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Urgent Care
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of America



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Productivity Without Peril: Pain-free Steps for Efficient Encounters



Managing flow in the urgent care center can be daunting. Volume and acuity are variable, staff is inconsistently engaged, and our patients can create more unpredictable challenges than a “Wipeout” obstacle course. Those who master the chaos move through the day with the effortless grace of a Kung Fu master. Those who don’t resemble something closer to a “Pinball Wizard.” So, what’s the secret sauce? Can efficiency be trained, or is it hard wired? How do we ensure that quality doesn’t suffer under the weight of productivity pressures? To manage such demanding and conflicting priorities, here is a list of tips that I have found helpful in improving the efficiency and effectiveness of patient encounters:

- Determine a preliminary action plan before entering the room. Based it only on two goals: 1) differentiating stable vs. unstable illness and injury; and 2) addressing the “patient agenda” in a supportive and validating way.
- Work with support staff to ensure a patient is prepared adequately for the exam. If it is a knee, leg, foot, ankle or hip problem, then the extremity must be exposed before a provider enters the room. Patients with shoulder and upper back issues need to be in gowns. I don’t feel the need to put a patient with low back pain in a gown, because the examination can be done easily by lifting the shirt.
- Speak clearly and with appropriate volume. Annunciate and communicate in a very emphatic manner.
- Wash your hands while beginning interview, but remember to speak clearly and loudly while doing so.
- Immediately ask the patient to get up on the exam table. Doing so clearly marks the beginning of the encounter and allows for simultaneous examination where appropriate.
- Establish good eye contact and give verbal and non-verbal validation throughout the interview.
- Validate! Patients want to be made to feel that they made the right decision by coming in to be seen.
- Don’t be afraid to use humor where appropriate.
- Keep the history and physical limited to determine “stable vs unstable” or to address a patient’s agenda. Everything else is unnecessary and does nothing to build patient confidence.
- Provide the patient with expectant management based on the expected results of diagnostic testing. Be very specific

so that there is no need to return to the room when results are complete.

- Handle hostility with compassion. Do not fight fire with fire, even if you feel that a patient is out of line.
- Use validation and empathy when treating a dramatic or hysterical patient, even if you believe he/she is overreacting. It may seem counterintuitive, but this will disarm a patient, foster cooperation and trust, and lead to a more efficient and effective encounter.
- Order diagnostics or interventions without hesitation and move on to the next encounter. Know ahead of time what, specifically, you are looking for (no open-ended work-ups). Diagnostics should provide you with critical information that can change your decision-making or allow you to address something in the patient agenda. Allow the nursing staff to do their job and wait for the next set of information before re-engaging.
- Do not write work notes/school notes. Task the nurse or medical assistant with this.
- Allow the nurse to do wound cleanup and dressing after procedures.
- Use sticky notes or forms to give orders needed for discharge. DO NOT re-enter the room to discharge unless absolutely necessary. If you have done expectant management, the patient should already know your plan based on predicted results of testing.
- Give patients the responsibility to make follow-up appointment while ensuring them that the center staff can help if they are having trouble.

This list is intended to give a clinician specific tools for managing the encounter efficiently without sacrificing quality or patient satisfaction. In a typical shift seeing 30 to 50 patients, 3 minutes saved per patient can save 90 to 150 minutes per day. That’s productivity at work. ■

Lee A. Resnick, MD
Editor-in-Chief

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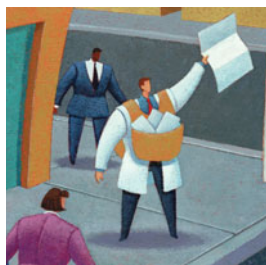
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Thoroughly evaluate patients who complain of dental or oral pain.

Christopher McKenna and John Shufeldt, MD, JD, MBA, FACEP



IN THE NEXT ISSUE OF JUCM

Urgent care clinics are filled with patients who are ill or injured, and pain is a common presenting symptom. But pain is subjective and pain scales may be inaccurate or not reflect a patient’s real perception of pain or the issues that may be contributing to it. Overtreating pain may result in serious morbidity or mortality and potential for addiction, whereas inadequate treatment can leave a patient with discomfort and dissatisfaction with care. Strategies for effective management of acute pain are the subject of next month’s cover, the first of a two-article series aimed at helping urgent care providers treat discomfort adequately while simultaneously protecting themselves from dissatisfied patients and potential litigation.

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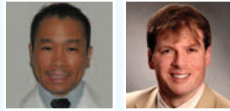
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JUCM CONTRIBUTORS

A thorough history and physical examination are important when a patient presents with neck pain, which is the subject of this month's cover story. Written by Ranier Ng, DO, and Michael Rowane, DO, MS, FAAFP, FAAO, it underscores the wide range of possible diagnoses and their significance and, thus, the need for a systematic approach. The first step is determining whether the condition is life-threatening to the patient, such as a structural injury for which special care and surgical intervention are required. No imaging usually is required for uncomplicated, atraumatic neck pain and algorithms such as the Canadian C-Spine Rule are useful for determining whether imaging should be obtained. Management varies, depending upon whether a patient's neck pain is simple or involves myelopathy or radiculopathy.



Dr. Ng is a clinician/faculty member at MetroHealth Medical Center and Dr. Rowane is the Director of Medical Education at University Hospitals Medical Center, both in Cleveland, OH.



In this month's case report, Christopher McKenna and John Shufeldt, MD, JD, MBA, FACEP, discuss the rare but potentially life-threatening condition Ludwig's angina, an infection of connective tissue on the floor of the mouth and in the deep neck spaces. The patient was a type 1 diabetic who had presented to the urgent care clinic multiple times with complaints of pain from oral caries but failed to act on referrals to a local dentist. When dealing with a patient with Ludwig's angina, ensuring an adequate airway is crucial and full recovery is possible with aggressive antibiotic use and airway support with or without surgical drainage.

Mr. McKenna is an undergraduate pre-med Public Health

Sciences major studying at Santa Clara University. Dr. Shufeldt is principal of Shufeldt Consulting and sits on the editorial board of *JUCM*.

Are you a "walking billboard" for your urgent care practice? If not you should be, because as an entrepreneur, you are the "product" and calling attention to what your practice offers can increase awareness and raise revenue. That's the message of this month's practice management article by Alan A. Ayers, MBA, MAcc, on wearing your brand. Brand recognition is what sets a practice apart from the competition and Mr. Ayers advocates making branding—such as displays of your center's name, logo, and location on T-shirts, buttons, and bumper stickers—a team effort involving you, your entire staff, and even your patients.



Mr. Ayers is Associate Editor, Practice Management, *JUCM*, Content Advisor, Urgent Care Association of America, and Vice President, Concentra Urgent Care.

Also in this issue:

John Shufeldt, MD, JD, MBA, FACEP, discusses what urgent care providers need to know, say, chart or do—and some things not to do in real time during patient encounters.

Nahum Kovalski, BSc, MD, MDCM, reviews new abstracts on literature germane to the urgent care clinician, including studies of acute heart failure, probiotics and diarrhea, chronic urticaria and autoimmune disease, and ultrasonography for pediatric skull fracture.

In Coding Q&A, **David Stern, MD, CPC**, discusses coding for fracture care and laceration kits, and reimbursement for extended hours.

Our Developing Data end piece this month looks at full-time physician, physician assistant, and nurse practitioner benefits. ■

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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.

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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An Exciting and Bright Future

■ LAUREL STOIMENOFF, PT

It gives me great pleasure to introduce UCAOA's Chief Executive Officer, P. Joanne Ray. Joanne comes to us as an accomplished executive with almost 30 years of experience in association management and development. Her previous leadership positions include senior roles within the American Society for Gastrointestinal Endoscopy, Emergency Nurse's Association, and most recently as the Executive Director of the American Association of Cardiovascular and Pulmonary Rehabilitation, a 3,000-member multidisciplinary medical association. Each of these organizations experienced exceptional growth and enhanced member support and engagement as a result of her leadership. Joanne is a graduate of Valparaiso University, lives near our Naperville office and has also been involved in the arts and theatre.

I am confident that the acumen and insight Joanne brings will complement where UCAOA is in its evolution.

UCAOA is growing as is the industry we passionately support. I am confident that the acumen and insight Joanne brings to UCAOA will be a perfect complement to where this organization is in its evolution. The Board of Directors looks forward to working with an executive of her caliber. Joanne officially joined UCAOA at our Fall Conference in New Orleans. Look for Joanne's first column as CEO in the December issue of *JUCM*. Please join me, along with the Board of Directors, in welcoming Joanne Ray to UCAOA. ■



Laurel Stoimenoff recently served as the Urgent Care Association of America's interim Executive Director.



Joanne Ray
UCAOA Chief Executive Officer

Here's a brief interview with Joanne Ray, UCAOA's new Chief Executive Officer:

What drew you to UCAOA?

The role that UCAOA members and member institutions stand to play in the future of US healthcare is what initially attracted me to UCAOA. Once I researched more and met some of the incredibly committed staff and board members, I knew this was a great place to be!

You have a long history of non-profit experience—how will that background lend itself to your role here at UCAOA?

For more than 25 years, I have committed my career to representing and enhancing segments of healthcare and nonprofit service. From effective and efficient national office management and stewardship of the association's resources to rallying around, embracing and addressing the key issues confronting the industries and individuals who are members of our association, I bring a wealth of applied experience and look forward to working with the leaders of UCAOA.

Evaluation and Management of Neck Pain in Urgent Care

Urgent message: The differential diagnosis of neck pain is broad. A systematic and effective approach is required to rule out life-threatening conditions.

RANIER NG, DO, and MICHAEL ROWANE, DO, MS, FAAFP, FAAO

Neck pain is a frequently encountered complaint in urgent care. About two-thirds of the population will experience neck pain at some point in their lives.¹ Many patients experience a sense of debilitation with every movement of their neck.

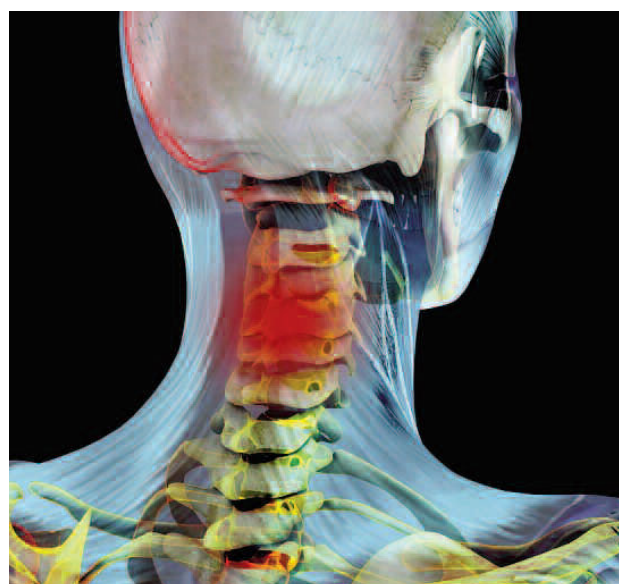
Patients may perceive neck pain anywhere in the posterior aspect of the cervical spine, ranging from the superior nuchal line to the spinous process of the first thoracic vertebrae.² Management of acute neck pain in an urgent care clinic can be challenging because a determination first must be made about whether the condition is life-threatening to the patient.

The differential diagnosis of neck pain is broad, as indicated by the conditions listed in **Table 1**.

Because of the wide range of potential diagnoses and their significance, it is important for an urgent care provider to have a systematic and effective approach for evaluating and managing neck pain, such as that described in this article.

