

NICHE

CENTERS:



THE GOOD,
THE BAD,
& THE UGLY

WHEN IT COMES TO FREESTANDING IMAGING CENTERS, WHEN IS THE TIMING BEST TO CARVE OUT AN IMAGING SPECIALTY?

HERE, THOSE IN THE
KNOW PROVIDE TIPS FOR
BOTH NEW AND LONG-
STANDING CENTERS
LOOKING FOR A NICHE.

by Dana Hinesly

Do one thing, and do it well. That's sage business advice—or is it? Independent imaging centers working toward a niche can seem like a great idea. Equipment is becoming more affordable, hospitals are backlogged, and the proliferation of independent imagers is encouraging. But as with any entrepreneurial venture, gaining a foothold in the world of freestanding imaging centers demands diligence and preparation.

LOOK BEFORE YOU LEAP

"Any healthcare business is about patient volume and reimbursement," says Jeremy Hogue, president and CEO of Sovereign Healthcare (Newport Beach, Calif). "Once you understand those [issues] and can make accurate assumptions, everything else is secondary."

In a nutshell, know the depth of the water before diving in. Will there be enough business? Who's the competition? Does managed care dominate the area? For anyone interested in staking their claim in the independent imaging arena, answering these questions is a critical first step. Often, the most straightforward way to determine how receptive referring physicians will be to a new business is to ask them.

When considering whether to capitalize on a staff radiologist's expertise in women's health by adding breast imaging and MRI services, the team at Universal Imaging (Auburn Hills, Mich) took a poll.

"We did a market survey of our referring physicians who use those services," says Universal Imaging President Phil Young. "We simply asked [them], 'If we would offer [these services], would [you] be interested in supporting us?'"

Reversing that tactic works just as well—visit physicians in the area and ask them what specialties or services they are missing. And sometimes, the answers are just waiting to be found. For example, busy radiologists and technologists are accustomed to physician and patient complaints. The next time someone grouches about lengthy wait times or lackluster service, take note.

"You get a feel for what kind of service exists through word of mouth," says Donald T. Fitzgerald, MD, of Quest Imaging Medical Associates Inc (Bakersfield, Calif). "If they're not happy with the level or quality of service, the turnaround time, whatever, they'll mention it." Any of these complaints could indicate an unmet need in the area.

IDLE HANDS

Even with a clear need, steady business is not guaranteed. To stay alive, an imaging center requires a steady flow of patients, preferably from day one. Opening those doors in the right community is key—land at just the right spot, and it'll be hard to keep up with the work. Getting there, however, is a combination of luck and hard work.

"Knowing the demographic assessment of a market is important," says Steve Forthuber, senior VP and chief development officer of Radiologix (Dallas). "Does the community have the proper numbers in terms of population, referring physicians, and payors?"

The goal is to build a business in an area underserved by existing facilities. Determining where that is takes legwork. Market surveys will help, as will befriending the city's planning department to learn the direction of area businesses and population growth.

NICHE CENTERS

“We went carefully over where the population was and where it was moving,” says interventional radiologist Donald Cornforth, MD, of Quest Imaging. “We knew where roads were going and where the applications for new development were being filed.”

Really, it's a simple equation: No customers equals no imaging center. Before breaking ground, try to get a handle on where the business will come from. Professionals moving into their own businesses should assume nothing. Don't guess at how much business existing referrers will send your way; go straight to the source for that information.

“Determine your top 20 to 25 referring physicians, who comprise about 80 percent of your business. Sit down with them and have a heart-to-heart,” Young advises. “Ask them, ‘If I make this change, how will it affect our relationship?’”

Even then, erring on the side of caution is safest, no matter how loyal referring physicians are now or promise to be.

SEEK PROFESSIONAL HELP

Intimidated by the thought of going it alone? Services are available to help gather the information and develop business plans for imaging centers of every size, improving their chances of succeeding in a competitive market. One example is GE Healthcare's Performance Solutions Group (Waukesha, Wis), which offers a team to help with the all-important market analysis by interviewing local physicians, producing both candid feedback and customized advice for how an imaging center might differentiate itself in the market.

