axial load, leading to a proximal tibial impacted fracture
- Radiographic findings include a transverse impacted fracture in the proximal tibial metaphysis. The fractures are usually not angulated or displaced. Bilateral fractures can occur

Pearls for Urgent Care Management and Considerations for Transfer

- Treatment is usually conservative with immobilization. The fractures usually heal without permanent disability or impairment

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



An 80-Year-Old Man with Rhinorrhea, Cough, and Intermittent Dizziness

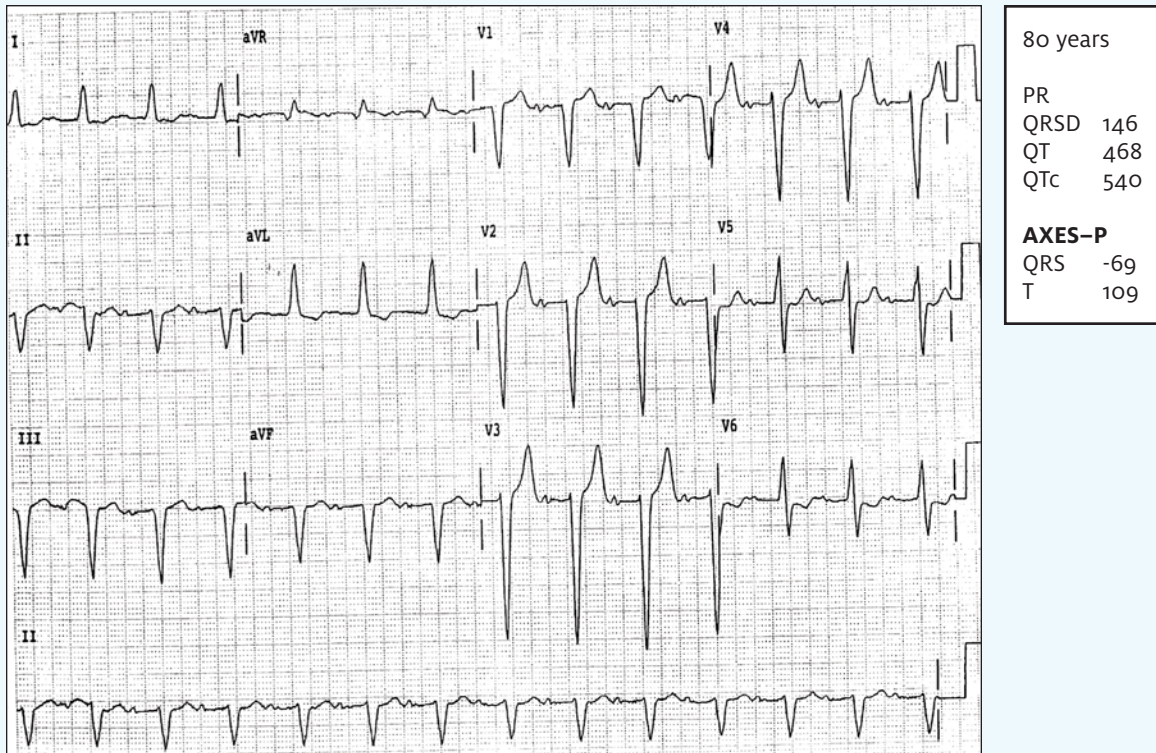


Figure 1.

Case

The patient is an 80-year-old man with history of hypertension and high cholesterol who presents with rhinorrhea and cough. On further history, he admits to 2 months of intermittent dizziness, not worsening. He denies any chest pain/discomfort, SOB, or sweating. No neuro symptoms.

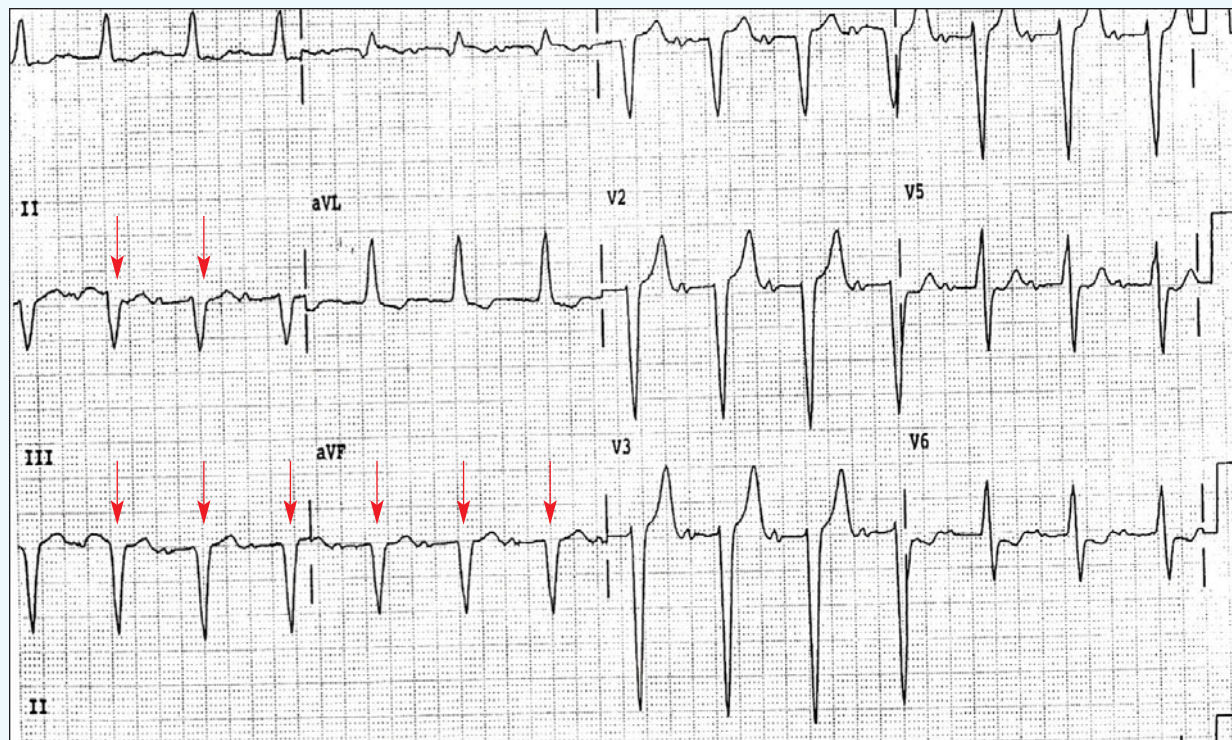
Upon exam, you find:

- **General:** A&O, NAD
- **Lungs:** Clear bilaterally

- **Cardiovascular:** Regular rhythm, without m,r,g
- **Abdomen:** Soft and nontender
- **Ext:** No edema or asymmetry, pulses are 2+ and equal in all extremities, no pain with palpation

An ECG is performed before you evaluate the patient. Review the ECG and consider what your diagnosis and next steps would be. Resolution of the case is described on the next page.

THE RESOLUTION

**Differential Diagnosis**

- Second-degree heart block
- Third-degree heart block
- Junctional rhythm
- Q waves in the inferior leads, indicative of previous MI or LBBB
- Acute inferior MI

Diagnosis

This ECG shows a sinus rhythm (a P wave preceding each QRS) with a rate of 80, but the PR interval is prolonged, reflecting first-degree AV block (normal PR interval is 120-200 ms).

As there is a p wave before each QRS, this is not a junctional rhythm.

Second-degree block involves a dropped beat (either Mobitz 1 or 2). Third-degree AV block has complete absence of AV conduction without relation of the p waves and the QRS complexes, typically at a rate in the 30s. Neither second- or third-degree AV block is reflected on this ECG.

There is no evidence of ST elevation in the inferior leads (II, III, aVF), so this is not an acute inferior MI.

The Q waves present in the inferior leads are likely indicative of a previous MI. Note that with the widened QRS complex (normal is 80-120 ms) there is a nonspecific intraventricular conduction delay which could also indicate that left bundle branch block

(LBBB) is present and the Q waves present inferiorly could also be due to the LBBB.

