

**Agency for Health Care Administration
State Center for Health Statistics**

**Document Abstract
January 2006**

Title: **Emergency Department Utilization Report**

Summary: The Florida Agency for Health Care Administration (AHCA) has prepared a report on emergency department (ED) costs and utilization in Florida. AHCA initiated collection of all visit records to a hospital ED, beginning with visits in January 2005. This report describes demographic and other characteristics of visits to the ED and presents preliminary data on factors that have implications for hospital costs.

Between 1994 and 2004, the number of ED visits in Florida increased by 40.9%, while there was a decrease of 5.3% in the number of EDs. Several factors may affect ED utilization including, federal and state laws, population growth, proportion of the uninsured, access to providers, and patient and provider preference.

The data reveal that almost 70% of visits were to persons under age 45 years and that visits by females were 18.5% higher than males. The majority of visits had an acuity level of low to moderate, and Medicare accounted for the largest proportion of high-acuity visits. Among the most frequent principal diagnoses were upper respiratory infection, middle ear infection and viral infection.

Future Policy Implications: The increasing utilization, and potential misutilization, of emergency department services poses challenges to Florida's health care delivery system. Analysis of the data in AHCA's ED database should direct policymakers to find opportunities for the containment of costs.

Relevant Florida Statutes: Section 408.062(1)(i), F.S., directs the AHCA to conduct a study on the use of emergency department services by patient acuity level.

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Executive Summary

The hospital emergency department (ED) is the one place where a person cannot be denied services regardless of ability to pay, and also serves as the provider of last resort. Presently there are pressures on EDs that may affect utilization. In Florida over the past ten years the number and rate of ED visits have increased, while the number of hospital EDs has decreased and the percentage of the uninsured has increased as well.

In 2004, the Legislature authorized AHCA to conduct a study of ED utilization and costs, specifically, conduct a study on *the use of emergency department services by patient acuity level and the implication of increasing hospital cost by providing nonurgent care in emergency departments* (s. 408.062(1)(i), F.S.). Simultaneously, AHCA initiated collection of all visit records to a hospital ED, beginning with visits in January 2005. This report describes demographic and other characteristics of visits to the ED and presents preliminary data on factors that have implications for hospital costs.

Between 1994 and 2004, the number of ED visits in Florida increased by 40.9%, while there was a decrease of 5.3% in the number of EDs. Several factors may affect ED utilization including, federal and state laws, population growth, proportion of the uninsured, access to providers, and patient and provider preference.

The data source for this report was the AHCA's ED database, encompassing records collected January through March 2005. However, the complete database was not yet available, and it contained approximately 33.3% of the number of visits as estimated by AHCA hospital financial data. That is because the process of reporting ED visits to AHCA is new to the facilities, resulting in some data reporting difficulties and discrepancies. It is expected that next year's ED annual report will represent a complete database. Nevertheless, the preliminary results depict the type of analyses that can be achieved.

The data reveal that 69.3% of visits were to persons under age 45 years and that visits by females were 18.5% higher than males. The majority of visits had an acuity level of low to moderate, and Medicare accounted for the largest proportion of high-acuity visits. Among the most frequent principal diagnoses were upper respiratory infection, middle ear infection and viral infection.

Based on the results of the data analysis, the following recommendations are suggested: (1) The analysis of the AHCA ED database should be encouraged to focus efforts on specific areas of utilization and cost that can be identified from these data, and (2) the AHCA hospital inpatient database should also be analyzed to determine the extent of hospitals' problems with providing services on an emergency basis.

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Introduction

Hospital emergency departments (ED) provide the first line of response to life-threatening injuries and illnesses. The ED is the one place in the health care delivery system where a person cannot be denied services regardless of insurance coverage or ability to pay. The ED also serves as the provider of last resort for persons who cannot access care elsewhere.

While the importance of the ED in the delivery of health care is undeniable, there are pressures on EDs that can affect utilization and ultimately compromise care. The number and rate per population for ED visits have increased over the past ten years at both the national and state level. In Florida, the number of hospital EDs has decreased over that time, while the percentage of uninsured individuals, who may use the ED as a provider of last resort, has increased. Facing these trends in ED utilization, the Florida Legislature acted to study the situation in depth so that recommendations may be devised and implemented.

Legislative Directions and Mandates

The 2004 Affordable Health Care for Floridians Act (Chapter 2004-297, Laws of Florida) authorized the State Center for Health Statistics (State Center) of the Agency for Health Care Administration (AHCA) to conduct a study of ED utilization and costs. Section 408.062(1), F.S. states that the agency shall conduct research, analyses, and studies relating to health care costs and access to and quality of health care services as access and quality are affected by changes in health care costs. Such research, analyses, and studies shall include,

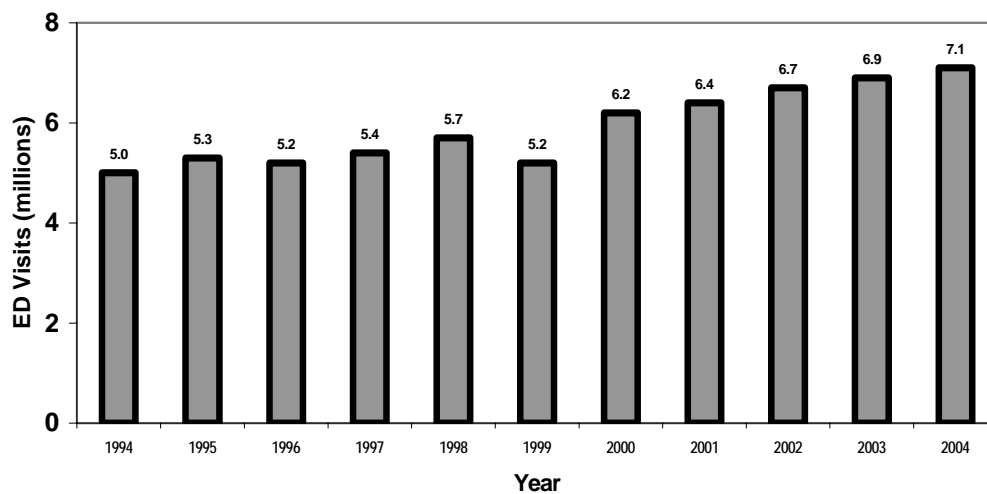
- (i) The use of emergency department services by patient acuity level and the implication of increasing hospital cost by providing nonurgent care in emergency departments.

As a means for achieving this goal, the State Center initiated collection of patient records for all visits to a hospital ED, beginning with visits in January 2005. The ED database is intended to give researchers and policymakers a more detailed look at the reasons why people seek care at the ED, the costs and the payers for these visits, and the diagnoses seen and procedures performed in that setting.

State and National Trends in Emergency Department Utilization

Visits to EDs across the United States reached a record high of nearly 114 million in 2003, even though the number of EDs decreased by 12 percent from 1993 to 2003, according to the National Center for Health Statistics (NCHS).¹ Similar figures are seen for Florida, which had record high visits to the ED in both 2003 and 2004. **Figure 1** shows the growth in ED visits from 1994 to 2004. Between 1994 and 2004, the number of ED visits in Florida increased by 40.9%. Accounting for increases in population, the visit rate per 1,000 persons increased by 12.9% over the same period.

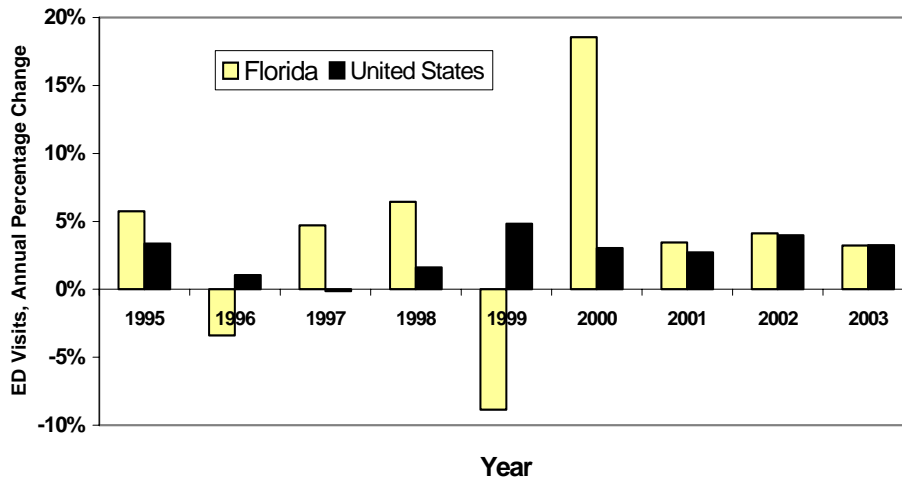
Figure 1
Emergency Department Visits
Florida, 1994-2004



Source AHCA Hospital Financial database

A comparison of the annual percentage change in ED visits for Florida and the United States from 1994 to 2003 is presented in **Figure 2**. From 1994 to 2003, visits increased by 26.2% in the U.S. and by 36.8% in Florida.

