

# Financial Considerations for Office-Based Intervention Labs

An introduction to the revenue potential and costs of setup and operation.

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Vascular specialists have seen a steady decline in their professional fees year after year in the past decade. For example, in 2007, the CMS national payment rate for CPT code 35475 for an arterial angioplasty was \$479. By 2013, the rate had declined 37% to \$302. The decline has come both in the form of reduced payment for specific CPT codes and in the bundling of CPT codes resulting in net reductions in payment. It is increasingly difficult for vascular specialists to derive their revenue from hospital-based services only. In seeking other sources of revenue, they have usually looked to expanding their vascular labs and joining ambulatory surgery centers.

In recent years, another option has emerged in operating an intervention suite in the physician office. Technological advances in minimally invasive vascular procedures have made it possible to safely and quickly perform many endovascular procedures in an outpatient setting in the physician office. Almost all peripheral diagnostic and interventional procedures involving angioplasty, stent, atherectomy, and thrombectomy can now be performed in the physician office. In addition to being a very attractive proposition for many physicians because it allows them to exercise more control over the patient experience, quality of care, and increase their productivity, it also offers an alternative opportunity to capture a very significant source of new revenue.

## OFFICE-BASED INTERVENTION LAB REIMBURSEMENTS

Medicare and many insurance payers reimburse procedures performed in the physician-office setting at a different, higher rate. This rate is called the “non-facility” or “global” fee (the professional fee physicians receive for services performed in the hospitals is called the “facility” fee). The “global” fee refers to the fact that the rate combines payments for both professional and technical services provided by the physician office. Table 1 shows examples of the difference in Medicare payment rates for some typical vascular CPT codes.

The nonfacility fee is typically much higher than the facility fee, from three to 19 times the facility fee (Table 1). This higher fee is, in part, to reimburse the physicians for the technical component of the service provided by the physician office, such as staffing, equipment, supplies, and other overheads, since the physician will have to bear all the expenses for procedures performed in the physician office.

By taking on the risks and responsibilities of managing an intervention lab in his/her office, the physician has an opportunity to capture a very significant new revenue stream and, by managing the intervention lab well, will increase his/her net earnings. In this article, we consider the major financial issues involved in setting up and operating a physician office-based intervention lab.

TABLE 1. THE CMS NATIONAL PAYMENT RATE FOR 2014

CPT	Description	Nonfacility/Global Fee	Facility/Professional Fee	Multiple of Global over Professional Fee
37224	PTA femoral/popliteal	\$3,919	\$481	8
37225	Atherectomy (w/wo PTA) femoral/popliteal	\$11,190	\$649	17
37226	Stent (w/wo PTA) femoral/popliteal	\$9,188	\$533	17
37227	Atherectomy and stent (w/wo PTA) femoral/popliteal	\$15,065	\$782	19
37236	Stent (non-lower extremity)	\$2,863	\$482	6
36247	Third order catheterization, lower extremity	\$1,607	\$335	5
75625	Aortogram	\$153	\$57	3

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## ESTIMATING POTENTIAL REVENUE

As a quick and dirty estimate, the potential revenue that the office-based intervention lab could bring in is typically about 10 times that the professional revenue the practice is currently bringing in for outpatient endovascular cases performed in the hospital or ambulatory surgery center (ASC). This gives the physician a rough idea of whether the practice has the potential to make the project worth pursuing.

To obtain a more accurate projection, the physician needs to consider the following:

### How many cases can be done in the intervention lab?

Potentially, almost all outpatient endovascular cases can be done in the office-based intervention lab. In practice, however, and especially in the first year, it is probably not realistic to expect to transfer all outpatient hospital and ASC cases to the office-based intervention lab. Clinically and logistically, it may take some time for the physician and the office staff to become comfortable with doing their full repertoire of cases, especially those that are more complex. There might also be other contractual/legal (eg, noncompete agreements) or business challenges that prevent the practice from moving some health maintenance organization (HMO) and hospital cases to the

office. Some payers may also require the office intervention lab to be accredited by a recognized accreditation organization before allowing their patients to be treated there. The physician needs to make a realistic estimate of the number of cases the practice could do in the first year and subsequent years.

