RADIOLOGY REIMBURSEMENT DECLINES DON’T NEED TO BE INEVITABLE
Radiologists are well acquainted with ongoing changes in coding and reimbursement rates, which have had the cumulative effect of reducing reimbursement for radiology services. The fundamental changes driving the lower reimbursement (reflected in last year’s Affordable Care Act, the latest Medicare Fee Schedule and other industry regulations) are beyond the control of any one practice. Code bundling, RVU changes and reimbursement rates are in the hands of the government and insurance companies, despite strong efforts by the ACR, RBMA and others to advocate for the radiology industry.

An analysis of year-over-year trends across all of our radiology clients shows that 2009, despite a weak economy, saw reimbursement increase by an average of 4 percent. In contrast, 2010 saw total reimbursement decrease by 6 percent. This trend continued in the first quarter of 2011 with an additional 7 percent decline.

However, these reimbursement trends can hide a key factor affecting reimbursement which practices may be able to influence.

The same trend analysis of our radiology clients shows that 2009, despite the weak economy, had procedure volume increase by an average of 5 percent. In contrast, 2010 showed procedure volumes declining at 3 percent. First quarter 2011 data indicate that procedure volumes declined by an additional 3 percent, 1 percent if adjusted for the combined abdomen/pelvis codes effective on January 1.

According to a recent study conducted by The Moran Company, released in February by the Access to Medical Imaging Coalition (AMIC), the volume of advanced imaging services delivered...
to Medicare beneficiaries decreased in 2009 for the first time in 11 years, potentially signaling the end of the era of rapid growth in medical imaging volume. Their study concluded that advanced imaging volume decreased by 0.1 percent and the amount of overall imaging services declined by 7.1%.¹

These trends represent a "sea change" for radiology practices used to a steady increase in volume: a sudden decrease is not only unfamiliar; it can wreak havoc with compensation models and other pillars of practice operations.

However, there is another way to look at practice volume: it is a factor that may be in your control more than is often realized.

Why have radiology services declined over the last year or two and are there ways to improve radiology volume and thereby revenue? Our experience suggests at least four places to look:

• Are you the radiology practice of choice for referring physicians?
• Are you the radiology practice of choice for referring patients?
• Has your practice lost business by farming out night and weekend call coverage to teleradiology firms?
• Are other providers in your area, such as cardiologists and surgeons, performing more of their own tests in order to streamline and increase their business?

ARE YOU THE RADIOLOGY PRACTICE OF CHOICE FOR REFERRING PHYSICIANS?

Everyone knows that radiologists obtain their business from referring physicians. The January/February 2011 issue of the RBMA Bulletin describes how radiologists should look at their referring physicians as customers and that "your job is to know and understand your customer and what they want, as well as being proactive about fulfilling those needs."²

Whether a practice is hospital-based or an imaging center, there is an opportunity for proactive marketing to referring physicians in your hospital or area. As an example, at MGH in Boston, the radiology department pays for marketing services specifically to welcome new physicians by greeting them with contact and protocol information, as well as a fleece sweatshirt with the MGH radiology department logo on it.³

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New physicians often join the hospital staff at the same time each year. Make sure you have a plan in place to promote your services to them. Watch for announcements of new physicians and medical practices in your community and send them a brochure or, even better, meet with them to introduce your services. Most fundamentally, recognize that referring physicians have more choices every day.

Along with marketing to referring physicians for new business, it is important to keep your referring base as loyal customers. In fact, loyal referring physicians are your best source for new referrals. One of our clients is encouraging radiologists to provide more verbal feedback to referring physicians, based on the common sense view that regular feedback will encourage regular referrals. Another client remembers the “old days” when a referring physician would walk into the radiology department to look at films with him, because they didn’t want to wait on the report. Now, with reports available quickly and online, that human interaction is lost, contributing to commoditization pressure.

A survey of our clients shows that the vast majority analyze referral patterns on a regular basis, most often monthly. However, relatively few have a formal program for developing and retaining loyal referring physicians though several are considering developing one. Those that do have a program include measures such as website marketing, an open house, lectures, CME credit seminars, and even sponsoring a golf event!

