ED Observation Units

Gwinnett Medical Center, Lawrenceville, Georgia

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- President, GES Observation Services

Objectives

- Understand potential benefits
- Operational considerations
- Coding and billing
- Documentation

The Problem

- Average ED LOS Nationally = 5.5 hours
- Average Hospital LOS = 3-5 days
- Increased RAC scrutiny of <24 hour hospital admits
- Defines subset of 6 - 24 hour patients

Three Choices

1. Prolonged ED stays
2. Inpatient bed anywhere in the hospital under outpatient observation status
3. Place in dedicated observation unit

- Accelerated Diagnostic or Therapeutic Protocol

Evolution of ED Observation Units

- Initial ED Observation Units = 30 years ago
- 2003 National Survey (Graff):
  - 19% of US hospitals with ED Observation Units
  - 12% planning
- 2003 Survey of Academic Centers:
  - 36% of US hospitals with ED Observation Units
  - 45% planning
- 2007 National Ambulatory Care Survey
  - 36% of US hospitals with ED Observation Units
  - 50% of those managed by the ED
- Current ACEP policy recognizes that dedicated ED Observation Units (rather than general inpatient beds or ED acute care beds) is best practice
- Requires commitment of staff and resources

Emory Study

Characteristics of the 18 Participating Hospitals

- Total Number ED visits – 1.28 million
- Total Number Hospital Responders – 18
- Average Number Hospital Beds – 602 (+/- 213)
- Hospital Inpatient Occupancy Rate – 82.3% (+/- 8.5%)
- Average ED Visits in 2007 – 75,570 (+/- 24,895)
- Average Number ED Beds – 59 (+/- 19)

Dr. Ross, et, al, Emory University

Emory Study Continued	
Average Number of Beds in the EDOU	13.3 (+/- 7.4)
Percent of ED census that is observed	7.2% (+6.7)
Number of EDOU beds per ED beds	4.25 ED beds / 1 EDOU bed
Number of EDOU beds per ED visits	1 EDOU bed / 7,461 ED visits
Daily number of EDOU patients / EDOU bed	1.14 patient / bed / day
Average Number ED Patients	4,430 (+/- 3,478)

Dr. Ross, et, al, Emory University

What Is Observation?

CMS Definition

Observation services is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Must be reasonable and necessary.

- Clinical determination usually made within 24 hours; although can sometimes span two or even three calendar days
- Observation is an outpatient hospital status; not inpatient
- Two Overnight Rule to be effective in 2014

Observation Services Are Those Services:

a) Furnished on a hospital's premises
b) Includes use of a bed/periodic monitoring by nursing and other staff
   - Location of the bed is not important
c) Reasonable and necessary
d) To evaluate a patient's condition
e) Determine the need for possible admission as an inpatient
f) Ordered by a physician
g) Usually to not exceed one day – but may go up to 48-72 hours

Services Not Qualified for Observation Status

- Observation services for the convenience of the patient or physicians that are not medically necessary and do not qualify
- Outpatient treatment procedures
- Routine pre or post operative services related to an ambulatory procedure visit
- Planned overnight stays after surgery
- Stay waiting for extended care facility placement
- Concurrent observation care with other outpatient encounters like chemotherapy, radiation therapy or dialysis
- Observation prior to planned procedure or surgery

Observation Must Be Ordered Prospectively

- Can retrospectively assign due to long delays or does not meet admit criteria
- Time is a diagnostic tool to determine stability of the patient or diagnosis
- For facility, Condition Code 44 is exception

Gwinnett Medical Center – Lawrenceville

- Annual ED Volume (2012):
  – Adult = 71,500
  – Pediatric = 30,037
- Admission Rate:
  – 15% all patients
  – 21% adult only
- Level II Trauma Center
- Certified Stoke Center
- Certified Chest Pain Center

Gwinnett Medical Center – Duluth

- Annual ED Volume (2012):

– Adult and Pediatric = 39,296

ED Observation Unit

- Closed unit (ED physicians only - Protocol driven)
- 10 bed unit on the 4th floor
- Private rooms with remote telemetry
- Volume = 2,803 (FY13 - billed patients)
- Average daily census = 7.68
- Average length of stay = 10.93 h
- Hours of operation = 24/7
- Staffing:
  - Nursing = Flex 5:1 ratio
  - Tech/Secretary = 1 at all times
  - 1 dedicated Midlevel (8a-4p) (+ PI Rad Reviews)
  - 1 ED supervising Physician 24/7

Potential Benefits of ED Observation

ED and ED Physicians	Hospital
• Improved throughput • Risk management – less inappropriate discharges • Reduced LWBS • Improved patient satisfaction • Decreased ALOS • Decreased patient	• Decreased unnecessary admissions – time to decide • Free up inpatient beds • Improve efficiency and LOS – for short term cases • Avoid EMS diversion: 15% volume accounts for 34% of admissions

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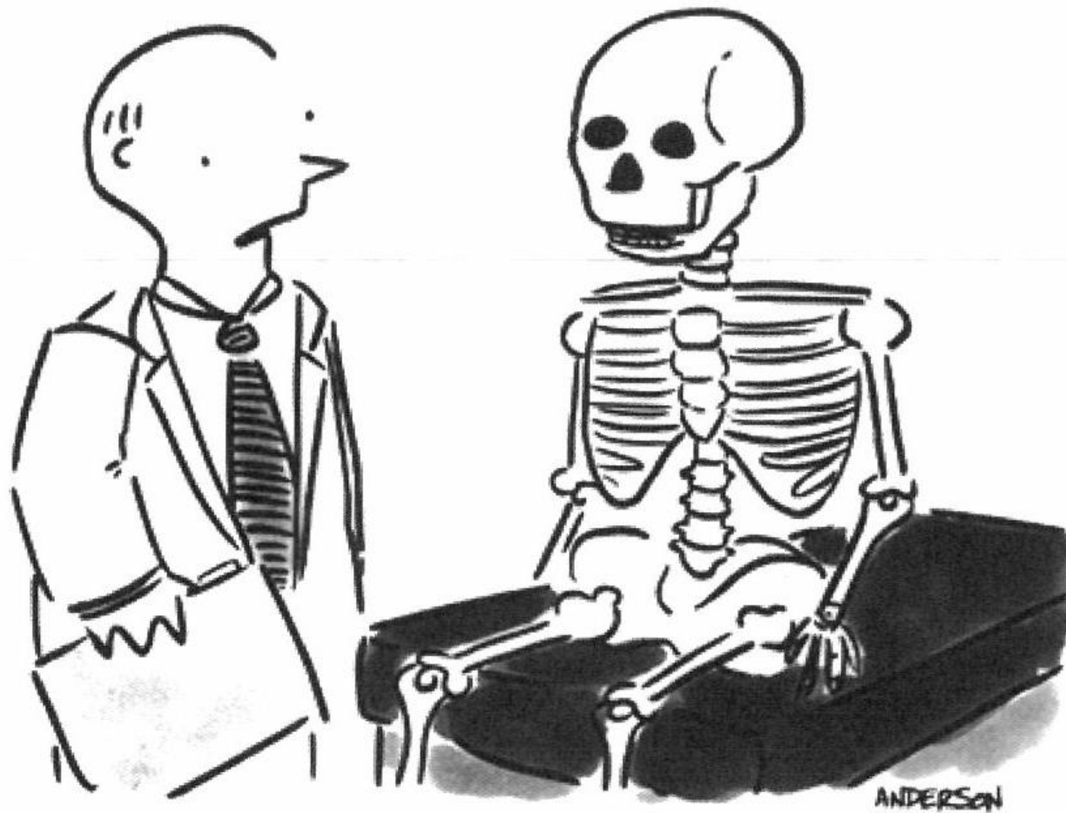
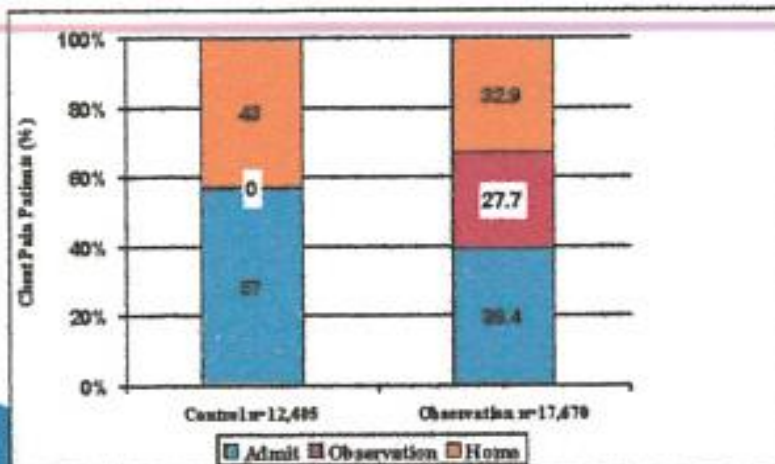


"Still, let's do an x-ray just to be sure."

