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Urgent care cheat sheet. Urgent care billing cheat sheet pdf.

It's been nearly two years since new evaluation and management guidelines took effect, causing some providers to struggle with adjusting their documentation habits after 25 years with the old guidelines. Urgent care centers responded by offering training programs to help staff navigate these changes.

URGENT CARE VS THE ER

WHAT YOU NEED TO KNOW by @FastMedClinics



When illness or injury strikes, should you go to an urgent care clinic or the emergency room? What exactly is the difference between the two?



While the terms **urgent** and **emergency** suggest that they're very similar, the reality is that urgent care clinics and emergency rooms are distinct services which are each best suited for specific situations.

To know which one is the right choice when you or your loved ones need treatment, it's important to understand the answers to these key questions:

WHAT MAKES URGENT CARE CLINICS DIFFERENT FROM EMERGENCY ROOMS?

Both urgent care clinics and ERs have experienced medical staff and labs on site. So, what's the difference? **ERs can provide a higher level of care, but at a higher cost.**



ERs are usually part of hospitals, while urgent care clinics are not



ERs have fast, 24/7 access to trauma-specific resources and many specialists

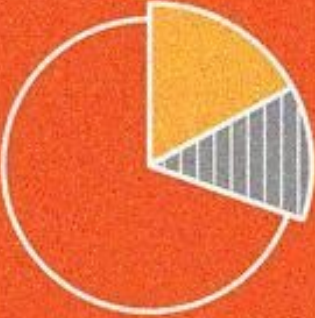


ERs are focused on emergencies; less-severe cases are not their priority

WHAT CONDITIONS ARE URGENT CARE CLINICS AND ERs BEST SUITED FOR?

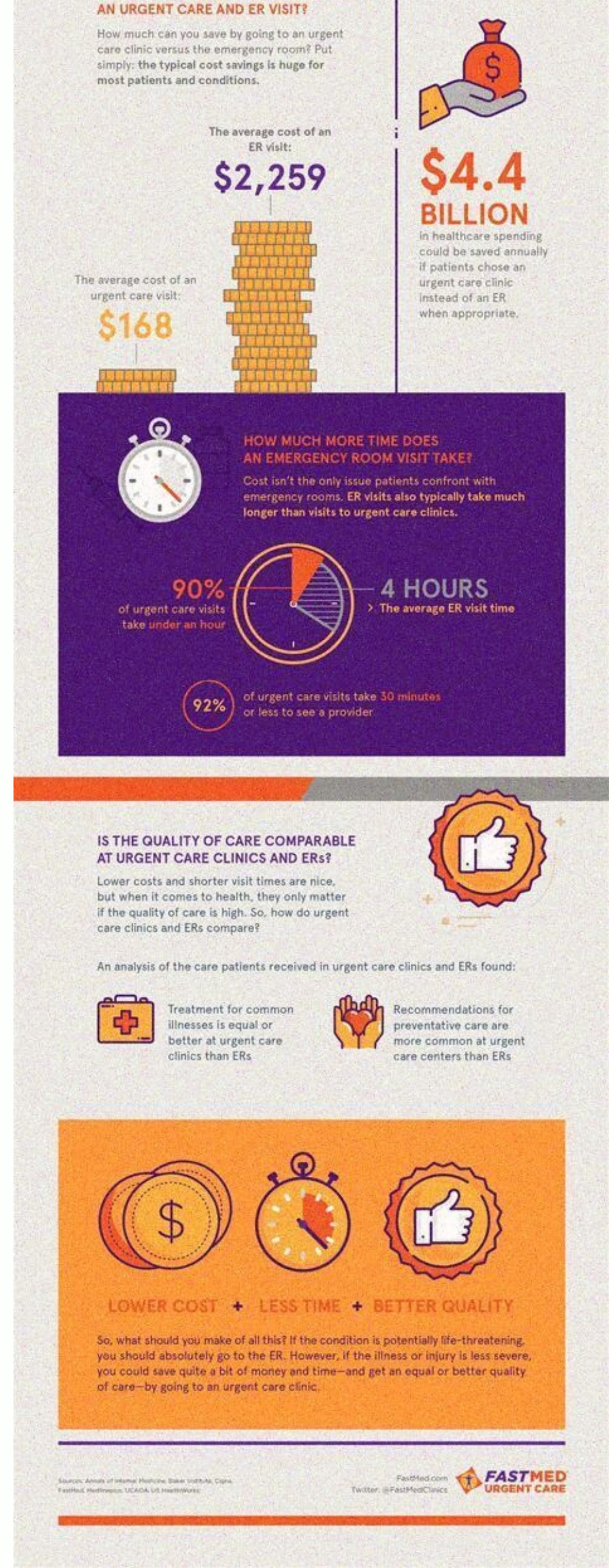
Urgent care clinics are best suited for non-life-threatening situations, while emergency rooms are best suited for severe conditions. Some examples of each include:

URGENT CARE CLINICS	EMERGENCY ROOMS
- Animal bites - Dehydration - Ear pain - Fever - Lacerations - Localized infections - Mild asthma - Minor burns - Nosebleeds - Painful urination - Persistent diarrhea - Rashes and other skin irritations - Simple fractures and sprains - Sore throat - Vomiting	- Abdominal pain - Confusion - Coughing blood - Drug overdoses - Head injuries - Seizures - Severe allergic reactions - Severe burns - Severe chest pain - Severe diarrhea - Severe vomiting - Shortness of breath - Spinal injuries - Sudden vision changes - Uncontrollable bleeding



13%–27% of ER visits could take place at an urgent care clinic

WHAT'S THE COST DIFFERENCE BETWEEN



Every patient case is unique due to their distinct risk factors, impacting the approach to their care. To provide an accurate diagnosis, I'd need to review your documentation. Using a differential diagnosis helps support the level of problem addressed and tests ordered.



