Diverticulitis in the Urgent Care Setting

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The Secret of Success: Caring Is Believing

“People don’t care how much you know until they know how much you care.”

Dr. James Gore, an old friend and an urgent care pioneer, shared those words of wisdom with me during a recent conversation. We were discussing the current state of health care and the challenges we face in urgent care with the rabid market activity we are seeing. We chatted a bit about the new faces and the outside interests entering the industry, and we laughed about all the mistakes being made by people looking for a quick buck. Those of us who have been in the business long enough know how much time and attention urgent care practices require in order to function properly and effectively meet the sometimes fickle needs of our patients. We know how complex and layered this business is. We know how regional and local the dynamics are. And we have the scars to show that we have learned from our mistakes and survived against the odds.

Yet it seems like many think that the urgent care model can be deconstructed into its individual parts, and that these can be mass-produced at scale and still achieve the same results. The flaw in this approach is that its success requires rapid growth and taking advantage of efficiencies. The problem with that is the lost opportunity to learn and pivot, one step at a time. There are no shortcuts to experience, and experience is the ultimate determinant of success for any business with a complex model with thin margins.

In response to this problem, I have seen large operators take two approaches: the “smarter than thou” approach and the “talent acquisition” approach. In the first approach, investors with strong track records in operating other businesses apply methods from those businesses to scale up an urgent care company. The risk is that they grow the company too fast and make too many assumptions, tantalized by their success with other business models. Many will end up putting on the brakes and reorganizing the business in response to underperformance. Ultimately, these investors have to slow down and learn the business just like the rest of us.

In the “talent acquisition” approach, a skilled and charismatic operator (usually a physician) who has successfully built a regional network of 2 to 10 centers is hired to be the operative and leadership model for scaling up. The problem here is twofold: First, the transaction has made the seller financially comfortable and unmotivated. When your entire life savings is no longer at stake, it is human nature to slow down a bit. Second, what works for 2 to 10 centers is often not a good template for scale. A charismatic leader depends on personal interaction to influence others. Once that influence is diluted, this approach becomes much less effective. Unfortunately, for many it’s the only leadership tool they have developed. Entrepreneurs can be quite ineffective in an organizational structure where communication and management require discipline, patience, and collaboration.

This brings me back to the opening quote: “People don’t care how much you know until they know how much you care.” I can’t help but think that Dr. Gore has succinctly and eloquently summed up the secret sauce for success in urgent care. Big or small, independent or integrated, investor-owned or entrepreneurial venture, urgent care centers all have to answer to the same customer. And the core driver of consumer behavior in health care, more than any other variable, is whether the patient feels cared for. In fact, every other layer of this business is a commodity except for the care experience. You can find revenue-cycle expertise and financial and real estate know-how. Health-care operators and managers are ubiquitous, and the supply chain is full of options. But although all of these are critical functions, none of them matter to the patient. Unless you are focused relentlessly on the who and how of the care experience, you will not have sustained success in this competitive environment. Discovering how to deliver this experience, the elements that contribute to it, and the talent profiles of the people who execute it is the key to solving the urgent care riddle, regardless of how much you know.

Lee A. Resnick, MD, FAAFP
Editor-in-Chief, JUCM, The Journal of Urgent Care Medicine
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About 6 million people in the United States have a nonhealing wound, and as the population ages, that number may rise exponentially. In the first part of this two-part article, authors Nathan M. Finnerty, MD, Collin G. Kaide, MD, and Michael Weinstock, MD, write that by properly diagnosing and treating these wounds, urgent care providers have the opportunity to differentiate life-threatening illness from life-inhibiting disease and thus improve outcomes for this population.

**Diverticulitis in the Urgent Care Setting**

Abdominal pain due to acute diverticulitis is commonly seen in the urgent care setting. Much of the current treatment of this disease is in flux because it is under study, so we bring you this clinical update.

*Jilian Nicholas, DO, and Christopher Tangen, DO*

**Open-Book Management: Using Transparency and Gamification to Engage and Empower Frontline Staff**

Want to turn around employee disengagement and increase your urgent care center’s revenue? Try gamification to get your staff members feeling like part owners and to unleash their creativity in finding ways to help your center grow.

*Alan A. Ayers, MBA, MAcc*

**Pelvic Pain, Dysuria, and Back Pain in an Adolescent Female**

In treating adolescents, health-care providers must work from a broad differential that includes diagnoses common to children, those common to adults, and those unique to adolescents. It is especially important that adolescents be given time to speak with their providers without their parents in the examination room.

*Joshua T. Bautz, MD, LT, MC, USNR*
Editor-in-Chief Lee Resnick writes that with all of the changes in health care in general and in urgent care in particular, some appear to think that the urgent care model can be deconstructed into its individual parts and reassembled to create large-scale entities. But the unique mix of each urgent care center with its local culture means that such a thing is not possible. The core driver of consumer behavior in health care is whether the patient feels cared for. Thus, unless urgent care operators maintain focus on the who and how of the care experience, they will not succeed over the long term in this competitive environment.

Diverticulitis affects more than 40% of the Western world and approximately 74% of patients older than 80 years. Jillian Nicholas, DO, and Christopher Tangen, DO, explain how to differentiate between uncomplicated and complicated forms of the condition, and they provide a clinical update on disease management.

Nicholas is a traditional rotating intern with a surgical focus at UH Regional Hospitals in Richmond Heights, Ohio. Tangen is a specialist in sports medicine as well as Program Director of the Traditional Rotating Internship at UH Regional Hospitals.

Staff members who are emotionally invested in their work can hugely improve both the patient care experience and the bottom line of urgent care centers. How do center owners engender that level of personal investment? One popular tool is an open-book management style called the Great Game of Business. In our Practice Management section, author Alan A. Ayers, MBA, MAcc, explains how and why it works.

Ayers is Practice Management Editor of the Journal of Urgent Care Medicine, a member of the board of directors of the Urgent Care Association of America, and Vice President of Strategic Initiatives for Practice Velocity, LLC.

Author Joshua T. Bautz, MD, LT, MC, USNR, writes that treating adolescents requires finesse. First, some diagnoses are unique to this group of patients in comparison to children and adults. Second, adolescents may not provide all of the details pertinent to their medical history if they are not given time to speak with a health-care provider without their parents present.

Bautz is finishing his final year of postgraduate residency in emergency medicine at Vanderbilt University Medical Center in Nashville, Tennessee.

Also in this issue:

In Health Law and Compliance, Ron Lebow, JD, discusses prohibition by state laws of the doctrine of the corporate practice of medicine, and how business arrangements to skirt those laws may present substantial legal risks to providers.

Lebow is a New York–based transaction and regulatory counsel for Michelman & Robinson, LLC, focused on business, contract, corporate, and regulatory matters affecting hospitals, urgent care centers, and individual physicians across the United States.

Sean M. McNeely, MD, and the Urgent Care College of Physicians review new reports from the literature on the large percentage of clinical trials for which findings remain unpublished and the effect of lack of access to that data on patient care, the use of an intranasal nonsteroidal anti-inflammatory drug in pain treatment, the risk of myocardial infarction in older patients with influenza, teething toddlers who have fever, trimethoprim-sulfamethoxazole (TMP-SMX) in treating abscesses, whether to give codeine to children, the effectiveness of gout treatments, and TMP-SMX in methicillin-resistant Staphylococcus aureus.

In Coding Q&A, David Stern, MD, CPC, discusses fractures: codes for initial and follow-up treatment, codes for treatment of sequelae, and what services and supplies are billable.

Our Developing Data column provides statistics on which months were the busiest for patient visits to U.S. urgent care centers in 2014.

To Submit an Article to JUCM

JUCM, The Journal of Urgent Care Medicine encourages you to submit articles in support of our goal to provide practical, up-to-date clinical and practice-management information to our readers—the nation’s urgent care clinicians. Articles submitted for publication in JUCM should provide practical advice, dealing with clinical and practice-management problems commonly encountered in day-to-day practice.

Manuscripts on clinical or practice-management topics should be 2600 to 3200 words in length, plus tables, figures, and references. Articles that are longer than this will, in most cases, need to be cut during editing.

We prefer submissions by e-mail, sent as Word file attachments (with tables created in Word, in multicolumn format) to editor@jucm.com. The first page should include the title of the article, author names in the order they are to appear, and the name, address, and contact information (mailing address, phone, fax, e-mail) for each author.

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FROM THE CHIEF EXECUTIVE OFFICER

National Urgent Care Awareness Month: May 2016

P. JOANNE RAY

Celebrate National Urgent Care Awareness Month in May by drawing attention to the role of urgent care and helping your community determine where best to go when medical attention is needed. The month’s focus is on educating payors, media, and the public on when to seek medical treatment at an urgent care center versus a hospital emergency department, a freestanding emergency department, or a retail center.

