The Maryland Self-Referral Law: History and Implications

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Many previous studies have shown that nonradiologist physicians who can refer advanced MRI and CT examinations to themselves or within their practices use these modalities at a much higher rate than those who refer their examinations to unaffiliated radiology facilities. This led Maryland to pass a unique self-referral law in 1993 to directly address self-referred advanced imaging. The authors discuss the politics and economics of self-referral and provide a comprehensive review of the creation, progression, and impact of this landmark law.

Key Words: Self-referral, Maryland, advanced imaging, US health care, Stark

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INTRODUCTION

Over the past 3 decades in the United States, health care practices outside of radiology have purchased and operated imaging equipment to self-refer their patients' imaging examinations [1]. Before this, these nonradiology practices referred imaging to unaffiliated radiology facilities that could afford to perform and interpret the examinations [2]. Once equipment ownership became feasible for nonradiologists, proponents of self-referral claimed that performing in-office imaging with a radiologist's interpretation expedited and enhanced patient care [3]. However, in the 1990s, research found that such self-referrals caused excessively high rates of imaging with no improvement in patient care [3,4]. Because self-referring practices billed technical imaging fees through owning and operating equipment, lawmakers felt that these practices had a financial incentive to image patients that was not present when practices referred to unaffiliated radiology facilities [4,5]. Thus, in 1993 the federal Stark Law was expanded, and unique legislation was passed in Maryland to prevent financially driven imaging self-referral [6-8]. However, only the Maryland law provided adequate regulation of self-referral.

The federal Stark Law, 42 USC § 1395nn, was expanded to regulate physician imaging self-referral within Medicare and Medicaid to self- or family-owned imaging equipment [7]. Unfortunately, it provided a problematic exception for the self-referral of in-office ancillary imaging [8]. This exception was intended to permit cost-effective radiography and sonography in physician offices, but no wording or interpretation of the law explicitly limited ancillary services to these modalities [8]. Thus, when expensive advanced imaging equipment, including MRI and CT, became more affordable, practices purchased and operated in-office MRI and CT scanners and claimed their use as ancillary under this exception [7,8].

US lawmakers did not anticipate this within the Stark law, and as a result, from 2004 to 2010 self-referred MRI studies billed to Medicare increased by 80%, compared with a 12% increase in non-self-referred studies [9]. In fact, in 2006 self-referral increased the total cost of imaging by $3.6 billion [10]. Furthermore, in 2007 even after the Deficit Reduction Act reduced technical reimbursement for advanced imaging, self-referring nonradiology practices continued to increase their MRI and CT volumes, while volume in radiology groups declined [11]. In 2010 alone, Medicare spent $109 million on 400,000 self-referred MRI studies that would not have occurred in a non-self-referral setting [9].

Fortunately, Maryland insurers noticed high volumes of expensive self-referred MRI and CT imaging early in 1993 [12,13]. The Maryland General Assembly recognized the financial hazard this posed and chose to pass a unique self-referral law in 1993 that resembled the federal Stark Law, but additionally regulated self-referrals to all local insurers and explicitly excluded costly advanced imaging from in-office ancillary services [14,15]. The state's attorney general (AG) at the time

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stated that the law counteracts over-utilization from physicians referring to facilities in which they themselves are invested [16]. This law was the first of its kind and drastically affected imaging within Maryland [17]. However, its enforcement by the Maryland Board of Physicians and within the court system did not begin until 2004, after complaints were made against self-referring practices [18]. This triggered an intricate judicial and legislative battle in Maryland that is reviewed in this paper, beginning with the creation of the law.

