

# **Freestanding Emergency Departments**

*an Information Paper*

*Developed by Members of the  
Emergency Medicine Practice Committee*

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## **Freestanding Emergency Departments**

A freestanding emergency department (FSED) is a facility that receives individuals for emergency care and is structurally separate and distinct from a hospital. The owner can be an individual (physician or non-physician), a corporation, a governmental unit, a limited liability company, a partnership (if a partnership name is stated in a written partnership agreement), or all partners in a partnership (if a partnership name is not stated in a written partnership agreement).

There are two distinct types of FSEDs: the hospital outpatient departments (HOPDs) and the independent freestanding emergency departments (IFSEDs). The HOPDs are owned and operated by, or licensed through, medical centers or hospital systems. Assuming the medical center or hospital system accepts Medicare payments, the HOPD falls under the same rules and regulations as the medical center or hospital, and the personnel and staff must be credentialed by the hospital. Medicare does not recognize IFSEDs as emergency departments (EDs) and does not have a provision for payment for the facility fee. Private insurance companies may not recognize IFSEDs as EDs and may pay a lesser fee or no facility fee, unless the IFSED is licensed, such as in Texas.

The Centers for Medicare and Medicaid Services (CMS) rules apply to all patients treated in facilities that accept funds from Medicare, even those patients not covered by the program. This is an important distinction, as IFSEDs generally do not accept Medicare assignment. Thus, they are not regulated at the federal level beyond the basic rules that apply to all publicly accessible areas (e.g., the Americans with Disabilities Act) or to all employers (eg, the Family and Medical Leave Act.)

HOPDs are EDs that are established geographically separate from a hospital's main campus. They operate as a provider-based department of the hospital and are allowed under the Medicare/Medicaid conditions of participation (CoP) as described in 42 CFR 482.1 through 482.57. CMS instructs that the capabilities and capacity of the hospital's main campus (not just the off-campus ED) be used when determining whether there has been a violation of the Emergency Medical Treatment and Labor Act (EMTALA). A HOPD may be seen as a way to bring access to tertiary care services to more geographically remote areas or to expand the inpatient catchment area of the parent hospital.

Some states prohibit FSEDs. Some IFSEDs have attempted to be recognized by CMS as "hospitals that specialize in emergency care." However, CMS has interpreted the definition of a hospital found at Section 1861(e) of the Social Security Act (that the provider is primarily engaged in the provision of services to inpatients) to mean that the provider devotes 51% or more of its beds to inpatient care. While they concede that this "51% rule" has not been formalized, the CMS memorandum on the topic places the burden on the applicant to demonstrate that its primary service is inpatient care. A freestanding ED is unlikely to succeed in such recognition (Center for Medicaid and State Operations/Survey and Certification Group Memorandum Ref: S&C-08-08.)

### Federal Regulations and Accreditation

HOPDs are subject to all of the requirements as their parents' hospital-based EDs, including 24-hour per day operation and EMTALA obligations. Both EMTALA and Medicare CoP apply to HOPDs. The requirements are spelled out in 42 CFR 413.65 and the CMS Memorandum of January 11, 2008 referenced S&C-08-08.5.

The rules for HOPDs fall into two categories. The first provides the definitions regarding HOPDs found mainly in 42 CFR 482.1 through 482.57 and 42 CFR 413.65. The second addresses the rules regarding ambulance transfers between an HOPD and the main campus, found mainly in the Medicare Benefit Policy Manual Chapter 10 Section 3.3.

The definitions regarding HOPDs found in 42 CFR 482.1 through 482.57 and 42 CFR 413.65 are fairly clearly delineated in the Center for Medicaid and State Operations/Survey and Certification Group Memorandum Ref: S&C-08-08 and are quoted below:

The most common scenario occurs when a Medicare-participating hospital that offers emergency services seeks to establish an ED located away from the main campus and to have that ED operate as a provider-based department of the hospital. Services of the provider-based ED would be included under the hospital's Medicare Provider Agreement. Such arrangements are acceptable, so long as the off-campus ED complies with:

