

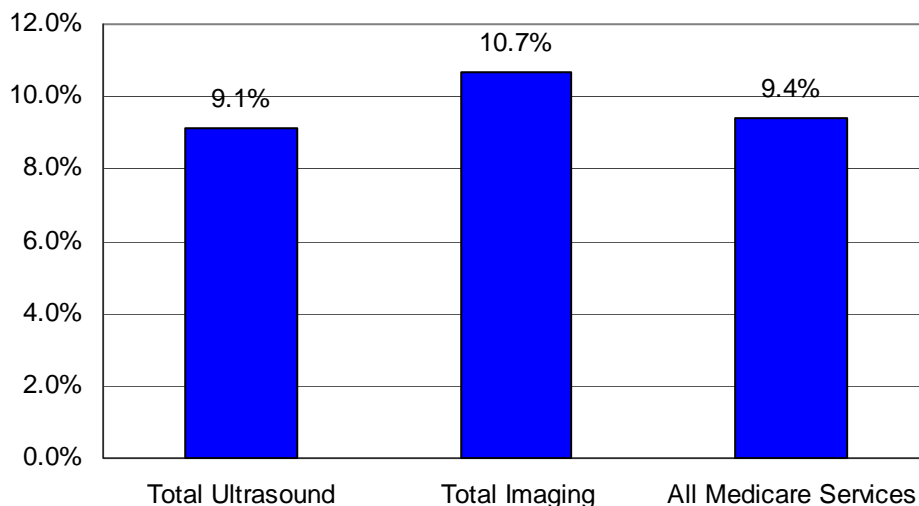


Talking Points: Physician Self-Referral

According to a March 2005 Study Conducted by the Lewin Group:

- Estimates of the costs associated with the self-referral of imaging services are likely overstated, based on evidence that indicates physicians with access to imaging equipment and no financial interest use imaging services more often than referring physicians.
- There are important benefits from physicians being able to self-refer for imaging services, such as more timely access to study findings and better patient compliance. These benefits are hard to quantify and have not been studied at length. Nevertheless, they represent important benefits that should be considered in any policy discussion on the delivery of imaging services.
- Referring a patient to a radiologist may add medical costs, because it requires an additional visit to the radiologist to take and interpret the image and permits higher billing from the referring physician for the follow-up evaluation and management service.
- Self-referral is not the key driver of growth in imaging services; fast-growing radiology dominated imaging services account for 31 percent of imaging services and 41 percent of the growth in imaging

What is the true growth in the volume of imaging services? The Lewin Group study has shown that the growth in diagnostic imaging is very close to growth in all Medicare Part B services for the 2001-2003 period. Ultrasound imaging has been increasing at a slower pace than all Medicare Part B



services.

**Source: The Lewin Group's Analysis of the Medicare Physician/Supplier Master Summary File. All imaging includes BETOS categories I1A-I4B. Total ultrasound includes BETOS I3A-I3F; total imaging includes Betos I1A-I4B.*

Self-Referral (Stark) Law's In-office Ancillary Service exception: Some radiology groups have suggested that the most effective way to curb office based imaging services is to eliminate the statutory provision within the Stark II self-referral law that expressly permits it. However, elimination of the Stark II in-office ancillary services exception will dramatically affect the manner in which multi-specialty medical groups' function. While other Stark II exceptions may be utilized by medical groups, such as the employee or prepaid plan exceptions, it is unlikely that a majority of medical groups' physician compensation arrangements fall completely within these exceptions. Consequently, retention of the in-office ancillary exception is critical for a majority of medical groups to continue to legally operate.

The in-office ancillary services exception permits medical group physicians to refer their patients for ancillary services provided within the medical group. These services include **all** designated health services as delineated in the Stark statute, not just imaging services. Moreover, this exception permits medical group physicians to refer patients to each other. Consequently, elimination of this exception would prohibit a primary care physician in a medical group from referring a patient with a prostate condition to the group's urology department. Additionally, elimination of the exception would prohibit the same urologist from referring that patient for imaging services within the medical group.

Eliminating this exception, as advocated by radiology groups, would make medical groups' focus on care coordination, team building, practice integration, etc, effectively moot. Such a result contradicts the Institute of Medicine's conclusions in its 2001 *Crossing the Quality Chasm* report that stressed these factors and others as means to creating a new health system for the 21st century.

Other Points

The use of ultrasound in direct patient care outside of an imaging laboratory:

- decreases the time required to make an accurate diagnosis;
- enhances access to treatment;
- improves the clinician's ability to make an accurate diagnosis;
- reduces invasive procedures; and
- results in efficiencies for the health care system.