Interventional radiologists provide necessary and valuable services to hospitals and patients. The current state of interventional radiology coverage in hospitals is in crisis and, in the authors’ opinion, appears to threaten access to interventional radiology in many regions and high-quality patient care. Interventional radiology procedures historically provided exclusively by radiologists are continually being given away piece by piece to physicians in other specialties, such as cardiologists and vascular surgeons. When other physician specialists “share” in the work, they typically provide a higher share of the daytime work, while leaving the interventional radiologists with a disproportionate or the sole responsibility and burden of night and weekend call. This results in decreased revenue for groups providing interventional radiology services while maintaining the obligation to provide the same level of IR coverage and staffing. An unintended consequence is the loss of interventional radiologists who become disenchanted by the loss of the “good-quality” work—that is, loss of the variety and volume of exciting and challenging interventional procedures. When this happens, many groups are unable to sustain the capability and staffing to provide on-call interventional radiology coverage to hospitals.

Although not required by the Joint Commission, Medicare or any federal or state law, most hospitals desire to contract with a radiology group to ensure coverage for radiology services at the hospital 24 hours per day, seven days per week. Despite most hospitals wanting so-called exclusive contracts, most of these hospitals are only willing to grant true exclusivity for “radiologist” coverage or for on-call coverage. The principal benefit to a radiology group of entering into a contract is the promise of exclusivity to provide all radiology services for the hospital’s patients. In exchange for this exclusivity, radiologists agree to be subject to heightened controls and to assume obligations beyond what they would have absent a contract (such as continuous call coverage, noncompete restrictions and performance standards).

A contract with too many exceptions to exclusivity may be at increased risk of challenge under antitrust laws.

Even the rare existing exclusive contract with no exceptions to exclusivity does not preclude hospitals from asking the group for a waiver of exclusivity or an amendment to the contract to allow other specialists who bring patients the nonexclusive right to provide certain radiology services. Most radiology groups have few desirable alternatives to accommodating the hospital’s request. If the group does not agree to permit other specialties to provide services, the radiologists may be perceived by hospital administration as uncooperative. They may also be portrayed in a negative light to other physicians and may lose the support of the medical staff.

The problem in most modern-day contracts is that the bargained-for exclusivity that in past years had so readily been given to radiology groups in exchange for their provision of guaranteed call coverage has been and continues to be eroded. An exclusive contract where a radiology group is the genuine exclusive provider of all radiology services has become an ancient relic, especially with respect to interventional radiology. Unfortunately, although the concept of total exclusivity is a vestige of the past, the concept of exclusivity for call responsibility remains. Although hospitals are far less resistant to enforce exclusivity as to nonradiologists, they remain resistant to impose or enforce nonradiologists’ call obligations.

The best strategy for a group is not to just say “no” but to negotiate with the hospital in good faith to reach a mutually agreeable solution. The group should ask for something in return, some consideration given by the hospital in exchange for the group’s agreement to add exceptions to exclusivity. Groups may feel subtly (or not so subtly) coerced or threatened with the possibility of termination or replacement by the hospital if they do not agree to give up exclusive services. In this situation, the radiology group’s only recourse may be to terminate the contract. Many groups are generally not in a position of great power and may choose to compromise by allowing exceptions to exclusivity and, in return, obtaining some additional benefit from the hospital.

There should be as few exceptions to exclusivity as possible. A contract with too many exceptions to exclusivity may be at increased risk of challenge under antitrust laws. The hospital and the incumbent group may find themselves defending an antitrust suit.

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brought by a radiologist who sought privileges but was denied them even when numerous nonradiologist physicians had been granted privileges to perform imaging services despite the so-called exclusive contract. This will depend on the specific facts of the situation and the particular hospital’s market share.

Exceptions to exclusivity should also be kept as narrow as possible, such as limiting the exceptions to specifically listed procedures and specifically listed physicians, groups or specialties. The radiology group may retain the exclusive right to perform all procedures within the radiology department or within a dedicated angio suite. If forced to share an angio suite, the radiology group should seek control of the schedule and scheduling priority. When forced to give up exclusivity for interventional radiology services to allow other physicians to provide such services, those other physicians should be required to share on-call coverage responsibility for procedures they are credentialed to perform. Call coverage should be shared pro rata, on the basis of the percentage of procedures, and not per capita by physician. It is hardly equitable when two vascular surgeons do 50 percent of the interventional radiology services, and eight radiologists perform the other 50 percent of the work, but the radiologists are responsible for 80 percent of the call.

In lieu of (or in addition to) other physicians sharing interventional call coverage, the hospital may compensate the radiology group for its provision of call coverage on an exclusive basis. The amount of compensation must be consistent with fair market value, and may be structured in the form of an hourly or daily payment or an annual amount of compensation for the number of radiologists necessary to provide the call. Some groups also receive financial assistance in the form of malpractice subsidies, teleradiology reimbursement, income guarantees or recruitment assistance. According to the Medical Directorship/On-call Compensation Report, a recently reported survey by the Medical Group Management Association, 58 percent of providers in physician practices not owned by hospitals receive some form of additional compensation for on-call coverage, mostly in the form of a daily or hourly rate. Hospitals are increasingly realizing the need to compensate physicians for on-call coverage. In addition to financial compensation, the hospital may provide support for the radiology group’s call coverage in the form of other concessions in a hospital contract. For example, the hospital contract may permit the radiology group to provide technical and professional component interventional (and other) radiology services outside of the hospital to nonhospital patients.

Without support from the hospital in some combination of sharing call coverage with other physicians, payments or the ability for a group to provide outside services to support its IR practice, it will be difficult for a radiology group to recruit and retain interventional radiologists necessary to provide the level of on-call coverage. Interventional radiologists may not find enough procedures to maintain their skills and will not be happy with the work that is left to them. Interventional radiologists will be increasingly dissatisfied with the lifestyle sacrifices that leave them attached to a beeper and not able to enjoy a glass of wine or quality time with their families in the evening.

Some diagnostic radiology groups are actually getting out of the business of peripheral angiography altogether. An increasing number of radiology groups have exclusive agreements to provide general diagnostic radiology services only. This leaves the hospital with no exclusive provider of coverage for interventional procedures, resulting in lower efficiency and quality for patients. These issues are present to some degree at a vast majority of hospitals.

In our view, these problems will not necessarily be solved on a hospital-by-hospital, group-by-group basis, although considerable grass-roots progress can be made through negotiation using the principles outlined in this article. Interventional radiology, as a specialty, needs to pull together and make solving the IR coverage dilemma a high priority. It should be prominent on the specialty’s policy and advocacy agenda. Any real solutions to these problems will likely require a national coordinated grassroots effort by members.

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Have you experienced on-call availability issues in your hospital? Go to the Members Forum on www.SIRweb.org and let us know in the General Discussion area.