PHYSICIAN SELF-REFERRAL: An Old Problem Becomes Even More Pervasive

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Physician Self-Referral

- Two types: In Office and Joint Ventures
- In-Office: Physician orders a test or diagnostic procedure for a patient that is performed in the physician’s office or group practice.
- Definition of in-office is vast and includes lease agreements and payment per click arrangements.
- Joint Ventures: Physician ownership of freestanding health care facilities to which he/she refers patients but which he/she may or may not directly provide services.
Self-Referral in the Early 1990s

- Physician joint ventures were becoming widespread. Many policymakers viewed these as kickbacks for referrals.
- Ineffective enforcement of the anti-kickback statute.
- Congressman Pete Stark introduced his legislation by noting that what is needed is a bright line to give providers and physicians clear guidance about what types of arrangements are permissible.
Empirical Evidence

Studies from the late 1980s and early 1990s examined an array of health care services and entities.

Consistent findings show that self-referral:
1) increases utilization, 2) higher reimbursements per case; 3) limits access for uninsured and underinsured, 4) impinges on competition in the marketplace, 5) mixed effects on quality.
Subsequent Legislation

- Legislation enacted by the federal government during the mid 1990s prohibits physicians from referring Medicare and Medicaid patients to health care entities in which they hold an ownership interest (Stark II).

- About half the states enacted similar laws that apply to all patients regardless of type of insurance coverage.
Concerns about Self-Referral Laws

- Some state prohibitions directly parallel the federal statute, while others are much more limited in scope.
- While these laws have had some impact on mitigating the problems with self-referral arrangements, loopholes have limited their effectiveness in curbing this practice.
LOOPHOLE 1

- Federal prohibition only applies to Medicare and Medicaid patients
- If a physician practices in a state that has no state self-referral law, the physician can refer privately insured patients to health care facilities in which he/she has an investment interest.
LOOPHOLE 2

- Federal prohibition exempts certain types of facilities--ASCs and until recently “whole” hospitals.
- Ambulatory surgery centers were exempt because they were regarded as an extension of physician’s practice.
- The “whole” hospital exception was eliminated with the enactment of the Affordable Care Act in March 2010. However, existing physician-owned hospitals were grandfathered and thus continue to operate but under restrictions.
LOOPHOLE 3: The In-Office Ancillary Services (IOAS) Exception

- This provision in the federal law permits physicians and group practices to provide most “designated health services” such as diagnostic imaging, radiation therapy, physical therapy within their offices under certain conditions.

- This exception has resulted in new forms of referral arrangements for “designated health services” that were designed to take advantage of the exception.
The In-Office Ancillary Services Exception in the Stark Law

- Primary justification for the IOAS exception was patient convenience: to enable physicians to provide simple x-rays or lab tests that could be performed as part of the office visit.

- Group practice component was designed to exclude from the prohibition large multispecialty groups such as the Cleveland clinic where physicians are paid a salary.
The In-Office Ancillary Services Exception in the Stark Law

- The presumption was that referring physicians who belong to large multispecialty practices would not derive substantial economic benefits from making referrals to other members of the group.

- In response to declining or stagnant reimbursement rates throughout the last decade, many referring physicians have incorporated ancillary services into their practices.
Evidence on New Types of Self-Referral Arrangements

- In a study published in *Health Affairs* in April 2007, Mitchell analyzed data from a large private insurer in California to identify the self-referral status of providers who billed for advanced imaging in 2004 to document the extent of such referral arrangements tailored to meet the IOAS.

- Evidence shows that many referring physicians who bill private insurers for advanced imaging are in lease agreement or payment per click arrangements.
Almost 61% of non-radiologist physician providers who submitted bills for MRIs did not own the equipment, nor was it located on site.

Nearly 64% of self-referral CT providers billed the insurer but had either a lease agreement or payment per click arrangement.

In contrast, 70% of self-referral PET providers had the equipment on site.

