

 **QUANTITATIVE ANALYSIS**  
for U.S. health care leaders

# ASC Services Outlook

A guide to opportune ASC services – now and in the future

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Although ambulatory surgery centers (ASCs) are becoming more commonplace as a site of care, not every service is a smart ASC investment. To understand where to invest for the future, health care leaders need a clear view into the outlook for ASC services.

This report provides leaders with national, ASC-specific data on 27 services of interest, including how much these services have already shifted to the ASC, and how much ASC growth they may or may not see in the future.

Overall, based on the data, we were able to place services into one of four categories – volume drivers, differentiators, riskier additions, or future contenders. This framework, outlined on pg. 8, can aid leaders in prioritizing ASC service investments and ensuring investments align with their goals.



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# Overview

**Research question:** What is the current and future outlook for ASC services?

**Problem:** ASCs are all the buzz right now, but health care leaders lack centralized and comprehensive data to understand the larger ASC service landscape, particularly across different services. Without this, leaders struggle to make the right investments for current and future care settings.

**What we did:** We analyzed de-identified national claims data to explore both the extent of shift to the ASC and ASC volume growth prospects. We did this for 27 services identified by Advisory Board researchers and members as areas of general strategic importance with ASC potential.

**What we found:** The services we analyzed can be placed into one of four categories based on their current (as of 2019) presence in the ASC and their ASC volume growth potential. These categories are:

1. **Volume drivers:** Core ASC volume drivers with strong growth potential
2. **Current differentiators:** Services with less ASC adoption currently, but high ASC growth potential
3. **Riskier additions:** Services with relatively widespread adoption, but limited volume growth potential
4. **Future contenders:** Services with minimal current ASC presence and projected volumes, but should be monitored for future growth and differentiation opportunities

# What we did: Analysis methodology

We created a framework to categorize a subset of services into four categories that define their ASC outlook. Service categorization was based on two metrics:

1. Current (as of 2019) presence in the ASC market
2. Future ASC volume potential

To determine current presence in the national ASC market, we analyzed claims data sourced from Optum’s de-identified Clinformatics® Data Mart Database to identify, for each service, the percentage of hospital referral regions (HRRs) that saw greater than 0 volumes performed in an ASC in 2019.<sup>1</sup>

To size future volume potential, we first pulled projected national 2026 volumes by service from Advisory Board’s [Market Scenario Planner](#) tool. Next, we analyzed the Clinformatics® data to identify the percentage of each service’s total volumes performed in the ASC setting in 2019, including within each HRR. From there, based on those ASC shares, we identified the 75<sup>th</sup> percentile HRRs for each service and assumed these markets represented a moderately aggressive scenario of ASC shift potential. We then, for each service, multiplied the 75<sup>th</sup> percentile ASC share by 2026 total projected volumes to estimate volumes that might reasonably be performed in the ASC by 2026. Finally, we divided these projected volumes by the total number of HRRs (n=284) to estimate volume potential for an average market.

To then categorize services based on these two metrics, we plotted each on a quadrant chart. The vertical axis represents current adoption and was divided using the average percentage of HRRs with greater than 0 cases in the ASC across services, excluding any outliers. The horizontal axis represents volume potential per market and was divided using the average number of cases needed to break-even in a two-OR ASC (1,476).

Finally, we conducted market research to provide details on the ASC outlook for each service.

1. Analysis was conducted for each OPG (outpatient procedure grouping) in a service and percentages were averaged across OPGs to arrive at a measure of that service’s ASC adoption.  
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# What we did: Services analyzed (1/3)

