The Feasibility of the Hybrid OBL/ASC Model for Cardiovascular Procedures: Does it Work for You?

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For over 10 years, both diagnostic and interventional peripheral vascular (PV) procedures have commonly been performed at an office-based lab (OBL) within the physician practice location. Several factors have influenced the shift of PV procedures away from the hospital to alternate settings, but two stand out as the key catalysts for this shift: (1) PV procedures are traditionally unregulated, and (2) PV provides a highly favorable cost-benefit analysis, especially given that the historical reimbursement for most PV procedures has been more favorable in an OBL as opposed to a hospital outpatient department (HOPD) or ambulatory surgical center (ASC).

However, in the last several years, the Centers for Medicare & Medicaid Services (CMS) has gradually recognized clinical advances by adding cardiac procedures to the Covered Procedure List (CPL), which allows reimbursement for device implants, diagnostic cardiac catheterizations, and most recently, low-risk percutaneous coronary intervention (PCI) in the ASC setting. Even though CMS approved cardiac procedures in an ASC, several factors have slowed its adoption, with the most notable being that cardiovascular services remain highly regulated in many states. For those permissible states, Corazon has witnessed pioneering hospitals readily developing ambulatory strategies to embrace the shift to an outpatient setting of care, rather than narrowly focusing on HOPD reimbursement losses.

Now that PV and cardiac procedures are in both outpatient settings of care (ie, OBL and ASC settings), there is a burgeoning interest among hospitals, physicians, and private investors in investigating how these specialties can utilize the same physical space while still reaping the financial benefits of each place of service. Correspondingly, this phenomenon led to the inception of the hybrid OBL/ASC model.

A hybrid OBL/ASC model operates on a schedule-based system where the outpatient procedural area functions and bills as an OBL on certain days of the week, while maintaining the ability to morph into an ASC, both operationally and financially, on the other designated days of the week. Although the adoption of the hybrid model sounds like a win-win from a financial perspective, there are several key factors when evaluating the feasibility of the hybrid model, such as volume opportunity, situational analysis, reimbursement differences, and implementation considerations.

Hybrid Model Feasibility: Market Size and Opportunity

In order to determine feasibility of a hybrid model, the first step involves determining the volume potential. As outlined below, there are four main data layers to justify the market size and volume opportunity for an OBL or ASC.

1. **Outpatient market data for the service area.** This can be challenging because market data that is available from the state hospital association (or a similar entity) is typically limited to inpatient discharge data. Since the patient population for an OBL or ASC is solely outpatient, this means that national or regional ratios must then be applied if you live in a state that only offers accurate inpatient data. For example, if inpatient PCI discharges represent 1000 cases in your service area, then apply an outpatient factor (national outpatient PCI is roughly 40%) to estimate the total outpatient PCI discharges (in this example, it equals 400 outpatient PCI cases).
2. **Eligible patients within an OBL or ASC.** There is no denying that certain patients will require hospital-level care, even if their procedure is considered outpatient. Therefore, appropriate patient selection is vital for an OBL or ASC. Patient selection can have an impact on patient safety, efficiency, and reportable events. Determining suitability depends on a variety of factors, such as a patient's medical history or the anticipated type of anesthesia. Other considerations include social factors, such as the availability of a responsible person to care for the patient at home. Ultimately, the decision to furnish services in the OBL or ASC setting should be based on the physician's clinical assessment of the patient's risk factors and pre-procedural optimization. Therefore, working collaboratively with physicians to determine a solid assumption of eligible patients is essential when determining the available patient population.
3. **Estimate market share capture.** Solid volume assumptions should rely on the current patient population within the physician practice and within the hospital. Another consideration should include how often the space operates as an OBL versus an ASC. Things to consider:
   - Analyzing the physician practice billing data and hospital outpatient patient mix can provide valuable insights into the volume potential for the hybrid OBL/ASC. For instance, both data sets provide information on patient origination, but they can also provide information on how much that particular physician's office contributes to the hospital outpatient volume. This can have a critical impact on the financial analysis, as it indicates whether the anticipated patient volume at the hybrid OBL/ASC results from a redistribution of existing patients from the HOPD, or from new patients entering the system.
   - The basis of the hybrid model is founded on how often the OBL and ASC operate per week. Determining which procedures are in each setting of care, and how often, can be challenging. For example, varying volume scenarios are likely to occur given the operational schedule of the OBL. If the OBL only conducts vascular procedures two days per week, these procedures would inevitably capture a smaller market share compared to cardiac procedures performed three days per week.