UCAOA has created the following resources for you at www.ucaoa.org/?UCAwareness:

- Download the UCAOA members’ media toolkit, which contains customizable media materials, helpful talking points, reference guides, outreach materials, and more.
- Customize the UCAOA press release “Urgency or Emergency? The Wrong Answer Could Be Costly” (www.prweb.com/releases/2016/02/prweb13226182.htm). Deploy this information to the resources within your own communities to help reinforce the important role your urgent care center plays in providing the best, most affordable patient care at times most convenient to them and to increase awareness of our vital industry.
- Reinforce the press release with the “Urgency or Emergency?” infographic at http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/Media/UCAOA-Infographic-UCvsER_FIN.pdf, which helps to explain to patients when to head for an urgent care center for treatment.
- Post this year’s flyer (http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/National_Urgent_Care_Awareness_Month_/UCAOA-NatlUCAAwareness-flyer_.pdf) in your urgent care center or repurpose it as an ad to run in local publications.
- Add Urgent Care Awareness banners (http://www.ucaoa.org/?ucawarenessbanners) to your website, to your social media pages, and even as an e-signature to your emails.
- Share “The Healthcare Industry’s Urgent Need for Urgent Care” (http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/Infographics/UCAOA-UrgentCareInfographic_.pdf), an infographic explaining the important role that urgent care centers play in keeping up with the everyday needs of the growing patient base. Distribute this to community groups and schools and ask them to share it with their constituencies.

The month is also a great opportunity to recognize your team members for their contributions. We encourage you to not only offer your thanks but also share valuable educational resources to advance patient care. Look for discounts on featured urgent care webcasts in the UCAOA Online Store in May!

If your center has a group membership, make sure you have provided your roster to the UCAOA so that everyone on your team has access and is aware of all the benefits afforded to them through your membership. If their names are not on file with the UCAOA, they will not be able to use benefits such as our online networking groups, helpful articles, tips in our weekly e-newsletter, and dozens of other online resources.

P. Joanne Ray is Chief Executive Officer of the Urgent Care Association of America. She may be contacted at jray@ucaoa.org.
Introduction
Abdominal pain commonly presents in the ambulatory setting, in anywhere from 1.5% to 8% of patients.\(^1,2\) With diverticulitis being a common diagnosis in the presence of abdominal pain, the clinical challenge in an urgent care setting is determining uncomplicated from complicated diverticulitis.

Diverticulosis
French pathologist Jean Cruveilhier described diverticulosis in 1849 as “bands of longitudinal muscle fibers in the sigmoid, a series of small, dark, pear-shaped tumors, which are formed by hernia of the mucous membrane through the gaps in the muscle coat.” Diverticula are described as outpouchings of mucosa and submucosa through the muscular layer of the colon (Figure 1) that arise in anatomic weaknesses within the bowel wall, such as areas where blood vessels penetrate into the wall.\(^3\)

In the Western world, the prevalence of diverticulosis is thought to be approximately 30% to 40% of the population,\(^4\) although that is likely an underestimate, because most patients have asymptomatic disease.\(^3\) During colonoscopy, diverticulosis is the most commonly noted finding, seen in approximately 42.8% of all colonoscopies and up to 74.1% in patients older than 80 years.\(^3\)

Diverticulitis
Up to a quarter of patients with diverticulosis develop diverticulitis.\(^4\) The term diverticulitis means that a diverticulum has become inflamed and infected, resulting in microperforation. The most common presenting symptoms of acute diverticulitis include abdominal pain and fever.\(^5\) Hospitalizations for diverticulitis represent 150,000 admissions and 24,000 elective surgical procedures per year in the United States. Multiple microbes, including both anaerobic and facultative bacteria, commonly contribute to the infectious etiology in diverticulitis. The most commonly suspected organisms are \textit{Bacteroides}, \textit{Prevotella}, and \textit{Escherichia coli}.

\textit{Clinical}

\textbf{Diverticulitis in the Urgent Care Setting}

\textbf{Urgent message:} Abdominal pain due to acute diverticulitis is commonly seen in the urgent care setting. This is a clinical update on the management and treatment of acute diverticulitis.

\textbf{JILIAN NICHOLAS, DO, and CHRISTOPHER TANGEN, DO}

\textit{Jilian Nicholas, DO, is a traditional rotating intern with a surgical focus at UH Regional Hospitals in Richmond Heights, Ohio. Christopher Tangen, DO, is a specialist in sports medicine as well as Program Director of the Traditional Rotating Internship at UH Regional Hospitals.}
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DIVERTICULITIS IN THE URGENT CARE SETTING

Peptostreptococcus, Enterobacteriaceae, viridans streptococci, and enterococci.4 Diverticulitis is categorized as uncomplicated or complicated according to whether there is an abscess or fistula, obstruction, or free perforation.6

Pathogenesis of Diverticulitis
Until recently, the pathogenesis of diverticulitis was thought to be obstruction of the neck of the outpouching diverticulum with a fecalith, which subsequently causes overgrowth of bacteria, inflammation, and eventually perforation with inflammation to surrounding structures. Recently, however, researchers have postulated that a change in the microbiota causes an alteration in immunity of the mucosa and results in chronic inflammation. Local infections caused by microperforation that result in formation of a small abscess can often be contained. However, with larger abscesses secondary to macroperforation, more serious complications can ensue, including peritonitis, fistula formation, and systemic symptoms.8

History of Present Illness
When you suspect that a patient has diverticular disease, it is important to ask about the following:
- Dietary habits
- Systemic symptoms
- Significant comorbid conditions
- Immunocompromise
- Localization of pain, and any radiation
- Previous colonoscopy

Physical Examination
Common presenting symptoms of diverticulitis include the following7:
- Abdominal pain in the left lower quadrant, which is present in 93% to 100% of patients with the disease
- Fever, present in 57% to 100%
- Leukocytosis, present in 69% to 83%

These are additional signs to look for during examination4:
- Guarding
- Rebound tenderness in the left lower quadrant
- Tenderness in the suprapubic area
- Hypoactive versus normal bowel sounds
- Palpable abdominal mass
- Fecaluria or pneumaturia, with fistula formation from the colon to the bladder
- Feces or flatus through the vagina, with fistula formation from the colon to the vagina

The differential diagnosis for diverticulitis includes the following:
- Irritable bowel syndrome
- Inflammatory bowel disease
- Carcinoma of the colon
- Endometriosis
- Ischemic colitis
- Infections
- Lactose intolerance
Making the Diagnosis

The diagnosis of diverticulitis is commonly made after clinical evaluation of presenting symptoms. Surprisingly, approximately half of the patients in whom the diagnosis of diverticulitis is made solely by clinical presentation do not actually have the disease and are later found to have different diseases. Imaging studies aid in the diagnosis of diverticulitis and help categorize severity of disease. The American College of Radiology suggests computed tomography (CT) as the initial diagnostic imaging modality (Figure 2) for patients presenting with left lower quadrant or right lower quadrant abdominal pain. Both CT and ultrasound are used to evaluate diverticulitis, but CT is preferred, especially because it has been shown to be highly sensitive (97%) and highly specific (100%) (Table 1). However, ultrasound can rival the accuracy of CT when used by experienced operators. Conventional radiology has poor diagnostic value and is not recommended for evaluating potential causes of abdominal pain.

Treatment

Outpatient Therapy Versus Inpatient Therapy

Outpatient treatment is recommended in the initial treatment for uncomplicated diverticulitis. It is also justifiable for diverticulitis with a peridiverticular abscess of <5 cm. Inpatient therapy for uncomplicated diverticulitis should be considered in patients who cannot tolerate oral hydration, who require narcotics, or whose condition does not improve despite outpatient therapy. Patients with complicated diverticulitis, such as the following, should be transferred to a hospital for treatment: elderly patients, immunocompromised patients, and those with significant comorbidities, peritonitis, fistula, or large or distant abscess formation (Tables 2 and 3).

Antibiotics

The use of antibiotics in the treatment of acute diverticulitis is currently being challenged. Theories about causes of diverticulitis now focus on inflammation rather than infection, bringing into question the benefit of antibiotic use. Recently, two randomized controlled trials and two systematic reviews of data on hospitalized patients with CT-diagnosed uncomplicated diverticulitis concluded that there was no clear benefit from antibiotic therapy. The studies focused solely on inpatient treatment of uncomplicated diverticulitis, and therefore their results cannot be generalized to the treatment of complicated diverticulitis or diverticulitis in the outpatient setting. Because of that limitation and the narrow population analyzed, the American Gastroenterological Association (AGA) recommends individualizing the use of antibiotics in select patients instead of routinely prescribing it in acute uncomplicated diverticulitis. Outpatient treatment
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Presented by: KONICA MINOLTA
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of acute uncomplicated diverticulitis without the use of antibiotics has not been investigated.6

Patients with complicated diverticulitis should still receive antibiotics and inpatient treatment (Table 4). Such patients include those who are immunosuppressed, are pregnant, have signs of systemic inflammatory response syndrome or sepsis, or have significant comorbid disease.

