CMPMedica
United Business Media

THE SECOND OF TWO SUPPLEMENTS FOCUSED ON CARDIOVASCULAR IMAGING October 2006

Cardiovascular imaging

A Special Supplement to DIAGNOSTIC IMAGING

CTA TRAINING

Turf talk obscures CTA's potential as team builder

Cardiologist/trainer urges specialties to consider partnership models that capitalize on strengths of both cardiologists and radiologists

By Tony DeFrance, M.D.

Rapid growth and acceptance of cardiac CT angiography have exceeded expectations and surprised many experts. Both cardiologists and radiologists are incorporating this technology into their practices and undergoing training to perform and read these studies. Hospitals are also buying new multislice scanners to stay in the game and retain some of the technical revenues associated with cardiovascular CT imaging.

The turf war between radiologists and cardiologists is already being tested by this new technology. We are at a point where the two specialties can band together, forming partnerships that accentuate relative strengths, or CTA can become the catalyst for increased feuding.

I provide training to mixed groups of cardiologists and radiologists in performing and interpreting cardiovascular CT. I've seen how individual radiologists and cardiologists can come to understand their relative strengths and weaknesses and the importance of working together. There is a process that emerges in these training courses that may provide a model for creating partnerships. When one operates from a mindset of scarcity, everyone loses. But believing that this new field brings opportunities for everyone is key to providing better patient care.

Dr. DeFrance is an interventional cardiologist and medical director of the Cardiovascular CT Angiography Education Center in San Francisco. He is also director of CVCTA for Liberty Pacific Medical Imaging based in California. He is a member of the Toshiba Medical Systems speakers bureau.

STEPS TOWARD PARTNERSHIPS FOR CARDIOLOGISTS AND RADIOLOGISTS

- List of goals prepared by each group
- List of concerns prepared by each group
- List of ideas about how a partnership would work
- Initial discussions about above documents
- List of sticking points
- Brainstorming of solutions to sticking points from both sides
- Initial pro forma and revenue model outline from both sides
- Review of equity-sharing profits and professional component profits
- Bargaining with an eye toward a win-win solution
- Consideration of professional mediator help if unable to reach an agreement
- Obtaining medical-legal consultation
- Building a business plan

SEEDS OF DISCONTENT

Radiologists have a number of resentments regarding cardiologists moving into the CT realm. Most of these rely on the perception that cardiologists have taken coronary angiography, echo, cardiac nuclear, and, increasingly, peripheral vascular interventions from them. Concern also exists about cardiologists' lack of knowledge about CT equipment, physics, and radiation exposure. Many radiologists see cardiologists' entry into CT as yet another example of their turf being infiltrated. There is action by the American College of Radiology and other organizations to have the government increasingly involved in regulating who can own and operate imaging equipment.

Cardiologists, on the other hand, believe that this technology will help them to better manage and retain control of patients and increase revenues in a declining reimbursement environment. In addition, many cardiologists feel that since they have the most expertise in invasive coronary angiography, they are the logical group to inherit CCTA. They also contend that cardiologists have a better understanding of the coronary and cardiac anatomy, the clinical implications of the CTA, and the best way to integrate it with patient management.

So who is right—and does it really matter? Both sides have valid points and arguments. Obviously, there are many other issues involved.

In the classroom setting, I hear cardiologists and radiologists expressing their opposing viewpoints and some of the debates that result. These discussions typically occur several days into a course after initial polite and politically correct interactions. They take place after the relative strengths of each specialty are understood and accepted.

Such conversations begin when the physicians have developed a relationship and realize they need one another. When these difficult discussions begin, I can see the doctors venting while trying to understand each other.

The physicians often talk about problems in their communities with members of the other specialty and seek advice about how to approach the situation. The cardiologists and the radiologists in the class band together to help solve these problems as a team. As a result, many of the class participants begin to get excited about joint venture opportunities and focus on potential positive outcomes.

Can this small group paradigm work in the real world? I believe that it can. I have implemented a successful CTA imaging center model that involves a cardiology/radiology team approach. I have also seen the team approach work in a number of communities where I have consulted on cardiovascular CTA.

There is no doubt in my mind that the most successful CTA centers have shared ownership between cardiologists and radiologists. Some of the biggest disasters, on the other hand, involve battles between the two groups that lead to financial losses or extreme changes in referral patterns. There are better ways to partner that satisfy both specialties. Approaching the issue with an eye toward a win-win solution is critical.