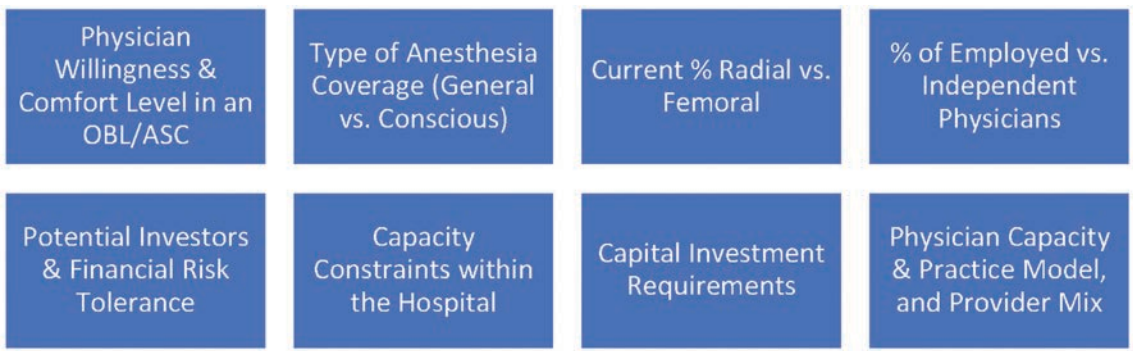

Figure 1. Make-or-break reasons for implementing a hybrid OBL/ASC.

Situational Analysis

One can go through the entire process of determining the volume opportunity for a hybrid OBL/ASC but without an accurate assessment of the existing circumstances, such efforts could easily

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become futile. At Corazon, the items (not limited to) listed in Figure 1 are 'make it or break it' reasons for implementation. For example, the equipment and space requirements can be quite extensive. Capital equipment requirements and supplies can cost upwards of $1 million, in addition to facility costs needed to build or renovate the space to meet mandated ASC standards.

Reimbursement Considerations

Unquestionably, the reimbursement in the separate place of service codes is the primary reason why the hybrid OBL/ASC model exists. As this model continues to gain further momentum, Corazon works diligently to stay on the leading edge of payment updates. When comparing reimbursement, the technical fee (versus the professional fee) is the primary differentiator because the physician collects the same professional fee regardless of the place of service. Table 1 illustrates a Corazon client case study comparison of 2023 Medicare technical payments for an OBL and an ASC for cardiac and vascular procedures with the highest utilization. The areas highlighted in green represent the place of service where the technical fee is more favorable to the provider.

Very recently, most peripheral vascular technical fees paid more in an OBL than in the ASC. However, as seen in Table 1, CMS has increased the ASC technical fees for select peripheral vascular procedure codes. It is essential for organizations to analyze the current procedural mix at the CPT code level to determine the reimbursement impact it may have on the hybrid OBL/ASC finances.

TABLE 1. 2023 Medicare Technical Payments Comparison for Cardiac & Vascular Procedures in an ASC and OBL.

CPT Code	Description	OBL Technical Fee	ASC Technical Fee
93458	Left heart cath	$715	$1,387
37220	Iliac revascularization (revasc)	$2,040	$2,864
37221	Iliac revasc w/stent	$2,509	$6,147
37224	Fem/popl revasc w/tla	$2,402	$3,009
37225	Fem/popl revasc w/ather	$7,924	$6,573
37226	Fem/popl revasc w/stent	$7,411	$6,492
37227	Fem/popl revasc stent & ather	$10,197	$10,984
37228	Tib/per revasc w/tla	$3,499	$5,669
37229	Tib/per revasc w/ather	$7,969	$10,358
37230	Tib/per revasc w/stent	$7,982	$10,575
37231	Tib/per revasc stent & ather	$10,723	$10,547

tla = transluminal angioplasty; fem/popl = femoropopliteal; ather = atherectomy; tib/per = tibioperoneal

Implementation Considerations

If the feasibility study demonstrates that the hybrid OBL/ASC model is financially sound, organizations must comprehend the unique operational requirements for implementation. Since the same physical lab will be billed as different places of service, the following must occur:

- Construction of the entire space should meet the ASC standards;
- The space cannot operate as an OBL and ASC simultaneously;
- Delineate designated days for the OBL and ASC;
- OBL and ASC must maintain separate operational documents (ie, policies and procedures, signage, identification, etc) for each;
- Individuals may only access documents, records, EMR, etc. that are designated for the current operational title;
- Maintain separate tax identification numbers and National Provider Identification (NPI) numbers;
- Medicare participation requires a certificate of compliance with conditions for participation;
- The OBL and ASC must contract with payers as separate entities.

Conclusion

While the hybrid OBL/ASC model has indeed gained traction and success, its long-term sustainability is thought-provoking. As CMS continues to add more procedures to the Covered Procedures List (CPL), increase ASC reimbursement, and add new bundled codes specific to ASCs (such as CPT Code C7523: Left heart angio w/IVUS or OCT), the hybrid OBL/ASC model's future appears more solidified. To determine which setting of outpatient care aligns with your organization, Corazon strongly recommends a targeted business plan for the cardiovascular OBL/ASC to understand the viability of services, operational requirements, market opportunity, financial commitment, and reimbursement.

A shift to the outpatient setting of care is happening in the cardiovascular field and many important stakeholders are incentivized by making such a shift happen. First, patients are attracted by the ease of access, affordability, and timely and efficient processes for the OBL and/or ASC. Second, physicians are afforded greater control over their practice through the ease of scheduling, greater staff expertise, and improved efficiency and productivity found in these ambulatory settings. And third, payors are demanding high-quality, low-cost services, which are cornerstones for OBLs and ASCs. Once these cardiovascular procedures move to the OBL and/or ASC, it is unlikely that they will move back into the acute care setting. How will your organization be part of the change? ■

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