



Diagnostic Imaging.

Imaging likely to feel effects of MedPac Stark laws plans

By Daniel F. Gottlieb, Esq. | May 25, 2010

In response to a dramatic increase in the volume and cost of diagnostic imaging and other ancillary services furnished to Medicare patients in referring physicians' offices, the Medicare Patient Advisory Commission is considering ways to rein in both. MedPac, which advises Congress on Medicare payment issues, is looking at a menu of changes to the Stark laws' in-office ancillary services exception (in-office exception) and certain physician payment reforms. While MedPac can only recommend, not enact, changes, its recommendations typically receive serious consideration from Congress and the Centers for Medicare and Medicaid Services and often become law.

If Congress or CMS were to adopt the more far-reaching changes to the in-office exception under consideration, it could determine whether Medicare patients receive imaging from radiologist-only practices, multispecialty physician groups, hospitals, or free-standing imaging centers. In addition, for manufacturers, the changes could reduce the size of the market for MR, CT, and PET imaging equipment by making it illegal, less profitable, and/or more difficult for physician groups other than radiologist-only groups to use the equipment to provide services to Medicare patients and other patients subject to states' "mini Stark laws."

The following section briefly summarizes the Stark laws' self-referral prohibition and the in-office exception. Section II discusses the reforms being considered to address the self-referral of imaging and other diagnostic services. Section III summarizes the next steps for MedPac's exploration of the in-office exception.

IN-OFFICE EXCEPTION

Unless an exception applies, the Stark laws prohibit a physician from referring a patient for "designated health services," including radiology and certain other imaging services covered by Medicare, to a physician group or other entity with which the physician has an ownership or compensation relationship. A request by a radiologist for an imaging service does not constitute a referral if the service is furnished as a consultation requested by another physician and is furnished by (or under the supervision of) either the radiologist, a physician employed by the same practice as the radiologist, or a physician who contracts with the radiologist's practice to furnish or supervise such procedures while onsite at the practice's facilities.

The in-office exception allows owners and employees of a medical practice that qualifies as a “group practice” under the Stark laws to refer Medicare patients for imaging services it provides. The group practice requirements are intended to assure that the medical practice is clinically, financially, and operationally integrated and not merely a loose affiliation of physicians who share profits from referrals.

Among the requirements are that 75% of the patient care services of the practice be provided by owners or employees of the group and that each owner or employee referring Medicare patients to the group for designated health services provides at least 75% of his/her patient care services through the group. The group practice definition also prohibits a group from compensating its members in any manner that directly takes into account the volume or value of their Medicare patient referrals.

If the group satisfies the group practice requirements, its physicians’ in-group Medicare patient referrals for designated health services must then satisfy the performance/supervision, location, and billing tests of the in-office exception. The performance/supervision test requires the designated health services to be furnished personally by one of the following individuals: the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual who is supervised by the referring physician or another physician in the group practice. The location test generally requires designated health services to be provided either in the same location where the group provides medical services or a centralized location owned or leased on a 24/7 basis for the provision of such services. The billing test requires the designated health services to be billed by the group practice or the physician performing or supervising the service.

DIAGNOSTIC IMAGING AND LABORATORY TESTS

MedPac is considering the following options to address studies indicating that referring physicians who own their own imaging equipment on average order more diagnostic imaging than other physicians.

Exclusion from in-office exception

MedPac is considering a recommendation that radiology and other imaging services be excluded from the in-office exception unless they are usually provided on the same day as an office visit or do not require advance scheduling and preparation by the patient. Under the first variation of this option, CMS would need to identify which imaging services are usually provided on the same day and thus would be permissible under the in-office exception. Ariel Winter, a MedPac analyst, said at the January MedPac meeting that Medicare data show, for example, that plain x-rays are furnished on the same day as an office visit more than 50% of the time while nuclear medicine tests and MRI procedures are furnished on the same day only 8% of the time.

Exclusion unless clinical integration

Another option is to prohibit self-referral for imaging under the in-office exception unless the group practice meets new, more demanding clinical integration requirements. MedPac would need to define the clinical integration requirements. Winter indicated, as an example, that each physician in the group could be required to provide a substantial share (e.g., 75%) of his/her services through the group. The substantial share requirement would be similar to the existing Stark group practice requirement that all owners and employees of the group making designated health services referrals provide 75% of their patient care services through the group practice. But it would also apply to independent contractor physicians hired to supervise designated health services. Thus, an orthopedic surgery practice could not engage a radiologist on a part-time basis to supervise MRI procedures.

Reduction of payment rates for self-referred tests

MedPac could recommend that CMS reduce payment rates under the Medicare physician fee schedule for self-referred imaging services. This proposal responds to studies by MedPac and the Office of the

Inspector General of the U.S. Department of Health and Human Services indicating that patients of referring physicians who own imaging equipment receive significantly more tests, on average. If this option is chosen, it would be necessary to determine the size of the payment reduction and whether it would apply to all diagnostic tests or only a subset, such as advanced imaging that is not typically performed on the same day as an office visit.

Payment policy changes

MedPac is also considering addressing self-referral for imaging and other diagnostic tests through payment policy changes and efforts to assure that Medicare payments accurately reflect costs. At its January and March meetings, MedPac discussed the option of bundling reimbursement for imaging with reimbursement for other items and services that are part of an episode of care. For example, reimbursement for a patient visit for a knee injury and an x-ray of the knee could be a single payment.

Preauthorization requirement for high utilizers

At the March MedPac meeting, one commissioner suggested that the Medicare administrative contractors could flag physicians who are high utilizers of advanced diagnostic imaging and require them to obtain preauthorization from the contractors for such tests. Theoretically, this approach would identify outlier physicians who appear to be ordering medically unnecessary diagnostic tests without burdening physicians who appear to be following practice norms.

MEDPAC'S NEXT STEPS

MedPac is expected to issue a report in June fine-tuning its ongoing analysis of the menu of options for addressing perceived overutilization of diagnostic imaging and other ancillary services by referring physician groups, but without a recommendation to adopt any particular approach. A MedPac report later in the year may include a specific recommendation that Congress or CMS adopt a particular approach in order to rein in Medicare spending. This timing makes it unlikely that Congress or CMS would implement any recommendation prior to 2012 at the earliest. Based on the public discussions at recent MedPac meetings, it appears that the commissioners may be leaning toward an incremental approach to this issue out of a desire to balance patient convenience and the benefits of integrated care with the goals of preventing overutilization and skewed clinical decision-making.

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