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## Minor Pain, or Major Risk?

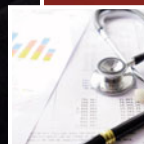
*Patients Presenting with Complications  
Post Bariatric Surgery*

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# Urgent Care Is the Best Place for Patients with ‘Hypertensive Urgencies’: Why We Should Stop Sending Patients with Asymptomatically High Blood Pressure to the ED



Most public health campaigns, with a few notable exceptions, have been abject failures. One undeniably successful example, however, has been awareness of the dangers of high blood pressure.

As recently as the early 1970s, when the Framingham Study was published, there was still considerable disagreement in the medical community about the risks of untreated hypertension. But in the face of mounting evidence, it soon became clear that persistently elevated blood pressure was dangerous to a number of organ systems. Additionally, it was also around this time when the terms “hypertensive emergency” and “hypertensive urgency,” defined respectively as severely elevated BP *with or without* evidence of acute organ injury/dysfunction, entered our clinical lexicon.

And so began an ongoing era of much semantic confusion.

Soon after this, in a fantastically enduring marketing move, the American Heart Association (AHA) labeled hypertension “the silent killer,” conjuring images of a masked assassin climbing through unsuspecting citizens’ windows at night as they slept. As public acknowledgment of the dangers of untreated hypertension grew over the ensuing decades, electronic blood pressure cuffs began appearing in grocery stores and pharmacies. Technology continued to improve and automatic cuffs got smaller and more affordable. Ultimately, we arrived where we are today—a situation where it is commonplace for many patients to check their blood pressures at home, often multiple times per day.

And while there are undeniable and catastrophic consequences to inadequately treated hypertension, this campaign combined with the increasing ubiquity of BP monitoring devices created an era of mutual neuroticism on the part of patients and

clinicians alike.

We’ve all seen such patients. They’re the unfortunate souls already prone to hypochondriasis. For them, blood pressure serves as an easily quantifiable and apparently global metric of health. And, as we’ve all witnessed, they tend to monitor it with painstaking ritual. They then agonize over these values which they’ve dutifully recorded in large binders like a high school student taking the SATs.

We as healthcare practitioners have certainly played our role in this *folie a deux*. Partially out of concern for the wellbeing of our patients, but undoubtedly out of some concern for malpractice liability as well, medical providers (but more often, I believe, allied health practitioners such as dentists, chiropractors, pharmacists) will instill a fear of imminent death in otherwise stable patients because of a single BP reading of 190/110.

These patients, who often have an acutely painful condition such as a broken tooth, may simply be experiencing an expected physiological response to the pain. Rather than receiving the care they sought for the broken tooth or strained neck, what commonly happens instead is that the patient is told by a member of the office staff that they need *immediate medical attention*. I’ve even seen ambulances called on occasion for asymptomatic patients who happen to check their blood pressure and get a high reading while leisurely shopping at the pharmacy.

Before the rise of urgent care as a prevalent setting for acute care needs, these patients were uniformly sent to the ED. Unfortunately, this still occurs with surprising frequency today. In the ED, these patients with severe asymptomatic hypertension, more commonly referred to in the past as “hypertensive urgency,” tend to receive highly variable care. Some patients get an EKG, others renal function testing. Some get troponins drawn and heads



CT'ed. Some get all of the above. Rarely in the ED, however, do patients get nothing done to them at all.

One reason so much testing is done in the ED when patients present with asymptomatic hypertension is that the testing can be accomplished easily—commanded instantly with just one click in the EMR. Moreover, the ED is an environment with a bend towards action, and patients generally expect things to be done to them when they go there (whether indicated or not).

The problem is that patients with severe asymptomatic hypertension generally don't need anything done acutely. The American College of Emergency Physicians' (ACEP) most recent practice guidelines actually state that "routine screening for target organ injury and routine ED medical intervention (ie: treating high blood pressure immediately) is not required."<sup>1</sup> This is because the rates of acute hypertension related complications (eg, ACS, hemorrhagic stroke) over the subsequent 30 days in such patients is quite low (<1% of patients).<sup>2</sup>

Additionally in cases of asymptomatic hypertension/hypertensive urgency, patients sent to the ED have been found unsurprisingly to be hospitalized more often and to undergo more testing than patients treated in an outpatient setting. But no associated improvements in clinical outcomes were found (ie, no fewer strokes or heart attacks) when these patients were sent to an ED for hypertensive urgency.<sup>3</sup>

Most importantly perhaps, though, is that sending people to the ED for asymptotically elevated blood pressure sends the wrong message. It continues to propagate the notion that high blood pressure is an emergency, which it almost never is (with one notable exception being possible pre-eclampsia in the latter half of pregnancy). Patients understandably internalize this notion that high blood pressure is an imminent and immediate threat. It causes them much stress and anxiety. They persevere over the exact numbers and recheck their blood pressure compulsively. And this ultimately leads to frantic phone calls and worried visits because "my BP keeps going up."

We need to liberate our patients from this mental blood pressure prison and give them permission to relax.

The weight of evidence from numerous studies on the subject suggests that hypertension is undoubtedly dangerous, but over the course of years, or even decades (*not* hours or days). In fact, lowering severely elevated blood pressure immediately and dramatically carries significant risk of precipitating cerebral ischemia (especially in the elderly). In other words, more often than not, we put patients at risk when we treat severe hypertension as an emergency.

Certainly, obtaining a serum creatinine to evaluate a patient's renal function and getting a baseline EKG is reasonable. But a creatinine of 1.7 and ST changes consistent with left ventricular hypertrophy don't mean that the patient is having a hypertensive emergency (eg, acute renal failure or heart failure/ACS), but rather these are expected findings of chronically, poorly con-

trolled BP. Again, sending these patients to the ED will simply add financial burden and stress to the patient—not exactly therapeutic when you're concerned about high blood pressure!

It is actually, therefore, quite apt that severe asymptomatic hypertension (specifically defined as >180/120) is still, at times, referred to as a "hypertensive urgency" because urgent care is the ideal setting for this to be addressed. In UC, patients can be assessed quickly for clinical signs/symptoms suggestive of hypertensive emergency/*acute* end organ damage. In the absence of concerning symptoms or physical exam findings of acute organ dysfunction (eg, severe chest pain, rales, neurologic deficits), current recommendations do not equivocate that gradually lowering blood pressure over the next few days, regardless of the degree to which the blood pressure is elevated, is reasonable and appropriate.<sup>4</sup> This may mean starting a first-line anti-hypertensive agent from UC or simply referring the patient back to their primary care provider for a visit the next day if feasible. What it does not mean, however, is sending an asymptomatic patient to the ED where they will wait for hours to be seen and receive a large bill with no appreciable benefit.

So, yes, we can agree that untreated hypertension is a "silent killer." But it doesn't kill swiftly, at least not without considerable noise (ie, dramatic symptoms). In the absence of such a ruckus, patients need education, reassurance, and gradual correction of their elevated BP much more than they need the stress and expense of emergency department care. And after you reassure them of this, try checking their blood pressure again. Most often, once patients hear that they are not, in fact, about to drop dead, their BP tends to come down quite nicely on its own. ■



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## 13 Bariatric Surgery Complications in the Urgent Care Center

With obesity an ongoing public health concern in the U.S., more patients are turning to surgical solutions to their own weight problems. Where more surgeries occur, however, more complications are sure to follow—with many concerned patients opting to visit an urgent care center for immediate attention.

*Tracey Quail Davidoff, MD, FACP, FCUCM*

**PRACTICE MANAGEMENT**

## 19 Pros and Cons of Urgent Care vs Primary Care Billing for Urgent Care Services



Does it really matter whether you use an urgent care code vs a primary care code for a given patient encounter? The short and easy answer is Yes! The rationale, and how to go about it, takes a little explaining.

*Alan A. Ayers, MBA, MAcc*

**HEALTH LAW AND COMPLIANCE**

## 23 Staying in Good Stead with OSHA Starts with Maintaining Proper Records



Like all government entities, the Occupational Health and Safety Administration runs on paperwork. Your ability to dutifully keep thorough and accurate records will have a direct impact on your ability to maintain a healthy occupational medicine business.

*Alan A. Ayers, MBA, MAcc*

**OCCUPATIONAL MEDICINE**

## 32 When Your Workers Comp Patient Is Reluctant to Return to Work



When you offer occupational medicine services, getting injured patients ready to go back to work as safely and quickly as possible goes with the territory. But what happens when your patient is less than committed to goal?

*Max Lebow, MD, MPH, FACEP, FACPM*

**CASE REPORT**

## 34 When Is Tachycardia in a Patient with URI Symptoms a Sign of Something More Serious?



Brugada syndrome has been associated with fever, viral infections, and pneumonias—bringing increased risk of ventricular tachyarrhythmias and sudden cardiac death with it.

*Kathleen B. Raschka, MD*

**IN THE NEXT ISSUE OF JUCM**

Pain should be viewed as the “fifth vital sign.” Or it shouldn’t. Opinions are varied—and passionately defended. In the April issue of *JUCM*, we’ll publish original research that examines whether patient-reported pain scores correlate with disease severity or disposition (either supporting or discrediting the notion that pain should be considered a vital sign). That article will be the first in a series of original research articles we’re proud to present in an effort to fill a significant void in academic urgent care medicine. Stay tuned!

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# JUCM CONTRIBUTORS

Every surgical procedure carries risk of postoperative complications. When a patient has certain issues going in, or has risk factors only tangentially related to their need for surgery, it's all the more likely that they'll run into unexpected problem after they're discharged.

Such is the case with obese patients who have bariatric surgery. Some of those post-op complaints barely warrant medical attention, while others are serious. Either way, though, urgent care is bound to be an appealing option when it could take days to get an appointment with a specialist, their surgeon, or their primary care provider.

In this issue's cover article, **Tracey Quail Davidoff, MD, FACP, FCUCM** writes about the complications patients who have had bariatric surgery are most likely to present with, from the benign to the potentially deadly. *Bariatric Surgery Complications in the Urgent Care Center* begins on page 13.



Dr. Davidoff is an attending physician at Advent Health Centra Care in Orlando, FL.

We usually think of the symptoms of upper respiratory disorders as being more straightforward. Still, there's danger in neglecting to look further than the obvious presenting complaint. Sometimes, urgent care providers will have the opportunity to identify a potentially lethal problem. One such case is the subject of *When Is Tachycardia in a Patient with URI Symptoms a Sign of Something More Serious?* (page 34), by **Kathleen B. Raschka, MD**. Dr. Raschka is an assistant professor of Family Medicine at Loyola University Medical Center.



Dr. Raschka is an assistant professor of Family Medicine at Loyola University Medical Center.

Something for management and coders to keep in mind is the question of whether it makes more sense to bill as an urgent care or a primary care entity. Fortunately, this is a topic **Alan A. Ayers, MBA, MAcc, CEO** of Velocity Urgent Care and senior editor, practice management for *JUCM*, is well qualified to discuss. You can read his article, *Pros and Cons of Urgent Care vs Primary Care Billing for Urgent Care Services* starts on page 19.



Mr. Ayers is also well-versed in maintaining compliance with standards laid down by the Occupational Health and Safety Administration. As is often the case when dealing with the government, demonstrating compliance with proper procedures through responsible record-keeping is essential to your survival. If you have occupational medicine clients, *Staying in Good Stead with OSHA Starts with Maintaining Proper Records* (page 23) is essential reading.

Another area urgent care operators who offer occ med services are familiar with is working with Workers Compensation cases. Your clients expect you to get their employees

back to work safely, and in a reasonable amount of time as determined by their physical readiness. Unfortunately, not all patients are so eager to get back on the jobsite. If you haven't had that experience, count your blessings—and read *When Your Workers Comp Patient Is Reluctant to Return to Work* (page 32), by **Max Lebow, MD, MPH, FACEP, FACPM**. Dr. Lebow is president and medical director of Reliant Immediate Care Medical Group, and a member of the Urgent Care Association Board of Directors.



## Also in This Issue

It would be pretty difficult to keep up with all the urgent care-relevant content published in medical journals every month. We try to help you catch the important stuff by offering synopses of the most essential articles in *Abstracts in Urgent Care* (page 28). We appreciate **Yijung Russell, MD** taking on that task this month. Dr. Russell practices in the Department of Emergency Medicine at Amita Health Resurrection Medical Center in Chicago.

Finally, recognizing that without efficient revenue cycle management even the best clinical practices in the world are bound to fail, we're pleased to bring you a new article by **Monte Sandler**, executive vice president, revenue cycle management at Experity. *Taking Pictures, Dog Paddling, and Apple Picking: A Metaphorical Approach to Healthy Revenue Cycle Management Metrics* begins on page 46.

## A Note of Appreciation for Our Peer Reviewers

We rely on the urgent care professionals who volunteer to serve as peer reviewers to ensure the content we publish is relevant and unbiased. For their work in reviewing content for the January, February, and March issues of this year, we thank:

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# CONTINUING MEDICAL EDUCATION

**Release Date:** March 1, 2020

**Expiration Date:** February 28, 2020

## Target Audience

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

## Learning Objectives

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

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

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

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## Bariatric Surgery Complications in the Urgent Care Center (page 13)

### 1. Risk of serious complications from bariatric surgery is:

- a. 1%
- b. Up to 10%
- c. 14%
- d. 23%

### 2. It is reasonable to suspect overeating or dietary noncompliance when patients who have had bariatric surgery present with:

- a. Dehydration
- b. Increased blood pressure
- c. Increased blood sugar
- d. Vomiting

### 3. The most common cause of mortality following bariatric surgery is:

- a. Anastomotic leaks
- b. Pulmonary embolism
- c. Respiratory failure
- d. Sepsis syndrome

## Pros and Cons of Urgent Care vs Primary Care Billing for Urgent Care Services (page 19)

### 1. On average, an urgent care contract pays how much more than a primary care contract?

- a. 18%
- b. Approximately 25%
- c. Around 30%
- d. It varies too widely to reasonably estimate

### 2. The most commonly cited reason for an urgent care operator to not offer primary care services is:

- a. Commercial contract restrictions
- b. The desire to maintain “urgent care” branding
- c. Staffing challenges
- d. Doing so would unnecessarily complicate the coding process

### 3. The reasons urgent care centers have higher operating costs than primary care offices include:

- a. Larger facilities
- b. More extensive on-site capabilities
- c. Higher staffing levels
- d. More complex documentation of the patient chart
- e. All of the above

## When Is Tachycardia in a Patient with URI Symptoms a Sign of Something More Serious? (page 34)

### 1. Modes of evaluation for patients with tachycardia include:

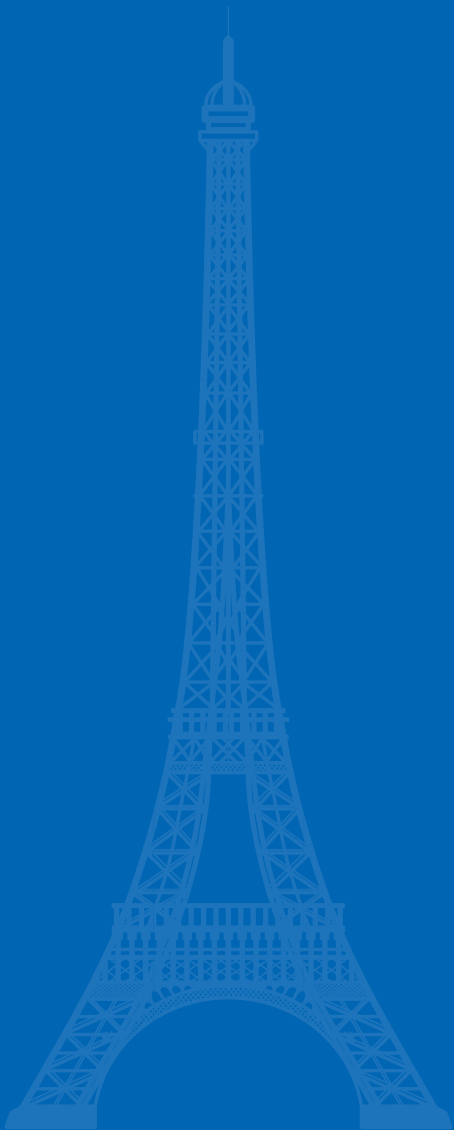
- a. Monitoring devices
- b. Echocardiogram
- c. Exercise testing
- d. Electrophysiological cardiac testing
- e. All of the above

### 2. Patients who present with a Brugada-type EKG and which of the following are at increased risk for sudden cardiac death?