### What is the case mix?

Of the cases that can be moved to the office, what is the case mix? It is useful to segment the cases into several broad categories (eg, diagnostic angiogram, lower extremity revascularization, hemodialysis access declot) to better estimate average payments and cost of supplies per case.

### What is the payer mix?

Medicare and many, but not all, payers will pay a higher nonfacility fee for office procedures. However, there are still some major commercial insurance payers that do not, as well as some HMOs and local independent practice associations. Some major commercial insurance payers have payment policies that vary from state to state; it cannot be assumed that if a certain payer pays a nonfacility rate in Texas, it will do so in California. The physician needs to check the payer mix and verify with the practice's major payers

that they will pay a higher nonfacility rate. This may affect the number of cases that can be performed in the office. It is not financially viable to do cases in the office if the insurance payer will only reimburse for the professional fee.

### **What is the average payment per case?**

Using the case mix and payer mix, the physician can estimate the average payment per case. If, as in most vascular practices, the patients are mostly Medicare, the physician can use the Medicare fee schedule to determine payments. Some commercial payers will pay more than Medicare rates, and some HMOs will pay less, but for most practices, the Medicare rate is a good proxy for the average payment. Take the CPT codes for a typical case and compute the payment, keeping in mind to apply the multiple procedure discounts where appropriate. Software, like VascuNote (Vascular Management Associates, Los Angeles, CA), will allow the physician to easily find the payments for different types of cases.

Knowing the average payment per case and the expected number of each case type lets the physician obtain a fairly good projection of how much revenue to expect from the intervention lab.

## **SETUP COSTS**

### **Build-out**

A major cost of setting up an intervention lab is, of course, the build-out itself. This is highly variable among practices depending on the practice's starting point. If the practice already has the appropriate space, it may cost about a \$100,000 or less to build it out; if not it may easily cost over \$1,000,000. Building out a new space can be very expensive, bearing in mind that it is not just the cost of construction, but also the architect's fee, possibly attorney's fee, permits, and so on, which will all add up. Certificate of Need usually does not apply to the physician-office setting, but the practice should check with their individual state laws.

### **Equipment**

The second major cost is equipping the intervention lab. The most expensive item will be the fluoroscopy unit. A mobile unit will be less expensive than a fixed unit and should be adequate for most practices. A new C-arm and imaging table with the appropriate resolution and software packages for vascular procedures will cost around \$300,000 to \$500,000. Other items include patient monitors, backup power, stretchers, and crash cart. By purchasing some refurbished equipment, the practice may be able to equip the intervention lab for

about \$500,000 or less. The practice can likely finance most of the purchases through leases or bank loans so the actual start-up capital for equipment may be no more than the first month's payment of the lease or loan.

### **Supplies**

The third major setup cost is stocking the intervention lab with the needed medical devices and pharmaceuticals. The decision on which devices to purchase depends on the type of cases the practice plans to perform, as well as the physicians' personal preferences. The practice should have at least 1 to 2 weeks of supplies on hand. Some items may be obtained on a consignment basis, that is, the supplier will place the items in the intervention lab, but the practice does not have to pay for them until it uses them. Depending on the practice's anticipated volume, the initial cost of stocking the intervention suite will probably range from \$100,000 to \$300,000.

## **OPERATING COSTS**

### **Supplies**

For a busy practice, the biggest operating cost will be supplies, such as guidewires, catheters, balloons, stents, laser fibers, pharmaceuticals, and disposables. The cost of supplies ranges from a few hundred dollars for a diagnostic angiogram to several thousand dollars for a complex revascularization case, and may determine whether it is financially viable for the physician to do the case in the intervention lab. In the hospital, physicians are usually unaware of the costs of supplies and have no economic incentive to keep costs down. In the office-based intervention lab, the cost of every item directly affects the bottom line, and therefore the physician's earnings. The best way to control costs is for the physician to be fully informed of the supply costs he/she used in each case. In order to do that, the office-based intervention lab needs to be able to track every item used in a case and its cost.