According to Dr. Richard Duszak, an interventional radiologist who is a member of the AMA CPT Editorial Panel and past chair of the Committee on Coding and Nomenclature with the ACR, referring physicians are looking for radiologists who 4:
- Provide quality interpretive reports,
- Are easy to get along with and take the time to educate the physician, and
- Provide the radiology service when it is needed, (including nights and weekends) and provide results in a timely manner.

The images of radiologists are that “We’re in these dark rooms sending electronic messages everywhere and anywhere,” according to Giles Boland, MD, vice chair of radiology at MGH. He suggests that radiologists become part of the clinical team and build trust and rapport with referring physicians by attending case conferences, meeting with the hospital’s chief of service, and making personal calls to referring physicians on pressing cases. 5

Dr. Boland also recommends that a practice standardize the format and style of reports among all of the radiologists. If each radiologist dictates their report in different styles, reading them is less efficient. If the referring physician knows where all the information is on the radiology report, it is easier and faster to read, another customer service advantage.

4 Ibid
5 Ibid
This highlights a step that might be overlooked: promoting the practice only works if all of the fundamentals are sound: quality reports, timely turnaround, ease of access, etc. A survey of referring physicians can be an easy and effective way to test the fundamentals and measure how well your practice is meeting expectations.

Who are the influential referring physician groups in your area and are they sending their patients to you for imaging services? Your RIS or billing company’s system should be able to provide you with information to assess your referring physician base. With this data, you will be able to determine who has been a loyal referrer in the past and who is a loyal referrer now, so that you know who to continue to keep happy and who you need to bring back as a customer.

One of our clients identified a local facility headed by a Nurse Practitioner who was referring studies to a competitor. The head of the practice made a personal call to the Nurse Practitioner and convinced her to try his practice. She did and the studies are now with our client. This level of attention highlights the best way to attract and keep referral business: personal relationships.

For hospital-based groups, taking steps to strengthen the relationship with hospital administration can improve credibility and, over time, lead to more referrals. One of our clients recommends that radiologists “add value by helping to influence utilization through data mining. For various reasons, hospitals want to selectively drive volume in certain areas but not others either because of greater margins, access, etc or because of payer contractual issues. Radiologists can help hospitals get, analyze and act upon this data to identify overutilizing or underutilizing referring physicians and then participate in targeted education. The same data can be mined for radiologist’ productivity and quality. For example, how often does Dr. X recommend MRI in a CT report compared to Dr. Y, or how often Dr. X finds a positive pulmonary embolus compared to Dr. Y. For mammography, the data can show call back rate per radiologist, positive predictive value for biopsies, etc. The goal is to rein in outliers (e.g. excessive call back rates) and set goals for the group as a whole. Data reported back to hospital quality committees can be used for Focused Peer Professional Evaluation (a Joint Commission requirement) and even for contracting better rates.”

ARE YOU THE RADIOLOGY PRACTICE OF CHOICE FOR PATIENTS?  
PATIENT-CENTERED RADIOLOGY: ANOTHER DIMENSION OF MARKETING AND CUSTOMER SERVICE

The internet provides patients with all kinds of medical information. Any ache or pain can be “Googled” creating relief, fear or confusion. Whatever the feeling, many patients are now much more involved in their medical decision making. This holds true when patients are sent for imaging services. Especially when patients fear bad results, they want their imaging results quickly and they do not care whether the results are communicated by radiologists or referring physicians.
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according to a study in the American Journal of Roentgenology, March 2011. This is a great opportunity for radiologists to serve a more integral role in patient care. Quickly learning imaging results from the radiologist not only reduces anxiety but the patient is receiving information from the actual person who read and interpreted the test, the expert. By delivering quick results to the patient, the radiologist is now participating in the decision-making process as an equal partner in the patient’s healthcare, which has been shown to have a positive impact on “health measures and outcomes.”

Communicating the results of imaging procedures, informing patients about available diagnostic imaging options, and providing their test results are ways radiologists can help patients be engaged in their care. Enabling patients to participate in decisions related to the outcome of imaging are important goals of patient-centered radiology. Giving patients a probability of disease before and after imaging can help inform them of their own individual risk.

In a 2010 article abstract, Stephen J. Swensen, MD and C. Daniel Johnson, MD, (Mayo Clinic radiologists and professors of radiology) state that “radiology is a target that cannot survive the forces converging on it unless it can become patient centered.”