Figure 2
Annual Percentage Change in
Emergency Department Visits
Florida and the United States, 1995-2003



Source AHCA Hospital Financial database; NCHS/NHAMCS

Other specific trends in Florida ED utilization include:

- A decrease of 5.3% in the number of EDs from 226 in 1993 to 214 in 2003.
- An increase of 43.7% in the average number of ED visits per day, 1993-2003.

National trends spotlighted in the 2003 NCHS report based on the NHAMCS survey include the following:

- From 1993-2003, the number of ED visits increased 26%. The U.S. Population rose 12.3% during this period and the 65 and over population rose 9.6%.
- In 2004, persons 75 and older continued to have the highest rate of ED visits (61.1 per 100 persons), while the next highest rate was for persons aged 15-24. Preliminary data for Florida revealed highest rates for ages 0-14.
- The most common reason given for an emergency department visit was abdominal pain (6.5%), chest pain (5.1 %) and fever (4.8%).
- The most frequently reported primary diagnoses were contusions (4.3%), upper respiratory infections (4.0 %), and open wounds.

Factors Affecting Utilization of Emergency Departments

Studies at both the national ² and state ³ level have sought to isolate factors that may affect utilization and costs of ED services. Some of the findings are summarized below.

Federal Laws Governing Emergency Services

Federal and state mandates require hospitals and physicians to provide emergency care regardless of ability to pay. In 1986, the U.S. Congress passed the Emergency Medical Treatment and Labor Act (EMTALA) that requires all hospital emergency departments to perform, within the capabilities of the hospital, an appropriate medical screening examination and, if the individual requires emergency treatment, to treat or stabilize the patient for transfer to another facility. Under EMTALA, emergency care cannot be delayed due to methods of payment or insurance coverage.

Population Growth

Florida is one of the fastest growing states in the nation. Current population survey data indicate that Florida's population grew by 24.8% between 1994-2004. Among the fastest growing segments are those of ages 75 and older and ages 0-24. These groups are more likely to need emergency care than middle age populations. National data indicate that the emergency department use rate for those of ages 75 years and older was 642 per 1,000 as compared to 442 per 1,000 for adults age 15-24.¹ Preliminary, incomplete data for Florida shows the reverse, where visit rates were higher for ages 15-24 than those for ages 75 and higher. That is not surprising given that younger age groups are more likely to be uninsured than the elderly.

Insurance Status

In many states, overcrowding of emergency departments has been attributed to the increased numbers of uninsured. National surveys have found that the uninsured are more likely to use emergency care than those that are privately insured.³ According to data from the Census Bureau's *Current Population Survey*, the percentage of uninsured in Florida increased by 20.2% between 1990 and 2001.

Furthermore, the Florida Legislature's Emergency Services Task Force³ reported that approximately 8.8% of all patients admitted through the emergency department in 2000 had coverage of "Self Pay" or "Charity." However, although EDs are sometimes thought to be magnets for indigent patients, the typical ED patient has insurance and indigent patients do not constitute a disproportionate share of ED patients.³ Thus, the rise in the percentage of uninsured cannot be the sole cause of increased ED utilization.

Access to Providers

Access to health care providers also affects emergency department use. If providers are not accessible, people are more likely to use emergency departments. Rural areas tend to have greater access issues for their populations. Also, if patient care is not properly managed due to lack of access to appropriate specialty or other care, emergency departments may in fact be used more frequently as the patient continues to have health problems.

As Florida changes, so has the extent of available medical services. Today, most health care specialties are available in Florida, although at the community level this is increasingly untrue. Unfortunately, many of these are not available to everyone all of the time. Another problem concerns the lack of specialty care physicians to staff the EDs. Evidence indicates that obstetricians, neurologists, orthopedists and other specialty physicians have less need for privileges at certain hospitals, thus reducing the number of ED shifts they work taking care of high-risk patients.³

Provider Preference

Hospitals may not discourage use for non-urgent care. To the extent that staff are already in place and not required for emergency care, the added cost of providing non-urgent care is minimal. Given the high rates of inpatient admissions through the ED, hospitals have found that the ED is one way to ensure a steady flow of insured patients to their facility.²

Malpractice Insurance Issues

According to a 2002 survey by the American College of Emergency Physicians, Florida physicians reported a malpractice insurance premium increase between 25 and 200% from 2001-2002. Increasingly, more physicians are going without malpractice insurance coverage and may be referring certain patients to the ED for care in order to reduce their risk.

Patient Preference

Patients may prefer to use emergency departments, even with long waits, for a variety of reasons including the fact that they can seek care without missing work. Sometimes, patients are told to go to the ED by their personal physician.

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Methodology

Emergency Department Data Collection

The Centers for Disease Control defines an “emergency department” as a hospital facility for the provision of unscheduled outpatient services to patients whose conditions require immediate care and is staffed 24 hours a day.¹

In 2004, the *Affordable Health Care for Floridians Act* included new language giving AHCA the authority to collect emergency department data from licensed short-term acute care hospitals starting January 1, 2005. Chapter 59B-9, F.A.C. has been revised to include the reporting of emergency department data for all emergency department visits occurring on or after January 1, 2005.

The emergency department data includes all emergency department visits in which registration occurs and the patient is not admitted for inpatient care at the reporting entity. The hospital inpatient data includes all patient records from those who were admitted to the hospital through the emergency department. For the purposes of this report, an emergency department visit is defined as one where a record is created and the patient is not admitted as an inpatient in an acute care hospital setting. Excluded from this database are visits where the patient left the ED against medical advice or discontinued care.

The reporting requirements in rule specify that all emergency department records must have a valid current procedural terminology (CPT) evaluation and management code occurring within the following ranges: 92281 through 92285 (see **Appendix A**). This code must be placed in the Principal CPT Procedure field. This code is important in that it is a source of data that indicates the level of severity of the patient’s condition upon arrival at the ED. Without an accurate recording and coding of this data item, it is difficult to classify ED visits by their urgency.

Data Elements

The emergency department dataset contains 98 data fields, including patient demographics, facility, payer, charges, procedures, and diagnoses. The dataset also includes three additional external cause of injury codes; patient reason for visit ICD-9 diagnosis code; and an hour of arrival code. A complete list of available data elements can be seen in **Appendix B**.

Quality Assurance

Beginning with January 1, 2006, all facilities must submit data for ED visits to AHCA via secure Internet transmission. The Interned Data Submission (IDS) system utilizes Secure Sockets Layer (SSL) 128-bit encryption to encrypt and decrypt messages sent between the browser and server. SSL is compatible with all recent Web browsers.

The IDS system initially checks all submitted files for completeness and accuracy. Frequently, the data arrives error-free and can be appended to the AHCA database in short order. Before the data from each of the facilities are permanently added to the ambulatory/emergency department database, two additional steps are performed to ensure the accuracy of the data. The data are processed and facilities are required to correct data errors.

The SCHS Data Collection Unit evaluates each submission and resubmission using a custom-designed internal audit system that checks each facility's submission for completeness, accuracy and validity. The data are passed through the in-house edit program to detect various known errors and to identify other potential errors in the submitted data. The program produces printed reports detailing each inconsistency in the data as well as printed summary reports.

The summary reports for each facility type are sent to the facility for correction and verification. The SCHS Data Collection Unit communicates directly with the assigned contact of each facility and provides specific feedback regarding compliance, completeness, accuracy and validity of the reported data. The Chief Executive Officer and Chief Financial Officer of each facility must personally certify the accuracy of their data. Finally, the facility makes appropriate corrections and resubmits the corrected data. Data are added to the main database only after certification.

All released data is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy law and procedures of the Agency.

The schedule for data reporting is presented in **Table 1**. For more information concerning the collection of Ambulatory/ED Patient data, please visit <http://ahca.myflorida.com/SCHS/apdunit.shtml>.

**Table 1
Ambulatory and ED Facility Data Reporting Schedule**

Quarter	Time Period	Ambulatory/ED Data Due Date
1st	January 1 - March 31	June 10
2nd	April 1 - June 30	September 10
3rd	July 1 - September 30	December 10
4th	October 1 - December 31	March 10 (Following Year)

Availability of Data

Although the database information for the first quarter of 2005 (January – March) was not complete, summary figures and tables were populated with data available on October 20, 2005. Data are not available until the aforementioned quality assurance process is complete.

Definition of Patient Acuity Levels

The grouping of visit data by patient acuity level utilizes the five “CPT Evaluation and Management Codes” as assigned by the facility to describe the initial condition of the patient upon arrival. These codes run from 92281 (indicating the lowest level of patient management), to 92285 (the highest level of patient management).

Table 2 displays a simplified description of these evaluation and management codes.

Table 2
Definition of Patient Acuity Groups
By CPT Evaluation and Management Codes

Low-Acuity Group:

- 92281 The presenting problems(s) are **self limited** or of **minor** severity.
- 92282 The presenting problem(s) are of **low to moderate** severity.

