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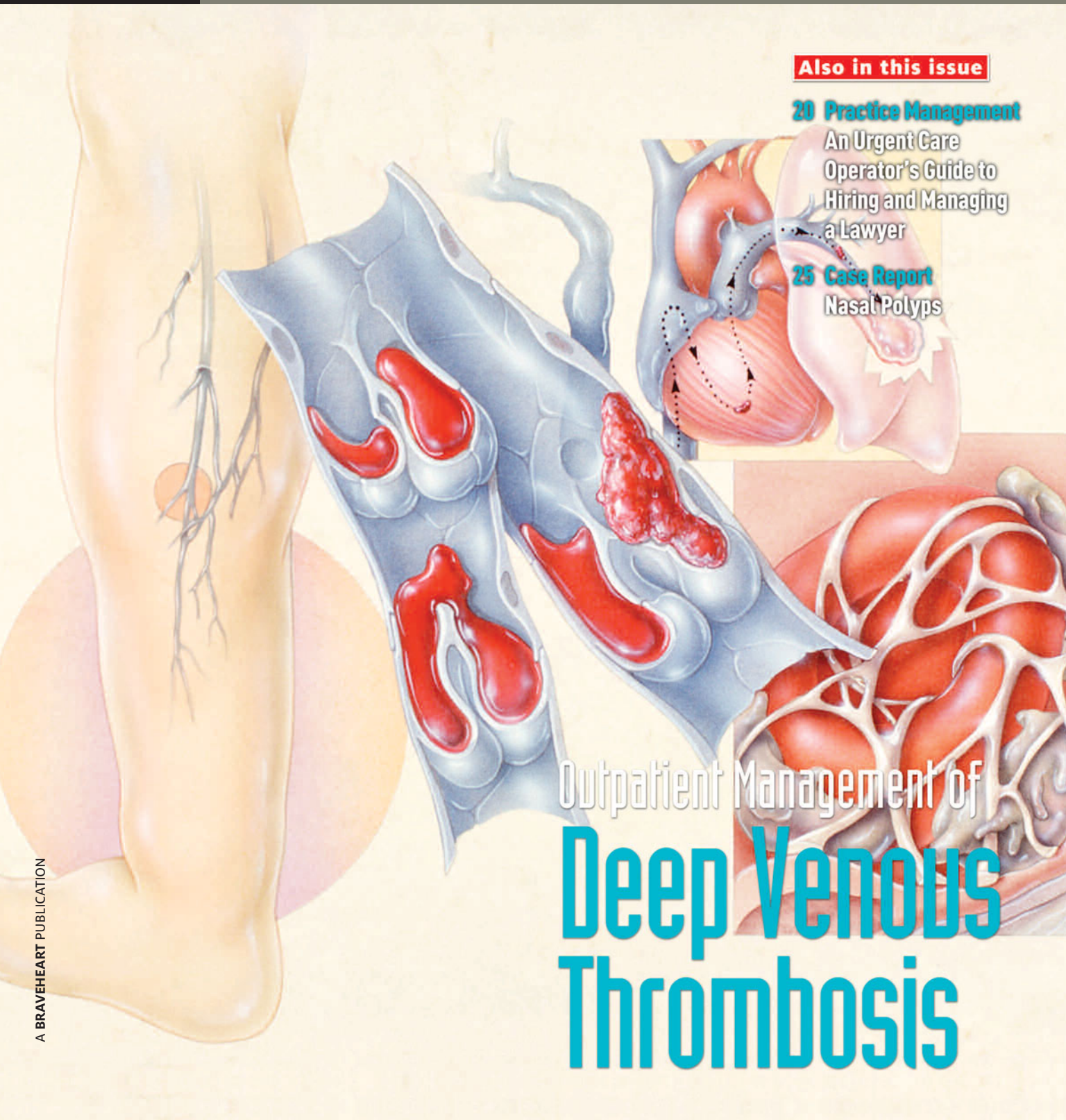

Also in this issue

Outpatient Management of Deep Venous Thrombosis

A BRAVEHEART PUBLICATION

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Risk Mitigation in Urgent Care: Part 3

In my previous column, I discussed three core areas where risk and potential liability exposure lurk and ways to mitigate that risk. This month, the last in the three-part series, I will focus on specific clinical policies and procedures that can effectively reduce liability risk and enhance patient safety, quality and patient satisfaction...the holy grail of high-performing practices.

Eliminating 'Pre-triage'

The term "pre-triage" is used to describe the all-too-common practice of determining the appropriate level of care for a patient prior to any physician evaluation. Examples include: 1.) "Pre-triaging" head trauma to the ED because it "might" need a head CT; 2.) "Pre-triaging" chest pain to the ED; 3.) "Pre-triaging" young infants with fever because the provider won't see babies; 4.) "Pre-triaging" abdominal pain because it "might" need a CT. Well, the fact is that most of these presentations, if given a fair and thorough clinical evaluation, DO NOT require evaluation in the ED and DO NOT need CTs. And even if they do, how can we determine the proper method of transfer WITHOUT a clinical evaluation? What if the abdominal pain is a ruptured AAA? What if the baby is grunting and cyanotic? What if the chest pain patient dies in his car? While the answers to each of these questions is obvious, it is common practice for the staff at urgent care centers to base their transfer decisions on a "quick eyeball" test. Worse yet, documentation of the decision-making is almost never done and vital signs are rarely taken. Eliminating "pre-triage" is a must for all urgent care practices and should be applied systematically and without exception to be effective.

Triage for high-risk complaints and high-risk clinical signs

Creating a policy and procedure for triage of high-risk complaints and clinical signs is an easy and extremely effective way to ensure that delays in evaluation do not occur for patients known to carry a higher risk. High-risk complaints include things like chest pain, shortness of breath or fainting spell. These complaints, and others like them, should be triaged by the clinical staff immediately. The triage may reveal that the risk is low or the story is less concerning. These patients can return to the waiting room. High-risk clinical signs include pallor, sweating, and confusion. When such clinical signs are present, a patient should be assessed immediately by the clinical staff. A full list of high-risk complaints and clinical signs can be found on the *JUCM* home page (*www.jucm.com*).

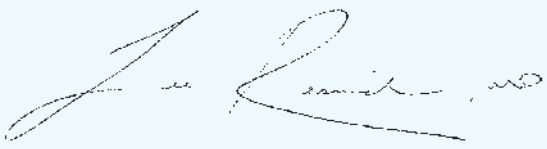
Abnormal vital signs

Abnormal vitals should ALWAYS be explained and evaluated. Elevated heart rate is an independent sign of cardiovascular compromise and frequently indicates a potentially unstable condition. Frequently encountered clinical entities that can present with tachycardia alone without hypoxia include PE and pneumonia. Don't miss these. Also, ensure that all clinical support staff are trained on AND their proficiency tested for proper procedure in taking vital signs and ranges in BOTH adults and children.

Follow-up for high-risk conditions

Consider a policy around follow-up for any high-risk complaint or diagnosis. Simply referring patients with these conditions to primary care for follow-up is not good enough. If you made the diagnosis, you are responsible for the outcome. Things like pneumonia, cellulitis, asthma, non-cardiac chest pain, and pyelonephritis require follow-up to ensure that interventions are working, vital signs are normalizing, and worrisome signs or symptoms are absent. For a full list of recommendations, go to *www.jucm.com*.

I hope you found this series informative, relevant, and actionable for your practice. Attention to some very basic principles, along with implementation of policy and procedure, can help protect you, your practice, and your patients from unnecessary risk and harm. ■



Lee A. Resnick, MD
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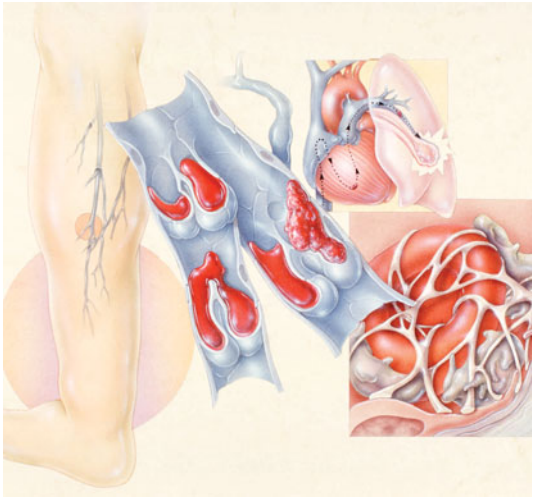


CLINICAL

9 Outpatient Management of Deep Venous Thrombosis

Urgent care providers are on the frontline in diagnosis of DVT. Outpatient management is a consideration for carefully selected patients.

Sabrina Sood, MD

PRACTICE MANAGEMENT

20 An Urgent Care Operator's Guide to Hiring and Managing a Lawyer

This article is a broad overview of how lawyers work and charge and what to do to avoid some of the most common pitfalls inherent in the attorney-client relationship.

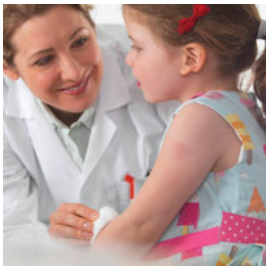
Alan A. Ayers, MBA, MAcc

CASE REPORT

25 Nasal Polyps

Differential diagnosis and careful attention to signs, symptoms and history are particularly important in management of patients with nasal inflammation.

Mohammed Noman Mohiuddin, MD



IN THE NEXT ISSUE OF *JUCM*

With next month's cover story, we conclude our two-part series on headaches, which is a common but challenging chief complaint in urgent care. The signs and symptoms of non-emergent headaches—which are the subject of this installment—have overlying components because they share involvement of the trigeminal nerve. This article will help urgent care providers identify and differentiate between key clinical features of conditions such as cluster, migraine, and tension headaches and make appropriate treatment decisions for patients with these diagnoses.

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Mission Statement
JUCM The Journal of Urgent Care Medicine supports the evolution of urgent care medicine by creating content that addresses both the clinical practice of urgent care medicine and the practice management challenges of keeping pace with an ever-changing healthcare marketplace. As the Official Publication of the Urgent Care Association of America and the Urgent Care College of Physicians, *JUCM* seeks to provide a forum for the exchange of ideas and to expand on the core competencies of urgent care medicine as they apply to physicians, physician assistants, and nurse practitioners.

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Every year, more than 300,000 individuals die due to deep venous thrombosis (DVT), or formation of a clot in the deep venous system, which is the subject of this month's cover story. As noted by author Sabrina Sood, MD, urgent care providers play a large role in frontline care of patients with acute leg pain, swelling, and discoloration. Accurate diagnosis requires a systematic approach, starting with use of the Wells criteria to assess risk of thromboembolism, and continuing to additional testing based on whether an individual is at high, moderate, or low risk. For the right patients, outpatient treatment can be considered and can be effectively managed in the urgent care setting.

Sabrina Sood, MD, is an urgent care fellow at University Hospitals of Cleveland, Department of Family Medicine, Case Western Reserve, Cleveland, Ohio.

Nasal congestion often bring patients to urgent care centers and was the presenting symptom in the child who is the subject of this month's case report, by Mohammed Noman Mohiuddin, MD. She also had dried blood in the nostril since being hit in the nose by a playmate's elbow the week before. The proximate cause of the child's condition might have appeared to be the injury but careful evaluation—which uncovered a history of treatment for sinusitis—pointed to a previously undetected underlying condition: A nasal polyp.

Mohammed Noman Mohiuddin, MD, is an urgent care physician in practice at Alexian Brothers Health System in Illinois.

Urgent care operators rely on a variety of other professionals for goods and services required to run a healthy business operation and among them are attorneys. In this month's practice management article, by Alan A. Ayers, MBA, MAcc, provides a broad overview of strategies for selecting an attorney for your urgent care business and maintaining a good relationship with your counsel. Included is information on how lawyers work and what they charge and tips for avoiding common pitfalls in the attorney-client relationship.

Alan A. Ayers, MBA, MAcc, is on the Board of Directors, Urgent Care Association of America, Associate Editor, *Journal of Urgent Care Medicine*, and Vice President, Concentra Urgent Care.

Also in this issue:

In Health Law this month, **John Shufeldt, MD, JD, MBA, FACEP**, discusses the potential legal pitfalls to physicians who offer medical advice to family members, friends, and others who ask for a free opinion.

Sean M. McNeeley, MD, and **The Urgent Care College of Physicians** review new abstracts on literature germane to the urgent care clinician, including studies of modification of the Wells criteria, antibiotic delay and URI, and headaches and neuroimaging.

In Coding Q&A, **David Stern, MD, CPC**, discusses codes for new versus established patients and Medicare exams, and perspective on the delay in implementation of ICD-10.

Our Developing Data end piece this month looks at the top 15 ICD-9 codes used by urgent care centers. ■

To Submit an Article to *JUCM*

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

Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, pictures, and references. Articles that are longer than this will, in most cases, need to be cut during editing. The information you provide should be of practical use to our readers, who have come to practice in an urgent care setting from a variety of clinical backgrounds. Your article should take their perspective into account by considering several key issues, such as: What immediate management is indicated? What labs or diagnostics are required? What are the next steps; with whom should the patient follow up? Who should be admitted or referred to the emergency room? Imagine yourself in the reader's shoes and ensure your article includes the answers to questions you'd be asking.

