



**Certificate of Need Application**

**Advanced Radiology MRI Centers  
Limited Partnership**

**Acquisition of 3.0 Tesla MRI Unit  
For Stamford Office**

**June 14, 2016**

June 14, 2016

Janet M. Brancifort, MPH, RRT  
Deputy Commissioner  
State of Connecticut Department of Public Health  
Office of Health Care Access Division  
410 Capitol Avenue, MS #1 HCA  
P.O. Box 340308  
Hartford, CT 06134-0308



Re: Advanced Radiology MRI Centers Limited Partnership  
Acquisition of 3.0 Tesla MRI Unit for Stamford Office

Dear Deputy Commissioner Brancifort:

Enclosed please find an original and four (4) copies of Advanced Radiology MRI Centers Limited Partnership's Certificate of Need Application for the acquisition of a 3.0 Tesla MRI unit. Also enclosed is a disc containing the entire submission and a check for the \$500 filing fee.

Please feel free to contact me with any questions. We look forward to working with you on this matter.

Very Truly Yours,

Jennifer Groves Fusco

/jgf

cc: Clark Yoder, CEO

## Application Checklist

### Instructions:

1. Complete the following checklist and **submit** as the first page of the CON application:
  - Attached is a paginated hard copy of the CON application (all social security numbers must be redacted), including a completed affidavit, signed and notarized by the appropriate individuals.
  - (\*New\*). A completed supplemental application form specific to the proposal type, available on OHCA's website under OHCA Forms (see previous page for the list of supplemental forms).
  - Attached is the CON application filing fee in the form of a check made out to the "Treasurer State of Connecticut" in the amount of \$500.
  - Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication*)
  - Attached is a completed Financial Worksheet (A, B or C) available at OHCA's website under OHCA Forms.
  - Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.
  - The following have been submitted on a CD:
    1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format; and
    2. An electronic copy of the completed application forms in **MS Word** (the applications) and **MS Excel** (Financial Worksheet)

### For OHCA Use Only:

Docket No.: 16-32093-CON Check No.: 27632  
OHCA Verified by: SL Date: 6/14/16

## General Information

Name of Applicant:

Name of Co-Applicant:

|   |  |
|---|--|
| <b>Advanced Radiology MRI Centers Limited Partnership</b> |  |
|---|--|

Connecticut Statute Reference:

**19a-638(a)(10)**

|                  |                                       |                               |                                 |  |
|------------------|---------------------------------------|-------------------------------|---------------------------------|--|
| <b>Main Site</b> | MAIN SITE                             | MEDICAID PROVIDER ID          | TYPE OF FACILITY                | MAIN SITE NAME   |
|                  | <b>Advanced Radiology Consultants</b> | <b>1710991617<sup>1</sup></b> | <b>Private Physician Office</b> | <b>Advanced Radiology Consultants Corporate Office</b> |
|                  | STREET & NUMBER                       |                               |                                 |  |
|                  | <b>3 Enterprise Drive</b>             |                               |                                 |  |
|                  | TOWN                                  |                               |                                 | ZIP CODE   |
|                  | <b>Shelton</b>                        |                               |                                 | <b>06484</b>   |

|                     |                                       |                      |                                 |   |
|---------------------|---------------------------------------|----------------------|---------------------------------|---|
| <b>Project Site</b> | PROJECT SITE                          | MEDICAID PROVIDER ID | TYPE OF FACILITY                | PROJECT SITE NAME                                     |
|                     | <b>Advanced Radiology Consultants</b> | <b>1710991617</b>    | <b>Private Physician Office</b> | <b>Advanced Radiology Consultants Stamford Office</b> |
|                     | STREET & NUMBER                       |                      |                                 |   |
|                     | <b>1315 Washington Boulevard</b>      |                      |                                 |   |
|                     | TOWN                                  |                      |                                 | ZIP CODE  |
|                     | <b>Stamford</b>                       |                      |                                 | <b>06902</b>  |

|                 |                              |                                 |   |
|-----------------|------------------------------|---------------------------------|---|
| <b>Operator</b> | OPERATING CERTIFICATE NUMBER | TYPE OF FACILITY                | LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator) |
|                 | <b>N/A</b>                   | <b>Private Physician Office</b> | <b>Advanced Radiology MRI Centers Limited Partnership</b>             |
|                 | STREET & NUMBER              |                                 |   |
|                 | <b>3 Enterprise Drive</b>    |                                 |   |
|                 | TOWN                         |                                 | ZIP CODE  |
|                 | <b>Shelton</b>               |                                 | <b>06484</b>  |

