Adding Value to the ED Practice - Observation Services Structured for Success

MCEP $traight Talk 2017
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CHIEF COMPLAINT: "He may have accidentally ingested some drugs."

HISTORY OF PRESENT ILLNESS: The patient is an almost 3-1/2-year-old little boy who found a baggy with at least one pill in it while playing out in the front yard at his grandparents. Apparently, it was not any of the family members medications. The parents noticed that he had this plastic baggy that had a pill in it. They asked him if he had taken any. His story vacillates between no and yes, so it is unclear. He was brought in here to be checked out.

REVIEW OF SYSTEMS: As above. He has had no vomiting. He has been fine other than a recent mild cough. No change in mental status. He seems completely normal. The child is inconsistent with his history. All other systems are negative.

EMERGENCY DEPARTMENT COURSE: Poison Control was consulted. He was case #1 5. Their recommendation was that he be given charcoal 1 gm/kg if he would drink it voluntarily, not to be forced upon him. He drank it right down, 15 gm. He was to have an initial EKG, which was performed showing sinus rhythm and rate of 82 with normal intervals and no ectopy. He has an EKG prior to discharge. He should be watched for six hours in the emergency room with q.1h. fingerstick blood sugars. His initial fingerstick was erroneous. He must have had sugar on his finger. It was over 300. I had it rechecked and it was 102. Subsequent fingerstick blood sugars ran in the 90s to 110 range. He was observed for the rest of the possible ingestion period. We were able to identify the single tablet in the plastic bag and it is a morphine tablet. The patient exhibited no signs of any toxidrome. His repeat EKG just prior to discharge though showed a sinus rhythm and rate of 77 with flipped T waves in the anterior leads with normal intervals. This is unusual in appearance. I spoke with Poison Control again about the EKG findings. They did not feel this was due to any known toxidromes, nor am I aware of any. The child looks fine. They agree he can safely be discharged.

IMPRESSION/DIAGNOSIS: Possible accidental drug ingestion.

Overt Obs for Previous Chart

- "OBS Note: Patient has **no significant** family history. Observation was begun at **11:15** and was necessary in order to determine **whether he would experience toxic effects requiring admission.** Upon re-evaluation, observation **and a second EKG** revealed that the patient could be **discharged**, which was done at **17:15.**

Emergency Dept. Observation

- Hospitals are reporting more observation care in the ED setting due to changes in hospital reimbursement.
- Facility obs payment for 2018 - package services makes this easier to report, has increased hospital obs payments.
- ED groups billing for obs - always been a problem. Often, emergency physicians spend a considerable amount of time with these patients for no additional payment.

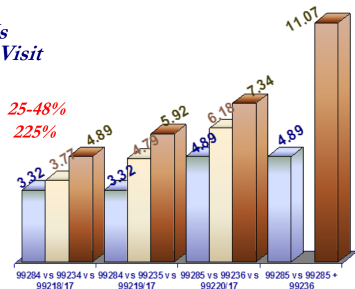
Emergency Physician Observation

- No pay for observation care and an emergency E/M service by the same physician group on the same day.
  - Prolonged care (99354-99357) was never the solution, though it's now reportable in addition to obs for some cases. (Obs E&Ms now have "average FTF times")
- Emergency code or observation code, but (almost) never both - Exceptions
  - ED E&M before midnight, Obs service initiated after midnight, requires two entirely separate charts. With no obs unit, separate charting is unnecessary and obs is rolled into E&M.
  - ED E&M and Critical Care, same patient, same day, is reportable to Medicare for obs but not for ED.
- Obs Unit OR Virtual Obs – status only, no separate unit

ED Physician Observation – 2018 RVUs

Observation RVUs Compared to ED Visit Levels

99285 vs 99220/217 *25-48%*
99236 + 99285 *225%*



ED Physician Observation – The Value

Who benefits from observation:

- Patient – keeps them from having to "survive" an admit, (though the public perception is that obs status means the hospital is greedy and you should have been admitted.)
- Hospital – gets paid for "soft rule-outs" that PROs may be denying
- ED Staff – brings resources from the inpatient setting down to the ED, may help throughput
- The Attendings – keeps them seeing patients in the office, makes room for admissions of higher value
- Payers – save significant money from reduced admissions
- The ED Physician - ???

Acute Care Spectrum Specialists – Partner with Your Hospital

- Consider staffing the Obs Unit, Critical Care, Hospitalists, Urgent Care and Outpatient Clinics. You measure in minutes what others measure in days. ED docs are good at decisions with limited information.
- Billing implications – denials of admissions and same-day ED visits, urgent care visits, obs cases.
  - MIPS measure reporting is easy for 2018, only 3 applicable measures but one, #407 MSSA for Bactremia, is rare
  - MIPS applicable for Obs now: **#1 Diabetes: A1c Control, #47 Care Plan.** Check again January, 2018.
  - MIPS ED: **#47 Care Plan, #130 Med Rec, #226 Tobacco Screening, #317 HBP Screening, #415 CT Minor HI**
- Best practice – create separate entities to relieve billing conflicts and sequester risk.

Acute Care Spectrum Specialists – Partner with Your Hospital

Ex. "***ABC ED, Inc.***", 10 partners, staffs ED

Forms "***ABC Obs, Inc.***" with a separate tax ID to staff the Clinical Decision Unit.

- Seek counsel - can all partners own or single partner with profits returned to ABC Emergency through management services agreement.

1. Provider with ***ABC ED*** treats ED patient, admits to ***ABC Obs*** and sees and treats same patient – Not Recommended.
2. Provider with ***ABC ED*** treats ED patient, admits to different provider in ***ABC Obs*** – Recommended.

- BONUS SLIDES – Recognizing and Documenting Medically Necessary Obs Care

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