High-Acuity Group:

- 92283 The presenting problem(s) are of **moderate** severity.
 - 92284 The presenting problem(s) are of **high severity**, but do **not** pose an immediate significant threat to life.
 - 92285 The presenting problems(s) are of **high severity** and pose an **immediate threat to life**.
-

See **Appendix A** for a complete description of the CPT Evaluation and Management Codes.

These few codes serve as a proxy for different levels of patient triage that happens upon entry to the emergency room. Two distinct groups were then formed from these five levels. The “Low Acuity” group corresponds with visits described as “nonurgent,” while the “High Acuity” group corresponds with visits described as “urgent” or “emergent.” Other groupings are possible, but these two groups were selected based on their similar descriptions of acuity and will be utilized to group visit records in the subsequent data analyses.

Other Sources of Data

In addition to the AHCA ambulatory/emergency department patient visit database, information on ED visits was taken from annual facility cost reports available from the AHCA hospital financial database. Unlike the patient visit database, information from the financial database are aggregated annually at the company level. Thus, there is a limited ability to drill down to more detailed levels of data.

Charges and Costs of Emergency Department Services

The term *cost* is often used to describe expenses incurred in the delivery of the service to the patient. Hospitals may experience losses when reimbursements received are less than expenses incurred in the delivery of the services to patients. The difference between gross charges for services delivered to patients and the net amounts received (from patients, their insurance companies, or covering managed care organizations) can be substantial as charges are raised overall to cover losses in certain areas.

The financial information collected from hospitals for services provided are charges, not true costs. Expense or net revenue data are not available. Additionally, most hospitals consider the detailed cost information that they may have to be proprietary and not subject to public scrutiny. For the 2004 reporting year, financial statements from Florida hospitals indicated that total costs including overhead was between 30% and 40% of total gross charges. However, there is no Florida data available to report actual cost incurred in the delivery of ED services. All figures for dollars spent on services provided in the ED are in terms of “charges” and not “costs.”

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Results

Data from the AHCA hospital financial database indicate there were 7,111,042 visits to hospital emergency departments (ED) in 2004, resulting in total charges of \$4,402,858,095. The average charge per visit was \$619. Total charges for visits increased by 457.0%, from \$791 million in 1994 to \$4.4 billion in 2004. Information from the financial database is limited to aggregate figures per individual hospital.

On October 20, 2005, all available records from the AHCA Emergency Department database collected during the first quarter of 2005 were selected for analysis. This quarter is the initial quarter of data collection for emergency department data. The available data show that there were 482,794 visits during this period, a figure that is less than the number of visits reported on data from the AHCA hospital financial database. The process of reporting ED visits is new to the facilities, resulting in some data reporting difficulties and discrepancies. It is expected that next year's ED annual report will represent a complete database.

In 2004, that database showed 7,111,042 visits for the entire year. That figure includes ED visits that subsequently became hospital inpatient admissions, of which there were 1,312,472 in 2004. According to the ambulatory patient data rule (Ch. 59B-9, F.A.C.), the AHCA ED database does not include ED visits that later become inpatient admissions. Thus, in 2004 we would expect 5,798,570 visit records in the AHCA ED database. Dividing that figure by four yields a quarterly expected number of visits of 1,449,643. Therefore, the AHCA emergency department database as of October 20, 2005, contained approximately 33.3% of the number of visit records expected.

The data tables in this report were created using the data available on October 20, 2005. Therefore, caution should be used in interpreting these results as the data may not represent a true random sample of the entire data population.

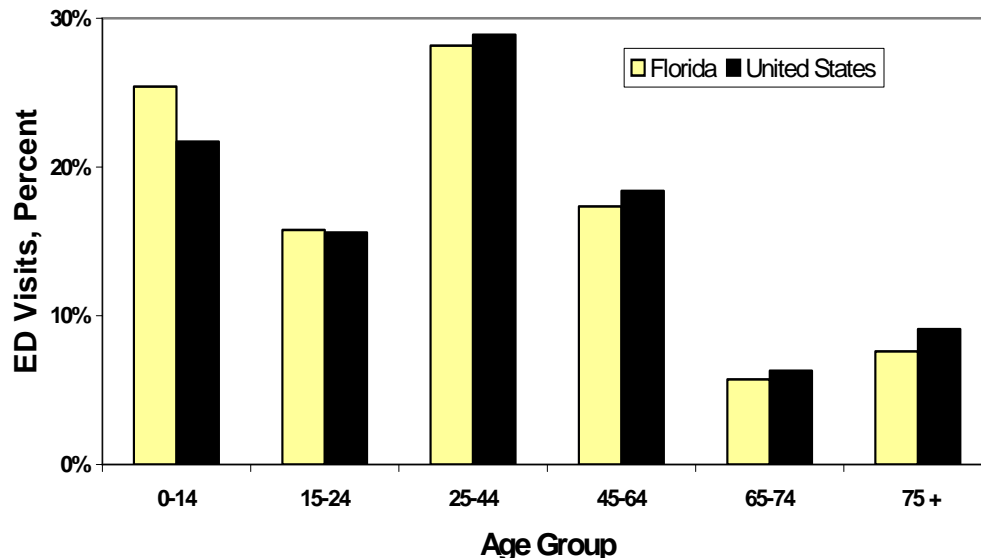
Demographics of Emergency Department Visits

Figures 3-5 detail ED visits by various patient demographics. The figures for number of visits are often expressed as a *population rate*, e.g., number of visits divided by total population for a particular subgroup. At present, population rates cannot be calculated on the Florida ED data set, because some records have not yet been certified. Once AHCA receives data on all ED visits for a full calendar year, then population rates can be calculated.

Figure 3 displays the percentage of ED visits aggregated by age group for Florida and the United States. Compared with the U.S., Florida had a higher percentage of visits by the young (ages 24 years and under) and a lower proportion of visits by the elderly (ages 65 years and over). In Florida, 69.3% of visits were to persons under age 45 years.

Figures for visit rates per population for the U.S. reveal that the highest rates were for ages 75 and over, followed by ages 0-24. Preliminary, incomplete data for Florida show the opposite situation, where the highest rates were for ages 0-24, followed by ages 75 and over.

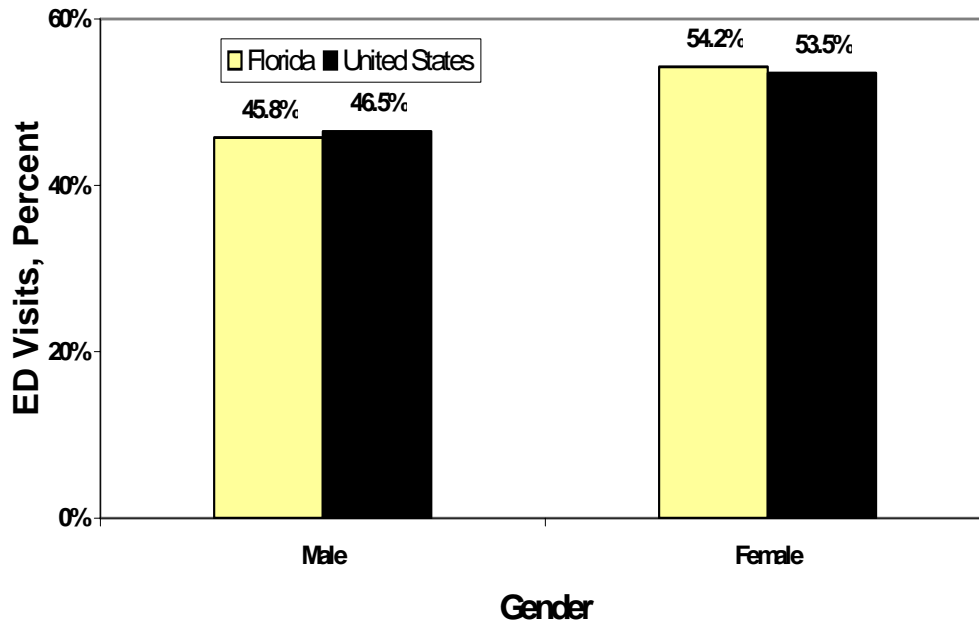
Figure 3
Percentage of Visits to the
Emergency Department by Age Group
Florida and United States



Notes: Figures for Florida in 2005, quarter 1. Figures for the U.S. in 2003.
Source: AHCA; NCHS/NHAMCS.

Figure 4 shows the percentage of ED visits by gender for Florida and the United States. Compared with the U.S., Florida had a slightly smaller percentage of visits by males and a slightly higher proportion of visits by females. In Florida, the percentage of visits by females was 8.4 percentage points higher than males.