Observation of selected conditions has been found to decrease the rate of missed diagnoses

- Decreased rate of missed MIs (4% to 0.4%) while admitting fewer patients.
  - Evidence – Graff / CHEPER, Pope



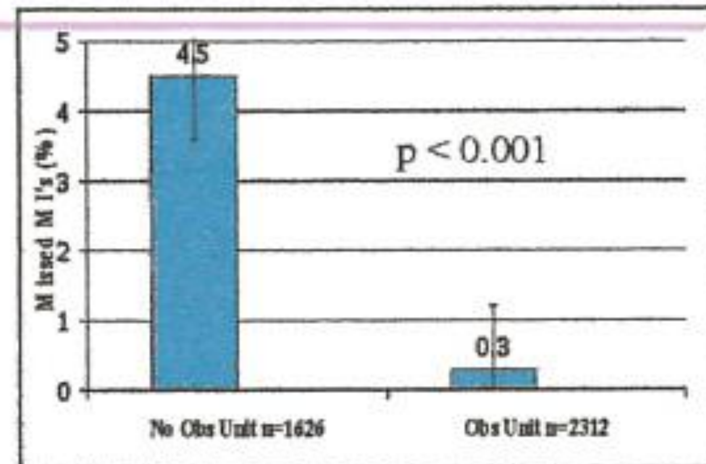
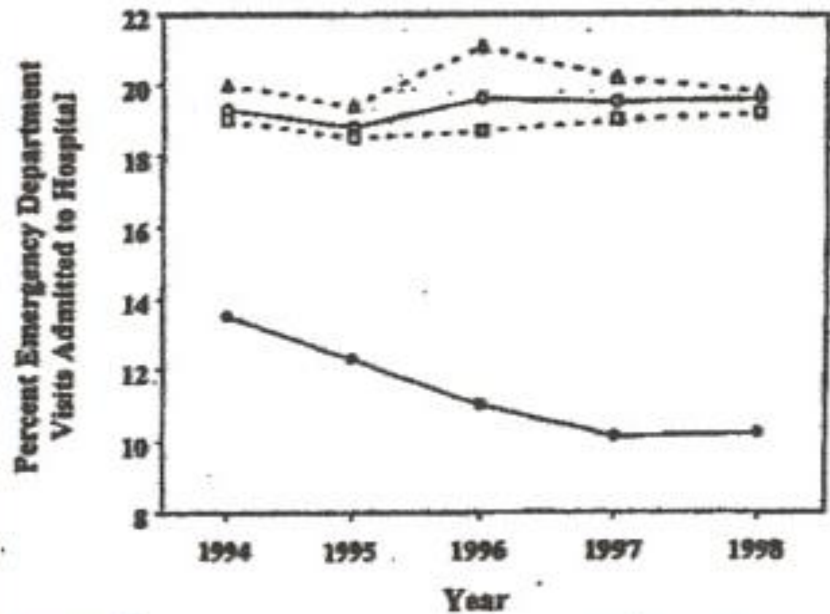


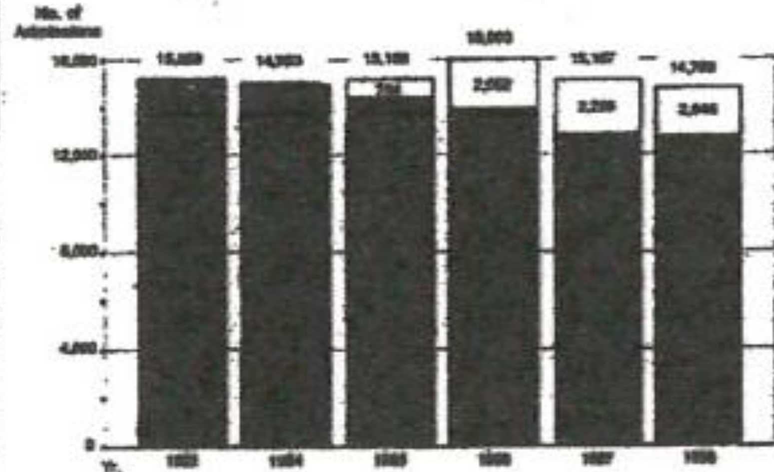
TABLE 2. Randomized Controlled Studies: EDOU Protocol vs. Inpatient Care

Condition (author/year)	No. Patients (Follow Up Period)	Primary End Point	Primary Outcomes*	Secondary Outcomes
Atrial fibrillation (Decker 2008)[33]	153 (6 months)	Conversion to sinus rhythm or rate control	Higher conversion to sinus (85% vs. 73%)	Less time to conversion (10.1 vs. 25.2 hours) with comparable clinical outcomes
Transient ischemic attack (TIA) (Ross 2007)[20]	149 (90 days)	Index visit length of stay and cost	Decreased index visit length of stay (25.6 hours vs. 61.2 hours), and lower 90-day total direct cost ($890 vs. $1547)	Fewer admissions (15% vs. 100%), more carotid imaging (97% vs. 91%) and echocardiography (97% vs. 73%). Comparable clinical outcomes
Syncope (Shen 2004)[34]	103 (2 years)	Diagnostic yield and hospital admission rate	More patients had an established diagnosis than by ED visit alone (67% vs. 10%), with fewer admissions (43% vs. 98%)	Fewer hospital bed days (64 vs. 140). Comparable survival (97% vs. 90%) and syncope free survival (88% vs. 89%) rates
Asthma (McDermot 1997; Rydman 1999)[17,35]	222 (8 weeks)	Hospitalization rate, relapse rate.	Lower admission rate (59% vs. 100%), with no difference in relapse rates	Lower cost ($1,202 vs. $2,247) and significantly higher global satisfaction outcomes in all areas
Chest pain (Farkouh 1998)[36]	424 (6 months)	Major adverse cardiac event (MACE) rate and resource utilization rate	No difference in MACE (3.3% vs. 7.1%) with lower resource utilization (RVUs)	
Chest pain (Roberts 1997)[18]	165 (8 weeks)	Length of stay and cost	Decreased index visit length of stay (33.1 vs. 44.8 hours) and total cost ($1528 vs. $2098)	Similar rehospitalization rates (6.1% vs. 4.8%), no deaths in either group
Chest pain (Gomez 1996)[37]	100 (30 day)	Length of stay and cost	Decreased index visit length of stay (11.9 hours vs. 22.8 hours) with lower 30-day costs ($898 vs. $1522)	No death or missed MI in either group

*EDOU outcome reported first, control (hospitalization) reported second.
RVU indicates relative value unit.

