Physician Self-Referral

Research and Health Spending Issues

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Overuse, Incentives, and Self-Referral

Many difficult-to-ignore indications suggest “overuse” of medical care

- Unnecessary, ineffective, or unwanted care
- Related to “overdiagnosis”
- How much? Estimates range from 10% to 30% of spending

Overuse, Incentives, and Self-Referral

Overuse occurs for a variety of reasons

- Provider norms, expectations, and beliefs
- Patient demand
- Fear of litigation
- Financial incentives
- Supply-sensitive care

These interact together and have both short term and longer term impacts

Self-referral is one part of this story

What Is Self-Referral, and Why Worry?

Physicians making referrals for medical services to an entity with which he or she has a financial relationship*

Common concern: Self-referral could lead to overuse of services, driving up costs, but not creating (sufficient) benefits for patients

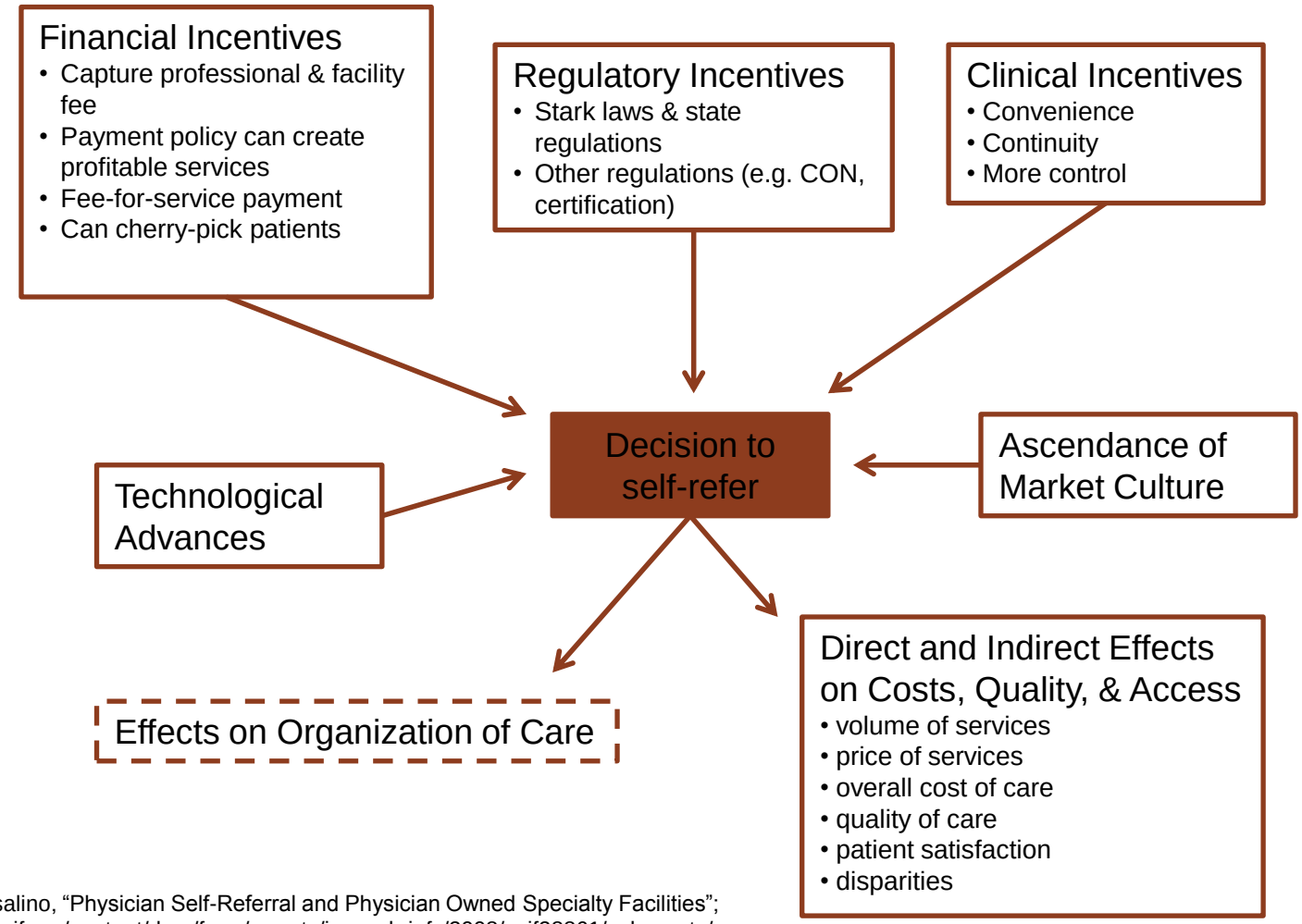
- or even possibly harming them

Could occur in many different areas, for example:

- Imaging
- In-office laboratory testing
- IMRT
- Surgical & endoscopic procedures
- Referrals to physician owned hospitals

*generally ownership, but also can be compensation arrangements; may be for physician or immediate family members

Causes and Effects of Self-Referral



Source: Casalino, "Physician Self-Referral and Physician Owned Specialty Facilities"; http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2008/rwjf28861/subassets/rwjf28861_1; accessed March 17, 2015

Current Regulation of Self Referral

"Stark" Law

- Federal law that prohibits self-referral for designated health services* billed paid for by Medicare and Medicaid, with important exceptions
- In-office ancillary service exception: physicians are permitted to self-refer for designated health services performed within their own offices
  - In-office exemption is large, and allows lease and "per-click" imaging arrangements
- Also other exceptions

California also has self-referral restrictions

Anti-kickback statutes and other laws can also apply