Recommended Follow-Up

Most patients with acute uncomplicated diverticulitis can follow up with their primary-care physician for monitoring of symptom resolution. If patients are prescribed antibiotics in an urgent care center, they should see their primary-care physician within 3 to 5 days. If their condition does not improve with conservative treatment or if symptoms worsen, they should follow up with their primary-care physician sooner or return to the urgent care center.

In addition, if there is concern about a possible underlying neoplasm not identified on CT images, a colonoscopy can be helpful in ruling out neoplasms. These patients should be referred to a gastroenterologist for colonoscopy. According to the AGA, a colonoscopy is recommended after an acute episode has resolved, to exclude underlying colorectal neoplasms. Colonoscopies are usually scheduled 6 to 8 weeks after an acute event, although optimal timing has not been established.6

Some patients may need consultation with a general surgeon for treatment of diverticulitis. The current standard of care recommends offering elective surgical resection to patients with more than two episodes of diverticulitis. In the past, surgical management was considered a reasonable treatment option. However, recent study findings have challenged this belief. The American Society of Colon and Rectal Surgeons suggest making the decision to use surgery on a case-by-case basis. It is important to weigh the risks and benefits of surgery and to keep in mind the possible complications, such as infections, anastomotic leak, and cardiovascular or thrombotic events.8 Up to 10% of patients who undergo resection have complications.6

These are important factors to consider when referring a patient with diverticulitis to a gastroenterologist:

- The timing and completeness of prior colonoscopy
- Comorbidities
- Persistent symptoms of abdominal pain or diarrhea
- Patient preference

These are important factors to consider when referring a patient for surgery:

- A history of two or more episodes of diverticulitis (the current standard of care)
- A lack of improvement with conservative treatment
- Generalized peritonitis or severe systemic symptoms
- The presence of immunocompromise
- Uncontrolled bleeding (without spontaneous cessation after administration of 4–5 U of packed red blood cells)

Prevention of Recurrent Acute Episodes

Nuts and Seeds

It has long been thought that intake of nuts and seeds provokes acute attacks of diverticulitis, but this is now being questioned. In 2008, approximately 47,000 U.S. men with diverticulosis were enrolled in an observational study that followed the subjects for 20 years. The study reported no increased risk of diverticulosis or complications in men who ingested nuts, popcorn, and seeds. Surprisingly, men who consumed either nuts or popcorn multiple times a week had a decreased risk for complications.9 Outside of that large observational study, data regarding consumption of these items are scarce. Therefore, the AGA advises that it is not necessary for patients with diverticulitis to avoid nuts and popcorn.6

Table 4. Outpatient Antibiotic Regimens (7–10 Days)

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Ciprofloxacin, 500 mg orally twice a day, and metronidazole, 500 mg orally three times a day</td>
<td></td>
</tr>
<tr>
<td>Amoxicillin-clavulanate, 875/125 mg orally twice a day</td>
<td></td>
</tr>
<tr>
<td>Cephalexin, 500 mg orally twice a day, and metronidazole, 500 mg orally three times a day</td>
<td></td>
</tr>
<tr>
<td>Trimethoprim-sulfamethoxazole orally four times a day, and metronidazole, 500 mg orally three times a day</td>
<td></td>
</tr>
<tr>
<td>Clindamycin, 450 mg orally four times a day</td>
<td></td>
</tr>
</tbody>
</table>


“If patients are prescribed antibiotics in an urgent care center, they should see their primary-care physician within 3 to 5 days. If their condition does not improve . . ., they should follow up with their primary-care physician sooner or return to the urgent care center.”
Mesalamine
The AGA also addresses the use of mesalamine in the prevention of recurrence. Multiple randomized controlled trials have been conducted with the primary end point being patients free of diverticulitis recurrence. Even though study results were conflicting, the majority of the studies did not find that mesalamine worked superiorly to placebo for preventing recurrence. The AGA currently suggests not using mesalamine for prevention of recurrence.

Rifampin
Rifampin is not currently recommended for recurrence prevention. Multiple studies showed a decrease in recurrence but did not show statistical significance, and thus more research is needed.

Probiotics
Probiotics are not recommended by the AGA at this time. Small studies with probiotics did show a reduction in recurrence, but it was not statistically significant. Owing to changing theories regarding the etiology of diverticulitis and the role that the individual microbiome plays, further studies are needed to clarify the potential of probiotics.

High-Fiber Diet
It has long been implied that a high-fiber diet will prevent diverticulosis and episodes of diverticulitis, and therefore physicians commonly recommend such a diet. Researchers who conducted an observational study of patients without known diverticular disease who had experienced their first episode of diverticulitis concluded that a high-fiber diet reduced the risk of recurrence. The AGA also references one small study that showed reductions in complications and surgery in patients with a high-fiber diet. Although the data are insubstantial for proving high fiber intake to be beneficial, the AGA does not believe that fiber intake poses any risks, and it therefore suggests fiber intake for patients with a history of diverticular disease. It is important to discuss the adverse effects of increased fiber intake, such as abdominal bloating, with patients.

Physical Activity
Vigorous activity should be considered as a possible preventative for recurrence. An observational study of approximately 47,000 men showed a decreased risk of recurrence in those with vigorous activity levels.

Nonsteroidal Anti-inflammatory Drugs
The AGA suggests avoiding use of nonsteroidal anti-inflammatory drugs (NSAIDs) in patients with previous episodes of diverticulitis. This evidence is extrapolated from observational studies that showed an increased risk of occurrence. However, even though aspirin is an NSAID, the AGA recommends against advising patients to avoid its use, because the added benefit of aspirin use is greater than the risk of a diverticular episode.

Conclusion
Diverticulitis is a common cause of abdominal pain that presents in urgent care facilities. Much of the current treatment of diverticulitis is in flux, being under study, and thus AGA guidelines are conditional and based on current low-quality evidence. Additional research is necessary to provide evidence for the practices we follow. The current recommendation is to treat acute uncomplicated diverticulitis in an outpatient setting. Patients with complicated diverticulitis, including those with significant comorbidities, immunosuppression, or peritoneal signs, and those with evidence of fistula, abscess, or perforation, should be transferred to a hospital for treatment.

References
“It’s the most important part of the job. Turnaround time is fun and technology is cool, but at the end of the day it’s all about patient care.”
-Dr. David Cohen, Founding Radiologist, Teleradiology Specialists

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Open-Book Management: Using Transparency and Gamification to Engage and Empower Frontline Staff

Urgent message: Urgent care operators can cultivate a sense of ownership using the techniques of open-book management, which entails teaching frontline staff members how a business makes money and turning the process of increasing profits into a game.

ALAN A. AYERS, MBA, MAcc

Introduction

Urgent care requires dedicated, engaged, and focused frontline staff members to deliver the types of patient experiences that spur repeat visits and positive word of mouth. Yet a Gallup poll conducted in 2014 showed that a paltry 32% of U.S. workers are truly engaged in their jobs. That means that more than two-thirds of America’s workforce is simply going through the motions—which engagement experts have clearly demonstrated has a damaging effect on a company’s bottom line.

This widespread disengagement was found to be especially prevalent among groups such as general laborers and customer-facing, or frontline, staff members, because they often perform the most physically and emotionally taxing duties while receiving the lowest pay. For an urgent care operator, likely dealing with slim margins already, a disengaged staff can have serious

Alan A. Ayers, MBA, MAcc, is Vice President of Strategic Initiatives for Practice Velocity, a member of the Board of Directors of the Urgent Care Association of America, and Practice Management Editor of the Journal of Urgent Care Medicine.

financial implications. General employee engagement levels, as they relate to their respective returns on salary, are illustrated by data from Human Capital Institute, a global talent management agency, in Table 1.

The hard truth of this staggering finding is clear: Essentially, the difference in value between a fully engaged employee and a disengaged employee is roughly double in terms of motivation, productivity, efficiency, accountability, and overall performance. It is why organizations readily spend millions on engagement experts; they know the numbers, and they know how dramatically an engaged-employee culture could potentially lift their companies.

But despite their sometimes massive price tags, not all employee engagement strategies originate from corporate boardrooms or focus groups. In fact, one of the most successful engagement philosophies was born at a struggling engine-remanufacturing plant in Springfield, Missouri.

### Introducing the Great Game of Business

In 1983, a plant manager named Jack Stack raised $100,000 with the help of his partners, and then borrowed $9 million more, to purchase Springfield ReManufacturing Corp. (SRC). At the time, SRC was a struggling division of International Harvester with slim prospects of survival. Although the plant was engulfed in financial problems, internal labor strife, and low morale, Stack and his partners knew that if they could somehow tap into the employees’ collective knowledge, they had a chance to turn things around, save jobs, and make the plant flourish.