CREATION OF THE 1993 MARYLAND SELF-REFERRAL LAW

The law was first sponsored by Delegate Ronald A. Guns in 1992 as House Bill (HB) 1347. It was drafted in reaction to national organizations' promoting imaging self-referral and a local increase in self-referred MRI studies billed to third-party payers [16,19]. The bill was assigned to the Senate Economic and Environmental Affairs Committee and the House Environmental Matters Committee for review [19]. To convince the committees of the bill's benefit, Delegate Guns presented data from studies showing that 38% of MRI scans prescribed by self-referring physicians in 1992 were medically inappropriate, that self-referring Maryland providers ordered an excessive volume of expensive imaging, and that self-referring physicians increased patient referrals by 13-45% compared with non-self-referring physicians [12,15,16,19]. Despite this evidence, HB 1347 did not receive committee support and was not passed [15,16,19].

Delegate Guns proposed the same legislation again in 1993 as HB 1280 and received significant support from Senator Paula Hollinger, who felt that the expensive cost of owning MRI and CT technology would create an inherent financial incentive for physicians to self-refer in high volumes [16,19]. With strong backing from the senator, the committees favored the bill with the Senate Committee stating that and stated that

> …various studies have concluded that self-referrals contribute to higher health care costs and unnecessary utilization of services. The bill is intended to eliminate the incentive for a health care provider to make referrals to a health care facility out of financial self-interest rather than for the benefit of the patient. [16]

With this support, HB 1280 was enacted as Chapter 376 of the 1993 Laws of Maryland under Health Occupations Article sections 1-301 to 1-306 [16,19].

ARCHITECTURE OF HEALTH OCCUPATIONS ARTICLE SECTIONS 1-301 TO 1-306

The law was drafted with 6 sections, 1-301 to 1-306, that define terms, illegal self-referral patterns, permitted exceptions, disclosure of ownership, and punishment [20]. Section 1-302 is the crux of the law and prohibits health care providers from making patient referrals for services at self- or family-owned health care entities and billing those services to any insurer or payer [15,16,20]. Within this section, intricate cross-referral patterns and self-referrals that occur unknowingly were also listed as prohibited, preventing practices in Maryland from hiding or claiming no knowledge of their referral patterns when accused [15,20]. However, what made the law noteworthy for imaging self-referral was not the prohibition [17,20]. It was the unique definition of in-office ancillary services in section 1-301(k) and the subsequent exceptions associated with this definition in section 1-302(d) that barred the excessive use of expensive self-referred advanced imaging [15,16,19,20]. The definition of ancillary services was written as follows [20]:

> Basic health care services and tests routinely performed in the office of one or more health care practitioners. Except for a radiologist group practice or an office consisting solely of one or more radiologists, "in-office ancillary services" does not include: Magnetic resonance imaging services; Radiation therapy services; or Computer tomography scan services.

This wording has prevented nonradiology physicians from claiming MRI, CT, and radiation therapy services performed on self-owned equipment as necessary "in-office ancillary services" [15]. It was incorporated because of Delegate Guns's economic data on local self-referred advanced imaging and was opposed by nonradiology lobbyists in Maryland because it closed the billing loophole that existed in the 1993 federal Stark law [16,19]. As a result, when the permitted in-office ancillary exception was outlined as exception 4 in section 1-302(d), only basic radiography and sonography directly performed and billed by a referring practitioner, a supervised employee of the practitioner, or a member of the practitioner's group qualified for the exception [16,19]. This effectively limited in-office self-referred imaging to the cost-effective modalities it was intended for and prevented the excessive use of expensive advanced imaging. Furthermore, section 1-302(d) also required that all ancillary services occurred in the same building as the referring practice, ensuring that they actually expedited patient care [20].

Overall, 11 exceptions were written by the legislators with 2 other noteworthy exceptions, including exception 2 for self-referral within a group practice and exception 3 for self-referred services performed under the direct supervision of the referring physician, that were also fortified against advanced imaging self-referral by the unique definition of in-office ancillary services. Furthermore, sections 1-303 to 1-304 have mandated that all providers that qualify for any of these exceptions provide their patients and payers with written and verbal disclosure of their beneficial interests, along with a permanent in-office display [20]. Also, these sections have required that facilities that operate MRI and CT