Determining the Origins of Cervical Problems

Neck pain can be classified into one of two groups, based on its origin. In some patients, the pain arises mainly from the joints, ligaments, and muscles of the neck, whereas in others, the signs and symptoms represent radiculopathy (that is, they are attributable to a single nerve root) or myelopathy (signs or symptoms due



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to a spinal cord lesion, stenosis, or compression).³ **Table 2** summarizes the important differences between symptoms of mechanical pain and neck pain associated with radiculopathy or myelopathy.

Patients with radiculopathy often present with neck pain that is intense and sharp and complain of a burning sensation that may radiate to the trapezius muscle, periscapular area, or down each arm. Weakness and paresthesia may occur, even weeks after the pain's initial onset. Neck pain that progresses insidiously is common with myelopathy, and these patients may complain of dexterity problems (clumsy hands), gait disturbances,

Ranier Ng is a clinician/faculty member at MetroHealth Medical Center, Cleveland, OH. **Michael Rowane** is the Director of Medical Education at University Hospitals Richmond Medical Center, Cleveland, OH.

and sexual or bladder dysfunction.³ A thorough history and physical examination are essential because management of neck pain differs depending on whether it is from injury involving the joints, ligaments, and muscles or involves radiculopathy or myelopathy.

History and Exam

An urgent care provider's clinical approach to the patient with neck pain first should take into consideration whether the underlying etiology is life-threatening, such as fracture, dislocation, instability, or a structural injury that requires special care and surgical intervention.⁴ A history must be obtained, including onset, location, and duration of the neck pain, and chronology as well as information on a recent or remote history of trauma. Any precipitating factors, associated symptoms (headaches, stiffness, and deformities), neurologic symptoms (weakness, numbness, paresthesia, changes in sensation, gait or vision), or constitutional symptoms (fever, weight loss) should be noted.³

Inquiries about past medical history should focus on known neck disorders (osteoporosis, osteoarthritis, disk disorders), surgery, risk factors for infection (such as immunosuppression, intravenous drug use, penetrating trauma or bacterial infections), prior episodes of neck pain, past diagnostic studies and treatment, and comorbid conditions (such as arthritis or cancer).^{3,5}

Physical examination should begin with evaluation of the patient's vital signs, posture, movement, and facial expression. Evidence of weight loss, pallor or adenopathy should also be noted. Neck pain can cause "splinting of the head" during position changes, therefore, active and passive range of motion should be assessed with rotation (chin to shoulder), lateral flexion (ear to shoulder), and flexion-extension.³

Lesions associated with inflammatory or neoplastic disorders usually are widespread and cause symmetrical restriction of pain and movement, whereas asymmetrical lesions are common with many types of mechanical neck pain, and the result is limited or painful movements.³ Palpate the structures of the head and neck for any bony abnormalities or deviations from the midline and evaluate for spinal and trigger point tenderness.^{4,6} A thorough systematic musculoskeletal and neurologic examination includes inspection and palpation of the posterior cervical triangle, the supraclavicular fossa, carotid sheaths, anterior neck and the extremities. Sensory, motor, and reflex testing should be conducted bilaterally, while noting any neurologic deficits. This enables one to determine the level of the sensory and motor involvement.

Table 1. Differential Diagnosis of Neck Pain

- Biomechanical neck disorders
- Traumatic events (i.e. whiplash, hyperflexion-hyperextension injuries)
- Vertebral degeneration
- Disk herniation
- Cervical spondylosis and stenosis
- Infiltration (metastatic cancer/spinal cord tumors)
- Inflammation
- Myofascial pain syndrome
- Temporal arteritis
- Infection
- Compression (epidural hematoma/abscess)

Table 2. Distinguishing Between Mechanical Pain and Pain Associated with Radiculopathy or Myelopathy

Hallmarks of Mechanical Pain

- Deep, dull ache, often episodic
- Localized, asymmetric ligament and muscle pain
- Neck movement aggravates symptoms; rest provides relief
- No history of specific injury
- Stiffness accompanies pain
- Pain referred from upper cervical spine toward head and from lower segments to upper limb girdle

Hallmarks of Radiculopathy or Myelopathy

- Sharp, intense, "burning" root pain
- Headache with involvement of upper cervical roots
- Neck hyperextension exacerbates symptoms
- Radiation to trapezius, scapula, or arm
- Numbness and motor weakness in myotomal pattern
- Shock-like sensations down spine to extremities

For example, A C5-C6 root lesion will often elicit tenderness over the brachial plexus at the Erb point in the supraclavicular fossa, whereas a C8-T1 root lesion will often cause tenderness over the ulnar nerve at the elbow.³ Bilateral or multilevel involvement usually implies a serious pathology.³

Table 3 lists the cervical roots and their corresponding sensory and motor functions and reflexes.³

Sensory symptoms of pain are difficult to evaluate, especially when motor signs are absent. That is often the case with cervical radiculopathies because of the discrete separation of the motor and sensory nerve roots at the cervical neural foramina and can explain motor-sparing deficits despite severe sensory symptoms.³

Provocation tests for neck pain can be performed and are useful in reproducing symptoms of radicular involvement. The Spurling test occurs when the practi-

Table 3. Signs and Symptoms of Cervical Radiculopathy**Neck, scalp**

- Disc space and its cervical root: C1-C2 (disk space); C2 (cervical root)
- Sensory abnormality: scalp
- No associated motor weakness or altered reflexes

Neck, shoulder, and upper arm

- Disc space and its cervical root: C4-C5 (C5)
- Sensory abnormality: Shoulder
- Associated motor weakness: Infraspinatus, deltoid, and biceps muscles
- Associated altered reflex: Reduced biceps reflex

Neck, shoulder, upper medial, scapular area, proximal forearm, thumb, and index finger

- Disc space and its cervical root: C5-6 (C6)
- Sensory abnormality: Thumb and index finger, and lateral forearm
- Associated motor weakness: Deltoid, biceps, pronator teres, and wrist extensors muscles
- Associated altered reflex: Reduced biceps and brachioradialis reflex

Neck, posterior arm, dorsum proximal forearm, chest, medial third of scapula, and middle finger

- Disc space and its cervical root: C6-7 (C7)
- Sensory abnormality: Middle finger and forearm
- Associated motor weakness: Triceps and pronator teres muscles
- Associated altered reflex: Reduced triceps reflex

Neck, posterior arm, ulnar side of forearm, medial inferior scapular border, medial hand, ring, and little fingers

- Disc space and its cervical root: C7-T1 (C8)
- Sensory abnormality: Ring and little fingers
- Associated motor weakness: Triceps, flexor carpi ulnaris, and hand intrinsic
- Associated altered reflex: Reduced triceps reflex

tioner applies gentle pressure to the patient's head during extension and lateral rotation, which will reproduce radicular pain with radiation into the ipsilateral (same side) of the upper extremity. The abduction relief test is done by having the patient place his/her hand of the affected upper extremity on the top of the head to obtain relief. That may indicate a soft disk protrusion causing radicular pain.^{3,4} Also, if neck pain occurs on the side away from the head movement, a ligamentous or muscular source of the pain should be suspected because these structures are stretched.⁴

Early cervical myelopathies can be recognized only if the examiner looks for them during a complete neurologic examination. Findings in patients with myelopathy include hyperreflexia, upper extremity weakness, impaired fine hand movement, and upper extremity spasticity.³ For example, if a cord compression is suspected, the Lhermitte sign can be elicited. This an elec-

tric shock-like sensation that radiates down the spine and often into the extremities when the neck is flexed. If there is concern for an upper motor neuron lesion, a Hoffman sign can be elicited. The test for this is to flick the tip of the middle finger as the hand is relaxed in a neutral position. A positive response is flexion of the patient's thumb and index finger into a pinching motion.³

Neck pain may also represent pathology in the lymph nodes, salivary glands, or thyroid gland and an urgent care provider should be conscious of those possibilities. Auscultate the carotid and the subclavian arteries for bruits, assessing for potential cerebral insufficiency, and the latter for a thoracic outlet or vascular steal syndrome. Examine the temporal artery and palpate for signs of inflammation or tenderness, because temporal arteritis can cause neck and shoulder pain.³

Table 4 lists selected "red flags" suggestive that neck pain has a serious underlying etiology that may require urgent attention.^{5,6} Evaluation for such problems should begin with initial patient triage.⁷

If you have any suspicion of a serious unstable life-threatening condition in a patient with neck pain, have the patient transported to the nearest emergency department for further management. If you are concerned about a cervical fracture, dislocation, or suspected instability, place a hard neck collar on the patient for stabilization before transport, or (if a collar is unavailable) have the first responder stabilize the patient's neck manually with both hands.

Imaging

The diagnostic need for imaging studies in a patient with neck pain depends on the clinical condition suspected and the duration of pain. Acute symptoms (ranging from days to weeks) of uncomplicated, nonradicular, nonmyelopathic, atraumatic neck pain usually require no imaging studies because the cause is likely benign and the treatment would be conservative.³

Plain films of the cervical spine may reveal pathologic changes in the bones or may indicate the potential for instability. There may be some benefit in obtaining a three-view cervical spine radiograph in patients with chronic neck pain symptoms (ranging from weeks to

Table 4. Selected Neck Pain 'Red Flags' Suggestive of Serious Etiology

- New-onset pain in patient younger than age 20 or older than age 55
- Patient history of neck surgery or violent trauma
- Dizziness/blackouts with movement
- Intractable/increasing pain
- Insidious progression
- Sensory changes in the hands
- Symptoms suggestive of neurologic changes (e.g., problems with walking or continence)
- Unexplained weight loss
- Lymphadenopathy

months), those who have neck pain and a prior history of malignancy or remote neck surgery, and patients with neck pain and any preexisting spinal disorders, such as rheumatoid arthritis, ankylosing spondylitis, or psoriatic spondyloarthropathy.³

If a degenerative disease is suspected, oblique views of the cervical spine may show cervical foramina and disk space narrowing, osteophyte formation, and any facet abnormalities. A flexion-extension radiogram may be useful if instability is suspected in a patient with rheumatoid arthritis or other inflammatory conditions. No other imaging is needed in patients whose radiographs show normal degenerative changes and who have no neck instability and no neurologic signs or symptoms.³

To help in diagnostic assessment of a patient seeking care for neck pain as a result of trauma to the neck, the Canadian C-spine Rule (CCR) (**Figure 1**) and the Nexus Low Risk Criteria (NLC) can be used.⁸ These algorithms are indicated for patients who are alert and low risk (history not indicating a serious debilitating injury such as major motor vehicle accident) and can be helpful in determining whether diagnostic imaging should be obtained.⁴

If radiography is indicated, computed tomography (CT) of the neck outperforms the standard radiograph (3 views) in detecting abnormal pathologies. It achieves higher predictability and accuracy and is recommended for patients with significant cervical trauma.⁴

When patients have neck pain with neurologic signs or symptoms, magnetic resonance imaging (MRI) would also be indicated. MRI also is indicated when plain radiographs show bony or disk margins destruction, cervical instability, or abscess. MRI can demonstrate accompanying soft tissue changes, such as epidural hematomas, and any traumatic disc protrusions.⁶ The urgency for MRI depends on the patient's clinical condition and potential deterioration. MRI is often difficult to obtain on an emergency basis. Therefore, CT is usually the first modality of choice for a suspected underlying life-threatening condition in an urgent care setting.^{4,6}

Neck Pain Presentations

Mechanical neck disorders can involve neck strain, neck sprain, hyperextension strain, acceleration-deceleration injury, hyperextension-hyper-

