Outpatient Interventional Oncology: Lessons Learned and Getting Started

Building a successful IO practice in the outpatient space is possible if you provide a high level of care, demonstrate value to your referring physicians, and put your patients' interests first.

By Alexander Kim, MD, FSIR

Interventional oncology (IO) was the main driver in my choice of interventional radiology (IR) as a profession. I spent the first decade of my career in an academic setting building an IO practice and performing high volumes of cases in all modalities, including chemoembolization, radioembolization, and percutaneous ablation. As I moved on to the outpatient space, I expected I would not be able to maintain the volume of cancer cases that I had in the hospital, but I did not fully appreciate how challenging it would be to build an oncology practice in the outpatient space. Although I am still in the process of building my outpatient oncology volume, this article discusses some lessons I have learned over the past 2 years since opening my office-based lab (OBL).

LESSON 1

Maintaining hospital presence is important to build an outpatient IO practice.

During my time in an academic hospital, I had gradually developed a reputation as the "go-to" practitioner of IO in the hospital. For a few years before I left, I was routinely seeing multiple oncology patients in each clinic day and performing numerous intra-arterial and ablation cases. Although I fully expected this volume to significantly reduce in the outpatient setting, I did not expect it to nearly vanish. I had been receiving patient referrals from community oncologists from outside of the hospital system and expected that some of those referrals might follow me into the outpatient space. To my surprise, not only did these community oncologists stop referring patients to me, they initially refused to even meet with me. It took many months and multiple calls to these oncology groups to even schedule a meeting. Although some of this may have been related to COVID, I believe the main factor was the lack of frequent interaction with these oncologists that I used to have in the hospital.

I realized I am not alone in this predicament as I met with other interventional radiologists in the outpatient space without hospital affiliation who have run into similar issues. I spoke with one interventional radiologist in the outpatient space who had been the first author of multiple articles in the academic setting and thought his research and academic background would help him reach community oncologists. Unfortunately, it hasn't turned out to be true. Anecdotally, the interventional

radiologists who can maintain a larger volume of outpatient IO practice generally are those who have been able to maintain a certain level of hospital coverage and actively participate in hospital tumor boards.

LESSON 2

Even if money is not the main motivator for your move to the outpatient space, it can impact your decision-making.

Our first cancer patient was a straightforward embolization case of a hepatocellular carcinoma tumor. However, our second cancer patient had metastatic colorectal cancer. She had responded exceptionally well to systemic therapy and had two visible small liver tumors left on imaging. I reviewed her imaging and recommended that she undergo percutaneous ablation to treat these lesions, which was consistent with my practice in the hospital. The two lesions were fairly superficial on CT, and I felt confident that I would be able to identify them on ultrasound.

Although the procedure may have seemed technically feasible, the practicality of the procedure was another matter. I did not realize that the actual cost of the microwave generator, even as a rental unit, would make routine ablations cost-prohibitive in an OBL. Generally, the generator is provided for free by the manufacturer as part of a contract wherein you commit to purchasing a certain amount of microwave probes. Not being sure of what our ablation volume may be, I was hesitant to commit to purchasing a certain number of probes. In that case, I would have needed to purchase the needle and rent the generator to perform the ablation. Given the procedural reimbursement, this meant I would be losing thousands of dollars to perform the procedure. Unfortunately, this patient was referred back to a hospital system to undergo her treatment.

LESSON 3

Industry collaboration is critical to starting an IO practice.

I have always felt that maintaining good relationships with industry was important as an interventional radiologist. As our field is so technologically driven, it is important to build those relationships to help stay up to date. Even in the hospital setting, I tried to find time to speak with anyone from industry who wanted to meet with me. As important as it was to maintain a relationship with industry in the hospital setting, it is absolutely critical when starting an IO practice in the outpatient setting.

From helping to navigate the regulatory maze and procure the required equipment and supplies to helping with referring physicians, working with your industry partners can significantly lighten your load when developing an IO practice. They are an invaluable resource to starting your practice and building your referral network of oncologists.

HOW TO GET STARTED IN OUTPATIENT IO

Given the various challenges, some of which are outlined previously, it is necessary to figure out how important having an IO practice is to you when considering an OBL. Given the wide breadth of our field, many (if not the majority of) IR OBLs do not regularly perform therapeutic IO.

If it is important to you to develop outpatient IO, try and engage industry partners from the start of the development of your lab. They can help you understand the amount of space and equipment that will be required to start your IO practice during the development phase. It is helpful to have a discussion with industry prior to negotiating with insurance to ensure that your contracts reflect all possible codes that may be needed for various procedures. This is especially important for radioembolization, as there is a passthrough code for the yttrium-90 (Y-90) product. Although Y-90 radioembolization can be a source of high revenue, it will put your practice in the red if you are not appropriately reimbursed.

Once the lab is opened, it is important to establish a relationship with oncology practices. As previously outlined, this is much easier to achieve if you can maintain a hospital presence. Otherwise, trying to schedule a meeting can at least provide some face time with oncology groups.

Although we may prefer to perform a lot of chemoembolization and radioembolizations to start, it is much more likely that the oncology group will start sending smaller cases (eg, biopsies, mediports). Although these are not as appealing (nor as well reimbursed), it is important to provide these services to build trust and work your way up to therapeutic cases.

Also, spend some time thinking about patient workflow. One advantage of the hospital system is that most (or all) of the equipment needed for an IO practice is under one (large) roof. Where will your

patients go for preprocedural imaging? How will they go from receiving a mapping angiogram from your office to obtaining their imaging? Do these centers understand what you are looking for in the posttreatment single-photon emission CT/CT report? Walk through what your patients will have to go through to obtain care from you to make it an easier and smoother process for them and you.

CONCLUSION

Ultimately, the quality of your work is going to be the most important part of building any practice, including IO. If you provide the highest level of care for your patients and provide value to your referring physicians, you will start to see some referrals. Referring physicians will recognize the value you bring and will preferentially refer patients your way. There are many stories about the unscrupulous outpatient practice that performs unneeded procedures for financial benefit. You certainly face different challenges as a business owner and a physician. But, I still believe that as long as you put your patients' interests first, while it may be slow, you can build a successful IO practice in the outpatient space. ■

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