- a. Dehydration
- b. Drug overdose
- c. Temperature >101.2° F
- d. Diagnosis of acute bronchitis

### 3. EKG appearance of Brugada is:

- a. ST elevation and R R' in leads V1 and V2
- b. ST elevation in leads II, III, and aVF
- c. Delta wave
- d. Q waves in the anterior precordium



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# On Demand. *In Demand*

■ LAUREL STOIMENOFF, PT, CHC

The Urgent Care Association (UCA) maintains a comprehensive list of urgent care centers (UCCs) in the United States. Our latest count places that number just under 10,000, and we anticipate that 2020 will be the year we firmly step over that threshold. UCA's most recent *Benchmarking Report* illustrated that the industry grew 9.6% from fourth quarter 2018 to 2019. The *Report* also supports year-over-year creep of UCCs into rural communities and an increase in visits per day from the prior year.

What is clear is that the demand for convenient access to quality healthcare services has not waned. And our evolution is ongoing.

## We Have Arrived

Urgent care is being welcomed into the mainstream, whether by our clinical colleagues, the government, or the consumer. Healthcare systems view urgent care as the *front door* to care delivery and leverage it as a patient acquisition strategy. Government agencies have been reaching out to determine how urgent care centers can participate in the event of a disaster or pandemic. The Mission Act specifically identified urgent care centers as a healthcare destination for eligible veterans. And just recently a study was published showing that from 2008-2016 adult visits to primary care providers decreased 24.2% in a commercially insured population, while visits to "alternative venues such as urgent care" increased 46.9%.<sup>1</sup> In short, *we have arrived*.

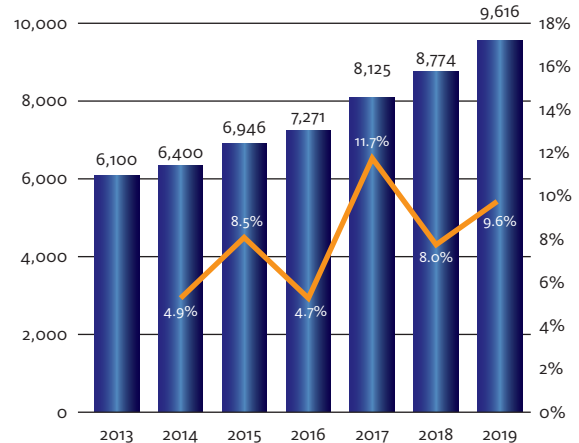
## Only the Paranoid Survive

But we need to listen to the late Andy Grove, who had an amazing career culminating as the CEO of Intel. He said, "Success breeds complacency. Complacency breeds failure. Only the paranoid survive." Urgent care's success came from being scrappy, nimble, and disruptive—and we need to figure out how to keep that edge. Otherwise, we risk blending into the mainstream and losing the forward-thinking momentum that has manifested in



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

## YOY Growth – Urgent Care Centers



Data source: Urgent Care Association 2019 Benchmarking Report.

over 9,600 healthcare destinations in record time.

## Be Part of the Solution at the UCA2020 Hackathon

So how do we keep that edge? The essence of UCA's mission is to advance the industry. UCA2020 will be held May 3-6 at the Paris Hotel in Las Vegas. It will include a Hackathon, where our members can join colleagues in thought leadership breakout sessions. We are borrowing the concept from the computer world and applying it to advancing urgent care. And we want to hear from *you*.

These sessions will be fun, fast-paced, and provocative and we know you'll take home valuable insights that you can apply in 2020 and beyond. Because, let's face it, we're all *in it to win it*. And we only win when we run faster and ahead of the rest because we're a bit paranoid. Bring your energy and your brain to the Hackathon. Together, we've got this! And stay scrappy, my friends. ■

## Reference

1. Ganguli I, Shi Z, Orav EJ, et al. Declining use of primary care among commercially insured adults in the United States, 2008–2016. Available at: <https://annals.org/aim/article-abstract/2760487/declining-use-primary-care-among-commercially-insured-adults-united-states>. *Ann Intern Med*. Accessed February 12, 2020.

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# Bariatric Surgery Complications in the Urgent Care Center

**Urgent message:** Obesity continues to be a significant health problem in the United States, with more and more patients opting for a surgical solution to their own weight loss challenges. As this trend continues, urgent care providers can expect to see more patients with post bariatric surgery complaints, ranging from the typical and benign to pulmonary emboli, anastomotic leaks, and respiratory failure.

TRACEY QUAIL DAVIDOFF, MD, FACP, FCUCM

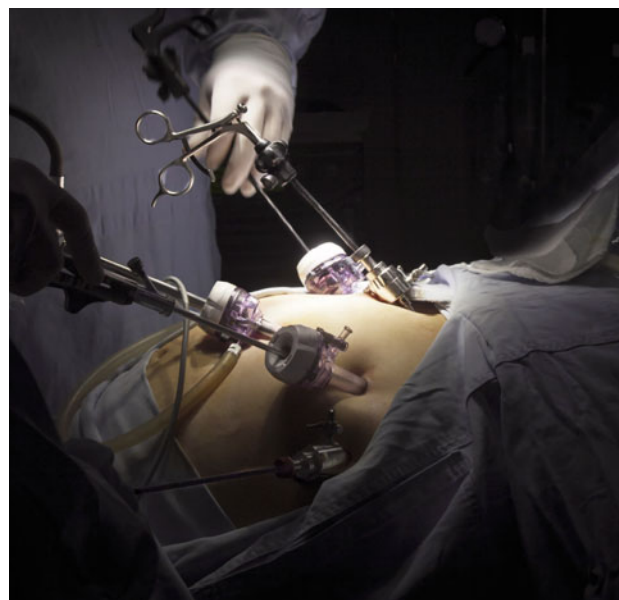
Obesity has become one of the foremost public health concerns in our time. It may result in poor self-esteem, depression, discrimination, as well as diabetes (DM), coronary artery disease (CAD), and obstructive sleep apnea (OSA). Because dieting in the morbidly obese is often futile or produces results that are short-lived, both providers and patients are looking for effective long-term solutions to this problem.

Bariatric surgery leads to sustainable long-term weight loss and may be curative for obesity-related conditions including DM and OSA.<sup>1</sup> As the number of patients undergoing these procedures increases, the urgent care provider needs to be aware of early and late complications. Recognizing the serious complications, knowing how to treat, and what to refer are key in providing appropriate urgent care to these patients.

## Introduction

In 2016, the CDC National Center for Health Statistics reported that 71% of U.S. adults over 20 were overweight, with 38% considered obese; this includes 21% of adolescents (12–19 years of age) and 17% of children (6–11 years of age).<sup>2</sup> Obesity and its related complications are the leading cause of death in both the U.S. and worldwide, with the resultant healthcare costs estimated to be \$147 billion per year.<sup>2</sup>

Bariatric surgery may offer a long-term solution to those with morbid obesity. However, the postsurgery period is a lifelong commitment with permanent health and lifestyle changes that require strict compliance.<sup>3</sup>



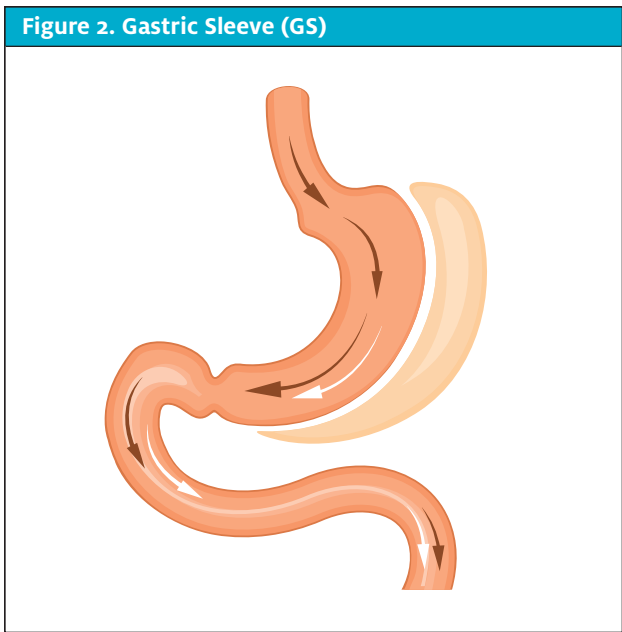
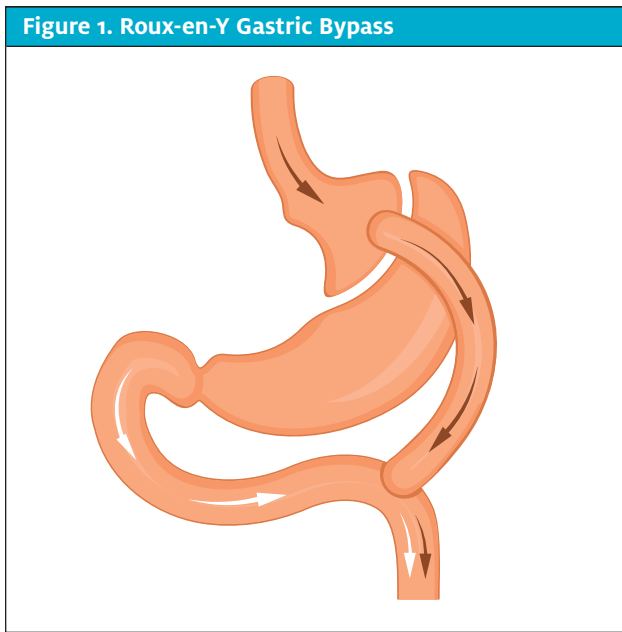
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## Indications for Bariatric Surgery

Indications for bariatric surgery include a BMI of  $\geq 40$  or a BMI of  $\geq 35$  with obesity-related comorbidities such as DM, OSA, CAD, nonalcoholic fatty liver, refractory hyperlipidemia, and/or debilitating arthritis.<sup>1,3</sup> Patients should have failed attempts to achieve a healthy weight loss or have been unable to sustain weight loss through other means.<sup>3</sup> The National Institutes of Health, American College of Surgeons, and American Society for Metabolic and Bariatric Surgery recommend that surgery

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be performed by a board-certified surgeon with specialized training in bariatric surgery, to include a specialized team with a nutritionist, exercise specialist, and a mental health professional.<sup>3</sup>

**The Procedures**

The most commonly performed bariatric procedures are the Roux-en-Y gastric bypass (RYGB), sleeve gastrectomy (SG), adjustable gastric band (AGB), and biliopancreatic diversion with duodenal switch (BPD/DS).<sup>3,4</sup> Although traditionally done as open procedures, currently all procedures can be done laparoscopically.

Other, less common, procedures include the gastric balloon, V-block therapy, and the Aspire Assist device.<sup>4</sup>

**Roux-en-Y Gastric Bypass**

The RYGB is considered the gold standard of weight loss procedures and has been the most widely performed. First, a small pouch that holds approximately 30 mL is created from the upper portion of the stomach, with the remaining portion of the stomach divided off. The small intestine is then divided, and the bottom portion is attached to the small stomach pouch. The final step is attaching the top portion of the small intestine further down the ileum, allowing the gastric juices and pancreatic enzymes from the bypassed stomach, pancreas, and bile duct to eventually mix with food.<sup>3,4</sup> (See **Figure 1**.)

This procedure causes weight loss by decreasing stomach volume, which causes early satiety; fewer calories to be

absorbed from the bypassed small bowel; changes in gut hormones that reduce hunger; and reverses mechanisms of type 2 diabetes.<sup>3</sup> Most patients will lose 60% to 80% of their excess weight and maintain 50% of the weight loss.<sup>4</sup>

RYGB may result in more complications than other procedures, lead to vitamin and mineral deficiencies (including iron, B12, calcium, and folate), require a longer hospital stay, and require strict patient adherence to diet and nutrient supplements.<sup>3</sup>

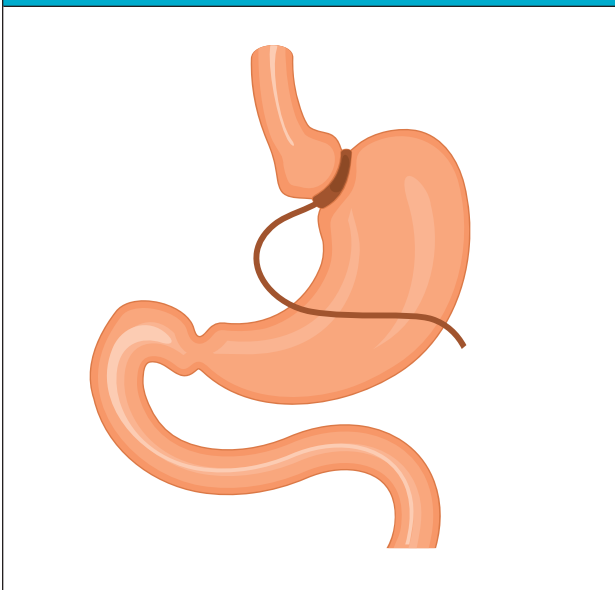
**Sleeve Gastrectomy**

The SG is done laparoscopically by removing approximately 80% of the stomach, leaving a tubular pouch. (See **Figure 2**.) This reduces intake by reducing volume and, thus, caloric intake. This procedure also has an effect on gut hormones and changes hunger, satiety, and blood sugar control. It is as effective as the RYGB procedure in terms of weight loss and remission of diabetes. The complication rate is less than that of gastric bypass, but disadvantages are that it is nonreversible and has the potential for vitamin deficiencies. Patients lose >50% of their excess weight and maintain about 50% of the lost weight off over time.<sup>3,4</sup>

**Adjustable Gastric Band**

AGB is performed by applying a band around the stomach, filled with saline and that can be adjusted by gradually decreasing the diameter of the band and restricting the flow of food through the stomach. (See **Figure 3**.)