ED Observation Units increase hospital capacity





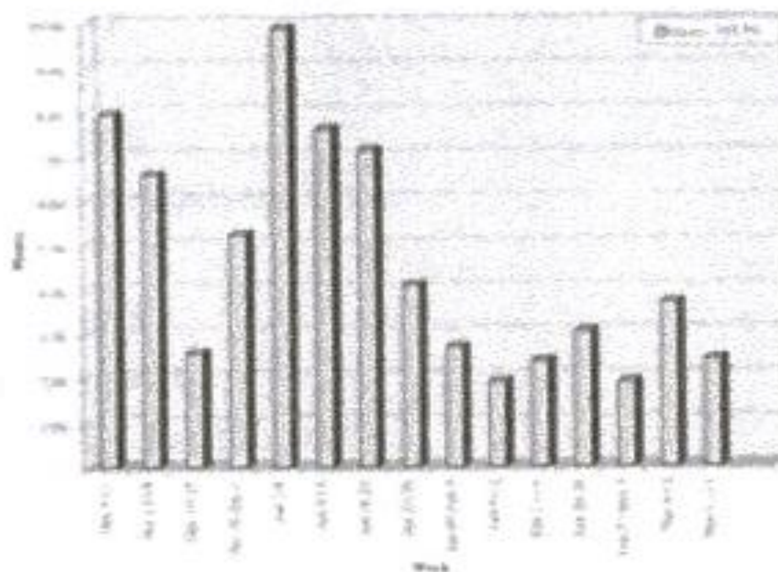
Martinez et al. The observation unit: a new interface between inpatient and outpatient care. Am J Med. 2001;110:274-277.

Effect of an ED managed acute care unit on ED overcrowding and EMS diversion

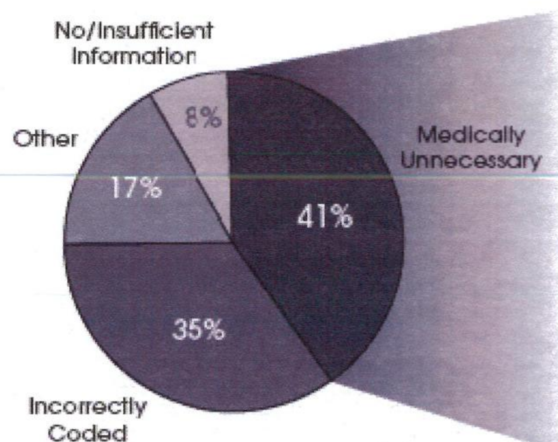
Kelen et al, Acad Emerg Med 2001;8:1095–1100

- Opened an EDOU
  - 54,000 visit/yr ED
- Before – after study design looking at:
  - Patients who left without being seen
  - EMS diversion hours
- RESULTS – Patients who left without being seen:
  - **Before = 10.1% of ED**
  - **After = 5.0% of ED census**

- EMS diversion hours:
  - **Before = 6.7 hr/100 pts**
  - **After = 2.8 hr/100 pts**



A Justifiable Concern Over 1-Day Stays



Top Five Medically Unnecessary Services

Paid Claims Error Rate, 2007

Service Type	(DRG)	Paid Claims Error Rate	Projected Improper Payment
Chest Pain	(143)	20.1%	$118M
Medical Back Problem	(243)	15.5%	$59M
Esop[2]/Gastroent[3]/Misc Digestive Disorder	(182)	11.9%	$164M
Nutritional/Metabolic Disorder	(296)	10.7%	$99M
Circulatory, Card Cath[4] WO Comp[5]	(125)	9.8%	$46M

Clinical Advisory Board Interview and Analysis, March 12, 2009

Observation Visit Lengths-Of-Stay Across Three Study Groups.

Emory/Grady
United States
Georgia
Percent of observation visits
0
2
4
6
8
8
16
24
32
40
48
56
64
72
80
88
96+
Length-of-stay (hours)

Ross M A et al. Health Aff 2013;32:2149-2156

HealthAffairs

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Emory Study
Type I Observation Unit

- 23%-38% shorter length of stay
- 17%-44% lower probability of subsequent inpatient admit
- $950 million in potential national cost savings per year
- 11.7% of short stay inpatients nationwide could be treated in Type I Observation Unit
- Savings of $5.5-$8.5 billion annually

Health Affairs December 2013, Dr. Michael Ross, et al.

Medicare Readmission Penalties

- ACA 2010 effective October 2012
- Frequency of 30 day readmission for 3 conditions
  - CHF, AMI and Pneumonia
- Hospital is compared to national readmission rates
- Outliers penalized (all Medicare payments):
  - Oct 2012: 1%
  - Oct 2013: 2%
  - Oct 2014: 3%

Observation Care Potential Negative Impact on Medicare Beneficiaries

- Medicare beneficiaries liable for approximately 20% of outpatient services, including observation
- In some situations, the full cost of self administered drugs provided
- Prolonged outpatient encounters do not count towards statutory 3 day minimum for SNF placement

What Conditions May Benefit

Diagnostic Uncertainty	Therapeutic Intensity – Short Term
• Single System Complaint R/O • More precise diagnosis needed to determine inpatient versus discharging home • Further diagnostic or monitoring needed	• Diagnosis established • Single system disease process • Reasonable expectation that intensive short term treatment may prevent admission • Requires treatment beyond length of typical ED stay

Gwinnett Medical Center Observation Protocols

1. Abdominal Pain / Possible Appendicitis, Colitis, Enteritis, Diverticulitis
2. Allergic Reaction Orders
3. Anemia
4. Asthma
5. Atrial Fibrillation
6. Cellulitis
7. Chest Pain / Cardiac Syncope
8. Dehydration
9. Drug Overdose
10. Hyperemesis
11. Hyperglycemia
12. Hypertensive Urgency
13. Pneumonia
14. Pyelonephritis
15. Renal Colic (Kidney Stone)
16. Vertigo

Other Possible Observation Protocols

1. Back Pain
2. Congestive Heart Failure
3. TIA
4. DVT
5. Croup
6. Hypoglycemia
7. Seizure
8. GI Bleed
9. Headache
10. COPD
11. Snake Bite
12. Minor Head Injury
13. Rectal Bleeding

Common Pediatric Conditions Managed in ED Observation Units

1. Asthma
2. Dehydration
3. Gastroenteritis
4. Pneumonia
5. Abdominal Pain
6. Seizures
7. Fever
8. Bronchiolitis
9. Croup
10. Poisonings

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"Apparently he was sitting on a wall."

Type of Unit

Closed Unit

- Admitting physicians limited to ED or ED/Hospitalist
- Patients in a designated
- Dedicated

Open Unit

- All physicians can admit
- May not be in one geographical area
- Patients may be taken care of by

Dedicated Unit Model

- Benefits
  - Protocol driven
  - Get needed tests quicker
  - Decreased length of stay
  - Ongoing costs potentially lower
  - Improved patient satisfaction
- Downside
  - Expensive to create
  - Requires increased staff
  - Requires dedicated space and resource allocations

Inpatient Scattered Model

- Benefits
  - No increased cost for the start-up
  - Easy to implement
  - No increased staffing
  - Use existing beds
- Downside
  - Inconsistency in checking results
  - Inconsistency in documenting appropriately
  - Delays in care
  - Increased length of stay
  - Decreased patient satisfaction
  - Resource intensive

Why ED Closed Unit

- Physician accountability and availability
- ED Mindset
  - Goal is to discharge as soon as patient is ready
- Inpatient bed = One stop shopping
- Most observation patients come from the emergency department

Dept Name	# Accounts	OBV Charges	Average OBV Hours Per Case	Average Daily Census	Average Length of Stay
Medical – PCU	82	$ 80,383.00	24.56	.22	1.02
Medical – Tel	862	$ 790,738.00	22.86	2.36	.95
Medical	291	$ 279,996.00	23.96	.80	1.00
Ortho – Surgical	317	$ 318,198.00	25.25	.87	1.05
Surgical	143	$ 128,049.00	21.62	.39	.90
Medical – Oncology	221	$ 239,246.00	26.51	.61	1.10
Medical Unit	192	$ 216,266.00	28.37	.53	1.18
Cardio ICU	7	$ 5,741.00	18.29	.02	.76
ICU	5	$ 3,474.00	16.20	.01	.68
Labor and Delivery	2	$ 2,771.00	16.00	.01	.67
Total Non ER	2,098	$ 2,064,862.00	24.47	5.75	1.02
ED Observation Unit	2,803	$ 1,545,654.00	10.93	7.68	.46

Policy and Procedures

- Clearly defined Inclusion and Exclusion Criteria to the unit in general and diagnosis specific
- Clearly defined standards of which physician and/or midlevel is responsible for each patient in the area
- Delineation of emergency physician and nursing staff responsibilities throughout the day and transfer of care between providers
- Circumstances that require notification of the responsible physician
- Maximum allowable LOS and means to handle outliers
- Description of how utilization and quality measures will be monitored and reported

