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Urgent Care
Association
of America



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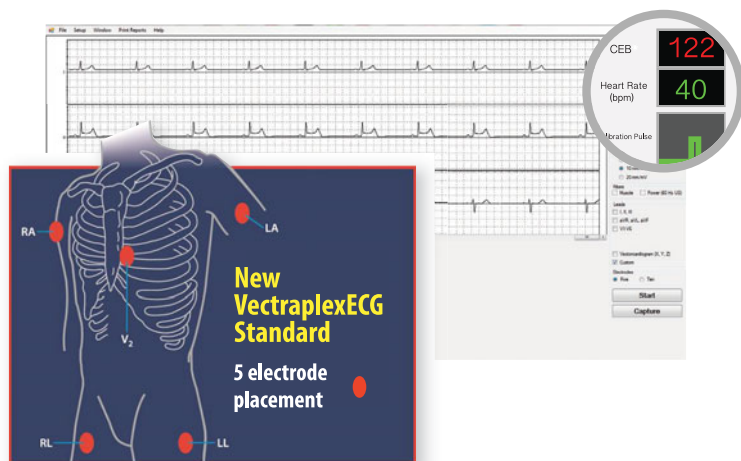
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LETTER FROM THE EDITOR-IN-CHIEF

Hey, Mr. Tax Man!



It's tax time again and that got me thinking. And thinking got me angry. And angry got me belligerent. And belligerent got me nowhere. So, I went back to thinking about it, and here's my take: Taxes are the contributions we make to society and the government so that it functions reasonably well, preserves our fragile democracy, and supports those who need our help. Yet, as a physician in a primary care specialty, like many of you, I can't help but feel resentful this time of year. I'm "taxed out," so to speak.

In a previous column, many years ago (October 2011), I postulated that a primary care physician, over the course of a typical career, has the same lifetime earnings, net the cost of education, as a structural iron worker. While this might come as a big surprise to the general public, it is unlikely to draw any sympathy. And I understand that. Yet, every year, around this time, the resentment bubbles up again. This year, however, was different.

While reflecting back on my 2011 column, I realized that I was in error. The initial results demonstrated that the lifetime earnings of the primary care physician and the structural iron worker were about the same. Wrong! In fact, the lifelong earnings of the typical primary care physician may just be quite a bit lower than the structural iron worker.

Why? Well, taxes of course. The problem? Let's say the primary care physician makes \$200,000, and the structural iron worker makes \$70,000, annually. On federal income tax alone, \$200,000 of income would generate almost \$50,000 more tax per year than an income of \$70,000 would. Over a 35-year career, that's a total of \$1.75 million more in taxes. So, after investing upwards of \$500,000 in education and delaying earnings until we are almost 30 years of age, the primary care physician gets the privilege of paying nearly \$2 million more in taxes than a high-earning tradesperson.

Combine that with the interest paid on the student loans (because we make too much money to qualify for the tax deduction on those loans), and the impact is even more staggering. Why should we be paying taxes on earnings we will never see, just because of the irrational sacrifices we made choosing a primary care career? It's a double-dip of sacrifice,

and that has been mostly ignored. Throw in the Medicare tax supplement, and the Affordable Care Act tax supplement recently added for "high earners" like us, and we just very well may be the most tax-burdened group in America.

"We should look for ways to offset the cost of 'becoming' a primary care physician."

The final straw? Most of those making more money than us, often in the form of capital gains or offset by business "expenses," are *also* paying less in taxes as a percentage of their income than we are. Essentially, all income groups, above and below our own, are paying lower tax than we are.

So, what's the point? This just sounds like a rant! Well, my ranting got me thinking again, and this is where this whole column comes together.

Primary care, with its relatively low earnings, extremely high burnout rate, and critical function in society, is essentially a public service. And as such, we should look for ways to offset the cost of "becoming" a primary care physician. While covering the real "cost" of higher education would be prohibitive, making the educational expenses tax deductible on a schedule that spans a typical primary care career just might make sense. It would encourage an ongoing commitment to primary care, reduce burnout, and spread out the economic impact.

We must look for ways to eliminate the double-dip of sacrifice that is inherent to our current tax system and turn the same system into a scheduled methodology for making primary care a rational, rewarding, and sustainable choice for years to come. ■

Lee A. Resnick, MD, FFAFP

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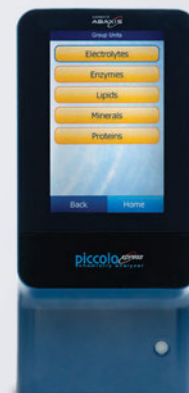
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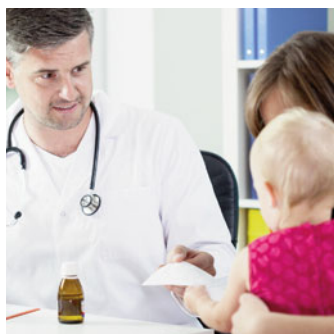
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CLINICAL

11 Pediatric Elbow Assessment: An Urgent Care Approach

Understanding the mechanism of injury—and knowing when to refer to orthopedics or the ED—increases the odds of making the right call, as well as seeing positive outcomes, when a child presents with an elbow injury.

Tulja Parmar, DO, Alicia Roman-Colon, MD, Christopher Tangen, DO

CASE REPORT

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An unusual diagnosis stemming from an unexpected mechanism of injury can make early assessment challenging. Considering multiple mechanisms and taking a thorough history ultimately led to the correct diagnosis and a good outcome for this patient.

Jonathon Swan, Ralph S. Bovard, MD, MPH,
Zeke J. McKinney, MD, MHI, MPH

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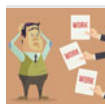


Your practice can be held liable for actions your employees take with patients. Consider whether—or when—it makes sense to consult sex offender registries before bringing on a new hire.

Alan A. Ayers, MBA, MAcc

PRACTICE MANAGEMENT

29 Who's the Boss? The Organizational Impact of Bypassing the Chain of Command



A proper chain of command greases the wheels for a smooth operation. When there's a kink in that chain, however—say, someone goes over his manager's head—the entire business can suffer.

Alan A. Ayers, MBA, MAcc

IN THE NEXT ISSUE OF JUCM

Urgent care clinicians must maintain a high index of suspicion in patients whose injuries may put them at risk for acute compartment syndrome. John Shufeldt, MD, MBA, JD, FACEP and Carli Nichta, MS-3 explain why, and offer related medical-legal pearls, in the April issue of JUCM.

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Mission Statement

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

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As *The Atlanta Journal-Constitution* points out in an article it published this past December, registered sex offenders are not allowed to drive ice cream trucks in Massachusetts, to work as tow truck drivers in Virginia, to serve as volunteer firemen in New York, or to appraise real estate in Georgia. What they can do, assuming they're otherwise qualified, is get a medical license in those states—and in 34 others.

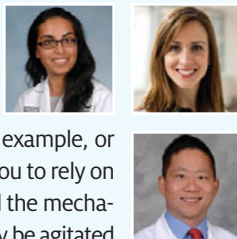
The question is, would you be comfortable hiring someone whose name appears on a sex offender registry as a physician, as a nurse, or to greet patients from a seat at the front desk?



Before you commit to an answer in your mind, read *Should an Urgent Care Operator Check the National Sex Offender Registry When Hiring Employees?*, by **Alan Ayers, MD, MAcc** (starting on page 25). It raises a number of compelling, possibly unsettling questions, but also drives home at least one sobering truth: Your practice could be held liable if anyone in your employ harms one of your patients. As the author explains, an estimated 79% of negligent hiring lawsuit verdicts go against employers, with average jury awards over \$1 million.

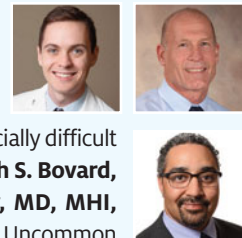
Mr. Ayers, who is vice president of strategic initiatives for Practice Velocity, LLC and practice management editor of *The Journal of Urgent Care Medicine*, explores dangers of a much less ominous variety—which could nonetheless still be the ruin of your business—in *Who's the Boss? The Organizational Impact of Bypassing the Chain of Command*. That “impact” could be a slow march toward disarray and disharmony among your staff, which of course could cause the entire business to suffer.

Speaking of suffering, trying to care for children who are in great discomfort can be difficult on many levels; they may be less able to articulate exactly where their pain is, for example, or when and how it began. This leaves you to rely on parents who may not have witnessed the mechanism of injury, and who would certainly be agitated to see their children in pain. Fortunately, **Tulja Parmar, DO**; **Alicia Roman-Colon, MD**; and **Christopher Tangen, DO** volunteer their expertise in making it as simple as possible in *Pediatric Elbow Assessment: An Urgent Care Approach* (page 11). The authors explain that with the right approach, it can be a relatively simple fix. Dr. Parmar is a second-year family medicine



resident at UH Regional Hospitals in Richmond Heights, OH. Dr. Roman-Colon is a board-certified radiologist with a subspecialty certificate in pediatric imaging at Texas Children's Hospital. Dr. Tangen is board certified in family medicine, with a Certificate of Added Qualifications in sports medicine from the American Board of Family Medicine and is program director of the Traditional Rotating Internship at UH Regional Hospitals.

Adults may be better equipped to assist in their own examination, but that doesn't mean they're easier to treat, of course. Uncommon injuries like triceps tears can be especially difficult to identify, as **Jonathon Swan, Ralph S. Bovard, MD, MPH**, and **Zeke J. McKinney, MD, MHI, MPH** explain in their case report, *An Uncommon Mechanism of Work-Related Partial-Thickness Triceps Tear* (page 17). In it, they offer tips on how the medical history and exam, combined with knowledge of characteristic diagnostic imaging findings, can provide invaluable clues toward early identification, which is critical in ensuring timely treatment and positive outcomes. Mr. Swan, who is a medical student, and Dr. Bovard are with HealthPartners Occupational and Environmental Medicine, at HealthPartners St. Paul (MN) Clinic; Dr. McKinney is with HealthPartners Institute for Education and Research in Bloomington, MN.



Also in this issue:

Sean M. McNeeley, MD and **Glenn Harnett, MD** highlight the most urgent care-relevant points of new literature concerning resistance to group A strep; the relative merits (or demerits) of screening for herpes; when it makes sense to stop monitoring arrhythmias; how much treatment is too much treatment for children, and more (page 20).

In *Coding Q&A* (page 35), David E. Stern, MD, CPC explains how to ensure you're getting the most reimbursement out of coding for services on campus, off campus, or even over the telephone.