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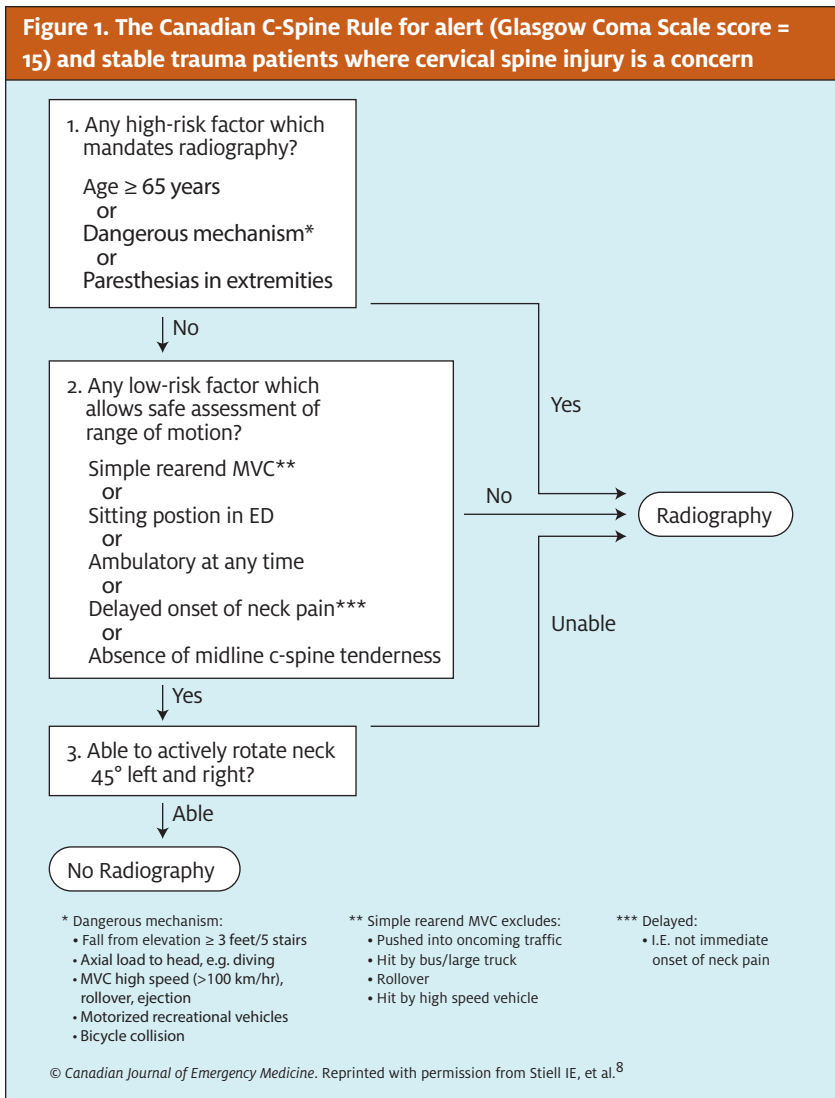
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be considered and the patient should be transported to the nearest emergency department or trauma center.³

A major complication from a hyperflexion-hyperextension injury is central cord syndrome. This syndrome can occur in the presence of cervical spondylosis, spinal stenosis, ankylosing spondylitis, or a disk herniation. Patients with central cord syndrome have weakness that is disproportionately greater in the upper extremities and accompanied by variable sensory loss.³

Cervical disk herniations can produce either acute radiculopathy or occasional myelopathy. The symptoms of acute cervical disk herniation include neck pain, headache, pain radiating to the shoulder and along the medial scapular border, and dermatome pain and dysesthesia in the spinal root distribution to the shoulder and arm. Patients with herniation will have motor deficits presenting as fasciculations, atrophy, weakness in the dermatome distribution of the spinal root, and loss of deep tendon reflexes. Those with cervical myelopathy, in contrast, present with hyperreflexia of the lower extremities, a positive Babinski sign, and rarely, loss of any sphincter control.³

Cervical spondylosis can present as loss of cervical flexibility, neck pain,

flexion injury, and whiplash. The majority of urgent care cases are a result of motor vehicle accidents, falls, sports and work-related injuries.³

A whiplash injury is a result of a sudden acceleration-deceleration event that occurs when the patient is in a stationary vehicle while it is struck from behind. These patients often complain of pain and stiffness. On physical examination, there may be tender paracervical muscles with a decrease in range of motion. The pain associated with a whiplash injury is often delayed for a number of hours after the accident. Other complaints may include headache, vertigo or dizziness, spatial instability, dysphagia, or hoarseness. If neurologic findings are noted after a whiplash injury, then brain/spinal cord injury or carotid and vertebral artery dissection should

occipital neuralgia, radicular pain, or progressive myelopathy and it is progressive and degenerative. It is caused by degeneration of the disks, ligaments, and facet joints. Osteoarthritis of the neck and degenerative disk disease are common clinical terms that are used for this condition. Cervical spondylosis is diagnosed on the basis of osteophytes, disk space narrowing, or facet disease on cervical radiographs combined with symptoms. Osteophyte spurs encroaching on the spinal canal can produce a cervical myelopathy.³ Spinal stenosis is usually a degenerative disease resulting from osteoarthritis. MRI can reveal a narrow spinal canal, which would confirm such a diagnosis.⁶

Metastatic cancer should always be considered and suspected in patients with chronic neck pain. Spinal cord compression may be the first sign of cancer. The patient may complain

of unremitting night pain, which can be indicative of a malignant process. Neck pain can be caused by metastasis to the cervical spine of lung, breast, or prostate cancer, lymphoma or multiple myeloma.³ Plain radiographs have a poor sensitivity and a 10% to 17% false-negative rate in detecting spinal metastases but can reveal bony destruction in the vertebral bodies, lytic lesions at the pedicles, and pathologic compression fractures. MRI is the gold standard in detecting spinal metastatic disease and cord compression.³

Radiculopathy can be confused with myofascial pain syndrome because both cause chronic neck pain. Psychological distress can contribute to the conversion of emotions into bodily complaints, such that nonpainful sensations are perceived as painful. Patients with such concerns have pain that is not on a dermatomal pattern, but rather, occurs in the neck, scapula, and shoulder. The neurologic examination of a patient with myofascial pain syndrome is normal.³

A patient with cervical epidural hematoma will present with neck pain followed by symptoms and signs of cord compression. That should be considered in someone taking anticoagulants or in a child with hemophilia.³

Management

Treatment of neck pain differs depending upon whether the condition is simple, involves radiculopathy, or involves myelopathy.³

Neck pain without radiculopathy or myelopathy

Most causes of neck pain without any clear underlying pathology improve with minimal intervention. Patients should be advised to avoid any activities that would exacerbate the pain and to return to their daily routines. In the urgent care clinic, if there is no contraindication, a patient can be given a ketorolac (adult: 30 to 60 mg) intramuscular injection or another oral nonsteroidal anti-inflammatory drug (NSAID) to help alleviate the pain. On discharge, the patient can be given a prescription for a NSAID, muscle relaxants, or a short course of oral opiates and encouraged to make a follow-up appointment with a primary care physician within 1 week to determine the need for any future physical or manipulative therapies.³

Patients with acute neck pain following a whiplash injury may also benefit from initial treatment with NSAIDs, muscle relaxants, or a short course of opiates. They should be advised to maintain neck motion as tolerated and to return to their daily activities.

Treatment of neck pain in patients with a rheumatologic or neoplastic condition depends on the stability of

the cervical spine and/or presence of cord compression. Analgesic medications with a course of oral glucocorticoids may be given if neither instability nor cord compression is present. However, admission and neurosurgical consultation should be considered if either complication is present.³

Providing relief from muscular tension and addressing psychobehavioral issues both should be considerations when prescribing treatment for a patient whose neck pain is a result of a myofascial pain syndrome. Include muscle relaxants and a short course of non-opioid analgesics for severe symptoms in initial treatment and advise follow-up with a primary care physician so that therapy can be optimized.³

Depending on the patient's history and clinical condition, osteopathic manipulation may be beneficial. Certain soft manipulative techniques can alleviate some of the discomfort from a neck strain or sprain. Patients usually present with tenderness mostly at the paracervical muscles, but tenderness also can occur at the sternocleidomastoid muscles. The Jones Strain-Counter-Strain technique is a simple treatment that can be used in an urgent care setting. It involves locating tender points along the neck's anterior and posterior muscles, assessing the patient's pain level, and applying pressure at the specific tender points when the neck is at a position of comfort. The pressure lasts about 90 seconds and its goal is to release the muscle tension in the neck.⁹

Radiculopathy-associated neck pain

As long as a patient has no evidence of myelopathy, initial treatment in an urgent care setting can consist of conservative management, such as activity modification, oral medication (anti-inflammatory agents, opioids analgesics, muscle relaxants, and a course of a self-weaning steroid dose pack). Immobilization with a soft or semihard cervical collar also can be considered. A patient should be encouraged to schedule a follow-up appointment within 3 to 5 days with his or her primary care physician for consideration of a specialist consultation, electrodiagnostic evaluation, and additional rehabilitation interventions. Indications for hospital admission include acute or progressive symptoms, signs of myelopathy, progressive upper extremity weakness, and intractable radicular pain that is unresponsive to outpatient treatment.³

Myelopathy-associated neck pain

Treatment decisions for patients with symptoms and signs of cord compression should be made in consultation and

conjunction with a specialist. Cervical spondylotic myelopathy is the condition in the spondylosis spectrum that causes the most impairment and disability. A patient with such a problem should be referred to a neurosurgeon for possible consideration of decompressive surgery. Additional therapy, such as steroids, can be prescribed along with the neurosurgical consultation.³ Once again, if there is any concern about progressively worsening symptoms, then a direct consultation with a specialist and admission to a hospital are required.

Conclusion

Neck pain is a complaint commonly encountered in urgent care. The discomfort can be debilitating to a patient and it is the provider's responsibility to appropriately evaluate and manage the condition. A thorough history and physical examination are essential, as well as heightened awareness of any "red flags" that signal an underlying serious condition. Applying such a systematic approach ensures that medical decisions and treatment options are appropriate to the individual patient who presents with neck pain. ■

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Practice Management

Wear Your Brand: Increasing Awareness of Your Urgent Care Center

Urgent message: An urgent care entrepreneur is the “product” and must become skilled at promoting him/herself. When you “wear your brand,” you call attention to what you have to offer, generating awareness of an interest in your urgent care center.

ALAN A. AYERS, MBA, MAcc

In a recent visit to a popular bakery-café, I noticed a young woman on the sofa working on her laptop. For passersby, there was no question about which candidate would receive her vote in the upcoming November presidential election. She sported a bumper sticker on her laptop, a recyclable water jug, a sweatband, and a lapel button—all bearing the insignia of her presidential choice. She had become a “walking billboard” for her candidate and was effectively “wearing his brand.”

As the proprietor of your urgent care center, you should market your facility with the same degree of boldness and confidence as that young political supporter. You may currently have a paid advertising campaign under way, or even have engaged a public relations professional to raise your center’s profile. But there is no substitute for the impact that you and your staff members have when you make your center’s name and logo visible to your local community.

Raising the visibility of your center’s name, logo, and location is part of the branding process. Simply put, branding is the “footprint” your center leaves in the medical marketplace—your facility’s name recognition

.....
Alan Ayers is Associate Editor, Practice Management, *Journal of Urgent Care Medicine*, Content Advisor, Urgent Care Association of America, and Vice President, Concentra Urgent Care.



and service reputation. Brand recognition is what sets you apart from your competitors. And it’s within your control because it occurs largely through your marketing efforts and through the service you provide your patients. Branding is a team effort—effective branding involves you, your entire staff, and even your patients.