It is very easy to tie up a lot of capital in inventory for endovascular procedures because so many different devices are used. Because a single missing device could compromise the outcome of a case, there is a tendency to try to have every device the physician might possibly need in stock. A working intervention lab easily stocks more than 1,000 unique devices. There are two ways to reduce the amount of capital tied up in inventory. The first is to purchase as many items as possible on consignment. The second is to keep inventory levels as low as possible, for no more

than 1 to 2 weeks, and do “just-in-time” ordering. The latter strategy requires the practice to invest in a real-time supply management system, because manually keeping track of inventory levels in a busy practice is very difficult.

On the other hand, in order to get the best pricing on specific items, the practice may have to make volume purchases or at least volume commitments. Obviously, the busiest practices will have the most leverage in negotiating the best pricing. Group purchasing organizations to date have not really offered much benefit in terms of pricing for endovascular devices.

### Staffing

The second most important operating cost is staffing. Clinically, at a minimum, the intervention lab will require two registered nurses, a scrub tech, an x-ray tech, and a few medical assistants. Additionally, the practice may have to hire new clerical and administrative personnel for scheduling, medical records, inventory management, coding and billing, and possibly a manager to oversee the intervention lab.

The need for clinical staff is usually quite obvious. The need for administrative staff may be less so, but it would be a mistake for the practice to overlook it. The practice needs to do a thorough review of the new workflow around the intervention lab. In particular, there are two important areas to consider. The first is quality control and compliance. Does it have the personnel to oversee and administer compliances with governmental regulations and operate in accordance with best practices required by accrediting organizations? The practice may have to engage outside consultants to help the practice formulate appropriate policies and procedures and train their staff.

The second area is in coding and billing. The operating intervention lab exerts a big and constant drain on the practice’s funds. The practice needs to be able to bill and collect just as quickly. Delayed or denied payment because of poor or tardy coding and billing could quickly cause the practice to run into cash flow problems. Interventional endovascular procedures could be very challenging to code. The practice should make sure it has the right personnel, make new hires, and/or outsource if appropriate. It should also consider investing in software to help the physicians and coding staff speed up the billing process.

### Equipment Leases and Interest Payments

If the build-out and/or equipment purchases were financed through leases and loans, there will

be monthly payments the practice has to make. The amount will depend on the amount, term, and interest rates. The average practice could easily have to make \$15,000 to \$30,000 per month on such payments until the leases and loans are paid off. Unlike other variable costs, these are payments the practice has to make regardless of whether the intervention lab is being used or not. Missed payments could compromise the practice’s credit rating, which, in turn, will result in suppliers giving unfavorable terms for payments. Because it takes a new intervention lab 3 to 6 months to bring in significant revenue, the practice needs to have enough working capital for 3 to 6 months of payments in the beginning.

### CONCLUSION

The office-based intervention lab offers one of the most attractive options that are within the means of even small practices to significantly improve their earnings in a climate of constant downward pressure on reimbursements for vascular specialists. That is not to say that reimbursements for office-based procedures are not subject to the same downward pressures as professional fees; they are, and the pressure will likely intensify in the next few years. However, unlike hospital-based services, the vascular specialists have full control over the cost components of office-based procedures and, by managing costs judiciously, there is still potential for significant earnings because of the high revenues involved for office procedures. It is a big undertaking, and there are other factors to consider, such as quality control and risk abatement to manage, to turn it into a successful enterprise. But ultimately, it has to be underpinned by sound finances because it will become by far the largest revenue and cost center of the practice. Vascular specialists need to have a good understanding of the factors affecting revenues and costs of this enterprise. ■

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