Getting the most out of your commitment to offer occupational medicine services can go a long way toward running a healthy business, too; to gain some insight into where the best places to find all the most viable patients may be, check out *Developing Data* on page 41. ■

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CONTINUING MEDICAL EDUCATION

Release Date: March 1, 2017

Expiration Date: February 28, 2018

Target Audience

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

Learning Objectives

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

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This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Case Western Reserve University School of Medicine and the Institute of Urgent Care Medicine. Case Western Reserve University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

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CONTINUING MEDICAL EDUCATION

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Pediatric Elbow Assessment: An Urgent Care Approach (p. 11)

1. The differential diagnosis of pediatric elbow pain includes which of the following?

- a. Radial head subluxation
- b. Forearm fracture
- c. Supracondylar fracture
- d. Elbow dislocation
- e. All of the above

2. To reduce a nursemaid's elbow (radial head subluxation) using the hyperpronation method, the examiner supports the child's arm at the elbow and places moderate pressure on the radial head with one finger. The examiner grips the child's distal forearm with the other hand and hyperpronates the forearm.

- a. True
- b. False

3. Which of the following is true of olecranon fractures?

- a. Olecranon fractures may occur when the child falls directly onto a flexed or extended elbow
- b. The child usually presents with pain, tenderness, and/or edema to the olecranon region
- c. Associated fractures are commonly greenstick or metaphyseal stress fractures
- d. Challenges to identifying olecranon fractures include the inability to visualize the fracture on an AP view and the fact that the ossification center is an epiphysis and may normally appear separated or irregular, and multiple ossification centers on the lateral view may be misinterpreted as fractures
- e. All of the above

Who's the Boss? The Organizational Impact of Bypassing the Chain of Command (p. 29)

1. In a business organization, the chain of command can be usurped in which of the following ways?

- a. An executive "dips down" to a line manager's direct reports, skipping the manager, and giving commands to the frontline staff members directly
- b. A frontline staff member skips past his/her immediate manager to get permission from a higher-level executive on something affecting the frontline role
- c. An outside consultant is hired to perform a strategic assessment of a business opportunity
- d. Both A and B
- e. None of the above

2. What are some consequences of the practice of "dipping down" in an organizational hierarchy?

- a. Ice cream on the top of the container gets consumed while ice cream on the bottom gets hard
- b. A manager becomes demoralized by the lack of trust or confidence demonstrated by his/her boss
- c. Frontline staff becomes confused on whose instructions to follow
- d. Decisions get made without leveraging the knowledge and experience of managers
- e. B, C, and D

3. Which of the following suggestions support the chain of command in organizations?

- a. Where an "open-door policy" exists, management must clearly differentiate the roles of "listening" vs "delegating"
- b. When a frontline employee approaches a higher-level executive with a problem, the executive should ask whether the employee has first addressed it with his/her immediate supervisor
- c. Only in extreme situations—such as an emergency or when a company policy has been violated—should the chain of command ever be usurped
- d. During the onboard process, make clear to new hires that the chain of command must always be followed; the starting point for all issues is the immediate supervisor
- e. All of the above

An Uncommon Mechanism of Work-Related Partial-Thickness Triceps Tear (p. 17)

1. Which are mechanisms of a triceps tear?

- a. Active overloaded contraction of an extended triceps muscle
- b. Lacerations
- c. Adrenergic steroid injection
- d. Volleyball serving
- e. All of the above

2. The "flake" or "Fleck" sign is an avulsed bone fragment on x-ray which may appear as a triangulated radio-paque density posterior to the elbow on lateral view.

- a. True
- b. False

3. Findings on plain film consistent with a triceps tear include all of the following, except:

- a. Excessive soft tissue swelling or hematoma
- b. Avulsed bone from the olecranon process
- c. A posterior fat pad ("sail" sign)
- d. A distal radius fracture
- e. A fluid-filled defect where the triceps tendon has retracted

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Beyond Access: Redefining Your Value Proposition

■ LAUREL STOIMENOFF, PT, CHC

Urgent care centers were the originators of convenient access to care for non-life- and limb-threatening illnesses and injuries. Consumers embraced the convenience, and the rest of the world noticed. New delivery models catalyzed by growing expectations for on-demand services have provided those seeking health-care services more options than ever before. If you are feeling the impact, it may be a manifestation of the successful model you developed—and now others are electing to modify or mirror it.

To ensure that urgent care continues to thrive in the new on-demand marketplace, we must ask ourselves what we can do to renew our value proposition. To do this, we must know what *today's* patient is seeking and anticipate what tomorrow's consumer will expect.

Convenience is Still Key

More than ever, convenience is a driver for healthcare decision making. Customers seek prompt, quality service that is most easily integrated into their busy lives. Urgent care continues to lead on this main value proposition; the 2016 UCAOA Benchmarking Survey found 92% of urgent care patients waited 30 minutes or less to be seen by a practitioner last year, and 90% of visits took 60 minutes or less to complete.

While telemedicine, retail, and other on-demand services are also finding niche roles in the continuum of care, urgent care remains a necessity due to our combination of broad scope of services, fast delivery of care, and great value. Studies indicate this trifecta of convenience will remain extremely important to the customer of the future—the millennials.

A 2016 UCAOA survey of patients from different age groups revealed millennials prioritize cost-savings and accessibility when making healthcare purchasing decisions. It is no surprise then that a study from the Health Industry Distribution Asso-

ciation (HIDA) showed 43% of millennials reported using an urgent care center in the last year.

Embrace Technology

Technology is no longer a supplement to our business—it is driving our business, as connectivity and accessibility are the new normal.

It can impact the customer experience at every stage of the patient visit. Time-saving check-in processes conducted online are becoming commonplace, as are providing patient alerts when a practitioner is ready to see them. Likewise, urgent care centers are integrating telemedicine to make better use of the medical providers when there are lulls in patient traffic.

Finding ways to improve our customer-centric service will continue to be an educational focus at the Urgent Care Convention & Expo in National Harbor, MD, April 29–May 3. We will discuss how best to cultivate healthy interactions with patients using current technologies, and why this engagement is vital to urgent care's future growth and success.

Prioritize Patients Over Process

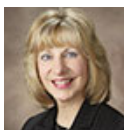
Urgent care centers often adjust their service model to accommodate payers, technology providers, or other third parties. Allowing these roadblocks to get in the way of delivering the optimum, on-demand care that patients are actively seeking would betray the foundation urgent care was built on: convenience and accessibility. If the *tail is wagging the dog*, it's time to step back and re-evaluate.

Look Back to Move Forward

As the market for on-demand healthcare continues to grow, urgent care must lead the way in efficiency, convenience, and a consumer-focused experience.

The upcoming UCAOA Convention & Expo will highlight market insights on the state of urgent care now and in the future.

However, we may find we need to take a step back to identify and eliminate barriers before pressing forward with a renewed focus on consumer needs and operational efficiency. ■



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

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Pediatric Elbow Assessment: An Urgent Care Approach

Urgent message: While pediatric elbow injuries can be a simple fix in an urgent care setting, understanding mechanism of injury and recognizing cases where referral is warranted help ensure positive outcomes.

TULJA PARMAR, DO; ALICIA ROMAN-COLON, MD; CHRISTOPHER TANGEN, DO

Pediatric musculoskeletal injuries comprise approximately 12% of the 10 million annual visits to urgent care centers and emergency departments in the United States. History, physical exam, and proper imaging remain the mainstay of diagnosis and treatment of many orthopedic-related chief complaints. The purpose of this article is to provide a simple and concise approach to evaluation of common pediatric elbow pathology in the setting of a recent elbow injury.

Radial Head Subluxation

Case Presentation

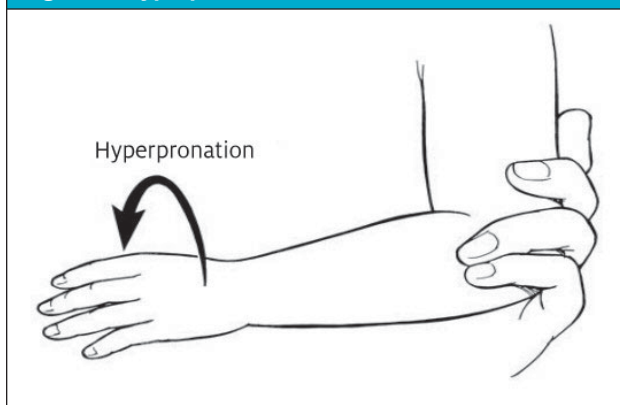
An 18-month-old boy is brought in by his mother with a chief complaint that he is moving his right arm less than usual and holding the arm very still and close to his body. This began after the patient was picked up by his sister. The child has had increased fussiness with passive movement of his right arm for the past few hours. Birth was full term with an uncomplicated pregnancy and delivery. Mother denies any previous injury or surgery to his right upper extremity. In the past, the patient's mother has seen the older sister pick the patient up by the wrists while playing with him. Vital signs include the following:

HR	100
RR	22
T	36.8°C
BP	90/70 mmHg



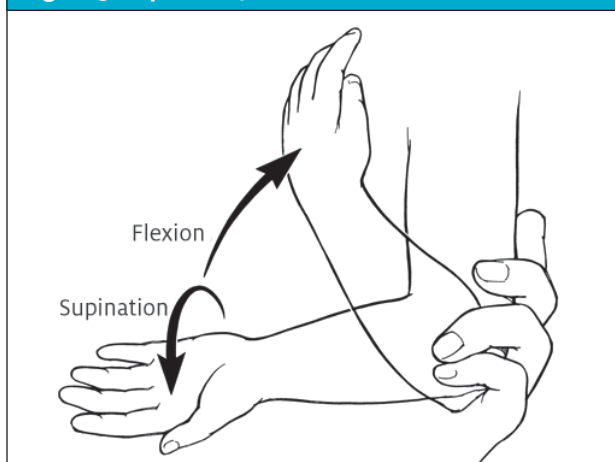
On physical exam, the child appears uncomfortable and fussy. Heart, lung, and abdominal exam are unremarkable. Radial pulse is strong with a capillary refill less than 2 seconds. Skin is intact with no obvious deformity. Musculoskeletal exam is positive for decreased movement of the right upper extremity compared with the left upper extremity. Right arm is kept flexed at the elbow and held close to the body. Patient exhibits increased crying with passive flexion and extension of the right elbow joint.

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Figure 1. Normal lateral view elbow.**Figure 2. Hyperpronation method.**

In this method, the examiner supports the child's arm at the elbow and places moderate pressure on the radial head with one finger. The examiner grips the child's distal forearm with the other hand and hyperpronates the forearm. A click may be felt by the finger over the radial head when the subluxation is reduced.

Differential diagnosis includes radial head subluxation, forearm fracture, and supracondylar fracture. Manual reduction for suspected radial head subluxation was attempted with the hyperpronation method (**Figure 2**) followed by the supination and flexion method (**Figure 3**). Within minutes following the intervention, the patient was able to actively move the upper extremity.¹

Figure 3. Supination/flexion method.