But they had seen that the traditional top-down, hierarchical management style was not going to work, so they came up with something novel: Open the books, teach employees how the business makes money, and turn the process of increasing profits into a game of sorts. Although it took them some time to refine and tweak the game, it turned out to be wildly successful. In a few short years, SRC’s revenue doubled, earnings quadrupled, and the debt-to-equity ratio shrank from an unwieldy 89 to 1 to a respectable 5 to 1. Morale and engagement levels skyrocketed, and turnover, absenteeism, and the number of product defects plummeted. All of this was made by possible by their creation of an open-book management style they dubbed the Great Game of Business (GGOB).

### Keys to the Game

Today, GGOB principles have been adopted by thousands of organizations, from Fortune 500 giants to freshly minted start-ups. Although space does not per-
mit an in-depth description of the GGOB here, the key concepts of the game can be summarized thusly:

- **Provide full transparency**: A GGOB company must open the books and show the company’s financial standing to its employees, regardless of whether the numbers are up or down. Leadership does not worry about competitors learning their financial numbers, because GGOB leaders understand that the competition cannot easily replicate their superior employee culture, collective know-how, and best practices.

- **Teach how the numbers translate**: The line items on the income statement do not matter much if employees do not understand them or grasp how their daily work influences these numbers. A GGOB company first teaches financial literacy to its employees, and then it shows employees exactly how their individual work or department moves the numbers up or down.

- **Keep score**: Once the numbers and their relation to employee output is understood, then goals to improve the numbers are implemented (Sidebar 1). This is done with scorecards, dashboards, and weekly huddles that help track and forecast the critical numbers (Sidebar 2), often in real time.

- **Make it a game**: One of the keys to Stack’s original concept was his understanding that people love games, so he applied the elements of a game—rules, teams, scores, results—to the daily operations of SRC. Of course, the games had various prizes that SRC’s employees valued, keeping them competitive, engaged, and motivated to push their teams and departments to victory.

- **Give employees a stake in the game**: This might be the most important factor in making the GGOB work. Through the disbursement of awards, recognition, gifts, and generous financial incentives like quarterly cash bonuses if their work games resulted in the company’s hitting its revenue targets, a dramatic shift took place. SRC’s employees were no longer just paid workers; they became de facto part owners in the company. This transformation from employee to part owner
unleashed unprecedented levels of accountability, innovation, performance, creativity, and unity. Employees understood that their daily work mattered and that they were a vital part of the company.

Of course, none of these principles would work if the prevailing culture did not support them. Hence, Stack, his partners, and SRC management made it a priority to tear down bureaucratic walls, boost morale at every opportunity, and have some fun. This included initiatives like encouraging shopworkers to paint their machines, hosting company fishing tournaments, and handing out turkeys at Thanksgiving. And it worked. SRC employees were so engaged that they began to take the reins unprompted, developing budgets and seeking out ways to reduce expenses.

**What Can Urgent Care Learn?**

As GGOB principles became more widespread, they were proven to be applicable to companies of virtually any size, across a multitude of industries. How might an urgent care operator, wrestling with many of the same employee engagement issues that plague the majority of American businesses, implement certain GGOB principles in their own operation? Of course, a medical clinic is not the same as an engine plant, so naturally there will be differences in scope and implementation. There are indeed principles, however, that will translate:

**Build Financial Literacy**

Urgent care staff, from physicians to front-desk specialists, should have a basic understanding of the income statement—in particular, the operating income. Operating income is critically important because it most accurately reflects how management drives revenue and controls expenses. The next step is to tie operating income line items to key performance indicators (KPIs), which helps to bring the numbers into a context that staff members understand. These KPIs should be in line with both urgent care industry benchmarks and the clinic’s size and scope of services, and they can include but are not limited to the following:

- **Days to bill and days in accounts receivables:** It is an urgent care truism that billing and collections are the lifeblood of any clinic, because you cannot meet payroll and other expenses with accounts receivable. Accounts receivable must eventually be converted to cash.
- **Evaluation and management code distribution:** Inconsistent coding will cause revenue fluctuations. Evaluation and management coding reflects the complexity of patient visits and directly translates to the compensation you receive. Although upcoding brings with it its own problems, undercoding due to incomplete or inaccurate documentation lowers reimbursements, which is essentially leaving dollars on the table.
- **First-pass resolution rates:** Above-average first-pass resolution levels indicate that claims have been documented, coded, and billed correctly. This is a clear indication of the cleanliness (i.e., completeness) of claims, which of course reduces resubmissions and delayed reimbursements.

These are but a few of the dozens of KPIs and metrics that urgent care management teams should track to gauge the health of their operation and identify trouble spots. But again, GGOB principles dictate educating staff on the financials so that they can see where their daily

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**Sidebar 2. Open-Book Management Begins with Defining a Critical Number**

In the Great Game of Business, a **critical number** or **wildly important goal** is the one thing that

- At any given time is going to have the greatest impact on the business
- The business must achieve in order to succeed or survive
- Clearly defines winning

Critical numbers must be measurable in order for teams to show progress. They are determined by performing a 360-degree appraisal of the business that addresses the following perspectives and data sources:

- **Financial perspective:** Historical financial statements, financial goals, industry financial benchmarks, and financial trends
- **Marketplace perspective:** Customer surveys, sales and marketing plans, competitive information, market growth, and customer and marketing intelligence
- **Management perspective:** Management interviews, management surveys, and strategic planning meetings
- **Employee perspective:** Employee interviews, employee surveys, and operational planning meetings

Market-based sales plans and supporting budgets are used to create pro forma financial statements for identifying the critical number. Once the critical number is identified, weekly huddles are held to share information from scoreboards that show the status of the critical number. When the critical number improves, wins occur and team members celebrate and are rewarded financially.

work impacts the pertinent KPIs, which in turn show up on the income statement.

Play the Game
When your staff knows and understands the numbers, then you can play games to improve them. Teams, rules, work groups, strategic decision-making, cross-training, fun prizes, scorecards, and dashboards are all key elements of the GGOB, and you can use them to foster a clinic-wide ethos of teamwork and accountability. When people go from being told what to do to being decision-makers, their level of ownership of the end result increases, and the company benefits all around.

Reward Success
Although a typical urgent care clinic is limited by the doctrine of corporate practice of medicine and anti-kickback statutes in what it is legally allowed to do as far as employee equity participation, there are still ways to reward staff members so that they feel they have a true stake in the game. Some common rewards include

- Paid time off
- Catered lunches
- Team outings off-site (athletic event, theater performance, or other group activity)
- Gift cards (restaurants, big-box retailers)
- Vouchers or certificates for services (manicures, massages)
- Commemorative plaques, trophies, awards, and certificates

A key point to remember with a reward system is that prizes should be given out regularly. GGOB businesses compensate winners of their business games as often as feasible, never going longer than quarterly disbursement. This frequency keeps everyone motivated and vested because the prize is never far enough in the future that they lose focus.

Conclusion
The GGOB began with one primary goal: to create a simple, straightforward, and replicable approach for harnessing the collective knowledge, experience, and common sense of employees, and then unleash it to improve the company. When the process is done correctly, the gains in efficiency, teamwork, profitability, and culture can literally transform a company.

Experts who have studied the GGOB suspect that beyond the rewards and bonuses, what really engages employees is being asked to participate in the big decisions on how to improve an aspect of business operations. This sense of empowerment and respect transforms the way employees see themselves and effectively unlocks levels of creativity, innovation, and problem-solving that would have otherwise remained dormant. After all, the person who performs the job every day understands it best.
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New urgent care EMR technology breaks the speed barrier

By: Dorothy Wallheimer

The fastest urgent care EMR just got faster with the launch of Chartlet.

The newest release in Practice Velocity’s award-winning electronic medical record offers one-click charting functionality to urgent care providers. It means charting on VelociDoc can be completed for many visits in about one minute.

“Since the beginning we’ve always had the dream of making the EMR faster than paper,” said David Stern, MD, CEO of Practice Velocity. “And even before Chartlet our clients have told us we were succeeding. Chartlet takes speed to the next level.”

Stern said he envisioned Chartlet almost 10 years ago when VelociDoc was first being developed.

“It’s taken time to make it a reality, but the launch represents a real evolutionary breakthrough in EMR technology and speed,” he said.

Chartlet is a tab that will appear within the EMR software and be accessible for about 80 percent of urgent care center chief complaints. When a patient comes in complaining of sore throat, sinus congestion, painful urination, cough/chest congestion, or back/muscle pain, the provider can use a single Chartlet template designed specifically for that issue.

“This is going to bypass everything else in the chart,” explained Sharon Thomas, Product Owner in Research & Development at Practice Velocity. “It’s just real slick and easy.”

“Any tests or other items ordered during a patient visit show up in real time in Chartlet,” Thomas said. “Providers can still work fast in the old view in VelociDoc, but they have to click back and forth between tabs. Now it’s all visible on one screen.”

