

Examining Self-Referrals

A no-fault approach to curbing abuse

FOR THE PAST 20 YEARS, many studies concerning the role of self-referral in medical imaging have demonstrated that physicians who have an ownership interest in imaging equipment order or perform more examinations than physicians who refer patients to an independent imaging facility. Concerns over self-referral have centered on the obvious financial considerations.

Radiologists see self-referral as a diversion of patients and fees to other physicians and as a poaching of their field of expertise.

Non-radiologists see self-referral as a means of making quicker diagnoses, and bridle at suggestions they are augmenting income in an era of declining fees. Payers, including governments, see self-referral as contributing to the increasing number of exams performed and as a major source of avoidable medical expenses.

These are all legitimate issues. But there are other concerns that deserve attention. For instance, is the quality of self-referred imaging studies and interpretations up to the standards demanded of radiologists? In my career as a practicing radiologist and chief medical officer of two radiology benefit management (RBM) companies, I have dealt with these issues for most of my professional life.

To date, most attempts to deal with these issues have involved state and federal legislation aimed at the financial incentives clinicians face when they derive fees through using purchased or leased equipment. Such attempts have been viewed as insulting to the professional ethics of physicians.

Payers have two other effective pathways to address the issue of inappropriate self-referrals. Both approaches remove implications that greed is the motivation for self-referral, and both focus on ensuring the quality and appropriateness of diagnostic imaging procedures. The



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adoption of privileging – limiting who is eligible to be paid to perform certain exams – and prior authorization – limiting clinical situations in which exams may be eligible for payment – can reduce waste without provoking turmoil in physician networks and turf wars among specialties. These tools are deployed by RBMs and some health plans, and both measures have proven effective in decreasing inappropriate utilization.

Privileging. Realizing that self-referral is more than just a volume-related issue and

that there are quality and convenience factors to be considered, some health plans and RBMs restrict exams they will pay for to providers meeting certain standards. Recognizing differing needs and capabilities specific to medical or surgical specialties and establishing standards based on the training and equipment needed for specific studies, these programs attempt to limit self-referred exams by focusing on quality issues.

This process requires balancing factors for each exam and specialty. These factors include the scope of residency or fellowship imaging training for each specialty; the availability of expertise among local or regional radiologists; the type and availability of specialized personnel and equipment that may be necessary for each exam; and the extent to which care may be delayed or inconvenienced by requiring out-referral.

Non-radiologists argue that they offer patient convenience, enhanced by real-time access to diagnostic information, and are competent to interpret problems and provide cost savings. Radiologists counter that they can offer rapid turnaround and cost savings, have access to superior technology, and possess training that goes beyond the problem being investigated.

Establishing privileging limitations can only follow

focused and transparent examination of each procedure. Even after careful processes, health plans will be faced with resistance from specialty organizations and people, especially those who have invested in imaging equipment that they may no longer be paid to use. Or these groups may be required to make costly equipment upgrades.

For example, consider pelvic sonography performed by gynecologists. It is counterproductive to limit an obstetrician's ability to perform pelvic and obstetrical ultrasound exams. These tasks are part of the process required to complete many office visits, and interpretations are part of their training. Beyond a basic ultrasound device, no specialized equipment is required and, in the absence of a registered sonographer, the exam can be performed by the physician. On the other hand, there are fewer persuasive arguments for permitting obstetricians to perform breast or abdominal ultrasound exams for which they may not have been adequately trained. These exams may require broader, more specialized expertise from a sonographer and interpreter.

In a similar fashion, lists of permissible self-referred and performed exams can be created for each medical or surgical specialty. Experience has shown that privileging can lead to a significant reduction in imaging volume without limiting availability, and possibly enhance the quality of care.

Prior authorization. While not a tool directed at combating self-referral, prior authorization might be the most effective option available. By requiring that all covered exams have sufficient clinical indications that are presented to an outside and presumably neutral reviewer, prior authorization imposes a speed bump on the road to obtaining an imaging exam. Several positive things occur when a well-founded, evidence-based prior authorization program is imposed.

First, referrers must organize their requests for imaging authorization in an accessible and logical fashion. A scribbled "MRI head" prescription is not sufficient to set in motion a process that expends several hundred dollars of someone else's money. A referrer has to balance the effort required to obtain prior authorization, and the possible negative consequences of being found to order too large a proportion of inadequately indicated

exams against the diagnostic value.

It should be noted that this step should take place under any circumstances. The circumspection in ordering that is fostered by the process has been shown to lead to actual reductions in the number of exams requested. This "sentinel effect" is a productive utilization management tool.

Second, the process can expose referring physicians to criteria and guidelines for imaging, which should be based on the best available evidence for using imaging procedures. With the rapid evolution of the field, this information may not be readily available. Many clinicians' decisions on imaging are influenced by what amounts to radiologist self-referral in the form of reports heavy with recommendations for further tests. The prior authorization process brings some control to this potential misuse of imaging by inserting objectivity into the process.

In addition, all rejection requests represent a two-direction educational opportunity. Most obvious is the chance for the RBM to bring additional information to the referring physician to explain why the requested study did not meet the appropriate criteria. This information can come in the form of a written explanation or by direct conversation between the referrer and the physician reviewer at the RBM. When this interaction takes place, the referrer can impart information to the RBM that may cause the criteria to be modified.

While legislative limitations may be necessary to define the marketplace for imaging, it is likely that lobbying and law tactics will find ways to meet legal requirements and preserve a significant ability of non-radiologists to refer imaging studies to themselves. All self-referral programs shouldn't be treated as abusive. However, the best way to curb the potential for abuse is to concentrate on the clinical aspects of how and why exams are performed.

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