PARTNERSHIP MODELS

Cardiovascular physicians control large numbers of patients with significant amounts of diagnosed and undiagnosed cardiac and peripheral vascular disease. The introduction of CTA technology allows for noninvasive evaluation of these patients. When cardiologists start looking for disease, more is found in all vascular territories. This generates more procedures and better care.

Conversely, radiologists have imaging expertise that cardiologists lack. Radiologists have a better knowledge of peripheral vascular anatomy and of the nonvascular anatomy. I believe that radiologists are required to overread all nonvascular structures on all CT studies. In addition, radiologists know more about CT operation, protocols, image acquisition and reconstruction, and contrast administration than the typical cardiologist.

'The most successful CTA centers have shared ownership between cardiologists and radiologists.'

Since radiologists do not control the flow of patients, no self-referral issues

arise from their partnership in an imaging center. That is not the case with cardiologists. The legal aspects of structuring the ownership of imaging equipment with clinical physicians must meet one of the safe harbor exceptions of the Stark laws in addition to satisfying state and federal antikickback laws. If a cardiologist is to have an ownership interest in a CT, then the CT must be installed at the office of the cardiologist where normal clinical services are provided.

'The key to a successful imaging center is to keep the CT table busy.'

The other option for a cardiology group is to lease blocks of time on a scanner. There are also regulations that must be met in order to do this, such as performing normal clinical services at the CT site at least eight hours a week. In this model, the cardiology group pays an hourly fee and then bills globally for any studies performed on their patients. The blocks of time must be paid for regardless of whether patients are scheduled. Also, the contract must be signed for a year at a time and cannot be renegotiated during that time period.

Cardiologists and radiologists can have a partnership in which both have an equity interest in the CT equipment, if that equipment is at the cardiologist's office. There are a number of strengths to this type of partnership. Cardiologists bring their patient volume to the scanner. Radiologists can usually bring a volume of nonvascular work to the scanner from previously established referring physicians. The key to a successful imaging center is to keep the CT table busy, something a good partnership can ensure.

Obviously, the exact structure of the partnership must be reviewed by an attorney who specializes in healthcare law. There are many nuances and gray areas. First and foremost, obtain expert advice.

Some imaging centers partner with other clinicians who order significant numbers of CT scans as well, including urologists, ENT specialists, oncologists, and orthopedists. It's important to keep tabs on the regulatory issues in these partnership arrangements, as the Office of the Inspector General is examining them closely.

EQUITABLE SPLIT

How cardiologists and radiologists work out equitable ways to split the professional component of the studies varies from center to center. In this case, split does not mean splitting fees on a single procedure, which is illegal. An equitable way must be found to divide the professional fee for reading cardiac and vascular studies. At most joint partnership centers, radiologists read the majority of peripheral vascular studies and also receive professional fees for all of the nonvascular studies.

Radiology overreads of the nonvascular structures on an exam read by a cardiologist are a bit trickier. Since fee-splitting is illegal, at some centers the radiologist provides a consultation to the cardiologist and can agree with or add to nonvascular findings. In this arrangement, the cardiologist pays the radiologist a predetermined fee for the consultation. At our center, radiologists read all vascular work below the diaphragm and in the head. The cardiologists read the cardiac structures and the thoracic vascular structures. We rotate the carotid reviews between the two specialties.

The bottom line is that these two specialties must figure out how to turn CTA into a win-win situation. Increased government regulation has already had a severe impact on the practice of medicine and physician job satisfaction. Either we deal with the potential opportunity that CTA represents and play together in the sandbox, or we will have the sand removed by others and thrown in our faces. ■

EXAMPLES OF PARTNERSHIP OPTIONS

Equity sharing

- Cardiology and radiology share in the ownership of the center
- Must be housed at cardiologist's site, or imaging center must include an office where cardiologist can see patients

Block leasing

- Radiologist owns imaging center and leases blocks of time to cardiologist at fair market value.
- Contract must be for one year. Time must be paid for regardless of whether patients are scheduled. Requirement for onsite clinical services: eight hours per week by cardiologist.

Lease-back model

- Cardiologist and/or radiologist purchase imaging equipment from vendor and form a leasing company. They lease the equipment to the imaging center, which is owned by the radiologists, at fair market value. There may be a fixed return on this investment.
- There can be no fluctuation in returns to the clinical physician based on volume of referrals.

CVCTA Education
www.cvcta.com
325 Sacramento Street
San Francisco, CA 94111
phone: 415.772.0908
email: info@cvcta.com