The 6th Annual 2018 Observation Medicine - Science & Solutions conference was recently held in Charleston, NC and featured a prestigious faculty of Observation leaders/authors, medical directors, and advanced practice providers, two tracks for those starting or expanding their observation unit, a new session Innovations and Research in Observation Medicine and well attended by participants from the east to west coasts.

Stay tuned for a Save the Date for the 7th Annual conference!

Captions:

Sharon Mace, MD, FACEP, FAAP, Medical Director of the Cleveland Clinic Observation unit and Editor of the Observation Medicine Principles and Protocols textbook giving an informative lecture on caring for the geriatric patient in the observation unit.

Matthew Wheatley, MD, FACEP, Medical Director of the Grady Memorial Hospital Clinical Decision Unit giving an interesting lecture on observation unit staffing.

This article was discussed during the last Observation Committee meeting. Here are the cliff notes:

Financial Viability of Emergency Department Observation Unit Billing Models

Baugh CW, Suri P, Caspers CG, Granovsky MA, Neal K, Ross MA.

*Acad Emerg Med*. 2018 May 16.

Observation volume has been steadily increasing across the country and there is a wide variety of staffing models. Current Procedural Terminology (CPT) policies predate modern observation care and prohibit professional billing for emergency services and observation services on the same date of service

by physicians from the same specialty and same group. If ED physicians (same group, same tax ID) also staff an OU, they are forced to bill for observation services instead of emergency services as both services are considered bundled into the single observation payment. However, if physicians provide observation services (most commonly in unstructured setting) under a different group/different tax ID then both the ED and observation encounter can be billed separately. This is the distinction between the one-service versus two- service models.

In this study, the annual and daily net financial impact of staffing an EDOU with an emergency physician using the one-service and two-service models at commonly used staffing levels and a range of daily patient encounters was modeled. Monte Carlo simulation was used.

The two-provider model becomes independently financially viable at a volume of 20 patients per day. The one-provider model is not financially viable at any volume without hospital subsidization, but loss is minimized near a throughput of 10 patients per day.

The article concludes by stating that reforms that remove restrictive professional billing practices are needed to encourage hospitals of all sizes to deploy the EDOU model, creating long-term value for patients, hospitals and payers.

The Observation Medicine section meets quarterly. Please contact [margarita.pena@ascension.org](mailto:margarita.pena@ascension.org) if you are interested in joining us.

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