<sup>1</sup> This is the NPI for Advanced Radiology Consultants, LLC. The practice's physicians have Medicaid Provider IDs, but the practice itself does not.

|                        |                    |                       |                         |          |  |
|------------------------|--------------------|-----------------------|-------------------------|----------|--|
| <b>Chief Executive</b> | NAME               |                       | TITLE                   |          |  |
|                        | Clark Yoder        |                       | Chief Executive Officer |          |  |
|                        | STREET & NUMBER    |                       |                         |          |  |
|                        | 3 Enterprise Drive |                       |                         |          |  |
|                        | TOWN               |                       | STATE                   | ZIP CODE |  |
|                        | Shelton            |                       | CT                      | 06484    |  |
|                        | TELEPHONE          | FAX                   | E-MAIL ADDRESS          |          |  |
| (203) 696-6125         | (203) 696-6130     | clark.yoder@adrad.com |                         |          |  |

Title of Attachment:

|  |   |  |
|--|---|--|
| Is the applicant an existing facility? If yes, attach a copy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project. | YES <input checked="" type="checkbox"/><br>NO <input type="checkbox"/>                              | N/A; no resolution required  |
| Does the Applicant have non-profit status? If yes, attach documentation.   | YES <input type="checkbox"/><br>NO <input checked="" type="checkbox"/>                              | N/A  |
| Identify the Applicant's ownership type.   | PC <input type="checkbox"/><br>LLC <input type="checkbox"/><br>Corporation <input type="checkbox"/> | Other: <input checked="" type="checkbox"/><br><b>Limited Partnership</b> |
| Applicant's Fiscal Year (mm/dd)  | Start 01/01   | End 12/31  |

**Contact:**

Identify a single person that will act as the contact between OHCA and the Applicant.

|                            |   |                 |                |          |  |
|----------------------------|---|-----------------|----------------|----------|--|
| <b>Contact Information</b> | NAME  |                 | TITLE          |          |  |
|                            | Jennifer G. Fusco                                 |                 | Attorney       |          |  |
|                            | STREET & NUMBER                                   |                 |                |          |  |
|                            | Updike, Kelly & Spellacy, P.C., 265 Church Street |                 |                |          |  |
|                            | TOWN  |                 | STATE          | ZIP CODE |  |
|                            | New Haven   |                 | CT             | 06510    |  |
|                            | TELEPHONE   | FAX             | E-MAIL ADDRESS |          |  |
| (203) 786-8316             | (203) 772-2037                                    | jifusco@uks.com |                |          |  |
| RELATIONSHIP TO APPLICANT  | Legal Counsel                                     |                 |                |          |  |

Identify the person primarily responsible for preparation of the application (optional):

|                    |  |                       |  |
|--------------------|--|-----------------------|--|
| <b>Prepared by</b> | NAME   |                       | TITLE  |
|                    | <b>Jennifer Fusco</b>  |                       | <b>Attorney</b>                                    |
|                    | STREET & NUMBER  |                       |  |
|                    | <b>Updike, Kelly &amp; Spellacy, P.C., 265 Church Street</b> |                       |  |
|                    | TOWN   | STATE                 | ZIP CODE   |
|                    | <b>New Haven</b>   | <b>CT</b>             | <b>06510</b>                                       |
|                    | TELEPHONE  | FAX                   | E-MAIL ADDRESS                                     |
|                    | <b>(203) 786-8316</b>  | <b>(203) 772-2037</b> | <a href="mailto:jfusco@uks.com">jfusco@uks.com</a> |
|                    | RELATIONSHIP TO APPLICANT                                    | <b>Legal Counsel</b>  |  |

# The ADVOCATE

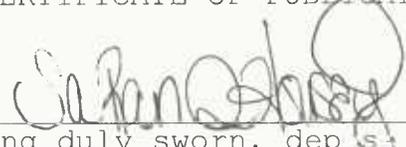
UPDIKE, KELLY & SPELLACY, P.C.  
ONE CENTURY TOWER, 265 CHURCH STREET  
NEW HAVEN CT 06510

