

## Cardiac Procedures: Is an ASC The Right Move?

*The Devil is in the Details*

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It is widely acknowledged that the COVID-19 pandemic has significantly impacted healthcare, with many patients postponing or avoiding medical attention in light of social distancing measures. Although there has been a decrease in both inpatient and outpatient activity in 2021 compared to 2019, it is anticipated that over the next 10 years, there will be an increase in activity levels beyond the estimated population growth.<sup>1</sup> This can be attributed to the aging population and growing prevalence of chronic diseases. The trend seen over the past 2 years regarding utilization, care delivery models, and site-of-care shifts is expected to accelerate to the lowest-cost setting of care.

Today, nearly 60% of major cardiovascular procedures, including diagnostic cardiac catheterizations, are performed in the hospital outpatient department and only 2% are performed in an ambulatory surgery center (ASC).<sup>1</sup> Overall, the number of ASCs has increased to 11,815 in 2022, an increase of 48% since 2018 and up from 5700 in 2018.<sup>2</sup> However, according to a MedPAC March 2023 report, there were 118 single-specialty cardiology ASCs billing Medicare in 2021 as opposed to 13 in 2016.<sup>3</sup> While ASCs accounted for 10% of all cardiology procedures in 2018, Bain & Company expects they will account for 30%-35% by the mid-2020s.<sup>4</sup> Currently, Centers for Medicare and Medicaid Services (CMS)-approved cardiology procedures on the ASC Covered Procedures List include device implants, such as pacemakers and implantable cardioverter defibrillators, diagnostic catheterization, and percutaneous coronary intervention.

### Reasons to Shift CV Procedures to an ASC

As the trend towards ASCs continues to grow, it is crucial to ensure that your facility keeps up with these changes. Here are some considerations to move CV to outpatient setting:

- Protecting current market share or providing the opportunity to geographically expand and provide care to underserved communities or remote, high-demand areas;
- Gaining financial opportunities by increasing patient throughput while offering cost-of-care reductions through efficiency and standardization of patient care;
- Improving staff satisfaction, recruitment, and retention as employees seek a more satisfying work/life balance;

- Attaining “The Triple Aim”: providing better outcomes and improved experience for patients.

Regardless of the industry-wide reasons, every organization has its own unique situation. In Corazon’s experience, the organizations that have proactively addressed the shift of cardiovascular procedures in the ASC setting of care are one step ahead of those who tend to or are forced to act reactively.

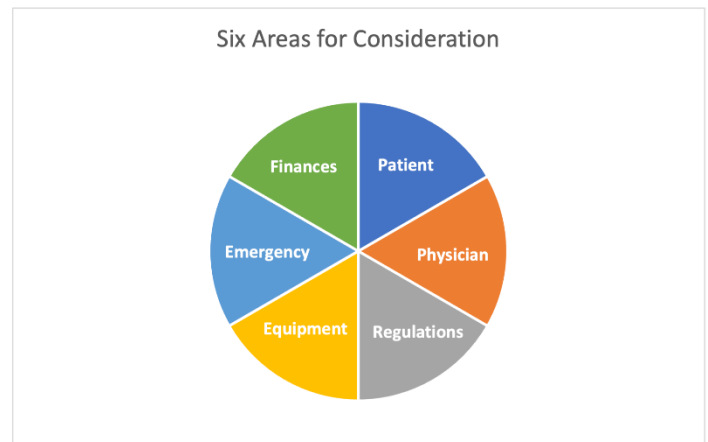


Figure 1.

Before shifting cardiac procedures to the ASC setting, we recommend organizations evaluate 6 key areas (Figure 1) to help make an informed decision. When discussing each topic, it is important that all key stakeholders (administrative leadership and physicians) are involved in open and honest communication.

1. **Patient Safety and Selection:** The safety of the patient is the most important consideration when deciding whether to move a cardiac procedure to an ASC. It is crucial to ensure that the ASC has the necessary equipment, facilities, and staff expertise to perform the procedure safely. Regarding patient selection, not all patients are suitable candidates for cardiac procedures in an ASC. Patients with complex medical histories, co-morbidities, or those who require emergency intervention may need to be treated in a hospital setting.
2. **Physician Expertise and Relationships:** It is essential to have skilled physicians and other healthcare professionals who are experienced in performing cardiac procedures in the ASC. Physicians should have the appropriate

board certifications, as well as training and experience in the specific procedures being performed. Keep in mind that relationships between the hospital and physicians may affect the speed of growth when attempting to shift from the hospital to the ASC. Physician dynamics can also come into play, as some may not want to operate in the ASC due to various reasons. Lastly, most cardiology groups are employed by health systems, and as a result, the health systems may play a more material role in the shift related to ASC structures, personnel, billing, etc. One other important consideration is the inclusion of independent practicing physicians.

