Tenacity and Timing Coalesce to Launch Our ASC

Dr. Sarang Mangalmurti discusses his journey and motivation for opening his ambulatory surgical center with the growth of cardiovascular procedures in out-of-hospital care sites.

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The migration of surgeries and procedures from the hospital setting to office-based labs (OBLs) and ambulatory surgery centers (ASCs) continues to expand due to patient demand, improvements in medical technology, and a more favorable financial model for providers, payers, and patients. Cardiac procedures performed in an ASC have a 35% to 50% lower cost than in the hospital, with those savings being passed on to insurers and, ultimately, the patients.[1] In addition, ASCs allow physicians greater diversity in treatment options,[2] providing an opportunity for a more personalized, patient-focused approach to care.

For cardiovascular procedures, this is largely driven by the Centers for Medicare & Medicaid Services (CMS) with the addition of new cardiovascular CPT codes to the list of Medicare-covered ASC surgical procedures over the last few years. For example, in 2018, the Medicare program added 17 cardiac catheterization–related procedures to the 2019 list of Medicare-covered ASC procedures. The following year, CMS issued a final rule authorizing the provision of percutaneous coronary intervention (PCI) in the ASC setting by approving the addition of six CPT codes to the ASC-covered procedures list for 2020.[3]

Last year, CMS announced a new payment policy that will apply to certain cardiac code combinations in ASCs that include "add-on" services for instantaneous wave-Free Ratio (iFR)/fractional flow reserve (FFR) or coronary intravascular ultrasound (IVUS) and noncoronary IVUS procedures. There is tremendous support for these payments that improve the patient experience, reduce costs, and promote the safety of cardiac procedures performed outside of the traditional hospital setting.

The spotlight on cardiovascular procedures in the ASC setting continues to shine brighter, making it more enticing and financially viable for physicians to open their own lab or expand an existing lab for cardiac procedures. Dr. Sarang Mangalmurti, owner of Bryn Mawr Medical Specialists, provides his personal insight on the ASC movement, how these trends have impacted his business and care strategies, and how he was locally involved in advocating for this movement in his community.

How did you first become involved in the OBL/ASC market?

I have always been part of large, multispecialty groups working out of the hospital. In 2015, I had my first experience with an ASC. That experience was eye-opening because it proved to me that a lot of cardiac procedures can be done safely in the out-of-hospital setting. Additionally, I realized that patients really liked that type of setting in terms of ease of access, greater flexibility, enhanced experience, and more personal attention. I knew at some point I wanted my own ASC that would be more proximate to my patients and provide them with quality service. That sentiment was shared by our cardiology group; however, the hospital was not interested in getting involved, so we were on our own.

Fast forward to 2020. Our practice, Bryn Mawr Medical Specialists, was serendipitously in the early planning phase for our ASC when CMS announced additional cardiovascular CPT codes to the list of Medicare-covered ASC surgical procedures. That was a major step forward for ASCs, and we knew that once Medicare had codes for reimbursement, it was only a matter of time before insurance companies and private

insurers would follow suit. So, we knew we were on the right track. We broke ground in early 2022 and our ASC opened later that year. It has been the best decision for us and our patients.

Did you open your ASC with an extended offering of cardiac procedures?

We had the basic procedures that we could do in the ASC without the approvals needed for the more complex big-ticket items. We could perform minor cardiovascular procedures, for example, venous work, some electrophysiology implants, and minor generator changes that you could do in the ASC.

We knew that eventually more complex procedures would get approved, but first we needed to obtain the Certificate of Need (CON) approval from the state of Pennsylvania. For us, when we finally decided to build the ASC and commit the dollars to it, it was somewhat a leap of faith. But, we could see that things were trending in the right direction. The societies, the government, and insurance companies—all key players in the industry—were going to want these cardiac procedures to come out of the hospital into the ASC setting. And so, even if we were just breaking even in the first couple of years, we were at least well positioned for the future. It turned out that the future came faster than we had anticipated.

We obtained our approval for PCI procedures relatively quickly. Late last year, Pennsylvania abrogated the requirement that cardiac catheterizations could only be performed in an acute care hospital and removed the waiver process for any ASC that opened to offer procedures that are on the CMS Covered Procedures List. This authorized us to add coronary artery procedures in our ASC and become a fully functioning cardiovascular ASC.

Did you have any reservations about performing procedures outside the hospital?

My comfort level in performing procedures outside the hospital evolved quickly after the closure of our hospital's surgical suite over 10 years ago due to budget constraints. The biggest factors for performing these procedures confidently outside the hospital are selecting your patients properly and doing the imaging and physiologic diagnostic testing that you need to make those procedures go smoothly and predictably.

