Advantages of the Office-Based Lab vs. the Ambulatory Surgical Center for Peripheral Artery Disease Procedures

The Business of Peripheral Interventions

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Disclosures

• **Stockholder:** American Vascular Access and its Subsidiaries
  American Vascular is a privately held company that specializes in developing, managing, billing and revenue cycle management of 12 Outpatient Vascular Centers in 8 states

• **Medical/Scientific Boards:**
  Associate Member: OEIS Outpatient Endovascular Interventional Society
  ASDIN American Society of Diagnostic and Interventional Nephrology
To Be or Not To Be?
An OBL or an ASC for PAD? Or a Hybrid?

Why?
For our Patients:
- Easier Access To Care
- High Quality Outcomes
- High Patient satisfaction
- High Physician Satisfaction

Shakespeare was a wise man
“It is estimated that there are 20 million patients in the United States with PAD.”
- Dr. Craig Walker, CIS Cardiovascular Institute of the South

“PAD represents an annual economic burden of up to $389 billion dollars in the United States per year. 57% of cardiovascular hospitalizations are for PAD.”
- Mary Yost, MBA, The Sage Group, 2015

Only 1% of the population is receiving outpatient endovascular care in an alternative setting.
Economics of PAD

PAD patients average age is between 65-69. This is a huge financial impact on Medicare, Medicare Advantage plans, and several other private and commercial payers.

Where the case location is done has a significant financial impact and different fee schedules.

CMS-recognized places of service:
- POS 11: Office Based Lab (OBL) also known as Outpatient Interventional Suite (OIS) or Extension of Practice (EOP) or Vascular Center
- POS 21: Inpatient Hospital-based
- POS 22: Outpatient Hospital
- POS 24: Ambulatory Surgery Center
- The hybrid model is POS 11 and 24 combined
Economics of PAD: OBL vs ASC vs Hospital

- Average PAD in ASC
  - $10,000 plus MD fee averaging $500.
  - Supply costs are included

- Average PAD case in Office-Based Lab (OBL)
  - $14,000 total (global) OBL reimbursement
  - Supply costs are included
  - MD reimbursement amount is included in the global fee

- Average PAD case in the hospital
  - $15,000-20,000 hospital reimbursement
  - $5,000 supply cost
  - $1,000 professional fee (MD payment) plus anesthesia
  - $26,000 Total plus

- For this presentation, we are comparing National Medicare Rates
## Economics of PAD

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>Total Costs to Insurance</th>
<th>MD Payment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office-based lab (OBL)</td>
<td>$14,000 +++</td>
<td>Included</td>
<td>Global fee (supplies included)</td>
</tr>
<tr>
<td>Ambulatory Surgery Center</td>
<td>$10,000</td>
<td>$500</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>$26,000</td>
<td>$1,000</td>
<td>Plus anesthesia and possible overnight admission</td>
</tr>
</tbody>
</table>

- **ASC ($10,000)**
- **OBL ($14,000)**
- **Hospital ($26,000)**
- **Physician ($500)**

Remains the most favorable
# PAD Procedures: OBL vs ASC rates

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT</th>
<th>2017 Final In-Office Rate</th>
<th>2017 ASC Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iliac PTA</td>
<td>37220</td>
<td>+$3,085</td>
<td>$2,209</td>
</tr>
<tr>
<td>Iliac PTA and stent</td>
<td>37221</td>
<td>-$4,576</td>
<td>$6,048</td>
</tr>
<tr>
<td>Fem/Pop PTA</td>
<td>37224</td>
<td>+$3,743</td>
<td>$3,473</td>
</tr>
<tr>
<td>Fem/Pop PTA with atherectomy</td>
<td>37225</td>
<td>+$10,957</td>
<td>$7,449</td>
</tr>
<tr>
<td>Fem/Pop PTA with Stent</td>
<td>37226</td>
<td>+$8,982</td>
<td>$6,569</td>
</tr>
<tr>
<td>Fem/Pop PTA with Stent and Atherectomy</td>
<td>37227</td>
<td>+$14,853</td>
<td>$10,869</td>
</tr>
<tr>
<td>Tibial/Peroneal PTA</td>
<td>37228</td>
<td>+$5,363</td>
<td>$4,187</td>
</tr>
<tr>
<td>Tibial/Peroneal PTA with Atherectomy</td>
<td>37229</td>
<td>+$10,804</td>
<td>$10,065</td>
</tr>
<tr>
<td>Tibial/Peroneal PTA with Stent</td>
<td>37230</td>
<td>+$8,254</td>
<td>$10,088</td>
</tr>
<tr>
<td>Tibial/Peroneal PTA w/ Stent &amp; Atherectomy</td>
<td>37231</td>
<td>+$13,371</td>
<td>$9,935</td>
</tr>
</tbody>
</table>