THE ADVOCATE  
9 Riverbend Drive South  
Building 9A  
P.O. Box 4910  
Stamford, CT 06907-0910  
Telephone: 203-330-6208  
Fax: 203-384-1158  
Legal.notices@sctn.com

## LEGAL NOTICE

Advanced Radiology MRI Centers Limited Partnership is applying for a Certificate of Need pursuant to Section 19a-638(a)(10) of the Connecticut General Statutes. Advanced Radiology will request permission to acquire an MRI unit for its office located at 1315 Washington Boulevard, Stamford, CT 06902. The capital expenditure associated with this acquisition is \$2,038,442.

## THE ADVOCATE CERTIFICATE OF PUBLICATION

I,   
Being duly sworn, depose and say that I am a Representative in the employ of SOUTHERN CONNECTICUT NEWSPAPERS, INC., Publisher of *The Advocate* and *Greenwich Time*, that a LEGAL NOTICE as stated below was published in THE ADVOCATE.

Subscribed and sworn to before me on this 12th Day of April, A.D. 2016.

  
Pamela Caluori/Notary Public

My commission expires on  
January 2018

### PO Number

### Publication

Stamford Advocate

### Ad Number

0002152481-01

### Ad Caption

LEGAL NOTICE Advanced Rac

### Publication Schedule

3/14/2016, 3/15/2016, 3/16/2016



# THE ADVOCATE

## CLASSIFIED MARKETPLACE

### SOUTHERN CT JOBS

203-330-6553 | classified@scni.com | Hours: 8:30 a.m.-5:30 p.m., M-F | Major Credit Cards Accepted

#### PUBLIC NOTICES

**LEGAL NOTICE**  
Pursuant to Conn. Gen. Stat. §§ 16-245c, 16-245d, 16-245e, 16-245f, 16-245g, and 16-41 and 42-110a et seq., the Public Utilities Regulatory Authority (PURA) will conduct a public hearing at Ten Franklin Square, New Britain, Connecticut, on Tuesday, March 22, 2016, at 10:30 a.m., concerning Docket No. 15-07-17 - PURA Investigation Into Direct Energy Services, LLC's Trade Practices. The PURA may continue the hearing. For information and the Notice of Hearing file with the Secretary of State's Office, contact PUBLIC UTILITIES REGULATORY AUTHORITY, JEFFREY R. GAUDIOSI, ESQ., EXECUTIVE SECRETARY. The public may call the Authority's office, at (860) 927-1503, option 4 (using a touch tone phone), commencing each day from 7:30 a.m., to be advised as to whether this hearing has been cancelled or postponed due to inclement weather. The Connecticut Department of Energy and Environmental Protection is an Affirmative Action and Equal Opportunity Employer that is committed to complying with the Americans with Disabilities Act. To request an accommodation contact us at (860) 416-5910 or [docsaccommodations@ctsonline.org](mailto:docsaccommodations@ctsonline.org).

**PUBLIC NOTICE - REQUEST FOR PROPOSALS - RFP No. 15-0022, Mechanical Contractor Services**  
The Housing Authority of the City of Stamford d/b/a Charter Oak Communities ("COOC") is requesting proposals from experienced Mechanical Contractors to provide Mechanical Contractor Services under RFP No. 15-0022.

There will be a non-mandatory pre-proposal conference at Clinton Manor, 22 Clinton Avenue, Stamford, CT 06901 (1st Floor Conference Room) on Tuesday, March 22, 2016 at 2:00 p.m. The cut-off date for questions (RFIs) is COB Tuesday, March 29, 2016.

Proposals will be received until 2:00 PM on Thursday, April 7, 2016 at Clinton Manor, 22 Clinton Ave., Stamford, CT 06901.

Before submitting a response, the respondent shall examine the entire RFP. The submission of a response will be construed as evidence that such an examination has been made. Requests for the full Request for Proposals should be emailed to:

[esthban@charteroakcommunities.org](mailto:esthban@charteroakcommunities.org)  
Peter Stohar, Procurement Coordinator  
Telephone: (203) 977-1400 Ext. 3322

All procurement decisions shall be at the sole discretion of Charter Oak Communities. Charter Oak Communities is an Affirmative Action/Equal Opportunity Employer. Prior to being awarded a contract for security services, the respondent shall provide COOC with an acceptable Affirmative Action/Equal Opportunity Employment Plan that documents all necessary and required steps to ensure equal opportunity under the law and applicable regulations.

