Dissecting the Cost of a Freestanding Emergency Department Visit

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Introduction to Freestanding Emergency Departments

Freestanding Emergency Departments (FSEDs) are walk-in medical facilities that hold themselves out to provide emergency care to the general public but are structurally separate and distinct from a hospital. In recent years this delivery model has experienced significant growth and across the United States today there are an estimated 350 to 400 FSEDs, with about a quarter of those located in Texas.

FSEDs may be operated by hospitals, physicians, physician groups or private investors; they may be located on integrated medical campuses with imaging, surgery, and specialists, in their own buildings at high-traffic intersections, or in retail strips adjacent to the likes of Starbucks and Whole Foods; and they may or may not bill Medicaid or be "in network" with insurance.

In regards to the scope of services offered, FSEDs generally offer more advanced life saving, imaging and lab capabilities than urgent care centers, have a board certified Emergency Medicine physician on site at all times, and are open 24 hours a day. But because of their signage visibility and retail positioning, their facilities resembling elegant day spas rather than "sterile" clinical environments, and their mass marketing via radio, billboards and direct mail—consumers can become confused as to when to appropriately use an FSED versus lower acuity facilities including urgent care centers.

Analysis of a Shopping Center Emergency Room's Charges[1]

In the Spring of 2013, a patient went to a privately-held freestanding emergency center complaining of low back pain, which had bothered him throughout the weekend. Although the patient was uncomfortable and questioned his ability to make it through the workday, this was not a new condition as the patient occasionally dealt with episodes of his "back acting up" and by no means did the patient believe he was experiencing a true medical emergency.

Upon arrival at the FSED—a contemporary glass and stone-fronted building located between Chick-fil-a and Bank of America—the front office took his insurance card, gave him some paperwork to complete—and soon enough he was whisked from the lobby's leather sofa to a wallpapered exam room by a licensed vocational nurse who took his vitals and medical history before the doctor conducted his examination. The patient was satisfied that the physician correctly diagnosed his "back spasm" and administered an injection, consistent with treatment

[1] Based on a freestanding emergency department bill and insurance explanation of benefits from an actual patient visit, with some details changed to protect the anonymity of the patient and the provider.

he had received for this condition in the past. The patient left satisfied with the patient experience and quality of medical care.

Several days after the visit, the patient received a bill from the FSED with the following charges:

CPT Code	Service Description	Billed Charges
99283	**Facility Charge, Level 3**	**$895.00**
94760	**Pulse Ox, Single**	**$53.00**
J1885	**Pharmaceuticals (Toradol 15mg)**	**$96.00**
96372	**Intramuscular Injection (IM/SQ)**	**$83.00**
99283	**Physician Evaluation and Management**	**$298.00**
	Total	**$1,425.00**

As an urgent care provider, if you're scratching your head over these charges—experience has been that FSED charges are up to ten times the cost of a comparable visit to urgent care.

Facility Fee

The primary culprit of high FSED prices is the "facility fee"—a fee historically charged by hospitals to cover the overhead of being prepared to handle any situation that presents (natural disaster, terrorist attack, ambulance diversion, etc.), offset losses incurred in treating Medicaid populations, and to subsidize charity care/sliding fee scales serving the poor and indigent (i.e. the "safety net" provided by EMTALA). Doctor's offices, including urgent care centers, generally incur no facility fee.

While FSEDs argue facility fees are necessary and appropriate because FSED's "have capabilities similar to hospital EDs," patients and payers have questioned the legitimacy of facility fees because the centers—particularly storefront physician-owned FSEDs that resemble "doctor's offices"—have a very different cost structure than full-service hospitals. Namely, FSEDs often do not accept Medicaid and routinely triage and refer out those without private insurance to hospital EDs.

"We Accept Your Insurance" versus "In-network Provider"

Although most hospital-affiliated FSEDs are contracted with insurance as in-network facilities, many independent FSEDs are not contracted despite advertising they "will bill your insurance." They're taking advantage of a "loophole" that requires payers to cover emergency services at "in network" rates. The purpose of this law is to assure people do get the care they need in an emergency—at the nearest ER. For example, if Hospital A were in-network and Hospital B were out-of-network--you wouldn't as a matter of policy want the patient wasting precious seconds to find the ER that accepted his/her insurance.

What happens is the FSED bills the insurance company as an out-of-network provider and even if the insurance company marks down its payment to “usual and customary charges,” “preferred provider,” or “in-network rates”—because there is no contract with the payer stating that the FSED will “take assignment” (only collect what the insurance company pays)—the FSED can then balance bill the patient. This leads to patient confusion and “fighting” with FSEDs (and their collection agencies) for weeks—especially if the patient went to the center under the impression that their insurance is “accepted by” (i.e. contracted with) the center.

