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# Section 1- Introduction to Observation

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## What is Observation?

*"Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."*

Medicare Claims Processing Manual, Chapter 12, section 30.6.8

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In the 2 MN terminology, Observation is medically necessary hospital monitoring that is not part of another service and not expected to extend the total care past 2 midnights.

It's a service provided to outpatients, not a status!

The rules I discuss apply to FFS Medicare- Commercial insurers/MA plans/Managed Medicaid make up their own rules



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## Who gets Observation?

ED or direct "admit" patients who are expected to stay in the hospital under two midnights

Post-procedure patients who need care past the normal recovery but under two midnights

Post-procedure patients who need recovery after the recovery room time

Late procedures who need recovery but recovery room closed

Post-procedure patients who need to spend a night in the hospital

Pre-procedure patients hospitalized the day prior for preparation or clearance

Patients who are staying because they can't get a ride home

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## Only the top two are "real" Observation

ED or direct "admit" patients who are expected to stay in the hospital under two midnights

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Late procedures who need recovery but recovery room closed

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## Status and Service

Only two statuses:

Inpatient- formally admitted as inpatient with an order from a qualified practitioner (physician or non-physician practitioner with admitting privileges)

Outpatient- registered at hospital to receive services but not admitted as an inpatient

Outpatients can receive observation as a service.

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## What's the problem?

Outpatients may not show up on physician census or be counted as body-in-a-bed for staffing

So, you can call them an observation patient, extended recovery patient, overnight patient, surgical recovery patient, etc. but they are all **outpatients**.



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## The 2-Midnight Rule

What is an Inpatient?

Surgical procedures, diagnostic tests, and other treatments would be generally appropriate for inpatient admission and inpatient hospital payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses at least 2 midnights and admits the beneficiary to the hospital based upon that expectation.

- 2014 IPPS Final Rule, p. 50944

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## What is an Outpatient?

Conversely, when a beneficiary enters a hospital for a surgical procedure not specified by Medicare as inpatient only under § 419.22(n), a diagnostic test, or any other treatment, and the physician expects to keep the beneficiary in the hospital for only a limited period of time that does not cross 2 midnights, the services would be generally inappropriate for payment under Medicare Part A. This would be the case regardless of the hour that the beneficiary came to the hospital or whether the beneficiary used a bed.



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## Who Stays and Who Goes?

"The crux of the medical decision is the choice to keep the beneficiary at the hospital in order to receive services **or** reduce risk, or discharge the beneficiary home because they may be safely treated through intermittent outpatient visits or some other care."

2014 IPPS Final Rule, p. 50945

Note- Intensity of services or severity of illness

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## Applying the Rule

Step 1- Ask: Does patient need to be in hospital for a medically necessary stay as determined by First Level Screening/Secondary Review

No- their stay would be for convenience- no safe discharge plan, wants to stay for medications

-Make alternate arrangements-SNF, home aide, hotel, voucher for meds

-Place in hospital bed as outpatient w/medically unnecessary Observation order

Yes- go to step 2

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## If they have necessity to stay then

Step 2- Estimate length of expected hospital stay, including any midnights already spent in hospital/ED
(clock starts with symptom-related care)

Clearly < 2 midnights- place observation

Clearly ≥ 2 midnights (or exception)- admit as inpatient

Unsure- secondary review

Remember: The ED doc determines they need to stay, admitting doctor/secondary reviewer gets to say how long they think the patient will stay

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## A Word about Screening Criteria

IQ and MCG criteria are still important

View your book as one set of criteria- **needs hospitalization** (pass In or Obs) or **does not need hospitalization** (fails In and Obs)

If they pass In or Obs (first level review by RN), they **need** to be in the hospital, but they still must be expected to need 2 MN to be admitted inpatient (so you can pass for In by IQ but be placed Obs, as with some TIA patients)

If they don't pass any criteria, they need secondary physician review to determine if the **need** for hospitalization exists and if there is the expectation of 2 MN.



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## The notes must explain why the patient needs to be in the hospital

"The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services."

42 CFR 482.24(c)

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## Why can't all our docs document like this?

Pt has fever and an elevated white count. Presentation is strongly suggestive of sepsis and will most likely require ID consult, and empiric antibiotics for now pending ID opinion. Work up for source of infection started. Cultures have been obtained and results will take 48 hours for documentation of source of infection and ID of organism. Monitoring of hemodynamics and attention to electrolytes and urine output indicated to avoid hemodynamic compromise and renal injury. A minimum two day hospital stay will be required and much longer if blood cultures are returned positive."