David Stern, MD, CEO of Practice Velocity

“It’s certainly made the charting experience not only a friendly experience, but also streamlined. It’s the fastest charting solution I have ever reviewed.”

The Practice Velocity team studied more than 100,000 patient visits before starting development of the Chartlet feature. That research allowed them to focus in on the five most common conditions for the initial Chartlet launch. More will be developed, and the company ultimately expects providers to be able to design their own Chartlets for any conditions most common to their practice.

Evan Dapo, PA-C, who works at MedAccess Urgent Clinics in Raleigh, North Carolina, is a product software consultant and reviewed Chartlet. He’s worked on multiple EMR platforms and helped during the development of Chartlet.

“It’s certainly made the charting experience not only a friendly experience, but also streamlined. It’s the fastest charting solution I have ever reviewed,” Dapo said.

Comparing his work on Practice Velocity’s VelociDoc with other EMRs, Dapo said: “It’s not even a close comparison as to how quickly I can make it through the more traditional urgent care visits. And that’s not even just the Chartlets themselves; it’s Practice Velocity’s software.”

“Chartlet versus the competition,” Dapo said, “it’s just night and day.”
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Discover Chartlet.

Practice Velocity’s #1-rated urgent care EMR now includes Chartlet, a single-page charting option allowing providers to move even faster through documentation. We’re talking patient charts completed in 1 minute. And chartlet covers roughly 80 percent of urgent care chief complaints.

If less clicking through tabs and more time treating patients sounds good to you, it’s time to try Chartlet.

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Corporate Practice of Medicine: Could Your Current Operating Structure Be at Risk?

Ron Lebow, JD

Urgent message: State laws prohibiting the corporate practice of medicine are often skirted by business arrangements that segregate a professional entity from a management company, but these arrangements can still pose significant risks to providers unless specific steps are taken to ensure the segregation of clinical and management activities.

Introduction

The corporate practice of medicine doctrine dates back to the inception of physician licensure laws. The tenet is derived from the legal requirement that only a licensed physician can practice medicine. Although our system has evolved since physicians first began to practice, requiring significant capital investment, business acumen, and administrative attention, this doctrine is still alive as a basis for imposing risk on parties to a deal between investors, management providers, and licensed professionals.

Risks

Providers, to skirt corporate practice of medicine laws, have historically created a legal structure in which a physician-owned professional entity contracts with a non-physician-owned management company. The professional entity passes all revenue through to the management entity. But there are significant risks with this arrangement, including the following:

- Physicians engaged in so-called doc-in-a-box relationships, where they are viewed as lending their license to business companies and acting in essence as glorified employees, can risk loss of their license.
- The business parties themselves risk actions by states’ attorneys general, who can use the violation to prosecute consumer fraud, impose significant fines, and even threaten criminal prosecution.
- Health-care payors can use the doc-in-a-box structure as a means to seek repayment under fraud-related allegations, particularly in the no-fault and workers’ compensation realm, where such allegations are becoming standard.
- Additionally, civil litigants can sue the management company and attempt to hold it responsible for malpractice injury, arguing that profit incentives resulted in inappropriate clinical decision-making. They justify such actions out of concern that the manager will exercise excessive control or pressure over the practice, directly impacting patient care, professional decision-making, and product and service recommendations, including those resulting in unnecessary service use.

In some cases, the management vehicle entity is also owned by a physician founder—but make no mistake, these same risks are still relevant to the founder’s business entity to the extent that it is engaged with other physician-practice entities.

Factors Indicative of a Violation and Remediation Strategy

Illegally Splitting Income from Patients and Payors Through Profit Sharing

The cornerstone of a doc-in-a-box argument is that the physician is not the master of their own domain and is not entitled to reap the full reward of their own practice—their own...
The right to hire and fire is proof positive of business control or pressure over the practice. The physician may be fearful, however, that such high initial charges will result in waiting too long for their own profit opportunity while the debt mounts. To alleviate this fear, because the parties rely on each other for mutual viability, the manager, as a creditor, can instead agree to wait in line, such that the physician-owner can pay themselves a certain amount of money per month after costs have been covered, and accordingly defer the profit margin (with interest accruing) until there is enough to cover it or a business sales transaction is consummated.

Wielding Undue Control over the Center’s Finances by Controlling the Bank Accounts to Which the Practice Owners Themselves Do Not Have Access
The party that controls the bank account is viewed as the true owner of the business. If the physician is locked out of the account, the violation is an easy case to make, and similarly when the money is swept from the physician account into the manager’s own account. The money should remain in the physician entity’s account, and the physician should have signatory authority over their own practice income. The manager might be granted additional signatory authority to administer payables, but if it pays itself, this could be viewed as inappropriate in some jurisdictions. As protection for the manager, collateral security should be secured over cash in the bank account, and, depending on the state’s enforcement environment, the manager might consider sweeping some specified portion of the funds into its own account to hold in the nature of a security deposit subject to replenishment. Naturally, after the investment of substantial funds and the guarantee of debt, more protection may be desired. Typically the physician practice owner will not be personally liable for any debt to the manager, with the fees payable only out of the actual profits available.

To create a disincentive against any threat to manager collateral rights, the contract might hold the physician personally liable in the limited instance that bank account funds or insurance payments are willfully diverted for the physician’s own gain. To ensure that money is available to cover the accruing debt or create a ready funding source for co-investment in future expansion when the practice goes from red to black on its financial statements, the agreement might include an obligation for the practice to maintain a minimum reserve (i.e., not distribute all practice entity profits to its owners and employees) that is based on a specified formula, to the extent of available cash. Finally, in the event of abandonment of the business by the practice, a liquidated-damages clause can be included in the agreement that allows for the manager to assess its damages against outstanding practice accounts receivable.

Controlling Hiring and Firing of Clinical Staff
The right to hire and fire is proof positive of business control and real ownership. The practice entity must retain ultimate control or pressure over the practice.

“Civil litigants can sue the management company and attempt to hold it responsible for malpractice injury, arguing that profit incentives resulted in inappropriate clinical decision-making. They justify such actions out of concern that the manager will exercise excessive control or pressure over the practice.”

Each aspect of the business relationship must be charged at a rate that is truly fair market value—a price that the market would negotiate in a bona fide arm’s-length transaction. However, the business investor may actually assume most if not all of the financial risk of the venture, with little or no capital contribution from the physician. The parties may decide to share this risk by entering into a percentage arrangement—where a percentage of profits or revenues is paid or split. In some states this is legal, provided that the percentage is justifiably fair market value, but a percentage could eventually fall outside of the range of fair market value as cash flow increases.

Percentage arrangements can also run afoul of legal prohibitions, such as the federal Anti-Kickback Statute and equivalent state laws. Accordingly, a flat annual fee or a combination of flat annual fees for various line items and variable cost charges should be used instead. The parties should also evaluate what portion of the investment constitutes a loan repayable by the physician entity, and formalize a promissory note representing the upfront lending.

Additional cash flow lending can be offered in the form of a contractual line of credit. Initial implementation charges from the manager, including recruiting, credentialing, marketing, and accounting may justifiably be very high for the first several years, but ultimately these would have to decrease for an existing site after a certain period of time as economies are established and these functions level out.
authority over the licensed professionals it hires, including the terms of employment. To protect against excessive compensation arrangements by the practice entity, covenants can be included in the management contract attesting that they will constitute fair market value. Commonly, the question boils down to whether the manager itself can fire the practice owner. In many cases the parties enter into a nominee ownership agreement, pursuant to which the business entity holds a contractual right to take away the stock in the professional entity from the physician and find a friendlier replacement to hand it to. In states that adhere strictly to the corporate practice of medicine doctrine, this is not permissible. The ability to remove someone is the greatest degree of control anyone can have to influence decisions and acts. In some states, it is only justifiable if the physician also has ownership in the management company, so that there is contractual privity between the individual owners and reasons borne out of fiduciary duty, which is essentially the obligation to act fairly to one’s business partners and the company of which one is a part. Even when a nominee ownership agreement is not permissible, making the physician practice owner also an owner in the management vehicle provides the added benefit of alignment of interests and an ability to enforce noninterference and proprietary secret covenants.

Conclusion
These are just some of the considerations and structuring options available. Over time, the corporate practice of medicine doctrine and how it is enforced should itself evolve to recognize the inherent value that business relationships and investment have to patient-care quality and cost containment. Nevertheless, clinical decision-making autonomy should always remain sacrosanct. Thus, there is a delicate balance in any such relationship.

“The party that controls the bank account is viewed as the true owner of the business. If the physician is locked out of the account, the violation is an easy case to make, and similarly when the money is swept from the physician account into the manager’s own account. The money should remain in the physician entity’s account, and the physician should have signatory authority over their own practice income.”
Case Report

Pelvic Pain, Dysuria, and Back Pain in an Adolescent Female

Urgent message: Adolescent patients present to urgent care facilities with unique needs and diagnoses. It is imperative that those who care for them be familiar with some of these diagnoses and keep in mind the importance of obtaining a full and accurate medical history and performing a thorough physical examination.