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

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JUCM is distributed on a complimentary basis to medical practitioners—physicians, physician assistants, and nurse practitioners—working in urgent care practice settings in the United States. To subscribe, log on to *www.jucm.com* and click on "Subscription."

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Looking Forward to the Next 10 Years

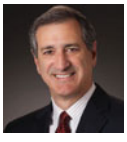
NATHAN NEWMAN, MD, FAAFP

The 10th National Urgent Care Convention in Las Vegas is now in our rearview mirror. This year's event attracted more than 1,100 attendees—one of the largest showings ever—and the sold-out Exhibit Hall surpassed previous years' records with 148 exhibiting companies – of which 60 were new to our annual event!

Our Spring Convention continued the 2013 Fall Conference's enhanced program of brand new clinical, practice management and Health Care Reform information that all members can readily use in their urgent care centers today. Also well attended was the Department of Transportation (DOT) Medical Examiner Training Course and testing program supporting new regulations requiring certification of all urgent care clinicians offering DOT physical examinations. If you were unable to attend, most of the main convention courses remain available through the UCAOA Online Education portal.

The UCAOA Health and Public Policy Committee continues to represent our industry, submitting a letter to Centers for Medicare & Medicaid Services (CMS) refining proposed health insurer requirements in the Affordable Care Act, which stated that "adequate access" must include alternatives to cost-effective health care other than the emergency department. The committee is also responding to CMS to address the inappropriateness of PQRS (Physician Quality Reporting System) incentives in the urgent care/episodic care setting as well as working to convey a definition of urgent care relative to Place of Service (POS) 20 at the specific request of CMS Chief Medical Officer Patrick Conway, MD, MSc.

The Consumer Product Safety Commission (CPSC) requested the assistance of UCAOA in communicating how we might play a stronger role in consumer and patient health and safety. We are being asked to help educate our members to report injuries related to products (toys, cribs, etc.) via saferproducts.gov. Our participation is voluntary, but the fact that CPSD recognizes urgent care centers as a key part of the national "safety net" underscores the growing awareness of urgent care and recognition of our role in the continuum of care.



Nathan Newman is president of the Urgent Care Association of America. He may be contacted at *info@ucaoa.org*.

"The fact that the Consumer Product Safety Commission recognizes urgent care centers as a key part of the national 'safety net' underscores the growing awareness of urgent care and recognition of our role in the continuum of care."

Thanks so much for your interest in our new Accreditation Program! More and more federal and state agencies as well as payors are requesting evidence of quality and safety in the urgent care industry. We expect this trend to continue. UCAOA offers the only existing urgent care accreditation that not only recognizes the more traditional processes associated with quality and safety, but also the scope of services provided. Our program was developed to fit your budget and guide your staff through the Accreditation process based on an understanding of the nuances of the urgent care industry.

Finally, remember to participate in the UCAOA 2014 Urgent Care Benchmarking Survey. It will provide you with national information and metrics to compare your staffing, compensation, billing, technology, marketing and much more as well as educate others outside our industry about urgent care and how we continue to be the fastest growing segment of health care.

Let's all remember the good ol' days of the past 10 years while looking forward to the tremendous promise that the next 10 years have for urgent care. Get involved and help us make it happen! ■

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Outpatient Management of Deep Venous Thrombosis

Urgent message: Urgent care providers are on the frontline in diagnosis of DVT. Outpatient management is a consideration for carefully selected patients.

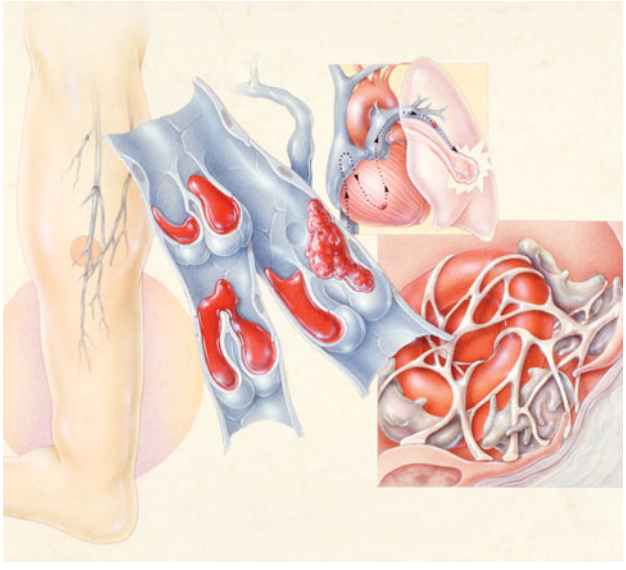
SABRINA SOOD, MD

Deep venous thrombosis (DVT) is formation of a clot in the deep venous system, usually in a lower extremity. Half of untreated patients with DVT will go on to develop the fatal complication pulmonary embolism (PE). Approximately 300,000 to 600,000 Americans die each year due to venous thromboembolism (VTE).[1]

Urgent care providers are typically the frontline for patients with acute leg pain, swelling and discoloration. A systematic approach to ruling out DVT will help get patients the appropriate care. Many urgent care centers do not have ready access to compression ultrasound, which is the gold-standard test to rule out DVT. Studies have shown that with use of a D-Dimer assay and risk stratification with the Wells criteria, providers can distinguish which patients need further study and which can be safely ruled out. These diagnostic criteria are proven to be superior to clinical judgment alone. With use of Wells Criteria and D- Dimer testing; only 1% of DVTs are missed. With use of clinical judgment alone, 5% of DVTs are missed.[2]

This article discusses how to use the Wells criteria as a clinical predictor for DVT and how the point-of-care D-dimer test contributes to decision-making. We will also discuss criteria for inpatient versus outpatient management of DVT, available treatment options, duration of therapy, and how this all relates to an urgent care setting.

Sabrina Sood is an urgent care fellow at University Hospitals of Cleveland, Department of Family Medicine, Case Western Reserve, Cleveland, Ohio.



Risk Factors for DVT and Patient History

Risk factors for DVT can be remembered by recalling Virchow's Triad: venous stasis, endothelial damage, and hypercoagulability.

In addition, one-third of patients who suffer from a DVT will have recurrence within 10 years.[1]

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References: 1. IMS Health, IMS National Prescription Audit™, August 2010 to November 2013, USC 61500 OPHTH ANTI-ALLERGY. **2**. PATADAY® Solution package insert. **3**. Formulary data provided by Pinsonault Associates, LLC, PathfinderRx, November 2013.

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Recent surgery, trauma, or presence of an infectious disease are examples of endothelial damage that can lead to DVT.

Pro-thrombotic states such as cancer, stroke, pregnancy, hormone therapy, obesity, and inheritable thrombophilias can also lead to DVT. Hormone therapy includes oral contraceptives, hormone replacement therapy, and appetite stimulants such as megace/megestrol. Inherited thrombotic states include protein C and S deficiency, anti-thrombin 3 deficiency, antiphospholipid antibody, hyperhomocysteinemia, factor V Leiden, and others.

Who should get a work up for thrombophilia and when? It is not cost-effective to test everyone with a DVT for a hypercoaguable state. Individuals with an unprovoked DVT prior to age 50, those with recurrent DVT, and patients with a family history of thrombotic states all warrant testing. Testing should occur prior to the start of therapy or 2 weeks after stopping therapy because treatment can interfere with the accuracy of test results.[3]

Differential Diagnosis

What are the differentiating features of DVT? How do you distinguish DVT from other diagnoses such as cellulitis, superficial thrombophlebitis, venous insufficiency, lymphedema, muscle tears, hematoma, and ruptured Baker's cyst? These differentials can often mimic DVT because they present with unilateral calf swelling and tenderness. Key elements in the history and physical can lead to the correct diagnosis. We will first discuss presentations of unilateral leg swelling in the acute setting.

Cellulitis of the lower extremity can be unilateral and present with swelling. The features that differentiate cellulitis from DVT are the infectious process, which often is associated with a precipitating factor such as a break in the skin. Because cellulitis is infectious, patients with it will also have constitutional

Table 1. Wells Prediction Rule for Diagnosing DVT

Clinical characteristic	*Score*
Active cancer (treatment within last 6 months or palliative)	1
Calf swelling where affected calf circumference measures >3 cm more than the other calf (measured 10 cm below tibial tuberosity)	1
Collateral superficial veins (nonvaricose)	1
Pitting edema (confined to symptomatic leg)	1
Swelling of entire leg: 1 point	
Localized pain along distribution of deep venous system	1
Paralysis, paresis, or recent cast immobilization of lower extremities	1
Recently bedridden for >3 days or major surgery requiring regional or general anesthetic in past 4 weeks	1
Previous history of DVT or PE: 1 point	
Alternative diagnosis at least as probable	-2
Risk score interpretation (probability of DVT): 3 points: high risk (75%); 1 to 2 points: moderate risk (17%); <1 point: low risk (3%).	

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symptoms such as fever and lymphadenopathy.

Thrombophlebitis or superficial venous thrombosis (SVT) is a non-infectious process that is due to inflammation and/or clotting of superficial veins. The patient history will often include varicose veins, which is the most common predisposing factor to SVT. The differentiating feature on physical exam is the presence of a painful, warm, palpable superficial vein. For diagnostics, an ultrasound is warranted to rule out concomitant DVT. The mainstay of therapy for SVT is nonsteroidal anti-inflammatory drugs (NSAIDs) and compression stockings. If the location of the clot is near the saphenous-femoral junction, anticoagulation should be given for 1 month because of the high risk of progression to DVT.

Medication side effects can also be a cause of lower-extremity edema. Common culprits are calcium channel blockers such as amlodipine, vasodilators, and drugs that trigger salt retention.

A ruptured popliteal cyst or Baker's cyst can present as unilateral leg swelling and discomfort. On exam, patients with the condition will present with fullness behind the knee due to synovial fluid accumulation in the bursa. Their history will often include rheumatologic disorder such as arthritis. The popliteal bursa can rupture, causing synovial fluid leakage and calf swelling. The treatment for this is often supportive care with close follow up to monitor for resolution. In extreme cases, the fluid can compress the deep veins of the calf and lead to DVT from venous stasis.

Muscle rupture and or hematoma can also cause unilateral swelling and pain. The patient will often give a history of trauma or new-onset strenuous exercise and subsequent development of a painful calf. The treatment here is largely supportive care.

Conditions that can cause edema in a chronic setting are venous insufficiency, lymphedema, and exposure to certain medications.

Venous insufficiency is a chronic cause of unilateral leg edema. The etiology is due to insufficient valves that cannot effectively pump blood back to the heart. Venous blood accumulates in the lower extremity, causing swelling. These patients will often have a differentiating feature on exam of hyperpigmentation and/or ulceration to the skin that is not seen with DVT. Another key feature is time. Venous insufficiency is a chronic condition that occurs over several months, whereas patients with DVT will present in a more acute setting.

Lymphedema, another chronic cause of leg edema, is accumulation of lymph fluid in the interstitial space due to obstruction of lymphatic flow. A key differentiating factor is timing. The development of swelling is slow in onset whereas DVT is usually rapid onset. Patients with lymphedema can present with a recent surgical history of lymph node dissection and subsequent swelling of an adjacent limb. The skin will also appear thickened and fibrous over time unlike an acute DVT presentation.

Physical Exam

Certain physical exam findings will lead an urgent care provider to include DVT in the differential diagnosis. It should be noted, however, that physical findings alone cannot be used to rule out a DVT.

Begin your exam by comparing the lower extremities, looking for a difference in calf circumference, swelling, erythema, or mottling of the skin. The affected extremity should be examined for a palpable chord and/or calf tenderness. Pain with dorsiflexion of the foot is a clinical sign of DVT (Homan's sign.) A thorough vascular exam should also be done.

