Self-referral in imaging creates a problem for our health care system in that it leads to higher utilization and costs. Although it is still widespread, there are indications that some states, some regional payers, and the Centers for Medicare & Medicaid Services have begun to take some actions to limit this potentially abusive practice. At the state level, these actions include consideration of anti-self-referral laws, crackdowns on scan-leasing schemes, the institution of mandatory facility accreditation programs, and bans on the installation of advanced imaging equipment in physician offices. Some commercial payers have instituted strict privileging programs in imaging, closed their panels to any facility that is not a full-service imaging provider, and begun requiring accreditation of advanced imaging modalities. The Centers for Medicare & Medicaid Services plans to institute an antimarkup rule and prohibit independent diagnostic testing facilities from leasing space or equipment to nonradiologist physicians, and it has indicated that tightening up the loopholes in the Stark laws may be in the offing. In this paper, the authors review all these recent developments and their implications.

Key Words: Medical economics, radiology and radiologists, socioeconomic issues, self-referral, utilization of imaging, Centers for Medicare & Medicaid Services rules


Self-referral in imaging is acknowledged to be one of the major threats facing radiology. More important, it is a threat to our health care system in that it creates a conflict of interest that may result in higher, and often unnecessary, utilization and costs. In an earlier article in this series, published in the November 2004 issue of the *JACR*, we reviewed some of the steps that could potentially be taken by the federal or state governments or health plans to try to alleviate the overutilization of imaging that self-referral causes [1]. Since that time, some important progress has been made in the effort to limit self-referral, particularly among several states and several major payers. In this article, we summarize these recent developments and urge readers to become familiar with them. You can then think about proposing some of the ideas to your own state lawmakers and payers, who are likely facing the same problems and might be receptive to some solutions. At the federal level, the situation is largely in a state of flux as of this writing, but we will review some of the recent developments there as well.

THE STATES

The Maryland Self-Referral Law

In 1993, the Maryland General Assembly passed a self-referral law, the Maryland Health Occupations Article, § 1-301(k)(2), which essentially prohibited nonradiologist physicians from owning computed tomographic or magnetic resonance imaging (MRI) units in their offices. The law had an in-office ancillary services exception, but the exception specifically excluded MRI, computed tomography (CT), and radiation therapy. A good recent history of this law was provided by Shavitz [2]. The law was not enforced for a number of years until, at the prompting of the ACR, Maryland’s attorney general took
on the case of an orthopedic surgery group that had its own in-office MRI unit. In early 2004, the attorney general came down strongly against the orthopedic group, stating in his opinion that “state law bars a physician in an orthopedic group practice from referring patients for tests on an MRI machine or computed tomographic scanner owned by that practice . . . The same analysis holds true for any other nonradiology medical practice.”

Although ownership of MRI units by orthopedic surgeons dropped thereafter, some apparently still remained in the business. This led to a petition by several Maryland payers for a ruling by the Maryland Board of Physicians on the propriety of self-referral by 6 orthopedic surgery groups to MRI units they owned. The Maryland Board of Physicians is the licensing board for all doctors in the state, and its rulings therefore cannot be taken lightly. In late 2006, after extensive research, the board held that a referral by an orthopedic practice for MRI studies to be performed on a unit owned or leased by that practice was an illegal self-referral within the meaning of the 1993 state law. The orthopedic groups thereafter filed suit in the Montgomery County Circuit Court challenging the board’s ruling. On October 18, 2007, the court handed down a decision upholding the board’s ruling [3]. The plaintiffs are now appealing the decision to the Maryland Court of Special Appeals. It is likely that an effort will be made at the 2008 session of the Maryland General Assembly to overturn the 1993 law.

The Maryland experience shows that a law barring self-referral for in-office MRI and CT is feasible and can withstand court challenges. Other states should be encouraged to pursue a similar approach, although it should be noted that such efforts have been made in several other states and have failed, largely because of opposition by the states’ medical societies and the American Medical Association, all of which seem to like self-referral.

The Illinois Attorney General’s Allegation of Illegal Kickbacks

In early 2007, the Illinois attorney general, Lisa Madigan, filed suit against 20 Chicago-area imaging facilities, alleging fraudulent billing practices and illegal kickbacks [4-6]. The allegations targeted scan-leasing arrangements between the imaging facilities and many of their referring physicians. The arrangements typically work something like this: A referring physician leases an MRI slot at an imaging center for a fixed, “per click” fee. The physician refers a patient to the center to fill that slot. The center performs the study, and its radiologist does the interpretation. The center then bills the insurer a global fee in the name of the referring physician and collects the reimbursement on the physician’s behalf (or the referring physician may bill the insurer directly). The arrangement is such that the reimbursement received is always higher than the per click fee paid to the center by the referring physician. The latter thus earns a profit simply by making the referral, without performing any medical service for the patient.