In the supination/flexion technique, the examiner supports the child's arm at the elbow and exerts moderate pressure on the radial head with the thumb or one finger. With the other hand, the examiner holds the child's distal forearm, and then pulls with gentle traction. While maintaining traction, the examiner fully supinates the child's forearm and then fully flexes the elbow in one smooth motion. A click may be felt by the finger over the radial head or a pop may be heard by the examiner, when the subluxation is reduced.

Radial head subluxation is the most common cause of arm disuse in children and is a unique elbow injury in children <5 years of age. With sudden traction on the distal radius, a portion of the annular ligament slips over the head of the radius and slides into the radio-humeral joint where it becomes trapped.²

History

This often occurs as the caregiver grabs the arm to prevent the child from falling or pulling away, or when a child is swung by the forearms during play. Radial head subluxations also occur during sleep if the forearm is rolled over. The child will hold the arm close to the body with the elbow either fully extended or flexed and pronated. There is tenderness over the anterolateral aspect of the radial head and pain with supination of the forearm.³

Making the Diagnosis

The diagnosis is made clinically with history and physical exam. Imaging should only be obtained to exclude a fracture or dislocation when history indicates an injury other than a minor pull or twist, or exam demonstrates focal tenderness or edema. On plain films, the radial head should point toward the capitellum in all views.¹

Figure 4. Lateral view of a nondisplaced type I supracondylar fracture.



Figure 5. Lateral view of a type II supracondylar fracture with minimal displacement.



A Monteggia fracture is a dislocated proximal radial-ulnar joint associated with a forearm fracture.

Management

Two techniques utilized for reduction include supination/flexion and hyperpronation methods. Following successful reduction, there is immediate pain relief. Reduction is confirmed when the child moves the affected arm, which typically occurs within minutes. After successful reduction, no additional treatment, immobilization, or activity restriction is necessary.

Supracondylar Fractures

History

Supracondylar fractures account for 60% of pediatric elbow fractures and are usually caused by a fall on an outstretched hand. Careful examination is needed because there is significant potential for neurovascular compromise.¹ Elbow effusions, decreased motion, and pain are common.

Making the Diagnosis

Examination should include evaluation for median, radial, or ulnar nerve injury. The median nerve is the most commonly injured nerve in supracondylar frac-

tures. Median nerve injury will result in a weak “OK” sign or lack of distal interphalangeal flexion when making an “OK” sign.² Injury to the radial nerve results in weakness of wrist extension, hand supination, and thumb extension (“thumbs up” sign). In addition, altered sensation is found in the dorsal web space between the thumb and index finger. Ulnar nerve injury causes weakness of wrist flexion and adduction, finger spread, and flexion of the distal phalanx of the fifth digit. This can be tested by asking the patient to firmly hold a piece of paper between the third and fourth digits.²

An indirect indicator of hemorrhage or effusion is displacement of the posterior fat pad, known as a “sail” sign, and indicates an occult fracture.⁴ On a normal elbow x-ray, the anterior humeral line runs through the anterior cortex of the humerus and intersects the capitulum in its middle third. There are three types of supracondylar fractures:⁵

- **Type I** – Nondisplaced. Has an anterior humeral line that intersects the capitulum, an intact olecranon fossa, no medial or lateral displacement, no medial column collapse, and a normal Baumann angle.
- **Type II** – Extends but does not completely transect with some cortical contact. Anterior humeral line does not intersect the capitulum.

Figure 6. Lateral view of a type III supracondylar fracture illustrating circumferential break in the cortex with displacement of fracture fragments.



- **Type III** – Has a circumferential break in the cortex with displacement of fracture fragments.

Management

Disposition depends on whether the fracture is stable or unstable. Stable closed fractures can be discharged home in a posterior arm splint with orthopedic follow-up within one week. Patients with open fractures need to be transferred to a facility with pediatric orthopedics on staff who can immediately reduce these fractures; a lack of immediate intervention can lead to permanent nerve damage and/or malunion.⁶

Salter-Harris Fractures

Salter-Harris fractures are physeal fractures that are classified as type I, II, III, IV, or V. A common way to remember the fracture line and its relationship to the growth plate is:

- S – Straight across (type I)
- A – Above (type II)
- L – beLow (type III)
- T – Through (type IV)
- ER – ERasure of growth plate (type V)

These fractures are best seen on AP and lateral views on the bones. Type I fractures are difficult to see on a plain x-ray, but bony tenderness on palpation aids in diagnosis.

Figure 7. Lateral view of an olecranon fracture and joint effusion.



Nondisplaced type I and II fractures of the elbow can be immobilized with a short-arm splint and placed in a sling for 3 weeks.¹ Volar splinting is preferred for type I, and sugar tong splinting is generally used for type II fractures. For displaced type I and II fractures, the extremity should be splinted and placed in a sling with urgent orthopedic consult for fracture reduction within the first 7 days. If type III, IV, and V fractures are identified in the urgent care setting, pediatric orthopedic evaluation is needed for reduction and possible internal fixation.⁷

A buckle fracture occurs at the distal metaphysis, where the bone is most porous, usually in younger children. This injury is caused by buckling of the cortex due to compression failure. Torus fractures are stable, and treatment is aimed at pain relief, comfort, and protection of the bone from any further injury using a short-arm cast or a splint.⁸ Children with splints may remove them at home after 3 weeks without orthopedic follow-up, but the patient should follow up with the primary care provider in 10-14 days. Orthopedic evaluation should occur for children with torus fractures and bowing of the arm, diminished range of motion, and continued pain. However, most children with buckle fractures do not require orthopedic follow-up.⁷

Olecranon Fractures

Olecranon fractures may occur when the child falls

directly onto a flexed or extended elbow, or with a fall on outstretched hand with valgus stress on the forearm. The child usually presents with pain, tenderness, and/or edema to the olecranon region. Associated fractures are commonly greenstick or metaphyseal stress fractures. Challenges to identifying olecranon fractures include the inability to visualize the fracture on an AP view, the fact that the ossification center is an epiphysis and may normally appear separated or irregular, and multiple ossification centers on the lateral view may be misinterpreted as fractures. Contralateral elbow plain films may be obtained for comparison. Greenstick or stress fractures with minimal to no displacement may be treated with a cast, with about 20° of elbow flexion; this reduces the distracting pull of the triceps muscle and allows proper healing. Follow-up consists of weekly x-rays for 2-3 weeks. Fractures with a step off >2 mm, displacement, or comminution with associated radial head or neck fractures require surgical intervention.¹

Coronoid Fractures

Coronoid fractures occur from a fall on an outstretched hand or direct fall on the elbow. Symptoms consist of pain, tenderness, and decreased range of motion. Type I involves the tip of the coronoid process; type II involves <50% of the coronoid; and type III involves >50% of the coronoid.⁴ A "B" subset of each type indicates dislocation of the fragment. For nondisplaced fractures, patients can be placed in a long-arm posterior splint with the elbow in 90° of flexion and the forearm in supination. Patient should have an orthopedic evaluation in 2 weeks. Displaced coronoid fractures should be transferred for emergent orthopedic evaluation for fragment fixation.

Septic Arthritis

History

Joint infection can be bacterial, fungal, or viral in etiology, but bacterial infection is the most common. Bacterial arthritis usually occurs in a single joint, most often of the lower extremity. Infections of the knee, hip, and ankle consistently account for at least 80% of cases, with the hip and knee affected most commonly.⁹ Bacterial arthritis presents classically with acute onset of fever and joint pain, swelling, limited range of motion, and possibly skin lesions. The extremity is held in a position of comfort.

Making the Diagnosis

Important questions to ask the patient and parents concern immunization status, recent penetrating joint

trauma or injury, previous history of bacterial arthritis, recent surgery, recent illness, and insect bites.¹⁰ Obtaining a proper history will aid evaluation for traumatic joint effusion, ligamentous injuries, juvenile idiopathic arthritis, gout, Lyme disease, and avascular necrosis.

Management

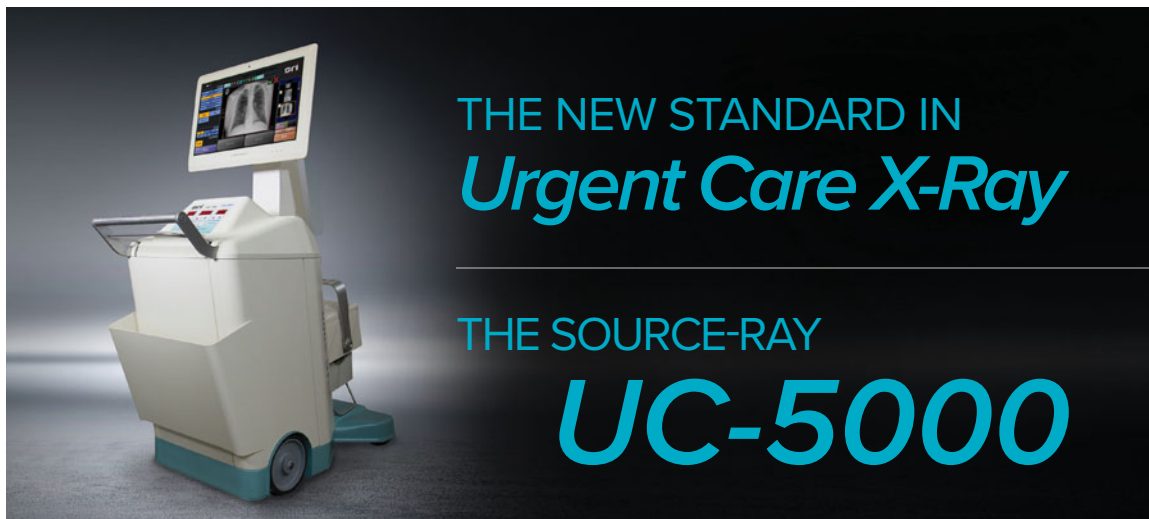
When suspecting a septic joint, initial imaging consists of x-rays to rule out osteomyelitis, fractures, or inflammatory arthritis. An ultrasound can be obtained to examine for effusion. Important lab work to order includes complete blood count, blood cultures, and synovial fluid analysis (ie, WBC count and differential, gram stain, culture, susceptibility testing) if possible. The patient should be started on broad-spectrum IV antibiotics.⁹ The final disposition of the patient should be transfer to the closest hospital with pediatric orthopedics for further evaluation and treatment.

Summary

Obtaining an accurate history from a pediatric patient can be difficult, possibly due to inability of the patient to verbalize or properly convey their feelings. Thus, an important aspect of an urgent care evaluation of a pediatric patient following an injury is a thorough physical exam and a low threshold for imaging. Commonly encountered injuries include supracondylar fractures, radial head subluxation, and Salter-Harris fractures, but septic arthritis, coronoid fractures, and olecranon fractures should also be considered. If the history or evaluation is suspicious for a complicated elbow injury, immediate referral or transfer from the urgent care center should take place. ■

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David J. Cohen, MD is Board Certified in Radiology and the Founder & Medical Director of Teleradiology Specialists



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An Uncommon Mechanism of Work-Related Partial-Thickness Triceps Tear

Urgent message: Triceps tears are an uncommon acute injury that can occur from multiple mechanisms, including direct trauma. Assessment of these injuries requires obtaining a medical history and exam and a knowledge of characteristic diagnostic imaging findings. Early diagnosis and identification in patients presenting to an urgent care center is critical to ensure that appropriate treatment is initiated in a timely fashion.

