Freestanding Emergency Care Centers

an Information Paper

Developed by Members of the
Emergency Medicine Practice Committee

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Definition
The term “freestanding emergency care center” (FECC) refers to a facility that provides on demand emergency medical care in a setting that is geographically removed (that is “freestanding”) from a hospital. Such facilities may be hospital or physician-owned, may operate 24 hours per day or on a more limited schedule, and may or may not receive patients by ambulance. According to a 2006 American Hospital Association (AHA) study\(^1\) there were 189 hospital-affiliated freestanding emergency care centers around the country. Two years later, in 2008, the Urgent Care Association of America (UCAOA)\(^2\) estimated that there were 8,000 urgent-convenience care facilities in operation.

Privately owned FECCs have been in existence for more than 40 years with the first such facility having been opened in Rhode Island. There is not much information available on how many privately owned FECCs or urgent care facilities exist today, in contrast to the traditional hospital-owned model that has been more widely described elsewhere. Since the state of Texas appears to be leading the development of privately owned FECCs, this paper focuses on the unique aspects of the practice, regulatory and insurance environment that has allowed for this to happen.

The Centers for Disease Control and Prevention (CDC) 2006 National Hospital Ambulatory Medical Care Survey\(^3\) breaks down hospital-based emergency medical care as being 15.9% immediate and emergent, 36.6% urgent, 22% semi-urgent, and 12.1% non-urgent. For the remaining 13.4% of visits the triage status was not known\(^1\). The typical FECC is prepared with both the appropriate staff and equipment to address the needs of ambulatory patients seeking emergency medical care and a few are capable of accepting ambulance patients as well.

Market Forces
The 2006 CDC Ambulatory Survey for Emergency Care reported that the number of hospital-based emergency care facilities decreased by 5% from 4,019 in 1996 to 3,833 in 2006. Over the same period of time, total emergency department (ED) visits grew by 24% from 90.3 million visits in 1996 to 119.2 million visits in 2006.\(^3\) On average, 40 of every 100 people visit an emergency department each year. Fewer EDs with higher patient volumes have translated into busier EDs with longer waits. This is especially true for non-emergent patients who are frequently pushed back in line by the arrival of emergency patients. Seven out of ten patients spent less than four hours in the ED. Nursing shortages and the boarding of inpatients in the ED pending inpatient bed availability have led to widespread ED crowding. In a 2007 AHA survey of 5,000 hospital administrators 65% of urban hospital administrators said their ED was at or over capacity.\(^4\)

While only 17.4% of ED patients in 2006 lacked some form of health insurance, the ED, more than any other care setting, mixes all social strata and acute medical needs together in one place. Given a reasonable alternative, many patients with less than emergent needs might prefer to avoid the ED.

Urgent Care Centers have become an accepted alternative to EDs for urgent medical care services. These facilities have changed patient and payer attitudes about what kinds of care can be delivered in non-hospital-based, on demand, and extended hours practices.

Increasing patient responsibility for first dollar care cost through higher deductibles and co-pays is encouraging patients to be more cost-conscious consumers. Many hospital EDs are becoming more aggressive in their efforts to collect money at the point of service. These factors serve to make alternative sources of emergency care of comparable cost more appealing to consumers.
Other Developments
There is a growing pool of emergency physicians with an interest in non-hospital-based emergency medicine practice. Some emergency physicians are seeking an alternative where they might have more control over their practice of emergency medicine.

The shrinking availability of on-call specialty resources in the typical ED is of increasing concern to many emergency physicians. FECCs have relatively little difficulty in securing specialty back-up services since their patients are seen as valuable referrals similar to those of any other physician in the community.

Relatively sophisticated point of care diagnostic testing and imaging capability is within the capability of the average FECC. Emergency physicians do not have to rely on the hospital for the ancillary support resources necessary to conduct a high quality emergency medicine practice.

