



FMV INSIGHTS

WHAT HOSPITALS SHOULD WATCH

Radiology PSA agreements are increasingly affected by:

- Shrinking reimbursement
- Staffing shortages
- Rising provider compensation
- Growing subspecialty demands
- Expanded coverage expectations

KEY FMV CONSIDERATIONS

Hospitals should carefully evaluate:

- Coverage structure
- Staffing models
- On-site requirements
- Teleradiology usage
- Subspecialty economics
- Total arrangement profitability

PSA TERMS SHOULD DEFINE

- Scope of services
- Coverage hours
- Restricted vs. unrestricted shifts
- Subspecialty obligations
- Use of APP coverage



AVOID FMV COMPLIANCE PITFALLS IN RADIOLOGY SERVICES AGREEMENTS

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Professional services agreements continue to play a critical role in helping hospitals and health systems ensure specialty coverage, manage costs, and support quality patient care. However, these arrangements are becoming increasingly complex as hospitals face escalating provider compensation requests, staffing shortages, inflationary pressures, and growing demands for subspecialty coverage. Negotiations are also frequently influenced by the potential risk of coverage disruption if agreements cannot be reached. As a result, it is increasingly important for hospitals to understand the financial and operational characteristics associated with hospital-based specialty service lines in order to effectively negotiate professional services agreements (PSAs) and maintain fair market value (FMV) and commercial reasonableness (CR) compliance.

Radiology presents a particularly challenging environment due to declining reimbursement, increasing compensation expectations, expanded imaging demand, and the growing need for subspecialty coverage. This article explores several key considerations associated with compliant radiology professional services agreements, including reimbursement pressures, coverage requirements, staffing models, and subspecialty service arrangements.

INCREASING COSTS AND SHRINKING REIMBURSEMENT IN RADIOLOGY

ABC Radiology Service, LLC, currently provides imaging services as the exclusive provider to a hospital client and has now approached them for the third time, requesting a \$450,000 subsidy under their PSA for interventional radiology coverage. The radiology group is stating that without an increased stipend, they will no longer be able to provide the necessary onsite interventional coverage due to low volume of interventional cases and rising costs for an interventionalist.

This situation is becoming increasingly common as radiology practices are restructuring their agreements with health systems. Historically, health systems entered into service agreements with radiology groups, often with little or no cash payments involved. The radiology groups agreed to provide comprehensive coverage in exchange for being the exclusive provider of radiology services. Unlike other hospital-based specialties, radiologists typically earned enough from professional fees to cover their costs, making these agreements mutually beneficial without direct financial compensation from the hospital.

The landscape is changing. The primary reason behind these changes is the rising financial burden on radiology groups to maintain continuous coverage. Radiology practices are now facing shrinking reimbursement in the face of significant staffing shortages and rising costs, making it difficult to maintain coverage with professional fees alone. From a revenue perspective, the American College of Radiology estimates a projected overall reimbursement decrease of approximately 2.8% on radiology services under the 2025 Medicare Physician Fee Schedule. [1] In addition, radiology groups have also been adversely affected by the No Surprises Act. While most physicians bill very few out-of-network (OON) claims, radiologists bill approximately 6.3% of their claims out of network. [2] A contributing factor to this level of OON billing is the site of service. According to the U.S. Department of Health and Human Services,

“Claims from emergency departments (13 percent) and ambulatory surgery centers (8 percent) are more likely to be billed OON than claims from office visits (4 percent).” [3] These sites of service are common to radiology and have had a direct impact on a portion of their revenues.

While revenues are facing headwinds, operating expenses are rising due to inflation as well as provider shortage in the context of rising demand. Not only are radiology practices experiencing rising costs in administrative services and supplies, but they are challenged with higher provider compensation requests from radiologists. An aging Baby Boomer population, imaging overutilization, and expanded diagnostic imaging capabilities are increasing the demand on an already strained supply of radiologists. [4] Radiologists are working harder, and it is reflected in the work relative value units (wRVUs) per FTE, according to the Medical Group Management Association (MGMA) survey data. [5]

“RADIOLOGISTS ARE SEEKING HIGHER COMPENSATION LEVELS COMMENSURATE WITH WORKLOAD GROWTH.”

Table 1 illustrates a wRVU growth rate at the median of 19.55% over the last few years. [6] Some of this increase in workload is being driven

by the pressures exerted from declining reimbursement and resulting in radiologists having to read more imaging studies per FTE to generate similar revenues and maintain compensation levels. Given their demand, radiologists are seeking higher and higher compensation levels commensurate with the growth in their workload. This direct impact on compensation can be seen in Table 1, which illustrates compensation and production data trends between 2019 and 2023. Not only did wRVUs grow, but median compensation for diagnostic radiologists increased by 12.2% over the last four years. [7] All these financial burdens are creating practice losses that are then being transferred to the hospitals through increased subsidy payments.