Diagnostics

In the outpatient setting, DVT can be ruled out with a

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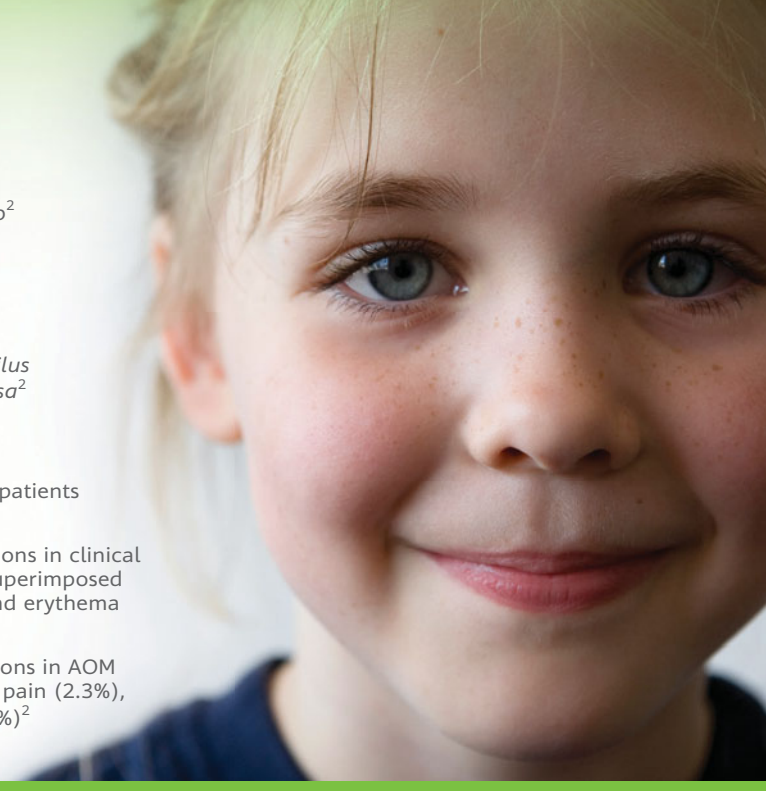

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- The power of an anti-inflammatory and antibiotic in each drop[2]

FIGHTS AGAINST KEY AOE-CAUSING PATHOGENS:

- *Staphylococcus aureus* and *Pseudomonas aeruginosa*[2]

FIGHTS AGAINST KEY AOMT-CAUSING PATHOGENS:

- *Staphylococcus aureus*, *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Moraxella catarrhalis*, and *Pseudomonas aeruginosa*[2]

Established Safety Profile

- No clinically relevant changes in hearing function in pediatric patients testing for audiometric parameters[2]
- The most commonly reported treatment-related adverse reactions in clinical trials in AOE patients: ear pruritus (1.5%), ear debris (0.6%), superimposed ear infection (0.6%), ear congestion (0.4%), ear pain (0.4%) and erythema (0.4%)[2]
- The most commonly reported treatment related adverse reactions in AOM patients with tympanostomy tubes: ear discomfort (3.0%), ear pain (2.3%), ear residue (0.5%), irritability (0.5%) and taste perversion (0.5%)[2]

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CIPRODEX® Otic is the **#1** presribed otic antibiotic drop among otolaryngologists and pediatricians since 2007[1].

INDICATIONS AND USAGE: CIPRODEX® Otic is indicated for the treatment of infections caused by susceptible isolates of the designated microorganisms in the specific conditions listed below: Acute Otitis Media (AOM) in pediatric patients (age 6 months and older) with tympanostomy tubes due to Staphylococcus aureus, Streptococcus pneumoniae, Haemophilus influenzae, Moraxella catarrhalis, and Pseudomonas aeruginosa. Acute Otitis Externa (AOE) in pediatric (age 6 months and older), adult and elderly patients due to Staphylococcus aureus and Pseudomonas aeruginosa.

Dosage and Administration: The recommended dosage is four drops of CIPRODEX® Otic suspension into the affected ear twice daily for seven days.

IMPORTANT SAFETY INFORMATION

Contraindications: CIPRODEX® Otic is contraindicated in patients with a history of hypersensitivity to ciprofloxacin, to other quinolones, or to any of the components in this medication. Use of this product is contraindicated in viral infections of the external canal including herpes simplex infections.

Warnings: **FOR TOPICAL OTIC USE ONLY; NOT FOR INJECTION.** This product is not approved for ophthalmic use. CIPRODEX® Otic should be discontinued at the first appearance of a skin rash or any other sign of hypersensitivity. Serious and occasionally fatal hypersensitivity (anaphylactic) reactions, some following the first dose, have been reported in patients receiving systemic quinolones.

Precautions: Use of this product may result in overgrowth of non-susceptible organisms, including yeast and fungi. If the infection is not improved after one week of treatment, cultures should be obtained to guide further treatment. The systemic administration of quinolones, including ciprofloxacin at doses much higher than given or absorbed by the otic route, has led to lesions or erosions of the cartilage in weight-bearing joints and other signs of arthropathy in immature animals of various species.

Adverse Reactions: The most commonly reported treatment-related adverse reactions in AOM patients with tympanostomy tubes: ear discomfort (3.0%), ear pain (2.3%), ear residue (0.5%), irritability (0.5%) and taste perversion (0.5%). The most commonly reported treatment-related adverse reactions in clinical trials in AOE patients: ear pruritus (1.5%), ear debris (0.6%), superimposed ear infection (0.6%), ear congestion (0.4%), ear pain (0.4%) and erythema (0.4%).

For additional information about CIPRODEX® Otic, please refer to the accompanying Brief Summary of full prescribing information on adjacent page.

References: 1. IMS Health, IMS National Prescription Audit, 2007 to March 2014, USC 62320 OTIC ANTNFCT W/ GLUCOCORT. **2.** CIPRODEX® Otic package insert. **3.** Formulary data provided by Pinsonault Associates, LLC, PathfinderRx, March 2014.

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CIPRODEX®
(ciprofloxacin 0.3% and dexamethasone 0.1%)
STERILE OTIC SUSPENSION

CIPRODEX®
(ciprofloxacin 0.3% and dexamethasone 0.1%)

STERILE OTIC SUSPENSION
BRIEF SUMMARY OF PRESCRIBING INFORMATION

For additional information refer to the full Prescribing Information

DESCRIPTION CIPRODEX® (ciprofloxacin 0.3% and dexamethasone 0.1%) Sterile Otic Suspension contains the synthetic broad-spectrum antibacterial agent, ciprofloxacin hydrochloride, combined with the anti-inflammatory corticosteroid, dexamethasone, in a sterile, preserved suspension for otic use. Each mL of CIPRODEX® Otic contains ciprofloxacin hydrochloride (equivalent to 3 mg ciprofloxacin base), 1 mg dexamethasone, and 0.1 mg benzalkonium chloride as a preservative. The inactive ingredients are boric acid, sodium chloride, hydroxyethyl cellulose, tyloxapol, acetic acid, sodium acetate, edetate disodium, and purified water. Sodium hydroxide or hydrochloric acid may be added for adjustment of pH.

CLINICAL PHARMACOLOGY

Microbiology: Cross-resistance has been observed between ciprofloxacin and other fluoroquinolones. There is generally no cross-resistance between ciprofloxacin and other classes of antibacterial agents such as beta-lactams or aminoglycosides.

INDICATIONS AND USAGE: CIPRODEX® Otic is indicated for the treatment of infections caused by susceptible isolates of the designated microorganisms in the specific conditions listed below:

Acute Otitis Media in pediatric patients (age 6 months and older) with tympanostomy tubes due to Staphylococcus aureus, Streptococcus pneumoniae, Haemophilus influenzae, Moraxella catarrhalis, and Pseudomonas aeruginosa.

Acute Otitis Externa in pediatric (age 6 months and older), adult and elderly patients due to Staphylococcus aureus and Pseudomonas aeruginosa

CONTRAINDICATIONS

CIPRODEX® Otic is contraindicated in patients with a history of hypersensitivity to ciprofloxacin, to other quinolones, or to any of the components in this medication. Use of this product is contraindicated in viral infections of the external canal including herpes simplex infections

WARNINGS

FOR OTIC USE ONLY (This product is not approved for ophthalmic use.)

NOT FOR INJECTION

HYPERSENSITIVITY: CIPRODEX® Otic should be discontinued at the first appearance of a skin rash or any other sign of hypersensitivity. Serious and occasionally fatal hypersensitivity (anaphylactic) reactions, some following the first dose, have been reported in patients receiving systemic quinolones. Serious acute hypersensitivity reactions may require immediate emergency treatment.

PRECAUTIONS

General: As with other antibacterial preparations, use of this product may result in overgrowth of nonsusceptible organisms, including yeast and fungi. If the infection is not improved after one week of treatment, cultures should be obtained to guide further treatment. If otorrhea persists after a full course of therapy, or if two or more episodes of otorrhea occur within six months, further evaluation is recommended to exclude an underlying condition such as cholesteatoma, foreign body, or a tumor.

The systemic administration of quinolones, including ciprofloxacin at doses much higher than given or absorbed by the otic route, has led to lesions or erosions of the cartilage in weight-bearing joints and other signs of arthropathy in immature animals of various species.

Guinea pigs dosed in the middle ear with CIPRODEX® Otic for one month exhibited no drug-related structural or functional changes of the cochlear hair cells and no lesions in the ossicles. CIPRODEX® Otic was also shown to lack dermal sensitizing potential in the guinea pig when tested according to the method of Buehler.

No signs of local irritation were found when CIPRODEX® Otic was applied topically in the rabbit eye.

Information for Patients: For otic use only. (This product is not approved for use in the eye.) Warm the bottle in your hand for one to two minutes prior to use and shake well immediately before using. Avoid contaminating the tip with material from the ear, fingers, or other sources. Protect from light. If rash or allergic reaction occurs, discontinue use immediately and contact your physician. It is very important to use the ear drops for as long as the doctor has instructed, **even if the symptoms improve.** Discard unused portion after therapy is completed.

Acute Otitis Media in pediatric patients with tympanostomy tubes: Prior to administration of CIPRODEX® Otic in patients (6 months and older) with acute otitis media through tympanostomy tubes, the suspension should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness which may result from the instillation of a cold suspension. The patient should lie with the affected ear upward, and then the drops should be instilled. The tragus should then be pumped 5 times by pushing inward to facilitate penetration of the drops into the middle ear. This position should be maintained for 60 seconds. Repeat, if necessary, for the opposite ear (see dosage and administration).

Acute Otitis Externa: Prior to administration of CIPRODEX® Otic in patients with acute otitis externa, the suspension should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness which may result from the instillation of a cold suspension. The patient should lie with the affected ear upward, and then the drops should be instilled. This position should be maintained for 60 seconds to facilitate penetration of the drops into the ear canal. Repeat, if necessary, for the opposite ear (see dosage and administration).

Drug Interactions: Specific drug interaction studies have not been conducted with CIPRODEX® Otic.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in mice and rats have been completed for ciprofloxacin. After daily oral doses of 750 mg/ kg (mice) and 250 mg/ kg (rats) were administered for up to 2 years, there was no evidence that ciprofloxacin had any carcinogenic or tumorigenic effects in these species. No long term studies of CIPRODEX® Otic have been performed to evaluate carcinogenic potential.

Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin, and the test results are listed below:
Salmonella/Microsome Test (Negative),
E. coli DNA Repair Assay (Negative),
Mouse Lymphoma Cell Forward Mutation Assay (Positive),
Chinese Hamster V79 Cell HGPRT Test (Negative),
Syrian Hamster Embryo Cell Transformation Assay (Negative),
Saccharomyces cerevisiae Point Mutation Assay (Negative),
Saccharomyces cerevisiae Mitotic Crossover and Gene Conversion Assay (Negative),
Rat Hepatocyte DNA Repair Assay (Positive).
Thus, 2 of the 8 tests were positive, but results of the following 3 in vivo test systems gave negative results:
Rat Hepatocyte DNA Repair Assay,
Micronucleus Test (Mice),
Dominant Lethal Test (Mice).

Fertility studies performed in rats at oral doses of ciprofloxacin up to 100 mg/kg/day revealed no evidence of impairment. This would be over 100 times the maximum recommended clinical dose of ototopical ciprofloxacin based upon body surface area, assuming total absorption of ciprofloxacin from the ear of a patient treated with CIPRODEX® Otic twice per day according to label directions.

Long term studies have not been performed to evaluate the carcinogenic potential of topical otic dexamethasone. Dexamethasone has been tested for in vitro and in vivo genotoxic potential and shown to be positive in the following assays: chromosomal aberrations, sister-chromatid exchange in human lymphocytes and micronuclei and sister-chromatid exchanges in mouse bone marrow. However, the Ames/ Salmonella assay, both with and without S9 mix, did not show any increase in His+ revertants.

The effect of dexamethasone on fertility has not been investigated following topical otic application. However, the lowest toxic dose of dexamethasone identified following topical dermal application was 1.802 mg/kg in a 26-week study in male rats and resulted in changes to the testes, epididymis, sperm duct, prostate, seminal vessicle, Cowper's gland and accessory glands. The relevance of this study for short term topical otic use is unknown.

Pregnancy: Teratogenic Effects; Pregnancy Category C.
Reproduction studies have been performed in rats and mice using oral doses of up to 100 mg/kg and IV doses up to 30 mg/kg and have revealed no evidence of harm to the fetus as a result of ciprofloxacin. In rabbits, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion, but no teratogenicity was observed at either dose. After intravenous administration of doses up to 20 mg/kg, no maternal toxicity was produced in the rabbit, and no embryotoxicity or teratogenicity was observed.

Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals.

Animal reproduction studies have not been conducted with CIPRODEX® Otic. No adequate and well controlled studies have been performed in pregnant women. Caution should be exercised when CIPRODEX® Otic is used by a pregnant woman.

Nursing Mothers: Ciprofloxacin and corticosteroids, as a class, appear in milk following oral administration. Dexamethasone in breast milk could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. It is not known whether topical otic administration of ciprofloxacin or dexamethasone could result in sufficient systemic absorption to produce detectable quantities in human milk. Because of the potential for unwanted effects in nursing infants, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: The safety and efficacy of CIPRODEX® Otic have been established in pediatric patients 6 months and older (937 patients) in adequate and well-controlled clinical trials. Although no data are available on patients less than age 6 months, there are no known safety concerns or differences in the disease process in this population that would preclude use of this product (see dosage and administration). No clinically relevant changes in hearing function were observed in 69 pediatric patients (age 4 to 12 years) treated with CIPRODEX® Otic and tested for audiometric parameters.

ADVERSE REACTIONS In Phases II and III clinical trials, a total of 937 patients were treated with CIPRODEX® Otic. This included 400 patients with acute otitis media with tympanostomy tubes and 537 patients with acute otitis externa. The reported treatment-related adverse events are listed below:

Acute Otitis Media in pediatric patients with tympanostomy tubes: The following treatment-related adverse events occurred in 0.5% or more of the patients with non-intact tympanic membranes.

