

Scanning for dollars Joint ventures in imaging

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Reader take-away

- Learn the compliance risks of adding imaging services to your medical practice
- Learn the laws and certifications that apply to imaging ventures
- Learn the joint-venture models to choose from

Medical groups are looking at imaging services as a source of much-needed revenue. But they often lack the patient volume to justify purchasing expensive imaging equipment such as magnetic resonance imaging (MRI), computerized tomography (CT), nuclear cameras and positron emission tomography (PET). Consequently, many practices seek partnerships with other groups, hospitals and imaging companies to gain access to the technology and generate revenue.

This article discusses the latest models for imaging joint ventures and the compliance obstacles medical groups will face.

Compliance

Through the 1980s, imaging joint ventures were quite common. Then the Medicare anti-kickback safe-harbor regulations and the Stark law forced the unwinding of many joint ventures, often on terms unfavorable to physician investors. Medical group administrators are often wary of joint venture proposals because of complex and sometimes contradictory Medicare and state laws. Unless an imaging joint venture is both financially *and* legally feasible, it's not worth pursuing.

Stark law—The physician self-referral, or Stark, law (42 U.S.C. Section 1395) prohibits a physician from making a referral to an entity for the furnishing of a designated health service paid for by the Medicare program if the physician has a financial relationship (either through ownership, investment or compensation) with the entity receiving the referral, *unless* an exception to the prohibition exists. Stark-covered designated health services include MRI, CT, ultrasound and other radiological and imaging technologies.



Note that Stark does not cover diagnostic nuclear medicine performed outside the hospital.

Stark's key exception is for in-office ancillary services, which requires:

- **Supervision**—The test must be furnished by the referring physician, a physician who is a member of the same group practice as the referring physician, or by an individual supervised by the referring physician or another physician in the group practice;
- **Location**—The services must be furnished in either the same building where the physician or another member of the group furnishes substantial physician services unrelated to the Stark-covered services or in a centralized building used exclusively by the group to provide ancillary services; and
- **Billing**—The services must be billed by the group.

Ventures involving time-sharing of imaging facilities may have difficulty meeting the location requirement.

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Antikickback law—The federal antikickback law (42 U.S.C. Section 1320-7b) is violated if a recipient of a medical group's referrals for imaging services paid for by Medicare, Medicaid or other federal health programs compensates the group – directly or indirectly – for the referrals. Penalties range from fines and exclusion from the Medicare and Medicaid programs to imprisonment for up to five years.

Potential problem areas for imaging joint ventures include:

- Payments below market value to radiologists to supervise and interpret scans;
- Payments below market value by referring medical groups for equipment, space and services acquired from the joint venture;
- Payments above market value by the joint venture to medical groups that supply equipment and other items to the venture; and
- Improperly structured profit distributions from joint ventures.

Purchased diagnostic test rule—The Medicare Purchased Diagnostic Test Rule (PDTR) (Carriers Manual Section 15048) provides that if a physician bills for diagnostic tests performed by an outside supplier, the physician cannot be paid by Medicare for more than what the supplier charged.

To avoid the antimark-up provisions of the PDTR—at the minimum—the physician must personally perform the test or supervise it, or have it supervised by a physician with whom s/he shares the practice. The level of physician supervision required is set forth in Section 2070 of the Carriers Manual, that is, general, direct or personal supervision (discussed below). The supervi-

sion requirement is *not* met when supplier personnel administer the test. However, the recently revised PDTR seems to permit supervision of technicians leased from the supplier.

Reassignment prohibition—In general, Medicare prohibits a physician who furnishes a service from assigning to someone else his/her right to receive payment unless an exception applies (Carriers Manual Section 3060). For example, if a medical group participant in an imaging joint venture contracts with an independent radiology group to interpret scans, the medical group may not be able to bill globally to include the radiologists' interpretation unless the tests are initiated by a physician or medical group independent of the person or entity providing the tests, and of the physician or medical group providing the interpretations.

Tests ordered by the medical group for its own patients, therefore, would not be considered independently initiated. One possible solution: The medical group can employ the radiologist part-time and have him/her interpret tests at the medical group's office.

Physician supervision requirement—To meet the requirements of the Stark in-office ancillary services exception, qualify for Medicare coverage and/or avoid application of the PDTR, medical group physicians will need to provide appropriate supervision (that is, general, direct and personal) of the technician performing the test. Nuclear diagnostic tests using the 78000 series of common procedural terminology (CPT) codes, for example, require only general supervision. General supervision means that the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.

Certain MRI and CT scans with contrast material require direct supervision, which means that the physician is in the office and immediately available for assistance and direction throughout the procedure. Direct supervision does not require the physician's presence in the room where the procedure is performed. However, some states may impose more stringent supervision requirements than Medicare.

IDTF certification—To bill the Medicare program, imaging joint ventures may need certification as independent diagnostic testing facilities (IDTFs). Lay-operated imaging facilities will generally require certification, as will medical groups doing substantial testing for nongroup patients.