*key designated services: imaging, clinical lab tests, physical therapy, radiation therapy

Use of MRI by Orthopedists and Neurologists Increases After they Acquire MRI Equipment

EXHIBIT 2

Changes In Magnetic Resonance Imaging (MRI) Use Measures Before And After Physicians First Billed For MRI

	Orthopedists		
	Mean MRI use, before first MRI bill (*N* = 107,188)	Mean MRI use, after first MRI bill (*N* = 163,567)	Pre-post change, unadjusted
NUMBER OF PROCEDURES PER 1,000 EPISODES			
On day 0	5	13	7***
Within 30 days	74	103	28***
Within 90 days	92	124	33***

SOURCE Author's analysis of Medicare claims data. **NOTES** Adjusted estimates based on regressions that control for patient demographics, Medicaid status, prior-year health spending, comorbidities, index-visit diagnosis, and year and month of index visit. Regression adjustment models included physicians who bill for MRI and traditional MRI users. Regression *N* = 1,129,660 orthopedist patient episodes and *N* = 459,231 neurologist episodes. $^{**}p < 0.05$ $^{***}p < 0.01$

Source: Baker, "Acquisition of MRI Equipment by Doctors Drives up Imaging Use and Spending" Health Affairs, 2010

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	Mean MRI use, before first MRI bill (*N* = 107,188)	Mean MRI use, after first MRI bill (*N* = 163,567)	Pre-post change, unadjusted	Mean MRI use, before first MRI bill (*N* = 16,234)	Mean MRI use, after first MRI bill (*N* = 26,408)	Pre-post change, unadjusted
NUMBER OF PROCEDURES PER 1,000 EPISODES						
On day 0	5	13	7***	19	31	12***
Within 30 days	74	103	28***	241	287	45***
Within 90 days	92	124	33***	268	324	56***

SOURCE Author's analysis of Medicare claims data. **NOTES** Adjusted estimates based on regressions that control for patient demographics, Medicaid status, prior-year health spending, comorbidities, index-visit diagnosis, and year and month of index visit. Regression adjustment models included physicians who bill for MRI and traditional MRI users. Regression *N* = 1,129,660 orthopedist patient episodes and *N* = 459,231 neurologist episodes. **$p < 0.05$ ***$p < 0.01$

