# Dialysis Access Centers

Experts use their experience to review the differences between ambulatory surgery centers and office-based practices for the treatment of dialysis access.

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Outpatient dialysis access centers are emerging as an efficient and cost-effective tool for managing dialysis access. As a result, the number of new outpatient centers in the US has grown exponentially over the past 5 years. The vast majority of these centers are "office-based" practices and provide percutaneous interventional procedures such as catheter placement, fistulagrams, and access declotting. However, surgical placement of new access grafts or fistulae typically takes place in either a hospital or ambulatory surgery center. The sentinel decision for groups contemplating opening an access center is whether to run an office-based practice or ambulatory surgery center (ASC). Our group decided to build an ASC in order to offer the full spectrum of services to our patients, but the decision to do so was complex. To date, our center is successful and offers imaging (ultrasound mapping and follow-up), surgery (new access and surgical revision), and percutaneous procedures (catheter placements, declots, fistulagrams, etc.). Despite many challenges along the way, the synergy created by having all services under one roof has more than made up for the extra work and expense required to build an ASC.

This article reviews the differences between an ASC and an office-based practice for the outpatient treatment of dialysis access. Specifically, we review the regulatory hurdles, compensation issues, and scope of practice offered in the two settings. Ideally, this article may help those considering an access center in deciding between the two options.

There are some significant differences between an office-based access center and an ASC. If the center is office-based, the staff is not able to perform open surgery nor is it required by the State Department of Health to have stringent building criteria. The hurdles faced when opening an ASC are daunting when compared to an office-based practice. The Centers for Medicare & Medicaid Services (CMS) regulates the different types of practices by denoting which services it will pay for at an office-based practice, an ASC, or a hospital. CMS does not set up any specific regulations or requirements for who can open an office-based practice versus an ASC. To receive Medicare reimbursement as an ASC, the ASC must apply to be certified as such by the Medicare program. CMS will also pay for some services at more than one type of practice (Table 1). The fee CMS will pay for procedures it reimburses at more than one setting will vary. Although reimbursement rates vary from one city and state to the next, ASCs and outpatient centers are

**Figure 1. View from post- to preoperative area. Regulations require that these areas are separate.**

always reimbursed substantially less than hospitals for the same procedures. Either way, performing procedures at an outpatient facility offers the healthcare system substantial savings across the country.

The two regulatory areas involved in setting up an ASC are the Medicare program and the State licensure.

## MEDICARE PROGRAM

In the ASC area, the Medicare program takes the route it follows in many other areas. Specifically, it will not dictate what procedures have to be performed in an ASC or physician's office, but it will identify the procedures that it will pay for if done in an ASC, which Medicare may or may not reimburse if performed in a physician's office. The simplest way to explain this is by grouping the procedures in increasing intensity:

*1. Simple surgical procedures that are not on the ASC fee schedule.* These procedures will only be reimbursed as an office-based procedure. Although these may be performed in an ASC, they will not be reimbursed by CMS if performed there. Examples of this are many minor dermatologic procedures.

*2. More intensive surgical procedures that are identified on the ASC fee schedule.* These procedures may be performed either in an ASC, an office-based procedure, or in a hospital surgery center. When billing the professional component, the physician identifies the site of service as billed in a physician's office, ASC, or hospital. If the site of service is a physician's office, the physician will receive a higher professional fee to cover office costs, but there will be no facility fee. If the site of service is identified as an ASC or hospital, the physician professional reimbursement is lower; however, the ASC or the hospital bills for the facility fee. An office-based practice cannot bill a facility fee. An example of this type of procedure would be a venous angioplasty; it is reimbursed at all three types of settings at three different rates.

In 2008, CMS substantially expanded the list of services that qualify for facility payment in ASCs. The newly added ASC procedures were formerly office-based procedure services that were performed in physician's offices at least 50% of the time. Beginning in 2008, payment for these office-based procedure services is the lower of the ASC rate or the practice expense portion of the physician fee schedule payment rate that applies when the service is furnished in a physician's office (this amount covers the equipment, supplies, nonphysician staff, and indirect costs of a service). The reason for this payment methodology is that CMS seeks to minimize financial incentives to shift primarily office-based services to ASCs.