Service	Outpatient procedure groupings <sup>1</sup>
Appendix <sup>2</sup>	Laparoscopic appendectomy; Open appendectomy
Bariatric	Laparoscopic gastric bypass; Laparoscopic gastric restrictive procedures
Breast	Open breast biopsy; Percutaneous breast biopsy; Brachytherapy catheter implantation; breast reconstruction/revision; breast reconstruction/revision with implant; Cyst/abscess drainage; Lesion removal; Lumpectomy; Mastectomy; Other procedures
Cardiac cath	Diagnostic cardiac catheterization; Heart biopsy; Intravascular coronary ultrasound; Other diagnostic cardiac catheterization; Other transcatheter cardiac procedures; Percutaneous transluminal coronary artery angioplasty; Percutaneous transluminal coronary artery stent placement
Cataract procedures	Extracapsular phacoemulsification with intraocular lens implantation; Intracapsular cataract removal with intraocular lens implantation; Intraocular lens implantation/revision; Other cataract procedures; Secondary cataract laser surgery (yag capsulotomy)
Colonoscopy	Diagnostic/screening colonoscopy; Procedural colonoscopy
Colorectal/Lower GI	Anus/rectum abscess drainage; Anal fissure procedures; rectum biopsy; Fecal incontinence/rectal prolapse procedures; Anus fistula repair; Hemorrhoid fixation; Hemorrhoid injection; Hemorrhoid ligation; Hemorrhoidectomy; Anus lesion destruction; Other anus/rectum procedures; Other bowel procedures; Anus/rectum tumor destruction/excisions
Electrophysiology (EP)	Cardiac event recorder implant; Cardiac event recorder removal; Electronic evaluation of cardiac event recorder; Electronic evaluation of ICD; Electronic evaluation of pacemaker; Electrophysiology study; Heart electrode procedure; ICD implant; Intracardiac catheter ablation; Intracardiac echocardiography; Other EP procedures; Pacemaker implants; Tilt table tests
Endoscopic nasal/sinus procedures	Diagnostic endoscopic sinus surgery; Procedural endoscopic sinus surgery; Diagnostic nasal endoscopy; Other nasal/sinus endoscopy procedures
ERCP <sup>2,3</sup>	Diagnostic ERCP; Procedural ERCP
EGD <sup>4</sup>	Diagnostic EGD; Procedural EGD

1. Some OPGs were excluded from this analysis either because they had no 2019 claims available or because they likely had no ASC potential (0 ASC volumes and majority physician office volumes) and would skew analyses.

2. While data for these services was analyzed given their strategic importance, these services were ultimately excluded from the grid and subsequent market research as we found that, for now, they had no current ASC presence or future volume potential.

3. Endoscopic Retrograde Cholangiopancreatography

4. Esophagogastroduodenoscopy

# What we did: Services analyzed (2/3)

Service	Outpatient procedure groupings <sup>1</sup>
Fusion (spinal)	Cervical spinal fusion; Lumbar/thoracic spinal fusion
Gallbladder	Laparoscopic cholecystectomy
Hepatobiliary /pancreatic <sup>2</sup>	Bile duct catheter implantation/removal; Other liver laparoscopic procedures
Foot/hand	Achilles tendon repair; Foot amputation; Hand amputation; Hand arthroplasty; Foot bone excision; Hand bone excision; Foot bone removal; Foot bone repair/revision; Bunion correction; Carpal tunnel injection; Carpal tunnel release; Morton's neuroma excision; Foot exploratory surgery; Palm fasciotomy/fasciectomy; Foot fusion; Hand fusion; Ganglion excision; Hammertoe repair; Foot joint lining removal; Hand joint lining removal; Foot joint/muscle release; Hand joint/muscle release; Foot tendon lesion excision; Foot lesion excision/curettage; Hand lesion excision/curettage; Foot lesion incision/drainage; Other foot procedures; Other hand procedures; Endoscopic fasciotomy; Extracorporeal shock wave therapy (EWST); Fasciectomy/Fasciotomy; Foot soft tissue biopsy; Foot tendon/muscle repair/revision; Hand tendon/muscle repair/revision/incision; Trigger finger release; Foot tumor excision
General gynecology procedures	Vagina/uterus brachytherapy placement; Cervical cauterization (cryocautery); Cervical cauterization (electro/thermal); Cervical conization (cold knife/laser); Cervical conization (leep); Cervical curettage; Colposcopy cervical curettage; Cervical dilation; Diagnostic hysteroscopy; Non-obstetrical dilation & curettage (D&C); Hysteroscopy endometrial ablation; Vagina lesion destruction; Vulva lesion destruction; Ovary lesion drainage; Laparoscopic ovary lesion removal; Other adhesiolysis; Other hysteroscopic procedures; Vagina repair/revision; Hysteroscopy uterine adhesiolysis; Vulvectomy
Hernia	Epigastric hernia repair; Inguinal hernia repair; Laparoscopic inguinal hernia repair; Other laparoscopic hernia repair; Umbilical hernia repair; Ventral hernia repair
Hysterectomy	Laparoscopic-assisted vaginal hysterectomy (LAVH); Laparoscopic supracervical hysterectomy (LSH); Total laparoscopic hysterectomy; Vaginal hysterectomy
Joint replacement	Total hip arthroplasty (THA); Total knee arthroplasty (TKA); Unicompartmental knee arthroplasty (UKA); Shoulder arthroplasty

1. Some OPGs were excluded from this analysis either because they had no 2019 claims available or because they likely had no ASC potential (0 ASC volumes and majority physician office volumes) and would skew analyses.