JONATHON SWAN; RALPH S. BOVARD, MD, MPH; ZEKE J. MCKINNEY, MD, MHI, MPH

Introduction

Triceps tendon (TT) tear is the least common of all tendon injuries and comprises <1% of all upper extremity injuries.¹ Partial tears of the TT typically affect the distal tendon.² The commonly accepted mechanism of injury for triceps tear is an active overloaded contraction of an extended triceps muscle.¹ Injuries may also occur from lacerations, adrenergic steroid injection, volleyball serving, hammering, and weight lifting.^{1,3} An uncommon mechanism of triceps tear is a direct impact injury to the posterior elbow; thus, this type of injury may be less commonly considered as a diagnosis in these instances.⁴ Plain film findings, such as the so-called “flake sign,” may be helpful in the diagnosis of these injuries.² As clinical outcomes may vary relative to the time from injury to repair, early diagnosis and treatment are important for restoring full function.⁵

Case Report

A 59-year-old male with no history of elbow injuries was working as a welder for the local parks and recreation department. On the date of injury, he tripped over cables at work and fell, striking the posterior aspect of his dominant elbow against the hard edge of a metal tabletop. He had immediate discomfort of the posterior

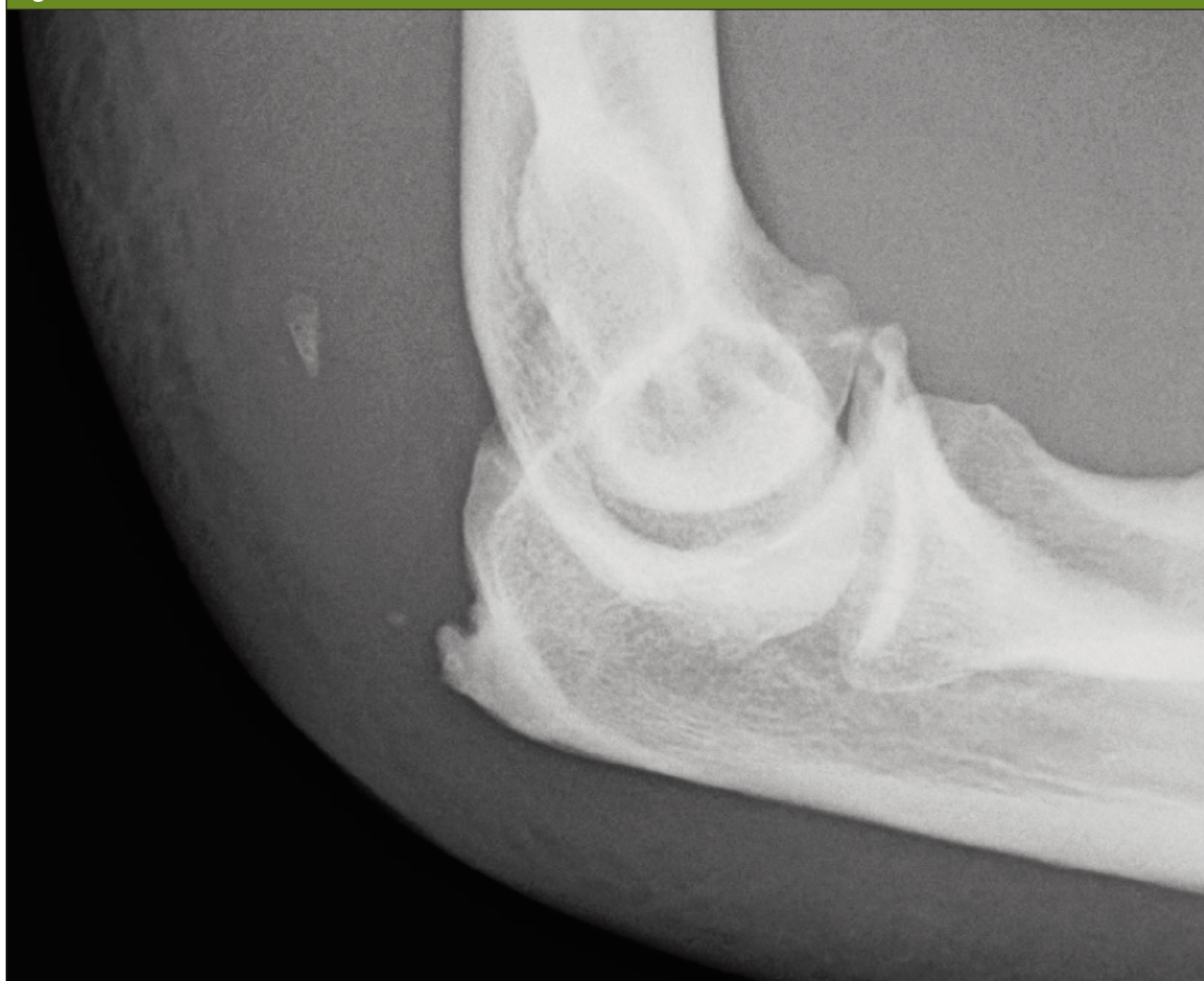


elbow, but was able to move the elbow with pain.

The initial clinical examination on the date of injury revealed swelling and tenderness of the posterior aspect

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Figure 1.



of the elbow. Range of motion was limited to 10° of decreased extension and 90° of flexion, compared with 0° at full extension and no hyperextension of the uninjured elbow. The radial head and biceps insertion were nontender. The remainder of the upper arm and shoulder examination were unremarkable. Four-view (anterior-posterior [AP], lateral, oblique, and radial head) plain films of the elbow and two-view (AP, lateral) plain films of the humerus were performed. The radiology report of the elbow x-ray (**Figure 1**) on the date of injury was negative for fracture or dislocation, but noted mild degenerative arthritis. Additional findings included mild soft tissue swelling, a hypertrophic spur along the posterior aspect of the elbow, and two small corticated bony densities posterior to the distal humerus. There was no

evidence of acute bony avulsion at the TT insertion.

The initial presentation of the injury was felt to be most consistent with a posterior elbow contusion. The initial treatment was conservative, consisting of home range-of-motion exercises, ice, elevation, an over-the-counter nonsteroidal anti-inflammatory medication, and a sling for comfort. A physical therapy referral was placed in follow-up 4 weeks after the injury occurred.

Due to persistent pain, a magnetic resonance image (MRI) was ordered at the seventh follow-up visit. An MRI study nearly 3 months status postinjury demonstrated a high-grade partial tear involving approximately 30% to 40% of the distal TT accompanied by mild atrophy of the triceps musculature. Based on this finding, the patient was referred to an orthopedic surgeon for further

evaluation. The TT was surgically repaired 3.5 months following the original injury. During surgery, the superficial 50% of the triceps muscle was noted to be retracted several centimeters from its distal insertion. The TT was sutured to an anchor placed over the posterior cortex of the posterior ulna, and the procedure was accomplished without complications.

Fourteen weeks postoperatively (7 months after the original date of injury), he was released back to work without restrictions.

Discussion

This case demonstrates a unique mechanism of TT injury from a direct traumatic impact to the posterior elbow rather than from an excessive contraction of a flexed triceps muscle. This mechanism has not been reported frequently in the literature.^{1,4,6} It is important to maintain clinical suspicion if a likely contusion or strain injury fails to respond within the normal period of expected healing. Elaborative imaging studies will include baseline radiographs and musculoskeletal ultrasonography or MRI. Plain film signs of a distal TT tear include excessive soft tissue swelling or hematoma, avulsed bone from the olecranon process, a posterior fat pad (ie, “sail” sign), or a fluid-filled defect where the TT has retracted.² The finding of an avulsed bone fragment on x-ray is commonly described as a “flake” or “fleck” sign; this may appear as a triangulated radiopaque density posterior to the elbow on lateral view measuring 0.4–1.9 cm in length and typically retracted at least 2.4 cm proximal from the olecranon.^{2,7}

Surgical repair for incomplete or partial tendon tears is controversial, since nonsurgical treatment is often effective in treating partial tears.^{3,5,6} Nonsurgical treatment may range from no intervention to restrictions of 4–6 weeks in an extension splint.^{1,5} Nonsurgical treatment may be ineffective in individuals who routinely extend weight above their heads, such as some workers, children,

“Early diagnosis of triceps tears is critical to ensure that appropriate treatment is initiated in a timely fashion to minimize prolonged impairment.”

and some athletes.⁵ Chronic TT injuries may require autograft reconstruction using the palmaris longus tendon or other reconstructive procedures.⁸ The possibility of less-than-favorable outcome increases with delayed diagnosis and underscores the importance of an appropriate treatment algorithm.

In this case, the patient’s work demands resulted in ongoing pain and a failure to respond to conservative management. The determination of which patients may require

surgical intervention suggests that collaborative management between the occupational or treating physician, the orthopedic surgeon, and the physical therapist should begin early in such injuries.

Key Points

- Direct trauma to the triceps tendon is an uncommon mechanism for triceps tears and is reported infrequently in current literature.
- Surgical intervention may be necessary for partial triceps tears in patients who have persistent pain or who fail to respond to conservative management.
- Early diagnosis and identification of triceps tears are critical to ensure that appropriate treatment is initiated in a timely fashion to minimize prolonged impairment.

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ABSTRACTS IN URGENT CARE

- Clindamycin to Reduce Resistance to Group A Strep?
- No Recommendation to Screen for Herpes
- When Do You Stop Monitoring Arrhythmias?
- Assessing Overtreatment of Children
- Update: Guidelines for Earwax Impaction
- Use Cardiac Risk Scores with Caution
- Stinging Insect Hypersensitivity
- Looking at Epi for Older Patients?

■ SEAN M. McNEELEY, MD and GLENN HARNETT, MD

Each month the Urgent Care College of Physicians (UCCOP) provides a handful of abstracts from or related to urgent care practices or practitioners. Sean M. McNeeley, MD, leads this effort.

Clindamycin Reduces Resistance to Group A Strep

Key point: Another use for clindamycin.

Citation: Andreoni F, Zurcher C, Tamutzer A, et al.

Clindamycin affects group A streptococcus virulence factors and improves clinical outcome. *J Infect Dis.* 2017;215(2):269-277.