Learnings/What to Look for:

- The inferior leads, II, III, and aVF are limb leads which reflect changes at the bottom portion of the heart, typically with blood supply from the right coronary artery (RCA)
- Q waves are present if there is a Q-wave which is one box (0.04 ms) wide and one box deep
- In addition to evaluating ECGs for acute ischemia, they should be checked for possible past infarction

Pearls for Urgent Care Management and Considerations for Transfer

- Evidence of old MI can be incidentally found on ECGs
- Assess for ongoing ischemia clinically (chest pain/discomfort, shortness of breath, diaphoresis, arm/shoulder/neck/jaw pain) and with assessment of the ECG for ST elevation, ST depression, or T wave inversion
- If the patient is asymptomatic and the Q waves are found incidentally, further evaluation can be done as an outpatient
- If there are clinical or ECG changes of ischemia, the patient should be emergently transferred to the ED

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A 48-Year-Old Woman with a Facial Lesion

Figure 1.



Case

The patient is a 48-year-old woman who presents with a single lesion on her cheek/face. As a healthcare worker herself, she says she is concerned that the excoriation might get infected. She denies knowing anything about the possible cause, but insists on receiving treatment.

Notably, she is a frequent visitor to your urgent care center in spite of the fact that she is in excellent physical health. However, she has been diagnosed with borderline personality disorder.

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

THE RESOLUTION

Figure 2.

**Differential Diagnosis**

- Acne excoriée
- Factitial ulcer
- Prurigo nodularis
- Neurogenic ulcer

Diagnosis

This patient was diagnosed with factitial ulcer. A manifestation of dermatitis artefacta, these occur secondary to a patient digging, excoriating, or generally manipulating their own skin—a psychiatric condition in and of itself, in which patients self-induce lesions in order to satisfy a need to assume the “sick role.”

Learnings/What to Look for

- Patients are unlikely to admit creating the lesions themselves
- Diagnosis of self-abuse tends to occur more frequently in women and in those working in healthcare
- Factitial ulcers should be differentiated from malingering, in which lesions are created deliberately for secondary gain, such as collecting disability or obtaining prescriptions

Pearls for Urgent Care Management and Considerations for Transfer

- Lesions are often produced by digging, picking, biting, cutting, injecting, and puncturing. Be vigilant for wounds that may be complicated by gangrene, abscess formation, or other life-threatening infections
- Treatment requires a multidisciplinary approach. In the urgent care setting, treat the wound according to its severity
- In patients for whom there is no known psychiatric diagnosis, recommend consultation with a mental health provider

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Creating the 'Ideal' Urgent Care Experience

Urgent message: For owner-operators truly committed to creating “the ideal urgent care experience”—a thriving operating model that benefits patients, employees, and investors alike—a commitment to operational excellence, a perfecting of the patient experience, and the embrace of an empowered, engaged employee culture must form the bedrock principles of their practice.

ALAN A. AYERS, MBA, MACC

Driven largely by millennials and Gen Xers who place a premium on convenience, alongside Baby Boomers utilizing their newly acquired Medicare benefits, urgent care centers continue to experience a significant surge in demand. According to the 2018 Urgent Care Association Benchmarking Report, the total number of U.S. urgent care centers grew 8% from 2017 to 2018 alone, with those clinics handling roughly 89 million patient visits per year. Despite this huge expansion in urgent care volume and utilization, though, some markets are already experiencing oversaturation, which has led to fierce competition for local patients' urgent care spend.

So even with the ready growth and profit potential available in owning-operating a center or chain of urgent cares, merely placing a Grand Opening sign in front of a new clinic or maintaining a mediocre status quo in an established clinic in no way guarantees patients beating down your door, nor a well-oiled, humming operation. Rather, independent of your marketing mix or your high-traffic, high-visibility location, it will require a concerted effort to create the kind of “ideal” urgent care experience that delights patients, provides workplace fulfillment for your staff, and drives the kind of robust revenues that garner your center/chain the kind of high valuation that makes it an attractive asset to potential investors and buyers.

Developing a Modern-Day Urgent Care ‘Playbook’

This approach is all about building a consistent, scalable,



repeatable, measurable, and predictable operating model—one that has been refined and tested, can be implemented and replicated easily, and has all the necessary ingredients to create a thriving urgent care experience when executed. It requires the development of a modern-day urgent care “playbook” of sorts that factors in today’s changing healthcare landscape, advances in technology, the growing competition from market dis-

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rupters, and the needs and preferences of emerging patient cohorts who are driving demand and innovation. To that end, the modern-day urgent care “experience” playbook should be built upon these three foundational pillars:

1. Operational excellence
2. Patient experience
3. An engaged, empowered employee culture

When the modern-day playbook is executed properly, these three pillars interact and interconnect on every level. They’ll combine in an interdependent fashion to facilitate the smooth functioning of the whole, which is the sort of “big picture” game plan required to develop a truly holistic model that fulfills the promise of the ideal urgent care experience. In the following sections, we’ll briefly examine each of these foundational pillars, along with some basic strategies for their practical execution.

Operational Excellence

The guiding theme of each of the pillars of the ideal urgent care experience should be one of *No wait, no waste, and no hassle*, with operational excellence being no exception. For operational excellence, this means the center’s operating philosophy and culture should be centered around improving workflows that boost patient throughput, eliminating unnecessary administrative burdens for providers and staff and identifying and correcting errors, friction points, and bottlenecks at every opportunity—all of which are built upon a set of highly optimized processes. The following are several *No wait, no waste, no hassle* operational excellence principles upon which urgent care workflows and processes can be built:

- **Preventative culture:** Staff should be trained to anticipate and recognize potential issues before they arise, and be empowered to take corrective action. An effective preventative culture is best instilled through consistent and repeating messaging, to the point where it becomes a company mantra. One example on the administrative side is first-pass resolution rates on claims submissions; this directly impacts urgent care revenue. The center’s culture must be one that is hypervigilant on ensuring accuracy in coding and documentation to prevent rejected claims, which result in wasteful rework, costing the center valuable time (and money) to go back and correct the error. Similarly, failing to ensure that a patient’s demographics are double-checked and up to date at registration/check-in can result in costly denied claims. Overall,

throughout the entire operation, “getting it right the first time” must be the overarching standard that permeates all clinical and administrative activities and processes.

- **Continuous improvement:** Just because a process has been in place for a while does not mean it can’t be improved. In fact, over time, many organizational processes become “jury-rigged” such that they’ve become little more than inefficient band-aids that basically serve to “plug the dyke” to temporarily stem leakage. This is why it’s essential to cultivate a mindset of always searching for ways to make the operation more efficient, improve quality, remove non-value-added tasks from roles and processes, and upgrade the level of service. Rather than making excuses as to why an established but inefficient process is too difficult to change, a culture of continuous improvement must instead be embraced and reinforced at every touchpoint. In the modern-day urgent care setting, continuous improvement initiatives will rely heavily on the practice management (PM) solution and the electronic medical record (EMR) working in concert to capture and analyze both clinical and administrative data. These systems can track key performance indicators (KPIs), create KPI dashboards, and generate reports, allowing clinics to closely monitor their important metrics. So, when the metrics fall below expected benchmarks, they can be traced back to the processes that underpin them, which then are evaluated for improvement.

Continuous improvement initiatives will also lean heavily on input from front-line staff, as they are the people who execute the processes day in and day out, understand the urgent care operation from the patient’s perspective, and deal firsthand with the interconnectivity of all the clinical and administrative roles, systems, policies, and processes.

- **Inventory management systems:** For the center’s medical supplies, this service is available either free or at a nominal cost from leading medical supply houses. Inventory management systems allow the center to reduce supply expenses by creating a formulary of pre-approved items, preventing staff and providers from ordering expensive, unnecessary supplies. The inventory management system also enables the center to reduce excess inventory by providing visibility of current inventory levels and

setting minimum on-hand and reorder quantities, which prevents hoarding supplies or redundant purchasing. Supply inventory levels will be based on the number of patients seen, which, again, can be closely tracked through the KPIs provided by the PM and EMR systems.

■ **Maximizing labor and controlling labor expenses:**

As labor management is critical to controlling expenses, KPIs are a primary factor in helping the center better align staffing numbers with morning, evening, weekend, and seasonal patient volume trends and expectations. Additionally, centers should consolidate redundant tasks (eg, managers of each center in a chain/organization spending valuable time each day processing invoices) into a single, dedicated role towards freeing up providers and managers to focus on coaching staff, patient care, and customer service. There should also be an effort to consolidate roles and cross-train whenever feasible. For example, consider cross-training radiology technicians (RT) as medical assistants (MAs) and/or vice-versa. A \$22-\$25/hour RT is typically the second highest paid position in the center, after the provider, which means that if the “typical” urgent care sees 35 patients and only 10% to 15% get an x-ray, then the RT is only doing a 20-minute x-ray four times over a 12-hour shift. Alternately, there are states where an MA can be trained to take x-rays, as modern equipment is very easy to use under a “basic machine operator” or “limited scope x-ray” license. Hence, it's much more cost effective in terms of labor expense to employ an MA who's trained to do x-rays rather than hiring a more expensive RT whose college training includes MRI, CT, ultrasound, and other modalities that are rarely if ever used in urgent care (and thus not fully utilized).

