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A new strategy to profit from interventional radiology

By Mark F. Weiss, AuntMinnie.com contributing writer, Cecilia Kronawitter, AuntMinnie.com contributing writer

May 23, 2016 -- A confluence of trends has created a new business opportunity for interventional radiologists: profiting from the ownership of interventional radiology ambulatory surgery centers (irASCs).

As you're undoubtedly familiar, surgeons in many specialties have profited for decades from their investment in ambulatory surgery centers. Reimbursement from Medicare and from other payors to those ASCs is based on current procedural terminology (CPT) coded facility fees, which, depending on the procedure, can be quite significant.

Until recently, this same opportunity hasn't been feasible for interventional radiologists.

First, there was a dearth of CPT codes enabling ASC facilities to bill and collect for interventional procedures.

Second, interventional radiology suffered from the image of the specialty as a "service" as distinguished from a surgical specialty. This has resulted in an artificial cap on referrals from other medical specialists.

Trends create new opportunity

Three major trends have come together to foster the birth of the irASC concept: an essential payment-related regulatory change, a shift in the self-view of interventional radiologists, and the insurance industry's rapprochement with physician-owned ASCs.

There are now more than 40 surgical CPT codes for interventional radiology procedures, 10 of which were added in 2016 to Medicare's Ambulatory Surgical Center Fee Schedule.

Without a CPT code, there is no way for a facility fee to be billed and collected from a government program or a commercial payor. The existence of this expanded set of codes now enables outpatient interventional radiology surgical facility fees to be billed and collected by an irASC.

Facility fees for irASC cases can run well into the four figures per procedure. For example, CPT code 37241, which relates to certain vascular embolization or occlusion procedures, generates Medicare irASC reimbursement (i.e., the facility fee alone, which is paid in addition to all physician fees) of more than $5,900.

Although exact prices can't be discussed due to antitrust restrictions, some interventional radiology procedures that would result in a hospital charge of around $25,000 (exclusive of any physician fee) can be performed in an irASC setting for an all-inclusive (facility plus all physicians) fee in the range of $10,000 to $15,000. This would still be quite profitable to the irASC due to the much lower surgery center cost structure of an independent freestanding facility.

Attorney Mark Weiss.

Image shift

Traditionally, interventional radiologists have viewed themselves as radiologists who happen to be interventionalists. Other medical professionals viewed them similarly. This commonly shared viewpoint resulted in interventional radiologists being seen in the same light as radiologists in general: providers of a medical service to referring physicians.

Cecilia Kronawitter, president of HDA Enterprises.

Now, however, interventional radiologists are beginning to shift their professional image to that of interventionalist surgeons who happen to be radiologists. Their primary "customer" is the patient.

Note that this same type of shift is occurring in other specialties in which interventionalists were seen as subspecialists within a larger, organized medical specialty -- for example, interventional cardiology.

Even as recently as several years ago, many insurance carriers fought against reimbursement to physician-owned facilities on the grounds of supposed overutilization, conflict of interest, and "double dipping."

Today, however, payors are waking to the huge cost savings resulting from moving procedures outside of the hospital, even outside of hospital outpatient departments. Citing the same example used above, their concern over conflict of interest is outweighed by their financial interest in reducing $25,000 hospital fees (plus the additional physicians' fees) to all-inclusive ASC fees of $10,000 to $15,000.

irASC structure -- a coordinated approach

Developing a successful irASC requires a coordinated approach among legal counsel, a developer, design professionals, and a management company experienced in the nuances of structuring, building, accrediting, and operating an irASC facility.

Structuring an irASC begins with the basic question of who will own it.

Is the facility to be owned by interventional radiologists alone, by a traditional radiology group, or via a joint venture between physicians and a hospital?

Although there are significant compliance issues involved, including issues under the federal antikickback statute, under the right circumstances, interventional radiologists may be able to collaborate with other medical specialists on the development of an irASC.

In addition to issues under the antikickback statute and its state law counterparts, there's a range

of other federal and state compliance issues to be taken into account.

In a similar vein, developing an irASC requires architectural, design, and construction sensitivity to the unique nature of the facility, and compliance with federal, state, and accreditation standards. It requires a coordinated approach among the client, a development firm with specific irASC experience, the management firm tasked with day-to-day business operations, and deal-oriented healthcare legal counsel experienced in the irASC space.

irASCs present a tremendous opportunity for interventional radiologists and their groups to capture both the professional fee and the facility fee for many interventional procedures. With careful analysis and planning, investment in a properly structured and designed irASC can deliver a tremendous and ongoing financial return.

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