- Hospital CoPs found in 42 CFR 482.1 through 482.45. The expectation here is the same as for any department on the hospital's campus. This includes, but is not limited to, the following requirements:
  - Medical staff practicing at the off-campus ED must be part of the hospital's single organized medical staff as required by the Medical Staff CoP at 42 CFR 482.22.
  - The responsibilities of the hospital's Governing Body, as specified in the Governing Body CoP at 42 CFR 482.12, apply to the services and activities of the off-campus ED.
  - Nursing personnel at the off-campus ED must be part of the hospital's single organized nursing service and all nursing services must be provided in accordance with the Nursing CoP at 42 CFR 482.23.
  - Emergency laboratory services must be available to the off-campus ED during all of its operating hours, in accordance with the Laboratory Services CoP at 42 CFR 482.27(b)(1).
  - The off-campus ED must be integrated into the hospital's quality assessment/performance improvement (QAPI) program, as specified under the QAPI CoP at 42 CFR 482.21.
  - The medical records of patients seen at the off-campus ED must be part of the hospital's single medical record system and must satisfy the standards for the Medical Records Services CoP at 42 CFR 482.24.
  - Infection control practices at the off-campus ED must meet the requirements of the Infection Control CoP at 42 CFR 482.42.
- Requirements pertaining to the Hospital CoP governing emergency services found at 42 CFR 482.55. In particular:
  - The provider must demonstrate how the off-campus ED meets the emergency needs of its patients in accordance with accepted standards of practice for hospital emergency departments.
    - Neither the hospital CoP for emergency services nor the EMTALA definition of a dedicated ED (noted below) specifically addresses part-time versus full-time operation of an ED. Medicare payment rules include codes for both full- and part-time EDs.
    - All hospital EDs, including off-campus EDs, must comply with all applicable state requirements, including any requirements related to hours of operation.
    - Providers operating part-time provider-based EDs as permitted under state law are expected by CMS to document how the needs of patients will be addressed when they present at the off-site ED during hours when it is not in operation.
  - The provider must demonstrate how the off-campus ED satisfies the requirement at 42 CFR 482.55(a)(2) for its services to be integrated with the other departments of the hospital. This includes documenting how inpatient admissions and intrahospital transport of patients from the off-site ED to the main campus would be handled in a manner that is also consistent with the requirement at 42 CFR 482.13(c)(2) for patients to receive care in a safe setting.
  - The organization and direction of the emergency services at the off-campus location must be by a qualified member of the hospital's medical staff. In view of the provider-based requirement (see below) for integration of services between the off-campus ED and the main campus, CMS expects the hospital's main and off-campus EDs to be under the same overall medical staff direction.

- The policies and procedures governing medical care provided at the off-campus location must be established by, and remain an ongoing responsibility of the hospital’s medical staff. In view of the provider-based requirement (see below) for integration of services between the off-campus ED and the main campus, CMS expects the off-campus ED to operate under the same general policies and procedures as the ED at the hospital’s main campus, taking into account pertinent differences in the scope of their operations.
- Hospital CoPs found in 42 CFR 482.51 through 42 CFR 482.57 govern other optional services the hospital chooses to offer at the off-campus location. If any of these optional services, such as surgery, anesthesia, rehabilitation, or respiratory services, is offered at the off-campus ED location, that service must be provided in accordance with the applicable CoP. For example, if respiratory services are offered, those services must comply with the requirements of the Respiratory Services CoP at 42 CFR 482.57.
- According to EMTALA requirements at 42 CFR 489.20 and 489.24, the off-campus ED would be considered a “dedicated emergency department,” as defined at 42 CFR 489.24(b): “Dedicated emergency department” means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:
  - It is licensed by the state in which it is located under applicable state law as an emergency room or emergency department;
  - It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
  - During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.”

The EMTALA-related provisions include the requirement at 42 CFR 489.24(d) to provide individuals determined to have an emergency medical condition with either stabilizing treatment or an appropriate transfer to another hospital. In the case of an investigation of an EMTALA complaint alleging failure to provide a medical screening examination, stabilizing treatment, or an appropriate transfer from the off-campus ED, CMS investigators will consider the capabilities and capacity of the hospital’s main campus, not just the off-campus ED, when determining whether there has been an EMTALA violation.

- Requirements are found in 42 CFR 413.65 for a provider-based off-campus department of the main hospital. State agencies do not survey for compliance with the provider-based requirements per se, but the hospital would be expected to document its compliance. Among the clinical services requirements at 42 CFR 413.65(d)(2) are the following:
  - Professional staff of the off-campus ED have clinical privileges at the main campus of the hospital.
  - The hospital maintains the same monitoring and oversight of the off-campus ED as it does for any other of its departments.
  - The medical director of the off-campus ED maintains a reporting relationship to the hospital’s chief medical officer (or similar position) that is similar to that of a department medical director.
  - Medical staff committees of the hospital are responsible for medical activities in the off-campus ED.
  - Medical records are integrated into a unified retrieval system.