Hospital-Owned FECCs
Hospital-owned FECCs are subject to all of the requirements as their parent’s hospital-based ED, including 24-hour per day operation and EMTALA obligations. Both EMTALA and Medicare’s Provider Conditions of Participation apply in full to these facilities. These are spelled out in 42 CFR 413.65 and the CMS Memorandum of January 11, 2008 referenced S&C-08-08.5

Physician-Owned FECCs
In some states, most notably Texas, individual emergency physicians have built, equipped, and operate their own FECCs. In general, these facilities do not operate 24-hours per day and have tended to locate in affluent areas. Texas has been in the forefront of this development primarily because of its prompt pay insurance laws. The terms of these laws are such that the insurance company risks significant penalties and fines if it can be shown that the payer failed to pay a clean claim within 45 days of the receipt of the claim in paper format or within 30 days of the receipt of an electronic claim. These laws in Texas have in effect forced insurers to recognize FECCs and come to the negotiating table. There are currently (2008) several dozen of these facilities throughout the state of Texas but relatively few in the rest of the country.

While hospital-owned FECCs are clearly entitled to utilize the 9928* Evaluation and Management CPT code series for billing purposes Medicare prohibits their use outside the hospital-based ED setting. Most physician-owned FECCs meet this challenge by charging Medicare patients office visit code charges. Most other payers oppose the use of the 9928* code series outside of the hospital ED setting but lack the legal authority of the government to penalize it. Since the quality of the care delivered is not being challenged in most cases it often comes down to the FECC standing its ground while the patient fights the insurance company for the same payment it would have made had the patient gone to a hospital-based ED. The negative patient public relations and the risks of running afoul of the Texas Prompt Pay laws have brought most payers in Texas to the negotiating table.

Both hospital and physician-owned FECCs charge a facility fee comparable to that charged in a hospital-based ED. Since this fee is in general no more than the fee that would have been incurred anywhere else, it is difficult for the payer to argue that it should not be paid.

The emergency physicians who own and operate these facilities in Texas are by and large residency trained and board certified in emergency medicine, and practice in a setting that they say:

- Is on average closer to the patient’s home than the hospital ED,
- Has a shorter waiting time than the average ED,
- Is more modern and up to date than the average hospital ED,
- Has better staffing than the average ED,
- Has equivalent testing and imaging support services,
• Has no trouble securing on-call specialty back-up services, and
• Costs the same or less than comparable hospital-based ED care.

They therefore argue that they should be free to use (and most do use) the 9928* code series for their billing.

A few physician-owned FECCs operate as combined FECCs and Urgent Care Centers but almost none receive patients by ambulance since ambulance operators are concerned about their liability exposure if they do not deliver the patient to the most capable source of emergency medical care. Most people would still consider such source to be the hospital-based ED.

At least one non-Texas physician-owned FECC has added several inpatient beds and applied for hospital designation as a way of qualifying for reimbursement in a state that does not recognize FECCs and has no prompt pay law.

**FECC Regulation**
All hospital-affiliated FECCs are regulated and licensed in the same way their parent facilities are regulated and licensed. Privately held FECCs and urgent care centers are regulated in many states with the justification being the protection of the public from being misled by the use of the terms “emergency” or “urgent” in facility names and/or promotional materials.

**Other Organization’s View of FECCs**
The American Hospital Association emphatically states (early 2009) that they have no policy on physician-owned FECCs. Though they are strongly opposed to physician-owned hospitals, they have not extrapolated that position to physician-owned FECCs that could be identified.

Neither the American Academy of Family Physicians nor any other medical specialty society or organization has any policy statement on FECCs at the time this paper was written.

**Discussion**
Certificate of Need (CON) provisions generally apply to both types of FECCs. Texas’ lack of CON laws may again contribute to the growth of physician-owned FECCs in that state. Hospitals view placing a hospital-owned FECC as a way to stake out new market territory and often locate them to be a precursor to full hospital development.

As with physician-owned specialty hospitals, there is a concern that, as well-paying patients are siphoned off into private practice settings, the general hospital ED will be left with a disproportionate share of low-pay or no-pay patients who lack the wherewithal to go anywhere else. Payers and state governments have begun to lobby for regulatory oversight of physician-owned FECCs. As these facilities are forced to bear a higher administrative burden and perhaps made to operate 24-hours per day, their market viability is likely to decline.

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**References**

2. 2008 Urgent care benchmarking study results. Urgent Care Association of America.