Exclusion Generally

- Indecision – No clear diagnosis or plan
  - Rounding rule
- Unwanted patients – Clearly needs to be admitted but admitting service does not want
- Elderly with intensity of nursing issues – Multiple medications or mobility issues

ATRIAL FIBRILLATION

I. Transfer Criteria

A. Stable vital signs HR < 120 consistently for one hour with treatment
B. Normal lytes (except mild to moderate hypokalemia)
C. Low to normal dig level (if indicated)
D. Stable underlying cardiac disease – no evidence of CO-morbidity, (MI, CHF, PE, CVA)
E. Onset ≤ 48 hours
F. No chest pain after rate control
G. No ischemic changes on EKG

II. Exclusion Criteria

A. Unstable vital signs (HR over 120 after Emergency Department treatment)
B. Myocardial infarction
C. Unstable angina or ongoing chest pain
D. Significant concomitant dysrhythmia
E. Cardiac Tamponade
F. New embolic disease (PE, peripheral arterial)
G. Severe hypokalemia
H. Moderate to severe CHF
I. Hypertensive emergency
J. Chronic atrial fibrillation – onset > 48 hours or unknown

III. CDU Interventions

A. Serial exams and vital signs every 6 hours
B. Supplemental Oxygen
C. Continuous EKG monitoring
D. Pulse Oximetry
E. Meds:
- Digitalis
- B Blockers(caution with CHF or calcium channel blockers)
- Ca + Channel blockers (caution with CHF, hypotension and B blockers)
- Anticoagulants (requires consultation)
- Corvert administration
- Elective Cardioversion – requires cardiology consultation

III. Disposition Criteria

Home
A. Stable vital signs
B. Control of rate or conversion to NSR

Admission
A. Failure to correct to NSR
B. Cardioversion planned
C. Development unstable VS or chest pain

IV. Time Frame
10 hours

V. Quality Indicators

		Threshold
1.	Length of stay < 10 hours	(>90%)
2.	Hospital Admissions	(<20%)
3.	ICU admissions	(<5%)
4.	Return within 48 hours	(<10%)

5. All adverse outcomes will be reviewed by Medical Director.

GI BLEED

I. Transfer Criteria

- A. Abnormal HCT/HG values
- B. Previous GI history
- C. History of dark stool (or bright red blood) in last 24-48 hours
- D. Guaiac positive stool (not gross melena)
- E. No more than 2 episodes of bright red blood
- F. Guaiac positive NG drainage – no gross blood
- G. Stable VS – minimal orthostatic changes

II. Exclusion Criteria

- A. Unstable VS
- B. More than 2 episodes of bright red bleeding
- C. Significant orthostatic changes or other signs of active bleeding
- D. EKG Changes
- E. Temperature > 102.5
- F. Drop of Hct > 10 in 4 hours
- G. History of coagulopathy or esophageal varices

III. CDU Interventions

- A. Serial HCT/HGB
- B. Guaiac stools/emesis
- C. IV Hydration H_2 blocker
- D. Frequent VS
- E. NG irrigation
- F. Possible preps for Endoscopy Procedures

IV. Disposition

- **A. Home**
  1. Normal or stabilized serial exams/HCT
  2. Stable VS
  3. No deterioration in clinical condition
  4. Per GI consult
- **B. Hospital**
  1. Continual decrease in HCT/HG valves
  2. Increase in bright red bleeding, acute bleeding
  3. Deterioration in clinical condition
  4. High risk for ongoing blood loss
  5. Per GI consultation

V. Time Frame

- A. 20 hour observation

VI. Quality Indicators Threshold

1. Length of stay < 12 hours (>90%)
2. Hospital Admissions (<20%)
3. ICU admissions (<5%)
4. Return within 48 hours (<10%)
5. All adverse outcomes will be reviewed by Medical Director.

Gwinnett Hospital System

PLACE LABEL HERE

ASTHMA ORDERS
Emergency Department

The following orders will be implemented. Orders with a "❑" are choices and are **NOT** implemented unless checked.
Initial all handwritten order modifications and the bottom of each page when indicated (multipage).

1. Diagnosis & Status: Place in Observation for Asthmatic Bronchitis
2. Private Physician: ❑ None ❑ ______________________ Time Contacted ____________
3. Consults: ______________________________________
4. Diagnostics: Call all panic labs except those that are consistent with previous labs or if otherwise directed by physician
5. Laboratory: ❑ CBC, BMP, Urinalysis if not done
   ❑ Urine C&S
6. EKG if not done and patient > 50 years of age or has coexisting cardiovascular disease
7. Radiology: ❑ CXR PA and lateral clinical indication: shortness of breath
8. ❑ May be off telemetry for tests and transport
9. Vital signs: ❑ q 4 hrs ❑ q _____ hrs
10. Continuous pulse oximetry monitoring.
11. Respiratory Care to evaluate and treat per protocol (# 7504-10-03-01)
    or
    ❑ Albuterol 5 mg per inhalation q 3 hrs and prn
    ❑ Albuterol 5 mg per inhalation q 3 hrs and prn plus Atrovent (ipratropium) 0.5 mg q 6 hrs while awake
    ❑ Xopenex (levalbuterol) 1.25 mg per inhalation q 6 hrs and prn
    ❑ Xopenex (levalbuterol) 1.25 mg plus Atrovent (ipratropium) 0.5 mg per inhalation q 6 hrs while awake and prn
    ❑ Other ______________________________
12. Peak expiratory flow rate (PEAK flow) pre and post every respiratory treatment
13. O_2 per Respiratory Care Protocol (7504-10-01-03)
    - Adjust O_2 to maintain SpO2 $\geq$ 90% or 88% in COPD. Call physician for O_2 usage $\geq$ 4 L/min or $\geq$ 40%.
    - Reassess daily, wean O_2 to maintain SpO_2 > 90% or 88% in COPD. Wean to room air if SpO_2 is acceptable and patient has no known exclusions per 7504-10-01-03. May restart O_2 as needed.
14. Notify physician for clinical deterioration of respiratory status, fever, unstable vital signs or inability to maintain pulse ox > 92% on supplemental oxygen
15. Diet: ❑ Clear liquids ❑ Full liquids ❑ Regular ❑ __________ Consistent Carb diet
16. Activity (advance as tolerated):
    ❑ Bedrest ❑ Bedside Commode ❑ Bathroom privileges
    ❑ Up ad lib ❑ Up with assistance

HOME MEDICATION ORDERS: to be administered while in observation:

❑ No Home Medications

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Send copy to pharmacy Order writer's initials ________

PLACE LABEL HERE

ASTHMA ORDERS
Emergency Department

The following orders will be implemented. Orders with a "❑" are choices and are **NOT** implemented unless checked.
Initial all handwritten order modifications and the bottom of each page when indicated (multipage).

SCHEDULED MEDICATIONS:

17. IVF: ________________________ IV at ________________ ml/hr
18. ❑ SoluMedrol (methylprednisolone) 40 mg IV q 6 hrs
19. ❑ Aminophylline infusion 400 mg/500 ml (theophylline 500 mg/ml) D5W at ______ ml/hr
20. ❑ Singulair (montelukast)10 mg po q PM

PRN MEDICATIONS (See policy 520-06 for range orders and pain intensity guidelines)

21. If patient receiving insulin, initiate Hypoglycemia Treatment Protocol (form # 2513)
22. Mild Pain, Temp >100.5°F, HA: Tylenol (acetaminophen) 650 mg po or PR q 4 hrs prn❑
23. Nausea/Vomiting:
    Zofran (ondansetron) 4 mg IV or po q 6 hrs prn
    ❑ If N/V persists, add Reglan (metoclopramide) 10 mg IV q 6 hrs prn (5 mg if > 65 y/o)
    and/or ❑ If N/V persists, add Phenergan(promethazine) 12.5-25mg po or per rectum q 4hrs prn
24. Sleep: Ambien (zolpidem) 5-10 mg po at HS prn. If 5 mg given, may repeat x 1 dose after 2 hrs
    If > 65 year old, begin with 5 mg po at HS, may repeat x 1 dose after 2 hrs
    or ❑ DC Ambien. Give: ______________________________
25. Indigestion: Maalox XS (aluminum/magnesium/simethicone) 30 ml po four times daily prn
26. Stool Softener: Colace (docusate) 100 mg po bid prn; if patient has not had a bowel movement
27. Constipation: Milk of Magnesia (MOM) 30 ml po daily prn
28. Anxiety : Ativan (lorazepam) 0.5 - 1 mg po or IV q 8 hrs prn
    or ❑ DC Ativan. Give Xanax (alprazolam) 0.25 - 0.5 mg po q 6 hrs prn
29. Cough: Robitussin (guaifenesin) 15 ml po q 4 hrs prn
    If cough unrelieved by guaifenesin, give Hycodan (HYDROcodone/homatropine) 5ml q 4 hrs prn