When you “wear your brand,” you’re not just making

Table 1. Basic Items For Promoting Your Urgent Care Brand

- Polo or oxford-style shirt with your center's name/logo
- T-shirt with facility's insignia or slogan
- Name tags for you and staff members with individual name and center name/logo
- Buttons promoting special services, promotions or slogans (such as, "Ask Me About Urgent Care," or "Need a flu shot?")
- Bumper sticker, decal or wrap for your automobile
- Business cards, to be kept in your car and on your person for distribution
- Flyers, postcards, brochures, magnets and other promotional materials for distribution

your center's name, logo, address, web site and/or slogan visible to the public on a consistent basis. You're messaging that your center is open for business, enthusiastic about fulfilling patients' medical needs, supportive of the community and here to stay. You're also making a concerted effort to develop new relationships with potential patients by subtly speaking with people you encounter during your normal, everyday activities.

Items Needed to Wear Your Brand

The term "wear your brand" has both metaphorical and literal meaning. Metaphorically, wearing your brand adds a more personal, human touch to your marketing efforts when compared with paid mass advertising. It connotes an air of assurance and pride in your facility, your staff, and the services you offer.

Taken literally, wearing your brand means that your center's identity is conspicuous, both inside and outside the office. It signals that you don't mind letting the world know who you are, where you work, and what you do. It spurs their curiosity and motivates them to approach you and ask questions.

This literal interpretation can be accomplished with the use of apparel, promotional items or printed materials. Table 1 lists some of the items you will need.

If your center's budget cannot initially accommodate all of the things listed in Table 1, then any combination of three or four is a good start. The important thing is to begin the process of wearing your brand.

Wearing Your Brand at Community Activities

Although "wearing your brand" within your center's walls will reinforce your image with existing patients,

driving new business entails educating the public about the nature and benefits of urgent care and raising the public profile of your specific facility.

There are dozens of community groups and organizations that include people who share your interests and whose members could become your future patients. Chambers of Commerce, religious organizations, PTAs, athletic boosters, fraternal or veterans organizations, sororities, service organizations, and homeowners associations all represent fertile ground in which to sow your branding seed. Organizations are often looking for speakers—ask to make a presentation about urgent care. If they respond positively, have a PowerPoint presentation that can be geared to the specific needs and activities of the prospective audience.

First, your presentations at community meetings should focus on informing them about exactly what the term "urgent care" means. Let them know about the extended hours, the convenience of walk-in visits, short waits, and capabilities to treat patients of all ages. In addition, make the attendees aware of the benefits of urgent care as a less expensive, less time-consuming, and more convenient alternative to emergency rooms. One of the slides in your presentation could read: "Why wait hours in an emergency room when you and your family members can receive the same treatment in only a few minutes at an urgent care center?" Itemize some of the conditions your center treats in language the audience will understand, such as:

- Sprains, strains and fractures
- Cuts, scrapes, bruises and rashes
- Allergies, sinus infections, sore throats, cold/flu, fever
- Examinations for prescription refills for chronic illnesses, such as hypertension or diabetes
- School immunizations
- Athletic physical examinations

Next, you should provide information about your specific facility—such as its location, operating hours, clinical capabilities, certifications, and provider experience and personalities. Although "retail" in orientation, urgent care differs from other retail businesses in that urgent care medical needs arise somewhat infrequently. A patient may be aware of an urgent care facility and retain that information for future reference, but several months may pass before the patient has an actual medical need. But when that need arises, you want them to think of your facility as their first place to go.

During your presentation, ask for a commitment to visit the center, to take a tour, to receive a flu shot or obtain a sports physical, because people who commit are more likely to follow through. People have a lot of questions about health care in general so include a question-and-answer period to engage the audience, provide feedback, and generate interest and enthusiasm.

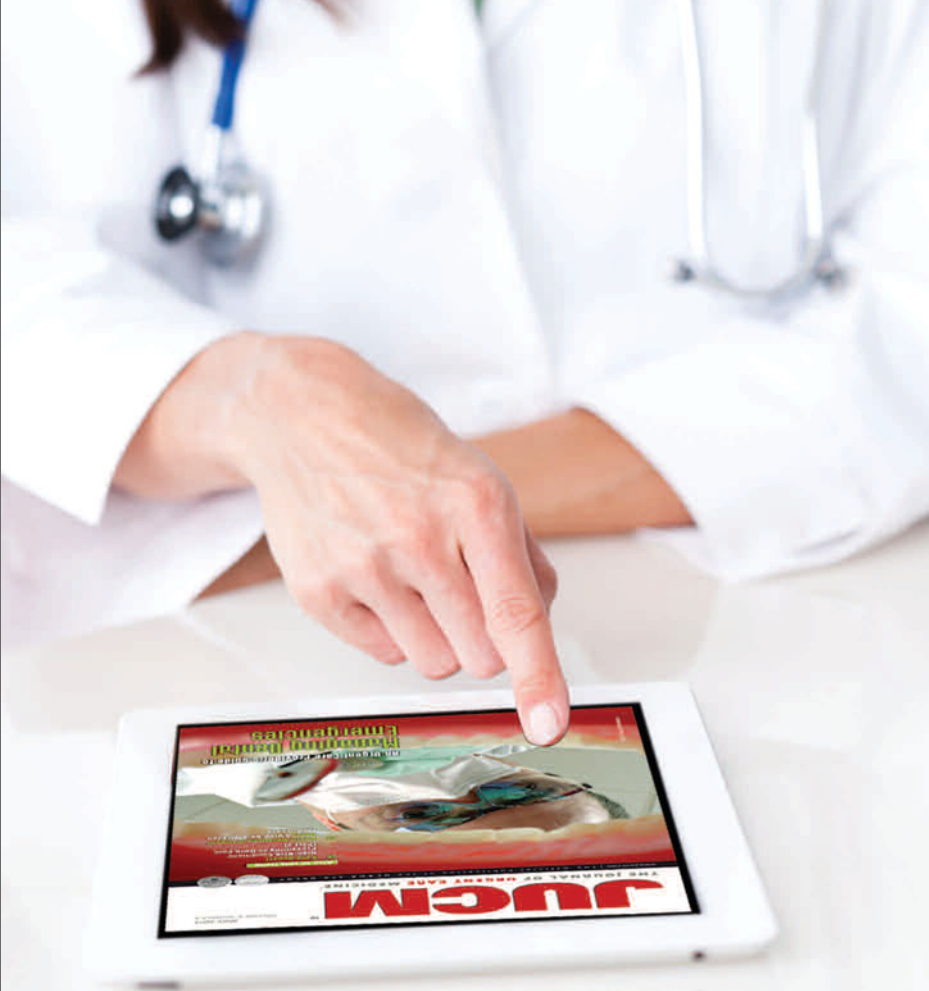
Last, have your staff members prepare small, individual gift bags to hand out to attendees. The gift bags may include marketing literature; candy or a healthy snack; branded items, such as pens, magnets, golf balls/tees, note pads, or water bottles. Handing out these bags at the end of the presentation will not only make the experience memorable, it will further disseminate your “brand.”

Wearing Your Brand Through Personal Contact

Are you an extrovert or an introvert? If you’re an extrovert, then branding through personal contact will be relatively easy for you. However, if you’re an introvert, you may need to become more comfortable engaging your brand through one-on-one, face-to-face encounters with potential patients.

During the course of your normal activities—such as getting your car washed, going to the grocery store, attending a sports event or getting your hair cut/styled—you may not always be wearing apparel displaying your center’s name and logo. But you will have many opportunities to make people with whom you come into casual contact aware of your facility.

If you’re seated in the waiting area of one of your regular stops, for example, you can strike up a conversation with the person seated next to you. Listen carefully for clues about their profession, family situation or lifestyle. Establish an affinity by identifying a common interest, such as children, pets or hobbies. As the conversation continues, introduce yourself, and



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hand them one of your business cards.

As you build a rapport, there are a number of ways you can make urgent care relevant to the individual. If he/she mentioned children, you can highlight your back-to-school physicals and immunizations. If a cruise or overseas travel is in his/her future plans, you can mention your travel vaccination evaluations. Or you can let person know that your center is an option if a family member sprains an ankle or experiences flu-like symptoms. Encourage your new contact to stop by the center and ask for you personally.

Wearing your brand through personal contact can also be achieved in other ways. One of the most overlooked resources for potential business includes people who you already know. Have you notified your network of family, friends and acquaintances about your urgent care center? Mailing them a personal note, including a promotional item that can be easily placed in an envelope (such as a refrigerator magnet, pen or keychain) will go a long way toward building your client base.

Leaving your literature at local business establishments is another way to wear your brand. For places you frequent (such as restaurants, coffee shops, dry cleaners), ask the manager or proprietor if you can leave business cards or brochures on their counter or bulletin board. Most of the customers who visit these establishments will reside in the immediate area and are potential patients for your center.

Getting Others to Wear Your Brand

The concept of wearing your brand can be expanded beyond you and your staff members. Your patients can become some of your best advocates. You may, for example, give away branded T-shirts, caps or other promotions with every flu shot or sports physical. That way, your patients become “walking billboards” and increase your center’s visibility. As they wear your apparel, they’ll spur word-of-mouth for your facility.

You can also offer your patients incentives to win T-shirts and other paraphernalia through social media websites like Facebook. People love to win free items. Conducting a health-related trivia contest once a month on Facebook, in which the prize is a T-shirt from your center, will have the following effects:

- Helps build your Facebook audience through more “fans” or “likes”;
- Attracts new people to your online presence through “shares”;
- Creates online “buzz”; and
- Engages your existing audience, ensuring regular visits to your Facebook and/or Twitter pages.

Becoming a sponsor for local athletic leagues, youth organizations, charitable fitness events, and health-related activities is another way to get others to wear your brand. These sponsorships can be low-cost efforts, but can go a long way toward building brand recognition in your community. For example, you could sponsor T-shirts for a municipal recreation department that include your center’s name, logo, and contact information on the back; you could donate equipment bearing your logo to the high school football team; or you could provide logo-embroidered gym sacks for individual team members. The possibilities are endless and the relationships you develop can be long-term and fruitful.

Conclusion

The concept of wearing your brand has many facets and can actually be quite enjoyable once you embrace it fully. The positive effects for your facility are numerous and include the following:

- It spurs word of mouth advertising and creates “buzz” about your center.
- It raises your center’s profile in the community.
- It leaves a visual impression for consumers to remember.
- It will, ultimately, increase your client base, revenues and profits.

As you market your urgent care center and “wear your brand,” you should never let an opportunity to inform new contacts about your facility pass you by. Wear your brand boldly, and with confidence. ■

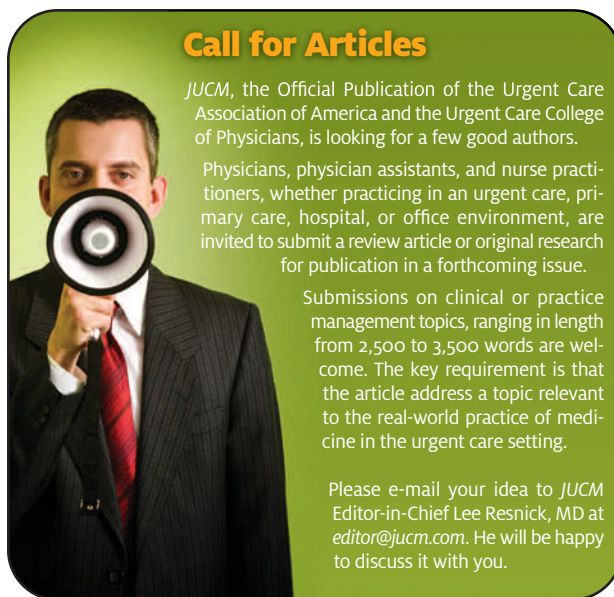
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Please e-mail your idea to *JUCM* Editor-in-Chief Lee Resnick, MD at editor@jucm.com. He will be happy to discuss it with you.