**Figure 3. Adjustable Gastric Band (AGB)**

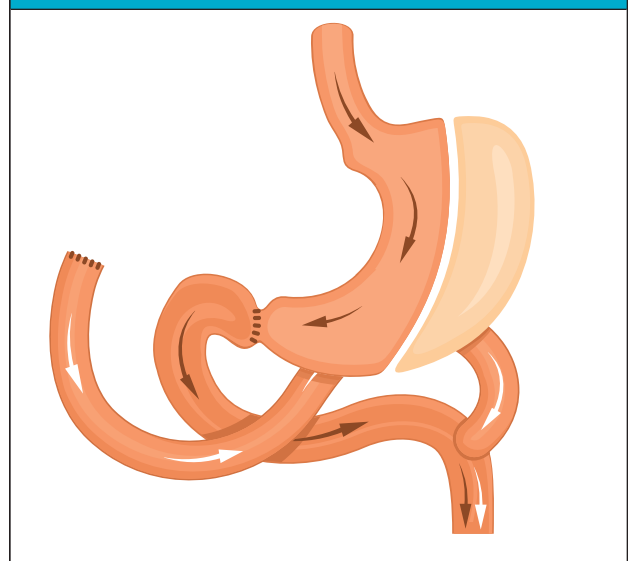
Patients experience reduction of hunger and early satiety but still absorb calories and nutrients as before. These patients lose 40% to 50% of their excess weight.<sup>4</sup> There is no cutting or rerouting involved, and it is reversible. Weight loss, however, is slower, bands can slip or erode, and patients can stretch the esophagus or stomach if they overeat. The highest rate of reoperation occurs with this procedure.<sup>3</sup>

#### ***Biliopancreatic Diversion with Duodenal Switch***

A BPD/DS is initiated in the same way as a gastric sleeve, but the intestine is divided and diverted similarly to the RYGB. The stomach empties directly into the distal small intestine, where it is joined by the pancreatic and biliary secretions from the proximal small bowel. (See **Figure 4**.) This results in less food intake and less absorption of calories and nutrients, and affects the gut hormones. This is the most effective surgery for patients with diabetes, and has the most reported weight loss of 60% to 70% of excess weight which remains at 5 years. Fat absorption is reduced by 70%.<sup>4</sup> However, this procedure also has the highest mortality and complication rate of all the procedures and is the most likely to result in deficiencies of protein, vitamins, minerals, calcium, zinc, and fat-soluble vitamins.<sup>3</sup>

#### ***Postsurgery Nutrition***

In all procedures, the patient with a now tiny stomach must comply with a diet plan gradually advancing from

**Figure 4. Biliopancreatic Diversion with Duodenal Switch (BPD/DS)**

clear liquids to a stabilization diet. (See **Table 1**.) Failure to comply may result in complications. In the long term, patients are required to eat a high-protein diet, eat small meals, eat and drink as slowly as possible, and are encouraged to eat healthy fruits and vegetables. Patients should maintain hydration, but should not drink fluids immediately before, during, or after meals, only between meals. Noncompliance with dietary restrictions results in nausea and vomiting, stretching of suture lines and enlargement of the gastric pouch, abdominal pain, constipation, obstruction, and dumping syndrome.

#### **Complications**

Overall, the risk of mortality for these procedures is 1%, with a risk of serious complications of up to 10%.<sup>1</sup> Patients more likely to have complications include males, ages >65, low functional status, open procedures, and a low-volume surgeon or low-volume hospital.<sup>6</sup> The complications can be divided into postoperative, the first few days after surgery, short-term, days to weeks after surgery, and long-term, weeks to years after surgery.

#### ***Postoperative period***

In the postoperative period, pulmonary emboli (PE), anastomotic leaks, and respiratory failure account for 80% of the mortality-related complications and are usually seen within 30 days of the procedure.

- The leading cause of death following bariatric surgery is PE.<sup>1,7</sup>

Table 1. Post Bariatric Surgery Diet Plan		
Phase	Gastric Bypass	Gastric Band
Clear liquid diet	Weeks 1-2	Week 1
Full liquid diet	N/A	Week 2, add protein supplements
Pureed diet	Weeks 3-4, add protein supplements	Week 3
Adaptive/soft diet	Months 2-3	Weeks 4-5
Stabilization diet	Month 4 and lifelong	Week 6 and lifelong

- Anastomotic leaks may present as persistent tachycardia, fever, rigors, hypotension, and severe abdominal pain, although pain is not required.<sup>7</sup> The patient may present with sepsis syndrome. Patients with suspected leaks should have a gastrografin contrast study with prompt surgical consultation. Exploratory laparotomy may be the only way to diagnosis a suspected leak.<sup>1</sup>

**Short-term**

Short-term complications include vomiting, wound infections, stomal stenosis, marginal ulceration and constipation.<sup>1</sup>

- Wound infections are more common in patients who have had open procedures.<sup>8</sup> Signs of infection include fever, pain, erythema, and purulence around the wound. These may occur up to 3 weeks after surgery in morbidly obese patients and should be treated aggressively with drainage and broad-spectrum antibiotics with MRSA coverage, if suspected. Wound infections may also result in incisional hernias.<sup>1,8</sup> Seromas may also occur but are usually painless, nonpurulent, and not associated with fever or erythema.
- Vomiting is common following bariatric surgery and may occur at any time after the procedure. Although in most cases vomiting is due to overeating and dietary noncompliance, an organic cause should be sought if the patient is intolerant to liquids. Stomal stenosis may occur in up to 20% of RYGB patients, resulting in persistent vomiting. The diagnosis may be made by UGIS and can be improved by endoscopic dilation of the stenosis.<sup>1</sup> Recurrent vomiting is more common following gastric band procedures. Severe cases may need IVF and TPN until they are able to tolerate oral feeds. Patients who frequently overeat may cause dilatation of their distal esophagus, causing regurgitation and nocturnal aspiration similar to achalasia.<sup>4</sup>
- Marginal ulceration may occur along the anasto-

motoc site in up to 16% of patients.<sup>1,4</sup> They may present as a GIB with hematemesis, melena, and orthostatic hypotension. Contributing factors include acid production by the gastric pouch, *Helicobacter pylori* infection, stress, and the use of non-absorbable sutures.<sup>4</sup> This may occur as both early and late complications. Early hemorrhage can occur from any of the staple lines or anastomoses sites. An endoscopic evaluation should be performed to identify the ulcer. NSAIDs increase this risk and should be strictly avoided in bariatric patients.<sup>1</sup>

- Postoperative constipation is common and results from narcotic pain medication (as NSAIDs are contraindicated), dehydration, and malabsorption. Patients should be hydrated and treated with stool softeners, laxatives, or enemas as indicated. Granular bulking agents should be avoided, as they may result in esophageal obstruction.<sup>1</sup>

**Long-term**

Long-term complications include cholelithiasis, postprandial hypoglycemia, dumping syndrome, persistent vomiting, and nutritional deficiencies.<sup>1</sup>

- Cholelithiasis and cholecystitis are common complications following rapid weight loss and may occur in up to 50% of these patients. In many cases, surgeons will perform prophylactic cholecystectomies during the bariatric procedure to prevent this. Bile salt administration may reduce this risk if the gall bladder remains.
- Postprandial severe hypoglycemia has been reported and thought to be due to pancreatic islet cell hyperplasia post bypass. Inappropriate insulin secretion may also occur. There is no specific treatment for this condition, only awareness and dietary modification.
- Dumping syndrome occurs due to the influx of undigested carbohydrates into the jejunum causing procholineric symptoms such as nausea, vomiting, diarrhea, tachycardia, and dizziness. It is a com-

plication of RYGB and BPD/DS that occurs after dietary noncompliance. It is self-limited and resolves after several hours of consuming sweets or foods high in sugar. Patients should avoid these items to prevent the syndrome.

- Vague complaints of abdominal pain may occur after any abdominal procedure. Obstruction is more likely to occur after laparoscopic gastric bypass rather than open procedures and may occur weeks to months after surgery. Internal hernias may also occur and are more frequent following a laparoscopic bariatric procedure.<sup>4</sup>
- Strictures may occur at any site of anastomosis resulting in food intolerance, vomiting, and abdominal pain. The incidence of this at the gastrojejunostomy site appears to be higher in the laparoscopic procedures.<sup>4</sup> Technical errors, anastomotic leaks, ischemia, and fibrosis may be responsible for the formation of strictures. Balloon dilatation may be required.
- The most frequent complication of the gastric band is “slippage” or prolapse of the stomach superiorly through the band. This causes obstruction of the lumen of the band and is associated with vomiting and gastroesophageal regurgitation. The misplaced band may be visible on radiographs. Any of the procedures that involve implantation of a foreign body to the external surface of the stomach can cause erosion through the gastric wall. This may be acute or chronic. Patients may present with abdominal pain, fever, signs of localized infection, or may have vague or no symptoms at all.<sup>4</sup> Failure or disconnection of the port have also been described.
- Nutritional deficiencies are common after the mal-absorptive procedures. Adherence to a high-protein diet is essential. Lifelong supplementation with a high-potency multivitamin, B12, and calcium should be continued. Some menstruating women may require parenteral iron supplementation due to poor absorption of enteral iron. Acute encephalopathy caused by thiamine deficiency has been reported.<sup>4</sup>
- A very small group of patients may develop protein malnutrition months to years following surgery due to anastomotic strictures, food phobias, or simply failure to consume enough protein. Alopecia is a relatively common early finding of protein malnutrition.<sup>4</sup> These patients will have repeated episodes of nausea and vomiting and dehydration, and may have renal or hepatic insufficiencies.

**Table 2. Foods to Avoid After Bariatric Surgery**

Nuts and seeds
Popcorn
Dried fruits
Carbonated beverages
Granola
Stringy or fibrous vegetables (celery, corn, cabbage)
Tough meats or gristle
Fried foods

Treatment includes TPN, dilatation of their strictures, if present, and re-education regarding proper diet until malnutrition has resolved.<sup>1</sup>

### Lifestyle, Medication, and Dietary Changes

For the first 1 to 2 months following surgery, patients may require liquid medications. Medications that do not come in liquid form can be crushed and mixed with liquid or sugar-free pudding or applesauce. Once the patient has progressed to a stabilization diet, pills can again be used. Larger pills may need to be broken or crushed.

Bariatric patients should be instructed to avoid NSAIDs for life<sup>1,2,5</sup> due to their high risk of GI bleeding and marginal ulcers. Patients should be instructed about specific names including brand names as well as common over-the-counter names. Many other specialties, for example dentists and podiatrists, are unaware that NSAIDs should be avoided, so patients need to be well educated and vigilant about taking them. Anti-osteoporosis medications and steroids should be avoided for the same reason. If absolutely necessary, steroids can be given with a PPI to prevent bleeding. Granular bulking agents used to add fiber and for constipation may cause obstructions and impaction in the esophagus<sup>1,5</sup> and in the intestines and should be avoided.

Controlled-release medicines should be avoided. The altered absorption and production of digestive enzymes can make their release unpredictable and patients may not receive the intended dosage.<sup>5</sup>

Clinicians should be aware that as a patient’s weight drops, they may note regression in their hypertension and diabetes, requiring lower doses of their current medications. Suspect this if patients present with hypotension, bradycardia, or hypoglycemia without another explanation. Toxicity at lower doses of other previously prescribed medications, such as psychiatric medications may also occur.

Nicotine increases the risk of GIB; patients should be encouraged not to smoke. Similarly, alcohol increases

Table 3. Long-Term Skin Changes Due to Nutrient Deficiency after Bariatric Surgery	
• Acne	• Glossitis
• Alopecia	• Pellagra
• Angular cheilitis	• Psoriasis
• Burning feet syndrome	• Seborrheic dermatitis
• Depigmentation	• Toxic epidermal necrosis
• Eczema	• Xeroderma
• Erythroderma	

the risk of bleeding and also may have increased absorption causing sensitivity to even small amounts.

Certain foods should also be avoided due to difficulties with digesting in both the stomach and absorption in the intestines. (See Table 2.)

Pregnancy is not recommended until 12-18 months after surgery due to nutritional deficiencies and inability to take in enough protein to support a growing fetus. Patients should be counselled to avoid pregnancy and may need birth control. Patients who become pregnant in the early months following bariatric surgery should be referred to an obstetrician immediately for careful monitoring.<sup>9</sup>

**Skin Changes Postsurgery**

Skin issues are common after massive weight loss. Most patients will need skin reduction surgery. Nutrient deficiencies can cause a variety of skin disorders (Table 3), as well as poor wound healing and reduced resistance to infection. Damage to elastin fibers and collagen from stretching followed by weight loss can also occur and make the loose skin behave differently when surgery is performed.

Approximately 90% of patients will have negative effects secondary to large amounts of redundant skin. These may include aesthetic issues, functional problems, and dermatosis, as well as difficulties with personal hygiene.<sup>8</sup> Chafing may occur due to layers of skin rubbing against each other causing irritation, dryness, and pain. Moisturizers such as Aquaphor, Eucerin, and commercially available skin lubricants may improve these symptoms.

Intertrigo or intertriginous dermatitis appears between skin folds as a moist erythema. It may be malodorous and weeping. It is usually itchy and tender. Friction between deep skin folds and absence of air circulation causes this rash to occur. This may be complicated by candida or bacterial infection. Irritant or contact dermatitis may exacerbate the condition. Fungal

elements can be identified with a KOH prep or Wood’s lamp. Erythrasma is a cutaneous corynebacterial infection presenting as red or brown macerated, scaly plaques that fluoresce red under Wood’s lamp.<sup>10</sup>

Skin fold disorders should be treated and prevented by washing the area daily with soap and water, then drying meticulously. A hair dryer on low setting may be used. Daily aeration of the affected area and application of drying powders are recommended. Absorbent clothing or layers of cloth to separate skin folds may also help.<sup>10</sup> Fungal infections should be treated aggressively with combination antifungal and steroid creams. Erythrasma should be treated with topical clindamycin or erythromycin. If cellulitis is present, oral antibiotics are necessary. Diabetes should be tightly controlled. Severe or recurrent cases should be referred for skin reduction surgery. ■

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Take-Home Points
<ul style="list-style-type: none"> <li>• Post bariatric surgery patients are becoming more commonplace in the urgent care setting.</li> <li>• NSAIDs should never be prescribed to these patients.</li> <li>• Suspect overeating or dietary noncompliance when patients present with vomiting. If they are also intolerant to liquids, the patient should be evaluated for an organic cause.</li> <li>• The most common complications in the first month postprocedure are pulmonary embolus and anastomotic leaks, and require a high index of suspicion.</li> <li>• Wound infections should be treated aggressively to prevent systemic infections and subsequent hernias.</li> <li>• As weight loss occurs, patients may present with hypotension or hypoglycemia as their hypertension and diabetes regresses.</li> <li>• A Wood’s lamp may be used to identify fungal infections and erythrasma when there is a rash between skin folds.</li> </ul>





# Pros and Cons of Urgent Care vs Primary Care Billing for Urgent Care Services

**Urgent message:** While it makes business sense for the minority of urgent care facilities that do contract with and bill insurance as a *primary care* practice, the majority contract and bill as *urgent care*, given higher reimbursement and the numerous other benefits this provides an urgent care operation.

ALAN A. AYERS, MBA, MAcc

In 2003, the Centers for Medicare and Medicaid Services (CMS) developed the “Place of Service-20” (POS-20), or “Urgent Care Facility” designation. It’s defined as “a location distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.”

As most payer contracts align with the guidelines set by CMS, in the absence of extenuating circumstances or specific contract language to the contrary, most urgent care facilities use POS-20. An urgent care does also have the option, though, to contract with and bill a payer as POS-11 (ie, a “doctor’s office”) if its operational circumstances and market warrant it.

Following is a snapshot of how the urgent care industry approaches this issue, courtesy of the Urgent Care Association’s *2018 Benchmarking Report*:<sup>1</sup>

- 86% of urgent cares provide an “episodic” scope of care
- 8% of urgent cares offer primary care in addition to urgent care, while roughly 3% are “hybrid” urgent care/PCPs
- Commercial contract restrictions are cited as the most common reason for not offering primary care services
- Similarly, 81% bill as POS-20 (urgent care), around 4% bill as POS-11 (PCP), and approximately 14% bill as a combination of POS-20/POS-11



- 11% of urgent care centers are dual contracted as UC/PCP

With those figures in mind, let us examine the advantages for an urgent care to contract and bill as POS-20, the few circumstances where it makes sense to contract

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and bill as POS-11, and the pitfalls of using POS-11 when POS-20 is the more appropriate and prudent choice.