The MRI and CT findings raise concerns about quality of advanced imaging provided under lease or payment per click agreements.
Recent Evidence on Self-Referral and the IOAS Exception

- Nearly all recent research has focused on advanced imaging.
- Consensus of the findings: self-referral results in increased frequency of use of advanced imaging and higher costs per episode of care in comparison to situations where patients are referred to independent radiologists to undergo the procedure.
Recent Evidence on Same Day Office Visit and Advanced Imaging

- Patient convenience is touted as the primary justification for the IOAS exception.
- Recent evidence refutes this argument.
- Sunshine & Bhargavan (2010)—Medicare claims for 2006-2007 and found only 15% of advanced imaging is performed on same day as office visit.
- MedPAC’s analysis of 2008 claims revealed that only 10% of advanced imaging occurred on the same day as the office visit.
Dearth of Evidence on Self-Referral and other Ancillary Services

- No recent research has examined the consequences of self-referral on use of services other than diagnostic imaging.
- Three designated health services of particular concern: physical therapy, anatomic pathology and radiation therapy.
Self-Referral: Implications for Physical Therapy

- Physical therapy treatments are billed under the physician fee schedule; physical therapists do not have a separate fee schedule.

- This raises concerns about quality because physicians can bill Medicare/private insurers for physical therapy treatments although PT services might be performed by an unlicensed medical assistant.
Self-Referral: Implications for Physical Therapy

- Empirical evidence from my work on Florida found that physician-owned PT/rehab facilities employed relatively few licensed PTs and PT assistants in comparison to centers owned by PTs.

- Some PTs are employees of physicians and bill under their own provider number; this makes it difficult to correctly identify self-referral and non self-referral physicians.
Self-Referral: Implications for Anatomic Pathology Services

Anecdotal evidence published in *Laboratory Economics*, a trade industry newsletter, reports that self-referral arrangements for anatomic pathology services involving urologists, gastroenterologists or dermatologists have proliferated in recent years.
Self-Referral: Implications for Anatomic Pathology Services

- Contrary to simple lab tests, anatomic pathology services are reimbursed under the Medicare Physician Fee Schedule.

- Each surgical pathology service has a technical component (payment for slide preparation) and professional component (payment for the pathologist’s examination & interpretation of tissue specimens).
Self-Referral: Implications for Anatomic Pathology Services

- Medicare’s and private insurer’s reimbursement for surgical pathology services is based on the number of jars submitted containing tissue specimens.
- Physicians who engage in the practice of self-referral for surgical pathology services have financial incentives to extract more tissue specimens and bill Medicare for an increased number of jars in comparison to physicians not involved in self-referral.
Self-Referral and Anatomic Pathology: Dearth of Evidence

- In 2007, the OIG of HHS published findings from audits of 3 urology practices.
- Results show that self-referral is linked to significantly higher use of surgical pathology services.
- Urology Tyler requested 4 surgical pathology specimens before they began insourcing pathology; afterwards they billed Medicare for 12 pathology specimens per prostate biopsy.
Prostate Cancer Treatment Options

- Active Surveillance
- Prostatectomy, da Vinci robotic surgery
- Low-dose rate (LDR) brachytherapy
- Intensity modulated radiation therapy
- Reimbursement varies substantially across the treatment modalities; IMRT has the highest reimbursement
Suppose a group practice of urologists hires a radiation oncologist to develop and monitor radiation therapy treatments for cancer patients seen by its physician members.

Each urologist has the financial incentive to refer all of his/her patients to the radiation oncologist who is either a member or employee of the urology group practice.

The radiation oncologist develops the treatment regimen for each referred cancer patient.
In-Office Ancillary Services Exception & Radiation Therapy

- Alternatively, each urologist could refer his/her cancer patients to an independently practicing radiation oncologist and avoid the conflict of interest inherent in self-referral arrangements.
- By doing so however, the urology group practice would forgo the additional revenues generated from billing Medicare/private insurers for all IMRT performed at a radiation center they own.
CONCLUSIONS

- Self-referral prohibitions enacted during the 1990s have exceptions, or loopholes, that have been exploited and thus have enabled the practice of self-referral to thrive.
- The most notable is the IOAS exception; growth in Medicare and private insurance expenditures on services that qualify under the IOAS have been substantial.