Adverse Event	Incidence (N=400)
Ear discomfort	3.0%
Ear pain	2.3%
Ear precipitate (residue)	0.5%
Irritability	0.5%
Taste perversion	0.5%

The following treatment-related adverse events were each reported in a single patient: tympanostomy tube blockage; ear pruritus; tinnitus; oral moniliasis; crying; dizziness; and erythema.

Acute Otitis Externa: The following treatment-related adverse events occurred in 0.4% or more of the patients with intact tympanic membranes.

Adverse Event	Incidence (N=537)
Ear pruritus	1.5%
Ear debris	0.6%
Superimposed ear infection	0.6%
Ear congestion	0.4%
Ear pain	0.4%
Erythema	0.4%

The following treatment-related adverse events were each reported in a single patient: ear discomfort; decreased hearing; and ear disorder (tingling).

DOSAGE AND ADMINISTRATION

CIRPODEX® OTIC SHOULD BE SHAKEN WELL IMMEDIATELY BEFORE USE.

Acute Otitis Media in pediatric patients with tympanostomy tubes: The recommended dosage regimen for the treatment of acute otitis media in pediatric patients (age 6 months and older) through tympanostomy tubes is: Four drops (0.14 mL, 0.42 mg ciprofloxacin, 0.14 mg dexamethasone) instilled into the affected ear twice daily for seven days. The suspension should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness, which may result from the instillation of a cold suspension. The patient should lie with the affected ear upward, and then the drops should be instilled. The tragus should then be pumped 5 times by pushing inward to facilitate penetration of the drops into the middle ear. This position should be maintained for 60 seconds. Repeat, if necessary, for the opposite ear. Discard unused portion after therapy is completed.

Acute Otitis Externa: The recommended dosage regimen for the treatment of acute otitis externa is: For patients (age 6 months and older): Four drops (0.14 mL, 0.42 mg ciprofloxacin, 0.14 mg dexamethasone) instilled into the affected ear twice daily for seven days. The suspension should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness, which may result from the instillation of a cold suspension. The patient should lie with the affected ear upward, and then the drops should be instilled. This position should be maintained for 60 seconds to facilitate penetration of the drops into the ear canal. Repeat, if necessary, for the opposite ear. Discard unused portion after therapy is completed.

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combination of two tools: Wells criteria and a D-dimer blood test. Patients can be risk-stratified with the Wells criteria into a high- or low-risk category for DVT (**Table 1**). A negative D-dimer test in conjunction with a low-risk score on Wells criteria can rule out DVT.[4]

The Wells criterion, which generates a possible score of -2 to 9, is a tool used to predict DVT. A score of 2 or greater places the patient at high risk of DVT and warrants imaging with venography. A low score of less than 2 puts the patient in a low-risk category and should be used in conjunction with a negative D-dimer test to rule out DVT.

What is the D-dimer and how good a test is it? D-dimer is a measure of the degradation of fibrin. In point-of-care testing, it has good negative predictive value, and a high sensitivity (91%-99%) but an average specificity of 60% for DVT.[2] Because the assay for D- dimer is not specific, a false-positive result is possible in association with any fibrinolytic process, such as cancer, surgery, disseminated intravascular coagulation (DIC) or trauma. A false-negative, on the other hand, is possible in a patient taking anticoagulation therapy. A D-dimer assay also is less accurate 1 week after the start of symptoms.[5]

Five different D-dimer point-of-care tests are commercially available: Vidas, pathfast, cardiac, triage, and the simple clearview. The first four are quantitative tests; clearview is the only qualitative test. A head-to-head comparison of the D-dimer studies for both accuracy and user-friendlines concluded that all five tests have high sensitivity or a high negative predictive value of 98%. However the most user-friendly tests are the triage and clearview D-dimer studies. Both require little calibration and therefore, are associated with fewer operator errors.[2,6]

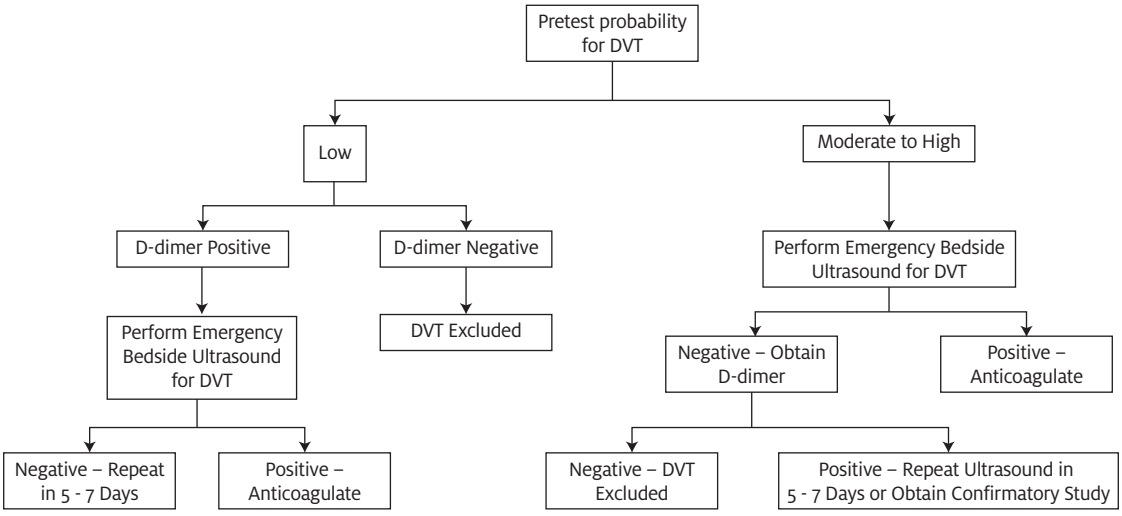
How does point-of-care testing for D-dimer compare with traditional central lab testing? A bioequivalence study was done in the emergency room setting to answer that very question. The study compared the Vidas point-of-care test with the traditional central lab D-dimer and found that point-of-care testing had a faster turnaround time by about 101 minutes. However, the Vidas test only predicted 83% of positive results from the central lab. The point-of-care test, therefore, while quicker is less accurate.[7] The study was limited in that it did not compare the other four available point-of-care tests for D-dimer. The gold-standard central lab test is a standard ELISA assay that has a sensitivity of 85% to 89%. Both the clearview and cardiac D-dimer studies have shown equivalent or greater sensitivity.

Does point-of-care testing have a place in the outpatient setting? It does in patients who fall into the low-risk category using the Wells criteria. A low-risk patient with a negative D-dimer point-of-care test can be safely ruled out and sent home.

Medical Decision-Making

If a DVT is suspected, the first step is calculation of the pretest probability with the Wells criteria. If the score is low or (less than 2), then a D-dimer should be checked. If the D-dimer is negative, DVT can be safely ruled out. If the D-dimer is positive, an ultrasound should be performed.

Figure 1. DVT Clinical Algorithm



If the Wells score is moderate/high, the first step is an ultrasound. If the ultrasound is positive, proceed with anticoagulation. If the ultrasound is negative, a D-dimer should be obtained to exclude DVT. If the D-dimer is positive and the Wells score is high, ultrasound should be repeated in 1 week to confirm accuracy of the study. The diagram in **Figure 1** very simply outlines the care path based on a patient's risk in conjunction with D-dimer testing.[8,9]

Treatment

Once a diagnosis of DVT has been made, what are the treatment options, what are the goals of therapy, and what is the duration of therapy recommended? Which patients are candidates for outpatient treatment and when should a patient be admitted for therapy?

The goal of treatment is to prevent DVT from developing into a fatal PE. Two distinct options exist for outpatient therapy: Low-molecular-weight heparin (LMWH) in combination with oral warfarin or oral rivaroxaban. Oral warfarin should be started at the same time as intravenous (IV) unfractionated heparin or subcutaneous LMWH. When an INR of 2 to 3 is achieved, heparin can be stopped and oral warfarin continued. The recommended starting dose of warfarin is 10 mg. LMWH is dosed by weight: 1 mg/kg subcutaneously (SQ) twice daily or 1.5 mg/kg once a day. Heparin should also be renally dosed. This treatment pathway would require lengthy patient education, including instructions on how to administer enoxaparin and dietary restrictions. Prior to discharge patients will also need primary care follow up for international normalized ratio (INR) monitoring to ensure therapeutic dosing. The enoxaparin/warfarin combination is a challenging treatment model in the urgent care setting for these reasons. A lot of resources and time are needed to ensure patient safety.

Rivaroxaban is a newer medication for anticoagulation that works by inhibiting coagulation factor Xa. The advantage of this medication is that it can be taken once a day orally. There is no need to bridge therapy with IV or SQ medication. Routine lab testing for INR is also unnecessary. The Einstein study published in *The New England Journal of Medicine* found that treatment of acute DVT and long-term treatment of DVT is safe and as effective as the traditional therapy with LMWH and oral warfarin. The study also found that there is an acceptable, low risk of bleeding with oral rivaroxaban and low risk of recurrence when treatment is completed.[10]

The disadvantage is there is no way to reverse the effects of the medication in the event of bleeding. In addition, there is no blood test to check for patient compliance. The burden of effective therapy is transferred from doctor to patient. Rivaroxaban cannot be given to patients with a creatinine clearance less than 30. Prac-

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Table 2. Duration of Treatment

NO treatment Distal LE DVT, asymptomatic and IF doesn't extend when followed with serial imaging. (Treat if extends.)
3 months Distal LE DVT, symptomatic (regardless of cause), or extending asymptomatic Surgery or risk factor- associated proximal LE DVT (regardless of symptoms) Unprovoked proximal LE DVT if high bleed risk Recurrent, unprovoked LE DVT or PE (high risk)
Extended/Lifetime Unprovoked proximal LE DVT (if low or moderate bleed risk) Cancer-associated DVT or PE (LMWH preferred over warfarin)

DVT = deep venous thrombosis; LE = lower extremity; LMWH = low-molecular-weight heparin; PE = pulmonary embolism

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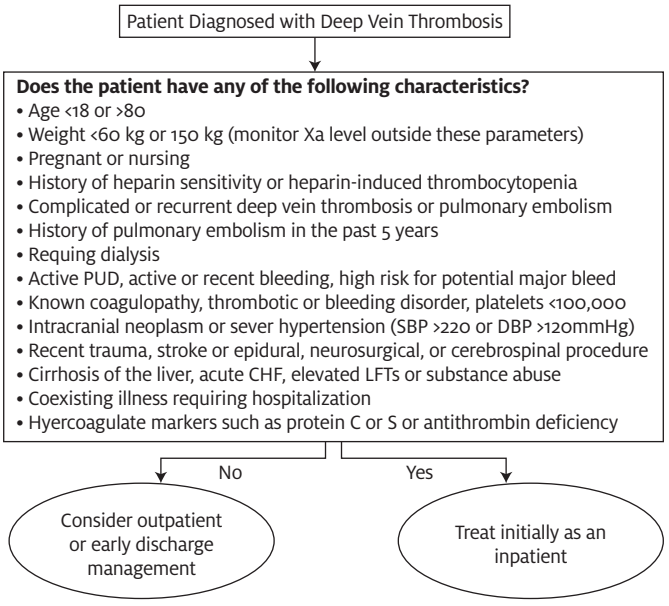
Figure 2. Guidelines for the Outpatient or 'Early Discharge' Management of DVT



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titioners should calculate the creatinine clearance with the Cockcroft –Gault formula to ensure that a patient is a good candidate for the drug.

Oral rivaroxaban is an excellent option for treatment of acute DVT in the urgent care setting for a few reasons. The need for extensive patient education is eliminated because drug administration is simply swallowing a pill. Furthermore, follow up does not need to be arranged prior to discharge because the drug does not need to be titrated nor an INR followed. The medication has no dietary restrictions. An urgent care provider would need a confirmatory ultrasound test to confirm a diagnosis of DVT and then treatment could be started in the urgent care setting.

The length of anticoagulation therapy is dependent upon the individual patient and is similar for treatment with either model enoxaparin or rivaroxaban. Treatment duration is at least 6 weeks to 3 months. A duration of 3 months is appropriate for the patient with a first DVT that is provoked. Treatment for 6 months is appropriate for an unprovoked first DVT. For recurrent DVT or a known prothrombotic condition, the duration of treatment is 12 months. **Table 2** illustrates factors that impact treatment duration.

What are the indications for inpatient versus outpatient management of DVT? How can urgent care providers better facilitate patient transfer of care when needed? **Figure 2** provides guidelines to help determine proper patient disposition.