2. While data for these services was analyzed given their strategic importance, these services were ultimately excluded from the grid and subsequent market research as we found that, for now, they had no current ASC presence or future volume potential.

# What we did: Services analyzed (3/3)

Service	Outpatient procedure groupings <sup>1</sup>
Middle/inner ear procedures	Labyrinthotomy; Myringoplasty; Other middle ear procedures; Staples procedures; Tympanic membrane repair; Tympanoplasty; Tympanoplasty with mastoidectomy; Tympanostomy
Other spine	Spine bone graft; Conventional discectomy; Drug infusion pump analysis; Drug infusion pump catheter implantation/removal; Drug infusion pump implantation/removal; Spine fracture treatment; Laminectomy; Other spine decompression procedures; Other spine procedures; Spinal cord stimulator lead/pulse generator implant/removal; Spinal puncture; Vertebroplasty
Urolithiasis	Extracorporeal shock wave lithotripsy (ESWL); Cystoscopy stone destruction/removal (litholapaxy)
Prostate	Prostate needle biopsy; Prostate brachytherapy placement; Prostate cryosurgical ablation; Prostate laser vaporization; Radical prostatectomy; Transurethral microwave therapy (TUMT); Transurethral resection of the prostate (TURP); Water-induced thermotherapy (WIT)
Sports medicine	Ankle/heel arthroscopy procedures; Arm/hand arthroscopy procedures; Other arm/hand procedures; Hip arthroscopy procedures; Other knee articular cartilage procedures; ACL reconstruction; Other knee ligament procedures; Knee meniscus repair/meniscectomy; Other knee procedures; Other sports medicine procedures; Other arthroscopy sports medicine procedures; Shoulder arthroscopy procedures; Other shoulder procedures; Shoulder rotator cuff repair
Uterine fibroid procedures	Uterine fibroid removal – abdominal approach; Hysteroscopy uterine fibroid removal; Laparoscopic uterine fibroid removal
Vascular cath	Arterial vascular catheterization; Central venous access procedures; Endovenous radiofrequency ablation; Intravascular peripheral ultrasound; Other endovenous ablation; Other transcatheter vascular procedure; Percutaneous transluminal peripheral artery balloon angioplasty; Percutaneous transluminal peripheral artery stent placement; Percutaneous transluminal peripheral venous balloon angioplasty; Transcatheter biopsy; Transcatheter embolization; Vascular sealing device implant; Venous catheterization
Vascular surgery	Endovascular abdominal aortic aneurysm stent graft implant; Hemodialysis access/shunt procedures; Other vascular surgery; Phlebectomy/vein stripping; Vascular exploration/revision; Vascular ligation; Venous thrombectomy

1. Some OPGs were excluded from this analysis either because they had no 2019 claims available or because they likely had no ASC potential (0 ASC volumes and majority physician office volumes) and would skew analyses.

# What we found: Overview

## 1 **Services can be placed into one of four categories based on current presence in the national ASC market and ASC growth opportunity.**

These categories are:

1. **Volume drivers:** Services that are core ASC volume drivers with strong volume potential
2. **Differentiators:** Services with less ASC adoption currently, but high future growth potential
3. **Riskier additions:** Services with relatively widespread ASC adoption, but limited volume growth potential
4. **Future contenders:** Services that currently exhibit a minimal ASC presence, but should be monitored for future growth and differentiation opportunities