“Our intent is to create a great experience for facilities, making it much easier for them to do business,” says Sean Burke, chief marketing officer of diagnostic imaging and services at GE Healthcare Technologies. “Whether it's a new center or an existing one, we want to help it be successful.” That means providing help in all aspects—from financial services to business planning to technology.

Aligning with experienced, savvy professionals is always wise, and that includes teaming with people interested in laying their own money on the line. With Sovereign Healthcare, each of its centers is a collaborative effort between physicians and investors.

“Our referring physicians are our partners as well as owners. We ask them to invest alongside us,” says Hogue, who explains that the process is similar to physicians investing in their own practices, but without the same risks of doing it alone. “Everything we do is with physician ownership, and that has the potential to drive a substantial amount of business to an imaging center.

“We don't subscribe to the ‘if you build it, they will come’ mentality,” he continues. “We work with doctors to decide whether or not a project is feasible and only move forward when it is. That way, it's a low-risk venture.”



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SO, YOU WANT TO START AN IMAGING CENTER?

After weighing the pros and cons, studying the market, and assessing your entrepreneurial mettle, you're still eager to break out on your own and start an imaging center. Great! Just keep these three basics in mind:

1) Get paid.

This one is about as basic as it gets. Money oils the gears of business; without it, the imaging center will grind to a halt. You want at least one billing-savvy staff member. These professionals also should keep the team abreast of any specific payor requirements for exams. Knowing what is reimbursable beforehand will prevent facilities from unintentionally volunteering their services.

"Some of the billing is very complex," cautions Donald T. Fitzgerald, MD, of Quest Imaging Medical Associates Inc. "You must be able to code properly; otherwise, you'll be denied and won't be paid for your work."

2) Fill the imaging center with experience.

"You cannot afford years of negative cash flow," says Donald Cornforth, MD, of Quest Imaging. "If you don't have a built-in clientele, you need well-qualified management with the ability to help set up and run the business, as well as to help market it."

No one does all things well, so the more expertise on board, the better. Of course, balance spending on staff against the speculative nature of self-employment. It's financially prudent to initially limit fixed costs. However, don't skimp at the expense of service.

"You don't want to come out and deliver poor service," says Steve Forthuber of Radiologix, adding that you should determine a threshold amount of staffing and develop contingency plans should the business grow faster than expected.

3) Determine the optimal level of technology.

Do you have a legacy system? Do you still want one? Consider starting as a fully digital imaging center. The advantages go well beyond eliminating the hassles of future conversions.

"Being an all-digital facility allows us to be much more efficient," Cornforth says. "It's not uncommon for a patient to come to us for a procedure, and by the time he or she gets to the doctor's office, the physician already has the report in hand."

—DH

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MORE THAN MEETS THE EYE

Women's imaging treats the whole person



The statistics¹ are daunting. In the United States, about 211,240 women will be diagnosed with breast cancer. Approximately 40,410 women will die from it. And that's just in 2005.

Although breast cancer deaths are declining—due, in part, to early detection—many insurance providers are reluctant to reimburse physicians for interventional screening.

The harsh reality is that many hospitals don't focus on breast intervention because it doesn't generate a profit. Hospitals take a loss on existing mammography programs primarily to create traffic for their breast surgeons and oncology departments.

Fortunately, the need for preventive treatment is being met by independently owned imaging facilities tending exclusively to women's breast health issues. These facilities are able to provide services only by staying *outside* the parameters of large insurance providers. Imaging centers practicing proactive healthcare and early detection can't participate in any type of HMO plan, where patients must be diagnosed before procedures will be covered.

"Women need to know that these services exist," says Nancy L. Elliott, MD, FACS, founder of the Montclair Breast Center (Montclair, NJ) and a member of the *Medical Imaging* Editorial Advisory Board. The facility treats approximately 6,000 patients regularly per year, many of whom are high risk. "There is no other place for these women to go. Yes, they can get a mammogram, but women with increased risk need more than just mammography."