■ **Optimized support services:** For service level agreements with internal and external support services and vendors such as outsourced billing, accounting, IT, payroll, and janitorial, every contract should be error-free, on schedule, and customized to the needs of the individual center. Expectations, performance level, remediations, termination clauses, and other contract terms should be clearly spelled out and adhered to by the service provider.

■ **Organizational forward thinking:** Businesses fail when they don't anticipate change or they react

poorly to it. As such, your center must remain on the cutting edge and prepare today for tomorrow. This might entail staying abreast of market trends and technology, paying attention to shifts across the healthcare landscape, keeping your “fingers on the pulse” of your local community's patient population (and their evolving wants and needs for becoming their urgent care of choice) and remaining lean and flexible in your organizational model so you can grow and adapt to change—which is inevitable.

Patient Experience

As the urgent care industry has evolved amid a changing landscape dotted with disruptive market entrants that expertly leverage nimbleness and technology, so has the expectations of the patient insofar as the experience they expect. Spurred by the proliferation of high-deductible health plans (HDHPs) that have shifted more of the financial burden of their healthcare onto the patient, patients are increasingly behaving like consumers who demand the same level of access, convenience, price transparency, and frictionless financial transaction that they enjoy from their other service providers. Consumers can order meals and event tickets, check wait times, and get real-time updates on their smartphones from the businesses they patronize; hence, they now expect the same convenience from their preferred urgent care. Couple that with the steady shift of urgent care from a largely walk-in business to an online appointment/reservation culture fueled by technology, and it becomes clear that to create an ideal patient experience, urgent care operators must employ systems, processes, and technology that both elevate the patient financial experience and seamlessly integrate with mobile technology. With that in mind, here are several actionable *No wait, no waste, no hassle* optimizations urgent care centers can make to meet the demands of patients' growing consumerism.

■ **Online reservation/registration:** Through any web-enabled device, patients should be able to “reserve their place in line.” While it's not an actual “appointment,” this feature is a welcome convenience since it allows the patient to “wait” from home, work, or while running errands, reducing their perception of the total wait since most of it does not occur sitting in an urgent care lobby. Patients should also have the option to register their information from their mobile device, further speeding up the actual in-clinic visit time. These

online reservation/registration systems also greatly benefit the urgent care staff, as knowing how many patients are waiting in “virtual line” helps pace the flow of patients through the center, versus the often-unpredictable ebb-and-flow that occurs with walk-in traffic. Better pacing of patients leads to more predictable throughput times, better utilization of staff, and more predictability in staff scheduling. It then becomes a matter of simply aligning the number of “slots” in the queuing system with staffing levels, then optimizing staffing by the number of patients per hour per staff person seen. A further benefit to shifting registration to mobile and electronic self-serve technology is it reduces the use of paper/toner, and “shifts” a good portion of the basic data entry work from the paid staff to the patient who essentially is working for “free.”

- **Two-way patient/clinic texting:** After a patient reserves their spot online, the queuing system should be designed to communicate expected wait times via text, as well as when to arrive at the clinic, or changes in wait times. Lab and test results, reminders, and refill requests should be available via text or dedicated online patient portal. Texting should also be used to conduct brief, after-visit surveys shortly after the patient leaves the clinic. This kind of survey is invaluable in gaining a rough idea of what your net promoter score (NPS) is and gives you the opportunity to respond immediately to unhappy patients and negative feedback.
- **Patient satisfaction rounding:** Patients who reserved their spot online in advance have far less tolerance for in-clinic delays than walk-in patients. The center, therefore, should have a patient satisfaction rounding policy in place, where patients in the lobby or waiting room are given an in-person update on when they will be seen. As a rule of thumb, the amount of time between direct patient updates, even when it's busy, should never exceed 10 minutes.
- **Financial best practices:** Consumerism in health-care has resulted in a discerning and empowered patient population that actively seeks out providers who place an emphasis on elevating the patient financial experience at every touchpoint. From price transparency, the actual financial transaction, clear explanation of insurance deductibles, copays

and other financial obligations, financial counseling and advocacy, and consolidated, no-surprise billing, patients now demand a straightforward, frictionless encounter. In fact, the financial experience is so central to patient satisfaction that a negative financial experience—such as receiving a bill for unexpected charges or being sent to collections—sometimes leads patients to post a negative online review *even if the clinical outcome was successful*. Bottom line, patients don't want price and billing ambiguity, uncertainty, or surprises after the visit. Especially for self-pay patients, they want clear, flat pricing and simple, straightforward ways to view and pay their bill. To that end, the center can help facilitate clean financial transactions by employing real-time insurance verification to determine patient responsibility, and digital tools such as credit card preauthorization to ensure collection of the patient's obligation at the time of service.

Engaged, Empowered Employee Culture

No matter how much cutting-edge technology your center can leverage, executing a high level of operational excellence and creating a satisfying patient experience would be difficult, if not impossible, without an engaged, empowered employee culture as a foundational pillar. All successful—and unsuccessful—cultures begin and end with the quality of its people, and their commitment to the success of the organization. After all, it's the people who execute the processes each day that ultimately determine whether it all adds up to a thriving, successful urgent care business.

Following are several practical considerations on how to keep your staff motivated, engaged, and empowered within the ideal urgent care operation.

- **Create a *bottoms-up* culture:** Millennials are now the most prevalent age group making up the workforce. And unlike the Gen Xers and Baby Boomers that came before them, they work best not within a *top-down* management style, but rather a more empowering *bottoms-up* workplace culture. In a *bottoms-up* workplace culture, employees have a voice and feel free to share opinions, insights, and ideas on how to improve the operation. Of course, a medical business like urgent care requires strict compliance to set regulations, policies, and procedures, but empowered employees feel free to offer suggestions for improvement without fear of negative repercussions from management. Ultimately, a bot-

toms-up culture engenders a level of ownership where people at every level see the big picture, are vested in the long-term success of the business, and understand how their specific role, actions and decisions drive the bottom line.

- **Engaging employees with KPIs:** One of the single biggest drivers of employee engagement is cultivating understanding and then “ownership” of the center’s KPIs. When team members understand the KPIs, how they affect the business, how their individual roles impact them, and how they can influence them, they become motivated by the feedback they provide. This leads to discussion, brainstorming, and teamwork on how to improve patient care and service delivery. In fact, many successful urgent care teams write their main KPIs on a white board daily, which they then review in their team huddles. Such teams also utilize “mini-games” to set goals and challenge themselves to move the metrics. Unsurprisingly, these methods drive great motivation and enthusiasm in tracking and driving the key numbers.
- **Employee rewards:** Consider rewarding employees for exemplary performance whenever feasible. Rewards can be as simple as a gift card in acknowledgement of an accomplishment or buying the team lunch when a targeted milestone has been achieved. Salary increases and yearly bonuses tied to performance should also be implemented where it’s financially feasible. This can help team members become more fully invested in the business and feel that their efforts will be financially compensated.
- **Gratitude and recognition:** Probably the most powerful drivers of employee engagement in the workplace, studies have shown that many employees value gratitude and recognition over financial compensation. Those same studies show that companies that practice gratitude and recognition outperform their competitors in metrics such as revenue growth and stock price, given that happy and appreciated employees are decidedly more productive. When employees feel that their work, their presence, and their contributions matter, they become ambassadors and cheerleaders for your center and its culture. And the way an urgent care operation treats its employees has a direct trickle-down effect on the way those employees treat patients. You can recognize a culture

of gratitude and recognition when you see employees’ pictures framed on the wall; when managers and providers seek out opportunities to “catch” someone doing the right thing; when management brings in coffee and donuts for the team; when management gives a team member a hand-written note or card thanking them for a job well done; when management spotlights and celebrates an employee on the company’s social media channels; when management shares with the team an anecdote of a patient praising an employee’s service and professionalism; and when management holds meetings for the sole purpose of saying *thank you* and acknowledging team member contributions.

“Operators who want to stand apart must take a hard look at the changing landscape and ensure that their urgent care operation—no matter its size—is fully optimized for today’s consumerism-focused, tech-savvy patient.”