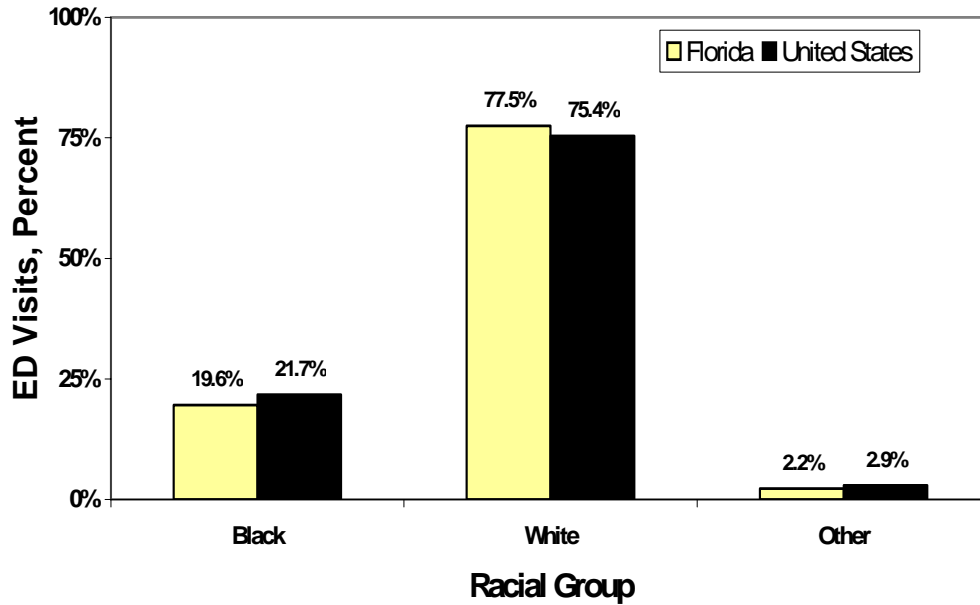
Figure 4
Percentage of Visits to the
Emergency Department by Gender
Florida and United States



Notes: Figures for Florida in 2005, quarter 1. Figures for the U.S. in 2003.
Source: AHCA; NCHS/NHAMCS.

Figure 5 displays the percentage of ED visits aggregated by racial group for Florida and the United States. (See **Appendix C** for a description of the racial categories included in **Figure 5**.) Compared with the U.S., Florida had a smaller percentage of visits by blacks and a higher proportion of visits by whites.

Figure 5
Percentage of Visits to the
Emergency Department by Racial Group
Florida and United States



Notes: Figures for Florida in 2005, quarter 1. Figures for the U.S. in 2003.
Source: AHCA; NCHS/NHAMCS.

Other Characteristics of Emergency Department Visits

Table 3 shows the number and percentage of ED visits aggregated by payer group. (See **Appendix D** for a description of the payer categories included in **Table 3**.) The payer for most number of visits was commercial insurance (including HMOs), followed by Medicaid, self-pay/uninsured/underinsured, and Medicare. Combined, self-pay/underinsured and charity comprised 23.4% of ED visits. See **Appendix E** for a frequency breakdown on each of the 15 payer categories collected by AHCA.

Table 3
Emergency Department Visits
by Payer Group, 2005, Quarter 1

Payer Group	Number	Percent
Medicare	71,562	14.8%
Medicaid	116,781	24.2%
Commercial Insurance	157,351	32.6%
Other Government	24,132	5.0%
Self-Pay/Underinsured	105,491	21.9%
Charity	7,477	1.5%
Total	482,794	100.0%

Source: AHCA

Table 4 shows the number and percentage of ED visits by day of week. The most frequently-visited day was Sunday (which begins at midnight, therefore encompassing part of “Saturday night”), followed by Monday. The least frequently-visited day was Friday.

Table 4
Emergency Department Visits
by Day of Week, 2005, Quarter 1

Weekday	Number	Percent
Monday	72,377	15.0%
Tuesday	69,474	14.4%
Wednesday	68,289	14.1%
Thursday	66,533	13.8%
Friday	62,164	12.9%
Saturday	71,503	14.8%
Sunday	72,454	15.0%
Total	482,794	100.0%

Source: AHCA

Table 5 displays the five most frequently visited hours of arrival to the emergency department. The top three most visited hours are between 10:00 a.m. and 1:00 p.m. A table showing the frequency and percentage of ED visits by every hour of arrival is presented in **Appendix F**. That tables shows that the least visited hours are between the hours of 2:00 a.m. and 7:00 a.m.

Table 5
Emergency Department Visits
by Hour of Arrival, 2005, Quarter 1
Five Most Frequently Visited Hours

Hour of Arrival	Number	Percent
11:00 a.m. to 11:59 a.m.	29,825	6.2%
10:00 a.m. to 10:59 a.m.	28,467	5.9%
12:00 noon to 12:59 p.m.	28,449	5.9%
7:00 p.m. to 07:59 p.m.	27,810	5.8%
6:00 p.m. to 06:59 p.m.	27,706	5.7%

Source: AHCA

Table 6 displays the number and percentage of ED visits by the length of stay. Visits to the ED should be less than one day in length. A one-day stay would be recorded if the patient visit begins late in the day and extends past midnight. Another reason for a one-day stay is that patients are being monitored or are under observation before being transferred to inpatient hospitalization or discharged home.

Table 6
Emergency Department Visits
Length of Stay in Days, 2005, Quarter 1

LOS (Days)	Number	Percent
0	420,797	87.2%
1	58,501	12.1%
2	2,618	0.5%
3+	878	0.2%
Total	482,794	100.0%

Source: AHCA

Table 7 shows that the vast majority of those who were discharged from the ED were discharged home. In 2004, there were 1,312,472 hospital inpatient admissions through the ED, accounting for 52.8% of all hospital admissions.

Table 7
Emergency Department Visits
Patient Status, 2005, Quarter 1

Patient Status	Number	Percent
Home	471,568	97.7%
Other Hospital	3,130	0.6%
Skilled Nursing Facility	1,691	0.4%
Intermediate Facility	1,064	0.2%
Other Facility	3,667	0.8%
Home Healthcare	390	0.1%
Home on IV Medications	7	0.0%
Expired	1,118	0.2%
Hospice-Home	26	0.0%
Hospice-Medical Facility	33	0.0%
Inpatient Rehabilitation Facility	100	0.0%
Total	482,794	100.0%

Source: AHCA

Emergency Department Visits by Patient Acuity Level

As described in the Methodology section, all ED visits can be defined by one of five Evaluation & Management codes (CPT-4). The codes delineate the relative severity of the person's condition upon arrival at the ED. See **Appendix A** for a complete description of each of the five Evaluation & Management codes.

Table 8 shows the number, percentage and average charge of ED visits as aggregated by acuity level. Note that about one fourth of all visit records were missing an acuity code (CPT evaluation and management) in the appropriate data field (labeled "Other Codes" on the table). The top three most frequent codes other than the CPT evaluation and management codes were, blood count, collection of blood by venipuncture, and radiologic examination of chest.

Of the five acuity levels listed, the vast majority (64.9%) were in the low to moderate severity category. Excluding "Other Codes" from the total yields 87.4% of all visits in the low to moderate category. Charges for both ED services and the total are related to the acuity level, where an increase in the severity level was related to an increase in the average charge.

Table 8
Emergency Department Visits
Frequency and Mean Charge
by Patient Acuity Level, 2005, Quarter 1

Acuity Level	Number	Percent	Charges	
			E.R.	Total
Minor	67,323	13.9%	\$239	\$570
Low-Moderate	144,207	29.9%	\$426	\$1,223
Moderate	101,659	21.1%	\$608	\$2,074
High-No Sig Threat	33,641	7.0%	\$839	\$3,496
High-Sig Threat	11,458	2.4%	\$1,138	\$4,687
Other Codes	124,506	25.8%	\$634	\$2,558
Total	482,794	100.0%	\$538	\$1,896

Source: AHCA

The five Evaluation and Management codes were aggregated into two groups, labeled “Low Acuity” and “High Acuity.” (See **Table 2** for the definition of these groups.) **Table 9** shows the number, percentage and average charge of ED visits as aggregated by charge category and acuity group. Low-acuity visits comprise 59.0% of all ED visits, while high-acuity visits comprise 41.0% of the total. The mean charge for low-acuity visits is less than half that for high-acuity visits, and the sum of total charges is larger for high-acuity visits. Compared with low-acuity visits, high-acuity visits had a higher percentage of charges for laboratory, while low-acuity visits had a higher proportion for radiology and the emergency room.

Table 9
Emergency Department Visits
Frequency and Mean Charge
by Patient Acuity Level, 2005, Quarter 1

Charge Category	Low Acuity Visits (N=211,530)			High Acuity Visits (N=146,758)		
	Mean	Sum	Pct Tot	Mean	Sum	Pct Tot
Pharmacy	\$44	\$9.3	4.3%	\$130	\$19.1	5.0%
Laboratory	\$142	\$30.0	14.0%	\$599	\$87.9	23.0%
Radiology	\$389	\$82.2	38.3%	\$781	\$114.6	30.0%
Emergency Room	\$367	\$77.6	36.1%	\$702	\$103.1	27.0%
"Other"	\$51	\$10.7	5.0%	\$229	\$33.5	8.8%
All Other Charges	\$23	\$4.9	2.3%	\$163	\$24.0	6.3%
Total	\$1,015	\$214.7	100.0%	\$2,604	\$382.1	100.0%

Note: "Sum" in millions.