## 2 **Joint replacement and electrophysiology are currently the only true differentiators among evaluated services.**

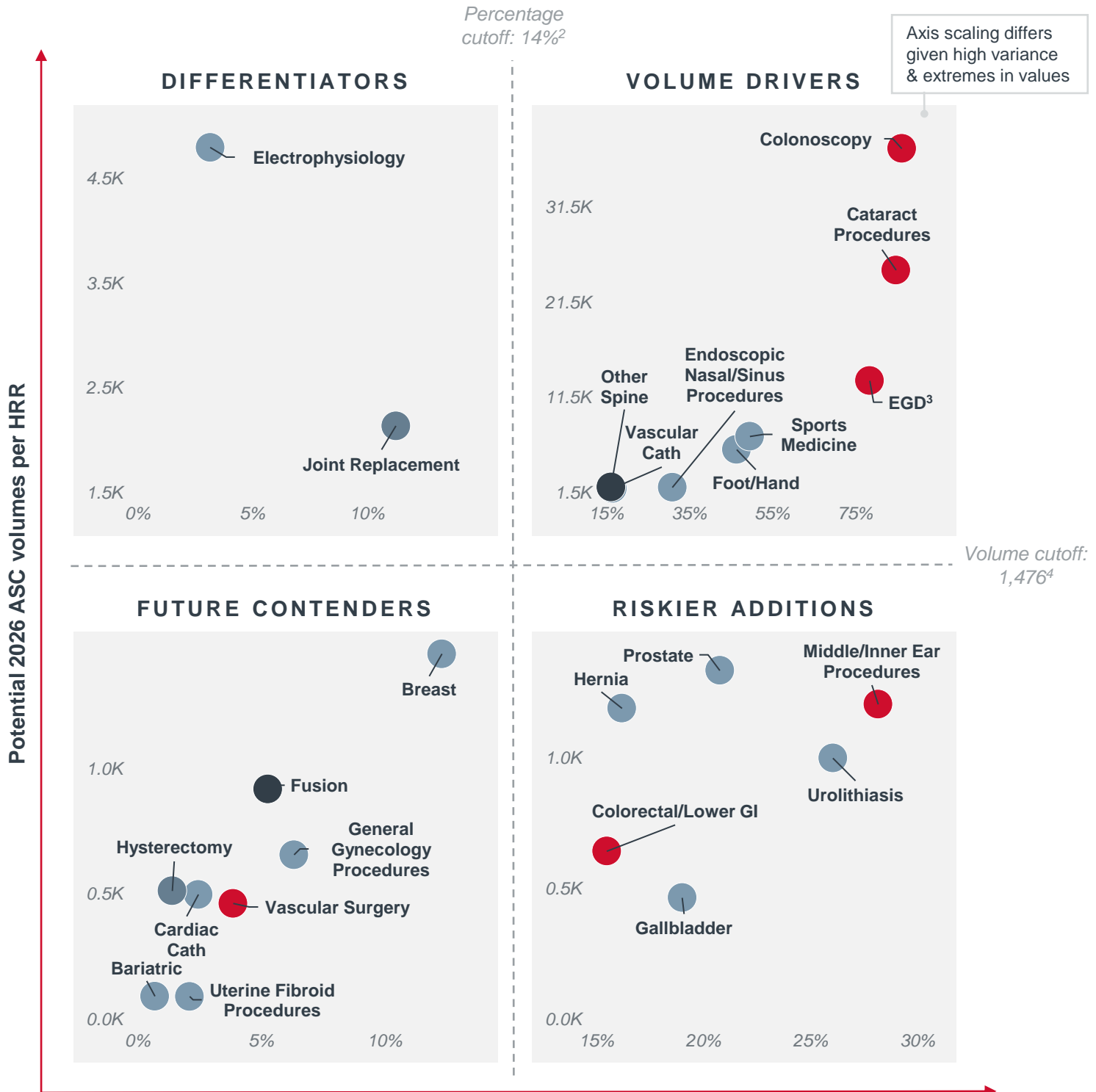
These services exhibited less ASC adoption as of 2019, but hold significant volume potential, providing healthcare leaders with an untapped opportunity. Both services saw many procedures – or in the case of electrophysiology, related cardiac cath procedures – added to the ASC list only in the last couple of years, so many volumes have not yet shifted to the ASC. But, as purchaser preference for lower-cost care sites continues to grow and with the operational and financial benefits physicians can reap from ASCs (especially now that cardiologists can build out more comprehensive CV ASC programs), we expect significant demand for ASC-based joints and EP.

## 3 **The majority of volume drivers tend to be low complexity and offer relatively low revenue.**

Evidently, many of the services that are currently driving ASC volumes are less complex and invasive, likely a reason for lower revenues per case, at least according to Medicare data. By nature, these services have significant volume demand nationally, so leaders will have to ensure there are sufficient volumes in their markets to break-even on efforts and investments given lower revenues.



# What we found: Outlook grid



1. Based on October 2021 CMS ASC payments rates  
 2. Average of all services' percent of HRRs, excluding outliers  
 3. Esophagogastroduodenoscopy  
 4. Volumes required to break-even in a 2-OR ASC

## Percent of HRRs with any ASC volumes

Source: Optum's de-identified Clinformatics® Data Mart Database; Advisory Board's Market Scenario Planner; ASC Payment Rates - Addenda 1 CMS; Advisory Board research and analysis.