Outpatient management is considered safe and effective therapy for DVT in appropriately selected individuals. Patients should be screened using the previously described inpatient criteria. They must also have a solid understanding of their condition and appropriate follow up. A supportive family and/or friends to help facilitate compliance, a working phone to call for help in the event of bleeding, and a way to return to the hospital in the event of an emergency are additional important

"Oral rivaroxaban is an excellent option for treatment of acute DVT in the urgent care setting for a few reasons."

factors, as is adequate pain control while at home. If these conditions are met, a patient can be considered a good candidate for home treatment with either enoxaparin or oral rivaroxaban.[3]

Conclusion

Many patients present to urgent care centers with symptoms of acute onset unilateral leg swelling. DVT is frequently in the differential diagnosis. Because of the high morbidity and mortality associated with progression of DVT to PE, a systematic approach must be taken to safely rule out VTE in the outpatient setting. The initial step with the Wells criteria helps to establish a patient's risk. High- or moderate-risk patients should be referred for Doppler ultrasound testing. Low-risk patients can have the D-dimer assay checked, and if the results are negative, DVT can be safely ruled out. Once the diagnosis is made, treatment decisions, including options for outpatient therapy, depend on individual patient characteristics. For the right patient, outpatient treatment can be considered and can be effectively managed in the urgent care setting. ■

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An Urgent Care Operator's Guide to Hiring and Managing a Lawyer

Urgent message: This article is a broad overview of how lawyers work and charge and what to do to avoid some of the most common pitfalls inherent in the attorney-client relationship.

ALAN A. AYERS, MBA, MAcc

Success in business entails being prepared and there will be times when it's unavoidably necessary for you, the urgent care operator, to engage the services of an attorney. From structuring and starting up the business, to reviewing and negotiating leases, to employment agreements and other personnel issues, to disputes with vendors—at some point competent legal representation may be not only advisable but even vital to the continued health of your center.

The purpose of this article is not to tell you where to find a lawyer or a law firm—referrals can be obtained by word-of-mouth or through local medical societies, bar associations, your bank, the Chamber of Commerce, or other business organizations—but rather to suggest some of the important considerations in selecting and maintaining a good working relationship with your attorney.

Do I Need an Attorney?

"Do I need expert advice or representation?" is the first and most obvious question when faced with a problem or circumstance that smacks of legal implications. Some believe that if you feel the need to ask yourself this question, the answer should always be "yes," if only to ask an attorney the same question and hear his or her views on it. In the final analysis, you should trust your own judgment and recognize your own limitations as to knowledge and experience in the particular field. Keep in mind, particularly, that many states (and federal Medicare regulations) have very specific requirements and restrictions that apply to various types of health care entities.

If you are still not sure whether you need an attorney, it's best to err on the side of caution. It's never too soon to ask the question; later can sometimes be too late.

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There are some circumstances in which the need for legal representation is without question. One is during the business startup phase, when the selection and formation of the business structure occurs and when ownership buyout or succession, management authority, future non-competition, and a whole host of other issues need to be considered.

Another decidedly "*yes*" situation is in the case of litigation: *any litigation*. No matter how small or seemingly insignificant, do not try to handle it yourself unless you are prepared for heartbreak. Of course, in those cases in which insurance coverage is in play—including malpractice and general liability claims—your insurance company will select a law firm and, depending on your coverage, may cover the costs of the litigation.

Choosing an Attorney

The ideal attorney-client relationship for an urgent care operator will be with someone who is competent in the applicable area of the law, ethical, accessible when you need access, and reasonably priced. So do you hire a large firm, small firm, or sole practitioner? The differences can matter a great deal.

A large firm will likely have lawyers on staff with expertise in a wide range of legal fields, so they can handle "in house" most if not all of your varying legal needs that might arise. The tradeoff may be higher legal fees because of overhead that covers impressive office space, lots of support staff, country club memberships, and political connections. Large firms also may rely heavily on associates and paralegals, so your "someone" will at times have many different faces.

A small firm, on the other hand, typically will be less expensive and more personal to deal with, but it may lack the range or level of expertise that you desire. The sole practitioner, particularly one sufficiently experienced in the practice of health care and health care business-related law, is somewhat of a rarity today. Expect any matter that strays too far from his or her field of concentration to be referred out to others; time availability may also be an issue for a sole practitioner who has to balance the needs of other clients.

Ultimately, the character and the expertise of the particular lawyer who will handle your legal matters outweighs the size of the firm. It really is a relationship, and it should be one with which you are comfortable. Only you can discern whether your lawyer

Table 1. Setting Expectations: Money- and Time-Saving Questions to Ask Your Lawyer

- Can you describe the overall scope of legal work necessary to be performed?
- What is the anticipated length of time to resolve this legal issue?
- What are the total anticipated expenses including both attorney fees and non-attorney costs?
- Who within your firm will be working on my matter, including associates and paralegals?
- Which actions will require my in-person appearance?
- What documents will I be required to produce, and when will they be due?
- Will any of my employees be involved, and what is the probable scope of their involvement?

will truly be representing "you."

As a final note, take a moment to check with the attorney-regulating authority in your state (usually the office of the State Supreme Court) for any past or pending disciplinary action against the attorney you are considering hiring.

Hiring an Attorney

After you have chosen a particular lawyer or law firm to consider hiring, invest some additional time in the process: Make an appointment and go to their office. It will be time well spent. You are (or will be) in charge of an efficient, complex urgent care facility, so use the same powers of observation you employ every day at your own center to get a feel for how this law office operates. It may speak volumes to you. Some firms charge for an initial consultation, others don't. Find out in advance. If they do charge, when making the appointment, tell them that the reason you are coming there is that you are considering hiring the attorney, either for ongoing, continuing representation or to handle a particular legal matter. Let them know that you do not expect to be charged for the lawyer's time during the interview unless and until you agree to hire him. In effect, you place the burden on the lawyer to tell you specifically when the clock gets turned on.

During the appointment, besides learning more about the person sitting across from you, a primary objective for you is to learn about the firm's expertise in the particular areas of the law that are of concern to you. Be prepared to ask specific questions. Has the attorney or the firm handled similar matters? What were the costs and the time involved in those cases, and what were the results? Keep in mind that to the extent expertise is lacking, you may end up paying for the acquisition of knowledge that another firm may already possess. On the other hand, every legal problem is unique, so a good general knowledge coupled with a short learning curve on the specifics may be acceptable to you.

The lawyer is obliged to reveal to you any anticipated conflicts of interest. Ask if any exist. Large firms, particularly those that specialize in health care, may represent or have represented your competitors. A firm may have had a past attorney-client relationship with your counter-party. Although you may be given assurances that all client information is kept confidential or that conflicting matters will be handled by different teams of attorneys within the firm (called "firewalling"), you will have to be the judge of whether you are comfortable with that.

If a lawyer does not have malpractice insurance, in most states, he or she is required to inform a potential client without being asked. Ask anyway and don't feel uncomfortable about it. You are well advised not to hire a firm that does not have such coverage.

The Fee Agreement

The final step in the process of hiring an attorney is the agreement as to how much you will pay for the legal representation to be provided to you. Most firms will (and in some states they must) provide you with a written Fee Agreement. Read it thoroughly and carefully and understand its terms before your sign and request a copy of the executed document. The lawyer should be happy to explain to you any provisions that are not clear to you. If no written agreement is provided (which may be permissible in some cases, such as a minor matter being handled for a flat fee amount) you should at least insist that the fee arrangement be memorialized in writing in some form, typically in a letter.

The two main components of the fee agreement are the attorney's fees and what are referred to as costs. As to fees (other than in the minor, flat-rate situation described above), look for an hourly rate; in multiple lawyer firms, different rates will apply for different levels of experience and expertise. Some firms may charge fees for paralegals' time as well. Secretarial time may not be charged to you. Hourly rates vary widely, but keep in mind that a lower rate from a less experienced

lawyer may not necessarily end up being bottom-line less expensive for you on a particular case. Sadly, too, some lawyers and law firms routinely reap the benefits of a "48 hour day." Contingent fee cases, in which the fee is a percentage of any money recovered (and which also require a specific written Contingent Fee Agreement), are typically only utilized in plaintiff personal injury claims and routine collection cases.

A lawyer may ask you at the outset of your relationship to pay fees and costs up front, as a retainer. This practice is quite common. By law this advance payment is not earned by the lawyer unless and until services in that amount have actually been provided to you. As long as the retainer is reasonably related to the overall anticipated cost and scope of the work you are asking be performed, it should not be viewed as anything other than a sensible business practice when dealing with a new client.

You will also be charged for costs, the definition of which also varies widely. Court filing fees, the cost of obtaining public records, investigators' fees, and anything else that is paid to others for services outside the firm will always be considered costs. Some firms also include such things as in-house copying costs, travel expenses, long distance phone calls, and the like, so, again, read the agreement carefully before signing it.

Questions to Ask About Legal Billing

When you bring a particular matter to your attorney for handling, ask for a "road map" of expected or anticipated action to be taken on your behalf including those listed in **Table 1**.

Litigation cases can be extremely time-consuming and expensive. Discovery—the pre-trial phase in which each party to a lawsuit requests evidence from the other party—can be particularly burdensome. What discovery costs are anticipated, who will be involved, the necessity of depositions and whether they will be transcribed, videotaped or both should be fully discussed and understood. The expense and time involved in a trial can be even worse, with an ultimate outcome that is fraught with unpredictability and risk. **Table 2** lists areas of inquiry when you bring your lawyer a litigation case.

To determine a settlement position, you must understand the strengths and weaknesses of your position, the law, the evidence on each side, and the arguments and counter-arguments to be made. A settlement or a trial outcome may be for money or for some type of injunctive action required of a party.

Table 2. Avoiding Surprises: Questions to Ask Your Lawyer When Litigation Arises

- What is your knowledge of, and experience with, the judge to whom the case is assigned?
- What are the possible and probable trial procedures and their potential schedules and timelines?
- How many lawyers will appear on my behalf at trial and what role will each play?
- What witnesses will be required, including any of my current or former employees?
- What are the anticipated non-attorney costs such as investigations, expert testimony, transcriptions, filing fees, and others?
- Will the non-prevailing party will have to pay any of the prevailing party's litigation expenses?
- What is the most likely outcome of the case and is settlement the best alternative?

Additional Ways to Control Legal Expenses

There are a number of ways to control or limit the legal expenses you incur at all points during the attorney-client relationship.

First, when bringing a matter to your lawyer for handling, always ask for an estimate of the total anticipated expense. When practical, set a budgeted high-end limit, one that is not to be exceeded without further consent from you. And memorialize it in writing.

Second, every bill you receive should detail all charges. Carefully review them, and do not be afraid to question or challenge something when warranted. Mistakes have been known to be made. Keep your own diary of time you spend with your attorney, and compare it to your attorney's invoice.

Associates and paralegals assigned to your case may not add much to the outcome, and can greatly escalate your expense. Insist that associate and paralegal work on your case be held to a minimum and be used only where cost effective and in a way that does not sacrifice experience. Be wary of large blocks of time being charged for "research." Research is a necessary component of proper representation, but it's also easy to justify and nearly impossible to disprove. A strong protest now and then may help minimize its abuse.

Phone call billing is handled by most firms on a set minimum cost-per-call basis, except where calls run long enough to bill for the actual time involved.

Some firms charge a minimum of 10 to 15 minutes per call and bill in time increments ranging from 6 to 30 minutes. Keep this in mind when you call your attorney for some innocuous reason, or you decide during the call to spend 6 minutes discussing last night's basketball game. When calling your attorney, know beforehand what answers you seek, and be direct and to the point. Get off the line when you have your answer. If the attorney has to return your call after you leave a message, be prepared for that call by having your notes with you. If you leave a long, drawn-out message concerning your questions, you may see a bill that you did not expect for the answers. You can keep the lawyer on set deadlines by calling for updates. The old adage that the "squeaking wheel gets the first oil" is as true in a law office as it is in any other business.

Another fee that can become burdensome is travel by the attorney or on your part. You should know how travel and expenses are calculated including time involved. If you're paying for the attorney's time to drive to your location, in addition to the time spent meeting with you, you can reduce costs by meeting at the law office instead. You should also determine whether any travel is necessary, who on the attorney's team is needed to appear, and to meet telephonically when possible. When meeting at the law office, ask about the office hours, flexibility after hours, and whether the firm has a parking facility or covers your parking.

Always remember that you are paying for a lawyer's time. That is his or her "stock in trade." You may personally like your attorney (and ideally you do), but social banter when he's on the clock can be a waste of your money. If you meet for a drink after hours and discuss your case, expect a bill—it may even include the price of the cocktails! When working for you, your lawyer is not your friend, he is your representative and confidant.

Firing Your Lawyer

Even the best of relationships can come to an end at some time. This is true for friends, spouses, employees, doctors, and, yes, even lawyers. You may lose confidence in your attorney for any number of reasons, such as tardiness, demeanor, unreasonable fees, or apparent impairment, or you may simply want to switch to someone else, for reasons difficult to articulate. Whatever the case, when the existing attorney-client relationship no longer works adequately for you (and when repairing it is not a viable option for you), it's time to move on. Keep in mind that the relationship is at-will: either party can end it at any time, for any reason, or for no reason at all. Expect a degree of disruption, particularly if your current lawyer is in the middle of handling one or more matters for you. You may have to pay for your new or prospective lawyer to review the work of your original lawyer in order to get up to speed—such services are both necessary and valuable.

But consider the other side of the coin. Your lawyer may have been doing all that he or she can, and may in fact have been doing an excellent job of representing you, but was not able to communicate with you in a way that you understood, perhaps giving you honest assessment of your position but in the process telling you things that you'd rather not hear. You may simply have been displeased with an adverse outcome that was beyond your lawyer's control. If you do go elsewhere, you start all over and you incur additional expenses, and you may end up in the same rut. Firing your lawyer is a decision to be made not hastily, but rather with reflection.

