# Outpatient Endovascular Centers

# Background

- Approximately 20 years ago, ambulatory surgical services and renal dialysis centers shifted to the outpatient setting
- Current migration of coronary angiography and endovascular procedures is what was to be expected given the trend
- 1995-2005: office based surgeries doubled
  - 2010: 10 million procedures being performed in outpatient setting

# Why the growth and interest?

- Insurers
  - Don’t want to pay for extended hospital stay
  - Generally cheaper to perform procedures in OBLs vs hospital
- Patients
  - Lower cost to patient
  - Increased convenience and comfort
- Physicians
  - Greater control over administrative aspects of procedures
  - Greater control of patient surgical outcomes
  - Financial advantage

# Future outlook

- Demand for OBLs and ambulatory surgical centers (ASCs) is growing in other parts of the world
  - National health care systems are increasingly offering procedures in the outpatient setting
- High growth expected as patients seek lower-cost alternatives to hospital care

# Why should it be considered?

- Patient and physician convenience
- Less costly  for patient
- Less costly for insurance companies
- More efficient
- Safe

# Partner advantages

- Facility ownership is a highly valuable proposition for physician partners
- Increased autonomy over patient scheduling, equipment, supplies, and staff selection
- Customized work environment

# Patient advantages

- Lower co-pays for the same procedures
- Comparable (some studies say better) clinical outcomes than hospitals
- Greater patient satisfaction
  - Less paperwork
  - Personal attention (friendlier staff)
  - Timelier service
  - More pleasing physical environment

# Patient satisfaction

- Overall satisfaction rates over 97%
  - Friendliness, comfort, convenience, quality, and perceived outcomes
- Patient satisfaction helps practice grow
  - More willing to return for future procedures
  - Enthusiastic recommendations to others

# Financial considerations

- Steady decline in professional fees over the past decade
  - Arterial angioplasty CPT 35475
    - CMS reimbursement 2007 $479
    - CMS reimbursement 2013 $302
  - Reduced payment for specific CPT codes
  - Bundling of CPT codes resulting in net reductions in payment

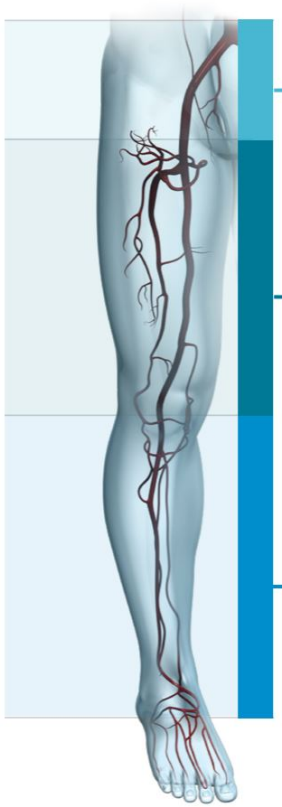
# Revenue potential

- Procedures performed in the outpatient setting are reimbursed at much higher rates than the traditional professional fees physicians bill for hospital procedures
  - The higher global fees include the professional fees and the technical fees that would otherwise go to the hospital

# LE ARTERIAL REIMBURSEMENT REFERENCE GUIDE

Boston Scientific

## 2018 Medicare National Average Payments



| | Lower Extremity (LE) PI Procedure Abbreviated Description | CPT® | APC | Hospital Outpatient Pay | ASC Pay | DRG | Hospital Inpatient Pay | MD In Office Pay | MD In Hospital Pay |
|---|---|---|---|---|---|---|---|---|---|
| Iliac | PTA | 37220<br>+ 37222 | 5192 | $5,085 | $2,525 | | | $3,122<br>$877 | $422<br>$196 |
| Iliac | PTA and Stent | 37221<br>+ 37223 | 5193 | $10,510 | $6,402 | | | $4,631<br>$2,595 | $521<br>$224 |
| Femoral / Popliteal | PTA | 37224 | 5192 | $5,085 | $2,525 | | | $3,790 | $467 |
| Femoral / Popliteal | PTA and Atherectomy | 37225 | 5193 | $10,510 | $7,024 | | | $11,130 | $637 |
| Femoral / Popliteal | PTA and Stent | 37226 | 5193 | $10,510 | $6,749 | | | $9,100 | $549 |
| Femoral / Popliteal | PTA, Stent and Atherectomy | 37227 | 5194 | $16,019 | $10,864 | • 252<br>• 253<br>254 | $19,492<br>$15,281<br>$10,928 | $15,062 | $765 |
| Tibial / Peroneal | PTA | 37228<br>+ 37232 | 5193 | $10,510 | $4,481 | | | $5,424<br>$1,210 | $572<br>$212 |
| Tibial / Peroneal | PTA and Atherectomy | 37229<br>+ 37233 | 5194 | $16,019 | $10,228 | | | $10,976<br>$1,464 | $742<br>$346 |
| Tibial / Peroneal | PTA and Stent | 37230<br>+ 37234 | 5194 | $16,019 | $10,207 | | | $8,389<br>$3,969 | $735<br>$300 |
| Tibial / Peroneal | PTA, Stent and Atherectomy | 37231<br>+ 37235 | 5194 | $16,019 | $10,276 | | | $13,605<br>$4,194 | $798<br>$420 |