# 01 Volume drivers

Volume drivers are core ASC services with strong volume potential.

## **Gastroenterology (Colonoscopies, EGDs)**

ASCs and specialized endoscopy centers have been long accepted as the primary site of care for minimally complex and invasive diagnostic gastroenterology procedures like colonoscopies and EGDs. Additionally, ASC adoption has been further exacerbated by an independent physician body, payer steerage, and consumer patient preference. Particularly because colonoscopies are a routine exam (recommended every 10 years or so, more if you are at higher risk), quick and easy access is of high value to patients. And because they are a routine exam, volumes will likely remain high if not increase.

While there has been a slight uptick in innovative, non-invasive colon cancer screening techniques that can be performed in a lab or office, they have not yet been adopted as the gold standard and therefore will likely not disrupt this business any time soon.

Since EGDs are not as routine as colonoscopies, volumes are and will likely remain a bit lower. That said, an aging population, rising obesity rates, and increased disease prevalence of esophageal cancer and GERD will keep volumes high for years to come. Given that many of these are diagnostic procedures, per-case revenues are quite low, and business is driven primarily by high volumes.

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 1. VOLUME DRIVERS

### **Cataract procedures**

Given low complexity and minimal complications, cataract procedures have been eligible for ASC payment for a long time, and ASCs are typically the primary site of care where these procedures are performed. This is also driven by a highly independent physician workforce, who have financial and operational incentives for performing cases in the freestanding setting. While Medicare per-case revenues are low, shorter procedure times allow providers to perform many cases a day, driving volumes. Additionally, an increasingly aging population will continue to boost demand in the foreseeable future.

### **Sports medicine, foot, and hand**

Sports medicine, as well as foot and hand procedures, are less invasive than other orthopedic procedures and typically involve a young and healthy patient population, with low risks for complications. For this reason, providers have embraced the ASC setting for several years now for these procedures to differentiate to young, consumerist patients seeking a low-cost, convenient care option. The ASC setting also offers an independent physician body operational benefits like low overhead costs and efficient OR turnover. This makes the sports medicine, foot, and hand market quite competitive, especially given how much demand there is and will continue to be. Medicare per-case revenues are higher than other volume driver services, though lower overall.

### **Other spine (e.g., cord stimulator, discectomy procedures)**

Many non-fusion spine procedures are less complex and invasive than spine fusions, and therefore have seen greater adoption in the ASC setting in the last few years. Given the prioritization of lower-cost care sites by purchasers (payers, employers, and patients) for lower complexity spine surgery, prevalence in ASCs will likely only grow. These procedures are financially attractive as well, with high average Medicare per-case revenues. However, other spine procedures offer lower projected volumes relative to other volume drivers, making them a borderline-risky addition.

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 1. VOLUME DRIVERS

## Endoscopic nasal/sinus procedures

Most endoscopic nasal/sinus procedures are diagnostic endoscopies, the majority of which are currently performed in offices. More complex endoscopic sinus surgeries have seen shifts from the HOPD to the ASC given clinical innovations like balloon sinus dilation, which allows these surgeries to be less invasive, costly, and time-consuming. High projected volumes and between 21-25% of most service volumes<sup>1</sup> performed in ASCs in more aggressive markets (i.e., the 75th percentile) drove this service into the volume drivers category, but its projected volumes are generally lower compared to its peers in this category given again, the majority of volumes likely continuing to be office-based. Given this and lower Medicare per-case reimbursements, stakeholders should identify whether projected volumes and revenues in their specific markets for these services will offset ASC investments.

## Vascular cath

Many lower-acuity vascular cath procedures were approved for office setting reimbursement over a decade ago, creating a procedural shift from the hospital directly to office-based labs (OBLs), where a majority of low-acuity vascular cath procedures are currently performed. Some procedures, e.g., percutaneous peripheral artery balloon angioplasties, have seen slightly greater ASC adoption, likely in hybrid OBL-ASCs and due to high per-case revenues, giving reason for vascular cath's higher ASC adoption overall, especially when compared to vascular surgery. Based on 75th percentile HRR site-of-care volume distributions, the majority of vascular cath volumes will likely remain HOPD (for more acute procedures) and office-based (for less acute procedures) in the near future. But some procedures may see greater ASC adoption, likely in the hybrid OBL-ASCs. This could be particularly true for venous catheterizations and percutaneous peripheral artery balloon angioplasties, however the magnitude of volumes associated with this potential shift are notably low compared to other volume driving services, making vascular cath a borderline risky addition.