**Reasons to Contract and Bill as POS-20**

**Higher reimbursement.** The chief reason to bill as POS-20 is the higher reimbursement. When available, urgent care contracts always pay more than primary care contracts. (Remember, 81% of urgent care centers bill POS-20.)

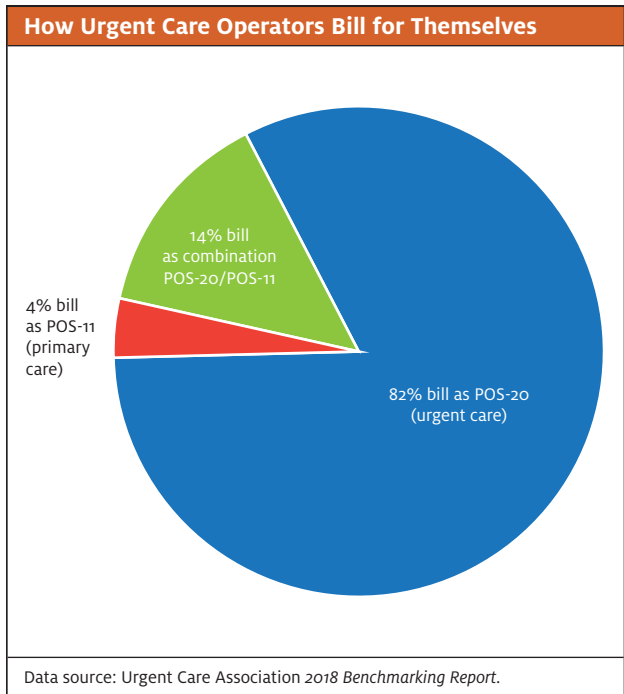
On average, an urgent care contract pays roughly 30% more than a primary care contract. Typical reimbursements for urgent care are about \$115.<sup>1</sup> Because the UCA benchmarking average includes about 20% of centers billing POS-11 (for reasons we’ll discuss shortly), that national reimbursement average is necessarily lower than what is typically seen for a “pureplay” urgent care, which ranges from \$130-\$160 depending on the area of the country.

Primary care contracts billed as POS-11, as mentioned, are considerably lower. At the national level, we’ve seen reimbursement for PCP contracts in the \$90s, which closely aligns with and is corroborated by data put forth by the American Academy of Family Practice.<sup>2</sup>

In states such as Virginia—which is unique insofar as the state legislature has established a website for reporting health costs and data—the average reimbursement for an adult primary care visit in Northern Virginia is listed as \$77.<sup>3</sup> This figure is even lower than the national average, due in part to the large supply of primary care providers in the Washington, DC metropolitan area—resulting from large numbers of international medical graduates migrating to the D.C. area—a large and expanded Medicaid population, and the overall regional growth of managed care organizations that drive down reimbursement rates. (Note: These are historical numbers and subject to change in 2020 with changes to CMS’s Medicare Physician Fee Schedule.)

**Higher operating costs.** The scope and nature of an urgent care operation entails higher operating costs than a primary care office and requires a greater capital and operating investment. To sustain the operation and remain profitable, it’s necessary to contract for the higher reimbursement that comes along with billing POS-20. The higher operating costs encompass some of the following:

- **The need for greater visibility** – Visibility to drive-by traffic is the number-one volume driver in urgent care. Urgent care facilities must be located in high-visibility, retail areas to draw ambulatory



patients from off the street, whereas primary care offices can be tucked away in less expensive office buildings. Retail developments incur higher rents than office buildings due to the visibility and traffic they provide, the larger common areas and parking lots, and the landscaping that must be maintained. Further, larger properties have higher taxes.

- **Larger facility** – Urgent care is a volume-driven business that focuses on speed and service. A center must have greater square footage than a primary care office so it can quickly and efficiently move more patients in and out. Additionally, the build-out, fixtures, furnishings, and equipment for an urgent care center require a greater capital investment.
- **Extensive onsite capabilities** – Urgent care, unlike primary care, must have the capability to treat a patient’s nonemergency presentation on the spot. This requires an onsite x-ray machine, a procedure room to set fractures and apply sutures, and onsite labs for providing an instant diagnosis. This entails having a larger space with more specialized rooms and equipment to diagnose and treat a variety of conditions. Additionally, some urgent care centers dispense medications onsite. These requirements necessarily mean greater capital investment than a primary care office.
- **Documentation of the patient chart.** From the

initial patient intake, primary care providers have a complete medical history for their returning patients, so there is no need to perform this kind of wellness exam on each visit. In an urgent care setting, though, each presentation is episodic, meaning the provider must perform a complete medical history and physical to address the specific medical concern, which requires more provider and staff time.

- **Higher staffing levels** – Urgent care centers must staff for nights, weekends, and holidays whereas PCP offices only staff for business hours 5 or 6 days a week.
- **Less productive labor** – Primary care visits are predictable and thus scheduled in advance, allowing the provider to adapt staffing levels to the expected demand. Urgent care, on the other hand, can have wide variability in demand depending on the season, day of week (eg, Monday mornings are the busiest), time of day (mornings are busier than afternoons), and factors such as whether flu or strep is going around. This requires staffing to the ebb-and-flow of walk-in traffic, so labor will therefore be less productive in urgent care.
- **Marketing expenses** – Primary care does not need to continually market to patients who are already established with the provider and will return three or four times a year for checkups and follow-ups. Urgent care is “retail medicine,” so there must be ongoing marketing campaigns to remain top-of-mind to consumers and create brand awareness in competitive markets.

**Foster PCP relationships.** To increase patient volumes, urgent care must cultivate mutually beneficial referral relationships with PCPs so that the PCP will refer their patients to the urgent care when the PCP office is closed, and a night/weekend/holiday need arises. Hence, when an urgent care center advertises services like “wellness exams” and “chronic disease management,” PCPs view the urgent care as direct “competition,” and may not refer their patients. Additionally, the POS-11 urgent care will not be found in payer directories when health insurance members search for “urgent care.” Urgent care and primary care should be complementary, not in competition.

**Primary care disrupts flow in urgent care.** The top metric for measuring patient satisfaction and labor productivity is time in the urgent care center—ie, door-to-door time. Performing activities that bill as POS-11 and not

POS-20 (such as an initial PCP intake, ordering and reviewing labs, or reconciling prescriptions) can be time-consuming, especially for a new chronic patient. Combining PCP services with urgent care would therefore lead to wide variability in visit length, resulting in longer wait times.

*“While there are a few legitimate circumstances when an urgent care would bill POS-11, billing POS-20 holds numerous benefits for urgent care operators—chief among them establishing a consistent record of urgent care utilization in a given market that justifies a higher reimbursement for all surrounding centers.”*

As an aside, it’s overall bad policy for patients to attempt to manage a chronic condition in urgent care rather than with a PCP. The chronic patient walks in off the street and potentially sees a different provider each visit instead of having scheduled follow-ups with a single primary care provider. Chronic patients with conditions like diabetes and hypertension need a solid “medical home” where the providers are connected to local specialists and have hospital admitting privileges—one reason payers are moving patients to “panels” and paying providers “risk incentives” for positive health outcomes.

In short, the further the business strays from the “core” urgent care services, the less likely it is to perform well on the factors that differentiate urgent care from other providers.

#### **Reasons to Contract and Bill as POS-11**

As outlined, contracting and billing as POS-20 holds numerous advantages for urgent care, which is why it’s

the standard. Payers set the reimbursement rates based on how much it should cost to deliver urgent care services and what's needed for an urgent care center to survive. There are a couple extenuating circumstances, though, where billing POS-11 makes business sense for an urgent care provider, listed below:

**Operating in a heavily saturated market.** In some heavily saturated markets such as those in Florida and New Jersey, insurance companies may inform new centers that their network is “full of urgent care” and an urgent care contract simply isn’t available in their area. When an oversaturated market isn’t accepting any new centers, the only alternative is to settle for a lower-reimbursing PCP contract if the center wants to open.

**Shortage of PCP access.** Let’s say the urgent care operates in a rural or urban area where there is less PCP access and people are relying on urgent care to meet their PCP needs. What’s often the case is that these same rural areas with few PCPs also lack sufficient population density to support a “pureplay” urgent care. The urgent care will then engage in a mixed model of UC/PCP to serve more patients in the area.

When there indeed is a business model that offers both primary and urgent care, it’s typically handled in one of two ways:

- All PCP visits are billed as urgent care. This disadvantages patients with higher copays for sick visits and higher out-of-pocket costs, though, as routine PCP services like vaccinations and wellness exams are typically not reimbursable under urgent care contracts.
- The urgent care sets up a separate PCP business under the same roof. Their PCP business has a unique tax ID, creates separate primary care (POS-11) contracts with payers, and implements a process to segregate which patient traffic is urgent care (ie, walk-in, episodic) vs primary care (ie, scheduled appointments, wellness exams, quarterly follow-up on disease states like diabetes).

In sum, there are situations and circumstances where an urgent care can bill POS-11 and still be a viable business. We’ve seen other cases, however, where urgent care facilities billing POS-11 have run into a host of problems related to not being able to cover operating expenses, inefficient patient flow, PCP referral issues, credentialing, getting claims paid, and staffing that led to their eventual closure. Hence, it behooves each individual urgent care operator to assess their market, business model,

facility, and capabilities before opting to bill and contract as POS-11 rather than POS-20.

**Conclusion**

For urgent care, billing POS-20 holds numerous benefits, chief among them establishing a consistent record of urgent care utilization in a given market that justifies a higher reimbursement for all surrounding centers. Additionally, the clear recognition of being an urgent care facility provides rationale for the higher costs of operating a walk-in facility when negotiating higher rates during contracting. While there are a few circumstances where an urgent care center could legitimately bill POS-11, those situations where it actually makes sound business sense are few and far between. POS-20 in the majority of cases is therefore the appropriate option to support a thriving urgent care operation. ■

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Summary
<ul style="list-style-type: none"> <li>• The chief reason to bill as POS-20 is the higher reimbursement. On average, an urgent care contract pays roughly 30% more than a primary care contract.</li> <li>• The scope and nature of an urgent care entails higher operating costs than primary care—and, therefore, a greater capital and operating investment. To sustain the operation and remain profitable, it’s necessary to contract for the higher reimbursement that comes along with billing POS-20.</li> <li>• Primary care practices in your area may view you as “competition” if you advertise that you offer primary care-type services, and bill POS-11 accordingly. This could put you at a disadvantage when it comes to cultivating mutually beneficial referral relationships with PCPs.</li> <li>• Reasons to bill POS-11 (primary care) are few and far between, but would include:                         <ul style="list-style-type: none"> <li>– Operating in a heavily saturated market, such as those in Florida and New Jersey. When insurers in an oversaturated market aren’t accepting new urgent care centers, the only alternative may be to settle for a lower-reimbursing PCP contract</li> <li>– Shortage of PCP access in a given market</li> </ul> </li> </ul>



## Staying in Good Stead with OSHA Starts with Maintaining Proper Records

**Urgent message:** Urgent care operators have a multitiered relationship with the Occupational Health and Safety Administration: as an employer required to provide a safe workplace for employees; in the context of helping occupational medicine clients maintain compliance with relevant OSHA regulations; and in maintaining thorough and accurate records of occ med employee cases.

■ ALAN A. AYERS, MBA, MAcc

When an urgent care operator opts to offer occupational medicine services, they're taking on more than the responsibility for helping their client's workers get back on the job as efficiently and safely as possible. They're also, even if they don't state it directly, assuring their clients that they'll be compliant with relevant regulations imposed by the Occupational Health and Safety Administration.

Compliance with OSHA regulations must be assured not only to the client, but also to OSHA itself—which can be achieved only through an understanding of and meticulous adherence to strict record-keeping standards. Here, we identify the most relevant to the urgent care occ med provider and offer guidance on how to remain compliant.

### OSHA Mandatory Record Keeping

**According to OSHA:** Most employers are required to maintain an accurate record of work-related injury or illness. This information allows employers, workers, and OSHA to evaluate the safety of a workplace, identify industry hazards, and develop better worker protections.



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**Relevance to urgent care:** For OSHA compliance, an urgent care operation will have a number of records and logs to maintain pertaining to workplace hazards, injury and illness, bloodborne pathogen training, hepatitis B vaccinations and exemptions, and additional training logs.

**How violations occur:** Not maintaining accurate and thorough records and for the required length of time. Not having written plans in place where required. In the event of an OSHA inspection, inspectors could levy citations and/or fines if they deem that the urgent care center has been negligent in its record-keeping.

**Steps toward compliance:** The following forms, logs, and written plans are relevant to the urgent care setting:

- **OSHA's Form 300** – Log of Work-Related Injury and Illness
  - Log for identifying the employee, job title, date of injury, location of injury, and description of injury
  - Must be completed within 7 days of recordable illness/injury
  - Required for any work-related fatality
  - Required for any work-related injury or illness that results in loss of consciousness, days away from work, restricted work, or transfer to another job
  - Required for any work-related injury or illness requiring medical treatment beyond first aid
  - Required for any work-related diagnosed case of can-



cer, chronic irreversible diseases, fractured or cracked bones or teeth, and punctured eardrums.

- Must be retained for 5 years
- If bloodborne pathogen exposure, retain for 30 years
- Employers must prepare in January, then post an annual summary of OSHA Form 300 in their workplaces from February 1 until April 30 of each year. The summary must be certified by the CEO and retained for 5 years

■ **OSHA's Form 301 – Injury and Illness Incident Report**

- OSHA Form 301 is used to further describe the severity and extent of a workplace injury or illness that is recorded in OSHA Form 300. Each injury or illness recorded on OSHA Form 300 or its equivalent must also be recorded on a Form 301 or its equivalent

■ **Training Records**

- Bloodborne pathogen annual training (must retain training records for 3 years)
- Emergency action plan training
- Fire prevention plan training

■ **Hepatitis B Vaccinations Records and/or Exemptions**

- All employees who either received a hepatitis B vaccination, were/are exempt, or declined vaccination
- If declined or exempt, requires waiver form

■ **Sharps Injury Log**

- Bloodborne Pathogen Policy (BPP) requires the establishment and maintenance of a Sharps Injury Log to record all contaminated sharps injuries in a medical facility
- Date and case/report number
- Type of device (eg, syringe, suture needle)
- Brand name of device
- Work area where injury occurred
- Brief description of how the incident occurred (ie, procedure being done, action being performed)

**Safety Committees**

Federal OSHA guidelines do not require urgent care/occ med operators to institute a Safety Committee. Creating one is recommended, however, and is a factor in reducing a fine if a citation occurs. Additionally, having a Safety Committee can lead to discounts on Workers Compensation insurance rates. Following are factors to keep in mind when devising and implementing a Safety Committee.