*3. Moderately intensive surgical procedures.* These procedures will only be reimbursed at an ASC or hospital setting.

**Figure 2. Surgical creation of a new access graft with the patient under sedation.**

For example, many same-day orthopedic procedures fit into this category.

*4. Most intensive surgical procedures.* These intensive procedures are not listed on the ASC fee schedule. Medicare will only reimburse for these procedures if they are performed in a hospital. For example, aortic stent graft procedures will only be reimbursed if performed in a hospital setting.

*5. Medicare certification and reimbursement once the center is up and running.* Medicare requires that you perform a small number of sample procedures and submit claims for them. Medicare may then take up to 4 months to certify the center and accept claims from the center. They may also send an inspector at a random, unannounced time during the months of waiting before certification. During this period, it is difficult if not impossible for a center that treats primarily Medicare patients to come close to breaking even. Thus, these costs need to be factored in to the start-up costs.

## STATE LICENSURE

The state of Minnesota and other states require the licensure of outpatient surgical centers. Under Minnesota law, an outpatient surgical center means "a free-standing facility organized for the specific purpose of providing elective outpatient surgery for pre-examined, prediagnosed, low-risk patients. Admissions shall be limited to surgical procedures that utilize local or general anesthesia and do not require overnight inpatient care."

*Outpatient surgery center* does not mean emergency medical services or physician's or dentist's offices. *Surgery* typically means the treatment of conditions by operative means, involving incision or repair of human tissues. States typically

**Figure 3. Ultrasound- and fluoroscopic-guided placement of a tunneled dialysis catheter.**

require new surgery centers to submit architectural and engineering drawings and specifications for new centers. The states require this prior to licensure. There are many other unique attributes required by state law for an ASC that are not required for an office-based center. For example, Minnesota state law requires that an ASC have a medical director, and in addition, a licensed RN is required to be the manager. There are specific building requirements, such as separate treatment areas for surgery and pre- and postoperative care (Figure 1). The operating room (OR) needs to be at least 225 square feet with a minimal dimension of 15 feet. There are specific requirements for scrub sinks, locker rooms, and restrooms. There are detailed requirements for the heating, electrical, and ventilation systems. The OR temperature must be between 70ºF and 76ºF, and the relative humidity must be between 50% and 60%. Each OR needs its own separate exhaust system, even if anesthesia gasses are not being used. Although these regulations are stringent, they do create an ideal atmosphere for patient care. An ASC is thus a more regulated environment and theoretically more sterile and safe for patient care.

## OUR EXPERIENCE WITH AN ASC

Our group decided to open an ASC equipped to deal with all of a dialysis patient's access needs. As a multispecialty group composed of vascular surgeons, as well as interventional and diagnostic radiologists, we felt uniquely qualified to offer all access services. In addition, we had an excellent relationship with a large group of nephrologists in our area. Before proceeding, we had long discussions regarding patient volumes expected, geographic location in order to best accommodate the population served, and discussions as to who exactly would work within the center (ie, nephrologists, surgeons, and radiologists). After extensive review, we decided to proceed.

The center was designed to meet our state's ASC requirements. Upon completion of construction, the site was inspected by the State Department of Health, the local fire department, and local building officials. After we opened, we had to perform five procedures on Medicare patients and submit them for CMS approval. Approximately 6 weeks later, we had our surprise inspection from CMS. They examined our policies and procedures, our governance, as well as our physical plant. The inspector examined our standard pre- and postoperative orders and other patient forms. They also interviewed our nurse manager. Within another 6 weeks, we were certified by CMS to be an ASC. During the 3-month waiting period, we were able to perform very few other procedures because most of our patient population has Medicare as the primary insurance. It is therefore important to factor this downtime into your start-up costs. However, during this time, we were able to do quite a bit of marketing. Specifically, we visited every dialysis site within 100 miles of our center and introduced ourselves to the staff at each location.