1. Spread of ASC volume share among 3 out of 4 endoscopic nasal/ sinus procedures (diagnostic nasal endoscopies, endoscopic sinus surgeries, and other nasal/ sinus endoscopies) in 75<sup>th</sup> percentile HRRs. 0% of diagnostic endoscopic sinus surgeries are performed in the ASC in this percentile, but volumes for this service are negligible.

## 02 Differentiators

Differentiators are services with lower ASC adoption nationally as of late, but strong volume potential.

### **Joint replacement**

Given its recent ASC-payable eligibility, joint replacements are currently considered one of the two differentiators among the procedures we evaluated. Providers in many regions, particularly less urban ones, have been slower to shift procedures out of the hospital given the high inpatient margins associated with them. However, in addition to ASC-payable eligibility, purchaser preference for lower-cost care sites and incentives for independent physicians to perform freestanding cases will cause volumes to increase greatly. Additionally, per-case revenues are higher than they are for most other ASC services, making ASC joint replacements an attractive investment.

### **Electrophysiology**

Despite CMS having approved key high-volume EP procedures for ASC reimbursement back in 2015, EP ASC adoption has been slower than the industry initially predicted given safety concerns, but more so due to the lack of financial incentive to shift cases. This is due to high investment costs (like needing as many devices as patients) compared to reimbursements and a small number of ASC-approved CV procedures to build out a CV ASC program with. While these investment costs are likely to persist, the gap between reimbursements by site of care continues to narrow, giving way to future growth. Additionally, with the recent approval of cardiac cath procedures for ASC reimbursement, there is now greater incentive to invest in CV ASC programs, which will likely drive significant growth of ASC-based EP volumes.

# 03 Riskier additions

Riskier additions are services with relatively widespread ASC adoption, but limited volume potential.

## Colorectal/Lower GI

These services primarily consist of office-based hemorrhoidectomies, a minimally invasive procedure to remove hemorrhoids. While hemorrhoidectomies and other colorectal/lower GI surgeries have seen some ASC adoption, one reason likely due to very high per-case revenues compared to other services (based on Medicare data), ASC volumes are and likely will remain minimal. In fact, office utilization could even see declines given the push to only perform hemorrhoidectomies on patients who did not respond to medical/non-operative treatments, leaving those eligible for surgery likely complex in terms of the severity of the hemorrhoid(s) and/or co-morbidities. Therefore, an increasing share of hemorrhoidectomies may be performed in HOPDs as opposed to ASCs or physician offices going forward.

## Hernia

Given the lower complexity and higher per-case revenues (based on Medicare data) of hernia repair surgery, these are good candidates for ASCs. These procedures, particularly umbilical hernia repairs, have seen greater ASC adoption in progressive markets. Procedures are still primarily HOPD-based nationally given growing use of robots for hernia repairs and the need to use general anesthesia and mesh often. In the future, umbilical hernia repairs may serve as an opportunity in the ASC as they may shift more aggressively from HOPDs to ASCs compared to other types of hernia repairs, but this service in general will likely remain primarily HOPD-based, making it a risky addition.



### 3. RISKIER ADDITIONS

#### **Gallbladder**

Gallbladder largely consists of laparoscopic cholecystectomies – or gallbladder removals – which are primarily performed in the HOPD. These procedures are often performed on patients with gallstones, which can cause extreme pain resulting in patients going to the ED and receiving emergent surgery in the ED or HOPD. Given the minimally-invasive nature of these procedures, they have seen notable adoption in the ASC as well, particularly for patients who present in the ED but can afford to delay and schedule the surgery at a later point. These procedures are poised for growth on surgical robots, however, which is likely to keep them primarily hospital-based in the future, though growth may be higher in markets where robots are available in ASCs. Additionally, gallstone pain is a common reason patients visit EDs and physicians may be hesitant to send patients home as delay in treatment can cause ED readmissions and poorer surgical outcomes, so ED utilization will likely persist as well. In all, gallbladder surgery initially presents as a favorable ASC opportunity given its minimally-invasive nature, cost effectiveness, and higher per-case revenues, but the condition treated isn't well-suited for the ASC in many patient and physician eyes, making it a riskier addition.