How has your ASC benefited from the recent approval of the complexity payments in ASCs?

The biggest benefit of the new complexity codes is that they allow us to add additional modalities as standard care to our procedure sets. When previously using these modalities, it raised the cost of your case without adequate compensation, and you're forced to be more selective of cases for the wrong reason. Now with the complexity codes, you can be more generous about using these useful modalities and not feel like you must be cost-conscious about it.

For example, diagnostics like IVUS or physiologic measurement with iFR/FFR are indispensable tools. We use IVUS daily in the peripheral vascular arena for vessel sizing and assessing plaque morphology. And in coronary space, they're extraordinarily useful.

In the end, you want to do what's right for the patient and not have to worry about anything else. That's the real benefit of it. The new codes provide us additional reimbursements and make it easier for our coders. The message is, "Look, we want you to be a doctor and not worry about being a businessman when it comes to these complex procedures being applied outside of the hospital."

Why do you use imaging and physiologic testing as part of your care strategy?

The biggest advantage of imaging and physiologic testing when you're performing complex interventional cardiology procedures outside the hospital is reducing the risk of adverse events and eliminating surprises. That's really the key. You want your interventions, especially your coronary interventions, to be as predictable as possible. IVUS is extremely helpful because if you look at a lesion angiographically and you're trying to get a sense of how calcified it is or whether you're going to have trouble expanding a balloon or a stent, IVUS gives you answers that angiography alone cannot. If IVUS shows that lesion is not that calcified, then you know that case can be performed in the ASC smoothly and without complications.

Conversely, if IVUS shows a lot of calcification and the lesion likely needs some calcium modification, then the case is not appropriate for an ASC. You don't want to be in the dark and start working on a complex stenosis and then realize you're stuck because you need an atherectomy tool that is unavailable in the setting you're in. So, utilizing IVUS is a good way to prevent surprises from happening.

Additionally, measurements like flow reserve and physiologic indices from iFR/FFR can give you a sense of what lesions need to be treated more urgently than others and which ones you can leave alone. These are all very useful tools—indispensable tools, really—for making these cases go smoother, making them more predictable, and reducing the risks of potential complications arising in an outpatient ASC setting.

How has your ASC impacted the community?

There are a couple of ways that our ASC helps the community. It gives the community another option in terms of site of service, especially a service that tends to have a very high patient satisfaction and far more convenience. The word gets out quickly that these procedures no longer need to be done in the hospital. That awareness of being able to get procedures done outside the hospital elevates the general medical knowledge and general medical experience of the community in a positive way.

The second way is the camaraderie that ensues among physicians. To succeed collectively, communication and coordination must increase to serve the patient base. So, whatever works well in terms of reducing the risk of complications and improving patient satisfaction or patient outcomes, we're more than willing to spread that knowledge and share with other physicians and other ASCs. That helps to grow our practice, as well as the collective ASC community.

What were your primary motivations to open your ASC?

We were committed to an ASC early on, and I think that was a good choice for Bryn Mawr Medical Specialists, and it's probably a good choice for a lot of like-minded physicians moving forward in concert with the direction reimbursement is trending. There's more regulation, but it's also a better environment to do the complex cases, especially cardiac cases and so forth.

There were really three things that drove us to think about our own freestanding ASC. Number one is, as a private practice group, we want to keep services contained under our own umbrella so we have control over the practice and can administer a higher level of care for our patients. That translates into a high level of patient satisfaction. We survey our patients, and almost uniformly, patients will say they have had a far better experience in the ASC before, during, and after the procedure.

Pre-procedure, it's far more simplistic to set up the patient's procedure because it's all done within our office. During the procedure, because we own the facility, we control the flow of patients coming in and out. We can avoid the long delays, endemic within the hospital, as we control the throughput. Post-procedure, patients are watched carefully, and I think this happens more so in the ASC than in the hospital, because the ratio of nurses to patients is often higher in a tight-knit ASC than in a large post-operative unit or post-catheterization area in the hospital setting.

The second benefit we've discovered is that patient safety improves. In our experience, patients tend to have fewer complications and lower rates of infection. The third benefit is the autonomy we have in deciding how the procedures are conducted and the devices that are utilized. We're making these decisions based on what we know is going to be in the best interest of our patients.

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What barriers did you have to overcome?

One of the biggest barriers we had to overcome was Pennsylvania state regulations. Pennsylvania has been one of the last states to allow these cardiovascular procedures to be done outside of the hospital setting. We had to prove to the state that there was a strong need for a particular procedure or set of procedures to be done outside the hospital—creating a CON. Beginning in 2015, we applied, did our due diligence, talked to our local health department and members of Congress, and lobbied in our local state government to try to inform them that these procedures should and can safely be done in the outpatient setting. Unfortunately, this was a process that we repeated for 7 years in a row before we ultimately secured approval.