Table 1: Provider Compensation and Production Data Trend – Median Level ^[8]

Radiology: Diagnostic	2019	2020	2021	2022	2023
wRVUs	9,605	8,640	9,540	10,216	10,587
Collections per wRVU	\$66.28	\$64.17	\$58.18	\$61.97	ISD
Compensation per wRVU	\$55.69	\$58.95	\$56.19	\$55.30	\$54.78
Total Compensation	\$508,472	\$511,454	\$515,460	\$525,722	\$570,709

KEY TAKEAWAY

The trend data by MGMA reports an increase in wRVUs at the median with a decline in reimbursement shown by the reduction in collections per wRVU over the same time period.

COVERAGE REQUIREMENTS DRIVE VALUE

Radiology coverage agreements often differ in how they outline the contractor's coverage responsibilities. Some agreements will list out the provider type, shift, and hours worked per shift to ensure the exact coverage desired. Others may only state that the contractor must provide "sufficient staffing" in order to cover the service over a 24-hour period. Under these vague terms, the contractor could fulfill the obligation by staffing with various types of providers, adjusting the total number of provider FTEs used, and/or utilizing a mix of on-site and off-site coverage. To ensure the contractor delivers coverage aligned with FMV support, it is advisable to include detailed coverage requirements. At a minimum, these should specify the type of provider, hours of restricted coverage, and use of teleradiology. The FMV support should reflect these detailed requirements to justify appropriate compensation.

For example, Table 2 illustrates two distinct radiology services that are exclusively covered by a radiology group under a PSA to provide 24/7 diagnostic coverage plus interventional radiology coverage on-site during weekdays.

Each service generates a similar number of reads with approximately 103,850 wRVUs per year. Staffing Model A utilizes less interventional radiologists and advanced practice providers (APP) to cover the service compared to Staffing Model B. Given the difference in compensation combined with the volume of wRVUs generated by each specialty type, staffing model B is more costly. While interventional radiologists do perform diagnostic reads, they do so at a lesser volume given their on-site requirement and focus on procedural work. Even at low volume facilities, interventional radiologists spend a portion of their time performing minimally invasive procedures guided by imaging. The time required for these activities reduces the amount of time they can spend on reading and interpreting diagnostic images. As a result, the compensation value of the staffing models above differs by as much as \$415,000 per year. Both are covering the service, however, the provider types, the case mix of imaging services, and their compensation can yield very different resource costs.

Table 2: Staffing Models based on Provider Type

STAFFING MODEL A	Provider	Comp / FTE	wRVU / FTE	FTEs	Total wRVUs	Total Value
	Diagnostic	\$602,751	11,612	8	92,896	\$4,822,008
	Interventional	\$618,719	8,189	1	8,189	\$618,719
	APPs	\$153,314	2,753	1	2,753	\$153,314
	Total Coverage				103,838	\$5,594,041
STAFFING MODEL B	Provider	Comp / FTE	wRVU / FTE	FTEs	Total wRVUs	Total Value
	Diagnostic	\$602,751	11,612	6	69,672	\$3,616,506
	Interventional	\$618,719	8,189	3	24,567	\$1,856,157
	APPs	\$153,314	2,753	3.5	9,635	\$536,599
	Total Coverage				103,874	\$6,009,262

KEY TAKEAWAY

Even when radiology services generate similar annual wRVU volumes, provider mix and coverage responsibilities can significantly impact compensation requirements. For example, the table above illustrates a difference of \$415,221 based solely on provider mix.

When evaluating for appropriate staffing, it is important to keep in mind the case mix of imaging modalities and calculate the wRVUs generated by the service line. The wRVUs will be a function of the physician's expertise in interpreting the image study, time required to deliver the diagnostic reports, and complexity of the modality. This can vary considerably. For example, a simple X-ray may require minimal time and effort for interpretation, while a more complex MRI or CT scan, particularly involving the brain, spine, or abdomen, demands greater expertise and a more detailed analysis.

As such, it is important for the PSA to delineate the following:

- **Scope of services:** Clearly define the specific services the radiology group will provide (i.e., diagnostic imaging, interventional radiology, subspecialty services).
- **Hours of coverage:** Establish expectations for on-site, remote, and after-hours coverage, including night and weekend shifts.
- **Subspecialty expertise:** Ensure the PSA outlines subspecialty coverage requirements (e.g., neuroradiology, pediatric radiology) based on the needs of the health system.