Conclusion

Though the urgent care business as a whole is booming, owner-operators who want to stand apart in their individual markets must take a hard look at the changing landscape and ensure that their urgent care operation—no matter its size—is fully optimized for today’s consumerism-focused, technological savvy patient. This entails developing a modern-day urgent care playbook that places a renewed focus on leveraging technology and systems to achieve operational excellence and elevating the patient experience at all the relevant touchpoints—particularly the financial experience. And above all, a keen recognition that peak potential will never be achieved without the buy-in of an engaged, empowered culture of employees who are truly committed to fine-tuning and executing the processes necessary to create a successful operation. Hence, by committing to all three foundational pillars, you, your staff and your patients can truly achieve the “ideal urgent care experience.” ■



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Abdominal Pain in the Younger Adult: Let's Not Forget Acute Diverticulitis

Urgent message: The differential diagnosis of abdominal pain is challenging because many symptoms and signs are nonspecific and because patients might often have concomitant medical conditions that could cause abdominal pain. Although diverticulitis is more common in older patients, failure to consider diverticulitis in the differential diagnosis of abdominal pain in the younger adult could lead to delayed diagnosis and undesirable complications.

FABRIZIA FAUSTINELLA, MD, PHD, FACP and L. ALEXANDRE FRIGINI, MD

Introduction

Diverticular disease of the colon is a significant cause of hospitalization in industrialized societies and an important contributor to healthcare costs. Several lifestyle factors have been associated with diverticular disease, including low dietary fiber intake, high red meat intake, lack of physical activity, high BMI (≥ 25 Kg/m²), and smoking (≥ 40 pack-years).¹ Diverticulitis usually presents with left lower quadrant pain, low-grade fever, nausea, and changes in bowel habits, but patients may also have right lower quadrant or suprapubic pain, associated with dysuria and urinary frequency.

The prevalence of diverticulosis increases with age, from <20% at age 40 to 60% at age 60. Approximately 5% to 15% of patients with diverticulosis develop acute diverticulitis.^{2,3} While the incidence of acute diverticulitis is higher in older individuals, approximately 16% of hospital admissions for acute diverticulitis are in patients under 45 years of age.⁴ Up to 50% of patients will experience recurrent bouts of diverticulitis.⁵ Although increasing age is associated with a higher risk of both local and systemic complication, the risk of recurrence seems to be higher in the younger individual.⁶

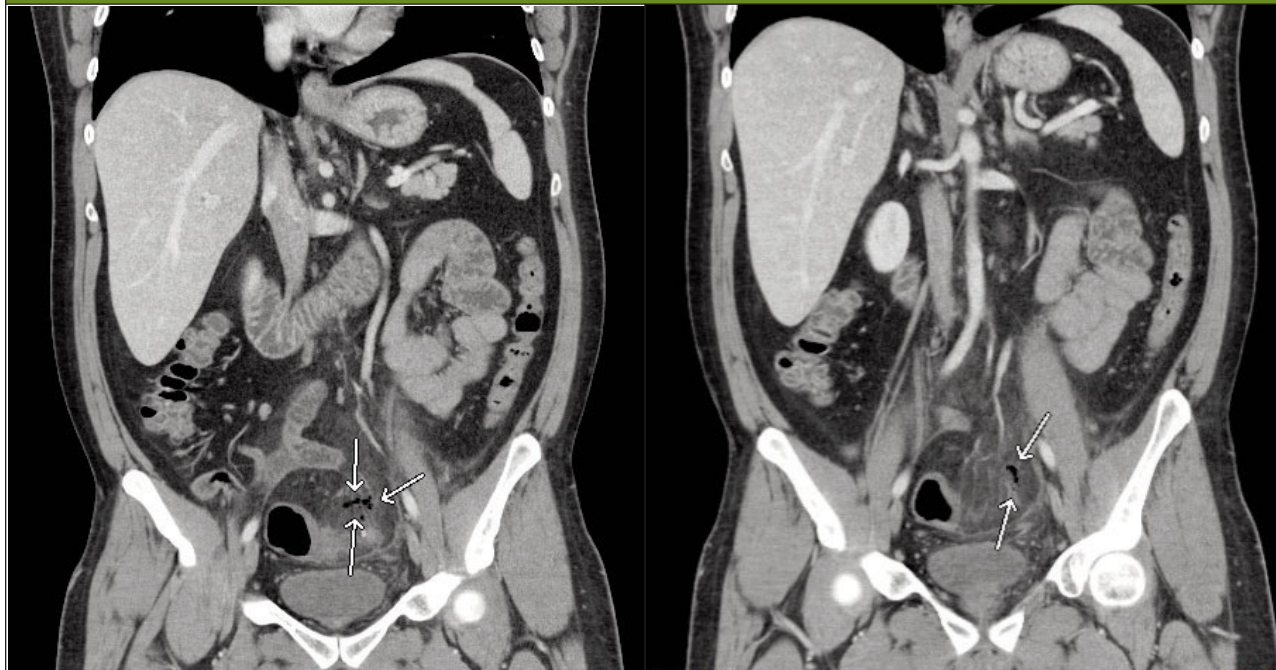


Presentation

A 38-year-old male presented to our walk-in clinic with a complaint of left lower abdominal pain, radiating to

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Figure 1.



the left groin, for 3 days. The patient also reported abdominal bloating, nausea, reduced appetite, dysuria, urinary frequency, and chills. He denied hematochezia, diarrhea, and vomiting. The patient stated that he had experienced severe constipation in the past and, as he hadn't had a bowel movement in over 4 days, he took laxatives at home; however, the abdominal pain did not improve. He also reported a history of kidney stones, but stated that the pain he experienced at that time felt "different" from the current episode.

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

- BP 120/70
- HR 113
- Temp 100.3° F
- RR 18
- SpO₂ 97%
- BMI 28.99
- Lungs: Clear to auscultation bilaterally
- Heart: Tachycardic, regular rhythm, no rub/gallop/murmur
- Abdomen: BS +; significant LLQ tenderness to palpation; + rebound tenderness; LLQ + rigidity

The patient was taken via wheelchair to the emergency department, located down the hallway from our clinic, due to the concern for an intra-abdominal disease process, abscess and/or perforation, with early signs of

peritonitis, as indicated by the physical exam findings. In the ED, a CT of the abdomen and pelvis with IV contrast was immediately requested for further evaluation. The CT scan was read as:

1. Gastrointestinal tract with hyperenhancement and focal colonic thickening of the sigmoid colon with adjacent pericolic fat stranding and trace of free fluid.
2. Sigmoid colon diverticulitis with extraluminal foci of air representing contained perforation.

Laboratory tests showed a WBC of 14.4 (ref. 4.5-12.0) with 75% neutrophils (ref. 34-67.9%).

The patient was admitted to the hospital and was medically managed with bowel rest, IV antibiotics (metronidazole and ciprofloxacin), and serial abdominal exams. He showed gradual improvement and was discharged, 4 days after admission, on oral antibiotics with a 3-week follow-up in the colorectal clinic and a 6-week follow-up for colonoscopy.

One month after discharge, the patient presented again with complaint of severe left lower quadrant pain x 1 day and was found to have perforated diverticulitis. The CT abdomen and pelvis was read as follows:

- Interval evolution of contained perforated diverticulitis within the left lower quadrant. Interval worsening of pericolic fat stranding and phlegmonous change without frank abscess formation. No signif-

icant change in the amount of extraluminal air.

The patient was admitted to the surgery service where he was managed again conservatively with IV antibiotics and bowel rest. After 3 days of hospitalization, he was discharged home on oral antibiotics for a total of 14 days' course.

A colonoscopy was performed 2 months after discharge and showed the presence of diverticulosis in the sigmoid colon and a pedunculated polyp, which was found to be benign.

Discussion

Diverticulitis, defined as inflammation of a diverticulum, is triggered by the erosion of the diverticular wall, caused by increased intraluminal pressure. This leads to inflammation and necrosis, with resulting micro or macro perforation of the diverticulum.

Lifestyle factors associated with diverticular disease described previously—low dietary fiber intake, high red meat intake, lack of physical activity, high BMI (≥ 25) and smoking (≥ 40 pack-years)¹—applied to our patient.

Abdominal pain is the most common symptom in patients with acute diverticulitis. In the vast majority of cases, the pain is located in the left lower quadrant due to involvement of the sigmoid colon. However, patients may report suprapubic pain due to irritation of the bladder from the inflamed sigmoid colon⁷ and right lower quadrant pain due to more uncommon cecal diverticulitis. Our patient reported suprapubic pain associated with symptoms of dysuria and urinary frequency.

