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Private Practice Trends in the US: Will Increasing Competitiveness Weaken the Profession?

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Certain trends are notable in private practice radiology in the United States (US), including a shift toward larger practice sizes, greater use of teleradiology, and a move toward commoditisation. In this article, many important elements of private practice radiology in the US will be reviewed with the goal of allowing comparison with other practice models elsewhere in the world.

An estimated 26,800 post-training radiologists were active in the US in 2003 (Cohen 2005). An ACR (American College of Radiology) survey shows that they are working in a variety of practice types: the most common is private single specialty practices (57%), followed by private multi-specialty (20%) and academic (18%). At the present time, the common radiology practice types in the US include:

• Private single-specialty practices employing one or more radiologists;

• Private multi-specialty practices consisting of several different types of physicians including radiologists working together, often in a clinic setting, near or attached to a hospital. Academic practices are a form of multi-specialty group practice associated with teaching institutions;

• Government practices, associated with Veterans Affairs or Military Hospitals;

• In some settings, radiologists have been hired directly by hospitals to provide care to patients, and

• Finally, radiologic services can be provided through locum tenens and other independent contracting arrangements.

Trends in Practice Settings

Different types of practice settings include single regional hospitals or tertiary care facilities, smaller suburban hospitals, rural hospitals, single or multispecialty clinics, free-standing imaging centres, teleradiology, or a combination of settings. The same ACR survey examined practice location with the most common setting being the main city of a small metropolitan area (33%) followed by the main city of a large metropolitan area (30%) and suburb of a large metropolitan area (21%).

Practice size has been changing over the past several years, with trends toward larger-sized practices increasing, especially during the period from 1990 - 2000. While practices with one - four radiologists are not extinct there has been a slight decrease to 29% from 22% from 1990 to 2007, while practices with greater than 30 radiologists have increased from 5% to 19% over the same period.

Groups with greater than 60 members have seen the largest growth since 2000. This may be because larger practices have advantages, including greater economies of scale, allowing better deals on capital purchases and greater access to quality marketing and management services. Also, the leverage to negotiate with providers increases with size, allowing larger groups greater flexibility when contracting with hospitals and insurers. Larger groups are able to subspecialise and adapt to practice changes more easily. Since one radiologist can still cover a night on-call in most groups, call coverage is potentially less frequent in larger groups although this has become less of an issue with the growth of teleradiology.

Disadvantages of Larger Practice Settings

Increased group size has the disadvantages of increased management complexity, especially with making group decisions, and with

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communication of issues to group members. Larger groups may foster less personal identity and lead to decreased tolerance of risk or sacrifice on the part of the individual members. The greater time required for management is often undervalued by radiology group members, even leading to resentment of group leaders who may be required to spend time away from the daily group activities. These management activities can have critical importance to the financial prosperity of the group. Many groups, therefore, employ non-physician managers.

How are Radiology Services Paid For?

There are several options for payment for radiologic services in the US including private insurance, Medicare, Medicaid, self-pay, or no-payment (indigent care or charity care). The process of image acquisition to actual payment for services can be complex but some important points can be made regarding certain steps in the process. In our practice, the patient's financial information is collected from the patient at the point of service and shared between the facility and our billing office.

The type of procedure performed is recorded using the Current Procedural Terminology (CPT) code set and the diagnosis is recorded using the International Classification of Diseases 9th revision (ICD-9) code set. The procedure and diagnosis codes and the patient's personal information are submitted on a standard form to the insurance provider.

Typically, two claims are submitted, one by the radiology billing office for the professional component of the services and one separately by the hospital or imaging facility for the technical component of the service. The technical component compromises the majority of the total fee (often 75 - 80%). Compensation for the exam is based on the CPT code with Medicare/Medicaid rates determined by the federal government. Private insurance companies typically contract with radiology groups to reimburse at a negotiated percentage greater than Medicare rates. Claims are then carefully reviewed. Insurance companies employ powerful software filters and medical directors who evaluate patient eligibility, provider credentials, and medical necessity.

Accepted claims are reimbursed for a percentage of the billed service and rejected claims are sent back for review. The rejected claim must be corrected and resubmitted and this process may have to be repeated many times. Submitting claims quickly and accurately is therefore very important to avoid rejections. Payment is typically due by 30 days but often can take 45 - 60 days. Periodic audits are very important for groups to maintain quality control and assure payments are appropriate and timely.

Future Challenges

Commoditisation

Image interpretation services are at risk of becoming a commodity. Recently, a reverse auction model for image interpretation has been implemented to have radiologists compete on price alone for interpretation contracts (Moan 2008). This is a growing trend. Potential risks of commoditisation are diminished quality control, decreased personal service, and a threat to local radiology practices when imaging services can be outsourced to the lowest bidder.

The rapid technological advancement of teleradiology and the growth of imaging centres owned by non-radiologist physicians have contributed to commoditisation. Proposed solutions include raising awareness of imaging as an integrated service, to add value beyond just image interpretation. Additional roles of radiologists include the determination of appropriateness of the study, quality control, adherence to safety and accreditation standards, and consultation with the referring clinician and sometimes patient.

Reimbursement

Diagnostic imaging is the fastest growing physician service in the US. Medicare spending on imaging increased from 6.4 billion dollars in 2000 to 12 billion dollars in 2005 (Medpac 2008). The government has had an increasing role in attempting to control costs including limits imposed on the reimbursement of the technical component of imaging services with the Deficit Reduction Act of 2005. Laws have been implemented to decrease over-utilisation, self-referral, and illegal kickbacks. There will be an increased role for accreditation and pay-for-performance requiring radiology practices to adapt accordingly.

Leadership

There is growing competition from non-radiologists wanting an increased role in the field of diagnostic imaging. The need for increasing the recognition of radiology as a distinct medical specialty has never been greater in the US. National societies such as the American College of Radiology have recognised this issue and are promoting both national and local marketing and branding campaigns. Radiologists should strive to add value to the services they provide to make themselves indispensable.

Summary

Challenges for the future include greater competition with a need for improved brand identity and declining reimbursement with increased focus on accreditation and pay for performance. Greater attention to the business matters of the field and increased training of our future leaders is critical. Quality training of future leaders and increased education regarding the business aspects of radiology is essential. Providing greater leadership opportunities earlier in the career of radiologists is important as is greater local and national involvement by radiologists.

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