Ambulatory Services: Urgent Care Background

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Ambulatory Services: Urgent Care Background Paper
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Contents

Urgent Care Background

History

The urgent care model developed in the 1970's with physicians opening up practices with extended hours targeted toward acute but non-emergent care. It is estimated that there are anywhere between 9,000 and 20,000 urgent care providers throughout the United States, with potentially as many as two new urgent care facilities opening each week[1,2,3]. There is no estimate for how many urgent care providers exist in New York State.

The history of the urgent care model includes periods of growth and decline, with declines being partially attributed to quality issues around staff training[4]. Other potential reasons for historical decline include growth in hospital-owned urgent care facilities that subsequently folded due to mismanagement (hospital management with union wages and exhaustive protocols may not have been appropriate for early urgent care models), and a lack of public understanding of the role of urgent care providers[5].

What is the Urgent Care Model?

The scope of operations, hours of operation, scope of services, and the nature of the physician-patient relationship are all important elements that define the urgent care model.

Scope of Services

Urgent care providers serve ambulatory patients with acute illness or minor traumas that are not life-threatening or permanently disabling.

Urgent care providers provide outpatient diagnosis and treatment services. Services may include a medical history, physical examination and treatment services such as those provided by a physician's practice. Example services include intravenous hydration, suturing of minor lacerations and providing occupational medicine therapies. Some urgent care providers also include advanced imaging services, in-house lab

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[1] McNeeley, S. "Urgent Care Centers: An Overview," *American Journal of Clinical Medicine*. Summer 2012. Vol. 9, No. 2.
[2] The Urgent Care Association of America. www.ucaoa.org/info/statistics.html.
[3] Stern, D. "Status of Urgent Care in the U.S. – 2005," *Business Briefing: Emergency Medicine Review. www.touchbriefings.com/pdf/1334/Stern.pdf*.
[4] McNeeley, S. "Urgent Care Centers: An Overview."
[5] California Healthcare Foundation. "*No Appointment Needed: The Resurgence of Urgent Care Centers in the United States,"* 2007, (pg. 7). http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/N/PDF%20NoAppointmentNecessaryUrgentCareCenters.pdf

services for immediate point-of-care testing, and point-of-care dispensing of pre-packaged pharmaceuticals[6].

Urgent care providers provide referral services for patients whose needs exceed the services they offer.

Scope of Operations

Urgent care providers are outpatient practices or facilities that primarily run on an unscheduled walk-in basis, serving patients as needed.

Hours of Operation

Urgent care providers typically offer extended hours beyond 9AM-5PM weekdays. They often include early and late weekday hours and weekend hours, and are often open on holidays. Some urgent care providers operate 24 hours a day, seven days a week.

Physician-Patient Relationship

There is no expectation of an ongoing physician-patient relationship with an urgent care provider. Once the acute illness or trauma has been treated, the patient is expected to continue ongoing care with their primary care physician or is referred to a specialist.

What they are NOT

Urgent care providers are not intended to provide well care, chronic disease management, or inpatient care or hospitalization. They also are not intended for emergency intervention for critical, major trauma, life-threatening or potentially disabling conditions or to be used as emergency rooms and, therefore, are not subject to the Emergency Medical Treatment and Labor Act (EMTALA), requiring acceptance of patients without regard for the ability to pay.

Some urgent care providers operate as physician practices (termed "Urgent Care Practices"). Some primary care practices may have an urgent care component, with designated hours for walk-in acute care. Larger urgent care facilities operate as licensed Diagnostic & Treatment Centers and are considered urgent care clinics or centers ("UCC"). UCC generally serve a large range of urgent care services including in-house diagnostic imaging and lab services.

While urgent care facilities may fall into these two over-arching groups from an operational standpoint, there can actually be a broad range of urgent care models[7], as presented in the following table.

[6] Please note, physicians are not permitted to dispense pharmaceuticals in New York State.

Urgent Care Models

	Basic		*Moderate*		*Advanced Level*	
Services	• Limited waive testing	• Expanded waive testing • No x-ray	• Expanded waive testing • EKG • Basic plain film x-ray	• Expanded waive testing • Draw station with same day results • Basic plain film x-ray	• Waive testing with point of care blood tests • EKG • Basic plain film x-ray • CT scanning Ultrasound	• Expanded waive testing with point of care blood tests • On-site STAT lab (CBC, comprehensive metabolic, liver function tests, etc.) • EKG • Radiology/ Imaging center (plain films, ultrasound, CT scan).
Hours	8-12 hours	8-12 hours, with some weekend and afterhours component	8-12 hours, with some weekend and afterhours component	12 hours or greater, with some weekend and afterhours component	12 hours or greater, with expanded weekend and afterhours component	16-24 hours, open 7 days per week with afterhours component

Note: Under the CMS Clinical Laboratory Improvement Amendments (CLIA) definitions, waived tests are categorized as "simple laboratory examinations and procedures that have an insignificant risk of an erroneous result," as determined by the Food and Drug Administration. Only those tests that are CLIA-waived can be performed by a laboratory with a Certificate of Waiver.