Swenson and Johnson suggest that radiology “must respond to patients’ wishes in everything that it delivers, and it must amass the data needed to prove that it does exactly that.” They go on to say this can be accomplished by accommodating the five primary wishes of patients:

1. To be given enough information to make decisions
2. For the correct exams to be ordered
3. For those exams to be performed safely
4. For sound interpretations to be communicated effectively
5. For the prices to be fair

They add that these wishes rely on a shift in values in radiology in which the needs of the patient supersede those of the radiologist, as well as those of the facility and the payer.

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Of the five wishes, reporting the test results is one of the most important areas in need of improvement.9 The radiology staff may know within minutes after a test that a patient has cancer but the patient may have to wait a week to hear the results from his or her physician. This is not good service.

There are several options for practices to speed up the results of radiology testing and to satisfy patients who are anxious to receive and understand their results.

1. The radiologist can speak with the patient after the imaging services, reviewing the results of the test.
2. In practices where patient contact is not possible, a system can be established that informs the referring physician of results on the same day of the test, ideally within a few hours. The radiologist or radiology staff should inform the patient that their referring physician will have the report within a few hours. Emerging technologies that allow referring physicians to access reports via their EMR or on mobile devices may be able to assist radiologists in disseminating results on a timely basis.
3. Make the report available on-line. This is controversial since many patients may not be able to understand the written report or place its content into proper context, which could result in a false understanding of the test(s) results.
4. Set up an email address or chat room where the patient can talk to the radiologist directly.10
5. Re-design the practice business model to make at least one radiologist always available for the primary function of patient interaction.

Although the results of some radiology services are communicated directly to patients, radiologists using CT, MRI and similar technologies rarely talk to or see patients. Communication of results to patients in all areas of radiology will advance the visibility and the role of the radiologist in patient health care twofold; first by creating informed and satisfied patients and second, those patients may then relay their experiences to their primary care physician, your primary referral source.

One of our clients recently saw the benefits of “patient-centric” first hand. A patient presented for an outpatient study with a prescription for a competing imaging center. The director decided to do the study even though it was unlikely they would get paid for it. The patient had such a good experience that they raved about our client to their referring physician. That physician is now a regular referrer.

10 Ibid
On the other hand, respondents to our survey of radiology practices are familiar with the term “patient-centered radiology” but have not made changes to operations or workflow to become more patient-centric.

There are those who say direct communication between radiologist and patient has the potential to increase costs and workload while reducing profits. However, the trend seems to be towards patient-centered radiology in order to prevent the commoditization of imaging services and improve the quality of radiology services. In addition, this personal touch and the attendant outcomes improvements are great marketing tools.

**DOES YOUR PRACTICE DELEGATE NIGHT AND WEEKEND COVERAGE TO TELERADIOLOGY FIRMS?**

The teleradiology industry provides many advantages to radiology practices, such as reducing on-call hours, access to subspecialty expertise, supplemental radiology services and fast turnaround times. However, in an article published in the February 2011 issue of the Journal of the American College of Radiology, David Levin, MD and co-author Vijay Rao, MD of Thomas Jefferson University, argue that farming out night and weekend call coverage to teleradiology firms contributes to the “commoditization of radiology, lowered reimbursement, displacement from hospital and outpatient reading contracts, greater encroachment by other specialties, and lowered quality.”

The discrepancy between nighthawk fees and professional reimbursement may further endanger conventional radiology practices. For example, if a teleradiology group reads an MRI for $55 and payors reimburse it at $70 or $80, payors will begin to ask why they need to pay the higher rate.

Levin and Rao noted that the reason why radiologists should be given exclusive rights to handle most imaging modalities in a hospital is because they have the most training and experience and provide the most complete and best imaging services of all types to patients in that hospital. This argument may lose its credibility when radiologists revoke these responsibilities every night and

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weekend. “If radiologists feel they are a crucial part of the patient care team only during normal business hours, why should other physicians or the hospital administration be willing to grant them exclusivity?” Outsourcing sets a precedent under which radiologists may lose turf battles in the future.

On the other hand, a survey of our radiology clients shows that the majority currently use teleradiology firms for night and/or weekend coverage. The reasons cited include having staff avoid night or weekend call, efficiency, and the ability to recruit (i.e. it is harder to recruit if radiologists will be on call).