There are other variations on this theme, such as leasing whole blocks of time, but in any event, Attorney General Madigan has taken the position that these sorts of deals represent fraudulent billing and illegal kickbacks. A similar suit had been filed against a radiologist in the US District Court in Florida in 2005 [5]. Also in 2005, the Louisiana Board of Medical Examiners issued an opinion that an arrangement under which a referring physician leases or purchases the technical and professional services necessary to provide imaging to that physician’s patients on an unscheduled, per use basis for less than that referring physician’s reimbursement from the insurance carrier violates the Louisiana antikickback law [7].

So, it is apparent that states can take action to stop this egregious practice, which clearly represents an illegal kickback. Radiologists should encourage similar actions in their own states and above all, should stay away from any involvement in this kind of scheme.

The New Jersey Quality Assurance Program

In 2001, New Jersey instituted a quality assurance program that was required for all facilities performing plain radiography [8]. The program was under the auspices of the state’s Bureau of Radiological Health and was based on site inspections, which assessed processor function logs, quality control procedures, radiation exposure, and image quality. The latter two parameters were determined by exposing a phantom, using a facility’s techniques for posterior-anterior chest, anterior-posterior lumbar spine, and anterior-posterior foot radiography. Measurements were made on the phantom images to ascertain background density, low-contrast resolution and detail, high-contrast resolution, noise or artifacts, film contrast, and density uniformity.

Over the first 5 years of the program, it was found that for the 3 types of radiography, average radiation exposure decreased, while image quality scores increased. Facilities with high-radiation exposure or poor image quality scores were given 30 days to correct the problems and report their corrective actions to the bureau. The program had a dramatic effect on the number of facilities that continued to perform x-rays. From November 2003 to March 2005, the number of physician offices doing so dropped from 1,494 to 1,295 (−13%). Among chiropractors, the number dropped from 1,293 to 852 (−34%), while among podiatrists, it dropped from 626 to 418 (−33%). Presumably, the dropouts were those
marginal providers who either couldn’t meet the standards or felt that it wasn’t worth the effort to try to do so. This is an excellent example of how a state-run accreditation program that includes site inspections can improve imaging quality and help limit utilization at the same time.

The West Virginia Moratorium

In 2006, the West Virginia Health Care Authority issued a moratorium on the installation of CT scanners in physician offices [9]. This was done in response to concern expressed by the West Virginia Hospital Association that if CT scanners were allowed to proliferate in physician offices, it would siphon away revenues the hospitals needed to provide care to the poor. In December 2007, the Health Care Authority announced its decision to rescind the moratorium. However, Governor Joe Manchin overruled the authority [10] and has kept the moratorium in effect. This policy prevents both radiologists and nonradiologist physicians from placing CT scanners in their offices, but it obviously helps the hospital-based radiology departments in the state. A better policy might have been to prohibit scanner installations only in the offices of physicians who can self-refer. In any event, it is an example of how a state agency can take action to prevent the proliferation of high-end imaging equipment in physician private offices and thereby limit self-referral opportunities.

THE COMMERCIAL PAYERS

The Highmark Imaging Initiative

Highmark Blue Shield is the dominant commercial payer in western Pennsylvania, including the Pittsburgh area. In 2005, Highmark introduced privileging requirements that restricted who could perform imaging, particularly high-end examinations such as MRI, CT, and positron emission tomography (PET). The requirements were updated in May 2007 [11]. To qualify for reimbursement, a provider of MRI or CT must offer at least 5 different imaging modalities. Most physicians other than radiologists would have a hard time meeting this requirement. A facility must be owned or leased on a full-time basis and open at least 40 hours per week. This would eliminate most of the per click or other part-time scan-leasing arrangements described earlier. A physician must be available on-site during normal business hours or available by teleradiology. All MRI facilities must be accredited by the ACR. The examinations must be performed by technologists who are appropriately licensed or certified. The stipulation on the ownership of positron emission tomographic scanners is somewhat ambiguous, but it seems that all facilities providing PET must be wholly or partially owned by hospitals. These requirements by Highmark have largely halted the installation of high-end imaging equipment in the offices of nonradiologist physicians in recent years (David S. Buck, MD, personal communication, January 2008).

Similar Restrictive Policies Implemented in Connecticut

Several payers in Connecticut have implemented policies aimed at improving imaging quality and restricting self-referral. The first of these was a privileging program instituted by Cigna in 1996 [12]. Privileges to perform imaging were limited only to certain specialists, who were allowed to do studies in which they presumably had some level of expertise, on the basis of training and tradition. No specialists other than radiologists were allowed to perform CT or MRI. Site inspections and site accreditation requirements were instituted by the payer, and many nonradiologist sites failed to pass muster [12]. For example, among the 92 nonradiologist offices that performed the greatest number of plain radiographic examinations, 78% were found to have at least one major deficiency. After the program was started, a substantial decrease occurred in the number of self-referred plain radiographic examinations performed in nonradiologist private offices.