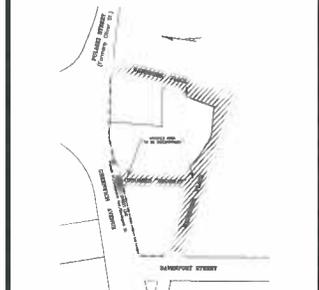
**CHARTER OAK COMMUNITIES**  
Vincent Tulo, Executive Director & CEO

#### PUBLIC NOTICE

The Darien Board of Education is requesting sealed bids for the purchase of Chromebooks. Bids for receiving bids is Thursday, March 31, 2016 at 2:00 p.m. Bids will be opened on that date and time. Specifications may be obtained on the district website at [www.darienps.org](http://www.darienps.org) or call 203-656-7465 to have them emailed. Darien Board of Education reserves the right to reject any and all proposals.

#### LEGAL NOTICE DIRECTOR OF ADMINISTRATION

**CITY OF STAMFORD NOTICE OF INTENT TO DISCONTINUE WATERSIDE PLACE AND UNNAMED HIGHWAY AFFECTING PROPERTIES OWNED BY O&G INDUSTRIES, INC. AND THE CITY OF STAMFORD CT**  
Notice is hereby given that the Director of Administration of the City of Stamford, CT will conduct a Public Hearing on Tuesday, March 22, 2016 at 11:00 AM, Administration Conference Room, 10th Floor, Government Center Building, 888 Washington Boulevard, Stamford, CT, upon application of the City of Stamford and O&G Industries, Inc. to discontinue Waterside Place and Unnamed Highway. Board of Representatives Resolution #3603 stating the intention to discontinue Waterside Place and Unnamed Highway, as well as the Mayor's Report on the discontinuance, are available for public inspection at the Town Clerk's Office, Stamford City Hall, 888 Washington Blvd., Stamford, CT during normal business hours.



The affected property is generally described as follows: Waterside Place and Unnamed Highway begins at land owned by the City of Stamford comprising what is Davenport Street and continues to additional land owned by the City of Stamford comprising what is Paluski Street in said City of Stamford. The total area of Waterside Place and Unnamed Highway is 18,280.35 square feet (4.2 acres).

At the above time and place, all interested persons shall be given an opportunity to be heard with respect to the proposed discontinuance or any assessment of benefits or damages as set forth in the Mayor's Report. The meeting is accessible to the physically handicapped. Hearing-impaired persons wishing to attend this meeting that will require an interpreter may make arrangements by contacting the Dept. of Social Services Administration office at 977-4029 at least five working days prior to the meeting.

For further information, please contact:  
Michael E. Handler  
Director of Administration  
City of Stamford  
(203) 977-4182  
Dated at the City of Stamford, CT this 15th Day of March, 2016

#### PUBLIC NOTICES

**TOWN OF NEW CANAN NOTICE OF TOWN COUNCIL MEETING**  
Notice is hereby given that a meeting of the Town Council of the Town of New Canan will be held at 7:00 p.m. on Wednesday, March 16, 2016 in the Town Hall - Meeting Room, for the following purposes:

- To consider and act upon a Special Appropriation from Unassigned General Fund Balance for Capital Nonrecurring Fund; Approval of a special appropriation of \$2,291,372 from the Unassigned General Fund Balance to be transferred to the Capital Nonrecurring Fund to fund projects that were removed from the budget with the intention of appropriating from Capital Nonrecurring funds.
- Approval of the following projects and a special appropriation of \$2,291,372 from the Capital and Nonrecurring Fund:
 