3. **Regulations:** Although CMS approved cardiac procedures in an ASC setting, it is important to keep in mind that state law governs the licensure and regulation of ASCs in many states. Approximately one-third of all states in the United States do not allow ASCs to perform cardiac procedures; therefore, it is vital to understand your individual state regulations. Of the permitting states, there are various tiers of regulation. For example, Illinois must submit a Certificate of Need (CON), whereas Texas requires nothing but the standard house-wide ASC accreditation such as Accreditation Association for Ambulatory Health Care (AAHC).
4. **Equipment and Technology:** The ASC must have the necessary equipment, supplies, and technology to perform cardiac procedures safely and effectively. This includes advanced imaging equipment, catheters, and other devices required for specific procedures. Access to capital for any project of this size needs to be assessed. Equipment alone can easily calculate over \$1 million USD of investment.
5. **Emergency Response Plan:** In the event of an emergency, it is crucial to have a well-defined plan in place for transferring patients to a hospital quickly and safely. The ASC should have emergency protocols and equipment readily available, and staff should be trained to handle emergencies effectively.
6. **Finances:** One of the primary reasons for moving cardiac procedures to an ASC is to reduce costs. It is essential to evaluate the cost-effectiveness of performing various procedures in an ASC versus a hospital setting to ensure that it is financially viable for both the patient and the healthcare provider. Likewise, it is important to analyze the procedure and payor mix of the hospital-based outpatient department and cardiologist group(s) to understand the influence payors can have on the bottom line. Although a cumbersome and complicated analysis, it is vital to determine the impact of moving low-risk, low-complication patients from the hospital to an ASC. Not only do you need to have a full understanding of the current volumes across

inpatient/ hospital-based outpatient department and ASC sites, but there are also differences in reimbursement which can be higher or lower depending on the procedure and structure of the ASC (i.e., 100% ASC or an ASC/office-based laboratory [OBL] hybrid model) (Table 1). Don't assume if the reimbursement is lower in the ASC or OBL that it is not a positive shift, as you need to factor in all volumes and costs per case to determine your break-even point.

### Financial Considerations 2023 Revenue Comparison

ASC vs. HOPD (technical fee comparison of national rates)

CPT CODE	CPT CODE DESCRIPTION	PROCEDURE CATEGORY	HOPD	ASC
92920	PCI with angioplasty; initial	PCI	\$5,215	\$3,274
92928	PCI with angioplasty/stent; initial	PCI	\$10,615	\$6,339
93458	hrt artery/ventricle angio	Diagnostic Cardiac Cath	\$2,958	\$1,489
33206	insertion of new or replacement Devices		\$10,329	\$7,557
33240	insertion of implantable defibril Devices		\$22,818	\$20,228
37221	iliac artery revascularization	Peripheral Vascular	\$10,615	\$6,599
37224	Fem/pop revascularization	Peripheral Vascular	\$5,215	\$3,230
37225	Fem/popl revas w/ather	Peripheral Vascular	\$10,615	\$7,056
37226	Fem/popl revas w/stent	Peripheral Vascular	\$10,615	\$6,969
37227	Fem/popl revas strt & ather	Peripheral Vascular	\$17,178	\$11,792
36902	intro cath dialysis circuit	Dialysis	\$5,307	\$2,327
36906	Thrmbc/nfs dialysis circuit	Dialysis	\$17,178	\$11,245
27447	Total knee arthroplasty	Total Knee	\$13,048	\$9,323
22612	lumbar spine fusion	Spine	\$21,898	\$15,901
63042	Laminotomy single lumbar	Spine	\$6,615	\$3,138

EXAMPLE: Corazon Client; comparison of OBL vs. ASC technical fees for PVI procedures

CPT Code	2023 OBL Technical Fee	2023 ASC Technical Fee
37221	\$2,509	\$6,147
37224	\$2,402	\$3,009
37225	\$7,924	\$6,573
37226	\$7,411	\$6,492
37227	\$10,197	\$10,984

Table 1.

### Conclusion

Careful consideration of all factors reviewed above is essential when deciding whether to move cardiac procedures to an ASC setting. A proactive evaluation will help to ensure that the patient receives safe and quality care, procedures are cost-effective for both the patient and the healthcare provider, and that the hospital and/or provider can balance the benefits financially.

Corazon has worked with many facilities and providers to help them understand the right strategy, time, and place by doing a thorough investigation that includes all the factors described above. As the saying goes, "The devil is in the details."



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