In this article, I'll address common questions we receive about these new guidelines. Every patient case is unique due to their distinct risk factors, impacting the approach to their care. To provide an accurate diagnosis, I'd need to review your documentation. Using a differential diagnosis helps support the level of problem addressed and tests ordered.

ACLS MEDICATION	
Drug	Dose / Use
Epinephrine	Cardiac Arrest: 1 mg (1:10,000) IV/IO every 3-5 min., endotracheal dose 2-2.5 times normal dose May increase myocardial ischemia, angina, and oxygen demand.
Vasopressin	Cardiac Arrest: 40 units IV/IO, can replace 1 st or 2 nd dose of Epinephrine - Epinephrine can be resumed 3-5 minutes after Vasopressin dose given. - Potent peripheral vasoconstrictor
Adenosine	Cardiac Arrest: 6 mg IV as a rapid IV bolus, chase with 20 ml saline flush - Can repeat with 12 mg IV rapid IV bolus - Transient side effects: flushing, CP, asystole, bradycardia, ectopy - Contraindicated in 2nd and 3rd degree blocks
Atropine	Cardiac Arrest: 0.5-1 mg bolus, can repeat every 3-5 minutes, max dose of 3 mg - Increases oxygen demand – precautions in MI and hypoxia - Avoid in hypothermia
Amlodarone	- Stable regular complex tachycardia - Stable irregular narrow complex tachycardia (atrial fibrillation) Cardiac Arrest: 300 mg IV/IO bolus, followed by 150 mg IV/IO bolus if needed Alternate (life threatening dysrhythmias): 150 mg IV over 10 min., then 1 mg/min. IV x 6 hours, then 0.5 mg/min. IV x 18 hours - Precautions in 2nd and 3rd degree blocks, bradycardia
Lidocaine	Hemodynamically stable monomorphic VT: Initial dose is 1-1.5 mg/kg; Refractory VF 0.5-0.75 mg/kg in 5-10 min. Max 3 mg/kg; endotracheal dose 2-4 mg/kg Can cause slurred speech, altered consciousness, seizures, bradycardia
Procainamide	Hemodynamically stable monomorphic VT: Pre-excited atrial fibrillation 20-50 mg/min. until suppression of arrhythmia or hypotension develops. QRS duration increases > 50% or 17 mg/kg given. Maintenance dose: 1-4 mg/min. Avoid in patients with CHF or QT prolongation.
Sotalol	Hemodynamic stable monomorphic VT: 100 mg (1.5 mg/kg) over 5 minutes Avoid in patients with CHF or QT prolongation.

In this article, I'll address common questions we receive about these new guidelines. Every patient case is unique due to their distinct risk factors, impacting the approach to their care. To provide an accurate diagnosis, I'd need to review your documentation. Using a differential diagnosis helps support the level of problem addressed and tests ordered. Chronic conditions are defined as lasting at least 1 year or until the patient's death. A chronic condition is considered stable when the patient has met their specific treatment goals. When evaluating patients with non-presenting chronic conditions, these factors increase data complexity and risk of complications. When considering an exacerbation versus a severe exacerbation, it's crucial to understand that the former doesn't require hospital-level care, while the latter usually does. After completing a year of training, I suggest conducting an external audit to assess your clinical opinion based on documentation and identify areas for improvement. In-house audits should focus on

outliers by acuity or diagnosis groups. The 2021 E/M guidelines have introduced significant changes, making it essential to understand them thoroughly to build confidence in your billing practices.

1. Code Accurately and ThoroughlyAccurate coding is crucial for timely reimbursement. Ensure that documentation supports the level of service billed, including necessary modifiers.

4. Use Modifiers CorrectlyModifiers can significantly impact reimbursement and claim processing. Familiarize yourself with common modifiers used in urgent care billing and apply them appropriately to avoid claim denials and ensure accurate reimbursement.

5. Stay Informed about Coding ChangesStay current with updates and changes to billing codes and guidelines by subscribing to industry newsletters, attending coding seminars, and regularly reviewing coding manuals. Implement updates promptly to maintain compliance and maximize revenue.

6. Resolve Denials EfficientlyDevelop a process for appealing claim denials, including gathering supporting documentation and resubmitting claims if necessary. Monitor denial trends to identify areas for improvement and implement strategies to minimize future denials.

7. Leverage Technology Utilize billing software and EHR systems designed for urgent care billing to streamline workflows, reduce manual errors, and improve efficiency.

8. Train Staff EffectivelyProvide comprehensive training on urgent care billing practices and procedures to your staff. Offer ongoing education to keep them informed about updates and changes in urgent care billing regulations and guidelines. Foster a culture of compliance and accuracy to minimize errors and maximize revenue.

ConclusionBy following these best practices for urgent care billing, you can navigate the complexities of this process with confidence and efficiency. With accurate coding, thorough documentation, correct use of modifiers, staying up-to-date on coding changes, efficient denial resolution, leveraging technology, and effective training, you can streamline your billing process and optimize revenue for your urgent care practice.