Necrotizing fasciitis is a life-threatening infection not frequently seen in the urgent care center, though it does occur. This article from the Infectious Diseases Society of America discusses the importance of adding clindamycin to the treatment regimen. No good quality evidence was present before this article proving the effect, but it was surmised that clindamycin reduces the resistance factors of group A strep. From their results, the authors recommend clindamycin be used early and at a high dose. For the urgent care provider, this is good information—and one more instance where a medication is used to help reduce resistance. ■

No Recommendation to Screen for Herpes

Key point: Potential harm outweighs benefits of serologic screen-

ing for genital herpes.

Citation: U.S. Preventive Services Task Force. Serologic screening for genital herpes infection: U.S. Preventive Services Task Force recommendation statement. *JAMA.* 2016;316(23): 2525-2530.

Prevalence of herpes may be as high as one in six persons in the United States. There remains no cure for herpes, although there are several antivirals that may decrease symptoms when taken in time. In this article, the U.S. Preventive Services Task Force reviews the accuracy, benefits, and potential harm of serological testing for herpes. They note a low specificity and high false positive rate. Due to the absence of a cure, along with the anxiety and concerns created by a false positive, they concluded the potential benefit was less than the harm. A false negative could also create problems, as well. This article can help the urgent care provider in discussion when patients ask for this type of testing. Even a true positive does not define the location of the virus. ■

When Do You Stop Monitoring Arrhythmias?

Key point: A rule to help predict which arrhythmias should be addressed.

Citation: Syed S, Gatién M, Perry JJ, et al. Prospective validation of a clinical decision rule to identify patients presenting to the emergency department with chest pain who can safely be removed from cardiac monitoring. *CMAJ.* 2017;189(4):E139-E145.



Sean M. McNeeley, MD, is an urgent care practitioner and Network Medical Director at University Hospitals Cleveland Medical Center, home of the first fellowship in urgent care medicine. Dr. McNeeley is a board member of UCAOA

and UCCOP. He also sits on the *JUCM* editorial board. **Glenn Harnett, MD**, is principal of the Resistance Consulting Group in Mountain Brook, AL.

Although many cardiac monitors are available in the United States, they are still a limited commodity. Concerns of arrhythmia in patients with chest pain and potential AC are a reason for monitoring. Almost 800 patients were evaluated with an endpoint of arrhythmia requiring intervention in the ED or within 8 hours of leaving. The rule proved 100% sensitive but only 36% specific. The rule used was the Ottawa chest pain cardiac monitoring rule. The rule required the patient to be chest pain-free and to have a normal or nonspecific EKG. Although not directly applicable to most urgent care center treatment, knowing which patients are less likely to have an arrhythmia needing treatment is helpful. This rule predicts that. ■

The Dangers of Overdiagnosing and Overtreating Children

Key point: *There's potential harm in providing more care than necessary to children.*

Citation: Coon ER, Young PC, Quinonez RA, et al. Update on pediatric overuse. *Pediatrics*. 2017;139(2).

This article reviews for overdiagnosis, overtreatment, and overutilization of medical care for children. Overdiagnosis included hypoxemia in children with bronchiolitis and skull fractures in children with minor head injuries. Overtreatment included concerns for long-term antibiotics in pneumonia; excessively long treatment of osteomyelitis with IV antibiotics; antidepressants for adolescents; and nebulized hypertonic saline for bronchiolitis, which may not be effective. And overutilization included CT scans for potential appendicitis. For the urgent care provider, several of these issues may be pertinent. Overdiagnosis of hypoxemia in children with bronchiolitis may cause unnecessary admission. The same surgeon might be present if skull fractures are overdiagnosed; minor head treatment, as well. Use of antibiotics, particularly intravenous when oral might be just as effective, could also be applicable. Finally, avoiding CT scans when possible to rule out appendicitis is also an area potentially applicable to urgent care. The overall idea of considering what physicians and other providers are ordering or performing that may be unnecessary on a population basis is important to ponder. ■

An Update of Guidelines for Earwax Impaction

Key point: *Treat only symptomatic patients.*

Citation: Schwartz SR, Magit AE, Rosenfeld RM, et al. Clinical practice guideline (update): earwax (cerumen impaction). *Otolaryngol Head Neck Surg*. 2017;156(1 Suppl):S1-S29.

This update to the American Academy of Otolaryngology-Head and Neck Surgery Foundation's 2008 Cerumen Impaction Guidelines provides updates on the management and prevention of

“The authors strongly suggest that repeat testing of cardiac troponin levels should be considered, even in low risk patients.”

cerumen impaction. They reiterated that clinicians should only treat cerumen impaction when it causes symptoms or prevents needed assessment of the ear. Injury to the ear canal in the manual removal of cerumen should be avoided. Guidelines continue to strongly suggest that patients at risk for, or with a history of cerumen impaction, should not insert any foreign body into the ear canals (including cotton swabs) as they may cause injury and worsen impactions. Lastly, the committee strongly recommends against the practice of ear candling/coning for the treatment of cerumen impaction as it may cause serious injury and there is little to no evidence that it is effective. For the urgent care provider, recommended treatment methods are the use of cerumenolytic agents, irrigation, and manual removal using instrumentation such as ear curettes. If urgent care management is unsuccessful, patients should be referred to a specialist. ■

Comparing Missed AMI Among Various Risk Prediction Scores

Key point: *Use cardiac risk scores with caution.*

Citation: Singer AJ, Than MP, Smith S, et al. Missed myocardial infarctions in ED patients prospectively categorized as low risk by established risk scores. *Am J Emerg Med*. 2017; Jan. 5. [Epub ahead of print]

This study compared the rate of missed AMI in ED patients prospectively categorized as low risk via the use of various cardiac risk prediction scores (ie, TIMI, HEART, GRACE, EDACS), as well as unstructured clinical impression. Unstructured clinical impression was defined as an estimate by the attending ED physician of the likelihood of acute MI as low, medium, or high based on clinical gestalt and either with or without two cardiac troponin (cTn) levels. When using the recommended low-risk cutoff points of the predictive tools, the results indicated that a TIMI score of 0 or a low unstructured clinical impression (combined with two negative cTn levels) were the only methods that did not misclassify any AMI patients. None of the other predictive tools were sensitive enough to reduce the risk of AMI to an acceptable missed rate, generally considered to be <1%. The authors strongly suggest that repeat testing of cardiac troponin levels should be considered, even in low risk patients. For the urgent care provider, cardiac risk scores should continue to be

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ABSTRACTS IN URGENT CARE

*"The data support current
recommendations for the administration
of IM epi to anaphylactic
patients in the elderly population."*

used cautiously when determining the safety of discharging patients with suspected AMI or acute coronary syndrome. ■

Update on Treating Stinging Insect Hypersensitivity

Key point: In severe reactions, prescribe epinephrine auto-injector and refer to an allergist.

Citation: Golden DB, Demain J, Freeman T, et al. Stinging insect hypersensitivity: a practice parameter update 2016. *Ann Allergy Asthma Immunol.* 2017;118(1):28-54.

This practice parameter update suggests that most insect stings cause mild local reactions, for which no specific treatment is usually required. Oral antihistamines and oral analgesics may reduce pain and itching associated with mild cutaneous reactions. Many physicians use oral corticosteroids for larger, local reactions, although definitive proof of efficacy through controlled studies is lacking. Antibiotics are not indicated unless there is a clear indication of secondary infection—eg, fever, chills, or sweats. Imported fire ants are common in the southeastern U.S. and their sting produces a characteristic sterile pustule. Patients with severe or systemic reactions should be prescribed an epinephrine auto-injector and instructed on its proper use. Patients should also consider obtaining and carrying a medical identification bracelet or necklace. These patients should be referred to an allergist for skin/lab testing and consideration of venom immunotherapy. ■

Why Are Older Patients Less Likely to Receive Epi?

Key point: IM epinephrine (epi) appears safe in elderly patients.

Citation: Kawano T, Scheuermeyer FX, Stentstrom R, et al. Epinephrine use in older patients with anaphylaxis: clinical outcomes and cardiovascular complications. *Resuscitation.* 2017;112:53-58.

This study examined the proportions of older (defined in this study as ≥ 50 years of age) and younger patients presenting with severe allergic reaction/anaphylaxis who subsequently received treatment with epi. Results revealed that 36% of the elderly group received epi, compared with 60.8% of the younger group. This appears to support the authors' hypothesis that older patients would be less likely to receive epi due to clinician concerns. The study also measured the rate of cardiovascular complications following IV or IM epi administration for anaphylaxis, including ventricular fibrillation/tachycardia, atrial fibrillation/flutter, acute stroke, elevated troponin, or new ischemic EKG changes. IM epi appeared to be safe in older patients with anaphylaxis, but cardiovascular complications were more common in those receiving IV epi. For the urgent care provider, the data support current recommendations for the administration of IM epi to anaphylactic patients in the elderly population. ■

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Should an Urgent Care Operator Check the National Sex Offender Registry When Hiring Employees?

■ Alan A. Ayers

Urgent message: Failure to identify risks in a new hire's background can result in "negligent hiring" liability for an urgent care operator, but there are also limitations in what information a center can seek on an applicant.

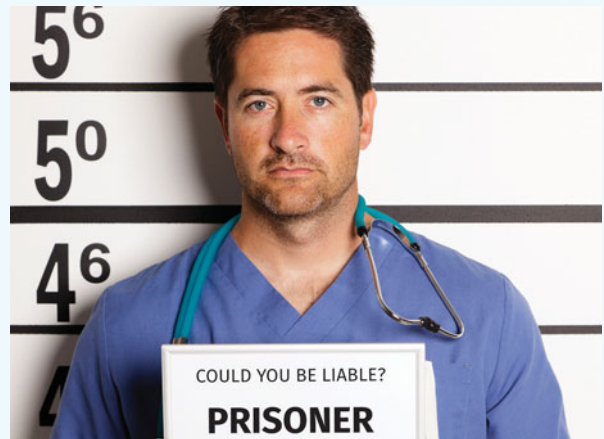
The approximately 7,100 urgent care centers in the United States employ physicians, NPs, PAs, RNs, medical assistants, technicians, and receptionists who provide walk-in patients with medical care for minor health conditions without an appointment. Most urgent care centers around the country are owned by physician entrepreneurs.

While many larger corporate and hospital-affiliated urgent care centers already have established human resources processes in place, properly vetting new hires is an important topic for smaller urgent care facilities and independent operators that may not have the bandwidth to employ a full-time HR specialist or who are unaware of critical hiring practices. This article examines the issue of whether an urgent care facility owner is required to consult the national sex offender registry in the hiring process.

For licensed professionals, such as MDs, DOs, NPs, PAs, and RNs, this issue can be resolved by the state licensing process, which may impose restrictions in light of past criminal convictions. However, there are numerous non-licensed staff who are employed at urgent care facilities, such as medical assistants, secretarial staff, and technicians. These individuals present a risk for the facility owner because their backgrounds are not typically subject to the heightened scrutiny of licensed professionals.