ADDITIONAL ORDERS:

____

____

____

____

Date	Time	Physician Signature	PID Number

Send copy to pharmacy

FORM 3-16337 REV. 10/2013

Gwinnett Hospital System

PLACE LABEL HERE

PYELONEPHRITIS ORDERS
Emergency Department

The following orders will be implemented. Orders with a "❑" are choices and are **NOT** implemented unless checked.
Initial all handwritten order modifications and the bottom of each page when indicated (multipage).

1. Place: Observation for Acute Pyelonephritis
2. Private Physician: ❑ None ❑ ________________________ Time Contacted: ______________
3. Consults: ____
4. Laboratory: UA and Urine Culture and Sensitivity if not already done ❑ CBC ❑ BMP
   ❑ hCG female > 12 years of age with no known sterilization
   ❑ Repeat CBC in 8 hrs from ED draw
   ❑ Other: ______________________________
5. Radiology ______________________________________
6. Vital signs: ❑ q 4 hrs ❑ q _____ hrs
7. Notify physician for: systolic BP > 200 or < 90
   diastolic BP >110 or < 40
   heart rate > 130 or < 50
   respirations > 30 or < 8
   temperature > 101
   inability to tolerate oral fluids after 20 hrs or increased abdominal pain
8. Diet: ❑ NPO ❑ Clear Liquids as tolerated ❑ Advance to full liquids or bland diet
9. Activity (advance as tolerated):
   ❑ Bed Rest ❑ Bedside commode ❑ Bathroom privileges
   ❑ Up ad lib ❑ Up with assistance

HOME MEDICATION ORDERS: to be administered while in the emergency department:
❑ No Home Medications

____
____
____
____
____

SCHEDULED MEDICATIONS:

10. IVF: ______________________________ at __________ml/hrs IV
11. IV antibiotic
    ❑ Cipro (ciprofloxacin) 400 mg IV q 12 hrs
    ❑ Rocephin (ceftriaxone) 1 gm IV x 1 dose
12. Oral antibiotic: When patient able to tolerate oral liquids and 1-2 hrs before anticipated discharge, give first dose of oral antibiotic if patient has not received IV antibiotic in the last 12 hrs
    ❑ Bactrim DS (trimethoprim/sulfamethoxazole) 1 tablet po x 1 dose
    ❑ Cipro (ciprofloxacin) 500 mg po x 1 dose
    ❑ Other: ______________________________

Send copy to pharmacy **Order writer's initials** ________

PLACE LABEL HERE

PYELONEPHRITIS ORDERS
Emergency Department

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Initial all handwritten order modifications and the bottom of each page when indicate (multipage).

PRN MEDICATIONS See policy 520-06 for range orders and pain intensity guidelines.

13. If patient receiving insulin, initiate Hypoglycemia Treatment Protocol (form # 2513)
14. Severe Pain: Morphine 1-4 mg IV q 4 hrs prn
15. Moderate Pain:
    Norco (HYDROcodone/acetaminophen) 5/325 mg or 10/325mg 1 tab po q 4 hrs prn
    or ❑ DC Norco. Give Percocet (oxyCODONE/acetaminophen) 5/325 mg or 10/325 mg 1 tab po q 4 hrs prn
16. Mild Pain, Temp >100.5°F, HA: Tylenol (acetaminophen) 650 mg po or PR q 4 hrs prn
17. Nausea/Vomiting:
    Zofran (ondansetron) 4 mg IV or po q 6 hrs prn
    ❑ If N/V persists, add Reglan (metoclopramide) 10 mg IV q 6 hrs prn (5 mg if > 65 y/o)
    and/or ❑ If N/V persists, add Phenergan(promethazine) 12.5-25mg po or per rectum q 4hrs prn
18. Sleep: Ambien (zolpidem) 5-10 mg po at HS prn. If 5 mg given, may repeat x 1 dose after 2 hrs
    If > 65 year old, begin with 5 mg po at HS, may repeat x 1 dose after 2 hrs
    or ❑ DC Ambien. Give: ______________________________
19. Indigestion: Maalox XS (aluminum/magnesium/simethicone) 30 ml po four times daily prn
20. Stool Softener: Colace (docusate) 100 mg po bid prn; if patient has not had a bowel movement
21. Constipation: Milk of Magnesia (MOM) 30 ml po daily prn
22. Anxiety : Ativan (lorazepam) 0.5 - 1 mg po or IV q 8 hrs prn.
    or ❑ DC Ativan. Give Xanax (alprazolam) 0.25 - 0.5 mg po q 6 hrs prn.
23. Cough: Robitussin (guaifenesin) 15 ml po q 4 hrs prn
    If cough unrelieved by guaifenesin, give Hycodan (HYDROcodone/homatropine) 5ml q 4 hrs prn

ADDITIONAL ORDERS:

____
____
____
____

Date ________ Time ________ Physician Signature ________________ PID Number ________

Send copy to pharmacy

Cellulitis Risk Stratification Observation

CELLULITIS PAIN RISK STRATIFICATION TOOL

UNACCEPTABLE DIAGNOSIS FOR OBSERVATION: SOCIAL ADMIT, FAILURE TO THRIVE, DIZZINESS, UNABLE TO CARE FOR SELF, NEEDS PLACEMENT, UNABLE TO AMBULATE, CHRONIC ... (ANYTHING)

Level of Care determination after Risk Stratification (Check One): ☐ Observation ☐ Admit (Use the appropriate admission order forms)

IF PATIENT MEETS ANY OF THE BELOW CRITERIA , THEN HE/SHE MUST BE ADMITTED, NOT OBSERVED.

*****DO NOT PROCEED TO PAGE 2. HOWEVER THIS RISK STRATIFICATION MUST BE COMPLETED & PLACED IN THE CHART*****

ADMISSION CRITERIA (criteria that exclude the patient from observation level of care)

- ☐ Septic or toxic appearance, T > 102F, wbc > 20,000
- ☐ Immunosuppressed
- ☐ Involves periorbit or orbit, neck, or >9% TBSA
- ☐ Extensive tissue damage, sloughing
- ☐ Deeper process: abscess, osteomyelitis, deep wound, supsicion of necrotizing fascitis
- ☐ Patient unable to care for self at home
- ☐ Patient already failed outpatient treatment
- ☐ Unstable vital signs
- ☐ Bite or puncture wound
- ☐ Post op infection
- ☐ Associated with diabetic ulcer

PATIENT MUST MEET ALL OF THE BELOW CRITERIA FOR OBSERVATION - CHECK APPLICABLE BOX(ES)

*****THIS RISK STRATIFICATION MUST BE COMPLETED AND PLACED IN THE CHART.*****

OBSERVATION CRITERIA (inclusion criteria that make observation level of care a possibility)

- ☐ H and P consistent with cellulitis
- ☐ Require > 1 dose parenteral antibiotics

Observation Unit Disposition Decision

Criteria		Decision
WBC nearly normal or significantly improved	All	**HOME**
Stable vital signs	criteria	
Taking po fluids and meds	present	
Area of cellulitis not increasing	Any	
No response to iv therapy, rising wbc	criteria	**ADMIT**
Inability to take po fluids or medicines	present	consider expert advice
Increase in skin involvement, fluctuance		
Temperatures failed to significantly improve		
Unable to care for self, no home care		

MD Signature: ____________ Beeper #: ______ Date: ______ Time: ______

Cellulitis Observation Physician Orders

ALLERGY STICKER

Date/Time:	Refer to Observation For Service of Dr. ______

DO NOT USE ABBREVIATIONS: µ, mcg, u, iu, QD, QID, QOD, B.I.W., T.I.W., MgS04, MS04, MS, HISS, RISS, AD, AU, AS

Please check box to activate the order. Cross out (X) any blank spaces prior to signing orders.