|   |            |                  |
|---|------------|------------------|
| IT Hardware / Software Replacement        | Gen Gov't  | 75,000           |
| Wide Area Network End of Life Replacement | Gen Gov't  | 40,000           |
| Police Vehicles Replacement               | Police     | 28,000           |
| Equipment for New Vehicle                 | Police     | 10,000           |
| Vehicle Chargeover Costs                  | Police     | 30,000           |
| Portable Radio Replacement                | Police     | 12,000           |
| Bullet Proof Vest Replacement             | Police     | 5,000            |
| Mobile Radio Replacement                  | Police     | 5,000            |
| Taser Replacement                         | Police     | 5,000            |
| Speed Safety Units                        | Police     | 5,000            |
| Replace Jail / Booking Area Cameras       | Police     | 10,000           |
| Personal Protective Equipment             | Police     | 11,000           |
| Chief Vehicle Replacement                 | Fire       | 80,000           |
| Radio's/Pagers                            | Fire       | 11,000           |
| Fire Tools                                | Fire       | 9,000            |
| SCBA Air Bottles                          | Fire       | 8,000            |
| EMTP                                      | Fire       | 10,000           |
| Wayway Athletic Field Fencing             | Recreation | 10,000           |
| Peddie Court Light Pole/Signage           | Recreation | 17,500           |
| Wayway Trail Extension                    | Recreation | 50,000           |
| Hopkiss Carpeting Latham Center           | Recreation | 40,000           |
| Latham Center Furniture Replacement       | Recreation | 7,500            |
| Sidwalks                                  | DPW Admin  | 150,000          |
| 1 W/D Dump/Sander Truck                   | Highway    | 185,000          |
| Sweeper                                   | Highway    | 81,000           |
| 2" Mower                                  | Parks      | 110,000          |
| Grass Seed Irrigation                     | Fields     | 20,000           |
| HS Track / Field Rebuild                  | Fields     | 50,000           |
| <b>Total Town Capital Expenditures</b>    |            | <b>2,292,072</b> |

- |   |          |                  |
|---|----------|------------------|
| New Exhaust Fan All Schools               | District | 15,000           |
| SPED Vehicles                             | District | 184,000          |
| Carb Repair/Replacement                   | East     | 25,000           |
| Masonry Restoration/Repair-Repoint Brick  | East     | 50,000           |
| Classroom Renovation                      | East     | 50,000           |
| Corridor Ventilation                      | East     | 50,000           |
| New Room Dairling Shades                  | South    | 25,000           |
| Grow Rd. Storage Bldg. Rehab Roof & Doors | South    | 25,000           |
| Classroom Painting                        | South    | 25,000           |
| Domestic Hot Water Boilers Saxe and South | West     | 125,000          |
| New Gym Floor Replacement                 | West     | 25,000           |
| Classroom Painting                        | West     | 50,000           |
| Northeast Walk/Port Circle Curb           | West     | 7,500            |
| New Bathroom Partitions (near room 217)   | West     | 42,000           |
| New Security Classroom Shades             | West     | 12,000           |
| (New) Replace Kitchen Ceiling Tiles       | Saxe     | 30,000           |
| Masonry Repair/Repair-Repoint Brick       | Saxe     | 100,000          |
| Repair Classroom Flooring                 | Saxe     | 30,000           |
| New Security Roll Down Gate-Cafe          | Saxe     | 5,500            |
| Domestic Hot Water Boilers Saxe and South | Saxe     | 25,000           |
| Classroom Painting                        | NCHS     | 25,000           |
| New Chiller Relief Valves (2) Safety      | NCHS     | 13,000           |
| <b>Total Bond Capital Expenditures</b>    |          | <b>2,006,970</b> |

3. To transact any other business proper to come before the meeting.



The City of Stamford will receive sealed Request for Proposals/Qualifications and competitive bids for the following projects at the Stamford Government Center, Purchasing Department, 10th Floor, 888 Washington Boulevard, Stamford, Connecticut 06901. All sealed bids will be publicly opened and read.

All Proposal and bid documents, drawings and specifications can be viewed/downloaded from our website [www.stamfordct.gov](http://www.stamfordct.gov). For questions regarding the purchasing or bidding procedure, call or email Beverly Averil, Purchasing Agent at (203) 977-4107 or [baveril@stamfordct.gov](mailto:baveril@stamfordct.gov).