Case Report

Ludwig's Angina

Urgent message: Thoroughly evaluate patients who complain of dental or oral pain.

CHRISTOPHER MCKENNA and JOHN SHUFELDT, MD, JD, MBA, FACEP

Ludwig's angina is a serious and potentially life-threatening connective tissue infection found on the floor of the mouth and in the deep neck spaces. More specifically, it is a bilateral infection of the submandibular space. The two compartments affected are the sublingual space and the submylohyoid space.¹ This condition usually presents in individuals who have dental infections, are immunocompromised and/or have poor oral hygiene. In children, tonsillitis is the most common cause of Ludwig's Angina or deep neck space infections, whereas an odontogenic origin is the leading factor in adults. The latter condition is of particular concern because if left untreated, it has the potential to cause sepsis, obstruct the airway, and cause respiratory collapse requiring an emergency surgical airway.²

Case Presentation

A 42-year-old male with type 1 diabetes presents to the urgent care clinic with a 2-day history of fever, chills, and facial swelling. Review of his past medical records reveals he has visited the center on multiple occasions, typically complaining of oral pain caused by dental caries. Despite multiple referrals to a local dentist, he continues to frequent the urgent care center and has not sought dental care. The patient's records contain multiple notes indicating that he says he cannot afford to get his teeth pulled. In addition, a note in the chart cautions that he is a "drug-seeker" and not to give him narcotics.

The patient tells you that for the last 2 days, he has had malaise, felt feverish, and his blood sugar has been elevated. He also notes a foul taste in his mouth and dif-



iculty swallowing. Examination of the patient's oral cavity reveals several cavities, dry oral mucosae, and woody, tender edema of the floor of the mouth and anterior neck.

Observations and Findings

Physical exam

Evaluation of the patient revealed the following:

Temp: 103.1 °F

BP: 168/90

P: 140

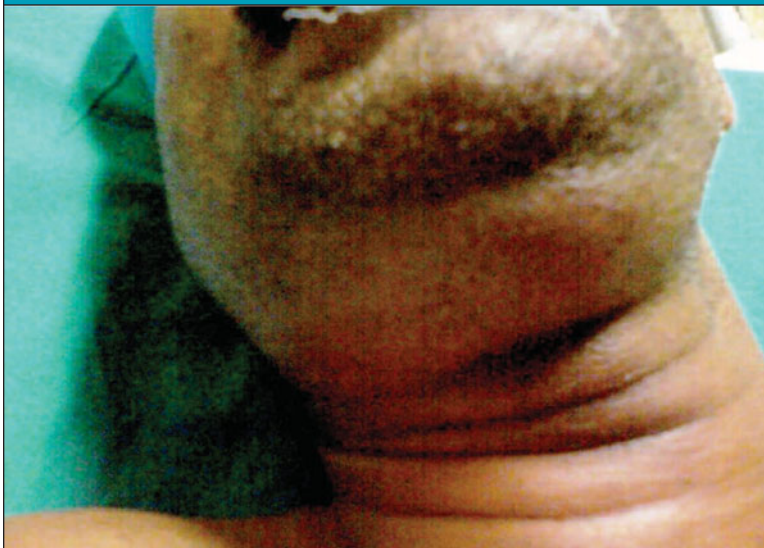
RR: 20

General: Awake, diaphoretic male in mild respiratory distress

HEENT: PERRL, TM'S NL, Oral Cavity: Dry mucosa, multiple dental carries, soft tissue swelling and boggy-ness to the sub-glottic tissue. Airway grossly patent,

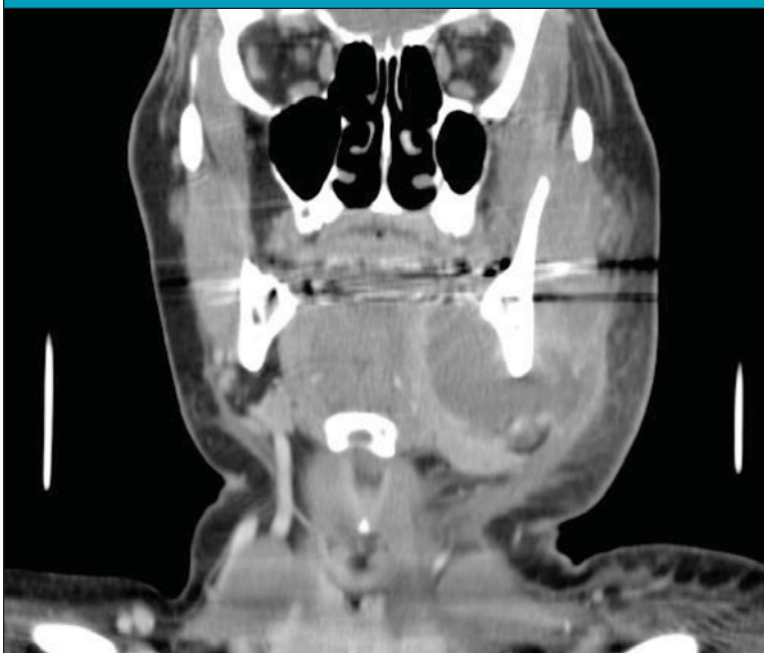
.....
Christopher McKenna is an undergraduate pre-med Public Health Sciences major studying at Santa Clara University. **John Shufeldt** is principal of Shufeldt Consulting and sits on the editorial board of JUCM. He may be contacted at jshufeldt@Shufeldtconsulting.com.

Figure 1.



Swelling in the submandibular area in a patient with Ludwig's angina. en.wikipedia.org/wiki/File:Ludwig_angina.jpg. Accessed September 28, 2012. Source: <http://www.casesjournal.com/content/1/1/19>
Laboratory Results/Imaging

Figure 2.



CT scan showing a large tooth abscess (right) with significant inflammation of fatty tissue under the skin. http://en.wikipedia.org/wiki/File:Abc%C3%A9s_dentaire_TDM_1.JPG Accessed September 28, 2012.

however, unable to visualize the posterior pharynx. Swelling pictured left.

Neck: Swelling of the submandibular area, extending to the thyroid cartilage (**Figure 1**); multiple, tender anterior and posterior lymph nodes; no meningeal signs, but patient cannot flex his neck forward due to swelling. Carotid pulse palpable bilaterally with bruits or thrills.

Lungs: Clear, equal breath sounds

Heart: Tachycardia without murmur

Neuro: No focal deficits, Cranial nerves grossly intact but cannot adequately test due to facial and neck swelling.

The rest of the exam is unremarkable.

Laboratory Results/Imaging

Imaging as well as laboratory studies are necessary in the diagnosis of a deep neck space infection such as Ludwig's angina. Lateral neck radiography may be necessary because of its ability to quickly reveal soft tissue swelling in the pre-vertebral region. These radiographs can also reveal radiopaque foreign bodies, subcutaneous air, air fluid levels, and erosion of the vertebral bodies. Mandible series also may be helpful in evaluating the presence of dental abscesses in the patient.²

A computed tomography (CT) scan is the most helpful imaging procedure because it can indicate the location, boundaries, and relation of infection to surrounding neurovascular structures. A CT scan should be the first option for imaging because of its ability to simplify deep neck space infections. A simple clinical examination is not sufficient for this situation and can lead to an improper or incomplete diagnosis.

Abscesses, as shown in **Figure 2**, are displayed as low-density lesions with rim enhancement, occasional air fluid levels, and loculations.³ A CT scan of the chest may be necessary if there is concern for spread of infection into the mediastinum. Magnetic resonance imaging can be used in the case of deep neck space infections, but it is not the first choice for imaging because of the time and costs associated.²

Laboratory examination includes a com-

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plete blood count with differential, electrolytes, and in this case serum acetone; blood cultures; and culture and gram stain of the abscess. The most common organism observed as a result of the deep neck space cultures is *Streptococcus viridans*.²

Note: unnecessary agitation could result in laryngospasm and complete upper airway obstruction, so any direct examination should only be performed with emergency airway equipment and personnel standing by.

Differential Diagnosis

1. Peritonsillar abscess
2. Dental or apical abscess
3. Epiglottitis
4. Parotitis or salivary gland infection/abscess
5. Severe gingivitis
6. Angioneurotic edema
7. Lingual carcinoma²

Diagnosis

Ludwig's angina

Important physical exam findings:

- Sub-glottic swelling
- Difficulty breathing
- Fever
- Neck pain
- Neck swelling
- Difficulty/painful swallowing
- Impaired speech
- Poor oral hygiene⁴

To confirm the diagnosis and ensure proper treatment, a needle aspiration of the submandibular space is indicated to direct therapy.

Ludwig's angina has four significant signs:

1. bilateral involvement of multiple deep tissue spaces;
2. gangrene with seroanguinous, putrid infiltration with little or no frank pus;
3. involvement of connective tissue, fasciae, and muscles but not glandular structures; and
4. spread via fascial space continuity, as opposed to the lymphatic system. Brawny induration of the floor of the mouth should signal airway stabilization.³

Course and Treatment

Depending on the severity of the infection, there are several courses of treatment that should be considered. In patients who have excessive swelling that leads to potential airway compromise, all precautions must be

undertaken to prepare for airway collapse. It is hoped collapse can be avoided with close observation and aggressive and proper antibiotic treatment.

If a patient's airway is blocked, fiberoptic intubation via the nasal route is a viable option. That should only be necessary if the cellulitis and swelling worsen or if respiratory compromise occurs.¹

Broad antibiotic coverage, typically penicillin-based, is emergently indicated. Antibiotic therapy should be administered for 2 to 3 weeks, or until there is evidence of clinical resolution. In most cases, follow-up dental treatment is necessary to definitively correct the dental infections and/or abscesses.

In addition, if an abscess has formed, surgical intervention for drainage is required, particularly if a patient is not responding to intravenous antibiotics. However, surgery is not normally done because of the rarity of a drainable collection of pus early in the course of the disease.⁵ Before the development of antibiotics, Ludwig's angina had a 50% mortality rate. Today, mortality due to Ludwig's angina has declined to less than 4%.²

Antibiotics and proper drainage are almost always preferable over surgical treatment and/or intubation. According to a review of deep neck infections by Broughton, 50% of deep neck infections can be treated with simple fluid aspiration, and should not necessitate a formal airway intervention. Another study by Plaza and McClay suggests that surgical drainage be introduced only if there is no improvement after administration of broad-spectrum antibiotics for 48 hours.³

Discussion

Ludwig's angina is a dangerous and potentially airway-compromising infection of the floor of the mouth and neck and, if not diagnosed and treated correctly, can prove life-threatening. This condition is complex for a plethora of reasons, the first being the complicated anatomy involved with the deep neck spaces. This complexity can lead to imprecise localization of the infection. However, in patients presenting with Ludwig's angina, nearly two-thirds have a dental source of infection involving the second or third mandibular molar teeth. In addition, the tissue most often affected by this condition is located under a substantial amount of uninfected soft tissue. Finally, an infection found in the deep neck spaces is unlikely to remain localized.²

Once the infection has established itself within the deep neck space tissue, it is known to spread rather quickly. Increase in tongue size to more than two to three times normal has been documented in some cases.