In 2004 and 2005, Oxford Health Plan and Anthem Blue Cross Blue Shield of Connecticut, respectively, instituted strict, specialty-specific privileging in imaging. According to the terms of the current Anthem program, any freestanding center wishing to be reimbursed for MRI or CT must become accredited by the ACR and must provide at least 3 imaging modalities. All MRI units must provide whole-body scanning (ie, extremity-only scanners are not allowed). Any center performing CT or MRI must be staffed on-site by a board-certified or board-eligible radiologist. In ultrasound, privileges are procedure-specific and limited to only radiologists and a few nonradiologic specialists: obstetrician/gynecologists are privileged for obstetric and gynecologic ultrasound and breast ultrasound, urologists for urologic ultrasound, cardiologists for echocardiography and vascular ultrasound, vascular surgeons and neurologists for vascular ultrasound, endocrinologists for thyroid ultrasound, and general surgeons for breast ultrasound. Providers of PET must be board certified in either diagnostic radiology or nuclear medicine. All imaging equipment of any kind must be owned by the provider or leased by the provider on a full-time basis (ie, no per click or block leasing allowed). Taken in their entirety, these provisions markedly restrict self-referral in imaging among physicians on the Anthem panel. The Oxford program is also quite restrictive, and other private payers in the state are implementing similar policies for nonradiologists.
Closed Panels: The Independence Blue Cross Policy on Cardiac Computed Tomographic Angiography

Independence Blue Cross strongly dominates the managed care market in the Philadelphia area (controlling approximately 70% of that market). Because of quality and overutilization concerns, the payer has chosen not to reimburse cardiologists for performing cardiac CT angiography in their offices. The basis for this is a longstanding policy that limits payment for ambulatory CT only to full-service imaging providers. In effect, this restricts cardiologists from performing in-office cardiac CT angiography. Independence Blue Cross feels that its current network of imaging providers offers sufficient access to its subscribers and that consequently, there is no need to expand it. The result is that in the entire Philadelphia metropolitan area, there does not seem to be a single cardiology practice that provides cardiac CT angiography in its private offices. Independence Blue Cross can take this position because of its strong market domination. The policy is obviously a strong deterrent to self-referral. It would likely be difficult for payers who have limited market share in other areas to take this “just say no” approach, but they should be encouraged to consider it.

A variant of this policy has been introduced in the New York City area by the Oxford Health Plan. When a prospective new provider wants to offer imaging services, the provider must apply for inclusion in Oxford’s panel. A committee of the carrier then reviews the provider’s credentials, assesses the needs of the community, and decides whether the applicant should be admitted to the panel. Although this has been promoted as primarily a quality initiative, it has apparently also been effective in limiting self-referral. It should be noted that some radiologists are displeased with this policy, because it favors incumbent practices.

United Healthcare and Accreditation

United Healthcare, another large payer, recently announced a new policy pertaining to imaging, one that we support. Beginning in the third quarter of 2008, all freestanding facilities and physician offices that perform advanced imaging in United’s network will have to be accredited by the ACR or the Intersocietal Accreditation Commission. The advanced imaging modalities covered by this policy are CT and CT angiography, MRI and MR angiography, PET, nuclear medicine and nuclear cardiology, and echocardiography. Some other payers are implementing a similar policy. This is also primarily designed to be a quality initiative, but it could potentially have a side benefit of making it difficult for marginal providers of advanced imaging to get into the business. However, many are skeptical as to any retardant effect on self-referral, because the financial rewards of advanced imaging in a setting in which demand is generated by the referring owners may more than compensate for the added burdens of accreditation. It remains to be seen what the ramifications of this policy will be after actual implementation.

THE FEDERAL GOVERNMENT

The Centers for Medicare & Medicaid Services 2008 Final Rule

The Centers for Medicare & Medicaid Services (CMS) final rule for the 2008 Medicare Physician Fee Schedule, published in the November 27, 2007, Federal Register, contained some significant provisions aimed at limiting self-referral. The most important was the antimarkup provision. This prohibits any health care entity or provider from profiting from, or marking up, either the technical component or the professional component of any service that is purchased or obtained under reassignment from another provider. In other words, one provider cannot bill Medicare a fee that is higher than what it paid another outside provider for that service. This gets directly at the type of scheme targeted by the Illinois attorney general, as noted above, wherein a physician leases an MRI, CT, or PET slot from an imaging facility for a predetermined per click fee, then refers a patient for a scan that is performed and interpreted by that imaging facility, and then bills the payer (Medicare in this case) a fee that is higher than the per click fee. The antimarkup provision would prohibit this widespread type of self-referral abuse. The CMS originally planned to institute this provision in 2008, but in response to outside pressure, it has now decided to delay implementation until January 2009.

