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

MCEP Straight Talk 2017
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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

<table>
<thead>
<tr>
<th>Visit Level</th>
<th>RVUs</th>
<th>2017%</th>
<th>2018%</th>
</tr>
</thead>
<tbody>
<tr>
<td>99285</td>
<td>2,500</td>
<td>25%</td>
<td>48%</td>
</tr>
<tr>
<td>99236</td>
<td>99285</td>
<td></td>
<td>225%</td>
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<tr>
<td>2018 RVUs</td>
<td></td>
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</tbody>
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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 oscillates 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 cold cough. No change in mental status. He seems completely normal. The child is consistent with his history. All other systems are negative.

EMERGENCY DEPARTMENT COURSE: Poison Control was consulted. He was case 415. Their recommendation was to not be given charcoal 1 gr/kg if he would drink it voluntarily, not to be forced upon him. He drank it right down, 15 gr. He was to have an initial EKG which was performed showing sinus rhythm and rate of 62 with normal intervals and no ectopy. He has an EKG prior to discharge. He was to be watched for 4 hours to ensure that there was no hypoglycemia, and no finger stick blood sugars. The initial finger stick was erroneous. He must here had sugar on his finger. It was over 300. I had it rechecked and it was 107. Subsequent finger stick 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 wheelchair primer. The parents exhibited no signs of the ingestion. His repeat EKG just prior to discharge showed a sinus rhythm and rate of 77 with flat 3 waves in the anterior leads with normal intervals. This is unusual in appearance. I agree with Poison Control again about the EKG findings. They did not feel this was due to any known toxicity, but as I aware of any. The child looks fine. They agree he can safely be discharged.

IMPRESSION/DIAGNOSIS: Possible accidental drug ingestion.
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

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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