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## Changing Status- Only Way

Outpatient to Inpatient → Order inpatient admission

Inpatient to Outpatient → Condition Code 44
Formally discharge patient
Patient dies

Even the person that ordered the admission cannot change back to outpatient without doing CC44

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## What is Observation to a doctor?

Another rule to try to figure out (or ignore)

Different set of codes for billing their services

For attending physician, no difference in pay

For consultants, less pay for same work

Risk that CMS will compare codes and deny doctor for billing incorrectly



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## Section 2 – Most Common Diagnoses

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## Section 3- Payment Structure

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## Why get it Right?

### Medicare Compliance Review of Northwestern Memorial Hospital for 2011 and 2012

For 22 of the 73 sampled claims, the Hospital incorrectly billed Medicare for observation hours resulting in incorrect outlier payments. Specifically, the Hospital included observation time for services that were part of another Part B service including postoperative monitoring or standard recovery care (10 errors), for time the patients remained in the hospital after treatment was finished (3 errors), or the medical record did not contain an order for the observation services (1 error). For the remaining 8 errors, the patient's condition did not warrant observation services. For 18 of these 22 errors, the Hospital also incorrectly billed Medicare for medications that were not supported in the medical records. Hospital officials stated that these errors primarily occurred because of inadequate procedures to correctly identify observation hours.

$3,723 from 22 errors extrapolated to $87,393 in overpayments- total overpayment $6.4 million

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## Hospital Payment for Observation

APC 8009 -

Includes level 4 or 5 ED visit/critical care ED visit/direct admit (G0379) and 8+ hours of Observation care

Pays $1,287 in 2015

No payment if T procedure day prior or same day

Revenue Code 0762

If under 8 hours, ED visit APC will be paid but no pay for observation time



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## Inpatient v. Outpatient Heart Failure

| | |
|---|---|
| APC 8009 for visit | $1,300 - $2,000 |
| DRG 293 "plain" | $10,543 |
| DRG 292 with CC | $13,483 |
| DRG 291 with MCC | $18,139 |

(teaching hospital in Northern California)

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## Inpatient Admission Payment

Baseline DRG payment – stratified by CC/MCC
Wage Index for Area
Readmission Penalty
VBP bonus/penalty
HAC penalty
DSH payment
IME and DME payment
Uncompensated care payment
Capital payments
Sole Community payment