These symptoms, along with the previous history of kidney stones, could have been deceiving and could have led to the wrong clinical diagnosis. Changes in bowel habits are commonly associated with acute diverticulitis, with constipation affecting about 50% of patients and diarrhea 25% to 35% of patients.⁷

Our patient reported constipation, although that seemed to be a chronic issue for him, another confounding factor. Nausea and vomiting can develop due to ileus, caused by peritoneal irritation or bowel obstruction. Our patient reported nausea, no vomiting. On physical exam, patients may have localized peritoneal signs with guarding, rigidity, and rebound tenderness, which were all found in our case.

The vast majority of patients with acute diverticulitis have no associated complications.

Our patient's CT scan showed focal colonic thickening of the sigmoid colon with adjacent pericolonic fat stranding and extraluminal foci of air representing contained perforation—common findings in acute uncomplicated diverticulitis.

Computed tomography of the abdomen has very high sensitivity and specificity (94% and 99%, respectively) for the diagnosis of acute diverticulitis and can exclude other causes of abdominal pain.⁸ About 15% of patients with acute diverticulitis have an associated complication, such as an abscess, frank perforation (free air under the diaphragm), fistula formation, or colonic obstruction.⁹

Advanced age, male sex, and several drugs, such as NSAIDs, opioids, and corticosteroids have been associated with an increased risk for perforation.^{10,11}

Indications for inpatient treatment include:¹²

- CT showing complicated diverticulitis

“Following conservative management of a first attack [of diverticulitis], approximately one-third of patients will have a second attack; this is exactly what happened to our patient.”

- Acute uncomplicated diverticulitis associated with: high fever ($\geq 102.5^\circ\text{F}$), sepsis, micro perforation (a few air bubbles just outside the colon or confined to the pelvis), significant leukocytosis, severe abdominal pain and diffuse peritonitis, advanced age, comorbidities, intolerance of oral intake, non-compliance/lack of social support/difficult access to healthcare, and failed outpatient treatment.

Our patient was admitted to the hospital due to the presence of micro perforation, tachycardia, leukocytosis, fever, and signs of peritonitis (although localized). He was treated with IV ciprofloxacin and metronidazole, which provide coverage for the gastrointestinal flora of gram-negative rods and anaerobes, particularly *Escherichia coli* and *Bacteroides fragilis*.

Following conservative management of a first attack, approximately one-third of patients will have a second attack; this is exactly what happened to our patient 1 month after the first hospitalization. Overall, between 16% and 42% of patients have one or more recurrent attacks after nonoperative management.^{13,14}

Although some studies have reported more severe recurrences of diverticulitis in patients younger than 40

“Prompt evaluation, with imaging studies, is required in patients with signs of peritonitis and suspicion for complicated diverticulitis (diverticular inflammation associated with an abscess, phlegmon, fistula, obstruction, bleeding, or perforation).”

years of age, other studies have not confirmed these findings.^{15,16}

Overall, approximately 20% of patients with acute diverticulitis will require surgical intervention at a point in time, due to a complicated episode or multiple uncomplicated episodes of diverticulitis.

At around 6 weeks, after resolution of the symptoms of acute diverticulitis, patients should undergo a colonoscopy to rule out colon cancer and other underlying pathology. In our particular case, the patient was found to have diverticulosis, as expected, and a benign colon polyp. ■

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Summary

- Diverticular disease of the colon is a significant cause of hospitalization in industrialized societies and an important contributor to healthcare costs.
- Although acute diverticulitis is more common in the older patient, it should definitely be kept on the differential diagnosis of abdominal pain in the younger adult.
- Patients with uncomplicated diverticulitis, ie, localized diverticular inflammation, with no signs of peritonitis, can be treated on an outpatient basis with broad-spectrum oral antibiotics against gram-negative rods and anaerobic bacteria, clear liquid diet, and follow-up in 2–3 days. Recent trials seem to suggest that in mild uncomplicated diverticulitis, the use of antibiotics does not improve outcomes. Therefore, in these cases, taking no antibiotics could be an option with appropriate follow-up; however this remains controversial.^{17,18}
- Patients with signs of peritonitis and suspicion for complicated diverticulitis (diverticular inflammation associated with an abscess, phlegmon, fistula, obstruction, bleeding, or perforation) require prompt evaluation with imaging studies.
- Computed tomography is the imaging test of choice and is useful to establish the diagnosis and the extent and severity of disease.
- Inpatient treatment is indicated in the following cases:
 - CT shows complicated diverticulitis
 - Acute uncomplicated diverticulitis associated with high fever ($\geq 102.5^{\circ}\text{F}$), sepsis, micro perforation (a few air bubbles just outside the colon or confined to the pelvis), significant leukocytosis, severe abdominal pain and diffuse peritonitis, advanced age, comorbidities, intolerance of oral intake, noncompliance/lack of social support/difficult access to healthcare, failed outpatient treatment.
- Follow-up colonoscopy at about 6 weeks is indicated, after resolutions of the symptoms, to rule out colon cancer or other pathology.

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ABSTRACTS IN URGENT CARE

- Why Rush a Stress Test?
- UTI in Children <2 Years of Age
- The Need (or Not) of Cholecystectomy in Biliary Colic
- Here Comes Telemedicine
- Wood's Lamp vs Slit Lamp for Evaluating the Cornea
- Syncope vs Seizure: First, Get the History Right

■ JOSHUA RUSSELL, MD, MSC, FAAEM, FACEP

Rush for Outpatient Stress Test Recommendation (Finally) Examined

Key point: *Rapid outpatient stress testing (ie, within 72 hours), which has long been recommended by the American Heart Association, did not decrease the short-term risk of major adverse cardiac events (MACE).*

Citation: Natsui S, Sun BC, Shen E, et al. Evaluation of outpatient cardiac stress testing after emergency department encounters for suspected acute coronary syndrome. *Ann Emerg Med.* April 5, 2019. [Epub ahead of print]

The management of low-risk chest pain has been a perpetual source of frustration for acute care clinicians. Concerns for missing ACS/MI (largely for fear of legal repercussions) have driven overly conservative recommendations and practices that have led to increases in spending and complications of unnecessary testing without improving patient outcomes.

One of the largest sources of frustration, in the era of more sensitive troponin testing, is how to coordinate quick outpatient follow-up for provocative testing (eg, exercise treadmill), for patients in an overburdened healthcare system. The issue is even more challenging in urgent care given the fact that many patients choose us because they do not have insurance and/or a primary care provider. However, the AHA has long recommended risk stratification after ACS is ruled out through provocative testing within 72 hours of discharge based on poor quality evidence/expert opinion.

These authors performed a retrospective review of over

24,000 patient visits from 2015-2017 across 13 different EDs in Southern California. Approximately 8,000 of these patients were discharged home with an order for an outpatient stress test. Only 31% of patients were able to complete the stress test successfully within 72 hours, despite being part of an "integrated healthcare system" (ie, Kaiser). Additionally, a full 10% of patients never completed any provocative testing at all.

However, more interestingly, the rates of 30-day MACE were exceedingly low among all patients. No patient who was discharged with low-risk chest pain died and only 0.7% had a non-fatal MI. Keep in mind this was after an entire month following discharge. It seems that, for the lowest-risk chest pain patients, we needn't lose sleep or pull our hair out if we cannot get them rapid outpatient follow-up. An obvious caveat is that this was an ED study and most, if not all, of these patients underwent serum troponin testing prior to discharge, which is still not widely available in urgent care. ■

What's the Disposition for Children with UTI Under 2 Years of Age?

Key point: *Children 2–24 months of age with UTI who are well-appearing and tolerating oral medications can safely be treated as outpatients.*

Citation: Chaudhari PP, Monuteaux MC, Bachur RG. Management of urinary tract infections in young children: balancing admission with the risk of emergency department revisits. *Acad Pediatr.* 2019;19(2):203-208.

Considerable variation exists in the practice of treating UTI in young children. I recall working with certain attendings during my Emergency Medicine residency training who would admit every child under 2 years who had a UTI regardless of their appearance. Other attendings I trained under would rarely admit a child for UTI unless they had no follow-up or were vomiting.



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“While over 90% of patients felt that their needs were adequately addressed via the telephone visit, 41% still expressed a preference for an in-person visit.”

So, who was right? I never followed up on the young children we discharged with UTIs, but I have since always had a moment of pause when discharging such patients.

This retrospective study sought to answer the question of whether or not discharging these patients on outpatient oral antibiotics is a safe and reasonable practice. The investigators reviewed over 41,000 ED visits for pediatric patients under 2 years diagnosed with UTI across 36 U.S. hospitals. Overall, these patients were admitted 27% of the time on average; however, the admission rates varied considerably between hospitals (from 6% to 64%).