- The services of the off-campus ED are integrated into those of the hospital’s main campus, and patients of the off-campus ED who require further care have access to all services of the main campus.

CMS encourages hospitals with off-campus EDs to educate communities and EMS agencies in their service area about the operating hours and capabilities available at the off-campus ED, as well as the hospital’s capabilities for rapid transport of patients from the off-campus ED to the main campus for further treatment. This is particularly desirable in the case of off-site EDs that are closer to another hospital than to their own main campus. Education is a way to facilitate informed decision-making by patients choosing where to seek emergency medical care and by EMS providers transporting patients in need of emergency medical care (Center for Medicaid and State Operations/Survey and Certification Group Memorandum Ref: S&C-08-08.)

The Joint Commission (TJC), at the behest of CMS, has a series of core measures developed by CMS and adopted by TJC’s ORYX program in order to be in alignment with CMS reporting requirements. (The ORYX program is TJC’s performance measurement and improvement initiative, first implemented in 1997.) The ED measures that specifically apply to HOPDs became available for selection by hospitals to meet their four core measure set accreditation requirement in January 1, 2012. These include:

1. OP-1 Median Time to Fibrinolysis
2. OP-2 Fibrinolytic Therapy Received Within 30 Minutes
3. OP-3 Median Time to Transfer to Another Facility for Acute Coronary Intervention
4. OP-4 Aspirin at Arrival
5. OP-5 Median Time to ECG
6. OP-18 Median Time from ED Arrival to ED Departure for Discharged ED Patients.
7. OP-22 Left Without Being Seen
8. OP -23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretations Within 45 minutes of ED arrival.

As these primarily deal with emergency topics (other than OP-6 Timing of Antibiotic Prophylaxis and OP-7 Antibiotic Selection which are outpatient surgery measures but could also be considered to be emergency topics,) it is clear these are designed to measure the performance of those HOPDs operating as FSEDs. The full details of the measures can be found in TJC’s Specification Manual for National Hospital Outpatient Department Quality Measures. Please note that the outpatient measures are maintained by CMS, not TJC.

The Medicare Benefit Policy Manual, chapter 10, titled “Ambulance Services,” describes the payment schema for ambulance transport from a HOPD to the main campus. In 10.3.3, “Separately Payable Ambulance Transport Under Part B versus Patient Transportation that is Covered Under a Packaged Hospital Service,” an algorithm to determine if an ambulance transport is a separately billable service is described.

1. Provider Numbers  
If the Medicare-assigned provider numbers of the two providers are different, then the ambulance service is separately billable to the program. If the provider number of both providers is the same, then consider criterion 2.
2. Campus  
Following criterion 1, if the campuses of the two providers (sharing the same provider numbers) are the same, then the transport is not separately billable to the program. In this case the provider is responsible for payment. If the campuses of the two providers are different, then consider criterion 3.
3. Patient Status: Inpatient vs. Outpatient  
Following criteria 1 and 2, if the patient is an inpatient at both providers (ie, inpatient status both at the origin and at the destination, providers sharing the same provider number but located on different campuses), then the transport is not separately billable. In this case the provider is responsible for

payment. All other combinations (ie, outpatient-to-inpatient, inpatient-to-outpatient, outpatient-to-outpatient) are separately billable to the program.

A later example in that chapter and section reads: “The transfer, ie, the discharge of a beneficiary from one provider with a subsequent admission to another provider, is also payable as a Part B ambulance transport, provided all program coverage criteria are met, because, at the time that the beneficiary is in transit, the beneficiary is not a patient of either provider and not subject to either the inpatient preadmission payment window or outpatient payment packaging requirements. This includes an outpatient transfer from a remote, off-campus emergency department (ER) to becoming an inpatient or outpatient at the main campus hospital, even if the ER is owned and operated by the hospital.” Thus as long as the patient is not formally admitted until arrival at the main hospital, the ambulance transfer is a separately billable event. However, if a patient is admitted prior to the transfer (ie, the admission order is timed before the patient leaves), the transport costs are the responsibility of the admitting hospital.

### State Legislation and Regulation

State legislation and regulation for freestanding emergency departments (HOPDs and IFSEDs) are ever changing. Some states like Texas have significant legislation regulating FSEDs while other states like New Jersey have no such legislation and have no provision for FSEDs. Because individual state legislation regarding FSEDs is dynamic, it is necessary for the reader to investigate the individual states for current regulations.