JOSHUA T. BAUTZ, MD, LT, MC, USNR


Introduction

Adolescent patients can represent unique challenges for health-care providers. In caring for them, providers must work from a broad differential, including diagnoses common to children, those common to adults, and also those unique to adolescents. Obtaining a thorough history of illness is of the utmost importance in these patients, but doing so is often especially challenging.

Case Presentation

A previously healthy 12-year-old girl presents to an emergency department (ED) with lower back pain. She is brought in by her mother. The girl is an active gymnast, but she does not report any specific trauma. Her pain is bilateral and nonradiating, and she describes it as having an intensity of 5 on a visual analog scale, on which the highest possible score is 10. It is worse with movement and when she sits up. She reports that she has not had any fever, urinary symptoms, weakness, or numbness. She reports transient relief with Tylenol.

Physical Examination

Her physical examination reveals normal findings regarding her heart, lungs, and abdomen. Her vital signs are unremarkable. She has no flank tenderness or midline tenderness, but she does show paraspinal tenderness.
over the lumbar region. She has a strength score of 5/5 on hip flexion and toe dorsiflexion, normal two-point discrimination in the upper and lower extremities, and negative findings on the straight-leg-raise test. It is noted that she has a normal gait but appears to be in pain when she moves.

**Diagnosis and Treatment**

She is given Motrin and ultimately discharged with diagnosis of musculoskeletal back strain.

One week later, the patient and her mother return to the same ED. This time, a urinalysis is done, and findings show many epithelial cells. The new diagnosis is urinary tract infection. Despite having no fever or dysuria, she is discharged home with ciprofloxacin.

When her symptoms fail to respond to the medication, she and her mother again return to the same ED. Notes indicate that the mother is angry and demands magnetic resonance imaging. The patient has benign findings on examination of the back, without any concerning neurologic symptoms. A plain film of the patient’s back is obtained, and a repeat urinalysis is done; the findings are unremarkable. The patient is interviewed without her mother present, and she reports no sexual activity, intravenous drug use, or problems at home. The family is told to follow up with their primary-care provider, but they are unable to get an appointment for several weeks.

When the pain worsens and the patient develops urinary retention, the patient and her mother present to a different ED. There, examination reveals normal vital signs but severe bilateral paraspinal back pain. A Foley catheter is ordered; however, a nurse notices abnormal anatomy when attempting to place the catheter. She alerts the ED physician. A subsequent genitourinary examination then demonstrates intact bulging blue hymen. The gynecology department is consulted, and the patient is admitted to the hospital for hynenotomy because the diagnosis is hematocolpos.

**Discussion**

Hematocolpos is the accumulation of blood in the vagina due to an imperforate hymen, a congenital condition characterized by lack of vaginal patency because of failure of canalization of the connective tissue in the hymen. Blood then accumulates behind the closed space, leading to hematocolpos (blood in the vagina), hematometra (retained blood in the uterus), and hematosalpinx (blood in the fallopian tube). Hematocolpos is estimated to occur in approximately 0.1% of female newborns. Its incidence is reported to be 1 in 2000.

The typical presentation is in a premenarchal female with cyclic lower abdominal and pelvic pain; however, the presentation can be variable. Between 40% and 60% of patients will present with urinary hesitancy or dysuria, but there are several reports of patients presenting with lower back pain. Although the physical examination is a key part of making the diagnosis of hematocolpos, it is imperative to perform pelvic and renal ultrasound imaging to confirm the underlying anatomic cause, because imperforate hymen, vaginal septum, and congenital vaginal abnormalities can all lead to the clinical symptoms of hematocolpos, and renal anomalies may be associated with genital anomalies.

The treatment for this condition is surgical intervention with hynenotomy. Failure to make the diagnosis leads to further accumulation of blood more proximal in the genitourinary system, including hematosalpinx. The presence of this blood is believed to destroy ciliary action in the fallopian tubes and can lead to adhesions and ultimately to endometriosis and decreased fertility.

This case is a difficult one both because the ultimate diagnosis, hematocolpos, is a rare diagnosis and because the presenting symptom, back pain, is an atypical presentation of this problem. Additionally complicating the care of this patient is that making the diagnosis relies on obtaining a sexual history and performing a genitourinary examination on a member of a population many of us are uncomfortable with—the preteen patient presenting with his or her parents.

Although performing a genitourinary examination on every patient presenting with back pain is not only impractical but also unnecessarily invasive, there are important take-home points from this case. Perhaps the most important of these is that adolescents are not the same as children. It is imperative to build time into your interview for a discussion with them separate from the parents. Because of this, the importance of obtaining an accurate sexual history cannot be overstated. It is only
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speculation, but one could argue that the key in making the diagnosis in this case earlier would have been in obtaining two essential pieces of the medical history early on—cyclical pain and lack of menstrual bleeding—and connecting them, allowing this process to lead you to performing a genitourinary examination.

In reality, however, hematocolpos is most often diagnosed in an ED on subsequent visits. Accordingly, two additional learning points from this case deal with subsequent patient encounters. When a patient presents a second time—or, as in this case, even a third time—additional and different items in the workup are indicated. In this case, we see the same workup (urinalysis and lumbosacral x-rays) being repeated. The findings from the patient’s medical history and physical examination do not argue for the use of magnetic resonance imaging that the patient’s mother had insisted on. The patient has no red flag back-pain signs or symptoms.

In a young gymnast with these examination findings, spondylolisthesis would also be a likely diagnosis, one that could be missed with a plain film and could be found more accurately with computed tomography; however, computed tomography was also not done or discussed. Interestingly, however, the patient’s examination findings were not even entirely consistent with the initial diagnosis of musculoskeletal back pain. She had negative findings on the straight-leg raise, and her symptoms did not diminish even though she refrained from gymnastics practice.

In a patient presenting multiple times with the same complaint without a clear diagnosis, something different must be done. In this case, if the examination findings do not support additional imaging or laboratory testing, that something different may only have to be obtaining additional age-focused medical history or conducting an additional physical examination. In a patient, she would have benefited from more timely follow-up, and yet the patient’s mother reported that they were unable to get an appointment with the primary-care provider for weeks. In a patient with an unclear diagnosis, this is not an appropriate time frame. Perhaps if the patient had been referred to a physical therapist or sports medicine specialist more urgently, it would have been revealed that her symptoms were not consistent with a musculoskeletal etiology, and the physician could have obtained a more thorough medical history and conducted a physical examination and tests that were more appropriate.

**Conclusion**

Hematocolpos represents a rare but important diagnostic challenge in the care of an adolescent patient presenting with pelvic pain, dysuria, and back pain. The case reported here highlights several important learning points, including these:

- Adolescents should be given time to speak with their physician without parents in the room.
- Sexual histories must be obtained from adolescent patients so that appropriate treatment can be provided.
- When patients present for subsequent visits, consider obtaining a more detailed medical history and performing a more comprehensive physical examination.
- In patients returning for multiple visits, expand the differential diagnosis.
- Ensure that there is timely outpatient follow-up.

**References**

Results Unavailable for 71% of Trials

Key point: Many research findings are not easily available to clinicians.

Citation: Chen Ruijun, Desai NR, Ross JS, et al. Publication and reporting of clinical trial results: cross sectional analysis across academic medical centers BMJ. 2016;352:i637.

Researchers investigated the amount of clinical trial findings at academic medical centers that are not published and thus not easily available to clinicians. In a cross-sectional analysis of academic medical centers, the investigators used ClinicalTrial.gov to identify all trials with a completion date between 2007 and 2010 that had a primary investigator at an academic medical center. They sought the percentage of such trials for which results were displayed that were defined as publication or appearing within ClinicalTrial.gov, including double-blinded trials with more than 100 patients. Results were published within 24 months of trial completion for only 29% of the trials. If more research results were available, better patient care might be possible.

Intranasal Nonsteroidal Anti-inflammatory Drug Helpful in Pain Treatment

Key point: Another study provides an alternative to opioid analgesia.


Using patient-reported outcomes from a pain-treatment study, researchers attempted to determine patient satisfaction with pain management with a nonsteroidal anti-inflammatory drug, opiate, or both, with the opiate as breakthrough therapy. The anti-inflammatory drug was nasally administered ketorolac, and in the “both” category, the opioid was clearly defined as rescue medication. Outcomes were self-reported by telephone over a 4-day period by a total of 824 patients with musculoskeletal or visceral pain. The decision about which treatment option to use was left to the health-care provider. Self-reported return to work and analgesia were higher with the ketorolac treatment than with either of the other options.