State laws—In addition to Medicare rules, states often have their own laws with which imaging joint ventures must comply. Some states have their own version of the federal Stark law that apply regardless of the payer. These "mini-Stark laws" are sometimes more troublesome than Stark itself. Almost every state has an antikickback law prohibiting payments for referrals. Some states have special licensing and supervision requirements for imaging facilities; others require a certificate of need to purchase, lease or otherwise establish an imaging facility.

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Joint-venture models

Determining the optimal model for an imaging joint venture requires balancing clinical requirements, physician and patient convenience, financial feasibility and compliance with federal and local laws. No one model is appropriate for all medical groups. Evaluate each approach for your specific circumstances.

Traditional joint venture—The traditional joint venture model involves independent physicians, medical groups and an imaging company or hospital investing in a jointly owned entity that provides and bills for imaging services, usually as an IDTF. Investors receive a share of the profits based upon their ownership interests rather than referrals. A “safe harbor” under the antikickback law may protect such arrangements if they meet certain conditions, including a requirement that not more than 40 percent of the value of the investment interests is held by investors who can make or influence referrals, and no more than 40 percent of the joint venture’s gross revenues come from referrals generated by investors.

Stark prohibits referring physicians from owning an interest in such ventures. But the law would not pose a problem if the venture provides services not covered by Stark, such as nuclear medicine, or does not scan Medicare patients. State antikickback and mini-Stark laws may also be problematic. The traditional venture model may still work when it scans only private-pay patients and when an imaging company and a group of radiologists—who do not refer patients—are the investors.

Nonprovider joint venture—Under this model, a medical group and other investors—which might include a radiology group, imaging company and/or hospital—co-own an entity that acquires the imaging equipment and other technical aspects. The joint venture does not attempt to qualify as an IDTF or other provider or supplier. Rather, it acts as a vendor selling aspects of the technical component of the test to the medical group, which is one of the owners of the joint venture. The group performs the tests on its premises and bills tests as in-office services.

Because the end-user medical group is a joint venture owner, the venture may not need to discount the price the medical group pays for tests because

it shares in the profits of the joint venture. Because the joint venture sells exclusively to the end-user medical group, the group needs to generate enough tests to make the arrangement financially viable. But the medical group may be able to accept referrals from nonmedical group physicians and referral sources. If it needs to contract with an independent radiologist for interpretation services, global billing may not be possible unless the radiologist reads the films at the group’s offices.

In a variation of the nonprovider joint venture model, the joint venture sells its services to a radiology group, entrepreneur or even a hospital.

Shared facility—Practices without sufficient patient volume to justify full-time use of expensive imaging facilities may choose to share a facility. A number of medical groups form an entity that acquires the imaging equipment and, on an as-needed basis, provides various aspects of the technical component to each member groups. The groups, in turn, pay the entity for their share of the expenses of the jointly owned entity based upon their usage. Each medical group bills for tests performed for its patients. Revenue is not pooled or shared.

A shared facility should qualify for the Stark law’s in-office ancillary services exception as long as it and all the medical groups occupy the same building. Each medical group must also supervise tests for its patients. This arrangement should not violate antikickback laws because the shared entity allows each medical group to provide tests to its patients, rather than making referrals to a jointly owned entity and receiving a profit distribution.

Block purchases of scanner time—As an alternative to a shared imaging facility, an independent medical group can purchase predesignated blocks of time to use equipment owned by an imaging company, whether from a mobile service or a fixed site. In such

an arrangement, the medical group pays a flat fee to use the scanner for, say, one day per week. Commitments usually extend at least a year. The medical group risks its money if it does not have sufficient patients to test and bill during its designated time.

The Stark law may create problems for a practice using a mobile imaging service that hooks up its truck in an adjacent parking lot. The government does not consider the truck as the same location as the medical group, so the Stark in-office ancillary services exception will not apply.

Therefore, this model is generally not available for ultrasound, MRI or CT for Medicare patients. But it can work for nuclear cameras and PET scanners, which Stark does not cover.

Note, however, that mini-Stark laws in some states cover nuclear medicine, such as California Business and Professions Code Section 650.01. Block-booking arrangements at a fixed site, rather than with a mobile service, also cannot meet the location requirement under Stark’s in-office ancillary services exception. Therefore, fixed-site agreements generally work only for non-Stark-covered nuclear scans or if the practice tests no Medicare or Medicaid patients. In either the mobile or fixed-site settings, the medical group must provide the requisite level of physician supervision of the test.

A practical drawback to purchasing a pre-set block of time is that patients and their physicians generally don’t want to wait until the scheduled day(s) to be scanned. In response, some imaging companies sell medical groups blocks of time that are not prescheduled. This obligates a practice to pay for hours purchased regardless of actual use but gives it more flexibility in scheduling patients.

Imaging joint ventures can offer medical groups affordable access to the latest technology and generate much-needed revenue. But potential compliance obstacles require groups to structure such arrangements carefully to preclude excessive risk. •

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