Leasing Imaging Facilities to Referring Physicians: Fee Shifting or Fee Splitting?1

It's déjà vu all over again.
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Included in a recent newsletter published by a community hospital was the following message from the hospital’s medical staff president, a board-certified internist (2):

In the face of increasing costs and decreasing reimbursements, many physicians are working harder and making less money. Not all physicians are content working harder for less income. Physicians have chosen other avenues in order to enhance their income. Various ancillary services such as dexam scans and ultrasound studies are being done in physician offices rather than in hospitals. These methods serve to redistribute a finite amount of healthcare dollars between primary care and subspecialty physicians.

Several weeks later, the journal Health Affairs published an article on “physician entrepreneurialism,” in which it was pointed out that to increase revenue in the face of steadily declining incomes, more and more physicians are beginning to invest in ancillary services such as imaging and laboratory testing (3). The health researchers who wrote the article reported that of all such services attracting physician investors, the radiologic examination magnetic resonance (MR) imaging was the most potentially lucrative.

Coincidently with the publication of the Health Affairs article, The New York Times (4) published a front page report describing how physicians whose “traditional sources of income” have been “squeezed” have discovered a new revenue source: diagnostic imaging. The New York Times writer reported that physicians’ average use of radiologic imaging procedures per Medicare beneficiary had increased to nearly three times the rate of physicians’ overall use of Medicare services from 1999 to 2002 and that Medicare spending for imaging during the same period had increased 50% versus a 30% increase in overall Medicare costs. The reporter further pointed out that physicians’ billing for radiologic services had increased 75% among family practice groups.

Seventeen months earlier, Brant-Zawadzki (5) had reported that when he became aware that the volume of physician referrals from one of his group’s loyal clinicians had decreased precipitously, he discovered the cause:

A freewheeling local competitor was offering lease time at his imaging center to our referring regulars for their patients. This arrangement allowed the clinicians to bill for the technical (and professional, if desired) component of an imaging study in return for negotiated lease payments to the site.

It would seem from the experiences reported in these articles that the phrase “redistribute a finite amount of healthcare dollars between primary care and subspecialty physicians” coined by the hospital medical staff president may well be a metaphor for the shifting of revenue from radiologists to primary care physicians. As the stories described in these articles suggest, this shifting of revenue is being accomplished by means of actual investment in or by leasing time for using radiologic equipment, or a combination of these mechanisms.

According to an attorney who is knowledgeable about radiology practices (Gree son TW, personal communication, 2004), the leasing of radiology facilities appears to have begun in large cities in California, Florida, New York, and Illinois and is now spreading to other parts of the country. At first glance, one might think that revenue shifting from radiologists to referring physicians is a new phenomenon. However, a brief review of the recent history of radiology practice economics reveals that the phenomenon of revenue redistribution is, as Yogi Berra aptly characterized it, “déjà vu all over again” (1).

The Advent of High-Technology Radiology Equipment and Referring-Physician Investors

A major change in radiology practice in the United States occurred in the 1970s with the advent of computed tomographic (CT) scanners. At that time, this equipment had a price tag of more than a half million dollars, which was substantially more costly than any imaging equipment that had been manufactured in the preceding 70 years of American radiology practice. By the 1980s, the price of CT scanners had risen to more than $1 million, and at the same time MR imaging units, with price tags ranging from $1 ½–$2 million, had begun appearing in the marketplace.

Hospitals, which previously had been eager to fund the costs of radiology...
equipment because Medicare and private insurers reimbursed them for these expenditures, increasingly began to encounter limited financial resources owing to declining third-party reimbursement. Venture capitalists and other private entrepreneurs began to fill the void by funding the costs of nonhospital imaging centers. As a result, the ownership of high-technology radiology equipment, which had previously resided with individual radiologists and hospitals, began to shift to outside business entities (6).

Business ventures are, by nature, profit driven: Their success is measured on the basis of returns on investments. Obviously, profits in an imaging center can be gained only when the volume of patient examinations is high. The stage was thus set for a phenomenon that was new to American radiology practices: enlisting the participation of physician owners, with the anticipation that referring physician investors, once they had gained a financial interest in an imaging center and knew that the returns on investments depended on the volume of business, would refer patients—who ordinarily would be referred elsewhere—to their center (7). The movement of physicians owning imaging centers quickly swept the nation.

