Practice Management Issues for Radiology Residents: Focus on Self-Referral

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INTRODUCTION

As residents, we are most concerned with learning interpretive skills, as well as becoming compassionate, competent physicians. Given the stress of passing all of our discipline's board examinations, only minimal time is devoted to the practical aspects of the business of radiology. To be more equipped to begin and succeed in our careers, as well as to plan for and participate in the future of our specialty, we believe that there should be more of a focus on economic, business, ethical, and legal issues affecting radiology in our 4 years of training.

Many training programs provide didactic series on noninterpretive skills. In addition, the ACR and the Association of Program Directors in Radiology created and distributed to all training programs a set of videotaped lectures to supplement residents' learning in such areas as practice management, ethics, and communication skills. Although additional good information is scattered throughout the radiology literature, residents may not have the time or inclination to explore it. Yet creating highly informed radiology residents is vital to maintaining the future economic and political fortitude of our specialty, which should be everyone's priority.

In this column, we discuss the phenomenon of self-referral, which is one of the many socioeconomic topics that should concern residents during their training and that require the attention of educated radiologists now and in the future. By highlighting self-referral, we hope that we will spark interest on the part of residents and provide a nidus for future learning.

SELF-REFERRAL

One of the most serious threats to the stability of our specialty is physician self-referral. In diagnostic radiology, this usually takes one of two forms: nonradiologist physicians refer their patients either to external imaging centers in which they have vested financial interests or to their own on-site imaging services. Examples are obstetricians performing ultrasounds, oncologists who invest in positron emission tomography scanners, and orthopedists who own their own magnetic resonance imaging (MRI) centers. Whereas in hospital settings, radiologists do the majority of the imaging, studies report that depending on the procedure in question, 60% to 90% of nonhospital radiography and sonography result from nonphysician self-referral [1].

Nonradiologists who perform their own imaging defend the practice by claiming that there is an increase in the efficiency of treatment and convenience to patients. However, radiologists, hospitals, third-party payers, and patients all lose from this practice, because self-referral leads to decreased quality and less accurate interpretations [2]. A lack of education pertaining to radiobiology and radiation protection also results in higher radiation doses to patients. Both in-office self-referral and referral to outside imaging centers in which referring physicians have financial interests are more likely to result in excessive or inappropriate examinations because of powerful financial incentives. One study demonstrated clearly that nonradiologist physicians who self-referred patients for imaging studies using their own equipment did so 4 times more frequently than radiologist-referring physicians. The same study showed that the self-referring physicians regularly charged significantly more than the radiologists for similar exams [3]. The General Accounting Office of the United States, in testimony to the Committee on Ways and Means of the House of Representatives in the spring of 1993, stated that physician owners of diagnostic imaging facilities in Florida had significantly higher referral rates for all types of imaging services than nonowners, particularly for the most costly studies, such as MRI and computed tomography [4]. This propensity for abuse places a fiscal strain on a health care system already under pressure, which results in increased premiums for consumers and employers. Self-referral also tends to lure the more lucrative patients away from hospitals, depriving hospitals of funds they could use to offer other valuable services to the community.

EFFORTS TO CURB SELF-REFERRAL

Self-referral has been addressed in Congress, with partial success. The 1972 Medicare-Medicaid Antikickback Statute was the first broad attempt to prevent any payments, in cash or in kind, that might knowingly influence the provision of services to patients under physicians' enrollment. If such intent was proved, criminal as well as financial penalties could be levied.

The years 1990 and 1995 saw the acceptance of the first and second Stark laws (named for their progenitor, Representative Fortney Stark) which prohibited payment for particular services to Medicare and Medicaid patients when the referring and providing parties were related financially. The first legislation—so-called Stark I—was limited to clinical laboratory services. Stark II expanded the domain of this civil prohibition to 10 "designated health services," of which radiology and radiation therapy were included. Thus, Stark II limited the ability of nonradiologist physicians to self-refer

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radiological services involving Medicare and Medicaid patients to freestanding facilities, although it still allowed for in-office self-referral. Unfortunately, the Stark laws do not apply to non-Medicare and non-Medicaid patients. Thus, the practice of self-referral persists in both forms despite extensive research demonstrating the societal problems caused by self-referral and considerable political effort, largely by the ACR, to terminate it.

The ACR and the Radiology Advocacy Alliance Political Action Committee have been committed to raising concern about self-referral in state legislatures and on Capitol Hill. However, the Republican-chaired Ways and Means Committee, which shares responsibility for health care legislation, is opposed to further restrictions involving self-referral. Therefore, help is required from ACR members to further monitor and curb these practices through their advocacy to government and third-party payers.

In an attempt to curb self-referral practices, some private payers have initiated their own utilization review models. By restricting imaging privileges and reimbursements to nonradiologist physicians, Moskowitz *et al.* [2] demonstrated that costs could be diminished while maintaining high quality. In that study, the significant reductions in the number of studies obtained after the imposition of the guidelines restricting reimbursement to only the technical component demonstrated the powerful influence of financial incentives in self-referral. In addition, significant deficiencies were found in terms of image quality and machine maintenance. Many nonradiologist physicians gave up performing radiological studies as a result of reluctance to pay for improvements.

To endure, radiology requires a unified message on this issue into the distant future—the time when today's residents will be our specialty's political leaders. This can only continue if more residents engage the ACR and support it with our time, effort, and research, providing hard data on the ill effects of physician self-referral. Also, we can encourage insurance payers to continue conducting their own utilization reviews, looking at who is ordering tests and how much extra cost they incur as a result. We residents are entering a complex world of health care, where malpractice litigation is rampant, million-dollar lawsuits are becoming the norm, and turf wars predominate. To survive, we must evolve. To excel, we must offer a superior product by tailoring our enlarging arsenal of available technology to the projected needs of the patients we serve. If we fail to respond to this crisis, and nonradiologist physicians' self-referral practices continue, we face the prospect of seeing our specialty fragment and ultimately disintegrate.

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