Source: AHCA

Table 10 shows the mean acuity level for ED visits aggregated by payer group. Acuity level was assigned with the value “1” if the evaluation and maintenance code was 92281, through the value of 5 if the evaluation and maintenance code was 92285. Using this methodology, the payer with the highest average acuity level was Medicare, while self-pay/underinsured had the second lowest acuity level. For more details on acuity level by payer group, see **Appendix G** which lists frequencies for each of the five acuity levels for each payer group listed in **Table 10**.

Table 10
Emergency Department Visits
Mean Patient Acuity Level
by Payer Group, 2005, Quarter 1
Sorted by Patient Acuity Level

Payer Group	Number	Mean Patient Acuity Level
Medicare	50,962	2.58
Charity	4,644	2.39
Commercial Insurance	113,067	2.39
Medicaid	93,636	2.35
Self Pay/Underinsured	77,830	2.31
Other Government	18,149	2.20
Total	358,288	2.38

Source: AHCA

A breakdown of ED visits by age group and acuity group is presented in **Table 11**. The data shows that for the younger age groups (under age 45 years) about 60% of ED visits are low acuity. However, as the ages increase the proportion of high-acuity visits increases. For ages 75 years and older, the majority of visits are of high-acuity. Additionally, figures for the mean and sum of charges by age group and acuity group are presented in **Appendix H**.

Table 11
Emergency Department Visits
by Age Group and Patient Acuity Level, 2005, Quarter 1

Age Group	Low Acuity Visits		High Acuity Visits		Total	
	Number	Percent	Number	Percent	Number	Percent
Ages 0-14 years	60,013	60.9%	38,528	39.1%	98,541	100.0%
Ages 15-24 years	34,344	61.0%	21,982	39.0%	56,326	100.0%
Ages 25-44 years	60,821	61.2%	38,608	38.8%	99,429	100.0%
Ages 45-64 years	33,449	56.8%	25,429	43.2%	58,878	100.0%
Ages 65-74 years	10,364	53.7%	8,946	46.3%	19,310	100.0%
Ages 75 years and older	12,539	48.6%	13,265	51.4%	25,804	100.0%
Total	211,530	59.0%	146,758	41.0%	358,288	100.0%

Note: Total excludes visits that cannot be classified by acuity level and invalid ages.

Source: AHCA

Table 12 shows a breakdown of ED visits by payer group and acuity group. The payer with the highest proportion of high-acuity visits is Medicare, while the lowest are self-pay/underinsured and Other Government. Additionally, figures for the mean and sum of charges aggregated by payer group and acuity group are presented in **Appendix I**.

Table 12
Emergency Department Visits
by Payer Group and Patient Acuity Level, 2005, Quarter 1

Payer Group	Low Acuity Visits		High Acuity Visits		Total	
	Number	Percent	Number	Percent	Number	Percent
Medicare	26,211	51.4%	24,751	48.6%	50,962	100.0%
Medicaid	54,682	58.4%	38,954	41.6%	93,636	100.0%
Commercial Insurance	66,817	59.1%	46,250	40.9%	113,067	100.0%
Other Government	12,183	67.1%	5,966	32.9%	18,149	100.0%
Self Pay/Underinsured	48,898	62.8%	28,932	37.2%	77,830	100.0%
Charity	2,739	59.0%	1,905	41.0%	4,644	100.0%
Total	211,530	59.0%	146,758	41.0%	358,288	100.0%

Note: Total excludes visits that cannot be classified by acuity level.

Source: AHCA

Reasons for Emergency Department Visits and Principal Diagnoses

All visits to the ED can be classified according to the patient reason for visit and the principal diagnosis. The patient reason is an ICD-9-CM diagnosis code that should best describe the reason why a person came to the ED. The principal diagnosis is a diagnosis code that is arrived at by a physician after all tests and other information have been assessed.

Table 13 shows the top five patient reasons for a visit aggregated by low and high-acuity visits. The data show that cough and fever were among the top five regardless of acuity. Among low-acuity visits, headache and earache were frequent reasons, while abdominal pain and chest pain were frequent reasons for high-acuity visits.

Table 13
Emergency Department Visits
Patient Reason for Visit
by Patient Acuity Level, 2005, Quarter 1

Low-Acuity Visits			
Reason (ICD-9-CM)	Description	Number	Percent
786.2	Cough	16,624	7.9%
780.6	Fever	13,778	6.5%
729.5	Pain In Limb	7,471	3.5%
784.0	Headache	6,346	3.0%
388.70	Earache	5,767	2.7%
All Low-Acuity Visits		211,530	100.0%

High-Acuity Visits			
Reason (ICD-9-CM)	Description	Number	Percent
780.6	Fever	11,513	5.4%
789.00	Abdominal Pain	7,731	3.7%
786.2	Cough	7,565	3.6%
786.50	Chest Pain	6,732	3.2%
787.03	Vomiting	5,819	2.8%
All High-Acuity Visits		146,758	100.0%

Source: AHCA

Table 14 shows the top five principal diagnoses aggregated by low and high-acuity visits. The data show that upper respiratory infection, middle ear infection and viral infection were among the top five diagnoses regardless of acuity. For low-acuity visits, pharyngitis was a frequent diagnosis, while gastroenteritis and abdominal pain were frequent diagnoses for high-acuity visits. Furthermore, a breakdown of the five most frequent principal diagnoses by selected payer groups is presented in **Appendix J**.

Table 14
Emergency Department Visits
Principal Diagnosis
by Patient Acuity Level, 2005, Quarter 1

Low-Acuity Visits			
Diagnosis (ICD-9-CM)	Description	Number	Percent
465.9	Acute Upper Respiratory Infection	8,950	4.2%
382.9	Otitis Media	7,526	3.6%
462	Acute Pharyngitis	5,357	2.5%
V58.3	Attention to Surgical Dressing	4,665	2.2%
079.99	Viral Infection	4,417	2.1%
All Low-Acuity Visits		211,530	100.0%

High-Acuity Visits			
Diagnosis (ICD-9-CM)	Description	Number	Percent
558.9	Noninfectious Gastroenteritis	5,047	2.4%
465.9	Acute Upper Respiratory Infection	3,909	1.8%
079.99	Viral Infection	3,418	1.6%
382.9	Otitis Media	3,151	1.5%
789.00	Abdominal Pain	3,081	1.5%
All High-Acuity Visits		146,758	100.0%

Source: AHCA

The data on patient reason for visit and principal diagnosis presented above are for persons who visit the ED but who are not admitted to the hospital as an inpatient. **Table 15** shows the top five principal diagnoses for hospital inpatients who were admitted through the emergency room.

Table 15
Principal Diagnosis for
Inpatient Hospitalizations
Admitted via Emergency Room
2005, Quarter 1

Diagnosis (ICD-9-CM)	Description	Number	Percent
486	Pneumonia	18,369	5.2%
428.0	Congestive Heart Failure	17,788	5.0%
786.59	Chest Pain	11,885	3.3%
491.21	Obstructive Chronic Bronchitis	9,041	2.5%
414.01	Coronary Atherosclerosis	7,438	2.1%
	Total	356,324	100.0%

Source: AHCA

In addition to receiving a diagnosis, persons visiting the emergency room often have a procedure performed before discharge. **Table 16** shows the top five procedures performed in the first quarter of 2005. The data show that nearly one third of patients do not have a procedure performed. The most frequent procedures were therapeutic injections followed by radiological examination and laboratory work.

Table 16
Emergency Department Visits
First-listed Procedure Performed
2005, Quarter 1

Procedure (CPT-4)	Description	Number	Percent
Blank	No Procedure	155,119	32.1%
90784	Therapeutic injection, intravenous	16,522	3.4%
99283	Evaluation/Management	16,229	3.4%
90782	Therapeutic injection	15,997	3.3%
71020	Radiologic examination, chest	15,269	3.2%
99282	Evaluation/Management	13,519	2.8%
80048	Laboratory, basic metabolic panel	11,520	2.4%
36415	Routine venipuncture for specimens	11,068	2.3%
Total		482,794	100.0%

Source: AHCA

Summary and Conclusions

The use of emergency departments in Florida has been increasing over the past ten years. The number of visits increased by 40.1% from 1994 to 2004, while the visit rate per population increased by 12.9% over the same period. Total charges for those visits increased by 457.0%, from \$791 million in 1994 to \$4.4 billion in 2004. Several factors have been hypothesized as leading to increased emergency department use, including:

- Changes in federal and state law,
- Growth in population,
- Rate of uninsured,
- Patient choice,
- Provider access and preference, and
- Malpractice concerns.

