Is There An Interventional Radiology ASC (irASC) In Your Future?

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Professional, business, and regulatory paradigm shifts occurring in interventional radiology present a new opportunity for interventional radiologists and their groups: Profiting from ownership of interventional radiology ambulatory surgery centers ("irASCs").

Some radiology groups have soured on the notion of developing imaging facilities due to declining technical side reimbursement and perceived conflicts with hospitals. The new opportunities for irASCs, however, have nothing to do with imaging facilities and with technical fees as commonly understood by radiologists. Reimbursement from Medicare and from other payors to an irASC is based upon CPT coded facility fees, which, depending on the procedure, can be quite significant, in some cases into the mid-four figures per procedure. Note that those facility fees are in addition to the professional fee for the interventional radiologist's own services.

The birth of the irASC concept is a result of a confluence of professional and business trends as well as a significant payment-related regulatory shift. In the hospital setting, interventional radiology has 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.

Interventional radiologists now are beginning to shift their professional image from that of radiologists who are interventionalists to that of interventionalist surgeons who happen to be radiologists. This same shift is occurring in other interventional specialties such as interventional cardiology.

On the business side, there's a huge push by insurers to move cases across the board from the very expensive hospital setting, even the hospital outpatient setting, to freestanding surgery centers. The magnitude of potential cost savings to payors cannot be understated.

Although exact prices can't be discussed due to antitrust restrictions, some interventional radiology procedures that would result in a hospital charge in the range of $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 and still be quite profitable to the irASC due to the much lower surgery center cost structure.

On the regulatory side, there are now more than 40 surgical CPT codes for interventional radiology procedures. The existence of those codes enables

12 Commonly Performed Outpatient Interventional Procedures

outpatient interventional radiology surgical facility fees to be billed and collected by an irASC.

The number of interventional radiology procedures that can generate facility fees for irASCs is growing. In 2016, for example, 10 additional interventional radiology CPT codes were added to Medicare's 2016 Ambulatory Surgery Center Fee Schedule. For example, CPT code 37241 in connection with certain vascular embolization or occlusion procedures generates

an irASC fee (i.e., the facility fee alone, which is paid in addition to all physician fees) of more than $5,900.

The growing scope of facility fee reimbursement to irASCs fosters a wide range of potential referral sources for interventional radiologists. The list includes—but is not limited to—cardiologists, oncologists gastroenterologists, gynecologists, orthopedists and urologists.

1. Percutaneous vertebral augmentation
2. Biliary stent placement
3. Kidney drain placement
4. Ablation of liver tumor
5. Ablation of renal tumors
6. Transcatheter intravascular stent placement
7. Insert tunneled intraperitoneal catheter percutaneous
8. Create passage to kidney (nephrostomy)
9. Vascular embolization/occluded organ
10. Removal of intravascular foreign body
11. Percutaneous cervicothoracic injection
12. Biliary endoscopy through skin

Source: Mark F. Weiss, JD, Cecilia Kronawitter

Competition concern

As mentioned above, some radiology groups have soured on the notion of developing imaging facilities due to perceived conflicts with hospitals. Won't those same concerns impact the decision to develop irASCs?

While any decision to move forward with the development of an irASC involves consideration of the political aspects of business reality, as interventional radiology becomes more and more of a surgical specialty, the impact of competition with a hospital needs to be viewed through the surgical lens, not the imaging lens. Certainly, some gastroenterologists might have shied away from developing a GI center because of fear of what the hospital might think, but finding them would require a search on par with Diogenes' search for the honest man.

Certainly, for interventional radiologists practicing independently of a diagnostic radiology group, the decision would be more akin to that of a gastroenterologist. Even for radiology groups comprised of both diagnostic and interventional radiologists, however, structural changes within the group, including splitting interventional radiology off into its own, but related, professional entity, can help allay concerns about perceived competition.

Additionally, and very practically, as interventional radiology becomes more and more a standalone specialty, there will be competition from independent interventional radiologists and their groups. Someone is going to be competing with the hospital, taking cases from it to an independent irASC.

irASC structure

There are many alternatives in connection with structuring an irASC, beginning with the basic question of who will own it. For example, an irASC can be owned by a traditional radiology group, by interventional radiologists alone, or jointly between one of those and a hospital (thus reducing the fear of being a competitor).

Importantly, although there are additional compliance issues involved, most notably compliance with the Federal Anti-Kickback Statute, it's possible that interventional radiologists and their groups can work collaboratively with other medical specialists—for example, interventional cardiologists, cardiologists and oncologists—on the development of an irASC.

Although complicated but not insurmountable, there is a wider range of federal and state legal and compliance issues, as well as accreditation issues, to be taken into account in connection with the business structure of an irASC. In addition to legal issues, developing an irASC requires architectural, design and construction sensitivity to the unique nature of the facility and compliance with federal, state and accreditation standards. Development of a surgery center requires a coordinated approach among the client, a development firm with specific irASC experience and deal-oriented healthcare legal counsel.

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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