**Request for Bid No. S-5528, REHABILITATION OF MERRIEBROOK LANE BRIDGE OVER MANAN'S RIVER**  
Bid Opening: April 6, 2016 at 11:00 AM  
Bid Deposit: 5%  
Mandatory Pre-Bid Walk Through: Tuesday, March 22, 2016, at 10:00 A.M., at the Project Site.  
All drawings can also be picked up from County Reproductions, 39 Baldwin Street, Stamford, CT 06902. Tel: (203) 348-3756; fax: (203) 348-2854. A non-refundable fee will be charged for these documents. Contact for Technical Questions: Paul Ginoth, Project Manager - Engineering Bureau at (203) 977-4850 or email [pginoth@stamfordct.gov](mailto:pginoth@stamfordct.gov).

**Request for Bid No. S-4527, BRICK RESTORATION AT STAMFORD HIGH SCHOOL**  
Bid Opening: April 19, 2016 at 11:00 AM  
Bid Deposit: 5%  
Mandatory Pre-Bid Walk Through: Tuesday, March 29, 2016, at 3:00 P.M., at Stamford High School, 55 Strawberry Hill Avenue (Meet at the front of the school).  
All drawings can also be picked up from County Reproductions, 39 Baldwin Street, Stamford, CT 06902. Tel: (203) 348-3756; fax: (203) 348-2854. A non-refundable fee will be charged for these documents. Contact for Technical Questions: Jeff Fardo, Construction Manager - Engineering Bureau at (203) 977-5227 or email [jfardo@stamfordct.gov](mailto:jfardo@stamfordct.gov).

Beverly Averil  
Purchasing Agent

#### LEGAL NOTICE

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Want back copies of a story that you need in The Advocate? Have them sent to your home or arrange to pick them up by calling 203-324-9799

Need some work done around the house? Find the right people to help you in our Service Directory.

#### GENERAL HELP WANTED

**DRIVERS**  
**PROFESSIONAL CHAUFFEUR**  
Full or Part Time for PRESTIGIOUS New Canan based limousine company. Experience preferred but will train the right candidate. We offer 20% commission and the average of net jumping vehicles. You must possess a valid CT drivers license with an "F" endorsement (public service license) and a valid DMV medical certificate. Must be fluent in English. Call Larry 203-966-5466

**DRIVER/LABORER** Local landscaping company seeks exp'd laborer and drivers w/valid and a clean drivers license. Contact 203-329-9665 Serious inquiries only.

**LAWN TECH WANTED**  
Applicants & Drivers lic. req'd. Top Pay-Start Immediately! Call 203-323-2325 or Email [lawndaisy@yahoo.com](mailto:lawndaisy@yahoo.com)

**MACHINE OPERATOR**  
Experienced Machine Operator wanted for landscape/site development co. in Greenwich, CT. CDL lic plus. Call Victor 203-969-2353.

**MASON** Experienced Mason needed for busy site developer contractor located in Greenwich, CT. Call Mike 203-969-2353

**MECHANIC HELPER**  
Exp preferred but will train depending on mechanical aptitude. We pay guaranteed. Health ins & forms provided. Ask for Chris/Charlie, Tpkennedy Service. Tel: 203-323-1782

**MECHANIC - Experienced FT**  
Needed for large landscape/site development co. Full knowledge of landscape equipment/mach truck fleet from pick up's to tri-axel dumper. Call Lou 203-969-2583

**PLUMBER**  
Busy plumbing & heating co looking for licensed mechanics or mty hrs exp. Must know residential & light commercial roofing. High compensated. 40% health ins available. Vac pay FT w/o loss. Have valid drivers license. Call 203-323-3743

**RESTAURANT / DINER EXPERIENCED COOKS WANTED**  
Linnell's & Oler's Cooks Competitive pay. Call 203-343-2979

**RESTAURANT BAR PERSON**  
Full Time opportunity for private Country Club in Greenwich. Good pay. Must work weekends. Call 203-969-0555 ask for Shayan

**TRUCK DRIVER - PART TIME**  
Part-Time Truck Driver wanted to deliver and pick up products and production materials to and from designated delivery locations in an efficient and safe manner. 25-29 hrs per week (weeknights), \$12 per hour.

Requirements:  
- Minimum of 1 or more years of experience operating trucks of up to 26,000 lbs. G.V.W.  
- Must possess a valid CDL  
- Must possess a license with a perfect driving record  
- Delivery experience in local area.

Must meet Driver physical standards as defined under the Commercial Drivers License. Able to safely lift/burden of at least 50 lbs.