Influenza May Predispose Older Patients to Myocardial Infarction

Teething in Toddlers Likely Does Not Cause Fever

Trimethoprim-Sulfamethoxazole Associated with Better Cure Rate for Abscesses

Food and Drug Administration Recommends Avoiding Codeine in Children

Prednisolone and Indomethacin Equally as Good in Treating Gout

More Evidence That Trimethoprim-Sulfamethoxazole Is Most Effective in Treating Methicillin-Resistant Staphylococcus aureus

Sean M. McNeely, MD, is an urgent care practitioner and Network Medical Director at University Hospitals of Cleveland, home of the first fellowship in urgent care medicine. Dr. McNeely is a board member of UCAOA, UCCOP, and the Board of Certification in Urgent Care Medicine. He also sits on the JUCM editorial board.
“Cardiac injury in older patients is a potential result of influenza infection. The study assessed data for 38,197 patients who were tested for influenza and then for myocardial infarction; 4469 had positive findings. Of those, 600 underwent biomarker testing for acute infarction within 30 days, and 143 had positive findings. Most of the diagnoses of acute coronary syndrome in those patients occurred within 3 days of an influenza diagnosis.”

Unfortunately, this was not a randomized trial, so the accuracy of its findings might be questioned. For urgent care providers, these findings are more evidence that opioid analgesia is less effective and may hinder the effect of other treatments for patients with musculoskeletal or visceral pain.

Influenza May Predispose Older Patients to Myocardial Infarction

Key point: Watch for an acute myocardial infarction after an influenza diagnosis in older patients.


Cardiac injury in older patients is a potential result of influenza infection. The authors in this study assessed data for patients in U.S. Veterans Affairs facilities who were tested for influenza and then for myocardial infarction (MI). Of 38,197 patients tested for influenza, 4469 had positive findings. Of those, 600 underwent biomarker testing for acute MI within 30 days, and 143 had positive findings. Most of the diagnoses of acute coronary syndrome (ACS) in those patients occurred within 3 days of an influenza diagnosis. Although this is a small percentage of the total infections found, it is much larger than would be expected in the general population. For the urgent care provider, these findings are a good reminder to consider MI or ACS when an older patient has influenza and other symptoms such as dyspnea or chest pain.

Teething in Toddlers Likely Does Not Cause Fever

Key point: Fever in toddlers is probably not caused by teething.


Parents commonly attribute fever in their toddlers to teething. Unfortunately, this may cause parents and providers to miss serious illness or treatable minor illness. There is little evidence that teething causes fever, as defined by the medical community. This meta-analysis included more than 3500 patients younger than 3 years who were teething and noted whether they had fever or other symptoms while teething. A fever was reported in approximately 25% of the children; however, the temperature was below the medical definition of fever. The most common symptoms were gingival irritation (87%), irritability (68%), and drooling (56%). Attributing a true fever to teething is probably ill advised. Making sure that parents understand this can prevent delayed diagnosis in some children.

Trimethoprim-Sulfamethoxazole Associated with Better Cure Rate for Abscesses

Key point: Consider adding trimethoprim-sulfamethoxazole in treating abscesses.


In general, the treatment of abscesses with properly done incision and drainage works well without the use of antibiotics. Past studies have not shown any benefit from administering additional antibiotics. This study was conducted to determine whether trimethoprim-sulfamethoxazole (TMP-SMX) benefits patients with abscesses. The authors believed that because of the significant cure rate for just incision and drainage, previous studies were too underpowered to prove a difference between such treatment and treatment with the addition of antibiotics. In this double-blind study, 1247 patients aged 12 years or older with abscesses were treated in one of five U.S. emergency departments with standard incision and drainage and then either TMP-SMX or placebo for 7 days. The primary outcome tracked was clinical cure of the abscess by 1 to 2 weeks after treatment. The cure rate was significantly better in patients treated with antibiotics than in those who did not receive them (80.5% vs. 73.6%). Antibiotic-treated patients also had less need for further intervention, lower rates of infection at other sites, and lower rates of subsequent infection in household members.

For the urgent care provider, these results are difficult to act on. Although the improvement rate is statistically significant, it is still a small percentage of all of the previously mentioned
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Food and Drug Administration Recommends Avoiding Codeine in Children

**Key point:** There are new recommendations to stop using codeine in children.


Several authorities have discussed the use of codeine products in children, and little evidence has shown that codeine is any better than ibuprofen for pain. Recently an advisory panel of the U.S. Food and Drug Administration recommended against the use of codeine for pain or cough in children. In Europe, it is considered contraindicated in children aged 12 years and younger. Codeine is metabolized to morphine, but in many children the rate of metabolism is unpredictable. Those who metabolize it more quickly are susceptible to greater adverse effects, and those who metabolize it more slowly may benefit less from it. In the urgent care setting, avoiding the use of codeine in this age group is probably best. It may be helpful to discuss with parents the warnings from the Food and Drug Administration and from European agencies and to point out the drug’s inferior performance in multiple studies.

Prednisolone and Indomethacin Equally as Good in Treating Gout

**Key point:** Prednisolone and indomethacin may have similar analgesic results in the treatment of gout.


The authors of this report note that several small studies have shown an equivalence between prednisolone and indomethacin in treating the symptoms of gout. For certain patients, each treatment presents its own benefits and risks. Knowing whether the two drugs are equivalent excludes one concern when deciding on appropriate treatment for an individual patient. In this double-blind multicenter, randomized, controlled trial from Hong Kong, 376 patients were evaluated for pain. On the basis of pain scores on a visual analog scale, the authors concluded that both medications had a similar effect on pain control. They do note that the diagnosis of gout was on clinical grounds, not on findings from joint aspiration, but this is the most common method for diagnosis at urgent care centers anyway. Thus, oral prednisolone and indomethacin may both be good choices for a patient presenting with gout.

More Evidence That Trimethoprim-Sulfamethoxazole Is Most Effective in Treating Methicillin-Resistant Staphylococcus aureus

**Key point:** Methicillin resistance in *Staphylococcus* infections is decreasing in children.


Over time, the percentage of methicillin-resistant *Staphylococcus aureus* (MRSA) infections has actually decreased. Data for children have not been available from larger studies to determine the trend, but between 2005 and 2014, researchers in this study retrospectively analyzed 39,000 patients at U.S. military hospitals with at least one sample with positive findings for *Staphylococcus*. Most of the samples were from ambulatory patients with skin and soft-tissue infections. The highest rates of MRSA infections were seen in children younger than age 5 years. They found that as with adults, the rates of MRSA infections have been decreasing, although regional patterns are still an issue. Interestingly, clindamycin resistance is increasing in only those *Staphylococcus* infections with methicillin resistance, moving from 10% to 17%. Trimethoprim-sulfamethoxazole once again proved most effective in treating MRSA infections. For the urgent care provider, this information may be helpful in choosing treatment regimens. As always, knowing local resistance patterns is very important.
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 e-mail the relevant materials and presenting information to editor@jucm.com.

**Wrist Pain in an Adult After a Fall**

**Case**

A 62-year-old woman presents with left wrist pain that began after she fell onto her outstretched left hand earlier in the morning while walking her dog. She has wrist pain throughout the range of motion, as well as some pain in her hand. She sustained no injuries to her head or neck, and she has no head pain, neck pain, chest pain, or shortness of breath.

View the image taken (Figure 1) and consider what your diagnosis would be.

Resolution of the case is described on the next page.
Differential Diagnoses
- Colles fracture (distal radius fracture with dorsal angulation of the fracture fragment)
- Smith fracture (distal radius fracture with volar angulation of the fracture fragment)
- Ulnar styloid fracture
- Scaphoid fracture
- Carpometacarpal dislocation

Physical Examination
On physical examination, the patient is found to be afebrile and to have a pulse of 112 beats/min, a respiration rate of 24 breaths/min, and a blood pressure of 146/93 mm Hg. She is alert and oriented, winces when she moves her left wrist, and has no respiratory distress.

Her left wrist does have evidence of deformity, but there are no breaks in the skin. She has a 3+ radial pulse, and sensation is grossly intact. She has no pain over the anatomic snuffbox. There are some superficial abrasions over the palmar aspect of her left hand, but they produce only very minimal discomfort with palpation. She has no elbow pain.

Diagnosis
An x-ray of the wrist (Figure 2) is ordered. Image findings indicate a Colles fracture, which is a distal radius fracture with dorsal angulation of the fracture fragment.

Figure 3 shows three views of a Colles fracture. Note that the carpal bones and bones of the hand are intact, and there is no ulnar styloid fracture.

Learnings
Wrist injuries account for 2.5% of emergency department visits. Lack of recognition of the fracture or improper treatment of it may lead to permanent functional disability. Injury to the distal radius requires assessment for concurrent injury to the carpal bones. The typical mechanism of injury with a Colles fracture is a fall onto an outstretched hand.

The distal radius is juxtaposed against the scaphoid and lunate carpal bones. The anatomic snuffbox is a triangular depression evident on the dorsoralial aspect of the wrist with extension of the thumb. This location should be palpated with every wrist injury, and the findings should be documented in the chart. For example, the documentation might read: “No pain with palpation at the anatomic snuffbox.”