Ensuring an adequate airway is of utmost importance when dealing with a patient suffering from Ludwig's angina.

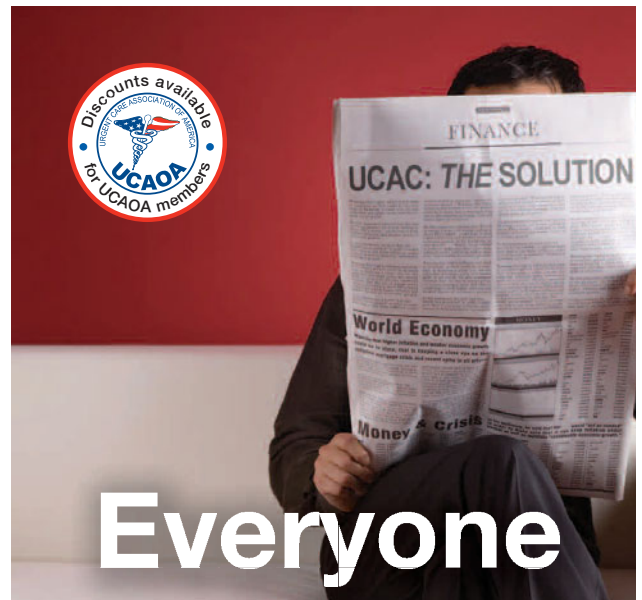
That can ultimately lead to posterior distention into the hypopharynx, superiorly against the palate, and protrusion from the mouth. In addition, the cellulitis from the submandibular space may spread from the styloglossus muscle into the parapharyngeal space, and then continue to the retropharyngeal space and the superior mediastinum.³

Ensuring an adequate airway is of utmost importance when dealing with a patient suffering from Ludwig's angina. This condition can prove incredibly difficult for even the most experienced physicians because of the potential for extensive swelling and distortion of the anatomy. However, if the airway is initially patent, proper antibiotic coverage should prove sufficient to mitigate the infection in the deep neck spaces.

Ludwig's angina is generally a rare condition, but one that can be treated with aggressive antibiotic use and airway support with or without surgical drainage. Full recovery should be expected if the infection is treated properly and attended to in a timely manner. Patients suffering from deep neck infections show no signs of predisposition for recurrence once their original infection and its source have been fully treated. ■

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William Gluckman, DO, MBA, FACEP
President, UCCOP



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



FIGURE 1

The patient, a 9-month-old male, suffered a blow to his left shoulder.

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

Resolution of the case is described on the next page.

THE RESOLUTION



FIGURE 2

Diagnosis: The x-ray reveals a mid-clavicular fracture (arrow). Pain control and follow up are appropriate for this patient. Abuse should be suspected because this is a severe fracture for a 9-month-old infant.

*Acknowledgement:
Case presented by
Nahum Kovalski, BSc,
MDCM, Terem Emergency
Medical Centers, Jerusalem,
Israel.*



FIGURE 1



The patient, an 87-year-old woman, presented with a circular and pruritic rash that had been present on her right shin for 3 days. She had no fever.

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

Resolution of the case is described on the next page.

THE RESOLUTION

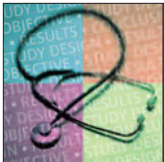
FIGURE 1



The photograph demonstrates nummular eczema, which presents as a coin-shaped dermatitis, most commonly on hands and legs.

The most common peak occurrence is in the seventh decade of life. Treatment includes skin moisturizers, topical steroids and, if secondary infection occurs, oral antibiotics.

Acknowledgement: Case presented by Nahum Kovalski, BSc, MDCM, Terem Emergency Medical Centers, Jerusalem, Israel.



ABSTRACTS IN URGENT CARE

- Acute heart failure
- Insurance in the ED
- Probiotics and diarrhea
- Imaging for PE
- Zinc and antibiotics
- Contact sports and learning
- Ultrasound for skull fractures
- Hyperthyroidism and health risks
- Urticaria and autoimmune diseases
- Clinicians' gut feelings
- Low-risk chest pain

■ NAHUM KOVALSKI, BSc, MDCM

Each month, Dr. Nahum Kovalski reviews a handful of abstracts from, or relevant to, urgent care practices and practitioners. For the full reports, go to the source cited under each title.

Acute Heart Failure: Hospitalize or Discharge?

Key point: A new tool for estimating prognosis could facilitate rapid risk assessment.

Citation: Lee DS, Stitt A, Austin PC, et al. Prediction of heart failure mortality in emergent care: A cohort study. *Ann Intern Med.* 2012;156(11): 767-775.

The decision to hospitalize or discharge a patient with acute heart failure (HF) is often difficult to make. To develop a prognostic model for acute HF suitable for use in the emergency department (ED), investigators in Ontario, Canada, studied clinical data on 12,591 HF patients treated at 86 hospitals from 2004 to 2007. Two-thirds of the patients were hospitalized; the rest were discharged from the ED. Sixty percent of the patients made up the derivation cohort (mean age, 75.4; 51.5% men), and 40% constituted the validation cohort (mean age, 75.7; 51.6% men). Overall 7-day mortality was 2%. Baseline characteristics were similar in the two cohorts, although creatinine and troponin concentrations and the rate of diuretic use were marginally higher in the validation cohort.

The investigators developed an emergency HF mortality risk grade (EHMRG) scale based on 10 factors that were independent predictors of 7-day mortality in multivariate analysis. Some

variables are multiplicative and some are additive; the EHMRG score can be calculated online. For each 20-point increase in the EHMRG score, 7-day mortality risk increased by 41% in the derivation cohort and by 39% in the validation cohort.

Published in *J Watch Card.* June 13, 2012 — Joel M. Gore, MD. ■

Change in Insurance Status Increases Emergency Department Visits

Key point: Change in insurance status, as opposed to actual insurance status, is associated with a more than 30% rise in ED use.

Citation: Ginde AA, Lowe RA, Wiler JL. Health insurance status change and emergency department use among US adults. *Arch Intern Med.* 2012;172(8):642-647.

The common wisdom that lack of insurance increases emergency department (ED) use has been repeatedly debunked. For example, ED visit rates in Canada, where universal insurance prevails, are nearly identical to those in the United States. In Massachusetts, the introduction of mandated insurance hardly affected ED visits.

Noting turmoil in the provision of health insurance brought on by the economic recession and by pending implementation of the Affordable Care Act, investigators examined the effect of recent loss or gain of insurance on ED use. They reviewed data for 160,000 adults who responded to the CDC National Health Interview Survey from 2004 through 2009.

Overall, 83% of respondents had insurance (5% of them were newly insured) and 17% did not have insurance (23% of them were newly uninsured). Twenty percent of the insured



Nahum Kovalski is an urgent care practitioner and Assistant Medical Director/CIO at Terem Emergency Medical Centers in Jerusalem, Israel. He also sits on the *JUCM* Editorial Board.

and uninsured groups had visited an ED in the 12 months before the survey. After adjustment for health status, socioeconomic status, and demographics, newly uninsured adults had 39% higher ED use than those who were continuously uninsured, and newly insured adults had 32% higher ED use than those who were continuously insured. Among the newly insured, those with Medicaid had the highest ED use.

Published in *J Watch Emerg Med*. May 18, 2012 — J. Stephen Bohan, MD, MS, FACP, FACEP. ■

Meta-Analysis: Probiotics Associated with Lower Risk of Antibiotic-Related Diarrhea

Key point: Probiotics seem to lower the risk of antibiotic-associated diarrhea (AAD).

Citation: Probiotics for the prevention and treatment of antibiotic-associated diarrhea. *JAMA*. 2012;307(18):1959-1969.

Probiotics seem to lower the risk of antibiotic-associated diarrhea (AAD), but the available research doesn't support conclusions about which preparations work best or which patients benefit most.

Researchers examined over 80 randomized trials in which probiotics were used to either prevent or treat AAD. In a subset of 63 trials including some 12,000 participants, they found a lower pooled risk of AAD among those receiving probiotics (0.58), compared with controls. They estimate the number needed to treat at 13 to prevent one case of AAD.

However, the authors found poor documentation of the probiotic strains used, unexplained heterogeneity among the trials, and little reporting on adverse effects of treatment. ■

Pulmonary Embolism: One Third of ED Imaging Avoidable

Key point: Up to one-third of computed tomography (CT) and nuclear imaging scans for suspected pulmonary embolism are potentially avoidable if emergency department (ED) personnel were less aggressive in ordering the tests for low-risk patients.

Citation: Venkatesh AK, Kline JA, Courtney M, et al. Evaluation of pulmonary embolism in the emergency department and consistency with a national quality measure. *Arch Intern Med*. 2012;172(13):1028-1032.

The study focused on ED imaging behavior for the 2,238 ED patients in the study who were recommended imaging to rule out the presence of pulmonary embolism (PE), despite a low pretest probability of PE. These patients were hemodynamically stable (systolic blood pressure ≥ 90 mm Hg) and had Wells scores for pretest probability of less than 2 points. Other factors include the attending physician's opinion about the most likely diagnosis and their gestalt pretest probability.

Findings demonstrated the value of D-dimer testing. About

11% of the avoidable imaging studies were derived from 394 patients who underwent imaging despite negative D-dimer results. The remaining 22% of avoidable imaging studies were associated with the potential application of the NQF criteria for 1,427 patients who did not undergo D-dimer testing. Fifty patients (1.3% of those imaged) were diagnosed with PE by imaging considered potentially avoidable by the NQF measure because no D-dimer testing was performed. The researchers identified only eight cases (0.2%) of patients who had a negative D-dimer before a positive diagnosis for PE with imaging considered avoidable.

Assuming 100% imaging specificity, it was estimated that adherence to the NQF guideline would have led to 11 missed PEs from eight patients with negative D-dimer test results and three patients who had not undergone D-dimer testing (93% sensitivity). Multivariate analysis demonstrated that the likelihood that imaging can be avoided decreased with increasing patient age or the presence of an inactive cancer, sickle cell disease, and pregnancy.

"Our results demonstrate the validity of the NQF measure and refute the notion that high measure performance is associated with the unintended consequence of missed PE," the authors write. They stress that the study was limited to identifying potentially avoidable studies, not definitely avoidable imaging workups for patients with no D-dimer testing performed. More research would be needed to make that determination. ■

Adding Zinc to Antibiotics Reduces Treatment Failures

Key point: Zinc is inexpensive. Its use could potentially decrease mortality in infants with serious infections in developing countries and reduce the proportion of infants needing second-line antibiotics because of treatment failure.

Citation: Bhatnaga S, Wadhwa N, Aneja S, et al. Zinc as adjunct treatment in infants aged between 7 and 120 days with probable serious bacterial infection: A randomised, double-blind, placebo-controlled trial. *Lancet*. 2012;379(9831):2072-2078.

Bacterial infections are responsible for more than one-quarter of neonatal deaths in India. Might the addition of zinc improve treatment outcomes, given findings of beneficial effects in animals and in children?

To find out, researchers conducted a double-blind trial involving infants aged 7 to 120 days who were treated for probable serious bacterial infection (based on clinical findings and elevated C-reactive protein levels) at any of three hospitals in New Delhi. The infants were randomized to receive 10 mg of oral zinc or placebo daily, along with standard antibiotic therapy.