STRUCTURING SUBSIDY SOLELY AROUND SUBSPECIALTY COVERAGE

The request for higher subsidies is often associated with radiology subspecialties requiring on-site direct physical assessment of the patient, especially those that involve interventional procedures or comprehensive consultation. These subspecialties include: a) neuro-interventional radiology, b) interventional radiology, c) breast imaging, d) musculoskeletal imaging, and e) nuclear medicine radiology. Given the requirement to be on-site coupled with the increasing compensation for these sub-specialties, many radiology groups are requesting a subsidy payment for the provision of these services in isolation of the economics of the other imaging modalities. Under an exclusive arrangement, isolating out a single service and excluding

the FMV analysis of all services could potentially lead to the arrangement being outside of FMV and, as a result, out of compliance with FMV and potentially CR requirements. While radiology groups may attempt to structure their subsidy arrangements around a particular subspecialty, health systems need to evaluate the economics associated with the exclusive arrangement in its entirety. Table 3 illustrates the fair market value (FMV) subsidy calculations associated with the ABC Radiology, LLC arrangement. The proposal calls for an interventional radiologist to be on-site at the hospital Monday through Friday, 8 am to 5 pm, for potential cases.

Table 3: Evaluation of FMV Compensation for Radiology PSA (ABC Radiology, LLC)

	Proposal Intvl Radiology Only	Program A (Favorable Payor Mix) Entire Rad Service	Program B (Poor Payor Mix) Entire Rad Service	
Revenue – Intvl	\$350,000	\$350,000	\$250,000	
Revenue – Diag	–	\$4,200,000	\$3,000,000	
Total Revenues	\$350,000	\$4,550,000	\$3,250,000	A
Expenses – Intvl	\$800,000	\$800,000	\$800,000	
Expenses – Diag	–	\$3,500,000	\$3,500,000	
Total Expenses	\$800,000	\$4,300,000	\$4,300,000	B
Subsidy	(\$450,000)	\$250,000	(\$1,050,000)	A – B

KEY TAKEAWAY

Analyzing interventional radiology coverage should be performed in the context of the entire radiology service line.

Note that ABC Radiology, LLC is proposing a subsidy of \$450,000 per year solely based on the revenue less expenses associated with the interventional radiology service. However, depending on the profitability of the radiology service in its entirety, the \$450,000 request may be outside of FMV. Under a favorable payor mix service, the program as a whole illustrates a profit of \$250,000. As a result, no subsidy is required under Program A. However, under Program B, the poor payor mix has resulted in lower collections which in turn generates an overall loss of \$1,050,000. In Program B, the analysis supports a subsidy of not only the \$450,000 for interventional radiology only, but up to \$1,050,000 for the entire service. Program A would be outside of FMV compliance if the hospital elected to pay ABC Radiology, LLC the requested \$450,000 subsidy.

In addition to the analysis above, it is important to note the radiology subspecialist will often perform diagnostic reads for the group while on a subsidized restricted shift. This is another important consideration for why it is imperative to situate a subsidy for subspecialty services in the context of all arrangements provided by the radiology group. Given the typical exclusivity that is characteristic of these arrangements, a careful reassessment will help ensure compliance across the service line.

KEY CONSIDERATIONS

As professional services agreements in radiology become increasingly complex, it's critical for hospitals to strategically address escalating costs, adapt staffing models, and meet the requirements of subspecialty services while ensuring Fair Market Value (FMV) compliance. By gaining a deep understanding of the financial impacts and operational demands specific to radiology, hospitals can negotiate agreements that align with FMV standards, balancing the need for high-quality specialty care with sustainable cost structures.

[1] American College of Radiology, Detailed Summary of Radiology Provisions in the 2025 MPFS Proposed Rule (2024), <https://www.acr.org/-/media/ACR/Files/Advocacy-and-Economics/Regulatory-Resources/2025-MPFS-PR-Detailed-Summary-FINAL.pdf> (last visited Oct. 20, 2024).

[2] Jay R. Parikh et al., Radiologists' Out-of-Network Billing Trends, 2007 to 2021, 21 Journal of the American College of Radiology 851–857 (2021).

[3] U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning & Evaluation, Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes: Baseline Trends and Framework for Analysis, First Annual Report (2023), <https://www.hhs.gov/sites/default/files/aspe-no-surprises-act-rtc.pdf> (last visited Oct. 26, 2024).

[4] E.I. Bluth et al., Medical Workforce in the United States, 23 Journal of Applied Clinical Medical Physics, Suppl. 1, e13799 (Dec. 2022).

[5] wRVUs are a measure used to quantify the value of the work performed by physicians and other healthcare providers. It is a part of the Resource-Based Relative Value Scale (RBRVS), which is used by Medicare and other insurance providers to determine reimbursement rates. Each medical service or CPT code is assigned a specific number of wRVUs, reflecting the time, skill, training, and intensity required to provide the service.

[6] MGMA, 2024 Physician Compensation Survey (2024) (wRVU production data).

[7] MGMA, 2024 Physician Compensation Survey (2024) (diagnostic radiologist compensation data).

[8] Compensation and production metrics were compiled by HMS from various national market surveys, including Medical Group Management Association, SullivanCotter & Associates, and American Medical Group Association.