#### **Prostate**

Prostate consists mostly of percutaneous biopsies, which, because of clinical and technological advances, have mostly shifted to the office setting where the majority of prostate biopsies are currently performed. The growth in urology-specific ASCs is likely one reason for the moderate adoption of prostate biopsies in the ASC. Conversely, TURPs<sup>1</sup> still see most volumes performed in the HOPD. Lower-volume procedures like laser vaporization and brachytherapy placement have seen some shift from the HOPD to the ASC, including likely to urology-specific ASCs. While these shifts from the HOPD are likely to continue, and some shift may occur for TURPs as well, future volumes will likely not support ASC investment. This, coupled with high-volume prostate biopsies continuing to shift to the office and lower Medicare per-case ASC reimbursement for most prostate services, makes prostate a risky ASC addition.

1. Transurethral resection of the prostate



### 3. RISKIER ADDITIONS

#### **Urolithiasis**

This service consists of bladder stone destruction/removal procedures (litholapaxies) and extracorporeal shock wave lithotripsies (ESWLs). Although ESWLs have lower volume demand, they have seen notable shift from the HOPD to the ASC in the past decade, likely giving reason for urolithiasis's overall higher ASC adoption currently. ESWLs have fast recovery times and low risks of complications, making them good candidates for ASCs. Additional shift of ESWLs will likely be to non-ASC freestanding settings like physician offices and labs. CMS's 22% reduction in ESWL ASC reimbursement in 2019 will likely make ASCs less attractive to urologists for these procedures. Additionally, higher-volume stone destruction/removal procedures – particularly non-emergent ones – have already shifted to physician offices, where most volumes will likely remain, as emergent procedures are typically performed in hospitals or urgent care centers. This all translates to lower projected ASC volumes for urolithiasis and makes the service a risky ASC addition.

#### **Middle/inner ear procedures**

Higher-volume tympanostomies and lower-volume tympanic membrane repairs and tympanoplasties have seen moderate adoption in the ASC. Additionally, the majority of even lower-volume myringoplasties and staple procedures are currently performed in the ASC. One reason for this high adoption could be the increased use of endoscopic techniques for these procedures, which are well-suited to be deployed in freestanding settings as they are often less invasive and don't require general anesthesia. However, ASC middle/inner ear procedure volumes overall are not and likely will not be sufficient to support ASC investment, as many volumes will likely remain HOPD-based given lingering concerns regarding the safety and efficacy of endoscopic techniques. Medicare ASC reimbursement for these procedures is also lower, making this service a risky addition.



# 04 Future contenders

Future contenders are services that have seen minimal ASC adoption as of late, but that should be monitored for future growth.

## Breast

As of late, most breast surgery volumes are performed in the HOPD, likely due to physician comfort. Surgeries like lumpectomies, breast reconstructions/revisions, and lesion removals have seen some, albeit low, ASC adoption. In the future, however, we might expect small shifts in breast surgery volumes across most procedures from the HOPD to the ASC. Lumpectomies, in particular, will likely see more aggressive shift than any other breast procedure. As opposed to some other breast surgeries that have low predicted shifts like mastectomies – lumpectomies may use only local anesthesia, making them more appropriate candidates for ASC shift. Lumpectomies are performed primarily either to remove fibroadenomas (noncancerous tumors) or cancerous tumors. We predict that lumpectomies to remove fibroadenomas will likely make up most of the lumpectomy volumes that would shift to the ASC. One reason being that because lumpectomies to remove fibroadenomas are more elective, they may be subject to more patient consumerism when it comes to choosing where to have them done, making the ASC appealing given its cost-effectiveness and accessibility. In the realm of surgeries to treat breast cancer specifically, like some lumpectomies and most mastectomies, shift will likely be slower. It is not off the table though given increasing payer interests in controlling oncology care costs, as seen by their efforts to shift infusion services to freestanding settings via pre-authorization and value-based payment arrangements. Breast cancer surgery is likely to be subject to similar efforts sooner than other cancer surgeries given relatively lower complexity.



#### 4. FUTURE CONTENDERS

### **Gynecology**

Most gynecology procedures – including general, uterine fibroid, and particularly hysterectomy procedures – have not yet been widely adopted in the ASC given procedure complexity and concerns around safety. Furthermore, OB/GYNs typically need to be near hospitals for labor and delivery, and near physician offices for gynecology exams, providing little incentive to perform cases in an ASC. Some procedures – particularly less invasive hysterectomies – could see slow growth in ASCs as physicians are increasingly specializing in just gynecological surgery and may be interested in reaping the operational and financial benefits of ASCs, including the relatively higher per-case revenues of ASC hysterectomies (general gyn and uterine fibroid procedures have relatively low per-case revenues in the ASC).