Treatment failure (defined as need to change therapy within

7 days, need for intensive care, or death within 21 days; assessable in 655 infants) occurred significantly less frequently in the zinc group than in the placebo group (10% vs. 17%; relative risk reduction, 40%). The death rate was nonsignificantly lower in the zinc group than in the placebo group (5% vs. 3%). Tests of zinc levels done at study entry showed that 44% of study infants had low baseline levels ($<9.2 \mu\text{mol/L}$).

Published in *J Watch Infect Dis*. June 13, 2012 — Mary E. Wilson, MD. ■

Contact Sports May Affect Learning in College Athletes

Key point: *Even one season of repetitive head impacts might have a negative effect on cognitive performance.*

Citation: McAllister TW, Flashman LA, Maerlender A, et al. Cognitive effects of one season of head impacts in a cohort of collegiate contact sport athletes. *Neurology*. 2012;78(22):1777-1784.

Concussion and traumatic brain injury in athletes has been a frequent subject in the lay press recently, given growing interest in chronic traumatic encephalopathy as a distinct neurodegenerative entity; however, scientific studies on the topic are few and often contradictory. To assess the effect of repetitive head impacts on cognitive performance, researchers prospectively compared pre- and postseason neuropsychological test results between 214 Division I college athletes who played contact sports (ice hockey or football) and 45 such athletes who played noncontact sports. Contact-sport athletes wore helmets that recorded acceleration, duration, and location of head impact.

Contact-sport athletes were exposed to a mean of 469 distinct head impacts per season. None of the athletes studied suffered a concussion during the season. Comparison of pre- and postseason test results demonstrated that repetitive head impacts during a single season did not have a short-term detrimental effect overall. However, significantly more contact-sport athletes than noncontact-sport athletes (22% vs. 4%) performed more than 1.5 standard deviations below their predicted score on postseason tests of learning and memory (1.5 standard deviations was prospectively selected as a marker of “significantly poorer than expected” performance).

Published in *J Watch Emerg Med*. June 22, 2012 — Richard D. Zane, MD, FAAEM. ■

Ability of Emergency Ultrasonography to Detect Pediatric Skull Fractures: A Prospective, Observational Study

Key point: *ER ultrasound for pediatric skull fractures has a positive predictive value of 97.2% and negative predictive value of 100%.*

Citation: Parri N, Crosby BJ, Glass C, et al. Ability of emergency ultrasonography to detect pediatric skull fractures: a prospective, observational study. *J Emerg Med*. 2012 May 10. [Epub ahead of print]

Blunt head trauma is a common reason for medical evaluation in the pediatric Emergency Department (ED). The diagnostic work-up for skull fracture, as well as for traumatic brain injury, often involves computed tomography (CT) scanning, which may require sedation and exposes children to often-unnecessary ionizing radiation.

This is a prospective study of bedside ultrasound for diagnosing skull fractures in head-injured pediatric patients. A consecutive series of children presenting with head trauma requiring CT scan was enrolled. Cranial bedside ultrasound imaging was performed by an emergency physician and compared to the results of the CT scan.

Bedside emergency ultrasound performs with 100% sensitivity and 95% specificity when compared to CT scan for the diagnosis of skull fractures. Positive and negative predictive values were 97.2% and 100%, respectively.

Compared to CT scan, bedside ultrasound may accurately diagnose pediatric skull fractures. Considering the simplicity of this examination, the minimal experience needed for an emergency physician to provide an accurate diagnosis and the lack of ionizing radiation, emergency physicians should consider this modality in the evaluation of pediatric head trauma.

Subclinical Hyperthyroidism Raises Risk for Mortality and Cardiac Events

Key point: *Risk was particularly high with thyrotropin levels $<0.10 \text{ mIU/mL}$.*

Citation: Collet T, Gussekloo J, Bauer DC, et al. Subclinical hyperthyroidism and the risk of coronary heart disease and mortality. *Arch Intern Med*. 2012;171(10):799-809.

The results of prospective cohort studies conflict on whether subclinical hyperthyroidism (thyrotropin level $<0.45 \text{ mIU/L}$, with normal free thyroxine and triiodothyronine) is associated with elevated incidence of coronary heart disease (CHD) or atrial fibrillation (AF). This meta-analysis combined the results of 10 such studies with 53,000 participants (median age, 59), of whom 2,188 (4%) had subclinical hypothyroidism.

During median follow-up of 9 years, in analyses adjusted for age and sex, the risk for those with subclinical hyperthyroidism compared to those who were euthyroid was increased 24% for overall mortality, 29% for CHD mortality and 68% for incident AF. Risks were even higher in those with thyrotropin levels $<0.10 \text{ mIU/L}$, and risks did not change substantially after adjustments for other cardiovascular risk factors. The risk attributable to subclinical hyperthyroidism, after accounting for

traditional risk factors, was 14.5% for total mortality and 41.5% for incident AF.

Published in *J Watch Gen Med*. May 3, 2012 — Thomas L. Schwenk, MD. ■

Chronic Urticaria Might Be a Harbinger of Other Autoimmune Diseases

Key point: *Subsequently diagnosed autoimmune diseases were 17 times more common in patients with idiopathic urticaria.*

Citation: Confino-Cohen R, Chodick G, Shalev V, et al. Chronic urticaria and autoimmunity: Associations found in a large population study. *J Allergy Clin Immunol*. 2012;129(5):1307-1313.

Chronic idiopathic urticaria (CIU) is defined by the presence of hives three or more times weekly for at least 6 weeks, with no identifiable trigger. Half of patients who experience CIU exhibit IgE autoantibodies or antibodies against high-affinity IgE receptors on mast cells and basophils; these antibodies are thought to be pathogenic.

An automated search of an Israeli medical database yielded 12,778 patients with CIU; 10.0% and 2.6% of patients had hypothyroidism and hyperthyroidism, respectively. Additionally, type 1 diabetes, rheumatoid arthritis, celiac disease, lupus, and Sjögren syndrome were significantly more common (odds ratio, 17.3) in CIU patients than in a matched control group without CIU. Women were at significantly greater risk for developing autoimmune diseases than were men. Of all autoimmune diseases that were diagnosed in the CIU population, more than 80% developed in the 10 years following diagnoses of CIU.

Published in *J Watch Gen Med* May 10, 2012 — David J. Amrol, MD. ■

Clinicians' gut feeling about serious infections in children: observational study

Key point: *Gut feeling has real clinical value.*

Citation: Van den Bruel A, Thompson M, Buntinx F, Mant D. Clinicians' gut feeling about serious infections in children: observational study. *BMJ*. 2012;345:e6144

This was an observational study, in a primary care setting in Flanders, Belgium, on a consecutive series of 3890 children and young people aged 0-16 years.

Of the 3369 children and young people assessed clinically as having a non-severe illness, six (0.2%) were subsequently admitted to hospital with a serious infection.

Intuition that something was wrong despite the clinical assessment of non-severe illness substantially increased the risk of serious illness (likelihood ratio 25.5) and acting on this gut feeling had the potential to prevent two of the six cases being missed at a cost of 44 false alarms (1.3%, 95% confidence interval 0.95% to 1.75%).

The clinical features most strongly associated with gut feeling were the children's overall response (drowsiness, no laughing), abnormal breathing, weight loss, and convulsions. The strongest contextual factor was the parents' concern that the illness was different from their previous experience (odds ratio 36.3).

A gut feeling about the seriousness of illness in children is an instinctive response by clinicians to the concerns of the parents and the appearance of the children. It should trigger action such as seeking a second opinion or further investigations. The observed association between intuition and clinical markers of serious infection means that by reflecting on the genesis of their gut feeling, clinicians should be able to hone their clinical skills. ■

Low-Risk Chest Pain Patients Can Be Monitored and Discharged Without Provocative Testing

Key point: *This single-center study suggests that deferring provocative testing to the outpatient setting is safe.*

Citation: Scheurmeyer FX, Innes G, et al. Safety and efficiency of a chest pain diagnostic algorithm with selective outpatient stress testing for emergency department patients with potential ischemic chest pain. *Ann Emerg Med*. 2012;59(4):256-264.e3.

Debate continues regarding whether provocative testing is needed before emergency department (ED) discharge for low-risk chest pain patients. Investigators at a single academic ED in Vancouver, Canada, studied the 30-day rate of missed acute coronary syndrome or death in 1116 patients with chest pain who were discharged after 6 hours of observation if they did not have objective ischemia or ongoing pain.

Overall, 26% of patients were deemed very low risk and were discharged immediately without further investigation, 24% were referred for cardiology evaluation during their ED visit, 24% were referred for outpatient provocative testing after their ED visit, and the rest were discharged after ED observation and testing without recommendations for further testing. Ninety-six percent of patients referred for outpatient provocative tests complied. Acute myocardial infarction was diagnosed in 39 patients (3.5%), all at the index ED visit. Unstable angina was diagnosed in 60 patients (5.4%) at the index visit and in 21 (1.9%) at outpatient testing. No cases of missed acute coronary syndrome or death at 30 days were identified by searches of regional databases and telephone follow-up.

Published in *J Watch Emerg Med*. May 4, 2012 — Daniel J. Pallin, MD, MPH. ■



What You Don't Know

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

In the late 1970s I read a book by Samuel Shem called *The House of God*. The book is about an intern in a New York hospital during his first year of residency. His senior resident, “The Fat Man,” coins a number of laws about surviving residency. One of them—“If you don’t take a temperature you can’t find a fever”—can be extrapolated to all sorts of questions, tests, and exams. People who know me will say that I don’t ask a ton of questions when my gut tells me that I probably don’t want to know the answer.

Reference this exchange:

23-year-old female patient: I think I have an STD in my throat.

Me: Why do you think that?

Patient: My throat hurts.

Me: I understand that but why do you think it is an STD?

Patient: I got drunk at a party and fell asleep with my mouth open.

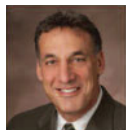
Me: Wow, what kind of party was it?

Patient: An all-girl party.

Really? Did I need to know that? I would have actually been better not knowing it because of course the second those words came out of her mouth my mind went to the physical contortions necessary for her to come to that conclusion—yuck. What kind of friends does this poor girl have—desperate, de-praved gymnasts?

That aside, there are some things we as providers need to know or figure out in the moment. Over the years, I have compiled a list of things we need to know, say, chart or do in real time (and a few we don’t).

1. Although very rare, you have seen this admonition previously: “Drug seekers with recurrent back pain” are a set up to miss a spinal epidural abscess. Danger Will Robinson!!! Fewer than 10% of patients with epidural abscess



John Shufeldt is principal of Shufeldt Consulting and sits on the Editorial Board of *JUCM*. He may be contacted at jshufeldt@shufeldtconsulting.com.

I know we all occasionally believe that we work in a ‘low-risk-environment’ but let me remind you; we don’t.

- present with the triad of back pain, fever and focal neurological deficits.
2. Do not discuss potential or filed medical malpractice claims outside a protected peer-review environment with anyone other than your attorney or your spouse. You will be asked during your deposition who you spoke with about the case.
3. Failure to inform a patient about an abnormal test is a red-flag issue. If the patient ultimately is diagnosed with the condition you neglected to mention you will have some things to defend. Example: A patient presents for an upper respiratory infection. You do a chest x-ray that does not show an infiltrate but does show a small nodular-looking density that you believe is a nipple shadow. The film is dutifully sent for an over-read. The radiologist report comes back with; “suspicious nodule on the right side which appears to be in the middle lobe. Also noted is pleural thickening. Suggest follow-up chest radiograph in 3 months or CT scan to further evaluate lesion.” If you do not inform the patient and the patient is diagnosed with lung cancer 2 years later you will be considered negligent.
4. I have been involved in two cases where a provider “lost” an important but damning sheet of the medical record (which others already had) or materially altered the chart to his/her own benefit. Besides losing the malpractice claim (once discovered, this behavior is not defensible) the provider had to defend his license in front of the state medical board. Do not ever alter or remove part of the medical record. If you make changes, date, time and initial the entry.
5. I know we all occasionally believe that we work in a “low-risk environment” but let me remind you; we don’t. Ur-

gent care is a very high-risk environment. Even higher than the emergency department. It is high risk because everyone, including the patients, thinks it is low risk and we can all be lured into a false sense of complacency. Remember: Worst first!