Overall, the ED revisit rate was (not unexpectedly) higher among discharged patients compared with children admitted for UTI. However, the ED revisits generally did not lead to hospital admission. Of note, the admission rate for neonates (<60 days of age) was, understandably, considerably higher than for older children and, therefore, the data cannot support routine discharge of children <60 days diagnosed with UTI. Certainly it's worth noting that, across many hospital settings, 89% of children under 2 months with UTI were admitted to the hospital. Therefore, there will likely be no shortage of clinicians pointing a finger at the urgent care clinician who discharges a neonate with UTI if there is a subsequent bad outcome. ■

Does Everyone with Biliary Colic Benefit from Cholecystectomy?

Key point: *Using a more restrictive approach to determine who is offered elective cholecystectomy resulted in fewer patients undergoing surgery, with no difference in proportion of patients who were pain free at 1 year. Cholecystectomy seems far from a “cure all” for presumed symptomatic gallstone disease, even with more restrictive patient selection criteria.*

Citation: van Dijk AH, Wennmacker SZ, de Reuver PR, et al. Restrictive strategy versus usual care for cholecystectomy in patients with gallstones and abdominal pain (SECURE): a multicentre, randomised, parallel-arm, non-inferiority trial. *Lancet*. 2019;393(10188):2322-2330.

Gallstones are a common incidental finding in patients who are evaluated for abdominal pain. Many of these patients are subsequently offered elective cholecystectomy for presumed biliary colic if the pain continues and no other obvious etiology

for the symptoms is found. However, many patients and clinicians alike are left frustrated in the all-too-common scenario where the patient's pain remains unchanged despite having the gallbladder removed. Moreover, there is no universal set of criteria defining a group of patients who will clearly benefit from elective cholecystectomy.

Because pain resembling biliary colic is often unsuccessfully treated with cholecystectomy, this group of investigators from the Netherlands performed a multicenter randomized trial across 24 hospitals to examine the differences in outcomes at 1 year between patients who were liberally offered cholecystectomy vs those who were only offered surgery if they met a set of relatively strict criteria. The five criteria for the more restrictive group were: severe pain, pain radiating to the back, pain lasting >15 minutes, epigastric or right upper quadrant pain, and pain relieved by analgesics.

Most significantly, about 40% of patients in both groups were not pain-free at 1 year after cholecystectomy. The restrictive strategy, however, did result in somewhat fewer patients undergoing surgery. Many patients with presumed biliary colic are miserable and, therefore, are understandably hopeful that surgery will result in symptom resolution. Data from this study suggest that whether patients with intermittent upper abdominal pain and gallstones undergo cholecystectomy or not, most will still have some abdominal pain 1 year later. This is helpful for counseling patients about reasonable expectations. ■

Are Patients Ready for Telemedicine to Replace Face-to-Face Visits in Primary Care?

Key point: *The vast majority of patients felt that their primary care needs were addressed adequately via video telemedicine visits; however, many still expressed preference for in-person visits.*
Citation: Reed ME, Huang J, Parikh R, et al. Patient-provider video telemedicine integrated with clinical care: Patient experiences. *Ann Intern Med*. April 30, 2019. [E-pub ahead of print]

The services provided remotely via telemedicine platforms have expanded rapidly in recent decades. Primary care is among the most enticing arenas for increased integration of telemedical services. This is because, for many types of visits to PCPs (eg, medication adjustments and coordination of care), in-person patient contact is not necessary. Office visits often require patients to miss work and force other inconveniences such as arranging childcare and transportation.

In this survey study, researchers polled approximately 1,200 Kaiser Permanente members from Northern California for their opinions on use of telemedicine for primary care-related issues. Eighty-two percent of the participants completed the scheduled visit. Unsurprisingly, the main motivation for scheduling in-person visits was improved convenience. While over 90% of patients felt that their needs were adequately addressed via

the telephone visit, 41% still expressed a preference for an in-person visit.

This study was a relatively small survey of a fairly affluent population in a closed healthcare network. Patients also had an established relationship with their PCP and were in generally good-to-excellent health. The results may not be generalizable to a more heterogeneous population, but the findings indicate that many (if not most) primary care needs can be handled without a face-to-face interaction. Certainly, visits with a PCP differ from urgent care visits in many ways; however, this study demonstrates that patients are acclimating to the concept of telemedicine. Because of the increased convenience of remote visits, expect to see patients preferentially choosing telemedical services when possible for unscheduled visits for urgent needs.

Wood's Lamp Is a Poor Substitute for the Slit Lamp When Evaluating the Cornea

Key point: Wood's lamp exams had poor sensitivity in identifying a variety of corneal injuries and pathologies compared with slit lamp exams.

Citation: Hooker EA, Faulkner WJ, Kelly LD, Whitford RC. Prospective study of the sensitivity of the Wood's lamp for common eye abnormalities. *Emerg Med J.* 2019;36(3):159-162.

Urgent care centers are a common destination of choice for patients with traumatic and atraumatic eye pain. In such cases, urgent care providers commonly reach for three ingredients: a topical anesthetic, fluorescein, and the Wood's lamp. The Wood's lamp typically uses long-wave UV light and, with the help of fluorescein and 2–3x magnification, allows for improved visualization of corneal irregularities.

In this first-of-its-kind study, the investigators sought to determine the test characteristics of Wood's lamp in identifying various corneal pathologies among 73 ED patients presenting with eye complaints. The slit lamp was used as the gold standard for diagnosis.

The performance of the Wood's lamp was disappointing, to say the least. The authors found that the Wood's lamp had an overall sensitivity of 52% and missed half the cases of corneal ulcer and herpes keratitis—potentially vision-threatening conditions when diagnosis/treatment is delayed. On the other hand, the specificity of the Wood's lamp was found to be 88%–100% for all conditions, suggesting that a positive finding with the Wood's lamp remains clinically meaningful.

Many urgent care centers still do not have slit lamps, and perhaps this needs to be reconsidered. However, the price point for a slit lamp makes widespread urgent care adoption somewhat impractical. Regardless, this article shows the danger of relying on the Wood's lamp exam to exclude significant anterior eye pathology. The most sensible approach for patients with a concerning history, but normal Wood's lamp exam, would be

“It is crucial that urgent care providers understand which condition [syncope or seizure] is at play so they head down the appropriate diagnostic pathway as early as possible. However, patient reports of such events are notoriously unreliable.”

urgent ophthalmology or ED referral, depending on your practice environment. ■

Syncope vs Seizure? Better to Get Your History from a Bystander Than the Patient

Key point: Witness reports of circumstances and patient appearance during loss of consciousness differentiate between seizure, syncope, and psychogenic seizure better than patient reports.

Citation: Chen M, Jamnadas-Khoda J, Broadhurst M, et al. Value of witness observations in the differential diagnosis of transient loss of consciousness. *Neurology.* 2019;92(9):e895-e904.

Patients with a witnessed loss of consciousness often present hours or even days after an event. The primary considerations after such episodes are seizure and syncope. The work-up for these two conditions differs significantly. Therefore, it is crucial that urgent care providers understand which condition is at play so they head down the appropriate diagnostic pathway as early as possible. However, patient reports of such events are understandably and notoriously unreliable.

The investigators in this study retrospectively examined approximately 200 cases of syncope, epileptic, and nonepileptic/psychogenic seizure (ie, PNES) presenting to a UK center for evaluation after loss of consciousness. They administered a 31-question survey to witnesses of the event and to the patients themselves. They found that the witnesses' reports better distinguished seizure, syncope, and PNES compared with the patients' reports of the events.

These results are not surprising and underscore the importance of a corroborating history when evaluating patients after loss of consciousness. These patients may present alone or have a family member or companion with them who didn't witness the event. Taking a few minutes to call an eyewitness to determine what they saw can be the most valuable intervention for ensuring this patient is not getting a neurology referral and an MRI of their brain when they had a simple vasovagal episode with a few myoclonic jerks. ■



The Consequences of a Medical Provider Quitting Without Notice

Urgent message: Patients and communities rely on access to urgent care to augment primary care shortages and decant overcrowded emergency rooms. A provider who quits without notice causes scheduling disruptions which could be considered “patient abandonment.”

■ ALAN A. AYERS, MBA, MAcc

Once a medical provider has accepted a patient into her practice, she is under an ethical and legal obligation to provide services to the patient as long as the patient requires them.¹ However, it's not uncommon for a physician at an urgent care center to seek a higher-paying job. How (if at all) does that affect the obligation to continue the care of a particular patient?