On January 1, 2005, AHCA was authorized to begin collection of records for all visits to the ED. On October 20, 2005, analysis was begun on the 482,794 certified data records collected, representing about one third of the visits as reported by AHCA's hospital financial database for the first quarter of 2005. Corrections and certification of data reports for this period are ongoing.

An analysis of the preliminary data from the AHCA ED database reveals that the majority of ED visits were from people who are female, white and between the ages of 25 and 44 years. The top two payers were commercial insurance and Medicaid. The majority of visits were for an acuity level of low to moderate, and Medicare accounted for the largest proportion of high-acuity visits. Among the most frequent principal diagnoses were upper respiratory infection, middle ear infection and viral infection.

In the analysis of the ED data, some deficiencies were observed in the data collected thus far. One problem with the data reported thus far has been inaccuracy in reporting CPT evaluation and management codes in the Principal CPT Procedure field. Approximately 25% of the codes have been inaccurately reported as other CPT codes or were left blank. It is recommended that the AHCA data collection staff continue working with hospitals to improve their data coding practices.

Another problem concerns the description of hospital costs, as opposed to charges. AHCA collects only charges for ED services, not true costs. Often, charges do not reflect the negotiated payment that is made to hospitals.

Based on a review of the literature on ED utilization and an analysis of the preliminary data available in the AHCA ED database, the following recommendations are offered:

- The analysis of the AHCA ED database should be encouraged to focus efforts on specific areas of utilization and cost that can be identified from these data. The AHCA hospital inpatient database should also be analyzed to determine the extent of hospitals' problems with providing services on an emergency basis.
- Data management and clean-up should continue in order to correct problems with the Patient Status and Principal CPT Procedure data fields.
- AHCA should communicate with hospitals to clarify current rule language on ED reporting (Ch.59B-9.018(2)(I), F.A.C.) to highlight the requirement that CPT evaluation and management codes must be appropriately placed in the "Principal CPT Procedure" data field.

Additionally, the following recommendations are proposed to help ease the increasing pressures on rising ED utilization:

- Increase the availability of alternate sites for nonurgent care, e.g., community health centers, urgent care centers and county health departments, especially for the uninsured.
- Remove the moratorium on licensing freestanding emergency departments in underserved areas of the state, as recommended in the AHCA publication, *Report on Freestanding Emergency Departments* (December 2004).
- Work with health plans to provide information to the public regarding alternatives to the ED.
- Encourage physicians to take ED calls by exploring community-based coverage for the ED. Provide, to the extent possible, the ability for communities to develop community-based call coverage, allowing the community and hospitals to better work together.

References

1. National Center for Health Statistics. (May 26, 2005). National Hospital Ambulatory Medical Care Survey: 2003 Emergency Department Summary, Advance Data Number 358. (PHS) 2005-1250.
<http://www.cdc.gov/nchs/pressroom/05news/emergencydept.htm>.
2. O'Malley, Gerland, Pham and Berenson (November 2005). Rising Pressure: Hospital Emergency Departments as Barometers of the Health Care System. Center for Studying Health System Change. Issue Brief, No. 101.
3. A Report to the Governor of Florida and the Florida Legislature: Emergency Services Task Force. (December 31, 2000). Florida Department of Health and Agency for Healthcare Administration.

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Appendices

- A. CPT Evaluation and Management Codes Used to Classify Acuity Level
- B. Ambulatory/ Emergency Department Patient Data Elements
- C. Definition of Racial Categories
- D. Definition of Principal Payer Categories
- E. Emergency Department Visits by Payer
- F. Emergency Department Visits by Hour of Arrival
- G. Emergency Department Visits by Payer and Patient Acuity Level
- H. ED Visits, Mean and Sum of Charges by Age Group and Patient Acuity Level
- I. ED Visits, Mean and Sum of Charges by Payer Group and Patient Acuity Level
- J. Emergency Department Visits, Top Five Principal Diagnoses by Payer Group

Appendix A

CPT Evaluation and Management Codes Used to Classify Acuity Level

The following codes are used to report evaluation and management services provided in the emergency department. No distinction is made between new and established patients in the emergency department.

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

99281 - Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- a problem focused history;
- a problem focused examination;
- a straightforward medical decision making.

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.

Usually the presenting problems(s) are self limited or minor.

99282 - Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- an expanded problem focused history;
- an expanded problem focused examination;
- medical decision making of low complexity.

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.

Usually, the presenting problem(s) are of low to moderate severity.

Appendix A (continued)

CPT Evaluation and Management Codes Used to Classify Acuity Level

99283 - Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- an expanded problem focused history;
- an expanded problem focused examination;
- medical decision making of moderate complexity.

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.

Usually the presenting problem(s) are of moderate severity.

99284 - Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- a detailed history;
- a detailed examination;
- medical decision making of moderate complexity.

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.

Usually, the presenting problems are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

99285 - Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status:

- a comprehensive history;
- a comprehensive examination;
- medical decision-making of high complexity.

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.

Usually, the presenting problems(s) are of high severity and pose an immediate threat to life or physiologic function.

Appendix B

Ambulatory/Emergency Department Patient Data Elements

DATA ELEMENT NAME		DESCRIPTION
1	Record ID Num record_id	A unique alpha-numeric code, up to seventeen (17) characters.
2	Report Year rpt_yyyy	The four-digit year.
3	Report Quarter rpt_qtr	A single-digit representing the quarter: 1 – January through March 2 – April through June 3 – July through September 4 – October through December
4	Type of Service Code service_code	A one digit code indicating type of service: 1 – Ambulatory surgery, as described in 59B-9.015(2)(a), F.A.C. 2 – Emergency department visit, as described in 59B-9.015 (2)(b), F.A.C.
5	Pro Code pro_code	An internal AHCA program code assigned to each facility type. 14 – Ambulatory/ED 23 – Short term acute care hospital 64 – Cardiac catheterization 66 – Lithotripsy
6	AHCA Ambulatory Center Number facl_nbr	An eight to ten (8-10) digit number assigned by AHCA.
7	Facility Region fac_region	The region within the State of Florida from which patient address is located (See list of regions, also known as Florida Local Health Council Districts).
8	Facility County fac_county	The county of facility within the State of Florida. (See attached description of Florida Counties by Number).
9	Patient Race or Ethnicity race	Self designated by the patient or patient's guardian. A single digit code indicating patients race/ethnicity: 1 – American Indian or Alaska Native 2 – Asian or Pacific Islander 3 – Black or African American 4 – White 5 – White Hispanic 6 – Black Hispanic 7 – Other. Used if self-designated race or ethnicity is not described above. 8 – No Response. Used if patient refused or failed to disclose.
10	Patient Sex sex	The gender of the patient, a single digit code: 1 – Male 2 – Female 3 – Unknown, used only if unavailable or unknown due to medical condition.

APPENDIX B (continued)

Ambulatory/Emergency Department Patient Data Elements

DATA ELEMENT NAME	DESCRIPTION
11 Patient Age in Years age	Calculates number of years between birth date and visit beginning date.
12 Patient Status patient_status	Patient disposition at the end of the visit. Must be two digit code: 01 – Discharged to home or self care (with or without planned outpatient medical care) 02 – Transferred to a short-term general hospital 03 – Transferred to a skilled nursing facility 04 – Transferred to an intermediate care facility 05 – Transferred to another type of institution (psychiatric, cancer or children's hospital or distinct part unit) 06 – Discharged to home under the care of home health care organization 07 – Left against medical advice or discontinued care 08 – Discharged to home under care of home IV provider 20 – Expired 50 – Discharged to hospice-home 51 – Transferred to hospice-medical facility 62 – Transferred to an inpatient rehabilitation facility including distinct units of a hospital
13 Patient Masked Zip Code masked_zipcode	The five (5) digit US postal service zip code of the patient's permanent residence. These codes are included unless the patient's residence is outside of Florida or resides in an area within the state where the population is less than 500 people. 00000 – Unknown Zip Codes 00008 – Other States and Territories 00009 – Not a U.S. resident 00011 – Masked Zip Code 32000 to 32499 00012 – Masked Zip Code 32500 to 32999 00013 – Masked Zip Code 33000 to 33499 00014 – Masked Zip Code 33500 to 33999 00015 – Masked Zip Code 34000 to 34499 00016 – Masked Zip Code 34500 to 34999 00007 – Homeless (Start 1/02, formerly 22222)
14 Patient's County county	County of residence. Florida patient's only. The patient's ZIP code is used to reference the U.S. Postal Services database. When a ZIP code crosses county lines, the county code will contain the code of the county that has the greatest proportion of that ZIP code's residents. (See attached description of Florida Counties by Number).
15 Patient State state	The patient's state of residence. The patient's ZIP code is used to reference the U.S. Postal Service standard state or territory.
16 Patient Visit Weekday weekday	One-digit field indicating day of week procedure was performed. 1 – Monday 2 – Tuesday 3 – Wednesday 4 – Thursday 5 – Friday 6 – Saturday 7 – Sunday

