# *ED Observation Care*

| | |
|---|---|
| **What is it?** | Patients are admitted to an observation status when time is one of the determinants of ultimate disposition. The purpose is to determine the need to admit. If you know when you walk in the room that pt will be admitted to the hospital, then it is not an observation case. Likewise, if assessents are complete but you are just waiting for pt to be moved physically (discharge, transfer, inpatient bed), this is not observation.<br>Observation encompasses *lack of diagnostic certainty* (e.g., abd pain) or *therapeutic intensity* (dehydration, COPD, asthma) that requires reevaluation. |
| **Which patients should be considered?** | In general, any patient that will be undergoing testing, therapies, evaluations &/or assessments (imaging, repeat exams, response to therapy) that will keep patient in dept 3-4 hours or more before final decision about disposition will be made. The amount of time is somewhat arbitrary and is not specified *except* by Medicare. |
| **What types of conditions?** | Asthma, allergic reaction, COPD, chest pain, SOB, abd pain (including pts undergoing CT abd pelvis w/ PO/IV contrast), flank pain, pelvic pain, dehydration, inebriation, trauma, alteration mental status, syncope, vaginal bleeding, overdose, etc. |
| **Where?** | Observation is a status, not a physical location. Observation can occur in the ED as long as requirements are met. |
| **What about Medicare?** | Medicare rules require either: 1) 8 hours of observation ***or***<br>2) observation that crosses midnight (i.e. spans 2 calendar days). |
| **What has to be documented?** | Major template (99285) level documentation that must include comprehensive *History*, *PMedHx*, *Social Hx*, *Family Hx* (can be as simple as "reviewed and not pertinent", comprehensive *ROS* (10 systems or phrase such as "all systems reviewed and otherwise negative", and comprehensive *Physical Exam*<br>*(Family history must be included to qualify for billing)* |
| **How do I do it?** | Document the following:<br>✥ time of entry (admission) to Observation Status;<br>✥ reason for obs;<br>✥ therapeutic interventions, response to therapy, reevaluations, test results & clinical course during obs status;<br>✥ time of release from Obs |
| ***Observation template*** | [*Pt*] was admitted to observation status within the ED at [*time*] for further assessment [or *response to therapy*, etc.] for [*clinical reason*]; after [*brief summary of tests, response to therapy, serial exam, imaging*, etc] it has been determined at [*time of discharge from obs*] that pt can be discharged [or *admitted for additional care*] |
| **Why bother?** | As a benchmark, let's use 99285, which represents the highest compexity of patient we see (short of critical care). 99285 would encompass most admissions, such as chest pain, abdominal pain, etc., and many of our big workups that are later discharged. For 2010, cpt 99285 allows 4.74 RVU. The corresponding, properly documented (same day) obs code is 99236, and the RVU for that is 5.84. Now, the $$ per RVU differs contractually by insurer, but this represents **23% increase in allowable billing**. |