Once the decision to discharge your lawyer has been made and conveyed to him or her, no lawyer, according to the rules of their profession, has a right to hold you to representation. The lawyer is entitled to be paid for all time expended and all services provided to you up to the time of discharge. The lawyer may not, however, hold your records or files hostage. They belong to you (with some exceptions, your new lawyer can advise you on this), and you are entitled to have them delivered to you. If litigation is pending, your lawyer must have court approval to withdraw from it, and you will be required to obtain substitute counsel or be prepared to represent yourself in the matter.

Conclusion

As an urgent care operator, you rely on others for many of the goods and services required of a healthy business operation. Each of them contributes to your success. Your lawyer is simply one more. The purpose of this article is to introduce you to some of what takes place in the realm of lawyers; how they perform their services and how they charge for them; how you can avoid some of the pitfalls inherent in the attorney-client relationship. It is intended to raise your awareness. After all, awareness is essential to good business decision-making and performance. ■

Case Report

Nasal Polyps

Urgent message: Differential diagnosis and careful attention to signs, symptoms and history are particularly important in management of patients with nasal inflammation.

MOHAMMED NOMAN MOHIUDDIN, MD

Overview

Nasal congestion and sinus symptoms are common urgent care complaints. Recurrent sinusitis, either from allergies or upper respiratory infections is frustrating to patients. Proper evaluation and treatment of underlying predisposing factors will help alleviate symptoms and address the disease process associated with polyps such as those seen in **Figure 1**.

Case Presentation

A 5-year-old female was brought in by her mother with complaints of left-sided nasal congestion and dried blood in her nose for 1 week. The child reported that her nose was injured by her friend's elbow while they were playing at school. At the time, she was noted to have bleeding from her nose for 10 minutes, which was controlled with nasal pressure. A few days later, the parents noticed dried blood in the child's left nostril and brought her to the urgent care center for evaluation. On further questioning, the child reported issues with recurrent sinusitis and seasonal allergies. She has been treated multiple times by her primary care physician for sinusitis. Her mother also reported that for the last 2 years, the child has been snoring loudly at night and her voice has been nasal.

Observations and Findings

Physical examination of the patient reveals the following:

Allergies: NKDA
PMH: as noted above

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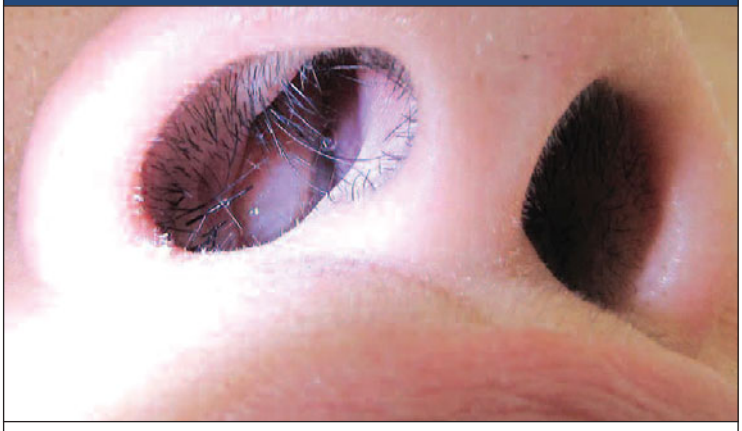
Medications: none
Family History: Maternal asthma and allergic rhinitis
Pulse: 80
Temp: 98.7°F
O_2 Sat: 100%
BP: 80/50.

The child was well developed, alert and oriented x3 and in no acute distress.

HEENT: + findings: bloody mucus discharge from the left nostril, completely obstructing the nasal cavity with mild tenderness over the bridge of the nose. The child was told to blow her nose and re-examination of the left nostril revealed a painless, soft, lobulated mass with edematous mucosa in the nasal cavity.

Figure 1. Nasal Polyp



Source: Wikimedia Commons. Uploaded by author MathieuMD

Oral examination revealed bilateral 2+ tonsillar enlargement without any erythema and exudates. No cervical adenopathy was present and the child's external ear canals were normal and her tympanic membranes were clear bilaterally.

The patient's lungs were clear to auscultation bilaterally with no rhonchi or wheezing. Her heart rate and rhythm were normal with normal s1 and s2 and no murmurs.

Diagnosis

Nasal Polyps

Discussion

Epidemiology

The prevalence of nasal polyps in the general population is 0.5% to 4.3% and in children it is 0.1%. Prevalence is increased in patients with selected conditions, including 36% to 96% in individuals with aspirin intolerance, 36% to 60% in association with intolerance to nonsteriodal anti-inflammatory drugs, 7% to 15% with asthma, 40% with cystic fibrosis, and 0.5% to 4.5% in patients with allergic rhinitis.

Likely risk factors for nasal polyps are aspirin sensitivity, asthma, and allergic rhinitis. The condition commonly involves paranasal sinuses and it may cause secondary bacterial infection and chronic nasal obstruction leading to orthodontic abnormalities, including high-arched palate and malocclusion.

Clinical presentation

Patients with nasal polyps present with nasal obstruction, rhinorrhea, sneezing, postnasal drip, decreased sense of smell, and rarely epistaxis (more common with cancer or invasive benign lesion). Physical signs include bilateral edematous swelling of nasal mucosa that usually originates in the ethmoid sinuses. The area around the middle turbinate may have an appearance similar to gray grapes. Because polyps are generally insensitive, probing with a blunt instrument may distinguish them from very sensitive swelling of the turbinate. Anterior rhinoscopy can be used to visualize large polyps and nasal endoscopy is required to visualize small polyps.

Differential diagnosis

Polyps that are unilateral may signal malignancy based on presence of neck mass, symptoms of headaches, diplopia, conductive hearing loss, tinnitus and referral to an otolaryngologist is appropriate for these patients. Suspect cocaine abuse in patients with nasal septal perforation, nasal irritation, crusting, recurrent nose bleed, and nasal stuffiness. Other signs and symptoms of cocaine abuse may be present in these individuals and they should be and referred to a behavioral health specialist for further evaluation.

Nasal foreign bodies are particularly in children aged 18 months to 5 years and in mentally ill or handicapped adults. The hallmarks of the presentation are unilateral, purulent, foul-smelling discharge, fever, and pain. Urgent referral to an ear, nose and throat (ENT) specialist is required for caustic foreign bodies such as button batteries. If threat to the airway is a consideration, take immediate action to relieve it before continuing with further assessment. If the diagnosis is uncertain, imaging is required. Nasal examination can be uncomfortable; anesthetizing the mucosa with a topical agent makes the procedure less traumatic and using a vasoconstrictor shrinks the mucosa, allowing easier examination and possibly easing removal.

Symptoms associated with polyps caused by allergic rhinitis include nasal itching, sneezing, clear nasal secretions, and transverse nasal crease. In severe cases, dark circles around the eyes can be appreciated. In patients with this presentation, look for associated asthma, eczema, chronic cough, and postnasal drip. Allergen avoidance, topical nasal steroids and antihistamines are the mainstays of treatment.

Nasal congestion, purulent drainage, and headache with facial pain or pressure is suggestive of infectious sinusitis. Acute sinusitis may last for 7 to 10 days whereas

chronic sinusitis can span more than 12 weeks. Predisposing factors include allergic rhinitis, upper respiratory tract infections, and certain environmental factors including smoking and second-hand smoke. The goals of treatment are relief of symptoms with supportive therapies and eradication of bacterial infections with antibiotic medications when necessary. Patients with recurrent sinusitis should be referred to an ENT surgeon.

Treatment

Most patients with nasal polyps should have a trial of medical treatment prior to surgery unless the diagnosis is unclear. Intranasal steroids are indicated for nasal polyps that cause mild to moderate symptoms. Mometasone nasal spray 200 mcg once or twice daily is appropriate to reduce symptoms and it may decrease the size of nasal polyps in patients who have chronic rhinosinusitis. Fluticasone nasal drops may reduce the need for functional endoscopic sinus surgery.

After 3 months of medical therapy, patients with nasal polyps should be re-evaluated. If their symptoms have improved, treatment should continue with topical steroids and follow up every 6 months. For patients whose polyps do not improve, a computed tomography (CT) scan is necessary. Those with severe symptoms may require a short course of oral steroids in combination with intranasal steroids, with follow up in 1 month. If the combination therapy produces improvement, the intranasal steroids should be continued. If not, a CT scan should be obtained and the patient refer to an ENT for endoscopic sinus surgery.

Conclusion

Seeking the underlying cause of nasal polyps will help establish the diagnosis in a timely manner and also facilitate proper management. Our patient was discharged home on intranasal steroids and with referral to an ENT surgeon. The child's mother was happy with our care because she never knew that her child had a nasal polyp that was causing recurrent sinus infection and snoring. ■

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The First Thing We Do, Let's Kill All The Lawyers

JOHN SHUFELDT, MD, JD, MBA, FACEP

I knew that would get your attention! Actually who Shakespeare was referring to in Henry VI was only the rare corrupt lawyer. Corrupt or not, the one thing lawyers have correct is that because their entire practice is "giving advice," they rarely do it for free. Bad advice has consequences. I'm not trying to be Doctor Downer but in medicine and law, it's called negligence.

As opposed to lawyers, doctors and other medical providers are constantly hit up for free advice and if you are like me, you don't whip out "The Square"[1] and plug it into your iPhone so that you can take a credit card payment. We simply hand out advice to anyone and everyone who asks. It's in our DNA to be the helpful, trustworthy conveyers of medical information we were trained to be.

Honestly, they never tell us this in school – that 24 hours per day we will be the go-to provider to everyone we encounter. If I had a nickel for every, "Hey, John, can I ask you a question" I'd have a lot of nickels. I admit, however, that it is a slippery slope. One question can lead to multiple questions, then to prescriptions and reviewing lab and imaging results. Truth is, I would be insulted if they didn't ask and I tell that to anyone who feels like they put me out by asking.

So, if we are going to do it anyway what can we do to have some protection? First, some context in case you don't get the seriousness of this issue. A young woman who finished her ob/gyn residency a few years earlier was in a relationship with a man she planned to marry. He happened to be a bodybuilder and reportedly had low testosterone discovered during a physical and lab evaluation. She was prescribing him and then injecting him with testosterone in order to restore his serum testosterone levels to normal.

"What would you do when an out-of-state relative calls for advice and a prescription and even sends you a picture via cell phone of what appears to be a superficial cellulitis?"

Low T was reportedly rarely ill but after a day of upper respiratory symptoms complained to the ob/gyn that his throat was sore. She performed an undocumented exam on him and prescribed him penicillin on the presumption that he had strep throat. During the day he became worse. She took care of him, by encouraging liquids and anti-pyretics. She even started an intravenous on him for hydration. You probably know where this is going. He developed a rapidly spreading purpuric rash, at which point she called an ambulance, which transported him to the hospital. He was removed from life support 2 days later and died of meningococcemia.

I know, the above true story sounds extreme, but haven't we all called in an antibiotic for a friend or family member? I agree, the testosterone is edgy but I can easily see how she started down this slippery slope to losing her license. She was trying to take care of someone she loved, she kept no written records of her care and, to top it off, she was accused of having a sexual relationship with her patient – never mind the fact that they were engaged.

The American Medical Association in Opinion 8.19 weighs in on this in their Code of Medical Ethics. Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when

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an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered."[2]

It may, however, be more insidious when friends and family ask us for help navigating the tricky waters of post-Affordable Care Act health care. A referral, a question about a new prescription or side effect or the familiar, "What do you think of this?" While in law school one of my classmates tried to drag me into the bathroom so that I could look at the rash on his scrotum – I'm not kidding. Other than avoiding a few unpleasant scrotum images burned into our minds, when does the line get crossed and you establish a physician-patient relationship and are now burdened with the legal and ethical obligations that come with it?

Hypothetical: What would you do when an out-of-state relative calls for advice and a prescription and even sends you a picture via cell phone of what appears to be a superficial cellulitis? The individual can't get in to see a doctor and is leaving for vacation in a few hours. Most of us would call in the appropriate antibiotic after asking all the pertinent questions – after all, this is a relative. What just happened? You are likely practicing medicine in a state where you probably don't have a license to practice and probably made no written record of the evaluation.

The challenge is that once you put your toe in the water, "That rash appears to be early shingles" you might as well have just taken a dive into the deep end. The follow-up question, "Oh no, I have heard that is painful and should be treated early with anti-virals, and other medications. What should I do?" Or " I have a slight headache" or "It feels like I have something in my eye and the rash has spread to my nose."

Here is how I approach these encounters. When asked, I usually respond, "I am not your doctor and because I don't know your entire history and can't (won't) examine you, it is hard for me to give you the care or advice you need." I then go on to ask a few questions and offer some suggestions, always with the caveat, "This is what your doctor would likely tell you and I suggest you call her."

One of the reasons I started the virtual medicine company MeMD was that I was concerned about this very issue and wanted to have some record of the interaction and a way to provide a prescription when necessary. I even give those that ask a "free coupon code" so all barriers are removed and they don't feel like I am trying to "drum up business." When they call, I make sure it is not me who is their treating provider.