25% higher reimbursement for PAD in OBL
Advantages of OBL vs. ASC for PAD

• Timing and Cost
  • OBL - $1 million, 6-9 months
  • ASC - $1.5-3 million, 12-18 months depending upon CON laws
Advantages of OBL vs ASC for PAD

• Office-based surgery accreditation vs. ASC accreditation
  • OBL can open with a CO and a scheduled accrediting body visit; this varies by state
  • OBL can open with a radiation safety inspection and physicist sign-off
  • 26 state health departments plus D.C. have jurisdiction on office based surgery meeting various thresholds*
  • The requirement is typically based on the levels of anesthesia or complexity of procedure performed*
  • Accreditation by a third party is the most typical way of satisfying the office based surgery state regulation – a few states, however, require their own survey*

* Amy Mowles, Mowles Medical Practice Management LLC
Advantages of OBL vs ASC for PAD

• Office-based surgery accreditation vs. ASC accreditation
  • ASCs have specific physical plant requirements; ASC-approved architect must submit plans
  • ASCs require anesthesia staffing and accreditation
  • CMS is the authority having jurisdiction for ASCs only; CMS does not govern office based surgery*
  • Accreditation is mandatory.

* Amy Mowles, Mowles Medical Practice Management LLC
ASC and Hybrid Critical Components

• A consultant is critical - will have a cost:
  $50,000-$195,000 for the project consultant

• CON or non CON state needs to be identified and will contribute to timeline; some states only review applications twice a year

• Single specialty or multiple specialty ASCs have different requirements

• Experienced ASC legal counsel is essential for structure and guidelines to be in Starke and Safe Harbor Compliance

• Payor contracting is essential particularly for Interventional Cardiology Procedures such as carotid stenting and implantable devices need to be approved in an ASC by the State Board of Medicine
What will CMS do?
Ready with your crystal ball? Here goes…

• In November of 2016, the ASCA stated that ASC rates would increase by 1.7 percent in 2018.

• In a March 2017 release, MedPAC (Medicare Payment Advisory Commission) recommended that CMS forego raising ASC rates and require ASCs to submit cost data.

• The DAC rates for ASC were increased by 300% and HOPD rates by 400% while decreasing in the OBL

No one knows if these rates will hold in 2018
What will CMS Do?

- CMS has targeted ASCs in the past and have made cuts and reductions. An analysis of investment dollars and ROI over time must be done to assure the risk and reward of conversion
- Legal structure may have to be modified
- ASC must be operational to be accredited and certified which is mandatory and not voluntary. ASC guidelines are available through ASCA
- Physicians will need to be credentialed and approved as an ASC provider and billed separately as professional and technical fees
- Payers will have to be contracted with and approved as an ASC for both professional and technical billing
Advantages of the OBL and the ASC

- OBLs and ASCs can be:
  - Hospital/Physician owned
  - Corporation owned
  - Corporation/Physician owned
  - Corporation/Hospital owned
  - Physician owned

Each state will have its own governance by its certificate of need laws and the CPOM (Corporate Practice of Medicine doctrine)
Economics of PAD: Summary

• The financial and resource impact of PAD to our economy and Health Care System as a Pandemic will continue.

• The Place of service will continue to shift to lower cost options as it will be directed by Medicare and Carriers and Patient Preference.

• Physicians will continue to have an opportunity to own or partner in OBLs and ASCs.

• All Specialties will work together in Treating Limbs and Saving Lives.
Together We Can Save One Leg at a Time

Rockettes with the US Navy
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