Here are links to a few states’ regulations:

#### Delaware

- Must provide services 24 hours per day.
- No stipulation about ownership.
- “Free Standing Emergency Center” shall not refuse to render a needed, medically appropriate emergency service to any person because of that person's inability to pay for the service.

#### Idaho

- Must provide services 24 hours per day.
- An FSED is owned by a hospital with a dedicated ED that also meets the staffing and service requirements.
- Capability of receiving ground ambulance
- HOPD/FSED is an extension of the main hospital.

Illinois (The law says the facility must be wholly hospital-owned meaning an IFSED is not allowed under these provisions.)

- Must provide services 24 hours per day.
- HOPD/FSED is wholly owned or controlled by an Associate or Resource Hospital.
- Emergency medical personnel must include at least one board certified emergency physician present 24 hours per day.

#### Rhode Island

- Does not require 24-hour operation.
- Can be owned by an individual and does not require hospital ownership or control.

#### Texas

- As of August 31, 2013 must operate 24 hours per day to be licensed as FSED.
- Hospital ownership/control not required.

- The Texas Department of State Health Services website provides a [directory](#) of the more than 70 freestanding EDs in Texas.

### Fiscal Impact on Hospital-based Emergency Departments

To an ACEP member, there is a significant difference between IFSEDs and HOPDs with regard to financial and volume impacts. None of the articles cited examined IFSEDs. They only looked at HOPDs in some cases that were very close to the parent hospital ED.

The overall trends of ED visits have been increasing rapidly over the last several decades while total numbers of EDs have been shrinking. The development of freestanding EDs appears to be located primarily in urban settings with the vast majority being attached to “home” hospital-based EDs.<sup>1</sup>

A chief concern of any administrator would be the assessment of fiscal impact on current ED operations when a new IFSED or HOPD opens in the immediate area. There is surprisingly little research on this topic. Most recently, a December 2012 article examined the impact of two HOPDs on the volumes and admission rate of the “home” department.<sup>2</sup> The article suggested that volumes for the “home” tertiary ED declined during the study period, while overall volume and admissions increased for the system (all EDs combined). However, in a follow-up conversation with the author of the study, volume at the “home” tertiary ED has returned to baseline since the study, and overall volume in the system has doubled over the last six years.

While there is little research on IFSEDs and HOPDs, there are a few more academic investigations on the impact of urgent care centers on EDs. A 2007 article<sup>3</sup> from the *Journal of Emergency Medicine* examined the impact of walk-in centers on accident and emergency departments in the National Health Service in the United Kingdom (UK). There was no significant change in volume or acuity for the accident and emergency centers.

Finally, there are several non-peer reviewed publications widely available, which are mostly marketing papers that discuss anecdotal successes similar to the impact study cited above.<sup>4</sup> While more research on this subject is needed, it appears that properly planned and developed HOPDs do not negatively affect the fiscal performance of ED systems. However, there is no current information as to the impact of IFSEDs or HOPDs that belong to a different (competing) hospital system. The evidence at hand suggests that in a market with a growing population, any negative impact would be temporary.

### Impact on Emergency Medicine Workforce

While the impact of FSEDs on the emergency medicine workforce has never been directly studied, the general concern is that they may add to the increasing nationwide shortage of emergency physicians. With more EDs and a less centralized emergency care network, arguably there would be more positions that need to be filled by the same number of physicians. On the other hand, many expect that FSEDs will be primarily staffed by nurse practitioners and physician assistants, moonlighting/per-diem physicians, emergency physicians wanting to add extra income in a less busy environment than the hospital ED, and those transitioning out of full-time practice, much as Urgent Care Centers are often staffed today. If these staffing assumptions are correct only a few physicians would be required to “oversee” and administer FSEDs, causing only a negligible effect on the emergency medicine workforce. However, this type of staffing would only apply to IFSEDs, since the federal rules for HOPDs are clear that the qualifications of the staff must be identical in the HOPD as they are in the hospital ED.

An indirect concern related to the emergency medicine workforce is the effect FSEDs will have on on-call services and coverage. In most cases, FSEDs refer or transfer patients out to receive consultant services, but in the cases where a FSED does have on-call or consultant coverage, there is concern this will siphon off coverage from other institutions. It may be enticing to consultants to stop taking call at a larger institution in favor of a smaller FSED with a theoretically lower acuity and patient volume. Similarly, the

opposite may prove true where FSEDs have a difficult time finding and retaining consultant services in favor of larger institutions with inpatient facilities, requiring increased patient transfer.

*Created by members of ACEPs Emergency Medicine Practice Subcommittee on Freestanding EDs, May 2013*

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