Non-Medication Orders	Medication Orders
DX: Cellulitis	☐ IV fluids:
☐ Vitals: q shift	@ ml/hr x liters
Diet (Check One): ☐ Regular/house ☐ Clear Liquids ☐ NPO	☐ Analgesics: use the pain control order set
☐ Carbohydrate Controlled (1800 kcal/day, no conc. Sweets)	**Antibiotics (check only one)**
☐ 2 gram Na ☐ Pureed ☐ Other:	☐ Cefazolin grams IV every hours
Acitivity (Check One): ☐ Ambulate ad lib	(usual dose for normal renal fx - 1 or 2 g IV q 8 hrs)
☐ OOB to BR* ☐ Ambulate with assist ☐ Other:	☐ Clindamycin 600 mg IV every 8 hours
*(For Lower Ext cellulitis OOB to BR recommended)	(For serious B-lactam allergy. If allergy NOT in Cerner,
☐ Insert Saline lock	Document Allergy **with reaction** e.g. hives, anaphalaxis, rash, etc)
Labs at (check box(es)): ☐ CBC ☐ lytes	☐ Vancomycin mg IV every hours
☐ other labs:	(usual dose is 15 mg/kg)
	Other considerations that would warrant different
☐ Notify MD for: HR < 55 or > 100	antibiotics include a history of an animal scratch, sea
RR < 12 or > 25	or aquarium exposure,or ticks. Consider expert advice
Temp < 96 F or > 100.4F	☐ Acetaminophen 650 mg PO/PR every
SBP < 100, SBP > 170, DBP > 120	☐ 4hrs ☐ 6 hrs (check one) PRN
SaO_2 < 90%	Pain Score 1 - 4 **and/or** Temp > 101F
☐ Care coordination consult	☐ For smokers: Nicotine (Nicoderm)
☐ Elevation of infected area	☐ 7 mg ☐ 14mg ☐ 21 mg (check one) patch topically Daily
☐ Venous Doppler/Ultrasound of ☐ L ☐ R lower extremety	☐ Heparin 5000 units SC every 8 hours
Indication	☐ Clotrimazole 1% cream topically twice daily to interdigital areas of feet
	Other Medications:

MD Signature: ____________ Beeper #: ______ Date: ______ Time: ______

Chest Pain Risk Stratification Observation
Page 1 of 2

CARDIAC PAIN RISK STRATIFICATION TOOL

UNACCEPTABLE DIAGNOSIS FOR OBSERVATION: SOCIAL ADMIT, FAILURE TO THRIVE, DIZZINESS, UNABLE TO CARE FOR SELF, NEEDS PLACEMENT, UNABLE TO AMBULATE, CHRONIC ... (ANYTHING)

Level of Care determination after Risk Stratification (Check One): ☐ Observation ☐ Admit (Use the appropriate admission order forms)

IF PATIENT MEETS ANY OF THE BELOW CRITERIA , THEN HE/SHE MUST BE ADMITTED, NOT OBSERVED.

*****DO NOT PROCEED TO PAGE 2. HOWEVER THIS RISK STRATIFICATION MUST BE COMPLETED & PLACED IN THE CHART*****

ADMISSION CRITERIA (criteria that exclude the patient from observation level of care)

- ☐ Diagnostic EKG changes or positive biomarkers
- ☐ Cardiac Risk Score 5 or greater points = moderate to high risk
- ☐ Continuing chest pain
- ☐ Unstable vital signs

PATIENT MUST MEET ALL OF THE BELOW CRITERIA FOR OBSERVATION - CHECK APPLICABLE BOX(ES)

*****THIS RISK STRATIFICATION MUST BE COMPLETED AND PLACED IN THE CHART.*****

OBSERVATION CRITERIA (inclusion criteria that make observation level of care a possibility)

- ☐ Cardiac Risk Score 2 to 4 points = low risk
- ☐ No continuing chest pain
- ☐ Stable vital signs

Observation Unit Disposition Decision

Criteria		Decision
Benign observation course	All criteria present	**DISCHARGE**
Stable vital signs		
Deterioration of clinical course	Any criteria present	**ADMIT**
Unstable vital signs or unstable dysrhythmia		
Diagnosis requiring inpatient admission		

HCC Cardiac Risk Score tool for Possible ACS

Non diagnostic EKG changes (1 point)
- ☐ EKG ST segment changes (< 1 mm ST seg change)
- ☐ OR T wave changes OR LBBB

Age / sex (1 point)
- ☐ (Male > 45 years old; Female > 55 years old)

Past history CAD (2 points)
- ☐ (Angina or PCI or Coronary surgery or MI)

Cardiac Risk Factors (up to 5 points)
- ☐ Family history of CAD
- ☐ hyperlipidemia
- ☐ diabetes mellitus
- ☐ history of smoking
- ☐ hypertension

Chest Pain (up to 3 points)
- ☐ substernal
- ☐ exercise related
- ☐ relieved with NTG

Chest Pain Equivalent (up to 4 points)
- ☐ syncope
- ☐ SOB/dyspnea
- ☐ rapid heart beat
- ☐ unexplained weakness

ADD UP TOTAL # POINTS ABOVE:

MD Signature: ______________ Beeper #: ________ Date: ________ Time: ______

HCC Form #1900 Revised 6-10 **Chest Pain Observation Physician Orders**

Chest Pain Observation Physician Orders
Page 2 of 2

ALLERGY STICKER

Date/Time:	Refer to Observation For Service of Dr. ______

DO NOT USE ABBREVIATIONS: µ, mcg, u, iu, QD, QID, QOD, B.I.W., T.I.W., MgS04, MS04, MS, HISS, RISS, AD, AU, AS

Please check box to activate the order. Cross out (X) any blank spaces prior to signing orders.

Non-Medication Orders	Medication Orders
INITIAL ORDERS:	**Aspirin Order (check applicable box)**
Dx: Chest Pain or Chest Pain Equivalent	☐ Aspirin 81 mg, chew 3 tabs PO now (unless taken in ED)
Cardiac Monitoring: Indication: (check one)	☐ Hold aspirin because **contraindicated**
☐ Chest Pain or ☐ Chest Pain Equivalent	☐ Patient received aspirin within 24 hours of hospital arrival
☐ Vitals: every 4 hours	☐ Acetaminophen 650 mg PO/PR every
☐ Saline lock / laboratory testing	☐ 4hrs ☐ 6 hrs (check one) PRN
☐ CK, CKMB, Troponin	Pain Score 1 - 4 **and/or** Temp > 101F
☐ Electrolytes, Creatinine, BUN	☐ Nitroglycerin paste ______ inches every 8 hours
☐ CBC with diff	☐ For smokers: Nicotine (Nicoderm)
☐ Glucose	☐ 7 mg ☐ 14mg ☐ 21 mg (check one) patch topically Daily
☐ Old Record to the Floor	**Other Medications:**
☐ EKG	
☐ CXR: Indication ______	
SUBSEQUENT ORDERS:	
☐ CPK/MB/Troponin I & EKG q 4 h x's 2	
☐ EKG prn for chest pain or dysrhythmia	
☐ Activity: Bedrest 4 h, then ambulate if stable & neg enzymes	
☐ May go off monitor for testing if stable	
☐ Diet : NPO from 4 am on ______ (Date)	
☐ Blood glucose before meals if glucose > 120 or diabetic	
☐ Cardiac Consult Dr.	
8a to 5p ☐ MD contacted by me at ____ m OR	
5p to 8a ☐ Message left for MD at #5276	
(Cardiologist to schedule stress study if appropriate)	

MD Signature: ______________ Beeper #: ________ Date: ________ Time: ______

Staffing

- Physician and/or Midlevel:
  - May be dedicated physician or midlevel provider depending on volume in the unit.
  - Must have responsible provider 24/7 when occupied
  - Must be immediately available to the unit
  - May have several duties
- Nursing:
  - 2003 Survey reported units were staffed with an average 4.2 patients per nurse.
  - In reality, 5 patients per nurse
  - American Journal of Emergency Medicine (MACE, et, al.)
  - Flexible staffing

Metrics

- LOS by diagnosis
- Percent of observation to inpatient conversion
- ICU admissions
- Number of patients / ED Observation beds / Day
- Financial measures
  - RVU per patient
  - Collections per patient
- PI review for appropriateness of admission

Coding and Billing

Facility Coding

Outpatient Prospective Payment System (OPPS)

APC 8002 – Level I Extended Assessment and Management Composite

Requires a level 99205 or 99215 clinic visit on the day of or the day before observation or a direct admission to observation.