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```
20141125     INPAT PRICER 2014.3 PSF 01/14 (DISCHRGS 10/2013-9/2014)  13:35
PROVIDER> 050025                                    PROV TYPE> 00 CEN-DIV> 9
EFF DATE> 20131001          * OPERATING AMOUNTS *  COST OUT THRES>      $0.00
   PATIENT0 ID>111-11-11111       O-FSP>    $9,463.68      DRG WGHT> 01.5031
         DRG> 291                 O-HSP>        $0.00       GM ALOS> 04.6
   ADMIT DATE> 12/01/2013       O-OUTLR>        $0.00    WAGE  INDX> 01.2477
   DISCH DATE> 12/05/2013 NEW TECH AMT >        $0.00 PR WAGE  INDX> 00.0000
  FY BEG DATE> 07/01/2013         O-DSH>      $613.25  GEO/STD CBSA> 41740/41740
  LEN OF STAY> 004                O-IME>    $2,663.14     RECL CBSA> 41740   NO
 OUTLIER DAYS> 000              READMIT>       $25.55CR  OP/CAP CCR> 0.330/0.028
 TRANSFER ADJ> 0.00000 NO         VBP>        $8.25     NAT LABOR> 3737.71
   CHARGES AMT>        $0.00     BUNDLE>       $0.00    NAT NLABOR> 1632.57
TOT OPER  AMT +    $12,722.77 UNCOM CARE>    $2,094.99   NAT FSP AMT>  $6,296.11
TOT CAPI  AMT +     $1,019.59  * CAPITAL   AMOUNTS *     OP/CAP DSH >0.259/0.094
      LOW VOL +         $0.00      C-FSP>      $750.87    OP/CAP IME >0.281/0.264
TOT DRG   AMT  =    $15,837.35     C-OUTLR>      $0.00   READMIT ADJ> 0.9973
PASS THRU AMT +     $2,301.52      C-DSH>       $70.81     VBP ADJ> 1.00087193290
*** TOTAL AMT =    $18,138.87      C-IME>      $197.91   BUNDLE  %  > 0.00
                                   MA-HSP>       $0.00
 ****>   14 CALC AS DRG PAY - PERDIEM DAYS = OR > GM LOS
DRG DSC> HEART FAILURE & SHOCK W MC
MDC DSC> DISEASES & DISORDERS OF THE CIRCULATORY SYSTEM
-------------------------------- --------------------------------
V = VIEW THIS PROV  A = ADD PROV  B = CHANGE BILL  R = PRT REPORT  Q = QUIT  ENTER>
```

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| Calculation | | Reimbursement Amount From APC | APC # |
|---|---|---|---|
| CPT-99285-25 APC-08009 Status-V Pymt(A)-$1179.8 | Observation | $1,179.80 | 08009 |
| UB-320 CPT-71020 APC-00260 Status-X Pymt(A)-$56.43 | xray | $56.43 | 00260 |
| UB-320 CPT-71020 APC-00260 Status-X Pymt(A)-$56.43 | xray | $56.43 | 00260 |
| UB-730 CPT-93005 APC-00099 Status-S Pymt(A)-$26.69 | EKG | $26.69 | 00099 |
| UB-730 CPT-9300577 APC-00099 Status-S Pymt(A)-$26.69 | EKG | $26.69 | 00099 |
| UB-300 CPT-36415 APC-19900 Status-N no-payment | venipuncture | $0.00 | 19900 |
| UB-300 CPT-80048 APC-19900 Status-N no-payment | CMP | $0.00 | 19900 |
| UB-300 CPT-83880 APC-19900 Status-N no-payment | BNP | $0.00 | 19900 |
| UB-300 CPT-84484 APC-19900 Status-N no-payment | troponin | $0.00 | 19900 |
| UB-300 CPT-85025 APC-19900 Status-N no-payment | CBC | $0.00 | 19900 |
| UB-460 CPT-94761 APC-19900 Status-N no-payment | pulse ox | $0.00 | 19900 |
| UB-762 CPT-G0378 APC-19900 Status-N no-payment | observation hours | $0.00 | 19900 |
| CPT-80048 APC-19900 Status-N no-payment | CMP | $0.00 | 19900 |
| CPT-85025 APC-19900 Status-N no-payment | CBC | $0.00 | 19900 |

**Total Claim - $1346.04**
**Patient Responsibility - $273.60**



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# Payment for Diagnostics

Other services

Services < $100 are packaged (not paid at all) into APC

| | | | |
|---|---|---|---|
| ECG | $27 | Labs (if no APC) | |
| CXR | $59 | CBC | $11 |
| CT chest | $249 | BNP | $46 |
| CT abd | $390 | CMP | $14 |
| UTZ abd | $135 | PT | $5 |
| MRI Brain | $426 | UA | $4 |
| ECHO | $420 | lipase | $9 |
| EGD | $670 | trop | $13 |
| Colonoscopy | $737 | draw | $3 |

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## Counting and Billing Observation Hours

Counting starts when obs order written

- If verbal order, authentication per hospital policy
  - (not prior to discharge)
- Carve out hours where patient receives active monitoring during a procedure– (to follow)

Ends when medically necessary observation ends

Except CAHs where hour counting ends with order



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## Observation Patients beyond the second Midnight

Patient presents at 12:05 am Monday with severe abd pain

Obs ordered at 2:00 am Monday, tests done, etc.

Doctor rounds at 9 pm Tuesday and patient stable

Patient requests to stay until morning

Doctor orders “discharge in am”

Patient discharged at 8 am Wednesday

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## What happened between 9 pm and 8 am?

Nurse continued to care for patient

or

Nurse disconnected monitors, took out call light and closed patient door



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## What happened between 9 pm and 8 am?

Nurse continued to care for patient

or

Nurse disconnected monitors, took out call light and closed patient door

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## The Convenience Patient