In a 2007 session at an RSNA meeting that has caused many articles to be written, Dr. James P. Borgstede stated that a full radiology service should properly include four components:
1. Pre-examination evaluation of the request for appropriateness and necessity
2. Supervising and monitoring the examination to ensure its quality
3. Exam interpretation
4. A post-examination evaluation with the referring physician and perhaps the patient as well

Dr. Borgstede argued that one or more of these elements has disappeared with the use of teleradiology services resulting in radiology service purchasers treating interpretations as an assembly line commodity that they can buy from the lowest cost provider. There is also a belief that the lower fees charged by some teleradiology companies has contributed to government and commercial payors reductions in reimbursement for radiology services.13

Levin & Rao recommend that radiologists cover their own practices 24/7 by considering ideas such as:
- Small radiology groups can consolidate into a single larger group to achieve the advantages of teleradiology.
- Radiology groups can remain separate, but work out a cooperative arrangement to share night and weekend call.
- Private groups could also form creative partnerships with academic radiology departments in their state to cover night and weekend cases as well as provide subspecialty consultations or overreads.

Radiology practices which currently don’t cover their night and weekend business should consider how much business it is and if it is worth a few nights of on-call work to keep their business intact and profitable. A quote from Dr. Borgstede: "The short-term perspective is to have someone take

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night call so I can sleep. The long-term perspective is to have a secure practice so I can sleep at night for the next 20 years.”

Under the direction of Board of Chancellors chairman, John A. Patti, MD, the ACR has developed a Night Coverage Registry, available on its web site, that contains in-practice night coverage models from 320 practices. These models can serve as templates for practices that want to “take back the night.”

ARE OTHER PROVIDERS IN YOUR AREA, SUCH AS CARDIOLOGISTS AND SURGEONS, PERFORMING MORE OF THEIR OWN TESTS?

Research done by David C. Levin, MD, professor of radiology at Thomas Jefferson University in Philadelphia, compared overall Medicare noninvasive medical imaging payments to radiologists and non-radiologist physicians from 1998 to 2008. Part B payments to radiologists grew at 24% per year from $2.56 billion to $4.65 billion. But non-radiologist payments grew from $2.02 billion to $4.81 billion, an average of over 60% per year. As a further example, the GAO found that in 2006 cardiologists obtained 36 percent of their total Medicare revenue from in-office imaging, compared with 23 percent in 2000.

Of course, everyone is aware of the requirements effective at the beginning of 2011 for physicians who refer patients for an imaging study at a facility where the physician has an ownership interest. At the same time, imaging equipment is becoming less expensive and more widely available. For example, there has been a steady increase in use of ultrasound by trauma surgeons, cardiologists, anesthesiologists and others. These physicians want the fast results even though radiologists offer more comprehensive interpretation abilities.

What options exist for radiologists wanting to slow or reverse this trend? The first is to be aware of changes taking place within the practice’s referring practices. Communicating your practice’s expertise and how it can help referring physicians provide better diagnoses is a next step. Where physicians have equipment in their office, without getting into a debate (“my equipment is better than yours”), it should be possible to identify specific types of cases where an overread is warranted. Specific, targeted expertise is a key asset for these discussions.

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Our survey of radiology practices revealed that about half feel they have lost business during the past two years to other specialties, including orthopedics and OB/Gyn. Those who have lost business and a few of those who haven’t, expect additional losses this year and next. When asked what steps practices have taken to reduce the impact, the primary answers are “better marketing” and “publicizing services.”

There is also an argument to be made that radiologists can and should help referring physicians and patients make correct choices for imaging studies, including when a study is not appropriate. This critical consulting role of the radiologist has been underutilized, resulting in a void that has been filled by radiology benefit management companies. Revenue associated with this function could be available to radiologists if they make the effort. With societal concerns about over-use of imaging, the radiology community needs to be seen championing the correct criteria for studies. Practices that take a leadership role have the opportunity to raise their profile with referring physicians and the patient community.

**SUMMARY**

The trend to lower radiology reimbursement rates is probably going to continue. Successful radiology practices are finding ways to offset rate declines with volume increases. Important areas being explored include promoting the practice with referring physicians, becoming more “patient-centric”, performing more night and weekend services in house, and encouraging non-radiologist physicians conducting studies to partner with the practice.