Urgent Care Centers: Key Legal Considerations
Complying With Corporate Practice of Medicine Laws, State Licensure Requirements, EMTALA Mandates and Reimbursement Laws

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Today’s faculty features:

Matthew R. Burnstein, Partner, Waller Lansden Dortch & Davis, Nashville, Tenn.
Kim Harvey Looney, Partner, Waller Lansden Dortch & Davis, Nashville, Tenn.
Lesli A. Love, Waller Lansden Dortch & Davis, Nashville, Tenn.
Jon M. Sundock, General Counsel and Chief Administrative Officer, CareSpot Express Healthcare, Brentwood, Tenn.

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U urgent Care Centers: Key Legal Considerations

Jon Sundock
jonsundock@carespot.com

Matthew R. Burnstein
matt.burnstein@wallerlaw.com

Kim Harvey Looney
kim.looney@wallerlaw.com

Lesli A. Love
lesi.love@wallerlaw.com
Why the Proliferation of Urgent Care Centers?

- Growth spurt began in mid-1990s and has continued
  - 2008-2009: added 330 new urgent care centers
  - 2010-2011: added 304 new urgent care centers

- Why the continued growth?
  - Acceptance by the public
  - Lack of access to primary care (no access or delayed access)
  - overcrowding in emergency departments (ED)
  - Long wait times at other providers (EDs especially)
  - Convenience of longer hours and walk-ins
  - Emphasis on high quality care
Current State of Urgent Care Centers

- Approximately 600 new urgent care centers added in 2011
- Approximately 9,200 urgent care centers exist today
  - An increase of 1,200 in just three years
- 150 million patient visits to urgent care centers each year in the U.S.
Current Distribution of UCCs

Number of Urgent Care Centers by County, 2011

Source: 2011 Urgent Care Association of America data
What Is an Urgent Care Center?

- No universal definition
  - Provide services that fall in between primary care and emergency department
- Urgent Care Association of America:
  - The delivery of ambulatory medical care outside of a hospital emergency department on a walk-in basis, without a scheduled appointment.
- Generally focused on episodic, acute care rather than on long-term management of chronic illness or preventive care
Common Characteristics of Urgent Care

- Walk-in or unscheduled care
- Extended hours, including weekends and evenings
- Provide an array of services beyond primary care
- Customer service approach to providing care
- Occupational health services often provided
Services Provided by Urgent Care Centers

- Primary Care
- Onsite radiology
- Simple fractures and lacerations
- Intravenous hydration
- On-site lab testing
- Medications— prepackaged pharmaceuticals and pain management
- Occupational Medicine and Worker’s Compensation
- Other services may include immunizations, travel medicine, and sports and school physicals
Future Role of Urgent Care Centers

- Primary care access problems to continue
  - A projected shortage of 45,000 primary care physicians by 2020
  - Increased insurance coverage under PPACA will add to the shortfall already predicted

- Increased use of EDs for non-emergency care
  - 2008-2011: Approximately 27% of visits for non-emergencies
  - Average wait times risen to over 4 hours

- Rising healthcare costs
Future Role of Urgent Care Centers

- Utilization projected to continue growing
- Current and future areas of growth include
  - Primary care
  - Non-emergent care
  - ACOs—urgent care centers could be an integral part of the organization in order to reduce visits to ACO’s ED

- Advantages
  - Reduce healthcare costs
  - Reduce overcrowding in EDs
  - Increased access to primary and urgent healthcare
Key Legal Considerations

- Corporate Practice of Medicine
- State Licensure
- Accreditation
- EMTALA
- Reimbursement
- Other Issues
Corporate Practice of Medicine

- The corporate practice of medicine doctrine prohibits employment of physicians by corporations.
- Purpose is to protect the integrity of medical profession by keeping it separate from corporate interests.
- State laws vary on the doctrine:
  - Strict prohibitions
  - Some Limitations
  - No prohibitions
Strict Prohibition Against Corporate Practice of Medicine: Texas

- Any corporation employing a licensed physician to treat patients and receive fees for those services is unlawfully engaged in the practice of medicine
- Employee-physician subject to disciplinary action or license revocation
- Narrow exceptions
  - Professional corporations formed by physicians
  - Independent contractor relationships under certain circumstances
  - Critical access hospitals if (1) only facility in community and (2) population of 50,000 or less
- Exceptions do not include most physician-entity relationships in Texas
Intermediate Prohibition Against Corporate Practice of Medicine: Illinois