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Background

Congress enacted the Sex Offender Registration and Notification Act as part of the Adam Walsh Child Protection and Safety Act in 2006.¹ This legislation also incorporated the National Sex Offender Public Registry (NSOPR), which links public state, territorial, and tribal sex offender registries in a single national search site.² It is important to note that the NSOPR does not have a single national database of all registered sex offenders nationwide. It uses web services to search the individual databases of the jurisdictions in real time.³

Discussion

Urgent care center owners must understand their obligations—if any—to search the database before hiring individuals. The potential liability is an important issue; if a center negligently hires a sexual predator who causes injury to a patient, owners could be liable for damages.

In most instances, there is a slim distinction between complying with state laws restricting the use of convictions in em-

Employee Background Checks: The Basics

Employee background checks can be a source of potential liability for employers. Employers must be very careful as to what kind of information they seek. When in doubt, it's best to contact an employment attorney for the specific rules in your state.

Things to keep in mind when conducting an employee background check:

- **Be reasonable:** Running a credit report and checking on references may make sense, but going further—reviewing court records, interviewing neighbors, or requiring physicals—may run afoul of workers' privacy.
- **Be business-related:** Background information sought must be directly related to the employee's job responsibilities.
- **Get applicants' consent:** Consent is required for certain sensitive information like credit reports. Consent is typically easiest asked for on the job application.

Records employers can likely consider, depending upon state law, when performing an employee background check:

- Credit reports
- Drug tests
- Driving records
- Social Security number
- Court records
- Character references
- Property ownership records
- State licensing records
- Past employers
- Personal references
- Sex offender lists

Records employers generally cannot consider when performing an employee background check:

- **Criminal records:** Varies by state and may be limited to certain types of employers like law enforcement and child care.
- **Bankruptcies:** Although a matter of public record, cannot be a factor in any hiring decision.
- **Workers compensation:** Information may be used only to determine if the applicant is able to perform required work.
- **Medical records:** Medical records are confidential and cannot be released without an applicant's knowledge or authorization. Employers can require a physical to determine ability to perform specific job functions.
- **Military records:** Military records can only be released under very limited circumstances.
- **Educational records:** Transcripts, recommendations, disciplinary records, and financial information are confidential and can only be released with consent.

Adapted from: <http://smallbusiness.findlaw.com/employment-law-and-human-resources/performing-an-employee-background-check.html>.

employment decisions and the responsibility of an employer not to engage in negligent hiring. As a result, state laws on the use of convictions in employment typically dovetail with legal rules on negligent hiring.⁴ The laws governing employer access to criminal records differ in each state. However, many state laws say these records can only be used by certain employers, such as law enforcement and child care facilities. Also, there are states that permit an employer to ask prospective employees about a criminal past—even if employers are not allowed to access criminal records.⁵

This particular aspect of this issue may be an urgent care owner's greatest exposure to liability. Working with a knowledgeable and experienced employment law attorney will help centers comply with the specific state rules.

Negligent Hiring

Eighty-four percent of HR professionals surveyed reported that background screening uncovered issues that would not otherwise have been found. This has resulted in an estimated 79% of negligent hiring lawsuit verdicts against employers, with average jury award over \$1 million.⁶

Negligent hiring must be a major concern for urgent care centers. In Illinois, for example, plaintiffs must prove three elements to establish a claim for negligent hiring: 1) the employer knew or should have known the employee had a particular unfitness for the position so as to create a danger of harm to third persons; 2) the particular unfitness was known or should have been known at the time of the employee's hiring or retention; and 3) this particular unfitness proximately caused the plaintiff's injury.⁷

Employers in California and in states with similar laws shouldn't make hasty employment decisions based on information obtained about an applicant through the national registry or a state criminal website. Such a decision could lead to costly litigation. However, in California, employers are able to protect staff and customers from potential risks: employers may make lawful employment decisions based on properly obtained criminal background checks and self-disclosed criminal history information.⁸ As a result, employers can make these hiring determinations based on court records documenting a sex offense conviction or conviction information self-disclosed by an applicant during the hiring process.⁹ Likewise, Texas enacted legislation in 2013 to protect employers from being sued for hiring people with prior criminal convictions.¹⁰

This result emphasizes the distinction between sex offender registry information and conviction records. Sex offender registry information in California, for example, is available online, while criminal conviction records are usually found by employers in a background check by a third-party service.

This distinction is critical, because background check companies must comply with state and federal fair credit reporting laws—which includes *inter alia* obtaining the applicant's con-

sent in advance and complying with the prescribed “adverse action” procedures.¹¹ Similarly, employment attorneys in other states say employers generally are not required to look at the registries.¹² Courts have held that there’s no legal duty to be aware that someone is on the list, and most states stipulate that an employer is not under a duty to inquire as to whether an employee has been convicted of crimes in the past.¹³ To that end, the New York Court of Appeals held that “[l]iability will attach on such a claim only when the employer knew or should have known of the employee’s violent propensities.”¹⁴

This exception from liability may very well come into play in the urgent care center setting. For instance, an urgent care center hires a person who is a registered sex offender, convicted of inappropriate behavior with a minor. As a result, if he is a licensed medical professional, he’ll have state-imposed restrictions on his ability to treat patients under age 21. If a staff member, there are no available licensing restrictions. In some jurisdictions, the employer may be liable for damages from a person’s actions. The Colorado Supreme Court addressed this scenario by endorsing the proposition that:

where an employer hires a person for a job requiring frequent contact with members of the public, or involving close contact with particular persons as a result of a special relationship between such persons and the employer, the employer’s duty of reasonable care is not satisfied by a mere review of personal data disclosed by the applicant on a job application form or during a personal interview.¹⁵

The Court went on to say:

in the absence of circumstances antecedently giving the employer *reason to believe* that the job applicant, by reason of some attribute of character or prior conduct, would constitute an *undue risk of harm* to members of the public with whom the applicant will be in frequent contact or to particular persons standing in a special relationship to the employer and with whom the applicant will have close contact, we decline to impose upon the employer the duty to obtain and review official records of an applicant’s criminal history.¹⁶

Thus, in this example, unless an employer in Colorado had reason to believe that a job applicant would be an undue risk of harm to patients, an employer’s duty of reasonable care doesn’t extend to searching for and reviewing official records of an applicant’s criminal history.¹⁷ Courts have held that under a negligent hiring theory, whether harm is foreseeable requires an assessment of “whether the risk of harm from an employee to a person such as the plaintiff was reasonably foreseeable as a direct result of the employment.”¹⁸

Conclusion

The courts have held that employers do not have a duty to make an inquiry as to a prospective employee’s criminal record—even where it’s known that he will regularly deal with the public. If the employer has made adequate inquiry or otherwise has a reasonably sufficient basis to believe the employee will be reliable and fit for the job, there’s no affirmative duty to investigate the possibility that the applicant has a criminal record, including a check of the national sex offender database.

References

1. Pub. L. 109-248, Tit. I, 120 Stat. 590 (2006). Among its many provisions, the Sex Offender Registration and Notification Act instructs states to maintain sex-offender registries that compile an array of information about sex offenders, 42 U.S.C.S. § 16914; to make this information publicly available online, 42 U.S.C.S. § 16918; and to provide a criminal penalty that includes a maximum term of imprisonment that is greater than one year for the failure of a sex offender to comply with the requirements of the subchapter, 42 U.S.C.S. § 16913(e).
2. National sex offender public website. <https://www.nsopw.gov/en/AspxAutoDetect-CookieSupport=1>. Every state has enacted its own specific laws that determine what information is to be displayed on the public registry website. National sex offender public website, FAQs, <https://www.nsopw.gov/en/Home/FAQ#answer-02>.
3. *Id.* Further, the U.S. Department of Justice does not maintain the sex offender information displayed on NSOPW. All of the information provided through the website is maintained by the separate jurisdictions. Access to that information is controlled by the agency within each jurisdiction responsible for registering sex offenders.
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7. *Helfers-Beitz v. Degelman*, 406 Ill. App. 3d 264, 939 N.E.2d 1087, 1091, 345 Ill. Dec. 907 (Ill. App. Ct. 2010).
8. Rod M. Fliegel & Justin T. Curley, *California’s New Megan’s Law Website: Employers Are Cautioned Not to Make Precipitous Employment Decisions*, Littler (January 1, 2005) <https://www.littler.com/californias-new-megans-law-website-employers-are-cautioned-not-make-precipitous-employment-decisions>.
9. *Id.*
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11. Fliegel & Curley, *supra*. Background check companies in California may not report records of conviction (even felonies) that, from the date of disposition, release, or parole, predate the background check report by more than seven years. As a practical matter, the attorney authors state that this may lead to a strange result that an employer may not learn of an old sex offense conviction through the background check process, even though the name of the employee is on the sex offender registry. *Id.*
12. Diane Cadrain, *Full Disclosure*, SHRM (September 1, 2007) <https://www.shrm.org/hr-today/news/hr-magazine/pages/0907cadrain.aspx>.
13. *Yeboah v. Snapple, Inc.*, 286 A.D.2d 204, 729 N.Y.S.2d 32, 33 (N.Y. Div. App. 2001) (citing *Amendolara v. Macy’s New York*, 19 A.D.2d 702, 241 N.Y.S.2d 39, 40 (N.Y. App. Div. 1963)). See *Fox Assocs. v. Robert Half Int’l*, 334 Ill. App. 3d 90 (Ill. App. Ct. 1st Dist. 2002); *Tallahassee Furniture Co. v. Harrison*, 583 So. 2d 744, 761 (Fla. Dist. Ct. App. 1st Dist. 1991); *Morse v. Jones*, 223 La. 212 (La. 1953).
14. *Yeboah*, 729 N.Y.S.2d at 33.
15. *Connes v. Molalla Transport System, Inc.*, 831 P.2d 1316, 1322 (Colo. 1992).
16. *Id.* (Emphasis added). The Court thought this to be an unwieldy obligation “To impose such a requirement would mean that an employer would be obligated to seek out and evaluate official police and perhaps court records from every jurisdiction in which a job applicant had any significant contact.” See *Mormol v. Costco Wholesale Corp.*, 364 F.3d 54, 59 (2d Cir. N.Y. 2004); *Valles v. Gen-X Echo B, Inc.*, 2013 U.S. Dist. LEXIS 155630 (D. Colo. Oct. 8, 2013) (“When adopting negligent hiring as a tort, the Colorado Supreme Court took into account the various considerations discussed above and made clear that an employer’s duty of care does not include searching for and reviewing criminal records, except in special circumstances...”).
17. *Connes v. Molalla Transport System, Inc.*, 831 P.2d 1316, 1322 (Colo. 1992).
18. *Connes, supra*; *Di Cosola v. Kay*, 91 N.J. 159, 450 A.2d 508 (N.J.1982). See Restatement (Second) of Agency § 213 comment d (1958); *Nowlin v. Moravian Church in Am.*, 228 N.C. App. 307, 313 (N.C. Ct. App. 2013).