After 3 months, we began to encounter a steady increase in volumes. Logistically, we learned that one OR and team could accommodate five open surgical cases or approximately eight percutaneous procedures each day. We have two ORs in our center, one of which is dedicated for open surgery (Figure 2), and the other OR is for interventional radiology procedures, equipped with a C-arm (Figure 3). We also learned that Mondays and Fridays were typically very busy for add-on procedures and required that some slots remain open. Most elective procedures were ordered to be done on Tuesdays or Thursdays, because most patients dialyze on Monday, Wednesday, or Friday. Human resource issues also took more time than anticipated. We learned that hiring a cross section of experienced and inexperienced personnel worked better than hiring too many "experienced" personnel with strong opinions on how things should be run.

We also began to understand our dialysis market. Becoming the major provider of these services is a mixed blessing. Although we clearly enjoyed the success, we also became a de facto clearinghouse for the numerous problems associated with dialysis access. Specifically, we learned that catheter days (determined by the number of patients dialyzed at a center via a catheter versus a fistula or graft), percentage of patients with grafts, and "difficult fistulae" are major concerns of the charge nurses at for-profit dialysis sites. CMS reimburses dialysis centers less if they have a high percentage of patients being dialyzed with a catheter versus a fistula or graft. We had to adopt and develop a system for weekly feedback with these sites. We also collect and pro-

**TABLE 1. SERVICES AND CPT CODES**

| Procedure | CPT Codes | ASC Reimbursable? | Office Reimbursable? |
|---|---|---|---|
| Thrombectomy: | | | |
| *Mechanical* | 37184 | Yes | Yes |
| Thrombolysis: | | | |
| *Infusion* | 37201 | No | Yes |
| Angioplasty: | | | |
| *PTA tibioperoneal trunk* | 35470 | No | Yes |
| Venous | 35476 | Yes | Yes |
| Stent: | | | |
| *Intravascular stent* | 37205 | No | Yes |
| Peripherally inserted central catheter | 36569 | Yes | Yes |
| Dialysis: | | | |
| *Fistulagram* | 36145 | No | Yes |
| *Declot* | 36870 | Yes | Yes |
| *Venous angioplasty* | 35476 | Yes | Yes |
| *Declot, any method* | 36558 | Yes | Yes |
| Venogram | 36005 | No | Yes |
| | 75820 | No | Yes |
| Vertebroplasty | 22521 | Yes | Yes |
| Kyphoplasty | 22524 | Yes | No |
| Foreign body retrieval | 37203 | Yes | Yes |
| | 75961 | No | Yes |
| Angiograms: | | | |
| *Aortogram* | 36200 | No | Yes |
| *Extremity* | 36140 | No | Yes |
| *Cavagram* | 36010 | No | Yes |
| *Carotid* | 36215 | No | Yes |
| *Visceral* | 36245 | No | Yes |
| Embolization | 37204 | No | No |
| | 75894 | No | Yes |
| Uterine artery embolization | 37210 | No | Yes |

vided quarterly data regarding outcomes, complications, and fistula rates to our nephrologists and referring centers. These data are unique in our marketplace and have proven to be an excellent tool in dealing with payors, competitors, and referrers alike. Current challenges concern reimbursement from private insurers for particular procedures, space issues (our center already feels too small), and reducing fixed costs. Despite all of this, the access center is profitable and ahead of performa to date. More importantly, the quality and coordination of care that the center provides to this patient population has demonstrably improved the management and outcomes of patients with end-stage renal disease in our area.

## CONCLUSION

ASCs are becoming commonplace across the country. They offer patients a more efficient and less costly environment for access care. Few centers are able to offer the complete range of access care including surgical procedures. We have found the ASC to be the ideal setting for access care. Although the regulatory hurdles and ongoing certification for an ASC are more stringent, we feel it offers patients the best care for their dialysis access. Our center is well-loved by the patients and the third party payors in Minnesota. ■

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2. Revisor of Statutes, State of Minnesota. Minnesota Statutes. Chapter 4675. Department of Health; 2000.