In 1992, a report published in the Journal of the American Medical Association (8) examined the prevalence and scope of physician joint ventures in Florida. The researchers found that 40% of Florida physicians involved in direct patient care had a financial investment in a health care business to which they referred patients and that nearly half of these physicians had a financial interest in a diagnostic imaging center. Other researchers estimated that 24% of all free-standing MR imaging facilities were at least partially owned by nonradiologist physicians (hereafter referred to as nonradiologists) and that 16% of all physicians had invested in an outside radiology facility to which they referred patients (9).

More than a decade ago, Hillman et al (10) directed the medical community’s attention to the high degree of imaging procedure overuse that was occurring as a result of primary care physicians referring patients to their own facilities rather than to radiologists for diagnostic imaging services. In a landmark 1990 New England Journal of Medicine article, Hillman et al, after analyzing 65,000 cases of outpatient care administered by 6,000 physicians for conditions such as acute upper respiratory symptoms, pregnancy, low back pain, and urinating difficulty, found that chest radiography, obstetric ultrasonography (US), radiography of the lumbar spine, and excretory urography were performed 4.5 times more often when nonradiologists referred patients to their own facility rather than to radiologists. Expanding this analysis 2 years later to a review of insurance claims that covered 10 clinical presentations, Hillman et al (11) found that nonradiologists’ referral of patients to their own facilities resulted in imaging examinations being performed 7.7 times more often than they were performed when patients were referred to radiologists.

Several articles in a 1993 issue of Radiology were focused on the underlying cause of radiologic procedure overuse: nonradiologist investment in radiologic imaging centers. Reflecting the importance of this subject at the time, five consecutive articles published in a single issue of Radiology (12–16) expounded on the perils of physician investment in radiologic facilities. In one of these articles, Evens (14) reported that at a time when physicians’ revenues were being challenged on many fronts, it was tempting for them to order more procedures, especially when there was an associated financial return. In another article, Muroff (15) asserted that “self-referral is a problem even more pernicious than that of physician-owned pharmacies because self-referral is a less visible and more insidious means of profiting from one’s patients.” In one of her two articles, Morreim wrote, “Illegitimate self-referral should be thwarted” (12).

In May 1992, the Council on Ethical and Judicial Affairs of the American Medical Association (AMA) tackled the subject of the overuse of radiologic imaging procedures by physicians who refer patients to facilities in which the physicians themselves have financial interests (17). The Council voiced concern about excessive profits being realized as a result of self-referral, admonishing that physicians should not be in the business of profiting purely from their ability to refer patients to outside facilities. Physicians are engaged in the special calling of healing, and in that calling they are the fiduciaries of their patients. They have different and higher duties than even the most ethical businessperson. . . . In general, physicians should not refer patients to a healthcare facility in which they have an investment interest.

Physician Antireferral Laws and the Leasing Loophole

The rapid growth of health care costs during the 1980s did not go unnoticed by federal lawmakers, particularly U.S. Representative Fortney H. “Pete” Stark. Attributing these rising costs to “increased utilization of physician-owned services . . . because physician owners are in the enviable position of being able to generate their own demand for the services they supply,” Stark called for legislative action to end what he termed the “horrormage of Medicare dollars” (18). Convinced that physician ownership of imaging centers (and laboratories) has a detrimental effect on society, Congress in 1989 passed the first physician anti-kickback law (known as the Stark law after its original sponsor) that prohibited a physician from referring patients for certain services to entities in which the physician had a financial interest (19). This law, along with further revisions of the Stark legislation and various antireferral laws that were passed by many states, effectively eliminated the legal ownership of imaging centers by referring physicians—but only for a time.

There is a legal adage that “where there is a law, there is a loophole.” In general, the Stark laws prohibit physicians from billing Medicare for designated health care services provided to patients who are referred to a facility in which the referring physician or an immediate family member has a financial interest. One of these designated services is radiologic imaging; however, nuclear medicine examinations (including positron emission tomography [PET]) are currently not bound to these laws. There are several exceptions, or loopholes, to the Stark laws that permit referrals under certain conditions. In the context of leasing radiologic equipment, the most important of these conditions is that of in-office ancillary services.

The in-office ancillary services exception has three requirements (Greens TW, personal communication, 2004): First, the service(s) at issue must be provided by the referring physician, a member of the referring physician’s group practice, or a health care provider who is directly supervised by the referring physician. The most common way for a referring physician to comply with this requirement is to enter into a formal agreement with a radiologist or radiology practice that provides the required imaging service(s) on behalf of the referring physician. In this case, the radiologist is considered a mem-
ber of the group practice. The second requirement is that the radiologic imaging service(s) must be provided in the same building as the group practice or at a centralized site that is used exclusively by the group practice. The third requirement is that the physicians providing or supervising the service(s) must bill for the procedure. In the most common type of leasing arrangement, radiologists assign their billing rights to the referring physician who has contracted with them.