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Who's the Boss? The Organizational Impact of Bypassing the Chain of Command

Urgent message: A chain of command exists in most organizations to assure efficient and accurate communication, orderly and organized business operations, and proper allocation of time and resources. When the chain of command is broken, however, the entire business can suffer.

ALAN A. AYERS, MBA, MACC

In American business culture, organizations are typically built in a hierarchal structure and follow an established chain of command. To ensure smooth and efficient operations, employees are generally expected to communicate work issues to the supervisor directly above them in the hierarchy for direction and resolution. Conversely, high-level managers, owners, and executives are expected to allow their direct reports to execute and communicate company directives to their workers as their job roles entail.

Ideally, everyone from the top down will adhere to the prescribed chain of command. However, there are instances when individuals will bypass the chain of command and initiate business communications with people two or more rungs above or below them on the hierarchal ladder. In an urgent care setting, some examples of this type of bypassing might include:

- An area operations director who oversees multiple centers bypassing a particular center's manager to directly engage the front office staff or the medical assistants.
- A frontline staffer sending an email to the corporate office (in a corporate-owned center) about an issue that was never brought to the center manager's/supervisor's attention.
- An owner-operator who has hired management only to bypass them frequently to give direction and convey directives to the medical assistants and billing/registration teams.
- An employed doctor in the center ignoring the entire corporate management hierarchy to direct staff per his will. Medical support personnel, conditioned to follow the doctor in matters related to patient care, yield to the doctor's interference in the business operation.



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Listening vs Delegating

Contemporary organizations tend to emphasize a “flattening” of the organization chart, with an emphasis on self-managing teams and leadership tuned into the “pulse” of colleagues at all levels. Such includes “open-door policies” among senior leaders to encourage transparency with the organization’s employees.

While there is nothing wrong with higher-ups “listening” to frontline staff, delegating directly to them can create problems. When senior leaders or directors skips over a middle manager or supervisor to delegate to employees directly, they act upon several assumptions which typically are incorrect:

- That the supervisor is not keeping the frontline employee busy. However, adding to the front line’s workload without consulting the supervisor may result in the frontline employee becoming overwhelmed or overworked.
- That the work isn’t already in progress and that the frontline employee’s other duties and projects are less important than what the senior leader is requesting. Believing the senior leader’s work to take precedent, the employee may neglect more time-sensitive work.
- That the middle management layer is superfluous, ineffective, or impotent. The not-so-subliminal message is sent that the middle manager adds no value to the interaction.

Likewise, when frontline staff learn that they can access upper management directly, it is critical that upper management refer employees back to their immediate supervisor to resolve questions regarding the delegation of work, delegation of job duties, or work performance.

Although there are rare instances when this practice can’t be avoided, frequently ignoring a company’s chain of command, regardless of which direction the bypassing is occurring, inevitably leads to a whole host of problems, and can throw an organization into chaos. In the following examples, we’ll look at both instances of workplace bypassing, briefly examine the ramifications of each, and offer several strategies to help nip the practice in the bud, restoring the proper following of the chain of command.

‘Typical’ Usurping of the Chain of Command

In this instance, an employee with a workplace concern or issue bypasses his or her direct supervisor, and addresses the issue with the boss’s boss, or someone even higher up the chain. One example would be an employee bypassing the immediate supervisor to com-

municate directly with a higher-up who may be a former boss with whom he or she had a good working relationship and has since been promoted. By habit or willfully, the employee might continue to seek their counsel without keeping their new supervisor in the loop. Or perhaps the employee feels the supervisor is inexperienced or incompetent in their job, and can’t provide enough direction. Either way, except in circumstances where the immediate supervisor cannot be contacted regarding an urgent issue or has violated company policy, this is always bad business etiquette. Such behavior inevitably creates issues for the immediate supervisor, and in the case of an urgent care operation, it can result in:

- The supervisor not being made aware of clinic issues, thereby having no opportunity to address or remedy them.
- The appearance to the supervisor’s boss/higher-ups that there is ineffective and/or poor communication with employees.
- The supervisor being unable to make effective and informed decisions regarding clinic issues and workplans, thanks to the staff rerouting important information outside of the department.

Naturally, usurping the immediate supervisor will create tension and friction, which can often spill over into the rest of the department or business unit. Not only is overall morale lowered when the supervisor feels marginalized and disrespected by the clinic employees, but it places the offending employee’s job security in jeopardy.

Dipping Down

When an owner, executive, or senior-level manager “dips down” to engage their direct report’s employees, this is also a bypassing of the chain of command, but from the opposite direction. A few reasons why a boss or owner might “dip down:

- The boss may have little or no confidence in the supervisor’s ability to effectively perform the job, with the resulting frustration leading them to engage the supervisor’s subordinates directly.
- The boss may overreact to minor issues, believing that they must fix every little problem that arises.
- The boss has a social management style, and likes to mingle and help employees.
- The boss has an inflated ego, which causes him or her to overstep their boundaries and unnecessarily flex their power and authority.
- The boss may be unaware or oblivious that he or she is creating a problem for their direct report.

In most cases of dipping down, the owner/boss will not inform the supervisor that they are indeed communicating with his or her subordinates. Thus, unless the employees say something, the supervisor is unaware that the boss is directing the staff.

Ramifications of Bypassing

The consequences of frequent bypassing in either direction can range from bruised egos to organizational chaos. And despite what the initiator may believe, bypassing has a negative impact on every party involved—including the bypasser.

Frontline or lower-level employees

When a frontline employee bypasses his immediate supervisor, it demonstrates a lack of respect and professional courtesy. Tensions between supervisor and employee may increase, trust and communication may break down, and disciplinary action can result. This leads to turnover, inefficient clinic operations, and overall lowered morale.

Conversely, when a higher-up bypasses their direct report and begins giving unsolicited directives to the frontline staff, uncertainty and confusion results. The frontline staff is left to wonder, "Whose orders am I to follow? My supervisor or her boss? Why am I stuck in the middle of their power struggle?" Being placed in such an awkward position where loyalties are forcibly divided between two workplace authority figures is stressful and anxiety-inducing, and a detriment to high-level performance.

Owner-operators, high-level managers, and executives

Interestingly, owner-operators and execs who dip down cause problems for not only their direct reports and the frontline staff, but themselves in the short and long term. By appropriating the time and manpower resources of their direct reports, the business as a whole will likely experience a number of lowered performance metrics. And if the higher-up's education and experience is in an area such as strategic planning, they may lack the knowledge and qualifications to effectively manage clinical employees on the front line (meaning they don't neces-

"The chain of command is in place for a reason; it promotes overall efficiency, timely and accurate communication, orderly and organized business operations, and the proper allocation of time, resources, manpower, and responsibilities into the most capable hands."

sarily understand that aspect of the business, and would be a poor proxy for the supervisor anyway). Additionally, interfering with the direct report's job duties distracts from their own responsibilities, also causing their individual performance to suffer.

Supervisors and managers

Whether it's employees skipping up rungs on the hierarchical ladder, or the bigwigs dipping down to engage frontline staff, it's the middle manager or supervisor who gets caught in the middle. If the operations manager is dipping down, for example, the supervisor is left wondering if his or her staff is

focused on their duties, or are they involved in the owner's side project? So not only does the supervisor now need to micromanage her employees, but the owner has undermined her authority in front of everyone. This behavior by the owner usually leads to frustration, lowered confidence, increased stress, and resentment in the supervisor.

Strategies to curtail bypassing

As the above examples illustrate, bypassing the chain of command, except in the aforementioned exceptions, hurts the entire business. The chain of command is in place for a reason; it promotes overall efficiency, timely and accurate communication, orderly and organized business operations, and the proper allocation of time, resources, manpower, and responsibilities into the most capable hands. Implementing the following workplace management strategies can be very effective in ensuring all organizational members are following the proper chain of command:

Frontline staff

- Give your immediate supervisor the opportunity to address your workplace issues or concerns before taking them to upper management. Your supervisor will appreciate the professional courtesy, which goes a long way toward building an effective and cohesive team.
- Avoid the temptation to take workplace issues to professional colleagues and associates who occupy posi-

“The urgent care professionals you hired probably understand their jobs in ways that you don’t. Resist the urge to jump in and dip down when you have an idea, plan, concern, or frustration.”

tions in the hierarchy above your supervisor. Instead, stick to the chain of command except in extreme cases.

Supervisors/middle managers

- Be professional and candid when discussing the owner/higher-up dipping down. Rather than making an emotional appeal, present facts, anecdotal evidence, and performance metrics that support your need to have complete control and autonomy over your staff. Employ concrete evidence that their bypassing is having a negative effect on operations. Ask questions to uncover why they feel the need to bypass you, and offer solutions on how all parties can meet their objectives by following the chain of command.
- During the onboarding process and periodically thereafter, frontline staff should be apprised of the correct protocols and the proper channels wherein their workplace issues, concerns, and directives can be addressed.

Owners/executives/upper management

- Owners, executives, and higher-level managers should avoid communicating with employees regarding workplace issues that the employee has not discussed with their immediate supervisor. Rather, they should steer the employee back to the immediate supervisor, and advise them on the proper communication protocols.
- Understand that the urgent care professionals you hired probably understand their job functions in ways that you don’t. Hence, resist the urge to jump

Summary

- A proper chain of command can help an organization assure efficient and accurate communication, proper allocations of resources, and orderly day-to-day operations.
- Staff, starting with frontline workers, are generally expected to communicate issues to the supervisor directly above them; conversely, upper management—including ownership—is expected to allow supervisors below them to execute and communicate company directives to their direct reports.
- A worker taking concerns to upper management instead of their own supervisor—going over their boss’s head, in other words—can leave the supervisor feeling disrespected, often resulting in friction that affects unit morale.
- Upper management “dipping down” can also result in the supervisor feeling marginalized or, worse, give staff the impression that the supervisor does not have the full confidence of upper management.
- Frontline staff and upper management alike are advised to follow the chain of command unless an operational emergency requires oversight of higher-ups or direct, immediate communication between the two.

in and dip down when you have an idea, plan, concern, or frustration, and present the information to individuals tasked with handling and executing your higher-level directives. Work together to find the best way to implement the initiative while respecting and honoring their position with their teams.

Conclusion

Organizations, both large and small, are structured to assure frontline staff, managers, and leaders have the information needed to do their jobs, have authority to make business decisions and/or allocate resources and direct staff, and are held accountable for their areas of responsibility. When senior leaders dip down by engaging frontline staff directly, or when frontline staff bypasses their immediate supervisors to go “straight to the top,” such undermines the organizational structure and introduces chaos and confusion to the organization. ■



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.