+ symbol denotes add-on codes relevant for other recognized vessels within Iliac and Tib-Per territories

• Denotes DRG assigned to patient w. MCC (major complications or comorbidities)
• Denotes DRG assigned to patient w. CC (complications or comorbidities)

Hospital in-patient payment rates are based on services rendered as reported with ICD-10 codes and documented diagnosis codes. See Boston Scientific Procedural Payment Guide for common procedure codes.

# Reimbursement comparison

- Hospital column only reflects what the hospital bills for the *procedure itself*
- MD in-office column is the “global fee” billed by the OBL

# Is it sustainable?

- Affordable Care Act has been a driving force in the rise of OBLs
- OBL-based procedures afford payors close to a 50% savings when compared to the hospital setting

# Is it safe?

## Office-based endovascular suite is safe for most procedures

**Krishna Jain, MD, John Munn, MD, Mark C. Rummel, MD, Dan Johnston, MD,** and **Chris Longton, RN,**
*Kalamazoo, Mich*

***Objective:*** **This study was conducted to identify the safety of endovascular procedures in the office endovascular suite and to assess patient satisfaction in this setting.**
***Methods:*** **Between May 22, 2007, and December 31, 2012, 2822 patients underwent 6458 percutaneous procedures in an office-based endovascular suite. Demographics of the patients, complications, hospital transfers, and 30-day mortality**

J Vasc Surg 2014;59

# Jain et al

**Table II.** Patient complications and procedures

| *Procedure type* | *Procedures, No.* | *Patients, No.* | *Complications, No.* | *Complications per* | |
|---|---|---|---|---|---|
| | | | | *Procedure, %* | *Patient, %* |
| Venous | 1019 | 785 | 22 | 2.20 | 2.80 |
| Aortogram | | | | | |
| No interventions | 571 | 464 | 4 | 1 | 1 |
| With interventions | 368 | 191 | 10 | 2.70 | 5.20 |
| Fistulogram | 2719 | 829 | 13 | 0.50 | 1.60 |
| Catheters | 1477 | 342 | 4 | 0.30 | 1.20 |
| Inferior vena cava filters | 57 | 24 | 1 | 2 | 4.20 |

Vascular. 2017 Apr;25(2):115-122. doi: 10.1177/1708538116657506. Epub 2016 Jul 9.

# Treatment outcomes and lessons learned from 5134 cases of outpatient office-based endovascular procedures in a vascular surgical practice.

Lin PH[1,2], Yang KH[3,4], Kollmeyer KR[3], Uceda PV[3], Ferrara CA[3], Feldtman RW[3], Caruso J[3], Mcquade K[3], Richmond JL[3], Kliner CE[3], Egan KE[3], Kim W[2], Saines M[2], Leichter R[2], Ahn SS[2,4].

Author information

## Abstract

Introduction The office-based endovascular facility has increased in number recently due in part to expedient patient experience. This study analyzed treatment outcomes of procedures performed in our office-based endovascular suite. Methods Treatment outcomes of 5134 consecutive procedures performed in our office-based endovascular suites from 2006 to 2013 were analyzed. Five sequential groups (group I-V) of 1000 consecutive interventions were compared with regard to technical success and treatment outcomes. Results Our patients included 2856 (56%) females and 2267 (44%) males. Procedures performed included diagnostic arteriogram, arterial interventions, venous interventions, dialysis access interventions, and venous catheter management, which were 1024 (19.9%), 1568 (30.6%), and 3073 (60.0%), 621(12.1%), and 354 (6.9%), respectively. The complication rates for group I, II, III, IV, and V were 3%, 1.5%, 1%, 1.1%, and 0.7%, respectively. The complication rate was higher in group I when compared to each of the remaining four groups ( $p < 0.05$). Nine patients (0.18%) died within the 30-day period following their procedures, and none were procedure related. Conclusions Endovascular procedure can be performed safely in an office-based facility with excellent outcomes. Lessons learned in establishing office-based endovascular suites with efforts to reduce procedural complications and optimize quality patient care are discussed.