Most attorneys recommend that a lease agreement between the referring physician and the imaging facility be drafted so that these parties can remain within the law. The agreement must be for a finite term, and the lease rate must be term based—that is, for a specified number of hours—or unit based—that is, for a specified number of examinations. Also, the agreement must be set up in advance, with the agreed leasing rate set at a fair market value that is not related to the number of referrals generated by the referring physician. In addition, the lease should cover all space, equipment, and personnel required to perform the imaging procedure(s). Non–Medicare patient referrals are not covered by the Stark legislation, but they may be subject to various antireferral laws in individual states.

Leasing arrangements clearly result in fee shifting from the radiologist to the referring physician. This brings us to the question of whether fee shifting is the same as fee splitting. To answer this question, we shall turn first to pronouncements of the AMA and the American College of Physicians. For example, US examinations performed by radiologists during this 6-year period increased 15%, in contrast to a 53% increase in US examinations performed by nonradiologists. The use of nuclear imaging procedures decreased 2% among radiologists but increased 208% among nonradiologists. The use of MR imaging increased 67% among radiologists but 252% among nonradiologists.

An Annals of Health Law article (22) examined the issue of fee splitting from both historic and contemporary viewpoints. Between 1914 and 1953, 22 states passed laws making fee splitting illegal, and today at least 36 states have such laws. The authors of the article point out, however, that in many state statutes, the distinction between payment for patient referral and payment allocations for professional services is often vague. Neither the article nor any other scholarly study or case law that we can find addresses the question of whether leasing arrangements constitute fee splitting. In a typical leasing arrangement, the radiologist employed at and/or the owner of a radiology facility negotiates with the referring physician a lease payment calculated on an hourly or number-of-examinations basis. The referring physician pays this sum directly to the radiology facility. A separate contract for interpretation may be negotiated directly with the radiologist. The negotiated lease payment is sufficiently low so that when referring physicians use their own providers in billing third-party payers at the maximum allowable reimbursement rates, they will realize a substantial profit. Does the profit gained by the referring physician—that is, the difference between the “retail” price billed to the third-party payer and the “wholesale” lease payment to the radiology facility—constitute fee splitting? At present, no clear answer to this question exists.

Overuse of Diagnostic Imaging Procedures

The issue of whether leasing arrangements violate the law or ethical principles remains vague. What remains far less vague, however, is the issue of whether self-referral results in the overuse of imaging procedures. Maitino et al (23) recently reported the results of a review of Medicare Part B claims filed between 1993 and 1999. The authors compared increases in the use of noninvasive diagnostic imaging procedures between radiologists and nonradiologists and found a far greater increase among the nonradiologists. For example, US examinations performed by radiologists during this 6-year period increased 15%, in contrast to a 53% increase in US examinations performed by nonradiologists. The use of nuclear imaging procedures decreased 2% among radiologists but increased 208% among nonradiologists. The use of MR imaging increased 67% among radiologists but 252% among nonradiologists.

Interestingly, although radiologists performed more than two-thirds of all noninvasive diagnostic imaging examinations during the 1993–1999 time frame, the overall use of these examinations among radiologists decreased 4%. The use of noninvasive diagnostic imaging among nonradiologists, on the other hand, increased 25%. According to Maitino et al (23), virtually all cases of increased use of noninvasive diagnostic imaging were attributable to nonradiologist use and were most likely the result of self-referral.

In a more recent analysis of data obtained from the Medicare Payment Advi-
Marketing and strategic planning. Examining the business principles of the radiology community is well served by the leasing phenomenon. Let us now consider whether fee shifting and price wars are beneficial for patients or the referring physician—is not beneficial for the radiology community. As Rao et al point out, “No matter who wins, the combatants all seem to end up worse off than before they joined the battle. … Price wars can harm an entire industry” (25) or an entire profession. It is well known to business educators and professionals that price wars should be avoided whenever possible. Marketing professors teach that competitors should try to differentiate themselves on the basis of their unique attributes or niches rather than on the basis of price.