- Permits hospital employment of physicians
- Employment by entities other than hospitals prohibited
- Illinois courts have construed the term “hospital” strictly
  - Covered entities: hospitals or entities directly or indirectly controlled by or under the common control of a hospital
  - Entities must meet the precise terms set forth in the statute
  - Illinois Supreme Court refused to recognize a non-profit health institute and voided a physician employment contract for not meeting the terms
Relaxed Prohibition Against Corporate Practice of Medicine: Indiana

- Permits physician employment as long as the terms of relationship do not violate statutory requirements:
  - “Entity does not direct or control independent medical acts, decisions, or judgment of the licensed physician”
- Most physician-entity employment relationships permitted as long as physician’s professional medical discretion is preserved
- Overall
  - Preserves purpose of corporate practice doctrine, but
  - Allows maximum flexibility of physician-entity employment relationships
## Comparison of State Prohibitions Against Corporate Practice of Medicine

<table>
<thead>
<tr>
<th>Strict (Texas)</th>
<th>Intermediate (Illinois)</th>
<th>Relaxed (Indiana)</th>
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<tbody>
<tr>
<td>Prohibits any corporation from employing a licensed physician</td>
<td>Prohibits any entity from employing physicians other than a hospital</td>
<td>Prohibits any entity from directing or controlling physician’s medical discretion</td>
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<td>Very Narrow Exceptions</td>
<td>Narrow Exceptions</td>
<td>Broad Exceptions</td>
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<td>Severe restriction—vast majority of physician-entity relationships do not meet exceptions</td>
<td>Fairly severe restriction—permits physician employment, but must meet very specific requirements</td>
<td>Flexible—allows a range of physician-entity relationships</td>
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Alternatives in States that Prohibit Corporate Practice of Medicine

- Physician ownership
- Forming a medical holding company
- Foundation model
- Friendly PC model
  - Physician forms a professional corporation (PC) and provides the physicians for the center
  - Non-physician owned company that opens the center contracts with the PC to provide management services
State Licensure

- Facility licensing varies greatly from state to state
  - Arizona is the only state that specifically requires licensing of urgent care centers
  - Urgent care centers may fall under licensing requirements for healthcare clinics
- CLIA Certificate of Waiver
  - Necessary if the center offers certain clinical laboratory testing
- X-ray permit
- Pharmacy license
- Other licenses depending on state
- Check Department of Health or similar state agency for licensing requirements
Accreditation

- Accreditation is through the Joint Commission
- 2010 publication of Standards for Urgent Care
  - Offered by the Joint Commission in collaboration with the Urgent Care Association of America
<table>
<thead>
<tr>
<th>15 Categories of Accreditation Standards</th>
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<tbody>
<tr>
<td>1. Environment of Care</td>
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<tr>
<td>2. Emergency Management</td>
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<td>3. Human Resources</td>
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<tr>
<td>4. Infection Prevention and Control</td>
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<tr>
<td>5. Information Management</td>
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<td>6. Leadership</td>
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<td>7. Life Safety</td>
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<td>8. Medication Management</td>
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<tr>
<td>9. National Patient Safety Goals</td>
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<tr>
<td>10. Provision of Care, Treatment, and Services</td>
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<tr>
<td>11. Performance Improvement</td>
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<tr>
<td>12. Record of Care, Treatment, and Services</td>
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<tr>
<td>13. Rights and Responsibilities of the Individual</td>
</tr>
<tr>
<td>14. Transplant Safety</td>
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<td>15. Waived Testing</td>
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EMTALA

Requires that a hospital with an ED provides a patient who presents with:

1. Medical Screening Exam (MSE); and
2. Treatment or necessary stabilization before transfer or discharge

- An MSE and treatment or stabilization must be provided regardless of the patient’s ability to pay
- Regulations contain specific EMTALA requirements
Application of EMTALA

- Treatment obligations of EMTALA do not apply unless the urgent care center is owned by a hospital or in a joint venture with a hospital and services provided are billed as a department of the hospital
  - No obligation to treat patients who arrive at the center
  - Triage policy – stabilize and transport
• Contracting and credentialing with payors for reimbursement is critical for financial success