There are eight carpal bones.

What to Look For
Important elements of the medical history include mechanism of injury, location of pain and exacerbating factors, and examination of the joint proximal and distal to the injury. If there is an associated laceration, inquire about tetanus status. If the patient reports a clicking sensation, this may indicate a scapholunate ligamentous injury.

The physical examination should include documentation of inspection of the skin for swelling, abrasions, and lacerations; palpation of the area of greatest pain in the wrist (distal radius and ulna), as well as the metacarpal bones; and palpation of the anatomic snuffbox. The neurovascular status should be documented, including gross sensation and pulse.

A nondisplaced or minimally displaced fracture can be splinted, with orthopedic follow-up. Indications for follow-up in an emergency department or for expedited orthopedic follow-up include the following:
- An intra-articular fracture
- A significantly displaced fracture
- An open fracture
- A fracture in which there is significant swelling, causing concern that there may be a compartment syndrome
- A Colles fracture with the possibility of a carpometacarpal dislocation

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Case

A 19-year-old college student presents to an urgent care center with pain at the distal interphalangeal (DIP) joint of the middle finger of his right hand. He reports that the pain started suddenly the previous evening when the finger was jammed while he was playing basketball. The pain is worse through the range of motion, but there is no numbness and no pain at the proximal interphalangeal (PIP) joint.

View the image taken (Figure 1) and consider what your diagnosis would be.

Resolution of the case is described on the next page.
The Journal of Urgent Care Medicine | May 2016 www.jucm.com

**Insights in Images: Clinical Challenge**

**The Resolution**

**Physical Examination**
On physical examination, the patient is alert and oriented, is not in acute distress, and is breathing comfortably. He has a temperature of 98.4°F (36.8°C), a pulse of 92 beats/min, a respiration rate of 16 breaths/min, a blood pressure of 112/76 mm Hg, and an oxygen saturation of 99% on room air.

His right middle finger has slight swelling over the DIP joint, but there are no skin color changes. When the hand is held parallel to the ground, there is a palmar droop to the distal phalanx. The neurovascular status is intact, with good capillary refill. He experiences pain with palpation over the DIP joint, mostly dorsally. Strength testing does not result in active dorsiflexion, but the patient can actively perform palmar flexion at the DIP joint. He has no pain with palpation of the PIP joint.

**Differential Diagnoses**
- Osteolytic lesion
- Finger dislocation
- Spiral fracture of the distal phalanx
- Comminuted fracture

**Diagnosis**
An x-ray is obtained that shows a mallet finger (Figure 2) with avulsion of the proximal aspect of the distal phalanx.

**Treatment**
Conservative initial treatment is the standard of care for type 1 injuries (closed injuries either with or without avulsion fracture) when there is an avulsion fracture involving less than one-third of the articular surface and no DIP joint subluxation. A splint can be applied to the DIP joint only; the PIP joint does not need to be immobilized. The DIP joint should be immobilized in full extension or slight hyperextension. Avoid excessive extension, because that may result in vascular compromise of the dorsal skin. Surgical management is typically reserved for patients with open fractures and severe injuries; these require transfer to an emergency department.

**Learnings**
Fingers are the fourth most common site of fractures in adults. Such fractures happen more commonly in men than in women, with the average age at occurrence being 36 years. The most common mechanism for a mallet finger injury is sudden, forced flexion applied to the distal aspect of a finger, such as in a blow against a fixed object or during sports such as basketball or football, causing hyperflexion or, rarely, hyperextension. The most commonly injured fingers are the index, ring, and middle fingers on the dominant hand. Injury to the extensor tendon may also occur from a laceration or a crush injury.

**What to Look For**
Look for the presence of visible deformity, and compare the injured finger to the other fingers. Assess the integrity of the skin, and look for swelling. Assess for open fracture, ecchymosis, and signs of infection such as erythema. The typical appearance of a mallet finger is seen from the lateral aspect; the distal phalanx is flexed. Palpate the dorsal aspect of the DIP joint, as well as the PIP and metacarpophalangeal (MCP) joints, for tenderness.

Assess strength by isolating the DIP joint: Stabilize the finger at the PIP and MCP joints and look for active extension of the finger by the patient. Also passively extend the finger. If the patient cannot do this, there may be entrapment of bone or soft tissue. Compare the injured finger to the other fingers. There is substantial variation in anatomy as well as age-related changes or arthritic changes, so a visible deformity is not necessarily diagnostic of injury or fracture. Check range of motion for flexion and extension, as well as lateral motion. If there is laxity laterally, this may indicate injury to a collateral ligament. Check the neurovascular status.

Obtain x-rays from three views: anteroposterior, oblique, and lateral.
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CODING Q & A

Fracture Care

David E. Stern, MD, CPC

Will you please help me understand initial visit, subsequent visit, and sequelae related to fracture care? If the patient is treated elsewhere for a fracture and the provider just stabilizes the fracture and instructs the patient to then come to my office for reduction, is this a subsequent visit or an initial visit?

International Classification of Diseases 10th Revision, Clinical Modification (ICD-10-CM) guidelines state that a seventh character, A, is used for the initial encounter for the injury or condition while the patient is receiving active treatment for the injury. Examples of active treatment are:

- Surgical treatment
- Emergency department (ED) encounter
- Evaluation and treatment by a new physician

Evaluation and treatment by a new physician is sometimes misunderstood by health-care providers and coders alike. You must determine whether the patient has previously received active treatment for this condition in any setting or by any provider.

For example, the patient is evaluated in an ED for a closed fracture of the distal phalanx of the right index finger. The ED provides comfort care by icing and immobilizing the finger, and then instructs the patient to follow up with an urgent care center in the morning. The ED’s billing department reports ICD-10-CM code S62.630A because this is the patient’s initial visit.

When the urgent care center rechecks the patient and reduces the fracture the next day, the patient is receiving initial active treatment for this fracture. The Current Procedural Terminology (CPT) code to bill is 26755, “closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each.”

Per the ICD-10-CM guidelines, you would again report ICD-10-CM code S62.630A because this is the first time the patient is receiving active treatment from the urgent care center.

Subsequent care is defined in the ICD-10-CM guidelines as “encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase,” and it is assigned using the injury code with the seventh character D, “subsequent encounter for fracture with routine healing.” Examples of subsequent care are:

- Cast change or removal
- Removal of external or internal fixation device
- Medication adjustment
- Other aftercare
- Follow-up visits after injury treatment

In the example of the patient with the phalanx fracture, if the fracture is healing as it should at the subsequent visit to the urgent care center, the center’s office would report S62.630D, “displaced fracture of distal phalanx of right index finger, subsequent encounter with routine healing.” CPT code 99024, “postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for . . . reason(s) related to the original procedure,” could also be included on the claim at no cost to represent the evaluation and management (E/M) portion of the visit.

Sequelae are the late effects of an injury and thus are assigned using the injury code with the seventh character S, “for use for complications or conditions that arise as a direct result of an injury, such as a scar formation after a burn. The scars are sequelae of the burn,” according to ICD-10-CM guidelines.
“Subsequent care is defined in the ICD-10-CM guidelines as ‘encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase,’ and it is assigned using the injury code with the seventh character D.”

For example, a patient sustained a fractured right ankle that is now healed. However, the patient is in pain and sometimes has a limp as a result of the injury. When the patient presents for treatment for the pain, you would assign ICD-10-CM codes G89.21, “chronic pain due to trauma,” and S82.891S, “other fractures of lower right leg.”

What services can we bill for when we provide definitive care for a fracture?

If you perform a service for definitive care of a fracture and plan to follow the patient through the healing process, you will bill the appropriate CPT code for the treatment performed, as well as CPT codes for any of the following:
- X-rays
- Cast supplies
- Splint supplies and/or durable medical equipment devices
- All supplies provided (e.g., sling, walking boot)

Refer to CPT codes in code range of 70000 through 79999 for the x-rays, and Healthcare Common Procedure Coding System Level II codes for the supplies.

If a separate E/M service was provided and documented separately during the initial visit, you would bill the appropriate E/M code (99201 through 99215) with modifier -57, which is described as follows: “decision for surgery: an evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.” You would not bill for the application of the splint or cast, because that is included in the CPT code for definitive treatment.

All postoperative visits for the fracture are included in the definitive care code for 90 days following the initial treatment.
Urgent care is a convenient and affordable option for all patients requiring immediate but non-emergency, non-life threatening care. As a vital link between primary care and emergency medicine, urgent care provides high-quality care by qualified healthcare professionals for sprained ankles and broken bones to eye infections and strep throat.

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- January, with 9.7% of all visits
- May, with 9.6% of all visits
- March, with 9.5% of all visits
- April and December, each with 9.1% of all visits

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