Elliott was motivated to open a women's health practice after working as a breast surgeon for Mount Sinai Medical Center and St Vincent's Hospital (both in New York). "As a breast surgeon, I saw many patients who had abnormal mammograms where a biopsy was recommended," she remembers. "But I would look at the film and realize that what the woman really needed was a *good* mammogram." Elliott estimates that nine times out of 10, a biopsy was unnecessary. Eventually, she eliminated the middleman and began performing mammograms in her office.

Beth M. Deutch, MD, also experienced frustration with the way women's breast exams were handled by large hospitals. During her 10 years as director of breast imaging at Monmouth Medical Center (Toms River, NJ), Deutch saw the number of mammograms performed climb from almost 3,000 to about 30,000 annually.

"The waiting times grew to four months for a screening appointment and two months for a diagnostic appointment," she says. "It was unpleasant for me to practice and unpleasant for the women who came in."

The frustration and lack of personal attention led Deutch to establish HerSpace Breast Imaging Associates (West Long Branch, NJ). As founder and medical director, Deutch has been able to create the patient-friendly environment missing from her former position. "I make all the decisions about how the practice should be run," she says. "I can decide based on the best interest of the patient and practice without ancillary political issues."

Patients aren't the only ones benefiting from the personalized attention available at these centers.

"We have tremendous staff satisfaction, because patients are treated well," Deutch explains. "I see techs walking arm-in-arm into the mammography room—at the patient's pace. They're treated like human beings, and the staff really appreciates that."

Elliott echoes the sentiment. "We're not just the Montclair Breast Center," she says. "We're Dr Lee [Melissa Lee, MD, breast imager at the center] and Dr Elliott. It's not just imaging, it's breast care."

Both physicians hope that other professionals follow their lead and create additional opportunities for women to find more sensitive, attentive care *before* they're diagnosed with disease.

"It's something really worthwhile, and more physicians should consider it," Deutch says. "I think it's like anything else in life—what's really good is not easy. It's difficult, it's a little bit painful, but I believe in the end, the patients and the physician do better."

—DH

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1. American Cancer Society. Overview: breast cancer. Available at: http://www.cancer.org/docroot/CRI/CRI_2_1x.asp?dt=5. Accessed May 25, 2005.

STANDING TALL AMONG GIANTS

Aside from securing a prime location, tackling the maze of reimbursement is one of the biggest components of succeeding in healthcare.

"When it comes to knowing the reimbursement, understanding who has captive contracts in the area is essential," Hogue advises.

Comprehensive market research should include details about which insurance providers are doing business in the area and whether a significant part of the patient population is subjugated by a managed care network.

The reality is that if there is a large percentage of HMO patients in the area and a freestanding center isn't contracted with the HMO, the venture is all but destined to fail. In these communities, the only viable solution is to join the large providers. Unfortunately, that is often easier said than done for privately owned facilities.

"If you're new with a niche modality, the managed-care payor might not want to deal with you at all," counsels Donnessa Vessakosol, director of corporate development at Radiologix.

Forthuber agrees that getting in the game could be difficult in an area dominated by HMOs, because the smaller a facility is, the less attractive it is to large insurers. "They might have a comprehensive network and say, 'We don't need another office to provide this service,'" he says.

Technology can set an imaging center apart, but sometimes it creates too much distance. When looking to target a burgeoning modality, be comfortable it is an emerging niche and not a passing "fad."

Also, in the race to be on the cutting edge, be careful not to get too far out front. It takes time for the payor community to adapt and recognize the latest technology. End up too far ahead of them, and reimbursements will be hard to find. Stand-up MRIs are a prime example.

"Payors don't reimburse any higher for a stand-up MRI than a traditional MRI," Hogue notes. Because stand-up MRIs cost four to five times more, the lack of additional reimbursement could impact a center's profitability.



To NICHE OR NOT TO NICHE

Without question, being a generalist makes a lot of capital sense. Although it costs more to purchase and maintain multiple modalities, this risk is offset by a broader client base. Full-service facilities also oblige physicians who prefer dealing with one imaging center that can handle all of their patients.