APPENDIX B (continued)

Ambulatory/Emergency Department Patient Data Elements

DATA ELEMENT NAME	DESCRIPTION																										
17 Hour of Arrival arrival_hour	The <i>hour</i> on a 24-hour clock during which the patient's visit <i>began</i> for ambulatory surgery (type of service=1); or during which <i>registration occurred</i> in the emergency department (type of service=2). <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">00 – 12:00 midnight to 12:59</td> <td style="text-align: center;">13 – 01:00 to 01:59</td> </tr> <tr> <td style="text-align: center;">01 – 01:00 to 01:59</td> <td style="text-align: center;">14 – 02:00 to 02:59</td> </tr> <tr> <td style="text-align: center;">02 – 02:00 to 02:59</td> <td style="text-align: center;">15 – 03:00 to 03:59</td> </tr> <tr> <td style="text-align: center;">03 – 03:00 to 03:39</td> <td style="text-align: center;">16 – 04:00 to 04:59</td> </tr> <tr> <td style="text-align: center;">04 – 04:00 to 04:59</td> <td style="text-align: center;">17 – 05:00 to 05:59</td> </tr> <tr> <td style="text-align: center;">05 – 05:00 to 05:59</td> <td style="text-align: center;">18 – 06:00 to 06:59</td> </tr> <tr> <td style="text-align: center;">06 – 06:00 to 06:59</td> <td style="text-align: center;">19 – 07:00 to 07:59</td> </tr> <tr> <td style="text-align: center;">07 – 07:00 to 07:59</td> <td style="text-align: center;">20 – 08:00 to 08:59</td> </tr> <tr> <td style="text-align: center;">08 – 08:00 to 08:59</td> <td style="text-align: center;">21 – 09:00 to 09:59</td> </tr> <tr> <td style="text-align: center;">09 – 09:00 to 09:59</td> <td style="text-align: center;">22 – 10:00 to 10:59</td> </tr> <tr> <td style="text-align: center;">10 – 10:00 to 10:59</td> <td style="text-align: center;">23 – 11:00 to 11:59</td> </tr> <tr> <td style="text-align: center;">11 – 11:00 to 11:59</td> <td style="text-align: center;">99 – Unknown</td> </tr> <tr> <td style="text-align: center;">12 – 12:00 noon to 12:59</td> <td></td> </tr> </table>	00 – 12:00 midnight to 12:59	13 – 01:00 to 01:59	01 – 01:00 to 01:59	14 – 02:00 to 02:59	02 – 02:00 to 02:59	15 – 03:00 to 03:59	03 – 03:00 to 03:39	16 – 04:00 to 04:59	04 – 04:00 to 04:59	17 – 05:00 to 05:59	05 – 05:00 to 05:59	18 – 06:00 to 06:59	06 – 06:00 to 06:59	19 – 07:00 to 07:59	07 – 07:00 to 07:59	20 – 08:00 to 08:59	08 – 08:00 to 08:59	21 – 09:00 to 09:59	09 – 09:00 to 09:59	22 – 10:00 to 10:59	10 – 10:00 to 10:59	23 – 11:00 to 11:59	11 – 11:00 to 11:59	99 – Unknown	12 – 12:00 noon to 12:59	
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11 – 11:00 to 11:59	99 – Unknown																										
12 – 12:00 noon to 12:59																											
18 Length of Stay los_days	Calculates number of days between visit beginning date and visit ending date.																										
19 Patient's Reason for Visit ICD-CM Code (Admitting Diagnosis) reason_admit_diag	The code representing the patient's chief complaint or stated reason For seeking care. If type of service =1 Space Filled If type of service =2 ICD-9-CM code or blank if patient fails to disclose or the information is not available consistent with records of reporting entity. Includes decimal point.																										
20 Principal Diagnosis Code prin_diag	If type of service=1 , the ICD-9-CM diagnosis code representing the diagnosis chiefly responsible for the services performed during the visit. Includes decimal point. If type of service =2 , the ICD-9-CM diagnosis code including decimal point or blank if patient status is "07" consistent with the records of the reporting entity.																										
21-(1 of 9) Other 29 Diagnosis (ICD-CM) Code other_diag, position_nbr (1) – (9)	Up to 9 secondary ICD-9-CM codes representing a diagnosis related to the services provided during the visit. Less than nine or space filled permitted consistent with the records of the reporting entity. Includes decimal point.																										

APPENDIX B (continued)

Ambulatory/Emergency Department Patient Data Elements

DATA ELEMENT NAME	DESCRIPTION
30 Principal Payer Code prin_payer	Primary source of expected reimbursement, one digit code: A – Medicare B – Medicare HMO C – Medicaid D – Medicaid HMO E – Commercial Insurance F – Commercial HMO G – Commercial PPO H – Workers' Compensation I – CHAMPUS J – VA K – Other State/Local Government L – Self pay. No third party coverage M – Other N – Charity O – Kidcare. Includes Healthy Kids, MediKids and CMS P – Unknown. Reported only if payer information is not available, and type of service is "2" and patient status is "07"
31 Pharmacy Charges pharmacy_chgs	Charges for medication. Charges are reported in dollars numerically without dollar signs or commas, excluding cents. Negative amounts are permitted if verified.
32 Medical and Surgical Supply Charges med_surg_chgs	Charges for supply items required for patient care. Charges are reported in dollars numerically without dollar signs or commas, excluding cents. Negative amounts are permitted if verified.
33 Laboratory Charges lab_chgs	Charges for the performance of diagnostic and routine clinical lab tests. Charges are reported in dollars numerically without dollar signs or commas, excluding cents. Negative amounts are permitted if verified.
34 Radiology and Other Imaging Charges rad_imaging_chgs	Charges for the performance of diagnostic and therapeutic radiology services including computed tomography, mammography, magnetic resonance imaging, nuclear medicine, and chemotherapy administration of radioactive substances. Charges are reported in dollars numerically without dollar signs or commas, excluding cents. Negative amounts are permitted if verified.
35 Cardiology Charges cardiology_chgs	Facility charges for cardiac procedures rendered such as catheterization. Charges are reported in dollars numerically without dollar signs or commas, excluding cents. Negative amounts are permitted if verified.
36 Operating Room Charges oper_room_chgs	Charges for the use of the operating room. Charges are reported in dollars numerically without dollar signs or commas, excluding cents. Negative amounts are permitted if verified.

APPENDIX B (continued)

Ambulatory/Emergency Department Patient Data Elements

DATA ELEMENT NAME	DESCRIPTION
37 Anesthesia Charges anesthesia_chgs	Charges for anesthesia services by the facility. Charges are reported in dollars numerically without dollar signs or commas, excluding cents. Negative amounts are permitted if verified.
38 Recovery Room Charges recovery_chgs	Charges for the use of the recovery room. Charges are reported in dollars numerically without dollar signs or commas, excluding cents. Negative amounts are permitted if verified.
39 Emergency Room Charges er_chgs	Charges for medical examinations and emergency treatment. Charges are reported in dollars numerically without dollar signs or commas, excluding cents. Negative amounts are permitted if verified.
40 Treatment or Observation Room Charges treat_observ_chgs	Charges for use of a treatment room or for the room charge associated with observation services. Charges are reported in dollars numerically without dollar signs or commas, excluding cents. Negative amounts are permitted if verified.
41 Other Charges other_chgs	Other facility charges not included in categories above. Charges are reported in dollars numerically without dollar signs or commas, excluding cents. Negative amounts are permitted if verified.
42 Total Gross Charges total_gross_chgs	The total of undiscounted charges for services rendered by the reporting entity. Sum of all charges must equal total charges, plus or minus 10. Charges are reported in dollars numerically without dollar signs or commas, excluding cents. Negative amounts are permitted if verified.
43 Principal ICD-CM Procedure Code prin_icdcm_proc	The ICD-9-CM procedure code representing the procedure or service most related to the principal diagnosis. May be space filled consistent with the records of the reporting entity or ICD-9-CM procedure code. Includes decimal point.
44-47 (1 of 4) Other ICD-CM Procedure Code other_icdcm_proc,position_nbr(1) – (4)	Up to 4 secondary ICD-9-CM procedure codes representing a procedure or service provided during the visit. Less than four or space filled permitted consistent with the records of the reporting entity. Includes decimal point.
48 Principal CPT or HCPCS Procedure Code prin_cpt_proc	A code representative of the services provided or procedures performed. If type of service =1 CPT code between 10000-69999, inclusive, or 93500-93599 inclusive. If type of service =2 , and patient status is not "07" contains HCPCS or CPT evaluation and management code. May be a blank field consistent with records of the reporting entity.