Long-term Effect on the Radiology Community

The potential negative effects of leasing arrangements on the radiology specialty extend well beyond financial considerations. Can fee-splitting practices erode the moral fabric of the radiology community? The ACR’s code of ethics calls for radiologists to maintain a “high level of ethical [and] exemplary professional conduct” (21) and to “deal honestly and fairly with patients and colleagues.” The code mandates that all professional actions of radiologists be governed by what is in “the best interest of the patient.” One cannot help but wonder whether the increasing common leasing arrangements in imaging centers have the best interest of the patient in mind. Armstrong (13) wrote, “Whenever a physician profits from patient care by referring patients to an outpatient diagnostic facility in which that physician has ownership, a conflict arises.” Armstrong then quoted a clinician with whom he had discussed self-referral as saying, “He is my patient, and I want a piece of the action.” Such a view, emphasized Armstrong, “reduces the patient to a possession of the physician, an object in the market place, and a means to the physician’s economic ends.” One certainly has to wonder whether fee shifting and price wars are adherent to even the spirit, if not the letter, of the ACR’s code of ethics.

Brant-Zawadzki (5) observed that “clinicians resent the hospital’s lock on imaging for their patients, resent not participating in income generated by their referrals, resent the salaries of the radiologists, and resent that Medicare reimbursement gets cut while practice overheads are growing.” While this observation is undoubtedly true, one must wonder whether the moral and just answer to differential overhead costs and income disparities among medical specialties is fee shifting or fee splitting.

In the Annals of Health Law review article referred to earlier (22), law professors propose that organized medicine, as well as state legislators and licensing boards, should take a more liberal view of fee splitting, in keeping with the economic pressures being imposed on all physicians today. “Fee splitting demands definition and revision to fit today’s environment,” argue these legal experts.

Given these kinds of attitudes among referring physicians and outside observers and the economic milieu in which both referring physicians and radiologists increasingly find themselves, it is not surprising that some radiologists elect to enter into leasing arrangements with referring physicians. Nonetheless, one must wonder about the long-term effects of such arrangements on the radiology specialty. Certainly, leasing arrangements can shift power and autonomy from radiologists to referring physicians. They can also incite a price war, decreasing the financial value of radiologic services. Additional issues worth considering are whether fee shifting reduces the status and position of radiologists in the medical specialty hierarchy and whether the image of radiologists in the eyes of the government and the public will deteriorate if leasing results in a substantial overuse of radiologic procedures.

At the 2003 and 2004 annual meetings of the ACR, many radiologists voiced concerns regarding self-referral and the leasing phenomenon. The ACR considers self-referral a major issue and presently is...
Radiology as a specialty occupies the moral high ground on the self-referral issue. ... Radiologists and their advocates must be consistent and careful to distinguish issues that are merely related to turf from issues that have true ethical merit. The questions that policy makers will be most compelled by are those relating to financially motivated self-referral and not to debates over turf by self-interested specialty groups.

Conclusion

Since the early days of the 20th century, radiologists have maintained their identity as a distinct specialty of medicine and have created a culture of independence. Through their national and local organizations, radiologists have maintained their identity as a distinct specialty of medicine and have created a culture of independence. Through their national and local organizations, radiologists have retained cohesive and unified in dealing effectively with the many challenges brought on by economic changes, government regulations, and turf issues with other medical specialties. Preserving the integrity of the radiology profession in the face of increasing pressures to negotiate leasing arrangements with referring physicians is the latest obstacle to be added to a long list of previous challenges the radiology profession has met and overcome.

Entering into a leasing relationship with referring physicians does not seem to violate the AMA’s Code of Medical Ethics (20). However, regarding most leasing arrangements, physicians do not seem to be adhering with any noticeable frequency to the Code mandate that they disclose their investment interest to their patients when making a referral; this observation prompts the question of whether the leasing of outpatient imaging facilities does indeed fall within the Code. Entering into a leasing agreement also does not seem to violate the ACR’s code of ethics or federal or state laws, although the Medicare Payment Advisory Commission is considering “tougher federal oversight and regulation” of physician-owned or physician-leased imaging equipment (29), and is not likely to lead to either riches or financial ruin. Thus, perhaps there will be no long-term effect of these arrangements on the radiology profession.

Fee shifting through leasing of imaging facilities may be simply “dèjà vu all over again”—in other words, simply another one of those troublesome snowstorms that will quickly pass into history and soon be forgotten—until the next snowstorm arrives. On the other hand, perhaps the leasing phenomenon will indeed entice some radiologists into trading long-term security for short-term gain and ultimately result in an irrevocable erosion of the value of radiologists. How these issues will eventually be resolved is yet to be determined.

References