Deductibles and Co-Insurance

To make consumers more aware of their health care choices, and to steer consumers towards lower-cost options, it's increasingly common that health plans make patients responsible for the first $1,000 to $5,000 out-of-pocket, depending on the plan. Similarly, under 80/20 co-insurance—a patient may be still responsible for 20% of what the insurance company "allows." The plan only “pays” its share of “allowed” charges once the “deductible” is met.

If the patient with the back pain described above had a policy with a $1,200 deductible—his transaction at the freestanding ED may have looked something like this:

Total Charges from the Freestanding Emergency Center	$1,425
Approved Charges (Net of Allowances, Adjustments to In-Network Fees) Paid by Insurance	$1,196
Write-off by the Freestanding Emergency Center	$229
Amount Applied to Patient's $1,200 Deductible	$1,196
Out-of-Pocket Cost Patient is Responsible to the Freestanding Emergency Center	$1,196
Amount Remaining of Patient's Deductible	$4

While the FSED did take some write-offs of services that either weren’t covered or that were adjusted down to “usual and customary”—the bulk of the billed charges were “allowed” by the insurance company. However, because the patient had a policy with an unmet deductible—one FSED visit nearly consumed the patient’s entire deductible for the year—and the FSED was able to go after the patient via its collections agency.

Not a Medical Emergency

Although FSED’s market their emergency capabilities, clearly this low back pain incident described did not require an “emergency” facility:

- Emergency rooms are appropriately used for trauma, resuscitation, or hospital admissions.
- The capabilities that differentiate FSED’s from urgent care—advanced life support, CT scan, STAT laboratory—were not needed for this patient's condition.
- The patient’s back spasm this was a long-term condition that was acting up. The patient's motivation to be seen immediately was pain/discomfort.

- The patient sought treatment on a Tuesday morning. Depending on the time of day, he could have been seen in urgent care or could have waited to be seen in urgent care.
- Although the patient was in pain, his life or limb would not have been in jeopardy by waiting until urgent care opened.
- The patient resides in an affluent, densely populated suburb of a major city with multiple in-network urgent care centers within 10 minutes of his house.

Thus, there is no logical reason in the facts presented that the patient could not have gone to an urgent care center.

Had the Patient Gone to Urgent Care

Most urgent care centers are in-network providers with the dominant third party payers in their market—including national payers like United Healthcare, Cigna, Aetna, and Humana; regional and state-specific Blue Cross Blue Shield payers; and local HMOs/PPOs. Had the insured patient with a back spasm sought urgent care instead of the FSED[2]:

- There would have been no facility fee saving $895.
- The physician charge would have been $105-175 instead of $298.
- There may have been additional charges for the test, injection, and drug but at a far lower cost:

Torodol	Billed: $96	Urgent Care: $40
Injection	Billed: $83	Urgent Care: $28
PulseOx	Billed: $53	Urgent Care: $0[3]

So, to line up the charges against one another:

	ER Center	Urgent Care
Facility Fee	$895	None
Physician Fee	$298	$150
Add-Ons:	$232	$ 68
Total Visit Cost:	$1,425	$218

But for this specific patient--the big catch is this--because he is insured with a national provider that was contracted with the urgent care:

- Urgent Care Co-Pay of $25-35
- The $218 would have been adjusted down to a contracted “case” rate of $105-145 which would have included the add-ons.
- The patient would have been responsible for approximately $125 in his high-deductible plan had he gone to the typical urgent care center.

[2] Based on a sample urgent care center fee schedule obtained from a member of the Urgent Care Association of America.
[3] This is part of taking vitals--would not have been billed separately (note: the EOB did not allow this service).

In sum, the patient would have saved nearly $1,000 by utilizing urgent care instead of the freestanding emergency department.

Educating the Public is the Key

Health care works most efficiently when there is a match between the acuity of a patient's medical condition and the capabilities of the treating facility and/or provider. While there may be an appropriate "plank" for freestanding emergency centers in the "spectrum" of health care delivery—the concern is when patients use these facilities for non-emergent conditions.

Insurance companies and consumer advocates are taking notice of the increasing number of FSED patients who are satisfied with their treatment but dissatisfied with their bills. For instance, Blue Cross Blue Shield of Texas is warning members about the exorbitant fees charged by FSEDs. On its website (http://www.bcbstx.com/trs/alert.htm), BCBS-TX clearly states that these centers are out-of-network, are not comparable to hospital EDs in level of care, and that treatment there may incur additional expenses to the patient.

For the urgent care provider, the business risk is that patients confuse urgent care centers and freestanding emergency rooms and that the "stigma" of high pricing carries over in consumers' minds to urgent care. The anecdote, perhaps, is for urgent care centers who face FSED "competition" to raise public awareness of when it's appropriate to utilize each type of facility, the fees incurred at each facility type including co-pays and total charges, and to promote advantages to the urgent care center including short wait times and board certified physician coverage.