# Why did we do it?

- Improve efficiency
  - Hand-picked staff
  - Remove variables of hospital scheduling and case turnover time
- Enhance patient satisfaction
- Direct involvement in the decisions that affect care, supplies, and quality outcomes
- Financial incentive of recovering more of the technical/facility fees

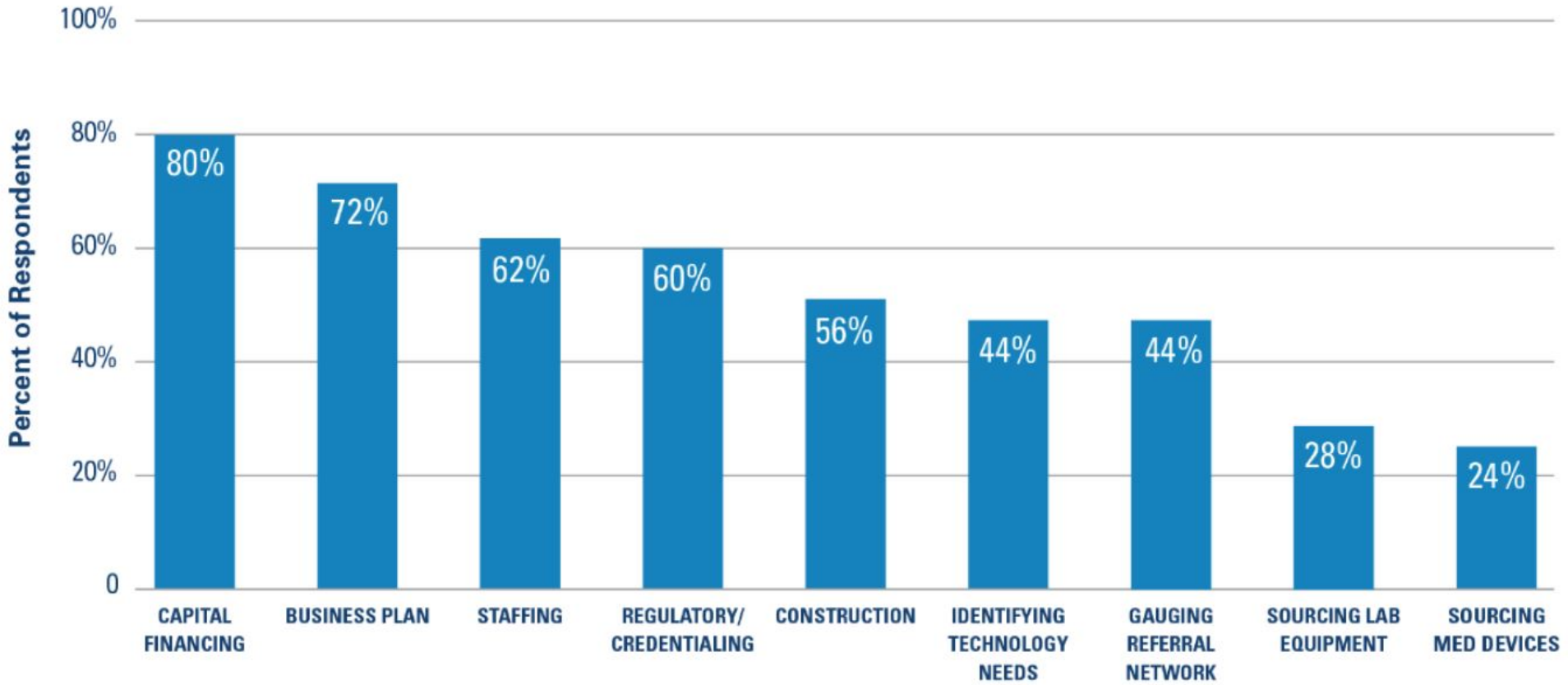
# Key considerations

- Do we have enough experience to consistently perform safe and effective same-day interventions with a sufficient patient base?
- Should we partner with a management company or consultant?
- What specific services will be offered?
- What our the main goals for opening a lab and what will be the impact on the existing practice?

# Key considerations

- Solo
- Joint venture with hospital
- Joint venture with national company

# Most selected challenges to becoming operational




Boston Scientific 2017 OBL/ASC Survey (n=50)

# Case volume

- Not realistic to expect all current outpatient hospital procedures will done in the OBL/ASC
- Will likely not do complex cases in the outpatient setting in the beginning

# Case mix

- Segment cases into categories to be able to estimate average payments and cost of supplies per case

# Payer mix

- Not all payers will pay a higher non-facility fee for office procedures
- Not financially viable to do cases in the office if the insurance payer will only reimburse for pro fees
- What is the average payment per case?
  - Medicare fee schedule is a good proxy (some insurance will pay less, some more)