A related provision applies to fixed independent diagnostic testing facilities (IDTFs). Henceforth, IDTFs are prohibited from leasing or subleasing their space, equipment, or practice locations to other physicians or entities. The prohibition does not apply to ownership or investment interests that radiologists might hold in imaging IDTFs. In essence, this approaches the scan-leasing schemes from another angle.

When CMS issued its proposed rule for 2008 in the summer of 2007, it solicited comments on whether changes should be made to the in-office ancillary services exception to the Stark laws. In discussing what kinds of equipment some physicians were acquiring under this exception, CMS acknowledged that some “of these types of arrangements appear to be nothing more than enterprises established for the self-referral of DHS [designated health services].” Nevertheless, when the 2008 final rule was issued, CMS deferred any changes to the in-office ancillary services exception. Instead, CMS said that the...
volume of comments it had received required more consideration and that more time was necessary to decide on the final details of any changes. The CMS did indicate, however, that it had sufficient information and the authority to issue additional rules in the near future, perhaps even before the next proposed rule for 2009. In the final rule, CMS commented,

A measured, thoughtful approach to the final physician self-referral rules is critical. We believe that the future rulemaking will address the public comments and present a coordinated, comprehensive approach to accomplishing the goals described in the proposed rule, namely, minimizing the threat of program and patient abuse while providing sufficient flexibility to enable those who are parties to financial arrangements to satisfy the requirements of, and remain in compliance with, the physician self-referral law and the exceptions thereto.

The willingness of CMS to confront this issue is encouraging.

There was another important provision in the initial CMS proposed rule that was left out of the final rule. This would have put a stop to the so-called “under arrangements” joint ventures between hospitals and their referring physicians. An example of this might be a cardiology group creating a joint venture arrangement with its hospital to provide inpatient and outpatient cardiac nuclear scans in the hospital. The hospital then bills globally for the scans and pays the cardiology group a fee for each one, presumably on the basis of fair market value. Although this is clearly a self-referral arrangement, it is currently permissible under both the Stark laws and CMS rules, because the billing entity (the hospital) and the performing entity (the cardiology group) are separate. Under the CMS proposed rule, both would have been considered designated health service entities, and the cardiology group would no longer have been able to refer to the joint venture, because the group had a financial relationship with it. The CMS did not include this change in its final rule because it apparently felt the specifics of its implementation were complex and required further consideration.

The Deficit Reduction Act of 2005

The Deficit Reduction Act, which took effect on January 1, 2007, has been analyzed extensively, and most readers are probably very familiar with it. It equalized Medicare technical component reimbursements for most office-based advanced imaging procedures with those paid to hospitals under the Hospital Outpatient Prospective Payment System. Because the fee schedule technical component reimbursements for office-based advanced imaging procedures were generally higher than reimbursements for those same studies under the Hospital Outpatient Prospective Payment System, the act negatively affected many radiology practices that have office components (including ours), as well as IDTFs that operate equipment in outpatient imaging centers. In spite of its negative aspect, there is a potential silver lining to this cloud, which is that it lessens the financial incentive for nonradiologist physicians to install MRI, CT, and PET scanners in their offices. In this respect, it may prove to help restrict self-referral.

CONCLUSION

The above information suggests that although self-referral is a large concern and source of frustration to radiologists, there is hope on the horizon. Government agencies in some states have begun to take some actions to limit this practice. The actions include consideration of anti-self-referral laws; cracking down on scan-leasing schemes, which in reality are nothing more than kickbacks; instituting mandatory accreditation programs on the basis of site inspections; and outright bans on the installation of high-end imaging equipment in private offices. Some commercial payers have begun strict privileging programs in imaging or closed their panels to any entities that are not full-service imaging providers. Others have begun to require accreditation of various modalities, such as that offered by the ACR. The Medicare program is scheduled to institute an antimarkup provision. It has prohibited IDTFs from leasing or subleasing their space or equipment to nonradiologist physicians. It has signaled its intent to consider closing loopholes in the Stark laws. Wherever possible, radiologists should try to get their own states and local payers to adopt similar policies. Publicizing the issue and these possible solutions to the news media is another worthwhile avenue. It is also crucial to keep up efforts to convince CMS, the Medicare Payment Advisory Commission, and Congress that something must be done to tighten up the in-office ancillary services exception to the Stark laws.

The developments cited herein are encouraging in many ways, but the battle is far from over. The ACR has been a vigorous proponent of reform, and all radiologists should support those efforts. We are clearly on the right side of this issue, and hopefully, the message will be forthcoming in the not too distant future that it is the end of the line for self-referral in imaging and the potential for abuse that it engenders.

REFERENCES