■ **Safety Committee Meeting Minutes**

- Employer and employee representatives
- Recommended to meet every 4 months

■ **Safety Committee Topics**

- Assessing and controlling hazards
- Assessing safety training and awareness topics
- Communication with employees regarding safety committee activities
- Developing safety rules, policies, and procedures
- Educating employees on safety-related topics
- Evaluating the safety program on a regular basis
- Inspecting the workplace
- Keeping job-specific training current
- Motivating employees to create a safety culture in the workplace
- Reviewing incidents of workplace accidents, injuries and illnesses

■ **Emergency Action Plan (Written)**

- Escape routes posted per fire code
- Procedure to account for all employees evacuated
- Rescue and medical duties by employees
- Responsibility for calling 911
- Train all employees then retrain annually

■ **Fire Prevention Plan (Written)**

- List of known fire hazards
- Fire extinguisher locations (and when last checked to ensure proper function)
- Evacuation procedures
- Annual fire inspection requirements under local municipal laws
- Training and annual retraining of employees designated to operate fire extinguishers

■ **Active Shooter Plan (Written)**

- Crime or unwanted individuals (recent situations: domestic abuse, threatening patient)
- Security alarm panic button location and proper usage

■ **Exposure Control Plan (Written)**

- Comprehensive plan for protecting against bloodborne pathogen exposure and other potential infectious materials (OPIM)

■ **Protective Equipment (Log)**

- Catalogue of scrubs/lab coats, gloves, face shields, eye protection, mouthpieces (resuscitation devices) in use
- Review annually as a leadership team for updates

■ **Facility Checklist** (independent of OSHA regulations)

- Urgent care centers should always have a “facility checklist” to assure the physical plant is clean, neat, and in good repair—primarily to eliminate facility

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issues as a detractor to achieving good customer service survey scores. The facility checklist also has value in regard to OSHA as it helps to ensure any hazards are identified and addressed, and that “compliance” measures are active.

There should also be one master log that lists every training that occurred in a given year. These records must be retained for at least 3 years. However, it is advisable that they be maintained for the duration of employment.

### OSHA Inspections

**According to OSHA:** To support and enforce the safety and health requirements of America’s workplaces, OSHA can and will conduct an inspection—without advance notice—of any of the 7 million workplaces over which it has jurisdiction. OSHA inspectors ensure compliance with OSHA requirements and assist employers and workers in reducing workplace hazards, injuries, illnesses, and deaths.

**Relevance to Urgent Care:** Given that an OSHA inspection will be unscheduled and unannounced, an urgent care should make sure that it’s always compliant with OSHA standards and guidelines. The following circumstances can trigger an OSHA inspection:

- **Imminent danger situations** – hazards that can cause death or serious physical harm
- **Severe injuries and illnesses** – fatalities, hospitalizations, amputations, or loss of an eye (must be reported to OSHA within 8 hours)
- **Worker complaints** – allegations of hazards or violations receive high priority. Employees are granted anonymity if requested when a complaint is filed. An employee concerned about any safety hazard can report it using the OSHA hotline (1-800-321-6742)
- **Referrals** – from federal, state or local agencies, individuals, organizations or the media receive consideration for inspection
- **Targeted inspections** – inspections targeted toward high-hazard industries or individual workplaces with a history of high rates of injuries and illnesses
- **Follow-up inspections** – to check if citations and violations cited during previous inspections have been corrected

**What to know:** If an OSHA inspector arrives onsite, your urgent care staff can “buy time” by verifying the inspector’s ID and calling the inspector’s office to verify their presence. This is perfectly legal and recommended for security purposes. Meanwhile, while the inspectors are waiting, the staff can quickly run through the facility checklist to ensure no hazards are present.

- The OSHA inspection is typically comprised of two parts:
- The inspector will review all training records, the OSHA

300 log, and the file of incident reports

- The inspector will tour the facility to identify and evaluate hazards. The inspector may also interview employees privately

If an OSHA inspector takes pictures or video (or uses an instrument to take environmental readings), employers are allowed to take photo/video of the exact same things so to visually document and record what OSHA was focused on.

*“To strengthen your center’s OSHA compliance, start with a thorough assessment of your facility, logs, records, and written plans to identify areas for improvement.”*

### Post Inspection

- The inspector will conduct a closing conference to discuss all unhealthy conditions observed and any violations found, or citations recommended
- Any proposed settlement can be appealed within 15 days

During an OSHA inspection, the urgent care operator should not be confrontational or defensive. Cooperate by producing records to demonstrate compliance efforts and offer a plan for remediation. If the inspection is regarding a specific incident, then the onus falls on the employer to prove to OSHA there was absolutely nothing reasonable the urgent care could have done to prevent the incident.

### New and Evolving OSHA Standards (Active Shooters, Workplace Bullying, Workplace Ergonomics)

**According to OSHA:** While OSHA does not currently have regulations or guidelines concerning active shooters, workplace bullying, or workplace ergonomics, they can cite them under the General Duty Clause of the Occupational Safety and Health Act, Section 5(a)(1). All employees are covered by OSHA under this section.

**Active Shooters:** “Enforcement Procedures and Scheduling for Occupational Exposure to Workplace Violence” is the directive OSHA released to its inspectors in 2017 to begin workplace training for violent events. In the absence of a defined OSHA standard, OSHA recommends that all employers consult the Department of Homeland Security’s Active Shooter Emergency Preparedness: Getting Started page ([https://www.osha.gov/SLTC/emergencypreparedness/gettingstarted\\_evacuation.html](https://www.osha.gov/SLTC/emergencypreparedness/gettingstarted_evacuation.html)) which is focused on the planning and evacuation stages of a violent incident.

**Workplace Bullying:** There remains a spirited debate as to whether workplace bullying is a violation of OSHA. Those who contend that bullying is indeed a violation point back to the OSHA

**OSHA Compliance Checklist for Urgent Care Operators**

Urgent care operators should be cognizant of the following in order to assure employee safety and compliance with OSHA standards:

- Every urgent care center should have a written Exposure Control Plan, available to all employees, reviewed and updated on an annual basis. That plan should include the following elements:
  - Universal precautions (treatment of all bodily fluids as an infection risk)
  - Engineering and work practice controls
    - Hygiene protocols (ie, guidelines for washing hands/skin, eyewash station to flush eyes upon any exposure)
    - Sharps injury prevention devices (ie, “safer” needles that retract or destruct)
    - Antimicrobial soap/cleaning supplies (for disinfection of surfaces and supplies)
  - Personal protective equipment
    - Employee dress code including scrubs for back office staff, white lab coats for providers, a requirement of closed-toe shoes, and a prohibition on “street clothes” (including Halloween costumes) when in contact with patients or patient specimens
    - Employees should be offered, and if appropriate the employer should pay for, personal protective equipment like eye shields, rubber gloves, and resuscitation guards
  - Postexposure medical actions and follow-up

- Every urgent care center should have a written Bloodborne Pathogens Training Plan, with orientation and training for all new employees, and annual refresher training conducted and documented
- Every staff member should be offered a hepatitis B vaccine at no charge, paid for by the employer (employees who refuse need to sign a Vaccine Declination Form which informs them that they may receive the vaccine if they change their mind in the future)
- Biohazardous waste must be identified by a sign or label indicating the hazard, including sharps disposal containers, segregation of soiled laundry and waste into a specially labelled closet or storage area, and pick-up by a certified disposal vendor
- Every urgent care center should maintain a log of sharps and needlestick injuries, to be analyzed for root cause and continual improvement opportunities
- Every urgent care center should identify any toxic substances requiring an SDS (generally not required since the quantity of any chemicals is small and in a vendor-labelled container), and assure all cleaning supplies and other substances are in their original labelled containers
- Every urgent care center must display the OSHA Form 300A summarizing workplace injuries between February 1 and April 30 of each year. Additionally centers must display OSHA Form 3165 (“It’s the Law” poster) or state equivalent in the breakroom or other prominent area.

General Duty Clause charging employers with providing a safe workplace free from harm—making the argument that bullying, intimidation, and verbal abuse can result in emotional, psychological, or even physical harm. OSHA even adopted its own antibullying policy in 2011 that protect its employees. Regardless of OSHA regulations, though, workplace bullying is a serious and growing issue that employers have begun to take more seriously in recent years; hence, urgent care should follow suit.

**Workplace Ergonomics:** Although there are no specific ergonomic regulations, OSHA will continue to cite ergonomic injuries under the General Duty Clause. Therefore, it’s the responsibility of the employer to ensure work areas and tools are in place to reduce work-related musculoskeletal disorders (MSDs), toward helping workers stay healthy.

MSDs are the result of prolonged exposure to ergonomic risk factors such as:

- Excessive repetitive movements
- Unsupported positions and awkward postures that can compress nerves and irritate tendons
- Static postures that impede blood flow and strain muscles

Even as there are no specific training requirements for ergonomics, employees trained to identify and avoid ergonomic hazards fare much better at avoiding them, resulting in fewer injuries and a safer workplace.

**Reporting to OSHA**

**According to OSHA:** All employers must report all work-related

fatalities, work-related inpatient hospitalizations of employees, work-related amputations and work-related loss of an eye to OSHA. Fatalities must be reported within 8 hours of discovery. All other work-related incidents must be reported within 30 days. Reporting mechanisms include:

- By telephone to the local OSHA office
- By telephone to the 24-hour OSHA hotline (800) 321-OSHA (6742)
- Electronic form on the OSHA website [www.osha.gov](http://www.osha.gov)

Additionally, when cultivating a “culture of compliance,” consider creating an anonymous reporting mechanism. This can be a third-party hotline reached anonymously by phone or email or it can be a simple “safety box” anywhere employees can make anonymous reports and suggestions. Presence of this feedback mechanism has been shown to lower an employer’s chance of receiving an OSHA violation by 25%.

**Conclusion**

The importance of OSHA compliance for urgent care, although not a topic that’s broached often, cannot be overstated. This holds especially true for bloodborne pathogen exposure, the greatest single safety risk in urgent care. To begin strengthening your center’s OSHA compliance, start with a thorough assessment of your facility, logs, records, and written plans to identify areas for improvement. OSHA provides free consultative services your center can access to help identify gaps and help provide recommendations for compliance. OSHA cannot give a citation when on-site in a consultative function, so there’s no

Select OSHA Requirements Regarding Recordkeeping and Reporting

OSHA spells out specific requirements of their recordkeeping policies on their website. Some are more directly applicable to employers than occ med providers, but in the interest of having a broad understanding of those requirements—which in turn may inform the services you’re able to offer—we present highlights adapted directly from *OSHA Injury and Illness Recordkeeping and Reporting Requirements*. The complete version is available at: <https://www.osha.gov/recordkeeping/index.html>.)

OSHA published a Final Rule to amend its recordkeeping regulation to remove the requirement to electronically submit to OSHA information from the OSHA Form 300 (Log of Work-Related Injuries and Illnesses) and OSHA Form 301 (Injury and Illness Incident Report) for establishments with 250 or more employees that are required to routinely keep injury and illness records. Covered establishments are only required to electronically submit information from the OSHA Form 300A (Summary of Work-Related Injuries and Illnesses). The requirement to keep and maintain OSHA Forms 300, 300A, and 301 for 5 years is not changed by this Final Rule. *OSHA views the 300a form data as confidential commercial information, and will not release it to the public.*

**Recordkeeping Requirements**

Many employers with more than 10 employees are required to keep a

record of serious work-related injuries and illnesses. (Certain low-risk industries are exempted.) Minor injuries requiring first aid only do not need to be recorded.

This information helps employers, workers and OSHA evaluate the safety of a workplace, understand industry hazards, and implement worker protections to reduce and eliminate hazards -preventing future workplace injuries and illnesses.

**Maintaining and Posting Records**

The records must be maintained at the worksite for at least 5 years. Each February through April, employers must post a summary of the injuries and illnesses recorded the previous year. Also, if requested, copies of the records must be provided to current and former employees, or their representatives.

**Electronic Submission of Records**

The Injury Tracking Application (ITA) is accessible from the ITA launch page, where you can provide the Agency your OSHA Form 300A information. The date by which certain employers are required to submit to OSHA the information from their completed Form 300A is March 2 of the year after the calendar year covered by the form.

need for undue concern when calling upon their representatives to inspect your workplace. Beyond OSHA, an urgent care centers Worker’s Comp carrier can also provide free advice.

In short, cultivating a “culture of compliance” requires a team effort which, when undertaken with earnest, will result in a workplace that’s safe and healthful for everyone. ■



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## ABSTRACTS IN URGENT CARE

- Take a Seat—Your Patients Will Thank You
- Buddy Taping vs Plaster Casting in Boxer’s Fractures
- Efficacy of Baclofen in Back Pain
- Rapid Testing for Gonorrhea and Chlamydia
- Five- vs 10-day Treatment for Strep Throat
- A Better Screening Test for ACL Rupture

■ YIJUNG RUSSELL, MD

### Sitting During an Encounter Is an Easy Way to Increase Patient Satisfaction

*Key Point: If a provider sits during an encounter, the patient feels that they care more, listen more, inform better, is polite, and spends more time.*

Citation: Orloski CJ, Tabakin ER, Shofer FS, et al. Grab a seat! Nudging providers to sit improves the patient experience in the emergency department. *J Patient Exp.* 2019;6(2):110-116.

**Relevance:** The hurried nature of acute care does not create an ideal setting for good communication, and patient satisfaction frequently suffers for perceived lack of it. Additionally, there is a positive correlation between effective communication and compliance. There are both verbal and nonverbal aspects of communication—and both can be improved.

**Study Summary:** The authors completed a prospective trial in two academic EDs—one control and one intervention. In the intervention ED, exam rooms had folding chairs for providers and signs saying *Grab a Seat*. Of 2,827 patients who were given a 12-question survey before and after the chairs were placed, only 13% thought it was important for providers to sit during encounters. However, the results indicate that sitting at any time during the encounter led to a perception that the providers cared more, listened more, informed better, were more polite, and spent more time with them. In addition, placing a chair with the *Grab a Seat* sign in the room increased the chance of providers sitting by 30%. ■

**Yijung Russell, MD** practices in the Department of Emergency Medicine at Amita Health Resurrection Medical Center in Chicago.

### Buddy Taping Is Noninferior to Plaster Casting for Uncomplicated Boxer’s Fractures

*Key point: Buddy taping the ring and little finger in uncomplicated boxer’s fractures results in similar functional outcomes as plaster casting, fewer missed days of work, and shorter ED stays.*

Citation: Pellatt R, Fomin I, Pienaar C, et al. Is buddy taping as effective as plaster immobilization for adults with an uncomplicated neck of fifth metacarpal fracture? A randomized controlled trial. *Ann Emerg Med.* 2019;74(1):88-97.

**Relevance:** Fractures of the fifth metacarpal bone (ie, boxer’s fractures) are among the more common hand injuries seen in urgent care. Boxer’s fractures which are minimally displaced, closed, and isolated injuries with <70% angulation are considered uncomplicated and managed nonsurgically with various methods of immobilization, including buddy taping and use of plaster casts and splints. As these methods offer different timelines for patients to return to work and hobbies, it is important to characterize and compare their efficacies.

**Study Summary:** Ninety-seven patients with uncomplicated boxer’s fractures were randomized to receive either buddy taping or plaster casting. Hand function at 12 weeks was measured via the quickDASH questionnaire, which presents 11 questions that assess pain, disability, and ability for everyday tasks. At 12 weeks, both groups had quickDASH scores of 0 (lowest degree of disability). There was also no difference in pain or satisfaction scores at 12 weeks, with both groups reporting a high level of satisfaction with their treatment. In addition, patients randomized to receive plaster casting missed a median of 2 days of work, whereas patients in the buddy tape group missed none. Finally, the buddy taping group had a median length of ED stay that was 36 minutes shorter than that of the plaster casting group. ■

### Adding Baclofen to Ibuprofen for Acute Lower Back Pain Does Not Improve Outcomes

**Key point:** Adding a muscle relaxant to ibuprofen led to no difference in disability or pain level at 1 week post ED visit for acute lower back pain.

**Citation:** Friedman BW, Irizarry E, Solorzano C, et al. A randomized, placebo-controlled trial of ibuprofen plus metaxalone, tizanidine, or baclofen for acute low back pain. *Ann Emerg Med.* 2019;74(4):512-520.