APPENDIX B (continued)

Ambulatory/Emergency Department Patient Data Elements

DATA ELEMENT NAME		DESCRIPTION
49-57	(1 of 9) Other CPT or HCPCS Codes other_proc, position_nbr (1) – (9)	Up to 9 secondary CPT or HCPCS procedure codes may be reported.
58-60	(1 of 3) External Cause of Injury Code ext_injury, position_nbr (1) – (3)	Up to 3 ICD-9-CM cause of injury codes representing circumstances or conditions as the cause of injury, poisoning, or other adverse effects recorded as a diagnosis. Less than three or space filled consistent with the records of the reporting entity. Includes decimal point.
61	Attending Physician ID Number attend_phys_id	The Florida license number of the attending physician, an alpha-numeric field of up to eleven characters. US = Military physicians not licensed in Florida NA = Patient was not treated by a medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or ARNP.
62	Operating or Performing Physician ID Number perform_oper_phys_id	The Florida license number of the operating or performing physician, an alpha-numeric field of up to eleven characters. US = Military physicians not licensed in Florida
63	Other Physician ID Number other_phys_id	The Florida license number of another physician, other than the attending or operating. May be blank or no entry consistent with the records of the reporting entity. US = Military physicians not licensed in Florida

APPENDIX C

Racial Categories

Racial Category	Race/Ethnic Description
White	White White Hispanic
Black / African-American	Black Black Hispanic
Other	Asian/Pacific American Indian Other
No Response	No Response

APPENDIX D

Principal Payer Categories

Payer Category	Payer Description
Medicare	Medicare
	Medicare HMO
Medicaid	Medicaid
	Medicaid HMO
Commercial Insurance	Commercial Insurance
	Commercial HMO
	Commercial PPO
Other Government	TRICARE
	VA
	Workers' Compensation
	Other Government
	Other
Self-Pay / Underinsured	Self Pay / Under-insured
Charity	Charity

Source: AHCA

APPENDIX E

Emergency Department Visits By Payer, 2005, Quarter 1

Payer	Number	Percent
Medicare	58,557	12.1%
Medicare HMO	13,005	2.7%
Medicaid	61,932	12.8%
Medicaid HMO	54,849	11.4%
Commercial Insurance	27,286	5.7%
Commercial HMO	63,387	13.1%
Commercial PPO	62,872	13.0%
Workers Compensation	11,480	2.4%
TRICARE	6,830	1.4%
VA	749	0.2%
Other Government	4,447	0.9%
Self Pay/Underinsured	105,491	21.9%
Other	626	0.1%
Charity	7,477	1.5%
KidCare	3,806	0.8%
Total	482,794	100.0%

Source: AHCA

APPENDIX F

Emergency Department Visits By Hour of Arrival, 2005, Quarter 1

Hour of Arrival	Number	Percent
12:00 midnight to 12:59am	13,136	2.7%
1:00 to 01:59	10,954	2.3%
2:00 to 02:59	8,806	1.8%
3:00 to 03:59	7,659	1.6%
4:00 to 04:59	6,886	1.4%
5:00 to 05:59	6,528	1.4%
6:00 to 06:59	7,682	1.6%
7:00 to 07:59	12,244	2.5%
8:00 to 08:59	18,821	3.9%
9:00 to 09:59	24,953	5.2%
10:00 to 10:59	28,467	5.9%
11:00 to 11:59	29,825	6.2%
12:00 noon to 12:59pm	28,449	5.9%
1:00 to 01:59	26,757	5.5%
2:00 to 02:59	26,339	5.5%
3:00 to 03:59	26,310	5.4%
4:00 to 04:59	26,672	5.5%
5:00 to 05:59	26,567	5.5%
6:00 to 06:59	27,706	5.7%
7:00 to 07:59	27,810	5.8%
8:00 to 08:59	26,456	5.5%
9:00 to 09:59	24,540	5.1%
10:00 to 10:59	21,580	4.5%
11:00 to 11:59	17,646	3.7%
Total	482,794	100.0%

Source: AHCA

APPENDIX G

Emergency Department Visits By Payer and Patient Acuity Level, 2005, Quarter 1

Patient Acuity Level

Payer	99281		99282		99283		99284		99285		Total	
	Num	Pct	Num	Pct	Num	Pct	Num	Pct	Num	Pct	Num	Pct
Medicare	7,472	11.1%	18,739	13.0%	15,098	14.9%	7,043	20.9%	2,610	22.8%	50,962	14.2%
Medicaid	17,939	26.6%	36,743	25.5%	28,917	28.4%	7,850	23.3%	2,187	19.1%	93,636	26.1%
Commercial Ins.	20,128	29.9%	46,689	32.4%	32,236	31.7%	10,453	31.1%	3,561	31.1%	113,067	31.6%
Other Government	4,292	6.4%	7,891	5.5%	4,419	4.3%	1,189	3.5%	358	3.1%	18,149	5.1%
Self-Pay/Underinsured	16,638	24.7%	32,260	22.4%	19,696	19.4%	6,627	19.7%	2,609	22.8%	77,830	21.7%
Charity	854	1.3%	1,885	1.3%	1,293	1.3%	479	1.4%	133	1.2%	4,644	1.3%
Total	67,323	100.0%	144,207	100.0%	101,659	100.0%	33,641	100.0%	11,458	100.0%	358,288	100.0%

Note: Total excludes visits that cannot be grouped by acuity level.

Source: AHCA

APPENDIX H

Emergency Department Visits Mean and Sum of Charges by Age Group and Acuity Level, 2005, Quarter 1

Age Group	Low Acuity Visits			High Acuity Visits			Total	
	Number	Mean	Sum	Number	Mean	Sum	Number	Mean
Ages 0-14 years	60,013	\$631	\$37.9	38,528	\$1,281	\$493.7	122,618	\$995
Ages 15-24 years	34,344	\$984	\$33.8	21,982	\$2,387	\$524.6	76,089	\$1,692
Ages 25-44 years	60,821	\$1,121	\$68.2	38,608	\$2,857	\$1,102.9	135,995	\$2,026
Ages 45-64 years	33,449	\$1,254	\$41.9	25,429	\$3,385	\$860.8	83,786	\$2,470
Ages 65-74 years	10,364	\$1,321	\$13.7	8,946	\$3,679	\$329.1	27,603	\$2,654
Ages 75 years and older	12,539	\$1,536	\$19.3	13,265	\$3,847	\$510.3	36,703	\$2,966
Total	211,530	\$1,015	\$214.7	146,758	\$2,604	\$3,821.5	482,794	\$1,896

Notes: Total includes visits that cannot be classified by acuity level and invalid ages.

Value of Sum is in millions.

Source: AHCA

APPENDIX I

Emergency Department Visits Mean and Sum of Charges by Payer Group and Acuity Level, 2005, Quarter 1

Payer Group	Low Acuity Visits			High Acuity Visits			Total	
	Visits	Mean	Sum	Visits	Mean	Sum	Visits	Mean
Medicare	26,211	\$1,385	\$36.3	24,751	\$3,684	\$91.2	71,562	\$2,738
Medicaid	54,682	\$759	\$41.5	38,954	\$1,837	\$71.6	116,781	\$1,360
Commercial Insurance	66,817	\$1,143	\$76.4	46,250	\$2,783	\$128.7	157,351	\$2,038
Other Government	12,183	\$994	\$12.1	5,966	\$2,443	\$14.6	24,132	\$1,626
Self Pay/Underinsured	48,898	\$916	\$44.8	28,932	\$2,407	\$69.6	105,491	\$1,710
Charity	2,739	\$1,321	\$3.6	1,905	\$3,395	\$6.5	7,477	\$2,714
Total	211,530	\$1,015	\$214.7	146,758	\$2,604	\$382.1	482,794	\$1,896

Notes: Total includes visits that cannot be classified by acuity level.

Value of Sum is in millions.

Source: AHCA

APPENDIX J

Emergency Department Visits Top Five Principal Diagnoses By Payer Group, 2005, Quarter 1

Medicaid			
Principal Diagnosis	Description	Number	Percent
465.9	Acute Upper Respiratory Infection	7,991	6.8%
382.9	Otitis Media	6,364	5.4%
558.9	Noninfectious Gastroenteritis	4,779	4.1%
079.99	Viral Infection	4,261	3.6%
780.6	Fever	3,790	3.2%
	Total	116,781	100.0%

Commercial			
Principal Diagnosis	Description	Number	Percent
847.0	Sprain Of Neck	5,044	4.3%
558.9	Noninfectious Gastroenteritis	3,729	3.2%
465.9	Acute Upper Respiratory Infection	3,449	3.0%
466.0	Acute Bronchitis	2,983	2.6%
382.9	Otitis Media	2,876	2.5%
	Total	157,351	100.0%

Self-Pay / Underinsured			
Principal Diagnosis	Description	Number	Percent
466.0	Acute Bronchitis	2,445	2.1%
465.9	Acute Upper Respiratory Infection	2,257	1.9%
784.0	Headache	1,761	1.5%
382.9	Otitis Media	1,728	1.5%
724.2	Lumbago	1,716	1.5%
	Total	105,491	100.0%

Source: AHCA

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