Are there times when it is appropriate to treat friends and family members? Absolutely! When it is an emergency, when no other care is available and the condition is time-sensitive, then go ahead and treat and document your evaluation just as you would any other episode of care. It can be as simple as a soap note written in an email to yourself. Encourage the individual to follow up with his/her own provider once the crisis is over.

"Take a lesson from our legal brethren that advice is never free. There is always a cost to receive and often to give information. Do not let yourself be the one who pays."

Take a lesson from our legal brethren that advice is never free. There is always a cost to receive and often to give information. Do not let yourself be the one who pays.

Take-home points:

1. Never prescribe controlled substances to yourself or a family member (unless in an emergency).
2. Document all episodes of treatment just as you would during any other evaluation.
3. Be cognizant of the fact that your "patient," because of embarrassment, may not be supplying you with the entire story.
4. Recognize the "slippery slope" of "Can I ask you a question?"
5. Identify those episodes where advice crossed into a doctor-patient relationship.
6. Don't opine on issues outside of your sphere of knowledge. The standard of care still applies.
7. Don't rely on the "Good Samaritan" doctrine to protect you; chances are that it won't apply.
8. Don't treat patients or opine while under the influence. The same rules apply as if you were in your office inasmuch as you are still practicing medicine.
9. If you open your office after hours to treat a friend, be aware that you may need a chaperone. The last thing you would want to be accused of is unwitnessed and undocumented inappropriate touching. ■

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ABSTRACTS IN URGENT CARE

- Modification of Wells criteria
- Antibiotic delay and URI
- Headaches and neuroimaging
- Age-adjusted D-dimer
- Inhaled steriods for pediatric URI

SEAN M. McNEELEY, MD

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

Modification of Wells criteria in cancer, previous DVT

Key point: Wells criteria for deep venous thrombosis (DVT) may need modification for patients with cancer or previous DVT.

Citation: Geersing GJ, Zuithoff NP, Kearon C, et al. Exclusion of deep vein thrombosis using the Wells rule in clinically important subgroups: individual patient data meta-analysis. *BMJ*. 2014;348:g1340.

Possible DVT is an important diagnosis to make, however, many urgent cares do not have access to ultrasound. A combination of Wells rule and D-dimer test has been proposed as a reasonable option for low-risk patients, but some investigators have found that there may be some subgroups that need further evaluation or modification of this method. The authors of this article attempted to corroborate previous studies. A meta-analysis was performed of 13 previous studies with a total of 10,002 patients. Criteria of a Wells rule score <1 and a negative D-dimer was able to reduce the risk of DVT to less than 2%. Most experts use less than 2% as an acceptable error rate when ruling out DVT. The authors noted that only previous DVT and cancer crossed the 2% threshold. The authors concluded that this combination was not useful in patients with cancer and patients with previous DVT needed one extra point added to the Wells rule score for significant sensitivity. Other findings from the review included an increased risk of blood clot with increasing Wells score and even a -2 Wells score led to a 5% risk of DVT. From an acute care perspective, it's important to understand that Wells rule score alone is not sensitive enough and that patients with cancer and previous DVT will need even more consideration than just having a normal D-dimer. ■

Sean McNeeley is an urgent care practitioner and Network Medical Director at University Hospitals of Cleveland, home of the first fellowship in urgent care medicine. Dr. McNeeley is a founding board member of UCCOP and vice chair of the Board of Certification of Urgent Care Medicine. He also sits on the *JUCM* editorial board.

Impact of antibiotic delay for URI on patients' beliefs, symptoms

Key point: Delaying use of antibiotics for upper respiratory infections (URI) may reduce total antibiotic use without changes in perceived symptoms and patients' belief in the need for antibiotics.

Citation: Little P, Moore M, Kelly J, et al. Delayed antibiotic prescribing strategies for respiratory tract infections in primary care: Pragmatic, factorial, randomised controlled trial. *BMJ*. 2014 Mar 5; 348:g1606.

Authors in the United Kingdom attempted to see how different methods of delaying antibiotic prescriptions for URI would effect total antibiotic prescriptions, patients' belief about antibiotics, and symptom scores. In this trial, 889 patients identified not to need immediate antibiotics were randomized to four methods to delay prescriptions or just not provided with one. The four methods were having patients call back for antibiotics, post-dating prescriptions, asking that patients come back to get previously written prescriptions, and getting the script during the visit, but being told to wait

before use. The study found the use rate for antibiotics was similar to previous studies (around 40%) with similar control of symptoms for all groups. These strategies were also associated with less strong belief that antibiotics are needed. For the acute care provider, this adds to the evidence that delayed prescriptions can reduce antibiotic use and may reduce the perception of need for antibiotics as well.

Headaches and utilization of neuroimaging

Key point: Neuroimaging continues to be used more than one would expect, given current guidelines.

Citation: Callaghan BC, Kerber KA, Pace RJ, Skolarus LE, Burke JF. Headaches and neuroimaging: High utilization and costs despite guidelines. *JAMA Intern Med* 2014 Mar 17; [e-pub ahead of print].

The authors of this article attempted to quantify the percentage of patient visits for headache or migraine that resulted in imaging. Data were obtained by using billing information in a retrospective fashion. Comparing 1995 to 2010, imaging increased from 5% to almost 15% despite guidelines and efforts by multiple groups to reduce the number of scans performed. Most experts agree that too many scans are performed based on other studies that have cited abnormal test rates from 1% to 3%. This potential overuse of imaging can both waste funds that could be used elsewhere in medicine and potentially cause increased risk of cancer in patients who are scanned by computed tomography. The cost of these scans is estimated to be near $1 billion annually. The authors concluded that perhaps patients are driving this increase more than providers and that more campaigns aimed at patients might help. From the urgent care provider perspective, carefully considering the need for imaging in each individual patient and informing patients about the risks and benefits may help reduce this expensive trend. ■

The value of age-adjusted D-dimer results

Key point: Age-adjusted D-dimer results appear to reduce need for further testing without decreasing sensitivity in patients over 50 years of age.

Citation: Righini M, Van Es J, Den Exter PL, et al. Age-adjusted D-dimer cutoff levels to rule out pulmonary embolism: The ADJUST-PE Study. *JAMA*. 2014;Mar 19;311:1117-1124.

D-dimer is frequently used as a first test in evaluation of patients with possible pulmonary embolus (PE). Unfortunately D-dimer levels increase with age, causing the test to be less helpful in older patients. In this study, investigators in several European cities attempted to see if an aged based cut-off for D-dimer levels could be used without increasing the failure rate of testing. The authors surmise a cut-off of age times 10 for patients over 50 would reduce the number of patients needing further investigation but found not to have a PE. The conventional cutoff has been 500 mcg/L. A total of 3,346 patients were considered with possible PE and the prevalence of PE was 19% for the group. A total of 2,898 patients were not considered high probability. Of them, 817 had a D-dimer below the traditional cutoff and 337 patients fell between the traditional cutoff and the new age-adjusted level. The authors used a 3-month embolic event rate in patients without anticoagulant treatment as the definition of success. Only one of the 331 patients failed. In patients over age 75 (673 were non-high probability), the new strategy increased the number of patients who could be excluded from 43 to 200. Although further studies confirming this new adjustment are probably needed, acute care providers with access to a D-dimer test may consider discussing this study with patients at low probability and with a D-dimer level between the standard and the age-adjusted value. ■

Inhaled steroids for pediatric URI

Key point: Inhaled steroids of no benefit for recurrent upper respiratory infection (URI)-induced cough in children without asthma.

Citation: Clavenna A, Sequi M, Cartabia M, et al. Effectiveness of nebulized beclomethasone in preventing viral wheezing: An RCT. *Pediatrics*. 2014;133(3):e505-512.

The authors of this study attempted to assess the effectiveness of nebulized beclomethasone in prevention of repeat viral wheezing in patients with a new upper respiratory infection (URI). A total of 525 patients aged 1 to 5 years were evaluated in a double-blind, randomized fashion. Treatment was twice daily for 10 days and the endpoint was wheezing diagnosed by a pediatrician. No significant differences were found between the groups. Children with asthma or even possible asthma were excluded from this study group. In their introduction, the authors noted that prescription of inhaled steroids to patients with viral wheezing was quite common based on previous research. From an acute care perspective, the temptation to prescribe inhaled steroids can be strong considering the desire of most parents to "get something" to help their child with an URI. This study does not note any definite harm from the nebulized beclomethasone but does show a lack of effectiveness and should be considered when treating young children with URIs. Interestingly parents rated both the treatment and control medications as effective at near 60% rate. That is quite a significant placebo effect. ■

INSIGHTS IN IMAGES

CLINICAL CHALLENGE

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

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

FIGURE 1

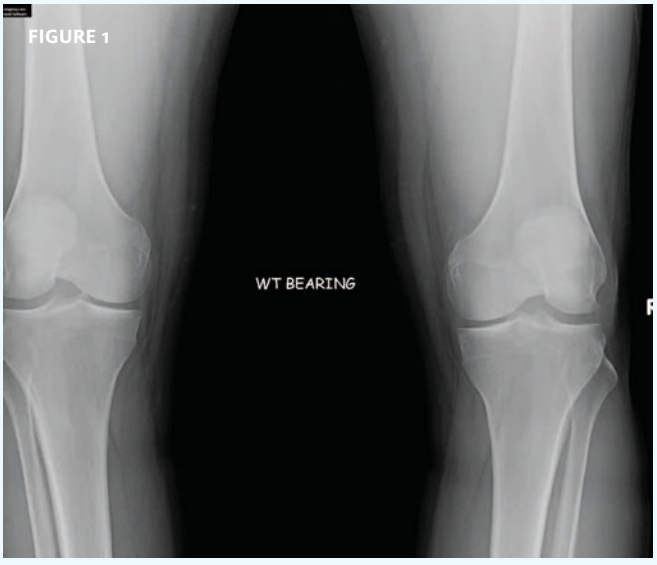


FIGURE 2

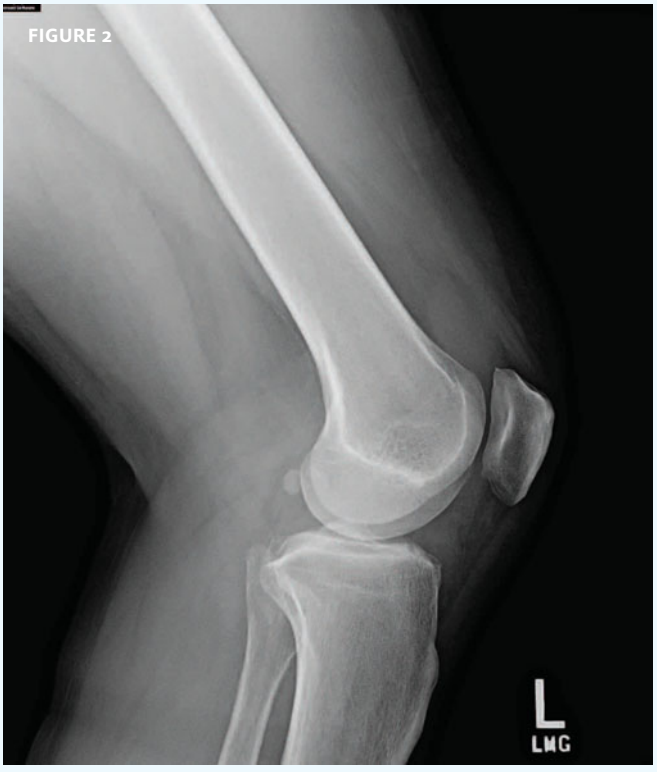
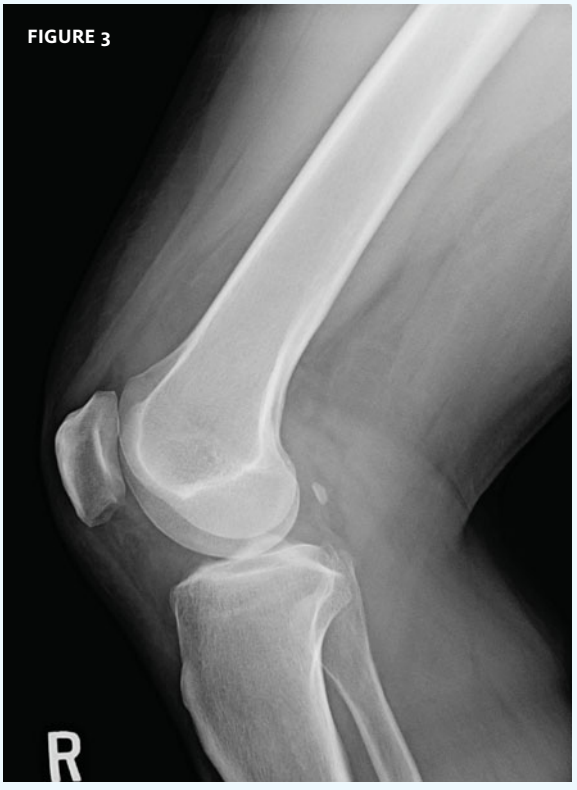


FIGURE 3



These x-rays were taken on a 49-year-old man with chronic bilateral knee pain that had increased over the past 6 months with ambulation. Examination was unremarkable.

View the images taken (Figures 1, 2, and 3) and consider what your diagnosis would be.