6. If a patient or the parent of a patient is intoxicated you should do everything in your power not to let the individual get behind the wheel. Note, you cannot physically restrain anyone but you should call the police.
7. If the radiologist states that the films are inadequate, you need to repeat them.
8. If you are going to discharge a patient who has a complaint/issue/diagnosis (headache, chest pain, shortness of breath, transient altered mental status, syncope, visual changes) that could come back to haunt you both, document the pertinent negatives and your thought process.
9. If you order a test, be prepared to address and deal with the result. Sending a patient home with a positive d-dimer or significantly decreased absolute neutrophil count that is not addressed in the medical record is a set up for a medical misadventure.
10. If you spoke with a consultant about a particular patient, write the date, time, name of the consultant and what he/she said in the chart. A consultant's memories can become very sketchy after a suit is filed.
11. Low-risk radiographs (that is, normal chest x-rays) and low-risk chest pains account for a very substantial percentage of malpractice cases in urgent care medicine. It is rarely the obvious issue/complaint that becomes problematic. Example: "I have an acute onset of crushing mid-sternal chest pain associated with shortness of breath and sweating and, oh by the way, my father and mother both died of heart attacks at the exact age I am now." I think we would all be on top of this one.
12. Minor head injuries in patients on Coumadin are by definition not minor. Every patient on a blood thinner (there are a lot of new ones) requires a CT scan as well as a follow-up scan to ensure that there is no delayed bleeding.
13. Patients with testicular pain need an ultrasound to evaluate for torsion. Relying on your physical exam to differentiate torsion from epididymitis will not protect the patient or you.
14. Providers have a duty to warn known or unknown but predictable third parties¹ (that is, partners of patients should be treated for STDs) Note: I am sure I don't want the names of the girls at the party.
15. Providers have a duty to warn patients about possible side effects, drug-drug, drug-food, drug-herbal interactions, fall risks, etc. while taking a medication. If the medication you are prescribing requires your DEA, you have a duty to warn the patient not to drive, operate machin-

ery, etc. because (see end note) you have a duty to warn unknown but predictable third parties.

16. Radiological images should be over-read. Ensure your facility has a mechanism in place to identify and then follow up on x-ray discrepancies that necessitate a change in management or follow up.
17. Read the notes of others before discharging a patient. I have been involved in numerous cases where the nurse or tech notes shoot the provider in the foot. If you document, "The patient presents with a slight headache" but the triage nurse documents, "The patient presents with the worst headache of his life" and the patient ultimately goes on to have a subarachnoid hemorrhage after you discharge him, you will have some explaining to do.
18. The same patient presenting more than twice with the same complaint needs to be figured out / admitted on the third visit.
19. What do you do when your patient lacks capacity to consent to or refuse care? Document very well why, in your estimation, the patient lacks capacity and have another competent adult opine on the record. If your judgment is reasonable, done in good faith, supported by the facts, well documented in the chart and other witnesses, you should be fine. There is a seminal case from the early 20th century called *Schloendorff v Society of New York Hospitals* that addresses this very question. In the case, Justice Cardozo wrote, "Every human being of adult years and sound mind has a right to determine what shall be done to his own body."
20. You should instruct a patient to return to your center or the emergency department immediately if his symptoms worsen or don't improve or if new symptoms develop.

As medical providers, we live and die by what we (and others) chart, what we do and the lengths we go to help our patients. You have come a long way for the opportunity to care for others. Don't let a lapse in judgment or documentation send you back.

Epilogue: My young lady with the sore throat simply had a positive strep screen and was treated with penicillin. Her discharge instructions read as follows: Fill your prescription and take all your medications as prescribed. Do not stop them once you start feeling better but continue until you take all the medications as prescribed. Use Tylenol for pain or fever and return immediately if worse or no better or if you cannot keep your medications down or develop new symptoms. Get a new set of friends. If the first thing that goes through your mind after waking up at a party is "which one of you" you are hanging out with the wrong group. ■

¹ *Tarasoff v. Regents of University of California*. Case involves a psychiatric patient who had rape and murder fantasies about a young coed. The treating psychologist did not warn Ms. Tarasoff or inform the police and the psychiatric patient killed Ms. Tarasoff.



Fracture Care, Laceration Kits, Reimbursement for Extended Hours

■ DAVID STERN, MD, CPC

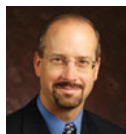
Q. When is it appropriate to use fracture codes without manipulation? If a patient comes in with pain in a finger after a fall and an E/M is performed, x-rays are taken to confirm a fracture, the finger is splinted and the patient is referred to an orthopedist, would that treatment constitute billing for initial care? If not, what must we do to be able to bill these?

A. CPT suggests that only the physician who provides the “restorative treatment” should code and bill for the fracture care.

CPT further states that “if cast application or strapping is provided as an initial service (e.g., casting of a sprained ankle or knee) in which no other procedure or treatment (e.g., surgical repair, reduction of a fracture, or joint dislocation) is performed or is expected to be performed by a physician rendering the initial care only, use the casting, strapping and/or supply code [99070] in addition to an evaluation and management code as appropriate.”

In your example, billing the E/M with modifier -25 (as long as the documentation is separate and identifiable from the procedure note), splint application (CPT 29130), x-ray, and supplies (HCPCS Q4049) used to make the splint would be appropriate because you do not plan any further treatment of the fracture. ■

Q. What code is used to bill for use of a laceration repair kit?



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A. HCPCS code A4550, “Surgical trays,” can be used for a wound repair kit. Keep in mind that if you are billing a wound repair code (CPT 12001-13160), per CPT guidelines, the supplies will be included in the repair code. If the items in the kit are considered “over and above” those usually included for use in wound repair, you could possibly bill HCPCS code A4550 in addition to the wound repair code. You need to be sure you can justify that the contents in the kit are truly “over and above” those you would normally use to repair a laceration and be prepared to prove it in case of an inquiry from the insurance company. ■

Q. Our provider performed a simple I&D (incision and drainage) and the patient was also given 1 g of Rocephin intramuscularly (IM). We billed the E/M code with modifier -25, along with CPT codes 10060, “Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single, 96372, “Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular” with modifier -59 and J0696, “Injection, ceftriaxone sodium, per 250 mg.” The payor bundled 96372, stating it is included with the payment of another procedure. How would you code this?

A. According to the National Correct Coding Edits, you have used modifier -59 appropriately to designate the IM injection was a distinct procedural service.

Review the payor rules to see if there is any bundling language included. If there is no rule stating that those codes will be bundled when billed together, consider submitting a letter of appeal for reconsideration of payment for the claim by the payor. If you find language in your payor agreement that supports the payment of the claim using appropriate

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CODING Q & A

Many major payors have made the decision that all IM injection codes are bundled into an E/M code (if coded).

modifier(s), be sure to include that information with your letter of appeal.

In this particular case, it might be helpful to include the CPT description of modifier -59 along with your supporting documentation detailing that the bundled procedure was not merely incidental, but was a distinct procedural service. If you are not sure of the appeals process, contact the payor for specific appeal instructions.

Many major payors, however, have made the decision that all IM injection codes are bundled into an E/M code (if coded), and are not separately billable on visits that also include an E/M code.

Worse yet, many payors have this policy but have not included it in their contract terms nor have they documented it in their provider manuals. ■

Q. Is the reimbursement different if an urgent care center is open from 8:00 a.m. to 11:00 p.m. versus 12:00 p.m. to 8:00 p.m.?

A. CPT code 99051 can be used when you provide services "during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service." Evening hours are generally considered to start at 5 p.m. regardless of a clinic's hours of operation. This code was designed to compensate your practice for the additional costs of being open extended hours.

Not all payors will reimburse for this code. Medicare does not reimburse for this code so do not bill it to them. However, some payors recognize the value and cost of these services and will reimburse for this code. Check the policies of each of your payors to see if you can receive compensation from them.

If the payor denies the code, you may be able to make this a point of negotiation when renegotiating a contract to get the payor to consider reimbursement for it. ■

Note: CPT codes, descriptions, and other data only are copyright 2011, American Medical Association. All Rights Reserved (or such other date of publication of CPT). CPT is a trademark of the American Medical Association (AMA).

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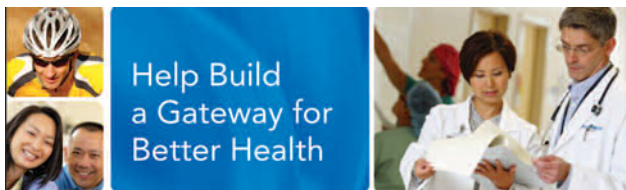
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DEVELOPING DATA

These data from the 2010 Urgent Care Benchmarking Survey are based on responses of 1,691 US urgent care centers; 32% were UCAOA members. The survey was limited to “full-fledged urgent care centers” accepting walk-ins during all hours of operation; having a licensed provider and x-ray and lab equipment onsite; the ability to administer IV fluids and perform minor procedures; and having minimal business hours of seven days per week, four hours per day.

In this issue: What employee benefits are physicians, physician assistants, and nurse practitioners receiving in your center?

FULL TIME PHYSICIAN, PA, and NP BENEFITS

The 2010 question specified full-time employed physicians. Questions were also asked about benefits coverage for independent contractors who were physicians and centers almost unanimously do not provide coverage for these types of workers, as would be expected.

Full-Time Physician Benefits			Full-Time Physician Assistant and Nurse Practitioner Benefits		
Benefit	2008 % that provided	2010 % that provided (13.6% of centers reported no full-time physicians on staff)	Benefit	Physician Assistants (37.84% reported no full-time PAs on staff)	Nurse Practitioners (51.72% of centers reported no full-time NPs on staff)
Health Insurance	68.7	72.4	Health Insurance	31.3	27.1
Retirement Plan	52.9	59.2	Retirement Plan	24.0	22.9
Malpractice Insurance	84.5	77.6	Malpractice Insurance	39.6	33.3
Life Insurance	n/a	48.0	Life Insurance	22.9	17.7
Short-term Disability	n/a	35.7	Short-term Disability	16.7	12.5
Long-term Disability	n/a	32.7	Long-term Disability	13.5	13.5
Vision Care	n/a	39.8	Vision Care	18.8	16.7
Dental Care	n/a	46.9	Dental Care	24.0	18.8
Continuing Medical Education	6.0	59.2	Continuing Medical Education	34.4	26.0
State Licensure Fee	59.5	53.1	State Licensure Fee	32.3	24.0
Profit Sharing	n/a	22.4	Profit Sharing	7.3	5.2
No Benefits	10.9	9.2	No Benefits	12.5	12.5

Acknowledgement: The 2010 Urgent Care Benchmarking Study was funded by the Urgent Care Association of America and administered by Professional Research Associates, based in Omaha, NE. The full 40-page report can be purchased at www.ucaoa.org/benchmarking.



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