Email resumes to [jobs@earthnetad.com](mailto:jobs@earthnetad.com)

**WELDER**  
Seeking extensive experience in Garage truck body and container body spray sitting tool. Safe, professional union worker with benefits including, pension, health insurance and paid time off.  
Experience a must!  
Joe 1-914-973-4203 / 914-698-0364 [jorlando@suburbanccarting.com](mailto:jorlando@suburbanccarting.com)

**HEALTHCARE & EMPLOYMENT OPS**  
RECEPTIONIST- FT for busy Stamford medical office. Exp a. Will train. Benefits. Call 203-353-1887 Fax 203-969-7191

#### SITUATIONS WANTED

**ATTENTION**  
The advertisers in this classification are providing a

**FASHION EDITOR:** for personal shopping, closet organizing, styling, house & party styling tool. NYC & Greenwich area. Exp. Refs. Call Elizabeth 317-280-7634.

**PREVIOUS EMPLOYER** (Greenwich) moved to FL. We are a couple, exp'd w/normal hours, hsa, manager, handy man, chauffeur. Great housekeeper & exp. healthy cook. Dog lovers! Ref's 203-554-7235

**PROFESSIONAL Cleaning** for home/office/business 20hrs w/week. Call Rose for info & free estimate. 914-562-1719 or 203-816-7181.

**WELL EDUCATED** Christian Gentleman looking for position as houseman for classy family. Speaks 4 langs, exc refs & exp 203-613-3969

#### NOVENAS

**St. Jude's Novena**  
May the Sacred Heart of Jesus be adored, glorified, loved and preserved throughout the world now and forever. Sacred Heart of Jesus, pray for us. St. Jude, Worker of miracles, pray for us. St. Jude, help of the hopeless, pray for us. Say this prayer 9 times a day, for 9 days. By the 9th day your prayer will be answered. It has never been known to fail. Publication must be promised. Thank you St. Jude for answering my prayer! (B.C.S.)

#### LOST AND FOUND

**FOUND: SHIBA INU** Tan, female, 1 year old. West Palm Beach, FL. FOUND: 4 chickens left in a box by 303 West Putnam. Contact Greenwell Animal Control 203-622-8299

**FOUND CAT** Black, male, in Somersville, Connecticut. 203-363-0220

**STAMFORD ANIMAL CONTROL**  
203-977-4437  
**FOUND:**  
IMP #C16-542 Gray Cat, Gray. DSH, found Willard Terrace.  
IMP #C16-243 Gray Cat, F. Gray/White. DSH, found Chestnut Street.  
IMP #R16-248 Gray Rabbit, M. White/Brown on Knapelbocker Ave. 203-363-0220

#### MERCHANDISE FOR SALE

**ABLANE EQW** With Wooden Base. Size Of An Real EQW \$400 Call 203-329-8770

**AIR PLANE BELT BUCKLE**, 1979 By Bergdorf Brass Works, #P39, Model #101 203-220-3570

**AMERICAN FLYER** #644 SD Gauge Locomotive. \$450 BO. 203-794-0206

**ANTIQUE 19TH CENTURY** vintage shoe and glass shoe set, 1899 is clearly visible \$20. 203-803-3866

**ANTIQUE 19TH CENTURY** vintage shoe and glass shoe set, 1899 is clearly visible. 203-803-3866

**ARMOIRE**, TV cabinet, only \$195. Bookkeeper's brand high quality. 203-970-8427

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**PUBLIC NOTICES**

**Legal Notice  
Zoning Board - City of Stamford**

**Application 216-04 - Notice** is hereby given that the Zoning Board of the City of Stamford, CT will conduct a Public Hearing on Monday, March 28, 2016 at 7:00pm in the Cafeteria, 4th Floor, located at the application of the STAMFORD ZONING BOARD, to amend the Zoning Regulations of the City of Stamford, Article III, to establish new regulations regarding Zoning and a definition for Colleges and Universities and the zoning districts where permitted, in order to support the growth and development of institutions of higher learning within the greater downtown area. The proposed amendments read as follows:

**1. TO AMEND ARTICLE III TO ESTABLISH A NEW SECTION 7.6, TO READ AS FOLLOWS:**

**SECTION 7.6 DORMITORY HOUSING**

1. Purpose. The purpose of this provision shall be to promote and regulate the development of privately owned dormitories (definition #25.5) to provide student housing at off-campus locations to serve educational institutions without being owned by the educational institutions, to serve student population needs without impacting neighborhood character and to increase the economic impact of students in the community without further impacting housing availability for non-student residents of the City of Stamford.