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 1

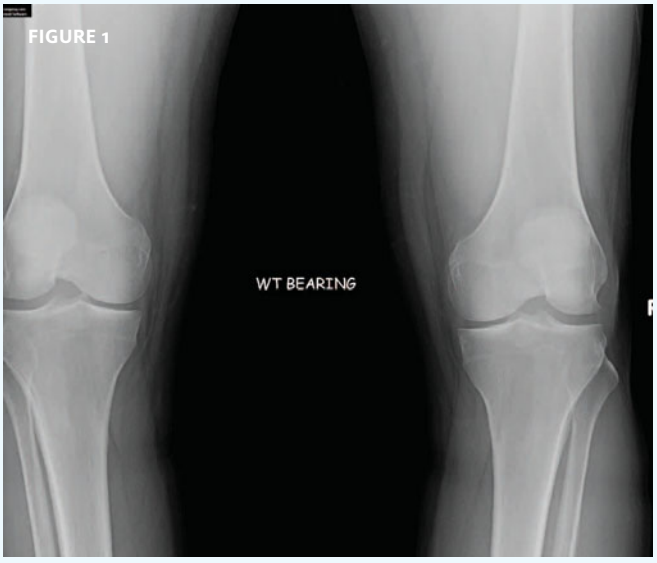


FIGURE 2

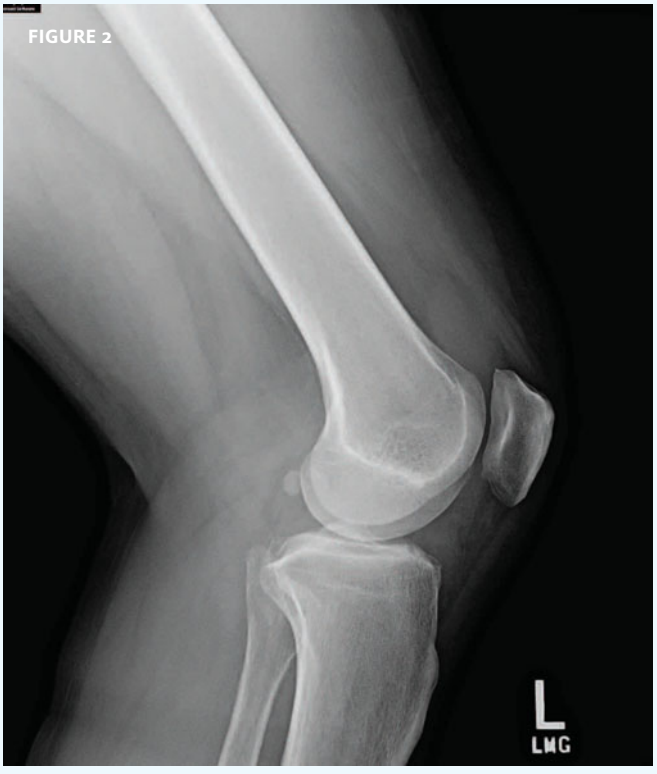
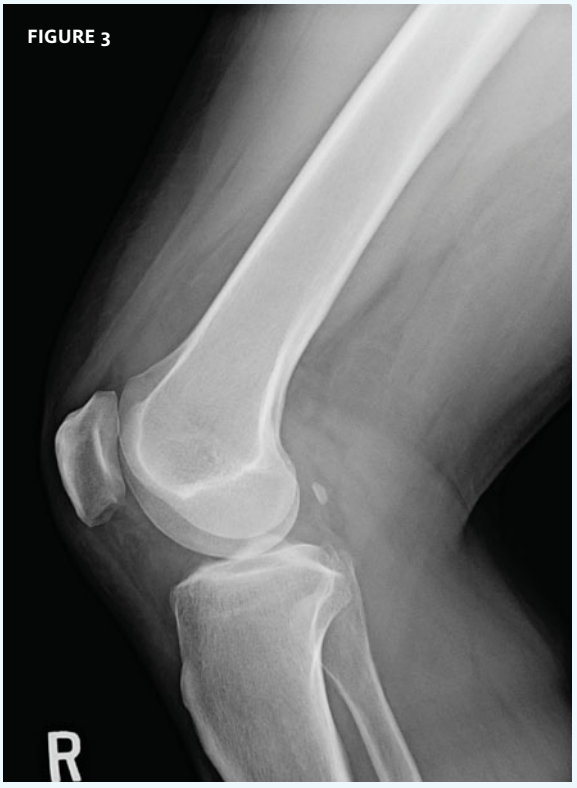


FIGURE 3



Diagnosis: The lateral images reveal sesamoid (accessory bone), most likely in the lateral head of the Gastrocnemius, indicative of Fabella syndrome. Fabella syndrome is characterized by posterolateral knee pain, predominantly bilateral. Referral to an orthopedist for further management is appropriate for this patient because removal of the ossified body usually is a consideration.

Acknowledgement: Case presented by Linda-Michelle Ledesma, DO, Urgent Care Extra, Phoenix, Arizona.

CODING Q&A

New vs. Established Patients, Medicare Exam, ICD-10 Delay

DAVID STERN, MD, CPC

Q. A patient with Medicare as his primary insurance needs a physical and EKG for clearance for an MRI with sedation ordered by his neurologist. Symptoms are imbalance along with pain in the shoulder, neck, and upper spine. Can I use the pre-op code V72.81 because there is sedation even though there is no actual surgery? Or should I just get a signed Advanced Beneficiary Notice (ABN) and expect a denial?

A. Yes, you can use code V72.81, "Pre-operative cardiovascular examination" because it also represents pre-procedural exams. According to ICD-9 guidelines, you should use this code for pre-procedural and pre-operative examinations. You will want to check your Medicare Local Coverage Determination (LCD) guidelines for approved diagnosis codes to determine whether to have the patient sign an ABN. In some cases, Medicare will cover EKGs with code V72.81 but you must also include the codes for the medical condition(s) that prompted the surgery or procedure.

Because Medicare does not recognize consultation (99241-99245) or preventive medicine (99381-99397) CPT codes, you will want to code the appropriate E/M code based on the level of work completed for history, examination, and medical decision-making. Please note that the chief complaint should be the complaint that the patient is suffering that requires surgery, and the HPI should relate back to that chief complaint. ■

Q. Most of our payor contracts require us to use HCPCS code S9083 "Global fee urgent care centers" which has not been an issue based on our case mix. For Medicare, Medicaid, and managed Medicaid, we are billing Evaluation & Management (E/M) codes with a Place of Service (POS) 20. What criteria are used to bill a new patient vs. established patient? Aren't all urgent care patients new patients? We do have patients return for follow up visits but we direct them to their primary care physician.

"According to ICD-9 guidelines, you should use V72.81 for pre-procedural and pre-operative examinations."

A. Unless specifically stated otherwise in a payor contract, urgent care centers follow the same guidelines for new vs. established patients as primary care practices. According to CPT guidelines, a new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the same specialty and subspecialty who belongs to the same group practice within the past 3 years. Professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may provide E/M services. You can read more on this subject in my columns in a previous issue of *JUCM*: http://jucm.com/magazine/issues/2009/0209/files/36.html

Obviously, those rules do not apply in cases where your contract calls for the use of HCPCS code S9083, "Global fee urgent care centers." That code is used in place of the E/M code, and (depending on the specific payor contract) often it is the only code billed, even when other services have been performed. ■

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

CODING Q & A

"Simply having the physician perform the venipuncture because no other staff is qualified is not a sufficient reason to bill 36410."

Q. In our urgent care center, the physician always inserts IVs because there is no other staff qualified to perform the procedure. Can we bill CPT code 36410?

A. CPT code 36410, "Venipuncture, age 3 years or older, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)" would only be used in cases where the physician's skill is required. Simply having the physician perform the venipuncture because no other staff is qualified is not a sufficient reason to bill 36410. CPT guidelines direct you to code 36415, "Collection of venous blood by venipuncture" for routine blood collection from a vein.

If the physician is also starting intravenous (IV) lines, the correct CPT code for an IV start is 36000, "Introduction of needle or intracatheter, vein." However, if you are also billing a procedure for IV therapy (96360-96549), then it would not be appropriate to bill 36000 with those codes. The National Correct Coding Initiative edits bundle 36000 into most invasive surgical services because it is not possible for the physician to perform such services without inserting a needle first. ■

Q. Has ICD-10 implementation really been delayed again?

A. Secretary of Health and Human Services, Kathleen Sebelius was absolutely adamant that there would be no further delays and ICD-10 would be implemented on October 1, 2014. On a bipartisan basis, however, Congress and the President stepped in and overruled her on April 1, 2014. On a side note, Ms. Sebelius resigned 10 days later. ■

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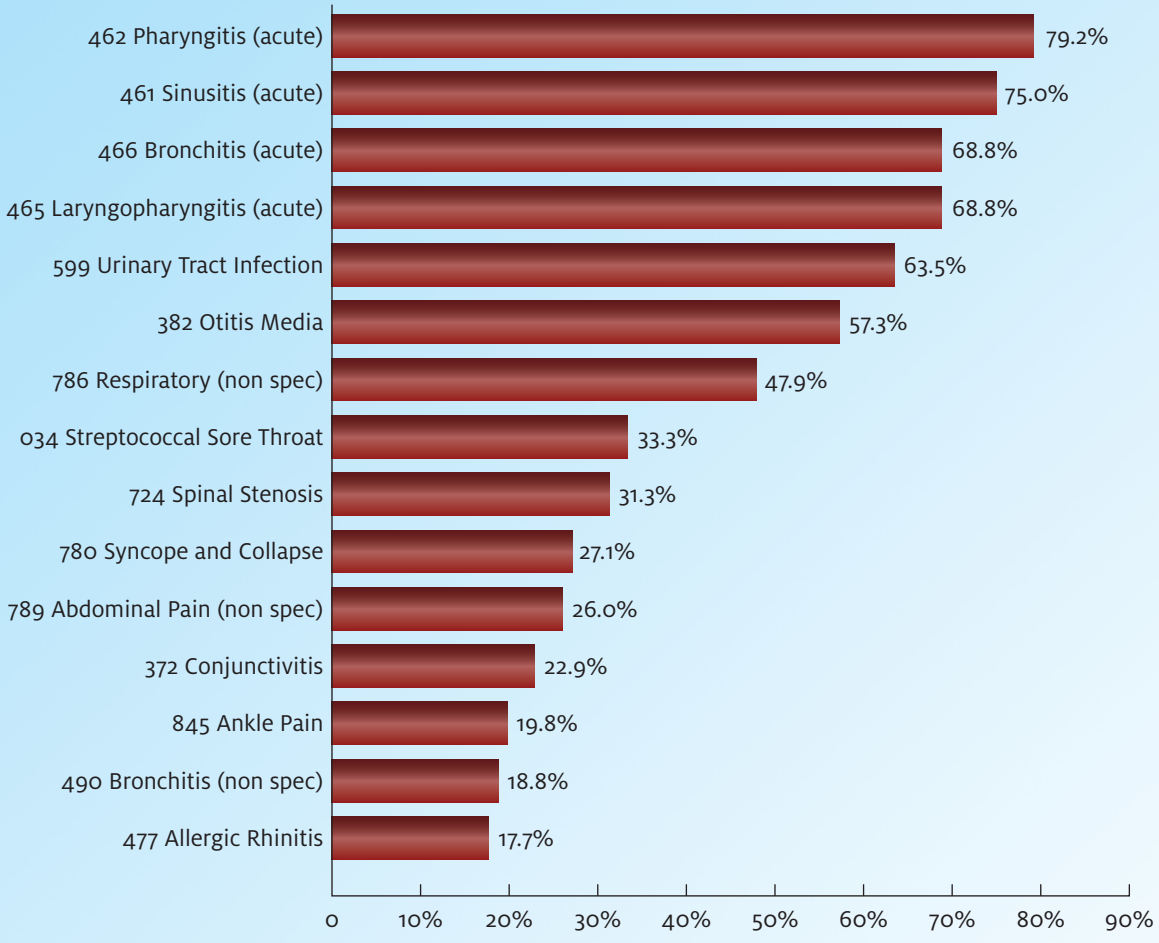
DEVELOPING DATA

These data from the 2012 Urgent Care Industry Benchmarking Study are based on a sample of 1,732 urgent care centers; 95.2% of the respondents were UCAOA members. Among other criteria, the study was limited to centers that have a licensed provider onsite at all times; have two or more exam rooms; typically are open 7 days/week, 4 hours/day, at least 3,000 hours/year; and treat patients of all ages (unless specifically a pediatric urgent care).

In this issue: What Are the ICD-9 Codes Most Used by Urgent Care Centers?

TOP 15 ICD-9 CODES



The International Classification of Diseases (ICD) is published by the World Health Organization and used to classify health conditions. ICD-9 is the version currently used in the United States. Urgent care centers can treat a wide variety of conditions, but the majority of visits fall into categories such as upper respiratory conditions, urinary tract infections, earaches, backaches, and stomach pain.

Acknowledgement: The 2012 Urgent Care Industry Benchmarking Study was funded by the Urgent Care Association of America and administered by Anderson, Niebuhr and Associates, Inc. The full report can be purchased at www.ucaoa.org/benchmarking.

10 years

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Look Forward to These UCAOA Events:

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Chicago, Illinois

Urgent Care Fall Conference
September 24-26, 2015
Sheraton New Orleans Hotel
New Orleans, Louisiana

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