So…patient continued to receive observation services but it was not medically necessary because the patient did not need to stay in the hospital at all.



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## Medically Unnecessary Observation

Separate out necessary and not necessary observation hours

| | 42 REV.CD. | 43 DESCRIPTION | 44 HCPCS/RATE/HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES |
|---|---|---|---|---|---|---|---|
| 1 | 0762 | Observation Services, per hour | G0378 | 4-1-15 | 20 | 2000.00 | |
| 2 | 0762 | Observation Services, per hour | G0378GZ | 4-2-15 | 11 | | 825.00 |
| 3 | | | | | | | |

Modifier –GZ indicates not medically necessary but no ABN given to patient

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## What about a patient who wants to stay but the doctor discharges? "staying AMA"

Get an ABN completed and signed by patient.

Separate out necessary and not necessary observation hours

Modifier –GA indicates not medically necessary and ABN given to patient.



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## Section 4- Consultant's Role

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## Section 5- The Patient

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## What is Observation to a patient?

Observation patient's status is Outpatient Part B

Self-administered medications not covered

- Getting reimbursement from Medicare D is daunting
- Bringing meds from home is a safety issue

Part B deductible and coinsurance apply

- $147 once yearly deductible
- 20% of approved charges up to $1,260 per line item

Days do not count for 3 day Part A SNF benefit

It makes no sense to them since they are in a bed in the hospital!

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## What the media tells people

**Shift in hospital admission policy can have costly implications for patients**

**Chicago Tribune, May 8, 2012**

"Naturally, an emergency patient isn't thinking about hospital status. However, being an inpatient can mean significant savings to you. So you should ask your doctor to see that you are admitted."

- www.chicagotribune.com/business/sns-201205081900--tms--savingsgctnzy-a20120508may08,0,360816.story



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## NBC News Report on Observation

"Medicare patients should be sure they are admitted"


This applies to the long observation stays of the pre-2 MN era with no SNF benefit.

http://www.ronaldhirsch.com/youtube-videos.html

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## But Observation costs patients a lot

Medically necessary observation stays cannot exceed two midnights. That's "the law."

The deductible for an observation stay is $147 and the coinsurance is 20% of the approved payment.

The 2015 inpatient deductible is $1,260, even if they stay only one day. That resets 60 days after discharge.

So to find break even point, $147 + ($Y x 20%)> $1,260

Y = $5,565



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That means that Observation is cheaper for patients as long as the approved charges during that one day stay do not exceed $5,565.

The average Observation stay Medicare approved payment is $1,741.

$1,741 x 20% copay = $348 + $147 deductible = $495 pt due

$1,260 - $495 = $765

That means the patient would have to receive $765 worth of self-administered medications in that one day observation stay in order for their financial obligation as an observation patient to exceed their obligation if admitted as inpatient.

Therefore, being placed observation is actually the much better financial option for the patient.

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## What is Observation to a doctor?

Another rule to try to figure out (or ignore)

Different set of codes for billing their services

For attending physician, few pennies difference in pay

For consultants, less pay for same work

Risk that CMS will compare codes and deny doctor for billing incorrectly



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## Physician Coding

Primary doctor- POS- 22- outpatient hospital
Initial visit- 99218-99220
Admit and discharge same visit- 99234-99236
Subsequent visit- 99224-99226
Discharge from Obs- 99217
From Obs to Inpt- 99221 or 99231-99233
Critical Care eligible 99291

Consultants- POS 22- outpatient hospital
99201-99205- if new patient
99212-99215- if established patient

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## Section 6- Hidden Expenses

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## Section 7- Carve Outs

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## Carve-out Hours

Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time.

MCPM Ch 4, 290.2.2



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## Carving Out Hours

Any separately billed ancillary service that requires ongoing monitoring/attendance must be subtracted from observation.