**Relevance:** Providers often prescribe “muscle relaxants” along with NSAIDs for patients who present with lower back pain in the acute care setting. This study sought to identify whether addition of a “muscle relaxant” made a meaningful difference when added to ibuprofen.

**Study Summary:** In this randomized, double-blind study, 320 patients presenting with functionally impairing back pain for <2 weeks were allocated to receive either ibuprofen and placebo or ibuprofen and a “muscle relaxant” (metaxalone, tizanidine, or baclofen). At 1 week postvisit, patients completed the Roland-Morris Disability Questionnaire, a validated scale often used in back pain research. In addition, patients were asked to score their pain level as none, mild, moderate, or severe. After 1 week of treatment, the average RMDQ score decreased from 19 to 10.8, with no significant difference detected among the four groups. There was also no clinically significant difference in reported pain levels or adverse events. ■

### Rapid Gonorrhea/Chlamydia Testing Reduces Errors in Treatment

**Key point:** Rapid GC and chlamydia testing in the ED significantly decreased under- and overtreatment of patients without increasing length of stay.

**Reference:** Gaydos CA, Ako M-C, Lewis M, et al. Use of a rapid diagnostic test for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* for women in the emergency department can improve clinical management: report of a randomized clinical trial. *Ann Emerg Med.* 2019;74(1):36-44.

**Relevance:** Sexually transmitted infection (STI) in women with *C trachomatis* and *N gonorrhoea* is common and the incidence of both infections is increasing in the U.S.—with widespread consequences, including infertility. However, the results of current assays are not available for 2-4 days, making their utility in the acute care setting limited.

**Study Summary:** In this randomized study, 254 women clinically deemed to need a pelvic exam and testing for GC/CT were

allocated to receive standard-of-care nucleic acid amplification testing or the FDA-approved rapid point-of-care GC/CT test GeneXpert, in addition to the standard-of-care. In the latter group, there was 100% agreement in results between nucleic acid amplification and GeneXpert. The results show that 46% and 57% of patients infected with *C trachomatis* and *N gonorrhoea*, respectively, were inappropriately not treated in the standard-of-care group. There was no undertreatment in the GeneExpert group. In addition, there was a significant increase in overtreatment (treatment in women who did not test positive for either organism) in the standard-of-care group when compared with the GeneXpert group. ■

*“There are an estimated 200,000 cases of ACL tears in the U.S. annually. Only 26% of acute ACL tears are correctly diagnosed in the emergency setting. Untreated, ACL tears can lead to deterioration of the meniscus and, ultimately, to the necessity for total joint arthroplasty.”*

### Five days of Penicillin is Noninferior to 10 Days for Strep Throat

**Key point:** Five days of treatment with QID penicillin V was non-inferior to 10 days of TID treatment in confirmed strep pharyngitis, and led to faster relief of symptoms and decreased adverse events.

**Citation:** Skoog Ståhlgren G, Tyrstrup M, Edlund C, et al. Penicillin V four times daily for five days versus three times daily for 10 days in patients with pharyngotonsillitis caused by group A streptococci: randomised controlled, open label, non-inferiority study. *BMJ.* 2019 Oct 4;367:l5337.

**Relevance:** Sore throat is one of the most common presenting symptoms in acute care settings, with group A streptococcus (GAS) the most common pathogen implicated. Current guidelines recommend 10 days of treatment with antibiotics for GAS pharyngitis. In the setting of antibiotic resistance, it is important for us to act as stewards in using antimicrobials as effectively as possible. In addition, reducing treatment duration could



increase patient adherence and decrease side effects (such as impacting the patients' microbiota).

**Study Summary:** In this randomized, noninferiority multicenter study, 433 patients were allocated to be treated with either penicillin V 800 mg QID for 5 days or 1000 mg TID for 10 days. The primary outcome was clinical cure at 5-7 days after the end of antibiotic treatment at the test-of-cure visit. Clinical cure at evaluation was 89.6% in the 5-day treatment group and 93.3% in the 10-day treatment group, with the 95% confidence interval crossing the noninferiority line (-10.04 to 1.9). In addition, only four patients, all in the 10-day group, experienced complications. Finally, time to first day of relief from symptoms was significantly shorter in the 5-day group according to the patients' treatment diaries. ■

**The Lever Test Can Detect ACL Rupture with 100% Sensitivity**

*Key point: The lever test was 100% sensitive and 93.75% specific for rupture of the anterior cruciate ligament, whereas the anterior drawer/Lachman test was only 40% sensitive and 100% specific for ACL rupture.*

**Citation:** McQuivey KS, Christopher ZK, Chung AS, et al. Implementing the lever sign in the emergency department: does it assist in acute anterior cruciate ligament rupture diagnosis? *J Emerg Med.* 2019;57(6):805-811.

**Relevance:** There are an estimated 200,000 cases of ACL tears in the U.S. annually. Untreated, ACL tears can lead to deterioration of the meniscus and, ultimately, to the necessity for total joint arthroplasty. A recent study estimated that only 26% of acute ACL tears are correctly diagnosed in the emergency setting. It is important to develop better methods to screen for ACL injury.

**Study Summary:** Forty-five patients were allocated to be screened for ACL tear using either the lever test or anterior drawer/Lachman test. In a subsequent follow-up, a sports medicine specialist completed evaluation of the patient, including MRI of the knee. Results show that the lever test is 100% sensitive, whereas the anterior drawer test is 40% sensitive for ACL injury. However, the lever test had 94% specificity while the anterior drawer/Lachman test had 100% specificity. ■

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## When Your Workers Comp Patient Is Reluctant to Return to Work

**Urgent message:** One of the occupational medicine provider's most difficult challenges is when a patient with a work-related injury or illness is judged ready to return to full duty, but the patient resists going back to work.

■ MAX LEBOW, MD, MPH, FACEP, FACPM

### Introduction

This article will address the problem of difficult-to-discharge patients who resist returning to full duty when their work-related injury/illness has resolved. We will discuss the process of early identification of work-reluctant patients while monitoring them through the treatment process, and identify ways to return patients to full duty in a compassionate, straightforward way that is consistent with good medical care and recognized occupational medicine guidelines.

### The Case

Your patient is a 28-year-old male plumbing assistant 28 days status post minor soft-tissue injury, which occurred when a coworker opened a door and struck him on his right shoulder. He completed his shift but presented the next day with 10/10 right shoulder pain. At that time, all diagnostic x-rays were negative. However, physical exam revealed tenderness and decreased range of motion secondary to pain.

The treatment plan, following American College of Occupational and Environmental Medicine guidelines, was non-steroidal anti-inflammatory medication, physical therapy, and home exercise. Because his job duties include lifting up to 40 pounds, he was placed on modified duty.

Now, after 4 weeks, the patient no longer has objective findings of the injury. However, he continues to insist that he is

unable to return to full duty due to continued severe pain, with no change from the first day of injury.

What is your next step?

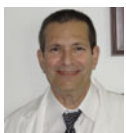
### Begin Discharge Planning on the First Visit

The chance of a difficult discharge can be mitigated by proper communication at the beginning of the case—starting with the first visit. Setting patient expectations at the onset of treatment is the most important early step. Remember, employees are bombarded by conflicting messages. Television and billboard Workers Compensation plaintiff attorneys are ubiquitous, promising that any workplace injury can turn into a financial windfall. Our job as occupational medicine professionals is to set realistic expectations so patients understand that they will get all the care they need and should return to full duty within a reasonable timeframe.

The timing of this discussion is important. Only after a thorough history and physical and completion of diagnostic testing, and after reviewing the diagnosis with the patient, should the subject of the time frame of resolution and discharge be discussed.

The occupational medicine provider who shows true empathy from the beginning of the case will have more effective communication. Building trust is essential. This sensitive discussion should be done in a reassuring and therapeutic way that lets the patient know the provider has their best interests as the guiding principle. However, making sure that the patient understands that you believe the injury/illness is self-limited, when that's the case, is essential.

The provider may get some clues of difficulties to come even at this early stage. If the patient disputes or is overly pessimistic that they will get better in a reasonable timeline, it may represent an early red flag that you are dealing with the employee



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with thoughts of secondary gain from their injury.

#### *Follow-up care—monitoring recovery*

Most contusions and strains will begin to resolve within the first 7–14 days. If the patient contends that they are having no improvement, it is important to review the history, physical, and mechanism of injury to assure that the diagnosis is correct. The provider should keep an open mind and be ready to seek additional information if indicated. This process may include additional diagnostic testing, such as MRI, and should include talking with the employer to find out if there are circumstances at the worksite that may affect response to treatment. A recent poor performance or conflict with coworkers or managers may help explain the patient's reluctance to return to work.

If the patient fails to improve even though the diagnosis is accurate and the treatment plan is appropriate, especially if subjective complaints are not supported by objective findings, this may be a clue that the patient will resist returning to full duty when the time comes.

The best way to approach all patients with work-related illness/injury is through close monitoring, encouragement, and reaffirming that the patient will be better soon.

An important step to returning the patient to full duty is to review the patient's modified duty restrictions at each visit. The goal should be a graded increase in duties at work, both to prevent deconditioning and to avoid the patient becoming "too comfortable" in their light-duty assignment. The occupational medicine provider must understand the patient's job description and job duties to best craft a modified duty position for the injured employee.

#### *Preparation for D-Day (Discharge Day)*

Up to this point, our goal has been to first prevent, then identify, cases of the potential work-adverse patient/employee, and to closely monitor their recovery process. However, at a certain point, using medical judgment and recognized occupational medicine guidelines, the difficult task of discharging the unwilling and uncooperative patient will present itself.

Since this is part of the occupational medicine landscape, every occupational medicine provider must have a plan to deal with the situation. If there is an anticipation that the patient will be dissatisfied with the return-to-work instructions, the provider should contact the patient's employer and apprise them of the situation. Working with the employer will avoid misunderstandings that can occur when their employee returns to the worksite unhappy.

#### *Talking with the patient*

The return-to-work conversation with the patient needs to be done in a nonjudgmental manner that stresses medical *facts* and deemphasizes medical *judgment*. The patient needs to

know that it is not the provider's sole decision that determines when the patient returns to full duty, but rather the medical facts of the case, that the human body is always healing and repairing; referencing published occupational medicine guidelines may be helpful.

If the patient still claims pain that is out of proportion to objective findings and inconsistent with the mechanism of injury, this must be acknowledged and discussed. The provider should not question whether the pain is real or imagined, but rather stress that persistent pain after a relatively minor injury is unusual.

If the patient truly is still in significant pain, there may be a cause that is not related to the original workplace injury. The provider should discuss and document in the record that continued pain is no longer considered to be caused by the injury and should be worked up by his primary care physician. Referring the patient back to the PCP for nonindustrial conditions is also an important risk management tool.

#### **Conclusion**

There will always be patients who will resist returning to work. These cases need not result in conflict and frustration, however. As we've discussed, there are specific steps that can be taken from the first clinic visit to the day of discharge that can assure that the patient receives the medical care they need, and is returned to work when it is medically indicated. The key is to use solid patient communication and medical care throughout the process. ■

#### **Take-Home Points**

- Setting patient expectations at the onset of treatment is the most important early step. Proper communication, starting with the first visit, reduces the chance of a difficult discharge.
- As occupational medicine professionals, it is our responsibility to ensure that patients understand they will get the care they need and are expected return to full duty within a reasonable timeframe.
- If there is an anticipation that the patient will be dissatisfied with the return-to-work instructions, the provider should apprise the patient's employer of the situation. Working with the employer will avoid misunderstandings that can occur when their employee returns to work unhappy.
- Red flags that a patient may be difficult to discharge include:
  - A pessimistic outlook for a timely recovery from the outset
  - Failure to improve even if the diagnosis is correct and the treatment plan is appropriate
  - Subjective complaints that are not supported by objective findings





# When Is Tachycardia in a Patient with URI Symptoms a Sign of Something More Serious?

**Urgent message:** Brugada syndrome is a genetic disorder associated with increased incidence of ventricular tachyarrhythmias and sudden cardiac death. There have been cases associated with fever, viral infections, and pneumonias—all conditions urgent care clinicians treat in abundance. This case report demonstrates how urgent care providers can diagnose a potentially lethal disorder when patients are being seen for febrile illnesses.

KATHLEEN B. RASCHKA, MD

## Case Presentation

A 55-year-old male with a history of hypertension, hyperlipidemia, and allergic rhinitis presented to a local urgent care with a 3-4 day history of productive cough and headache. He also complained of fatigue and postnasal drainage, in addition to chest congestion. He had no subjective fevers and his temperature was 37.2° C in clinic. He initially assumed his symptoms were allergy-related and tried several over-the-counter cold preparations to alleviate his symptoms. On review of systems, he denied complaints of chest pain, palpitations, edema, or shortness of breath. There was no reported family or personal history of cardiac disease. He took no regular prescription medications.

On examination, the patient was a well-appearing male in no distress. His vital signs were BP of 123/96 and a pulse of 128 bpm. His temperature was 36.8° C, respirations were 16, and his SpO<sub>2</sub> was 96%. His head and neck examination was unremarkable except for slight cobblestoning in the posterior pharynx. His cardiovascular examination was significant for a regular tachycardia. Respiratory examination was significant for diminished lung sounds at the bases bilaterally.

## Differential Diagnosis

The differential for the patient's tachycardia included



medication use (decongestants), pulmonary embolism (PE) (although not hypoxic), myocarditis, dehydration, or underlying undiagnosed cardiac condition. Of note, there was a low suspicion for dehydration, as he did not report any vomiting or diarrhea and was maintaining a

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Figure 1. EKG 1 in urgent care at 1327.

