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Outpatient Cardiology Is On the Way

Opportunities abound as heart care migrates to same-day settings.

National Cardiovascular Partners

• **IMAGING IS EVERYTHING** Outfitting a cardiac OR will include a radiolucent exam table that allows for a 360-degree view of the patient.

The recent addition of six cardiac interventional procedures to CMS's list of ASC-approved procedures for 2020 creates the opportunity for ambulatory surgical centers to add an emerging new service line. Cardiac catheterizations and stent placements might soon be regular and routine occurrences in outpatient settings. Here's what you need to consider if you want to get involved in a growing and potentially profitable service line.

• **Skilled staffing.** First and foremost, you'll need to find committed cardiologists who are willing to do their cases in the ASC environment. You'll also need to recruit highly skilled and experienced cardiovascular RNs and radiologic technologists. These are specialized positions that require years of training. It's not safe to assume that traditional OR staff members can adapt quickly to cardiology, so forming a separate team of experienced professionals is a must.

• **Start-up capital.** The main piece of equipment you'll need is a fixed C-arm designed specifically for cardiac procedures that mounts to the floor or the ceiling. The operating table for cardiac procedures has a radiolucent surface and is designed to allow for 360-degree views of the coronary vessels when the C-arm rotates around the patient. You'll also want to consider purchasing an ultrasound machine, micro-puncture needles and an assortment of sheaths, guidewires and stents. In total, these items could cost upward of $1 million. Pacemakers and defibrillators typically are delivered to facilities on consignment by the manufacturers, so there are no upfront costs to maintain an inventory of those devices.

• **Big footprint.** An interventional cardiovascular suite consists of a procedure room, an equipment room and a control room. The procedural space must be larger than a traditional OR — large enough to comfortably house the C-arm, the radiolucent table and ancillary equipment. Although square footage varies from facility to facility, you basically need the space of two standard operating rooms to make one fixed interventional suite.

• **Emergency equipment.** While emergent events are rare, they do occur and you must be prepared to manage them. Be sure to have a dedi-

cated crash cart that will be kept in the cardiovascular interventional suite. You should also have available an intra-aortic balloon pump (IABP), pericardiocentesis kit, temporary pacemaker and, if possible, covered coronary stents.

An IABP is a therapeutic device used to reduce the workload of the heart. For instance, if there is a critical blockage, the IABP can be used to augment blood flow to the extremities as well as to coronary arteries. Pericardiocentesis kits are used to treat symptomatic pericardial effusion or cardiac tamponade by aspirating fluid from the pericardial space. This can occur during angioplasty, or during pacemaker and defibrillator implants, with incidental lead perforation, typically through the right ventricle of the heart.

Covered stents are sometimes used when there is an arterial dissection or perforation. While there may be times when only a balloon is needed to treat the dissection, a covered stent could be used to treat major complications that require immediate attention. The size of the vessel and the location of the damage determines the need for a covered stent, non-covered stent or a simple balloon angioplasty.

• **Patient selection.** Prevention is the best form of emergency preparedness, and that starts with a precise list of guidelines for patient admission criteria. Cardiovascular patients often are of advanced age, have multiple comorbidities and may be more vulnerable than your typical same-day surgery patient. Before procedures, cardiovascular patients should undergo stringent pre-procedure testing, have lab work drawn and obtain medical clearance. When they arrive at the facility, they must be carefully reassessed and again determined to be a candidate for an outpatient procedure. These are elective procedures, so even slight changes in the patient's status might mean they shouldn't be treated on that particular day.

While adding cardiovascular cases is definitely doable, launching the service line is uniquely challenging and can be complicated. It's important to carefully consider the required staffing, space and equipment needs, and proceed with caution. OSM

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PIECE OF THE PIE

Preview of Payment Rates

CMS added 17 cardiac diagnostic procedures to the ASC-approved list last year, which has paved the way for six new stent-related intervention procedure codes (CPT codes 92920, 92921, 92928, 92929, C9600, C9601) in 2020.

In 2016, according to data in the Medicare Provider Access and Review (MEDPAR) file, Medicare beneficiaries underwent more than 523,000 cardiac catheterizations on an outpatient basis in hospitals, resulting in an estimated $682 million in payments, according to Ronald Hirsch, vice president of regulations and education for R1 RCM's Physicians Advisory Solutions, a consulting firm based in Chicago, Ill.

In 2020, CMS will reimburse hospital outpatient departments $2,899 and ASCs $1,377 for a cardiac catheterization procedure. For a cardiac catheterization with a stent, the proposed rate is $10,013 for HOPDs and $6,203 for ASCs. On average, eight to 10 stent procedures can be performed in one operating room each day. The cost per case is approximately $2,000, so an HOPD would make about $8,000 and an ASC would make about $4,200 for each procedure performed.

— Adam Taylor