



Free Standing Emergency Departments

NAEMSO Trauma Manager Council

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Two Types of Freestanding ED's

- ▶ There are two distinct types of FSEDs: an **Independent Freestanding Emergency Center (IFEC)**, and a **Hospital Outpatient Department (HOPD)**, also referred to as an offsite hospital base or satellite ED.
- ▶ **Independent Freestanding Emergency Center (IFEC)s** are owned, in whole or in part, by independent groups or by individuals. Some states have created licensing criteria to govern IFECs that closely follow the intent of the Emergency Medical Treatment & Active Labor Act (EMTALA) and other rules and regulations. Many states do not currently address licensing rules for IFECs. Texas, Rhode Island and Delaware allow the establishment of FSEDs without hospital affiliation. **At this time, CMS does not recognize IFECs as EDs. Therefore, CMS does not allow for Medicare or Medicaid payment for the technical component of services provided by IFECs.**



Types of Freestanding ED's

- ▶ **Hospital Outpatient Department (HOPD)s** are owned and operated by medical centers or hospital systems. **By federal regulation, if the medical center or hospital system accepts Medicare or Medicaid payments for emergency services at a HOPD, the HOPD falls under the same rules and regulations of the Centers for Medicare & Medicaid Services (CMS) as the ED of the medical center or hospital, and must comply with all CMS Conditions of Participation (CoPs) in 42 Code of Federal Regulations (CFR) 413.65.** CMS recognized Freestanding EDs in 2004. FSEDs that comply with CMS and EMTALA regulations can bill as a dedicated ED. In 2008 CMS divided the billing category for dedicated EDs into Type A and Type B.
- ▶ Type A- These EDs provide services 24 hours a day, 7 days a week and meet one or both of the requirements related to the EMTALA definition of a dedicated emergency department.
- ▶ Type B- These EDs incur EMTALA obligations but do not meet the Type A definition of providing service 24/7.
- ▶ This rule establishes a significant difference in billing and reimbursement between FSEDs and urgent care centers. In 2008, CMS reimbursed an average of \$138 for an urgent care visit and \$316 for an FSED visit.



Hospital Outpatient Department (HOPD)s continued

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2008 survey of 222 Freestanding ED's:

- ▶ 86% are hospital affiliated (number dropping as Texas and other states allow IFECs)
- ▶ 14% are independent (as noted above the number is growing)
- ▶ 89% are Joint Commission accredited
- ▶ 91% operate 24/7



CMS Required Criteria for HOPD's

- Freestanding EDs that are HOPDs must adhere to CMS criteria including:
- The antidumping provisions of 42 CFR 489.24 and Section 1866 and 1867 of the Social Security Act as applicable;
- **In the event the Main Provider is selected for a sample validation survey per Part 42 CFR 488.7 all approved off site locations as well as the main hospital campus must meet both the health and life safety code provisions under the Medicare Conditions of Participation (Part) 482;**
- Similarly a serious complaint allegation could result in a survey of the off-site location for compliance with the aforementioned conditions;
- When a Medicare beneficiary is treated in a HOPD the hospital has an obligation to provide written notice to the beneficiary of the amount of a beneficiary's potential financial liability prior to the delivery of services and must be one which the beneficiary can read and understand. HOPD may charge a facility fee (for cost of facility resources and overhead incurred including recognition of affiliated hospital component) to provide patient care and professional fees (for physician services). Both are recognized and paid by insurers; and
- Comply with the health and safety rules for Medicare participating hospitals found in 42 CFR Part 482.1-482.45

Differences Between Urgent Care Providers and Freestanding Emergency Departments Nationwide

	Urgent Care	Freestanding Emergency Department
Net Revenue per Patient	\$105 to \$135	\$350 to \$500
Co-Pay Charged	Typically \$35 to \$50	Typically \$75 to \$100
Facility Fee Charged	Typically no facility fee is charged, except in certain instances in which the center is part of a hospital complex. Typically one invoice for all services on site.	A facility fee is charged in addition to a professional fee for the providers. Patient is often billed separately by the facility and physician group.
Cases Treated	Typically low- to-moderate acuity, with the bulk of patients presenting with minor infections, flu symptoms, allergies, rash, lacerations, sprains/strains, and fractures.	Typically non-emergent with greater emphasis on musculoskeletal injury and lacerations. Patients self-triage for acutely rising conditions including high fever, automobile accidents, and asthma attack.
Operating Hours	Typically 10-12 hours a day, seven days a week.	Most are open 24-hours a day, 365 days a year although some privately held centers may operate 10-12 hours/day, seven days a week.
Square Footage	Typically 2,500 to 4,500 sq. ft.	5,000 to 20,000 sq. ft. depending on whether the center is independent or hospital-affiliated.
Trauma and Resuscitation	Providers typically certified in Basic Life Support although many have advanced life support certification. Center typically equipped with EKG, defibrillator and drug cart. Process is to stabilize patient, call 911, and then EMS transfers patient to hospital emergency room.	Providers certified in Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS). Capabilities to administer IV medications and perform cardiac enzyme and BNP labs. Process is to stabilize patient and admit to hospital (using contracted paramedic transport) under direct transfer agreement.

	Urgent Care	Freestanding Emergency Department
Provider Specialty	Typically family practice or emergency medicine with representation from internal medicine, pediatrics and other specialties. May or may not be certified by an ABMS-recognized board.	Typically board-certified in emergency medicine.
Laboratory	Varies by location. Typically CLIA-waived for point-of-care testing. Labs performed by medical assistants. Collection and send-out to reference laboratory for more advanced labs. Urine drug screening as a revenue center.	CLIA-certification for point-of-care testing plus automation for CBCs, D-Dimer, BNP, and cardiac enzyme testing. Laboratory technician on staff. Physician also utilizes microscope for diagnosis.
Imaging	Typically basic x-ray performed (depending on state law) by trained medical assistant or radiology technician. Consulting radiologist over-reads to validate diagnosis.	X-ray, low-resolution CT, and ultrasound performed by radiology technician, with consulting radiologist on-call to read images.
Provider Staffing	May be any combination of physicians, physician assistants, or nurse practitioners supported by medical assistants and technicians	Emergency medicine physician on staff during all operating hours typically supported by an emergency medicine nurse. Ancillaries like lab and imaging supported by cross trained technicians.



References



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