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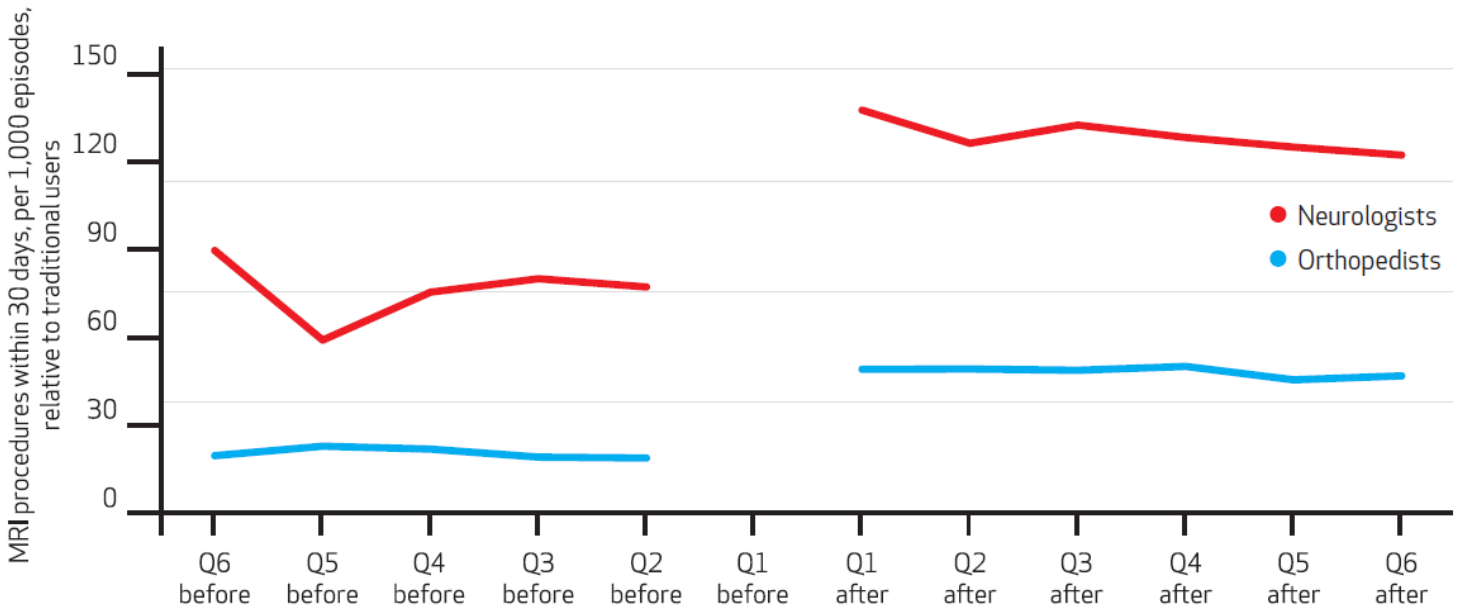
Use of MRI by Orthopedists and Neurologists Increases After they Acquire MRI Equipment

EXHIBIT 3

Regression-Adjusted Quarterly Magnetic Resonance Imaging (MRI) Use Rates For Study Physicians Who Began Billing For MRI, Relative To The Date Of First Billing For MRI



SOURCE Author's analysis of Medicare claims data. **NOTES** Rates are measured relative to use by traditional MRI users. Episodes that began in the quarter immediately preceding the initial billing for MRI were not included, to eliminate cases in which the ensuing episode could have been in progress at the time of the first billing for MRI.

Source: Baker, "Acquisition of MRI Equipment by Doctors Drives up Imaging Use and Spending" Health Affairs, 2010

A Few Other Key Sources

- GAO studies: significant self-referral in imaging, anatomic pathology
- MedPAC studies: imaging, cardiac hospitals, ambulatory surgery
- Mitchell (et al): imaging, pathology, IMRT
- Collectively, large effects of self-referral on utilization, with questionable benefits for patients

Summary

Self-referral is a part of the overuse story

Fueled by a range of forces, including but not limited to financial incentives

Current regulatory structure does not fully address self-referral

Economic impact appears significant, but precise estimates are difficult to develop and context-specific

Impact on patients could vary

- There may be benefits in some situations
- There are also important reasons to be concerned that self-referral often does not lead to benefits for patients

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