In addition, at least 8 units of G0378 (Observation services, per hour)

For 2013, the APC 8002 payment is $440.07

APC 8002 – Level II Extended Assessment and Management Composite

Requires a level 99284 or 99285 Type A ED visit or level 99225 Type B ED visit or Critical Care on day, or day before, observation status.

Reimbursed as a single payment for the combination of an ED visit and observation.

For 2013, the APC 8003 payment is $798.47.

Medicare Outpatient Code Editor

- Physician order to place in observation
- A HCPCS 99284, 99285 or critical care code or G0384 ED code billed same day or day before.
- Minimum of 8 hours excluding off floor/monitored procedure time.
- Under the care of a physician or midlevel during the time of observation care and documented appropriately in medical record with documentation of placing patient in observation status, progress note, discharge note, timed and signed.

Calculating Observation Time

Facility and Professional

- Starts: Time physician writes order to place in observation status.
- Ends (facility): When ALL clinical or medical interventions are completed including nursing follow up care after discharge orders are written (not time waiting for transportation).
- Ends (professional): When physician writes discharge order.
- Must exclude any time patient out of observation area without accompaniment of RN.
- Must exclude any time that a separately billable procedure was performed that required active monitoring.

Same Day Observation: 99234-99236

CPT Code	Code Description	Criteria for Use
99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date. Usually presenting problem(s) requiring admission are of low severity.	1. Requires these 3 key components: detailed or comprehensive history; detailed or comprehensive examination; medical decision making is straightforward or of low complexity. 2. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date. Usually presenting problem(s) requiring admission are of moderate severity.	1. Requires these 3 key components: comprehensive history; comprehensive examination; medical decision making of moderate complexity. 2. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same	1. Requires these 3 key components: comprehensive history; comprehensive examination; medical decision making of high complexity. 2. Counseling and/or coordination of care with other ith the /or

Medical record must clearly state that the patient is in "observation status" and clearly indicate that the patient was "observed" and "discharged from observation."

History, Examination & Medical Decision Making MUST be met for EACH of these three levels.

Initial Observation: 99218-99220

CPT Code	Code Description	Criteria for Use
99218	Initial observation care, per day, for the evaluation & management of a patient. Usually the problem(s) requiring OBS status are of low severity	Requires these 3 key components: detailed or comprehensive history; detailed or comprehensive examination; and medical decision making is straightforward or of low complexity.
99219	Initial observation care, per day, for the evaluation and management of a patient. Usually, the problem(s) requiring OBS status are of moderate severity.	Requires these 3 key components: comprehensive history; comprehensive examination; medical decision making of moderate complexity
99220	Initial observation care, per day, for the evaluation and management	Requires these 3 components: comprehensive history; comprehensive examination; and [illegible] lexity.

Per CPT, only the provider who is listed as the physician of record can report the initial observation E&M code.

Documentation must include the four components.

1 – Notation that the patient was placed in "observation status"
2 – Notations of periodic patient reassessments
3 – A discharge from observation evaluation
4 – A post-discharge from observation care plan

Discharge from Observation: 99217

CPT Code	Code Description	Criteria for Use
99217	Observation care discharge day management.	Utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is other than the initial date of "observation status." Documentation should support that the provider was personally present and performing this service

Per CPT, coding of the discharge from observation "…is to be utilized by the physician to report all services provided to a patient on discharge from "observation status…."

In order to code, there should be personal documentation by the "observing" provider indicating their presence and face-to-face service were provided.

Final decision of patient status or PE
Discontinuation of OBS care
Final diagnosis
Follow up instructions
Discharge instructions

Used with Codes 99218-99220

Subsequent Days: 99224-99226

CPT Code	Code Description	Criteria for Use
99224	Low severity – 15 minutes	Level 2 H&P and Low MDM plus OBS
99225	Moderate severity – 25 minutes	Level 3 H&P and Moderate MDM plus OBS
99226	High severity – 35 minutes	Level 4 H&P and High MDM plus OBS

New Codes in 2011

All require 2 of 3 components

LOS Criteria – CMS 8 Hour Rule

Professional Codes – Medicare

- Same day codes (99234-99236)
  - Must stay 8 hours
  - ED time is not included
  - Time of observation order to time discharged
- If same day, but less than 8 hours
  - May use initial day codes 99218-99220
  - Do not use 99217 with them
- CPT specifies mandatory 40-55 minutes as guidelines but no specific constraints

CPT Codes List "Typical" Times

Observation Times Provider "could" spend bedside or on Unit in direct care.

CPT Code	
99218	Initial observation care 30 minutes at bedside/unit/floor.
99219	Initial observation care 50 minutes at bedside/unit/floor.
99220	Initial observation care 70 minutes at bedside/unit/floor.
99234	Same day observation care 40 minutes at bedside/unit/floor.
99235	Same day observation care 50 minutes at bedside/unit/floor.
99236	Same day observation care 55 minutes at bedside/unit/floor.

Medicare (8 hour rule)

If a patient is admitted to OBS status…

- and discharged on the same calendar day AND the time in OBS status is less than 8 hours, use codes 99218-99220. Do not assign discharge code 99217.
- and discharged on the same calendar day AND the period of time is greater than 8 hours, use codes 99234-99236, as they represent a full day of care.
- on one calendar day and discharged on the following calendar day, you may use codes 99218-99220 for the initial day of observation, and 99217 for the day of discharge.
- and then admitted to the hospital on the same calendar day, you may code OBS codes 99234-99236 IF the period of time in OBS status is >8 hours. If the time is <8 hours, use codes 99218-99220.
- on one calendar day and admitted to the hospital on a subsequent calendar day, it is appropriate to code both the initial OBS code 99218-99220 for the initial day and 99217 for the day of discharge.
- on one calendar day and remains in OBS status for more than two

Documentation

99234-99236: Observation Same Day

Level	HPI	ROS	PSFH	PE	MDM
99234	Detailed (4)	Extended (2-9)	Pertinent (1)	5-7	Low
99235	Detailed (4)	Complete (10)	Complete (3)	8	Moderate
99236	Detailed (4)	Complete (10)	Complete (3)	8	High

Observation MDM Criteria

3 out of 3 History, Exam and MDM determine level			
History Type:	Detailed or Comprehensive	Comprehensive	Comprehensive
Examination Type:	Detailed or Comprehensive	Comprehensive	Comprehensive
Decision Making::	Straightforward/Low	Moderate	High
Obs CPT / Codes	99218	99219	99220
Observation Admit Discharge (same day)	99234	99235	99236

Physician Documentation

- Detailed History and PE (99218 & 99234)
  - HPI – 4 Elements
  - PFSH – 1 Area
  - ROS – 2 Systems
  - PE – 5-7 Organ Systems
- Comprehensive History and PE (99219/99220/99235/99236)
  - HPI – 4 Elements
  - PFSH – 3 Areas
  - ROS – 10 Systems
  - PE – 8 Organ Systems

Physician Documentation

- Same Specialty / Same Group
  - Emergency visit H&P as usual documented to the standard of a 4 or 5 E&M level
  - ** Beware of 3 of 3 PFSMH criteria
    - Need past medical history
    - Need social history

    AND
    - Need family history
- Timed and documented order to place in OBS status
- ED Observation progress note – Not mandatory
- ED Observation transfer note
  - Decision to place in observation
  - Reason for observation
  - Plan and end-point
  - Progress notes as warranted
  - Observation discharge note

Observation Discharge

Documentation Requirements (Code 99217)

- Discharge time does not need to be reported
- Discharge summary should include:
  - Final exam of the patient
  - Dates of admission/discharge
  - Discharge diagnosis
  - Discharge medication
  - Disposition/follow up
  - Hospital course - chronological summary of events, treatments, x-ray/lab/other test results, consultations, response to treatment, treatment instructions after discharge and prognosis.