Noridian: "If a patient is sent for an imaging procedure with an observation nurse, the time could be included in observation hours. However, if a patient leaves the observation area, sent without a nurse for a study or "goes for a smoke", providers should not bill the time."

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## Practical Application

Services where patient leaves the unit without RN-
- procedures, imaging, surgery

Services with RN "active monitoring"-
- blood transfusions
- dialysis
- chemotherapy/ high toxicity drugs
- slow IV push medications
- bedside scopes or procedures
- therapy evaluations and treatments



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## Steps to Compliance

- Develop (borrow/steal) a policy
- Decide which services include "active monitoring"
- Determine average time for "active monitoring"
- Calculate total observation hours from time of order to end of services
- Subtract active monitoring time from observation time

CMS doesn't specify what should be carved out; there is no "right" list

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## Section 8- Surgery

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## Observation and Surgery

Can you provide observation to a surgery patient?
Yes

Will you get more money for observation on a surgery patient?
No

Should you report observation on a surgery patient?
Yes

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## Surgery Patients and Observation Units- Yes or No?

Most post-op patients do not need Observation services; they need routine post-op care.

Most Observation unit nurses are versed in medical care but not surgery recovery or procedural recovery

Putting post-op patients in Observation unit throws off statistics – comparing chest pain patients to post-cardiac stent patients to post-chol'y patients; mixing up routine recovery and observation hours



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## Medicare Addendum E: Inpatient Only Procedures

Addendum E.-HCPCS Codes That Are Paid Only as Inpatient Procedures for CY 2011

| HCPCS Code | Short Descriptor | SI | CI |
|---|---|---|---|
| 47600 | Removal of gallbladder | C | |
| 47605 | Removal of gallbladder | C | |
| 47610 | Removal of gallbladder | C | |
| 47612 | Removal of gallbladder | C | |
| 47620 | Removal of gallbladder | C | |

Status Indicator C = Inpatient only

5 HCPCS codes (procedures) for "removal of gall bladder"
All inpatient procedures

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# Medicare Addendum B: All Procedures Listed

**Addendum B:** Quarterly update that includes all CPT/HCPCS codes.

Status indicators:

C – Inpatient only:

- Must be admitted *prior to* surgery.
- Hospital cannot bill if procedure is done as outpatient.

T – Outpatient procedure when done on stable patient *or* can be inpatient under certain circumstances.




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## Addendum B

Addendum B.-OPPS Payment by HCPCS Code for CY 2011

| HCPCS Code | Short Descriptor | SI | APC | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment | * Indicates a Change |
|---|---|---|---|---|---|---|---|---|
| 47552 | Biliary endoscopy thru skin | T | 0152 | 31.7356 | $2,185.82 | | $437.17 | |
| 47553 | Biliary endoscopy thru skin | T | 0152 | 31.7356 | $2,185.82 | | $437.17 | |
| 47554 | Biliary endoscopy thru skin | T | 0152 | 31.7356 | $2,185.82 | | $437.17 | |
| 47555 | Biliary endoscopy thru skin | T | 0152 | 31.7356 | $2,185.82 | | $437.17 | |
| 47556 | Biliary endoscopy thru skin | T | 0152 | 31.7356 | $2,185.82 | | $437.17 | |
| 47560 | Laparoscopy w/cholangio | T | 0130 | 38.6514 | $2,662.15 | $659.53 | $532.43 | |
| 47561 | Laparo w/cholangio/biopsy | T | 0130 | 38.6514 | $2,662.15 | $659.53 | $532.43 | |
| 47562 | Laparoscopic cholecystectomy | T | 0131 | 47.8453 | $3,295.39 | $1,001.89 | $659.08 | |
| 47563 | Laparo cholecystectomy/graph | T | 0131 | 47.8453 | $3,295.39 | $1,001.89 | $659.08 | |
| 47564 | Laparo cholecystectomy/explr | T | 0131 | 47.8453 | $3,295.39 | $1,001.89 | $659.08 | |
| 47570 | Laparo cholecystoenterostomy | C | | | | | | |
| 47579 | Laparoscope proc biliary | T | 0130 | 38.6514 | $2,662.15 | $659.53 | $532.43 | |
| 47600 | Removal of gallbladder | C | | | | | | |
| 47605 | Removal of gallbladder | C | | | | | | |
| 47610 | Removal of gallbladder | C | | | | | | |
| 47612 | Removal of gallbladder | C | | | | | | |
| 47620 | Removal of gallbladder | C | | | | | | |

C = Inpatient only
T = outpatient / can be inpatient

APC = ambulatory payment classification
No APC for inpatient procedures

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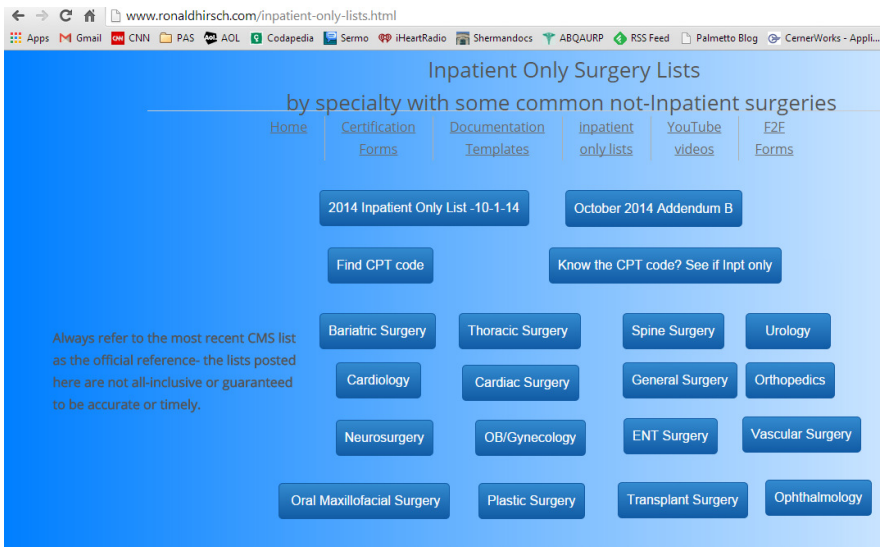


2015 inpt lists at ACPAdvisors.org- members section



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## Not on IOL = Outpatient

If it's not on the Inpatient Only List, it is Outpatient…