• Insurance companies

• Government payors
  o Medicare
  o Medicaid
  o TRICARE
Reimbursement Through Insurance Companies

- Determine the payors from which the center will accept payment
- Payors’ approved list
  - Start early as this can be an extended process
- Practitioners must be credentialed with the insurance company
- Contact the insurance company’s contracting department early in the process
Medicare, Medicaid, and TRICARE

- Typically lower reimbursement rates than private insurers
- Patient population may require acceptance of government payors
- Contracting is an extended process—start early
- Usually covers services retroactive to a requested date
- Must enroll in Medicare as a “Clinic/Group Practice”
- Physicians must enroll in Medicare using CMS Form 8551
- Coding and Billing
- Malpractice Insurance
- OSHA Standards for Medical Offices
- Physician Supervision Requirements
- Prescription Writing Authority
- Breath Alcohol Testing
- Employer Drug Testing/Screening
Coding and Billing

- Specify reimbursement amounts and payment codes in the contract
- CMS has designated two HCPS codes for UCCs
  - S9083—global fees; does not take into account the treatment provided
  - S9088—“add on code” for reimbursement of expenses unique to UCCs
- Some managed care organizations will only reimburse freestanding UCCs for professional procedure codes
Malpractice Insurance

- Malpractice risk for UCCs generally falls between that of primary care practitioners and EDs
- Risk factors for UCCs
  - Lack of long-term, well established patient relationships
  - Target for drug seekers
  - Target for robbery if UCC stocks medications
  - Discharge management—patient follow-up plan
  - Potential for underdiagnosing patients—rely on patients to correctly self-triage and select appropriate facility for care
OSHA Standards for Medical Offices

- OSHA has issued guidance on the following areas:
  - Bloodborne Pathogens Standard
  - Hazard Communication
  - Ionizing Radiation
  - Exit Routes
  - Electrical
  - Reporting Occupational Injuries and Illnesses

- Requirements apply to all medical offices—whether there are 2 or 200 employees
Physician Supervision Requirements

- State laws vary on requirements but issues are similar
- **Certified Nurse Practitioners and Physician Assistants**
  - Continuous and constant supervision or intermittent
  - Availability of supervising physician for consultation—generally must be at all times
  - Arrangements for a substitute physician to be available
- **Registered Nurses and Licensed Nurse Practitioners**
  - Frequency and length of time that physician must be “on-site”
  - Availability of supervising physician for communication and consultation—at all times
Prescription Writing Authority

- State laws vary as do requirements for Nurse Practitioners and Physician Assistants
- Nurse Practitioners (TN)
  - Must hold a certificate of fitness
  - Joint adoption of physician supervisory rules concerning controlled substances required
  - Can prescribe and/or issue controlled substances listed in Schedules II, III, IV and V
- Physician Assistants (TN)
  - Written protocols required—developed and agreed upon by physician and PA
  - Supervising physician may delegate authority to issue prescriptions or medication orders for legend drugs and controlled substances listed in Schedules II, III, IV, and V
Breath Alcohol Testing

- Policy setting forth the UCC’s procedure for Breath Alcohol Testing
- Use of U.S. Department of Transportation (DOT) procedures for modeling alcohol testing policies increasing

**DOT Procedures:**
- Initial tests for alcohol concentration:
  - Approved Saliva Screening Device operated by a trained Screening Test Technician (STT); or
  - Approved evidential breath testing device (EBT) operated by a trained Breath Alcohol Technician (BAT).
- Alcohol concentration of 0.02 or greater—Second EBT test to confirm
- An alcohol concentration of 0.02 or greater considered a positive alcohol test.
Employer Drug Testing & Screening

- Policies for setting forth the UCC’s procedure for drug testing
  - Employer provided forms for listing medications
  - Collection procedures
  - Chain of custody procedures
  - Security of the collection site
  - Privacy of individual
  - Retention and transportation of the specimen

- State-approved procedures can be used as a model for drafting UCC drug testing policies and procedures
## Overview of Issues