Perceived Benefits of Urgent Care Models

Urgent care providers potentially create savings for the healthcare system by diverting non-emergency patients from emergency departments that have substantially higher costs. Urgent care providers can handle patient overflows from existing entities and serve when physician practices are closed. Urgent care providers have a reputation for short wait times compared with emergency departments, and often emphasize strong customer service as one of their tenets.

[7] Boyle and Kirkpatrick, The Healthcare Executive's Guide to Urgent Care Centers and Freestanding EDs, 2012; pg. 13, Figure 1.2.

Staffing

Urgent care provider staffing models can vary, with no industry-accepted standard. The majority of urgent care providers use a physician-based model, with physicians trained in family practice or emergency medicine. Physicians work alongside medical assistants and office staff, and depending on patient volume, may also work with physician assistants and nurse practitioners; some models include medical technicians instead of registered nurses in order to reduce costs[8].

Quality

Over the past thirty to forty years, the urgent care industry has been establishing urgent care as a unique specialty of care, distinct from emergency care. The American Board of Medical Specialties does not currently recognize urgent care, and so board certification for urgent care has not been established. The Urgent Care Association of America (UCAOA) advocates for certification and accreditation of urgent care centers to further legitimize this area of medicine and establish high quality standards.

Accreditation

There are a few organizations that currently provide accreditation for Urgent Care.

- The Joint Commission (JCAHO): The Joint Commission accredits urgent care centers as a subset of ambulatory care[9].
- Accreditation Association for Ambulatory Health Care (AAAHC): The AAAHC website lists "Urgent and immediate care" centers as one of the types of organizations it accredits[10].
- National Association for Ambulatory Care (NAFAC): NAFAC has created a program that both accredits and certifies Urgent Care Centers[11].

Ownership, Organization and Governance of Urgent Care Providers

In the United States, the lines between urgent care models are at times blurry, and urgent care providers are owned and operated under several different models. In 2009

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[8] California Healthcare Foundation. "*No Appointment Needed: The Resurgence of Urgent Care Centers in the United States,"* 2007, (pg. 14). http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/N/PDF%20NoAppointmentNecessaryUrgentCareCenters.pdf

[9] The Joint Commission. "Seeking Urgent Care Accreditation." http://www.jointcommission.org/accreditation/ahc_seeking_urgent_care.aspx

[10] Accreditation Association for Ambulatory Health Care. "Accreditation." http://www.aaahc.org/accreditation/

[11] National Association for Ambulatory Care (NAFAC). "National Urgent Care Practice Standards Certification." http://www.urgentcare.org/CertificationStandards/tabid/134/Default.aspx

the Journal for Urgent Care Medicine published a study demonstrating that more than half of urgent care centers in the U.S. are physician-owned (see following table), but did not specify how licensing varies[12].

Ownership Model	**% in U.S.**
Owned by a corporation as part of a chain or network	**17.5**
Independently owned by one physician	**21.8**
Independently owned by two or more physicians	**32.3**
Hospital-physician joint venture	**3.8**
Hospital-owned on campus	**2.8**
Hospital-owned off campus	**22**

- **Corporate Urgent Care Chain/Network:** Urgent care chains are generally small, with an average of 2.7 locations[13]. Having multiple chain locations builds name recognition in a local area, consolidates costs, and can aid in negotiations such as for occupational medicine contracts.
- **Private Multispecialty Group Practice:** Within the realm of "Independently owned by two or more physicians," some urgent care providers are owned by larger multispecialty physician practices. The benefits of this arrangement are capturing patient overflows from nearby providers/healthcare facilities and expanded hours for their patients. This arrangement secures that patients served by the multispecialty practice will have continuity of care after an urgent care event.
- **Hospital Ownership:** A 2006 survey by the Urgent Care Association of America found that a little more than a quarter (26%) of urgent care facilities were hospital owned, consistent with the above table. Some hospitals run their urgent care facilities as a separate product-line, away from their medical campus, while some have UCC on-site, serving patient overflow. Many urgent care physicians do not maintain hospital admitting privileges. When a patient is referred to the hospital, they are either admitted through the Emergency Department, or admitted directly into the appropriate department, depending on existing arrangements between the urgent care facility and the hospital[14]. Hospital-owned urgent care facilities may charge a facility fee.