--unless the doctor documents clearly the expectation of a greater than two midnight recovery based on unique characteristics of that patient having that particular surgery.

If a doctor always keeps his non-Inpatient Only surgery patients beyond two midnights for routine recovery, you only admit or order Observation if they need more care beyond that routine recovery.

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## So when does the doctor need to order Observation post-op?

Only after that doctor's normal recovery for that surgery

and

If that additional care is not going to take the total period of hospital care beyond two midnights.



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## Indications for Post -Op Observation

- Persistent nausea/vomiting
- Fluid/electrolyte imbalance
- Uncontrolled pain
- Dysrhythmias
- Excessive/uncontrolled bleeding
- Psychotic behavior
- Unstable level of consciousness
- Deficit in mobility/coordination

TMF Health Quality Institute, (Texas Q.I.O.)

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## The proper role for Observation

Observation cannot be ordered pre-op- that means the doctor is expecting a complication

Observation cannot be ordered in recovery room unless the patient has already developed a complication that requires care beyond normal recovery (which can happen)



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## Observation ordered before any preplanned surgery

- Observation may not be ordered for a pre procedure prep, including pre op hydration or "renal protection protocol" or for cardiac or medical clearance.
- If prep or clearance cannot be done outside hospital due to patient issues (bed bound, dementia, requires supervision, etc.) use medically unnecessary observation w/wo ABN

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# Aetna Policy 0255- Pre-op Admission

- A planned major surgical procedure which requires an extensive bowel preparation (GoLytely, laxatives, multiple enemas) in a member with a comorbidity (e.g., chronic renal failure, elderly individual with muscle wasting and poor nutritional status resulting in a significant weight loss of greater than 10 %) whose condition places the individual at high-risk for electrolyte and fluid imbalances; or
- A planned surgical procedure on partially obstructed bowel which requires a slow but extensive bowel preparation pre-operatively; or
- An invasive diagnostic procedure (e.g., aortogram, arteriogram or cardiac catheterization, myelogram) with major surgery scheduled for the following day; or
- Close monitoring of blood sugars is required to provide adequate adjustment of regular insulin coverage in preparation for an operative procedure in a brittle insulin-dependent diabetic member (i.e., diabetic individuals who experience large, unpredictable changes in blood glucose, within short periods of time, as a result of very small deviations from schedule);



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- The member has a concurrent medical problem that requires specific inpatient treatment prior to major surgery (defined as craniotomy, laparotomy, median sternotomy, or thoracotomy) to reduce the operative risk or assure a more favorable outcome; or
- The member is scheduled for an open heart procedure requiring cardiopulmonary bypass (cardiac valve replacement or repair, coronary artery bypass grafting) and has unstable angina, congestive heart failure, severe hypertension, or significant ventricular arrhythmias; *or*
- The member requires conversion from coumadin to intravenous heparin (not subcutaneous heparin for a surgical procedure planned for the next day (individuals with mitral valve disease, especially with atrial fibrillation, may require 2 pre-operative days)

If this necessary pre-op care and routine post-op care will take them past the second midnight, you should admit as inpatient.

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## Standard of Care

Status T procedures all have a routine post-operative recovery that is less than two midnights.

If your physician routinely keeps patients beyond the second midnight, you do not order observation or consider admitting as inpatient until that routine recovery has ended.

-needs more monitoring that day only→ Observation

-needs another day in the hospital→ Inpatient



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If your urologists always keep their patients until POD #2, assess at that time for Observation or Inpatient

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## Routine Use of Post-Op Observation

"But our docs write '23 hr OPO' on post-op order for all patients that spend the night."

Don't fret; just get a clarification order to cancel the observation. Their status is still outpatient. Then teach the docs to stop writing it!



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## Section 9- Case Studies

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