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
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<tbody>
<tr>
<td>Reimbursement</td>
<td>Insurance Companies—start process early Medicare enrollment required for reimbursement—both the UCC and physicians</td>
</tr>
<tr>
<td>State Licensure</td>
<td>No License Required. Except in AZ.</td>
</tr>
<tr>
<td>CLIA Certification</td>
<td>CLIA Certificate Of Provider-Performed Microscopy Procedures Is Required.</td>
</tr>
<tr>
<td>Other Licenses</td>
<td>X-Ray Licensure, Pharmacy Licensure, and Others</td>
</tr>
<tr>
<td>OSHA Standards for Medical Offices</td>
<td>OSHA Standards Applicable</td>
</tr>
<tr>
<td>Physician Supervision</td>
<td>Certified Nurse Practitioners and Physician Assistants Registered Nurses and Licensed Nurse Practitioners</td>
</tr>
<tr>
<td>Requirements</td>
<td></td>
</tr>
<tr>
<td>Prescription Writing Authority</td>
<td>Nurse Practitioners v. Physician Assistant Written protocol requirements</td>
</tr>
<tr>
<td>Alcohol and Drug Screening</td>
<td>Alcohol policies based on DOT increasing Drug policies based on state-approved standards if available</td>
</tr>
</tbody>
</table>
Key Business Considerations

- Location, management, and services
- Issues in buying or selling an Urgent Care Center
- Partnering with hospitals and investors
Location

- Volume key to financial success
  - One study showed that a population of 20,000 to 30,000 was needed to sustain a UCC
- Currently, UCCs are concentrated in urban areas (distribution map on next slide)
- Convenience for patients
- Free-standing v. Hospital associated
Management of UCCs

- How will the UCC be managed?
  - Physician managed
  - Management company

- Customer service oriented management improves financial success of UCCs

- Leadership with a healthcare background is key
Services Provided

- **Target population**
  - Know the community’s demographic in order to tailor services to community’s needs

- **Specialty v. General**
  - For example, some UCCs focus specifically on pediatric care

- **One stop shop**
  - All services within the UCC or nearby referral locations
  - Goes back to the convenience factor
Buying or Selling an Urgent Care Center

- Buying an existing Urgent Care Center
  - Location
  - Competition
  - Reputation
  - Property—leased or owned
- Valuation
- Due Diligence
- Non-Disclosure Agreements
- Employment & Non-Compete Agreements
• Governing and Ownership Agreements
  o Voting
  o Officers
  o Compensation
  o Decisionmaking—Management and Control

• Retirement

• Sale of Ownership Interest

• Tax Considerations
Partnering with Hospitals and Investors

- Possible Ownership Models
  - Physician or group of physicians – 50%
  - Hospital – 27.9%
  - Corporation - 13.5%
  - Non-physician individual – 7.6%
  - Franchise – 1.0%

- With the wide range of services offered and extended service hours, integration is key to the successful growth of an urgent care center
Different Integration Models

- Group Practice Model
- Physician-Hospital Organization
- Management Company Model
- Accountable Care Organization
Group Practice Model

- Multiple physicians practicing under one form of entity at one location
- Multi-specialty group practices advantageous for UCCs
- Supergroup Model
  - A new practice entity formed by and among existing group practices
  - Owned by individual physician members or existing group practices
  - Higher volume of patients typically
- Advantages
  - Increased revenue
  - Greater input and control over range of care and treatment
- Criticism
  - Concerns over abusive arrangements and overutilization
Physician-Hospital Organization

- Provides healthcare services through a network of collaborating physicians and hospitals

- Characteristics
  - Clinical and economic efficiency and effectiveness are central to the design
  - Provides a wide range of services
  - Goal is seamless integration that greatly reduces or eliminates referrals to entities outside the system
Management Company Model

- Provides the facilities, office space, equipment, non-physician personnel, and non-professional services to an existing practice or other healthcare services provider
- Must be *commercially reasonable* and *reflect fair market value payment* for the goods and services
- Physician’s return on investment is limited to a reasonable return
- Must ensure the joint venture is a management company and not a healthcare provider
Accountable Care Organization

- Entity willing to become accountable for the quality, cost and overall care of Medicare FFS beneficiaries assigned to it
- Expected to meet specific organizational and quality performance standards
- If standards met, eligible to receive cost sharings
- UCCs can be an important intermediary in any ACO
  - Increased savings by reducing ED visits when primary care physicians are unavailable
  - Increased continuity of care