Sudden Midfoot Pain in an 8-Year-Old Boy

Figure 1.



Case

The patient is an 8-year-old boy with pain in the right foot for the last several hours. He refuses to walk on the foot. There is no reported injury.

On physical exam, you find there is a normal appearance to the foot (no erythema, swelling). However, there is pain with palpation over the plantar aspect of the mid aspect of the right foot.

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

THE RESOLUTION

Figure 2.

**Differential Diagnosis**

- Metatarsal fracture
- Lisfranc dislocation
- Osteolytic lesion
- Foreign body
- Osteomyelitis

Diagnosis

The x-ray shows a foreign body. There is a 4 mm linear radiodensity in the plantar aspect of the mid foot, just beneath the skin surface. There is no bone abnormality present.

Learnings/What to Look For

- Glass is radiopaque, independent of lead content or other additives.
- If a patient is cut by glass, even if a cut is not seen in the skin and even if a foreign body is not able to be palpated, an x-ray should be done.
- Plain radiographs will also show (poorly) metal, gravel, or bone, but will not visualize wood.
- If a wood foreign body is not seen on a plain radiograph, consider CT, MRI, or ultrasound.

Pearls for Initial Management and Considerations for Transfer

- Removal can be considered when the foreign body is superficial and easily palpable, but when it is deep or poorly visualized, consider the risks of blind probing, as this may damage tissues and lead to infection.
- Transfer to the ED is advised with severe pain, possible damage to blood vessels or nerves, diagnostic uncertainty, and in patients at high risk of infection, such as those with diabetes or who are immunosuppressed.
- In lieu of ED transfer in stable patients, consider contacting and arranging expedited referral to an orthopedist or plastic surgeon.



Maximizing Reimbursement for Services on Campus, off Campus, or on the Phone

■ DAVID E. STERN, MD, CPC

Q. We are coding for an urgent care group that is owned by a hospital and bills on a CMS-1500 for professional services and the UB-04 for facility services. We bill using Place of Service (POS) code 22. Is this correct?

A. Prior to January 1, 2016, the Centers for Medicare and Medicaid Services (CMS) POS code set did not differentiate between an urgent care operating on campus or off campus. As of January 1, 2016, the criteria for outpatient hospital services have changed. If the hospital elects to bill this way, the urgent care should use either POS 22 or POS 19, based on the following:

- POS -22: On Campus-Outpatient Hospital: A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- POS -19: Off Campus-Outpatient Hospital: A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

If your center qualifies to bill the facility fees, the hospital should already have criteria for the codes that they use. These criteria are not specified by CMS, but CMS expects them to form a bell-shaped curve. If the hospital has not adopted these guidelines, the urgent care could modify the suggestions offered by the American College of Emergency Physicians, available at <https://www.acep.org/content.aspx?id=30428>.



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

"POS 2 has been established as the location where health services are provided through telecommunication technology."

Q. Can you tell me what services we can bill when they're provided as a telehealth service?

A. You can find the complete listing of Current Procedural Terminology (CPT) codes for Medicare telehealth services at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html>. The list will include specific CPT and Healthcare Common Procedure Coding System (HCPCS) codes for the following types of service:

- Professional consultation
- Office and other outpatient visits
- Individual psychotherapy
- Pharmacologic management
- Advanced care planning
- Critical care consultations
- End-stage renal disease (ESRD) related services
 - At least one visit per month must be furnished face-to-face in order to bill for telehealth ESRD services.

Appendix P of the CPT guidelines also offers a list of codes that may be used for synchronous telehealth services.

Effective in 2017, CMS has established Place of Service (POS) 2 as "The location where health services and health-related services are provided or received, through telecommunication technology." More info about that can be found at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9726.pdf>. You must also include modifier -GT, "Via interactive audio and video telecommunications system" or -GQ, "Via an asynchronous telecommunications system" to the

appropriate CPT code. For non-Medicare claims, modifier -95, "Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system," must be attached to the appropriate CPT code.

For example, if you are billing Medicare for a level 3 established patient office visit, you would code 99213 with modifier -GT, using POS 2. If you are billing a commercial payor for the same service, you would code 99213 with modifier -95, using POS 2.

The 2017 Medicare Physician Fee Schedule (MPFS), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html>, provides a comprehensive explanation of reimbursement and coverage. Along with the POS and modifiers already noted, some of the highlights are as follows:

- Approved services will be reimbursed at the facility rate
- The patient receiving the service must be located in a telehealth originating site
- Originating sites are defined as
 - Rural health professional shortage areas (HPSAs)
 - County that is not included in the metropolitan statistical area (MSA)

"The 2017 MPFS provides a comprehensive explanation of reimbursement and coverage. Some of the highlights are listed here."

- Interactive technology must be used
 - Two-way, real-time communication between the patient and physician or practitioner
 - An exception is the approved use of asynchronous platforms for the demonstration projects in Alaska and Hawaii
- The patient and physician or practitioner cannot be at the same site
- The service must be furnished by a physician or other authorized practitioner
- The service must be furnished by an eligible telehealth individual

You will also include HCPCS code Q3014, "Telehealth originating site facility fee" on the claim form. ■

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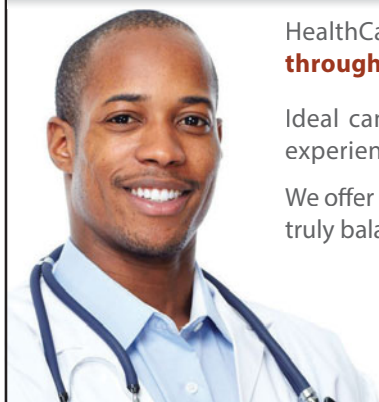
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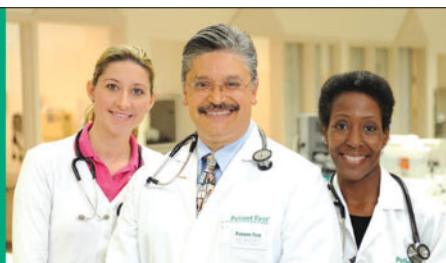
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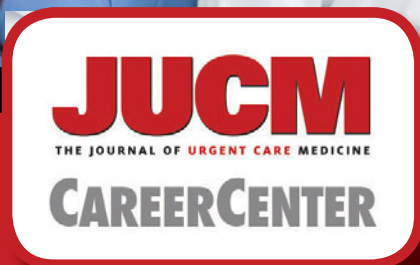
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DEVELOPING DATA

Over two-thirds of urgent care centers offer a blend of occupational medicine services (generally defined as treatment of workers compensation injuries, conducting physicals for compliance or fitness for duty, and substance abuse testing), according to the Urgent Care Association of America.¹ One challenge for those that do is that the overall incidence of workplace injuries has declined significantly this century, due to an overall shift from a manufacturing to a service and information economy, the offshoring/outourcing of U.S. manufacturing jobs, and employer investments in safety, prevention, and automation. Simply put, employees in less physically demanding jobs get injured less frequently. So, whereas private sector injury rates were nearly 5% in 2003, **Table 1** illustrates they have declined to just over 3% the last few years.

This decline has not affected all industries equally, however. As **Table 2** illustrates, injury rates in the public sector (ie, municipal employees such as police, fire, sanitation, transit and parks/recreation) are more than twice the private sector average. These are jobs that also require complex physicals, vaccinations, and drug testing. To build volume in occupational medicine, urgent care sales efforts should target employees in the highest incidence industries first, starting with municipal government employees.

The takeaway is if you're going to do occ med, focus on city police/fire, public transit, sanitation, and parks/recreation employees who have high injury rates.

URGENT CARE OCCUPATIONAL MEDICINE EFFORTS SHOULD FOCUS ON THE PUBLIC SECTOR

Table 1. Nonfatal Occupational Injury and Illness Incidence Rate, Private Sector²

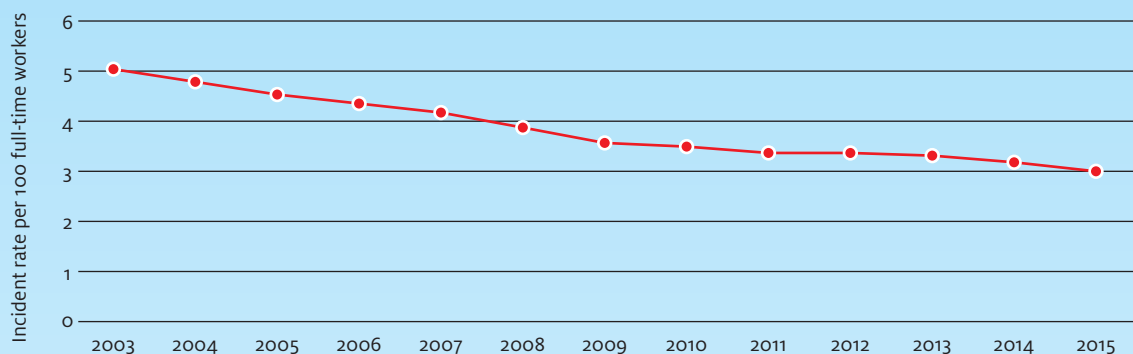
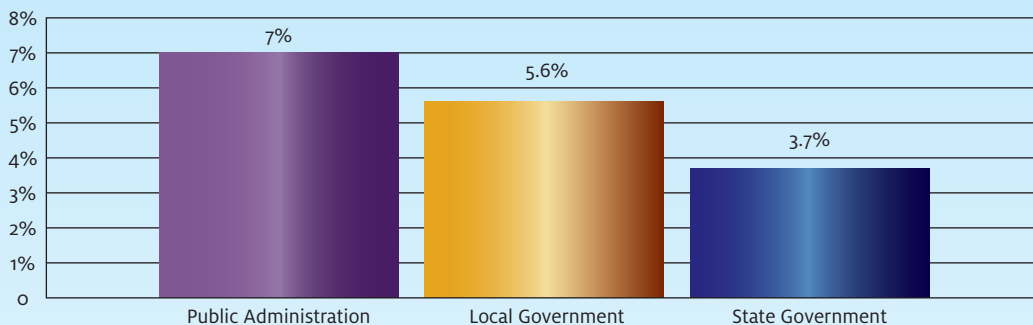


Table 2. Injury Incidence Rate, Public Sector³



1. Urgent Care Association of America. 2016 Benchmarking Study. Available at: benchmarking.ucaoa.org. Accessed February 19, 2017.

2. Bureau of Labor Statistics. Employer-reported workplace injuries and illnesses—2015. Available at: https://www.bls.gov/news.release/archives/osh_10272016.pdf. Accessed February 19, 2017.

3. Bureau of Labor Statistics – Incidence rates of nonfatal occupational injuries and illnesses by case type and ownership, selected industries, 2015. Available at: https://www.bls.gov/news.release/archives/osh_10272016.pdf. Accessed February 19, 2017.

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