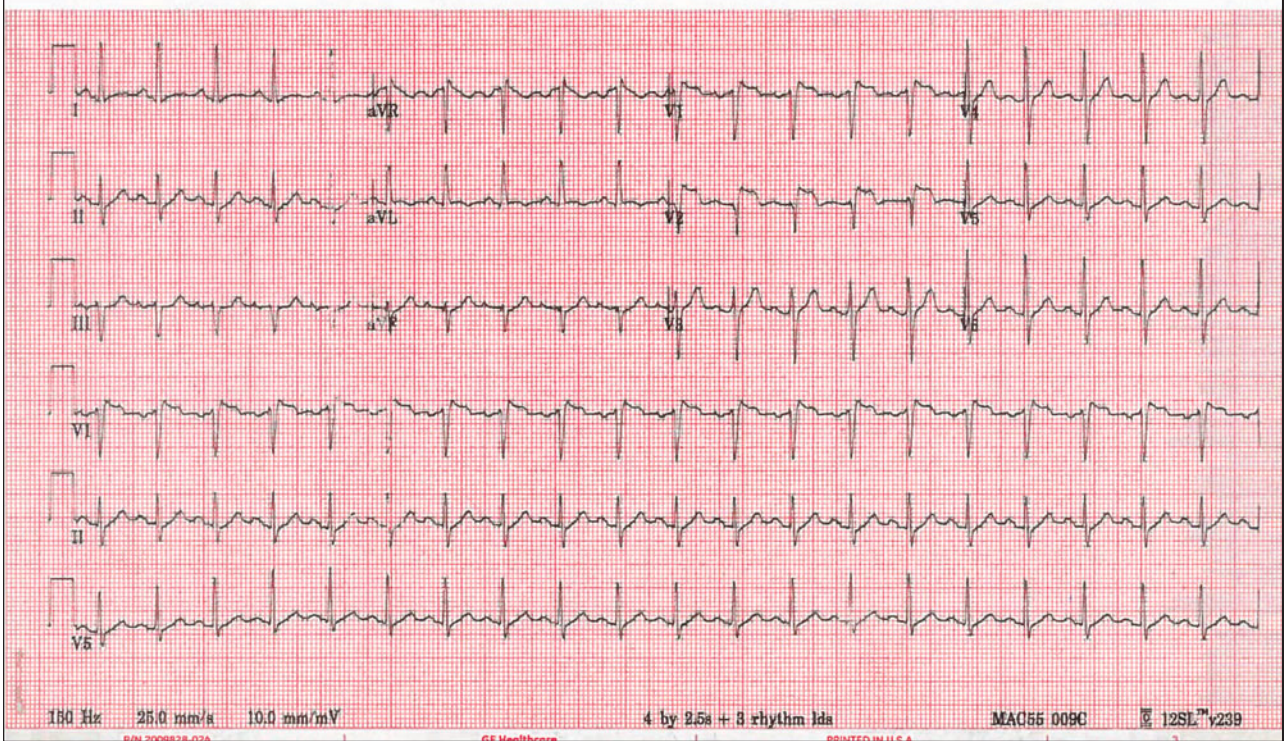
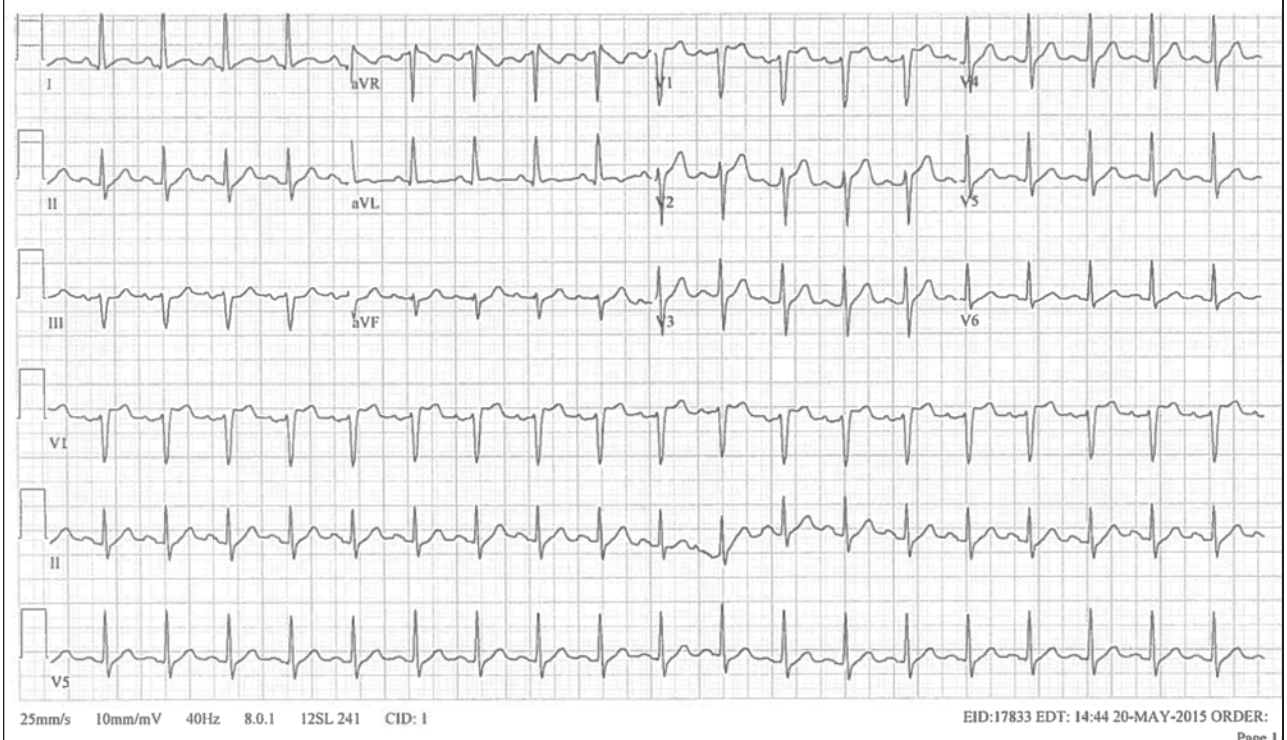
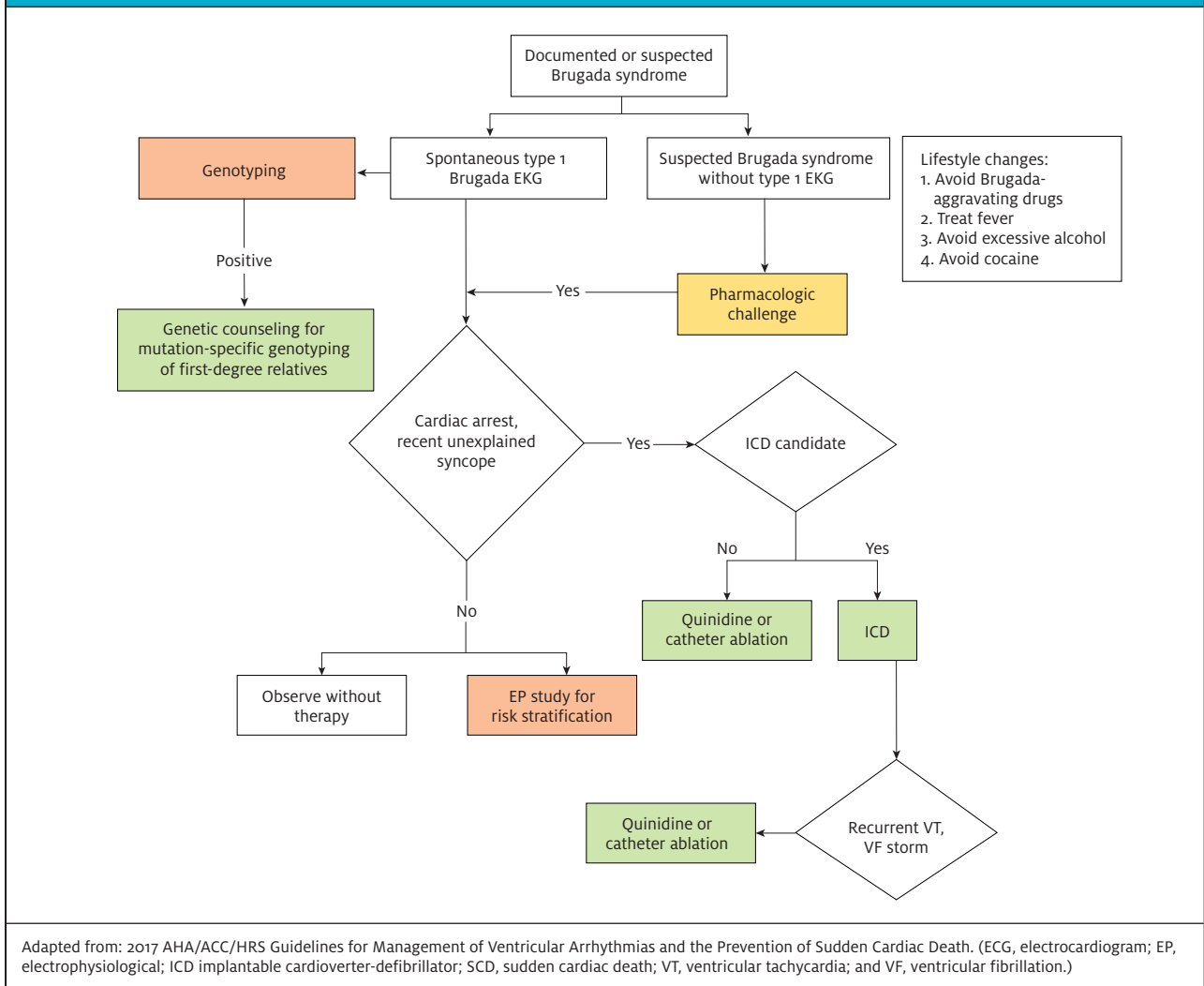


Figure 2. EKG 2 in emergency room at 1416.



**Figure 3. Prevention of SCD in Patients with Brugada Syndrome**



good oral intake. The differential diagnosis for cough and URI symptoms included viral URI, influenza, acute viral bronchitis, pneumonia, or allergy.

**Evaluation**

An EKG was ordered to evaluate the unexplained rapid heart rate (Figure 1), showing sinus tachycardia at 122 bpm, with ST elevation in V1 and V2 and T wave inversion in aVL. Although asymptomatic on examination, the etiology of the patient’s focused ST elevation was unclear, and the patient was treated as a potential STEMI. We administered aspirin 324 mg orally and placed him on supplemental oxygen for comfort. EMS was called and the patient was transported to the ED.

In the ED, patient was evaluated by a cardiologist. A

repeat EKG (Figure 2) showed improvement but not complete resolution of the ST elevation in V1 and V2. Prior review of an EKG performed in 2003 revealed a slight ST elevation/J point elevation in V2, but not to the same extent as the one performed in urgent care. The troponin was negative, and bedside echocardiogram showed no wall motion abnormality. The tachycardia improved after IV fluids. A chest x-ray demonstrated a mild perihilar infiltrate, and he was therefore diagnosed with pneumonia and discharged home on azithromycin (of note, the EKG did not show QT prolongation).

The patient followed up with cardiology 2 weeks after this, and had a normal EKG at that office visit. The diagnosis of the urgent care EKG was type II Brugada pattern. The patient had no symptoms, and subsequently wore



a continuous cardiac monitor for 2 weeks, revealing no significant atrial or ventricular arrhythmias. Therefore, no further testing was recommended.

### Brugada Syndrome

Brugada syndrome can be divided into two clinical entities:

1. Brugada syndrome, when symptoms are present in the setting of a Brugada pattern on EKG
2. Brugada pattern, when symptoms are absent

Brugada syndrome is most common in men, with an average age of 41, particularly in those of Asian descent. While the prevalence of Brugada syndrome among patients with Brugada patterns has not been well studied, a 2006 meta-analysis in the *Journal of Cardiovascular Electrophysiology* found that “the findings of a history of syncope or sudden cardiac death, the presence of a spontaneous type 1 Brugada EKG, and male gender predict a more malignant history.”<sup>1</sup>

Patients with Brugada syndrome may present with palpitations, lightheadedness, or syncope in the setting of characteristic EKG findings. In severe instances, Brugada syndrome can present as only cardiac arrest. It is notable that the arrhythmias generally occur more commonly at night and are not related to exercise.

On EKG, there is ST segment elevation in leads V1 to V2 in either of the following two patterns:

- Classic Brugada type 1: There is J point elevation and the elevated ST segment descends with an upward convexity to an inverted T wave.
- Brugada type 2: There is J point elevation but the elevated ST segment has a “saddle back” configuration due to the positive T wave.<sup>2</sup>

In some patients, these characteristics are transient or variable over time. Provoking factors include medications (sodium channel blockers, calcium channel blockers, beta blockers, tricyclic or tetracyclic antidepressants, lithium, and some local anesthetics), metabolic abnormalities involving potassium or calcium, alcohol, cocaine, vagal maneuvers, and fever. Patients with acute symptoms including fevers, treatment with sodium channel-affecting medication, drug overdose, or electrolyte imbalances who present with a Brugada-type EKG are at much higher risk of sudden cardiac death.<sup>3</sup>

Patients with EKG findings consistent with the Brugada pattern should first have other causes of ST elevation ruled out; immediate consultation with a cardiologist is recommended. In patients without symptoms, current recommendations are for observation without therapy (Figure 3).<sup>4</sup> In symptomatic patients,

management ranges from observation to pharmacologic challenge and/or therapy, to ICD placement or catheter ablation.

### Case Discussion and Resolution

The main challenge with this case was determining the etiology of the patient’s tachycardia, particularly as he was afebrile on presentation without symptoms beyond those consistent with a URI. Fever, viral infections, and pneumonias are common in urgent care and often cause mild benign tachycardia. The first step in distinguishing the benign tachycardia from the critical, however, is recognizing that there is an abnormality to be investigated. One review of emergency department patients found that abnormal vital signs, particularly unexplained tachycardia, were noted commonly in patients who experienced an unexpected death within 7 days of ED presentation.<sup>5</sup>

Tachycardia, or a heart rate >100 beats per minute, has a broad differential that spans from the benign to the life-threatening including patients with pain, fever, anxiety, medication or substance use, dehydration, blood loss, sepsis, and/or cardiac or endocrine emergencies. Though history and examination will often reveal the etiology, in our case, with a persistent and significant tachycardia, further work-up was pursued.

For the patient with tachycardia, possible modes of evaluation include monitoring devices, echocardiogram, exercise testing, electrophysiological cardiac testing, and basic laboratory evaluation to check for electrolytes, anemia, endocrine abnormalities, drug levels, and toxicology testing.<sup>6</sup> However, a 12-lead EKG generally provides sufficient information to decide if additional testing is immediately necessary.

While the patient in our case fortunately did not require additional therapy, his presentation served as a valuable opportunity to investigate an abnormal vital sign further, and rule out what could be a life-threatening arrhythmia for some patients. ■

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## A 17-Year-Old Male with Pain and Swelling in His Thumb

Figure 1.



### Case

The patient is a 17-year-old male who presents with pain and swelling in his left thumb. He reports that he fell off an all-terrain vehicle while “mudbogging,” bending the thumb back when he reached out to break his fall.

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



## THE RESOLUTION



Figure 2.

**Differential Diagnosis**

- Adductor pollicis tendon rupture
- Arthritic disease of the metacarpophalangeal joint
- Intra articular fracture of the ulnar base of the proximal phalanx
- Displaced intra articular fracture of the ulnar base of the proximal phalanx of the first digit
- Metacarpophalangeal dislocation

**Diagnosis**

This patient has a mildly displaced intra articular fracture of the ulnar base of the proximal phalanx of the first digit, also known as a gamekeeper's fracture—so called because, in an earlier time, the repetitive breaking of the necks of small game resulted in chronic injury to the ulnar collateral ligament of the metacarpophalangeal joint of the thumb. This is similar to skier's thumb, a reference to injury in which the ski pole or strap forcibly abducts the thumb during a fall or particularly aggressive pole-plant.

**Learnings/What to Look for**

- Determining mechanism of injury is critical for diagnosis of a gamekeeper's fracture
- Pain on palpation, bruising, and swelling are common signs
- The most frequent site of injury is at the attachment of the ligament to the proximal phalanx; a bony avulsion occurs in approximately 50% of injuries

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

- If the joint is stable, immobilization for 4 weeks in a cast or splint is warranted
- If the joint is not stable, refer to an orthopedist

**Acknowledgment:** Images and case provided by Experity Teleradiology ([www.experityhealth.com/teleradiology](http://www.experityhealth.com/teleradiology)).



## A 58-Year-Old Female with Syncope



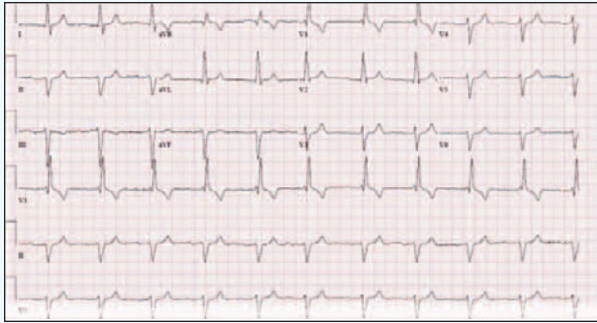
Figure 1.