Take the case of a hypothetical physician who's looking to increase her income, or perhaps has heard rumors that she might be cut from the schedule. To address this, she secures a similar position at a competing urgent care. Not wanting to forego income in the transition, she could submit her 2-week notice to her current employer and work right up to the start date at the new facility. Or, if she is under contract with her current employer, she may be required to provide a certain term of notice; leaving before the period has elapsed would be a violation of the employment contract. However, if she's an at-will employee, the urgent care owner has the right to terminate her the minute she fulfills her obligation to give notice; thus, being forthright about her situation could cost her 2 weeks' pay. As a result, she might choose to give no notice; doing so would protect her from immediate dismissal,² but could be deemed “gross misconduct,” insubordination, and abandonment of the responsibility to care for her patients.²

This article will address the question of whether such a physician has any legal or ethical obligations to her patients when she quits without notice.



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Is 2 Weeks' Notice a Law?

The requirement of employees to give notice of plans to quit is only a custom. There's no legal obligation, and employees are not required to give 2-weeks' notice.³ There are 49 states with at-will employment laws, which means that any employee can quit at any time, without notice—likewise, an employer can terminate an employee at any time.⁴ (The latter scenario was discussed in *How Best to Manage an 'At-Will' Termination* in the June issue of *JUCM*.)

Of course, without notice, an employee's departure can be disruptive; giving notice generally allows an employee to leave a company on good terms.⁵

Legal Obligations

Malpractice for patient abandonment

Patient abandonment is a type of medical malpractice that happens when a physician ends the doctor-patient relationship without reasonable notice or a reasonable excuse, and doesn't provide the patient with an opportunity to find a qualified replacement care provider.⁶⁻⁸ It's also defined as “when a physician leaves the employment of a group practice, hospital, clinic or other healthcare facility, without the physician giving reasonable notice and under circumstances which seriously impair the delivery of medical care to patients.”⁹⁻¹³

According to the AMA's Code of Medical Ethics, Opinion 8.115, a physician has the option of terminating the patient-physician relationship, but she must give sufficient notice of withdrawal to the patient, relatives, or responsible friends and guardians to allow another physician to be secured.

Patient abandonment in emergency rooms and urgent care situations

Urgent care owners should know that in some instances, emergency rooms and urgent care facilities are exempt from these notice requirements.

Ohio promulgated a regulation in 2013 stipulating that any physician leaving, selling, or retiring from a practice must comply with Administrative Code Rule 4731-27-03.¹⁴ Within 30 days of learning of a physician's termination or resignation, a medical practice must send notice by mail or by HIPAA-compliant electronic means to all patients treated by the departing physician within the past 2 years.¹⁴ However, the notification requirements in that state do not apply to physicians who have provided treatment *on an episodic basis, in an emergency department setting, or at an urgent care center.*¹⁴

In addition, notice of termination isn't necessary if the patient's care has been formally transferred to another physician who's not within the same medical practice, or when the patient is the person responsible for terminating the physician-patient relationship. This should be documented in the patient's chart.^{15,16}

Ethical Issues

Aside from the AMA Ethical Standards, an urgent care owner may consider some other standards of conduct that could give rise to a legal remedy for the physician's departure:

- *Availability of urgent care services in the community.* The urgent care's ability to be open and to deliver services hinges on its scheduling of a provider during all hours of operation. A sudden departure of a provider without notice may mean that the center is unable to staff its schedule and, thus, be required to reduce hours or even temporarily close—leaving patients to find care elsewhere. This translates into a loss of profits.
- *Continuity of care.* Established patients often return to urgent care to follow up on lab tests, for reexamination of an injury, wound care (suture removal), when symptoms don't improve, and for medication refills. A provider who quits without notice is unavailable for this follow-up with these patients. Further, urgent care providers are typically available to oversee referrals to medical specialties such as physical therapy or imaging, and if a provider leaves without notice, management of the patient's ongoing care may suffer or not occur.

However, the standard practice of medicine involves physicians transferring patients, eg, from an emergency room to an in-patient ward. When physicians rely on other physicians to assist in caring for their patients, it's not considered patient abandonment.¹⁷ A physician's transfer agreement with another physician is a mechanism to ensure continuity of care. Continuity of care for a patient is often maintained even without formal measures like transfer agreements.¹⁷

A key aspect of the continuity of care is the documen-

tation of charts by the departing physician. When a provider leaves without notice, she may have incomplete charts. This can create administrative and insurance billing issues. Further, that physician is unavailable to answer insurance questions or provide supporting documentation on claims, which can result in increased write-offs. The state may have regulations as to whether it constitutes patient abandonment for a provider to leave without documenting the transfer of care or by inappropriately terminating the patient/practitioner relationship.¹⁸ One solution, perhaps, is to withhold the physician's final paycheck until all charts are updated.

"If urgent care owners execute contracts with their physicians, they should include language that specifically details the circumstances and responsibilities for termination."

- *Supervisory responsibilities.* If the departing physician had supervisory responsibility for PAs and NPs but leaves without transitioning those responsibilities, the ability of those medical professionals to continue to provide care may be jeopardized if the urgent care can't find another physician to assume their supervision.¹⁹ Again, this may have an impact on the urgent care's financial stability and bottom line.
- *Reimbursement.* With urgent care billing, a physician and any PAs or NPs working under her must be "credentialed" by insurance companies to be considered part of their "network" and enable "in-network" contract reimbursement—a process that can take months. If a credentialed provider suddenly quits and is replaced with an as-of-yet credentialed doctor, the urgent care may not be paid by insurance. This can result in increased write-offs or patients paying out-of-network deductibles, depending on their insurance plan. The upshot is lost business.
- *Workplace efficiencies.* The unexpected departure of an urgent care physician can have a significant impact on the rest of the staff and on patients. Remaining providers and staff—particularly at centers staffed with multiple providers during a shift—may have to work harder and extra hours, and wait times and patient dissatisfaction may increase. If a center has to close temporarily or downsize operations due to losing a provider, support staff may also lose hours or employment. This, again, causes an economic impact on the urgent care.

What Legal Remedy Does the Urgent Care Owner Have in this Situation?

Although an urgent care physician quitting without notice can be upsetting and potentially create disarray, a claim of physician abandonment requires there to be some type of harm. When bringing a lawsuit, a plaintiff must prove that the physician ended the relationship at a critical stage of a patient's treatment without good reason or sufficient notice to allow the patient to find another physician, and the patient was injured as a result.²⁰⁻²³ Again, some states exempt urgent care facilities from patient abandonment notice requirements. Still, there can be consequences for the provider who leaves her employer or patients in the lurch:

- **Report to the medical board.** A physician who abandons her patients may be reported to the state medical board. Affected patients may be the first to file a complaint. Typically, the medical board will hold a hearing during which a hearing officer may recommend that the Board suspend the physician's privileges or issue a written reprimand for abandonment of patients.^{24,25}
- **Business interference.** An owner could claim that the physician's actions constituted tortious interference of the business's reputation and goodwill.²⁶ The elements of a cause of action for tortious interference with a business expectancy or relationship are: 1) a contract or valid business relationship or expectancy; 2) the defendant's knowledge of the relationship or contract; 3) intentional interference by the defendant causing or inducing a breach of the contract or relationship; 4) the absence of justification; and 5) damages resulting from the conduct of the defendant.²⁷ Courts require an element of malice or wrongdoing to sustain a claim of tortious interference with business relations.²⁸ This claim may be a high threshold for an owner to prove.
- **Breach of contract.** If the physician signed an employment contract, depending on the terms of separation, she may be in breach, presenting a claim for damages.²⁹ The urgent care must document the damage that it suffered, which may include loss of business, additional overtime paid to other providers, and other monetary expenses.

Similar to an action in tort, the urgent care owner must weigh its contract damages to determine if they are sufficient to expend the time and expense of legal action.

Takeaway

Except in Montana, employment is at-will, barring an employment contract. If urgent care owners execute contracts with their physicians, they should include language that specifically details the circumstances and responsibilities for termination.

For at-will physician employees, systems and procedures

should be in place to ensure an efficient transfer of care and documentation.

While there are potential actions for an owner to consider against the quitting doctor, urgent cares may be best served to proactively guard against damage to the practice by protecting against issues of continuation of care and inadequate staffing. ■

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Optimize Revenue with Improved Claims Denials Management

■ DAVID E. STERN, MD

No matter how diligent your billing staff is about billing charges out correctly, it is inevitable that you will receive claim denials from payers, whether they are justified or not. A claim denial means that no payment is being received for the service, and unless you have someone (or technology) analyze the denial to determine if the denial is appropriate or not, you will not receive payment for the service(s) rendered.