In 2020, several external factors converged to sway the decision in our favor. Medicare offered codes and reimbursement for PCI procedures in the ASC. The pandemic showed that you couldn't centralize these procedures in hospitals alone, because during the crisis, patients didn't have any options to get the kind of care they needed. Insurance companies started witnessing

rising costs of everything during the pandemic and recognized that getting these procedures out of the hospital and into the ASC lowers costs. As a result, insurance companies began pushing for more of these procedures to be done outside the hospital.

So, when we applied last year, suddenly the state was very receptive. We learned there was a bill going through our state Congress so we, along with other physician groups and lobbyists, doubled down on our efforts to get the final approvals and the governor's signature.

The process may be different in different states, but my advice for other physician groups is to confront it from multiple sources. You need to rally support from other people, including physician groups, consultants, lobbyists, and local officials, who share your interests in the bills or proposals that support your needs. You must be persistent and visible. You want to be that squeaky wheel.

What advice do you have for physicians who are looking to open an ASC?

My advice would be, "Do it now." With Medicare codes and their endorsement of these outpatient procedures, the time is right. Insurance companies are clear they want these procedures to migrate out of the hospital, and it's largely related to the lower cost of care that can be provided in that setting. We're also seeing the societies support the transition to out of hospital. Recently, the Society of Cardiovascular Angiography and Interventions (SCAI) released guidelines on out-of-hospital PCI without surgical backup. Soon, the public will recognize that most of these cardiovascular procedures can be safely accomplished outside the hospital. There's never a perfect time, but you don't want to miss a rising tide. I think that's what we're seeing and for the foreseeable future.

For the actual implementation, I think it's very important to find an industry partner that has a lot of experience setting up ASCs, whether building from scratch or modifying a medical office, outfitting it with the right equipment, and even the administration and logistic aspects. Industry partners like Philips and other management groups, that have tons of experience setting up and running OBLs and ASCs, make that process so much easier. It's worth the time, money, and energy to get them involved early on because they're going to steer you in the right direction. It's to their benefit for you to be successful because your success is their success.

We did our due diligence, talked to several companies and vendors on different options, and, in the end, chose Philips and their SymphonySuite solution. Philips wants to see the ASC market grow, they want to see their customers' labs be successful, and they want their customers to have a great experience. Those are the people you want in your corner.

How did you work with Philips?

Our practice owns a fair bit of real estate, so we already had selected the site for our ASC. Philips showed us some existing customer facilities and then helped us design the space and understand the process from the ground up. They helped us select the right equipment and diagnostics and how the throughput should be managed once the doors opened. With our best estimates of patient load, Philips was also able to accurately predict what other required products and disposables would be needed and what revenue would look like in the first few months.

Once you start, you want to have everything integrated and relatively seamless. For example, you want IVUS and physiologic measurements that you use often integrated on the table, and you want your system to communicate with your hemodynamics. Otherwise, you're constantly moving carts in and around, disrupting the flow.

The biggest advantage of working with Philips was their mastery of the ASC venue. From initial planning to building, equipping, financing, operating, and consulting, Philips representatives are well versed in all aspects of the ASC. We would not have been as successful as early as we were without them. ■

Philips OBL and ASC Solutions—SymphonySuite—is here to help you transition your OBL to an ASC or build a new ASC from the ground up. We are your trusted partner with the expertise, equipment and innovative imaging, physiology, and therapeutic device selection to help you safely and effectively treat PCI patients in an ASC.

1. Toth M. Coronary interventions in the ASC: now what? Does your health system have an ambulatory strategy? Cath Lab Digest. Published February 2020. Accessed May 4, 2023. https://www.hmpgloballearningnetwork.com/site/cathlab/content/coronary-interventions-asc-now-what-does-your-health-system-have-ambulatory-strategy
2. Carr JG. Office-based labs: an evolving healthcare model. Cath Lab Digest. 2017;25. https://www.hmpgloballearningnetwork.com/site/cathlab/article/office-based-labs-evolving-healthcare-model
3. Department of Health and Human Services; Centers for Medicare & Medicaid Services. Medicare program: changes to hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs; revisions of organ procurement organizations conditions of coverage; prior authorization process and requirements for certain covered outpatient department services; potential changes to the laboratory date of service policy; changes to grandfathered children's hospitals within-hospitals; notice of closure of two teaching hospitals and opportunity to apply for available slots. Fed Register. 2019;84:61142-61492. https://www.govinfo.gov/content/pkg/FR-2019-11-12/pdf/2019-24138.pdf