Self-Referral in Radiation Oncology

Background

Physician self-referral is the practice of a physician ordering a service for a patient that is performed either by that individual physician or by a facility from which they derive a financial benefit for the referral. Due to the inherent financial incentive to self-refer, the Stark Law was passed to place some restrictions on the practice of physician self-referral. Added to the Stark law in the early 1990s, the in-office ancillary services (IOAS) exception allows physicians to bill Medicare for the self-referral of certain services. This exception was originally intended to facilitate the rapid diagnosis and initiation of treatment during a patient’s office visit. Over the years, however, abuse of the IOAS exception has substantially broadened the exception, making it much easier for physicians to avoid the law’s prohibitions by structuring arrangements to meet the technical requirements, but this is not the intent of the exception. For example, the most common arrangement occurs when a group of urologists pool resources to open a free-standing radiation therapy center as part of their large urology practice. However, the radiation therapy services are not truly integrated with the physician organization because they will typically be set up in a geographic location separate from the urology practice. The radiation oncologist and his/her technical staff will function apart from the group on a day-to-day basis with little or no integration of the physicians, staff, locations or services.

For patients with localized prostate cancer, there are four courses of treatment considered “clinically equivalent,” according to a 2008 report by the federal Agency for Healthcare Research and Quality: external beam radiation therapy, radioactive seeds (brachytherapy), prostate surgery, and active surveillance. The report noted that because the treatments have varying side effects, individual patient preferences are an important factor in determining a management strategy. The National Comprehensive Cancer Network clinical guideline states that a patient with clinically localized prostate cancer should be informed about the commonly accepted interventions, and a discussion of the anticipated benefits and risks of each intervention should occur with the patient.

Determining the most appropriate prostate cancer treatment option is an involved process that depends on the patient’s preferences, age, concerns, comorbidities and physiology. Data shows that when referring urologists own radiation therapy facilities, they are so heavily incentivized to refer their patients for external beam radiation therapy services that their clinical decision-making becomes biased and likely leads to overutilization of radiation therapy. Specifically, these models channel referrals to a particular radiation therapy, called intensity modulated radiation therapy (IMRT). IMRT is particularly of interest because of the technical fees that are billed by the owner of the linear accelerator. In January 2009, the Institute for Clinical and Economic Review produced a report comparing the clinical benefit and costs of the various treatments for low-risk prostate cancer. The report concluded that the rates of survival and tumor recurrence are similar among the most common treatment approaches, although costs can vary considerably, with surgery and brachytherapy costing significantly less than IMRT.
Physicians, especially those who are in a position to refer patients for radiation therapy services, have realized that if the provision of these services and the related billing of the technical fees for the equipment can be “captured,” financial gain can be achieved based upon the referral decisions. This business dynamic has been identified, packaged and is being marketed to physician groups, particularly within the urology community, by for-profit companies that specialize in fueling the enthusiasm about lucrative joint ventures with financially aggressive physicians.

Message Points

• ASTRO is very concerned that new forms of physician business arrangements that have exploited the in-office ancillary services exception to the Stark law have led to a skewed system of referral decisions driven by profits instead of what is best for the patient. The patient is often not aware that the referring physician is deriving a financial benefit from the referral. More importantly, the patient may not be fairly offered and advised about the choice of therapies available.

• Under these arrangements, the quality of cancer care suffers.
  
  ➢ Practices steer patients toward the services they wish to offer, rather than those that might be best for the patient.
  ➢ Given the financial return that a urology group can realize on some radiation therapy treatments, there is considerable risk that “active surveillance,” surgery or brachytherapy will not be thoroughly presented to the patient as viable treatment options. Therefore, patients who may not need treatment could be treated, putting them at unnecessary risk for side effects.

• *The Wall Street Journal* investigated several group practices in 2010 that have used the self-referral exception to bring radiation therapy services into their offices. The article revealed two major findings:
  
  ➢ Urology groups that brought a radiation therapy machine into their practices had utilization rates well above national norms for IMRT treatment for prostate cancer. Moreover, the practice patterns for these groups showed dramatic utilization increases from before they owned the machines to after.
  ➢ These practices treated a higher than average number of men over the age of 80 with IMRT for their low-risk prostate cancer. Experts agree that in most instances, 80-year-old men and older with low-risk prostate cancer do not need aggressive treatment.

• In 2011, *The Washington Post* also featured a story that exposed self-referral abuses in radiation oncology. The article quotes world-renowned Johns Hopkins urologist, Patrick Walsh, MD, as criticizing the "for-profit motive" that is affecting treatment decisions for some physicians involved in self-referral arrangements.
• A *The Baltimore Sun* article in 2012 described how a Maryland urology clinic’s prostate cancer referrals for IMRT tripled after they purchased a radiation therapy machine. As the article states, “The more patients the Baltimore-area urologists referred for that expensive therapy alternative, the more revenue and profits they would generate.”

  ➢ The Maryland data is part of a national study by Georgetown University coming in mid-2012. It is expected to show that urology practices across the country drastically increased expensive IMRT referrals after they acquired a radiation therapy machine.

• By setting up a business model that tends to drive patient referrals to the most expensive treatment option, many cancer patients are denied the independent clinical judgment and choice they need and deserve.

• In addition, a published survey of radiation oncology residency program directors across the country revealed that 27 percent of residency programs in communities with this type of business arrangements reported a negative impact on residency training as a result of decreased referrals to their centers. While this is a small survey sample, it foreshadows large quality problems in the future if residents do not see enough patients to develop the expertise needed to treat prostate cancer patients.

• ASTRO is actively working to end these abuses by closing the loophole that allows for these arrangements. ASTRO is working to limit the use of the exception so that only robust, integrated and truly collaborative multi-specialty group practices can offer radiation therapy services through the exception.

• There’s still a chance to stop this abusive activity before it gets out of control, and lawmakers must act soon. Not only do we need to protect these patients, but this is undoubtedly resulting in unnecessary Medicare spending at a time when everyone wants to control health care costs, reduce the deficit and help sustain the Medicare program.