Denials come in different forms and can typically be classified into one of the following types and examples:

- Demographic denials
 - Incorrect member information including identification number, date of birth, participant name, guarantor information
- Coding denials
 - Diagnosis inconsistent with patient's age or sex, date inconsistencies, unbundling
- Benefit denials
 - Insurance ineligibility, preauthorization not performed, noncovered services, lack of medical necessity
- Backend billing denials
 - Duplicate claims, timely filing, failure to send requested documentation, credentialing

If you have someone analyze the denial, are you pulling resources from a billing team whose main purpose is to bill out new claims, or do you have someone who is dedicated to working the denials? Technology can also help automate root cause analysis and resolution workflow. All of these options are better than just billing the patient and hoping for the best.

Your first line of defense, obviously, is making sure your front desk staff is collecting the correct insurance data and verifying coverage. This is especially important in the Medicare and Med-

icaid population for managed care plans. That also includes understanding any payers that require preauthorization for the patient to be seen in your clinic. Getting the correct insurance information up front will help prevent denials for ineligibility or incorrect member/participant information; these are avoidable denials when the information is input correctly the first time.

Do you have a policy in place for Medicare patients and when Advance Beneficiary Notices (ABNs) are necessary? Having an ABN in place when services are not covered allows you to collect the payment from the patient since Medicare will not pay for them.

Questions to ask yourself include:

- Does your staff have a strategy in place to analyze the denials in order to target avoidable issues on future claims? If not, you could be delaying or even missing revenue.
- What are the most common denials your practice receives? A good start in developing a denials management process is understanding what those denials are—possibly for each payer since payers have different rules for filing claims. However, if you are just putting a process in place, you might want to start with a few payers at first to help develop the process. Decide how long you want to track denials, initially (eg, 3 months), to get a baseline ratio of denials to charges. Once you have a baseline, you can devise a plan of action to address the issues in order to prevent future denials.
- You can track denials automatically or manually utilizing the electronic remittance advice (ERA) or the explanation of benefits (EOB). While there are many different software companies that specialize in accounts-receivable management, it could be more cost-effective to work with your practice management system vendor to find out what is already offered that you might not be aware of.

Whatever method you use, make sure you have a solid plan with dedicated people reviewing the data on a regular basis. If a denial is preventable, put policies in place for employees to follow to avoid the denial in the first place.

A denials-management team should have a solid under-



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standing of the most common claim adjustment reason codes (CARC). The CARCs are standardized codes used by all payers and can be found at <http://www.x12.org/codes/claim-adjustment-reason-codes/>.

Of all of the denial reasons, the worst, and probably the most avoidable, is CARC 29, "the time limit for filing has expired." Billing staff should know what the timely filing limits are for all payers in and out of network, and make sure claims for the payers with the shortest timely filing periods are worked first. (Of course, best practice is to make sure claims for all visits are billed within just a few days of the visit, if not sooner.)

Mismanaging claims denials is not the only way you could be losing out on revenue. Another area you want to review regularly is claims reimbursement, making sure that you are being reimbursed appropriately according to your contracts with payers. Again, having dedicated staff reviewing and analyzing payment data is ideal.

If you do not have a claims denial process or team in place, you are probably missing out on revenue. If you do have a process in place, it might be a good time to review it with several departments to make sure you are covering all areas where denials could be coming from. ■

How Medicare Explains ABNs to Consumers

It may be helpful to understand how Medicare explains the concept of ABNs to their members. On a member-facing page within the Medicare website, ABNs are explained thusly:

- You may get a written notice called an 'Advance Beneficiary Notice of Noncoverage' (ABN) from your doctor, other healthcare provider, or supplier if both of these apply:

- You have Original Medicare
- Your doctor, other healthcare provider, or supplier thinks Medicare probably (or certainly) won't pay for the items or services you got

However, an ABN isn't required for items or services that Medicare never covers. The ABN lists:

- The items or services that Medicare isn't expected to pay for
- An estimate of the costs for the items and services
- The reasons why Medicare may not pay

The ABN gives you information to make an informed choice about whether or not to get items or services, understanding that you may have to accept responsibility for payment."

To read the entire discussion, visit <https://www.medicare.gov/claims-appeals/your-medicare-rights/advance-beneficiary-notice-of-noncoverage>



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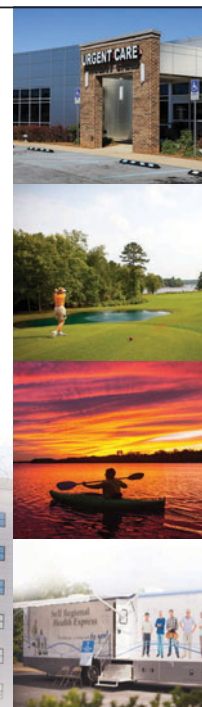
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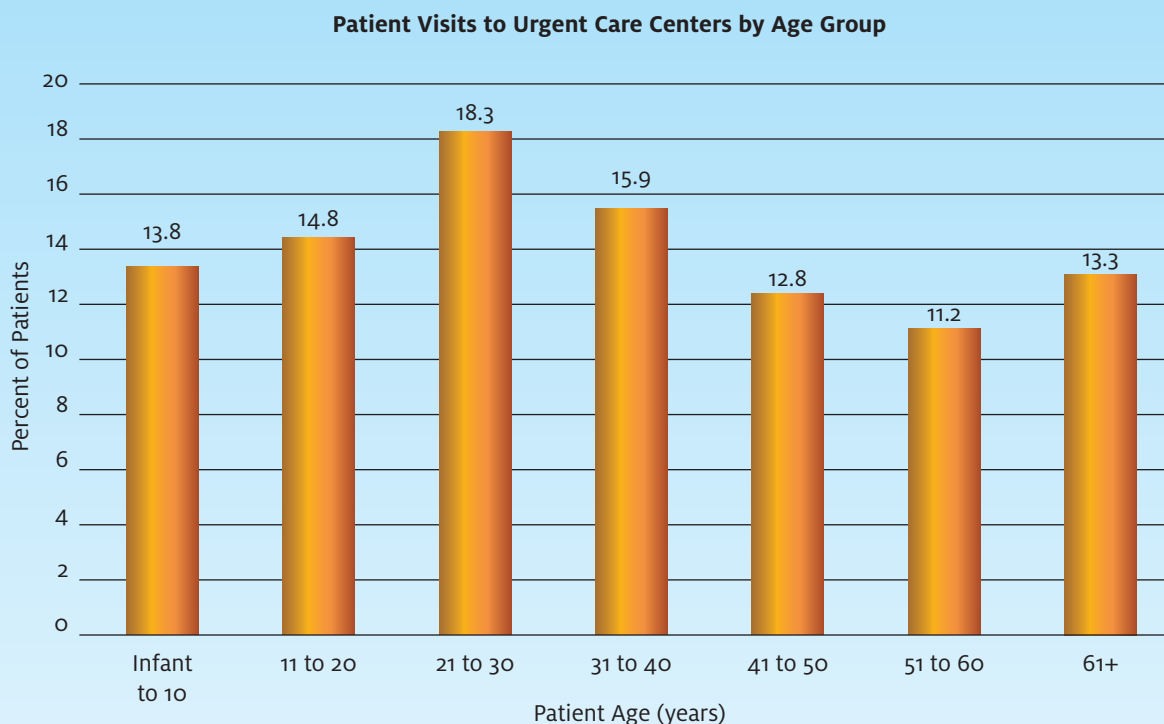
Urgent Care Is an Appropriate Setting for Any Age—But What Ages Are Showing Up the Most?

Pediatric urgent care is having a moment. New or expanding urgent care companies are trying to focus more on children—or dedicating themselves exclusively to caring for younger patients. As you may have noticed, *JUCM* is presenting more articles related to treating pediatric patients in the urgent care setting. On the other hand, as you can see in our case report or in Abstracts in Urgent Care, people in midlife and their later years are at least equally likely to walk through your door.

Clearly, no one is too young or too old to go to an urgent care center when the need arises.

This begs the question, however: What ages are most likely to show up in your urgent care center? You might have a good bead on your own norms, but *JUCM* undertook some research to determine what's most "typical" industry-wide. See the graph below to see how closely your patient population matches up. ■

URGENT CARE: THE RIGHT CARE FOR YOUNG AND OLD



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