Offering a variety of services also provides a buffer from regulation changes (see "Too Much of a Good Thing?" on page 25), drops in reimbursements, or waning physician referrals as they apply to a specific modality. Being dependent on any one particular brand or niche can be hazardous.

On the flip side, focusing on a specific modality positions an imaging center to better meet customer needs. Specializing also creates an opportunity for the imaging center to establish its reputation.

"Logic says a specialist would be more than expert in that area of medicine because they're focused," Young says. "There's a confidence that they'll do a better job."

Standing alone also can mean access to growing portions of the market, such as fee-for-service patients. As consumers become more informed, demand is growing

for preventive scans—procedures typically not covered by insurance.

"In our market, the competitive outpatient imaging centers were dominated by managed-care agreements, making it very hard for them to adequately service the fee-for-service patients," Cornforth says. "We saw that need as an opportunity." He estimates that currently 25% of Quest Imaging's business is from interventional services.

THE BOTTOM LINE

No matter how well-researched or plotted, any foray involves the risk of failure. For independent imaging centers, the key to success is found not only in having well-positioned offices and state-of-the-art facilities, but also in having the ability to provide the customer service and individual attention lacking from much of today's managed care.

"The one thing I'd stress is quality of service to both referring physicians and patients," says Paul Streiber, VP of corporate communications at Radiologix. "Making sure patients have a great experience is a good thing to replicate day after day." ■

Dana Hinesly is a contributing writer for Medical Imaging.



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TOO MUCH OF A GOOD THING?

The advent of restrictions on private diagnostic imaging

No one denies that diagnostic imaging is vital to the early diagnosis of disease. But some argue that the technology is being overused, and many of the nation's largest insurers are looking at ways to end unnecessary exams.

"It's a wise thing for payors to be doing," says Paul Streiber of Radiologix. "A lot of data supports self-referral trends—specialists with their own pieces of equipment utilize them more."

A program put in place by Highmark Inc (Pittsburgh), a Blue Cross Blue Shield provider serving northeastern and southeastern Pennsylvania, is leading the way to imaging restrictions. Scheduled to be implemented this summer, the new plan mandates that scans will be reimbursed only if imaging centers meet new standards, such as employing a full-time Board-certified radiologist, accepting patients some nights and weekends, and agreeing to random safety inspections.¹

Highmark is limiting self-referrals by requiring an imaging center to offer a minimum of five modalities. Acceptable² services include plain film, ultrasound (general or OB/Gyn), echocardiography, nuclear cardiology, mammography, and fluoroscopy.

Financial woes prompted Highmark's recent

policy changes, and the insurer estimates a 25%¹ savings on outpatient imaging costs. Though tangible results have yet to be realized, the program is being watched closely by an industry that is eager to curb out-of-control spending.

"It's interesting to see that a little while after Highmark started developing restrictive criteria, MedPAC recommended that Congress adopt similar measures for steering diagnostic imaging," Streiber notes.

The spring report, presented by the Medicare Payment Advisory Commission (MedPAC of Washington), recommended limiting which providers can bill Medicare for diagnostic imaging procedures in ways that mirror those in the Highmark program.

The report also advocates regulating qualifications of techs and supervisors, technical quality of images produced, safety procedures, and the training and experience of physicians. The proposal is to base standards on "some combination of physician training, experience, and continuing education."³

Opponents voice concerns that the new regulations are too restrictive and are biased toward hospitals that, unaccustomed to competition, are losing business to freestanding imaging centers.

Many worry that physicians will be burdened with additional paperwork and bureaucratic processes, and that preauthorization requirements will impede patient care. Perhaps the most irrefutable concern is that radiologists are already in short supply. Requiring one to be on-site at least 40 hours each might prove impossible for some facilities.

"This is important for those considering starting an independent, niche imaging center," says Phil Young of Universal Imaging. "Facilities buying a large piece of equipment might not be able to provide services if this is made a national plan."

—DH

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