### **Spinal fusions**

The safety and efficacy of ASC-based fusions remains a point of disagreement among the medical community, giving reason for a higher portion – and in the case of cervical fusion, a majority – of cases performed in the HOPD as of late. That said, due to purchaser (patient, payer, and employer) prioritization of low-cost care sites for spine surgery, fusions are expected to grow in ASC prevalence. Additionally, based on CMS reimbursement alone, ASC fusions are highly lucrative, but offer less volumes.

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4. FUTURE CONTENDERS

**Vascular surgery**

Vascular surgery includes mostly access/shunt procedures and phlebectomy/vein stripping. Access/shunt procedures have seen very little adoption in the ASC given the often complex nature of the surgery and patient population. Phlebectomy/vein stripping, on the other hand, given lower acuity, has seen greatest adoption in the office setting. In fact, many providers have dedicated vein clinics for these procedures. In the future, shift to the ASC will likely be minimal as access/shunt procedures will likely remain mostly HOPD-based and phlebectomy/vein stripping procedures mostly office-based. There may be some minor shifts in phlebectomy/vein stripping and other artery and vein procedures from the office setting to the ASC, but volumes are minimal. Per-case revenues for ASC vascular surgery procedures are also quite low.

**Cardiac cath**

In 2019, CMS added percutaneous coronary intervention (PCI) and diagnostic cath procedures to the ASC Covered Procedures list, so it is likely the data on adoption in this report is understated and that growth will be moderate in years to come. Physician skepticism around the safety of performing these procedures, particularly PCIs, in the ASC will likely persist, however. Additionally, PCI patients are even more complex, driving up ASC investment costs amidst moderate reimbursement rates. Diagnostic cath procedures, however, may see a faster rate of adoption given their lower complexity and costs. PCI’s approval was and is anticipated to promote greater CV presence in ASCs overall, including for EP procedures as well.

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#### 4. FUTURE CONTENDERS

### **Bariatric**

Given the clinically complex patient population that often undergoes bariatric surgery and the resulting surgeon reluctance to perform cases outside of the hospital, bariatric surgery has seen little adoption in the ASC. Additionally, requirements for specialized equipment drives up costs amidst relatively low volumes and low per-case revenues in the ASC, making a positive ROI challenging. Furthermore, bariatric surgery is poised for growth on the da Vinci robot which are primarily located in hospital settings currently. We may see slow ASC growth in the future as more minimally invasive techniques are adopted and as a way to increase patient access (given that services are typically offered at only 1-2 hub locations), but eligibility will be limited.

# ASC service outlook graph data

Category	Service	Percent of HRRs with >0 ASC volumes	Potential 2026 ASC volumes per HRR	Average Medicare per case revenue
Volume driver	Cataract procedures	85%	24,903	\$912
	Colonoscopy	86%	37,705	\$493
	Endoscopic nasal/sinus procedures	31%	2,038	\$1,736
	EGD <sup>1</sup>	79%	13,271	\$436
	Foot/hand	46%	6,021	\$1,175
	Other spine	16%	2,082	\$7,605
	Sports medicine	50%	7,412	\$1,689
	Vascular cath	17%	1,929	\$2,014
Differentiator	Electrophysiology	3%	4,801	\$10,242
	Joint replacement	11%	2,138	\$8,662
Riskier addition	Colorectal/lower GI	15%	644	\$746
	Gallbladder	19%	466	\$2,306
	Hernia	16%	1,191	\$1,710
	Middle/inner ear procedures	28%	1,206	\$962
	Prostate	21%	1,335	\$1,110
	Urolithiasis	26%	1,000	\$1,218
Future contender	Bariatric	1%	92	\$1,374
	Cardiac cath	2%	499	\$1,394
	Fusion	5%	919	\$8,552
	General gynecology procedures	6%	657	\$1,609
	Hysterectomy	1%	513	\$3,264
	Uterine fibroid procedures	2%	92	\$1,897
	Vascular surgery	4%	463	\$900
	Breast	12%	1,459	\$1,395

1. Esophagogastroduodenoscopy

Source: Optum's de-identified Clinformatics® Data Mart Database; Advisory Board's Market Scenario Planner; ASC Payment Rates - Addenda | CMS; Advisory Board research and analysis.

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Jinia Sarkar

## Program leadership

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