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[12] Weinick RM, Bristol SJ, Marder JE, DesRoches CM. "The Search for the Urgent Care Center," *The Journal of Urgent Care Medicine* 2009, vol. 3, pg. 438-40. http://jucm.com/2009-jan/ucupdate2.shtml.

[13] Dale, J. *"Benchmarking Your Urgent Care"* Presented at the Urgent Care Association of America Conference, April 2006, Lake Tahoe, Nevada.

[14] California Healthcare Foundation. "*No Appointment Needed: The Resurgence of Urgent Care Centers in the United States,"* 2007, (pg. 18).

- **Hospital-Physician Agreements:** The nature of hospital-physician agreements can vary.
  - Professional Service Agreements (PSAs)
  - Hospital-sponsored independent practice associations (IPAs)
  - Physician–hospital organizations (PHOs)
  - Hospital-sponsored management services organizations (MSOs)

Payment

It is widely accepted that the cost of care in urgent care settings is significantly less than in a hospital emergency room, however the level of savings created by this model is not known.

Reimbursement and Billing Codes

According to one study of urgent care coding and billing, many insurance companies do not see urgent care encounters as fundamentally different from primary care encounters from a billing perspective, meaning they are reimbursed at the same rates[15]. For larger more robust urgent care providers with the full range of urgent care services, expenses are generally higher than physician practices, and reimbursement similar to a primary care practice may not always sufficient. Other commercial insurers, however, reimburse urgent care providers at higher rates than primary care providers, or permit for higher co-pays for urgent care services than for primary care services[16]. In New York State, this could mean that depending on the insurer, urgent care practices may receive higher reimbursement than primary care practices, and licensed urgent care centers may receive higher reimbursement than other licensed diagnostic and treatment centers, creating an incentive to seek out licensure for maximum reimbursement of urgent care services. This difference in reimbursement is intended to promote cost savings created by diverting patients from more costly and over-burdened Emergency Departments, however it is unclear if urgent care providers are fulfilling this goal in New York State, or if they are unintentionally pulling patients away from primary care practices that have lower costs.

Alternatives used by urgent care providers to receive higher payments to cover their generally higher expenses, as compared to primary care facilities, are to reimburse at

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http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/N/PDF%20NoAppointmentNecessaryUrgentCareCenters.pdf

[15] California Healthcare Foundation. "*No Appointment Needed: The Resurgence of Urgent Care Centers in the United States,"* 2007, (pg. 20).
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/N/PDF%20NoAppointmentNecessaryUrgentCareCenters.pdf

[16] Clark Shaefer Hackett Consulting. *"Urgent Care Center Success Factors." 2008.*
http://www.cshco.com/pub/docs/Urgent_Care_Centure_Success_Factors.pdf

Specialist rates or negotiating higher fee schedules with Managed Care Organizations[17]. It may be beneficial for urgent care providers to use Problem-Based Coding (PBC) when filing reimbursement claims, but this must be negotiated with insurers in advance; many prefer to use the Evaluation and Management (E/M) coding model.

Payer Mix

According to the Urgent Care Association of America (UCAOA), in 2008 the Payer mix for urgent care providers was Private Insurance 50.8%, Medicare 14.5%, Medicaid (or similar public option) 9.99%, uninsured out-of-pocket 12.1% and Occupational Medicine 12.7%[18]. It is unclear if this analysis included urgent care practices, or just licensed UCC.

Facility Fees

Some urgent care providers are advocating for facility fees to make up lost costs from low reimbursement, and according to the UCAOA urgent care providers that are owned by a hospital are already implementing this strategy. While this may better support operating costs for urgent care, this strategy also increases overall healthcare spending costs that are counter to the benefits of the urgent care model.

Negotiations

Larger urgent care providers, urgent care providers with affiliations to healthcare networks, and urgent care providers owned by hospitals may have increased negotiation strength with health insurance companies, suppliers and other contracting entities depending on the market. For example, rural urgent care providers may be more successful in negotiations because of the more prominent role they play in the local healthcare system than urgent care providers in urban areas, where there may be more patient choice.

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[17] Stern, David, MD, CPC on behalf of UCAOA, *Problem-Based Coding (PBC) for Evaluation and Management (E/M) in Urgent Care Medical Coding*, http://www.ucaoa.org/info/files/problem_based_evaluation_&_management_(E&M)_urgent_care_coding.pdf

[18] Urgent Care Association of America, *2008 Benchmarking Study* (data points provided via email).