### Case

The patient is a 58-year-old female who reports having an episode of syncope earlier in the day. She denies chest pain, difficulty breathing, or recent illness. She has a history of hypertension, diabetes, coronary artery disease.

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

## THE RESOLUTION

**Differential Diagnosis**

- Myocardial ischemia
- Congestive heart failure
- Myocarditis
- Conduction system disease
  - Infiltrative (sarcoidosis, Lenègre-Lev)
  - Infectious (bacterial endocarditis)
  - Iatrogenic (valve replacement)
- Hyperkalemia
- Digoxin toxicity

**Diagnosis**

Right bundle branch block, left anterior fascicular block, first-degree AV block (trifascicular block). The ECG reveals a regular, wide-complex, sinus rhythm at a rate of 64 beats per minute. The PR-interval is prolonged (normal 120-200ms), indicating a first-degree atrioventricular block. The wide QRS complex (>120 msec), rSR' appearance in V<sub>1</sub>, and wide S wave in the lateral leads (V<sub>5</sub>, V<sub>6</sub>, I, aVL) indicate the presence of a right bundle branch block. There is also an extreme left-axis deviation (>45° deviation, indicated by a dominant S in the inferior leads II, III, aVF), which suggests an associated left anterior fascicular block.

Collectively, the findings of a right bundle branch block, left anterior fascicular block, and first-degree atrioventricular block suggest trifascicular disease or “trifascicular block.”

The term *trifascicular block* is a misnomer, as a true block of all three fascicles (the right bundle branch, left anterior fascicle, and left posterior fascicle) would result in complete heart block. Rather, the term references the presence of diseased conduction in all three fascicles with sufficient sparing of one fascicle (most commonly the left posterior fascicle), resulting in delayed conduction and manifesting as a prolonged PR interval (first-degree atrioventricular block). The American Heart Association guidelines suggest that use of the term “trifascicular block” be abandoned in favor of a description of the identified blocks independently (eg, right bundle branch block, left anterior fascicular block, first-degree AV-block).<sup>1</sup>

First-degree blocks are usually seen in active, healthy patients without heart disease. They typically represent a process within the atrioventricular node itself and are unlikely to progress to complete heart block. However, when accompanied by preexisting conduction disease (eg, right bundle branch block, left bundle branch block, or bifascicular block) they can indicate infranodal conduction disease.

Immediate referral to the emergency department is warranted when patients with significant conduction disease present with symptoms suggesting intermittent bradycardia (eg, syncope or presyncopal lightheadedness), as progression to higher degree blocks, including complete heart block, can occur. These patients should be evaluated for permanent pacemaker placement.

**Learnings/What to Look for**

- *Trifascicular block* is a misnomer. ECG interpretation should instead describe the identified blocks. Traditionally, the term has referenced blocks involving
  - Right bundle branch
  - Left anterior or posterior fascicular block
  - First-degree atrioventricular block

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

- Patients with multiple fascicle disease who are bradycardic or symptomatic with presyncope or syncope should be transferred to an emergency department immediately for evaluation
- These patients may need subsequent transfer to a facility with capability for permanent pacemaker placement after stabilization
- If multiple fascicle disease is identified in an otherwise asymptomatic patient (eg, ECG obtained for preoperative evaluation), a careful screening for signs or symptoms of occult cardiac disease should be performed; in some cases ambulatory electrocardiographic monitoring may be considered<sup>2</sup>

**References**

1. Surawicz B, Childers R, Deal BJ, et al. AHA/ACCF/HRS recommendations for the standardization and interpretation of the electrocardiogram: part III: intraventricular conduction disturbances: a scientific statement from the American Heart Association Electrocardiography and Arrhythmias Committee, Council on Clinical Cardiology; the American College of Cardiology Foundation; and the Heart Rhythm Society. Endorsed by the International Society for Computerized Electrocardiology. *J Am Coll Cardiol*. 2009;53(11):976-981.
2. Kusumoto FM, Schoenfeld MH, Barrett C, et al. 2018 ACC/AHA/HRS Guideline on the Evaluation and Management of Patients With Bradycardia and Cardiac Conduction Delay: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines, and the Heart Rhythm Society. *J Am Coll Cardiol*. 2019;74(7):932-987.



## A 42-Year-Old Male with a New Symmetrical Rash on His Legs



### Case

The patient is a 42-year-old man who presents with a symmetrical rash of palpable purpura on his legs. He also complains of a fever and arthralgia, but denies any headache or neck pain. He also discloses current infection with the hepatitis C virus.

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

## THE RESOLUTION

**Differential Diagnosis**

- Rocky Mountain spotted fever
- Leukocytoclastic vasculitis (LCV)
- Sjögren syndrome
- Acute meningococemia

**Diagnosis**

This patient was diagnosed with leukocytoclastic vasculitis (LCV), a small-vessel vasculitis that predominantly affects postcapillary venules in the dermis.

**Learnings/What to Look for**

- The clinical hallmark of LCV is palpable purpura; purpuric papules erupt symmetrically on the shins 7-10 days after an inciting factor. Other parts of the lower extremities, including the thighs and dorsal feet, may be involved. Less frequently, the buttocks, upper extremities, and abdomen are involved.
- Purpuric macules seen initially may give way to palpable purpura. In more advanced cases, bullae and ulcers may be seen.
- While the majority of cases are asymptomatic, LCV can be associated with pruritus, pain, or burning.

- Inciting factors may include medications (especially antibiotics, NSAIDs, and diuretics), pathogens (hepatitis viruses, HIV, Epstein-Barr, streptococci), malignancy, inflammatory bowel disease, or connective tissue disease.
- It is important to differentiate skin-limited LCV from systemic vasculitis. The latter should be suspected if fever, myalgias, malaise, lymphadenopathy, abdominal pain, melena, hematochezia, diarrhea, hematuria, lower extremity swelling, or paresthesias are noted.

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

- Skin-limited LCV does not require treatment beyond rest, elevation of the legs, ice packs, and removal of the inciting factor.
- Treatment of systemic vasculitis may require NSAIDs, oral steroids (prednisone or methylprednisolone), intravenous corticosteroids, or colchicine, depending on severity.
- Inpatient treatment may be required for patients with severe systemic vasculitis syndromes or organ dysfunction.

**Acknowledgment:** Images and case courtesy of VisualDx ([www.VisualDx.com/JUCM](http://www.VisualDx.com/JUCM)).



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## Taking Pictures, Dog Paddling, and Apple Picking: A Metaphorical Approach to Healthy Revenue Cycle Management Metrics

■ MONTE SANDLER

You have seen all the articles about benchmarking and standard revenue cycle management metrics. The repetition of these basic articles is nauseating. This is not one of those articles. To illustrate that, let's start by asking, what do photography, dog paddling, and apple picking have to do with your urgent care billing?

### Photography

Standard RCM metrics are like the settings on your digital camera. Most people set the camera to Program mode (or "P" for *program*) and the camera figures everything out for a good picture. Sometimes this works great. Other times the camera doesn't understand everything it needs to take a good picture.

The problem is that the P mode and camera can't tell whether the subject is moving fast or erratically or if the subject is stationary. The result is you have a picture where the lighting is perfect, but the subject is blurry.

In order to get a good photo, you must understand each of the setting on the camera. The settings are like the annoying and difficult quadratic equations that haunted us in high school. All the settings are related and if you change one, others must be adjusted to get the correct result. The same is true of your RCM program.

How can the RCM settings (or metrics) change the picture, and how do we monitor the details to avoid being surprised by the poor picture quality or RCM outcomes?



**Monte Sandler** is Executive Vice President, Revenue Cycle Management of Experity (formerly DocuTAP and Practice Velocity).

Camera	Revenue Cycle Management
Shutter speed	Days to bill/AR management
Aperture	Days sales outstanding
ISO	Accounts receivable aging
Focus	Getting a clear picture of how all of these settings work together

### Dog Paddling

Many RCM functions are operating in Dog Paddling Mode. This means the staff is doing all they can to just keep their head above water by getting the bills/claims out the door and managing the cash posted each month. They are just trying to keep themselves from drowning. There is no AR follow-up. Dog paddling is most obvious when reviewing AR metrics and follow-up notes.

### Apple Picking

Let's use one more metaphor—apple picking—to explain active accounts receivables management. The Dog Paddling Mode described above is equal to collecting apples that have already fallen on the ground, or picking those that you can reach from the ground—the low-hanging fruit, in other words. There is no extra effort or equipment being used to collect the money.

Active AR management can be easily explained using the Apple Picking example. The most efficient and effective apple pickers use all the tools at their disposal. This could include:

Apple Picking	Revenue Cycle Management
Ladders	Phone calls and online claim inquiry
Telescoping fruit pickers	Text message balance reminders
Muck carts	E-billing and online patient portal
Hard work	A great front desk person

Remember, each day a claim gets older its net realizable value (NRV) decreases. NRV is the amount of money you will receive in payment on that claim. Each month, run an AR aging report. Review the report by payer or by patient and select 20 accounts that are over 120 days old. Use your practice management system to navigate to the accounts and review the collection notes to verify that your staff is actively working your accounts receivable.

*“Pick all the apples to the top of the tree utilizing active AR management.”*

Even if your RCM metrics look great, the truth can be hidden in the details from you. Here are a few ideas to avoid any surprises:

- *Reconcile your collections to your billing system and your bank statement!* It is important to take a few extra minutes each month to reconcile your collections in your billing system to your bank statement. It is not as easy today as it was 10 years ago, though. In the old days, you made all the deposits yourself. It was easy to identify all the items on your statement. Today, there are payments coming in from many different sources, and sometimes it is difficult to tell what came from where, or what a given payment applies to because of the timing of ERA files.

The way to make it easier is to create a cash log using MS Excel. The rows will be the dates of the month. The columns will be sources of collections (office deposits, credit cards, ACHs with ERAs, and ACH without ERAs). You should make two extra columns in the spreadsheet, as well—the first will be Amount Posted and the second extra column will be Not Posted. The total of these two columns should agree with your bank deposit for that day. If an amount is not posted, you should note why you did not post it to your billing system.

The end of the month is sometimes tricky because of timing differences (TD). A TD could be an ERA file received from the clearinghouse that has not been received in your bank. To avoid this kind of reconciling item, wait to post the ERA to the billing system until you are sure the corresponding ACH has been received by the bank.

As a bonus, this reconciliation will make your year-end bookkeeping and tax preparation much easier. It also acts as a strong internal control.

- *Credits in AR.* Overpayment and credits can happen in many ways. These credits artificially understate the amount of your accounts receivable and the related metrics. These credits in AR often are liabilities. You could



owe someone this money. Sometimes it is the payer or the patient. Pay special attention to potential overpayments from government payers. These must be processed as soon as they are identified.

- *Unauthorized write-offs.* Institute a policy to have management review all noncontractual write offs. Verify that staff are not making your AR look better by prematurely writing off balances as uncollectable.
- *Misappropriated refunds.* Are you writing refund checks to patients? Be sure to separate the duties of the AR staff from the person writing the refund check. In order to write a refund check, you should require a Payer Pack. This should include all the documentation that caused the refund to be required, as well as the original claim for the date of service. It may include a copy of a check or receipt for the payment from the patient or their health savings account. The documentation may need to include the payment from the payer and any related correspondence. It is often helpful to print out a trial balance for the account that includes all the charges and the credits/payments.

Be sure the name on the check exactly matches the name of the party to be refunded. I also suggest that the mailing of these checks be handled by another party in the office to make sure there are strong internal controls related to segregation of duties.

### Conclusion

Stay focused on your revenue cycle. Understand the settings so you can monitor and control the process. *No dog paddling!* Pick all the apples to the top of the tree utilizing active AR management. Keeping your eyes open for the areas below the surface of the standard metrics will help you avoid surprises that could be hiding there. ■



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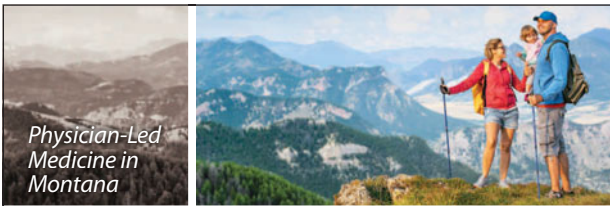


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## Thirty-Three Billion Reasons Patients Should Be Heading to Urgent Care Instead of the ED

Urgent care has flourished because of its defining attribute of providing high-quality, walk-in care more efficiently and less expensively than the emergency room offers. Yet, we continue to read articles in the mainstream media saying that so many people still flock to the ED with relatively minor complaints that during high-volume periods (like flu season), hospital and local health officials practically beg them to go to an urgent care center instead.

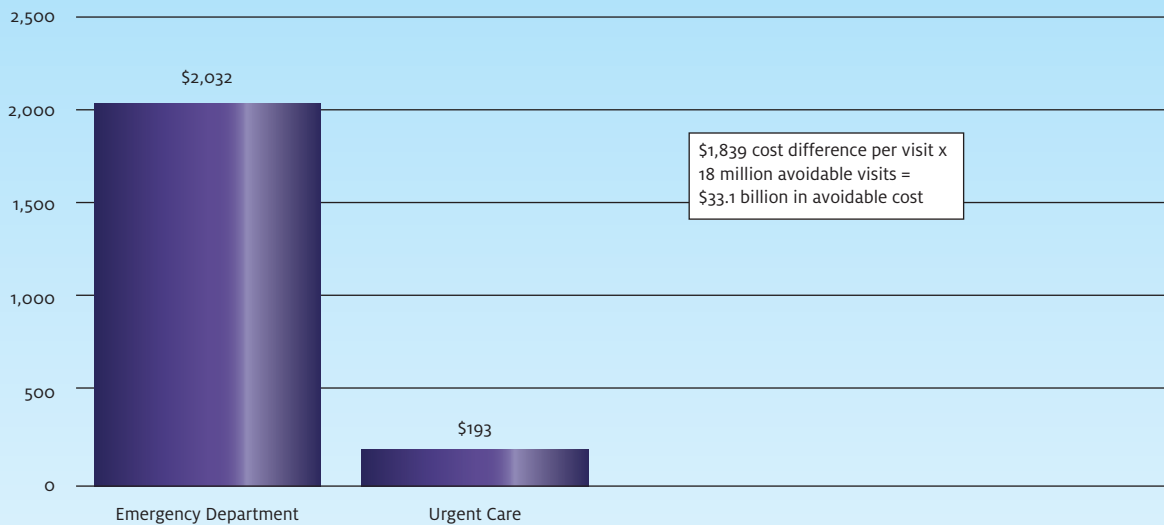
The question of why that is continues to be unanswered. However, it becomes more and more clear as time goes on that the more people go to the ED when they don't really need to, the more money is wasted. UnitedHealth Group—which, as a managed care organization, has a vested interest in this area—published data quantifying just how much, based on

### Complaints Reflected in the Data

Bronchitis	Low back pain
Cough	Nausea
Dizziness	Sore throat
Flu	Strep throat
Headache	Upper respiratory infections

the costs associated with 10 common primary care-treatable complaints presenting to the ED. Based on that, they determined that 58% of all ED visits (roughly 18 million out of 27 million) could be safely treated in an urgent care center. See below for the eye-opening specifics. ■

### COST PER VISIT FOR 10 PRIMARY CARE-TREATABLE COMPLAINTS



Data source: UnitedHealth Group. Graphic: 18 million avoidable hospital emergency department visits add \$32 billion in costs to the health care system each year. Available at: <https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2019/UHG-Avoidable-ED-Visits.pdf>. Accessed February 12, 2020.





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