Turf Wars In Radiology: Recent Actions Against Self-Referral by State Governments, Commercial Payers, and Medicare—Hope Is on the Horizon

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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.

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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

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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 thereupon 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