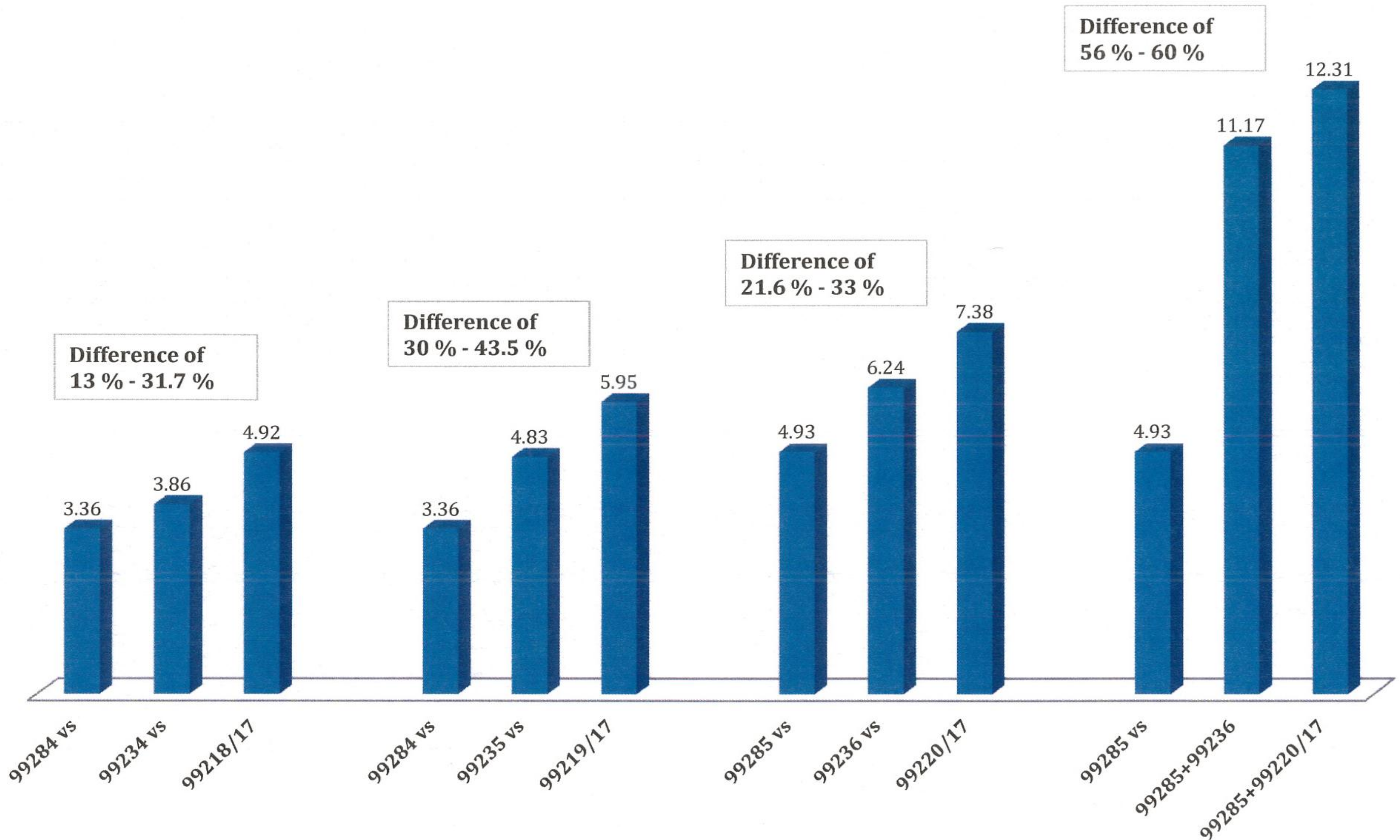
Financials

2013 RVU Rates

ED E/M Service	Total RVU	Overnight Observation	Total RVU	Same Day Observation	Total RVU
99284	3.36	99217	2.08	99234	3.86
99285	4.93	99218	2.84	99235	4.83
		99219	3.87	99236	6.24
		99220	5.30		

99217 + 99220 = 7.38 Total RVU

Obs RVUs Increase over ED Visit Levels



Economics of an Independent Obs Unit

- 10 Bed Unit
  - Turned 1.3 times per day
  - Blend moderate and high = 5.5 RVU / case
  - 71 RVUs …. $34 per RVU…. $2,400 daily…. $100 per hour
  - Cost: Hourly salary, overhead
  - Difficult to cover off shifts
  - Midlevel coverage with physician oversight
  - Shared ED shift / Observation supervision responsibility
  - Need volume to be profitable
  - Flexible nurse / staff coverage

Can I Bill for Both E&M and Observation?

Can your medical group bill for ED services and observation services if two different physicians are involved or use of midlevels ?

- Medicare:
  - If both physicians of the same specialty, same group – only one service may be billed – not both.
  - Answer is the same if one is a midlevel.
- CPT:
  - Strictly speaking, same specialty/same group does not apply but in practice, most payors apply the same rules.

The Observation Roll Up

American Medical Association

"When observation status is initiated in the course of an encounter in another site of service (e.g., hospital emergency department) all evaluation and management services provided by the supervising physician in conjunction with initiating the observation status are considered part of the initial observation care when provided on the same date."

CPT 2013

Billing for Both E&M and Observation

- Staff the observation unit with a physician/midlevel who performs only the observation care
  - Not the same who provided the ED care
- Bill observation under a separate Medicare Number (Tax ID Number) from all emergency care
- Must have separate full history and physical, order for observation and discharge note

Physician Rule Change 2011

- Final OPPS rule added new classification of services (nonsurgical extended duration therapeutic services)
  - Last significant period of time
  - Low risk
  - Requires substantial monitoring
  - Medicare beneficiaries liable for approximately 20% of outpatient services, including observation
- Direct supervision relaxed to general supervision once patient is stable as deemed by physician
- Direct – Physician or midlevel immediately available for further assistance and direction throughout procedure – does not need to be in room
- General – Care furnished under the physician's overall direction and control

Physician Documentation

Separate Entity / Tax ID Number

- Full history and physical exam to a level 5 ED visit PLUS 3 of 3 PFSMH by a physician or midlevel from the OBS service
- Timed and dated order for observation from the admitting physician
- Progress notes as warranted
- ED observation discharge note

Coding Overview

Sub Category	2013								2012	
	All		July		August		September		All	
	Freq	% Pts Seen	Freq	% Pts Seen	Freq	% Pts Seen	Freq	% Pts Seen	Freq	% Pts Seen
Observation 1 (99218/99234)	776	35.13 %	72	28.35 %	67	21.90 %	74	35.75 %	864	31.51 %
Observation 2 (99219/99235)	141	6.38 %	13	5.12 %	17	5.56 %	12	5.80 %	238	8.68 %
Observation 3 (99220/99236)	1289	58.35 %	169	66.54 %	222	72.55 %	121	58.45 %	1634	59.59 %
Other E&M (992xx)	0	0.00 %	0	0.00 %	0	0.00 %	0	0.00 %	1	0.04 %
All	0	0.00 %	0	0.00 %	0	0.00 %	0	0.00 %	0	0.00 %
# of Admits & Transfers		388		50		58		35		435
Acuity Rate		17.56 %		19.69 %		18.95 %		16.91 %		15.86 %
CPT / Visit		1.81		1.83		1.84		1.82		1.68
RVU / Visit		3.96		4.08		4.17		3.95		3.89
Charges / Visit		$ 615.44		$ 638.19		$ 656.22		$ 612.72		$ 610.85

As I suspected, you're full of bacteria. We're going to have to throw you away.

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5-8-09