2. Location. The dormitory site shall be located within one-half mile of the campus of the institution and shall be one or more of the following zoning districts: CCN, CG, MXD, MRD, RH or RMF.

3. Operations & Management. Dormitories developed by private for-profit organizations must meet operation and management standards substantially similar to those typically provided by the primary institution it serves, subject to the Zoning Board approval of an operations and management plan. At a minimum, the operations and management plan shall address the following:

a. On-site management staff to provide security, property management and support services programming and oversight of student conduct. b. Designation of a staff member to serve as community liaison with direct interaction with institutional security and city police. c. A policy defining resident conduct and behavioral expectations as well as response to policy infractions.

4. Development Standards. Dormitories shall be subject to the residential standards of the underlying zone, with four (4) dormitory beds equivalent to one (1) dwelling unit, and shall comply with the floor area, height, bulk and yard standards of the zoning district where located.

5. Usable Open Space. In consideration of site-specific characteristics including proximity to existing and/or planned public parks and open spaces, interior tenant amenities, campus amenities and other mitigating factors, usable open space shall be provided on site, with the amount, location, and design of such open space subject to determination and approval of the Zoning Board.

6. Vehicle Parking. Parking shall satisfy the residential parking standards, including parking reduction options, of the zoning district where located. For parking purposes, a dormitory room with six (6) beds shall be considered a three (3) bedroom unit, a dormitory room with four (4) beds shall be considered a two (2) bedroom unit, a dormitory room with two (2) beds shall be considered a one (1) bedroom unit and a dormitory room with one (1) bed shall be considered a studio unit. Required parking shall be located within 500 feet of the building served or alternatively may be located on the campus of the educational institution.

7. Bicycle Parking. Bicycle parking shall be provided at the rate of one (1) space per ten (10) residents with 80% of bike spaces being long-term spaces.

8. Below Market Rate Housing. There shall be no below market rate (BMR) requirement for a dormitory use.

**2. TO AMEND ARTICLE II, SECTION 3, DEFINITIONS, TO ADD NEW DEFINITIONS FOR "DORMITORY AND "COLLEGES & UNIVERSITIES", TO READ AS FOLLOWS:**

(NEW) 28.4. Dormitory. A building or portion thereof, arranged, intended, designed or converted to be used as a place of temporary residence for persons whose permanent place of abode is elsewhere, which includes sleeping rooms and share related facilities and are enrolled at an accredited college, university, or educational institution, provided that said dormitory is controlled or managed by said educational institution and complies with the standards of Article II, Section 7.6 of these Regulations. A dormitory does not include residences utilized by fraternities or sororities or clubs and lodges.

(NEW) 25.5. Colleges and Universities. Any building, structure and/or land principally and regularly used by teachers and students for instructional and educational purposes, at the post-secondary level, which is not under the direct supervision and control of the Stamford Board of Education and which is licensed by the State of Connecticut, or which is administered by an accredited educational institution or a bona fide religious institution. "Colleges and Universities" shall include land used for recreational purposes as an adjunct to the principal instructional or educational use and any dormitories connected with such schools, but excluding fraternities and sororities and excluding vocational or secretarial schools.

**3. TO AMEND ARTICLE II, SECTION 3, DEFINITIONS BY DELETING DEFINITION #25 "Colleges and Dormitories", and DELETE line from Appendix A, Table One**

**4. RELATED AMENDMENTS**

(ADD) a new line 17.5 entitled "Dormitory" to Appendix A, TABLE One, with the note "See Section 7.6", and permit by Zoning Board Special Exception in the CCN, CG, RH and RMF districts by placing a "B" in the appropriate column.

(ADD) "Dormitory" as a permitted use within the MXD DISTRICT by adding the following to Section 9-AAA-2(a): "Dormitory (subject to Section 7.6)"

(ADD) a new line 16 entitled "Colleges and Universities" to Appendix A, Table One, and permit by Zoning Board Special Exception in the CG, CG, RMF and RH districts by placing a "B" in the appropriate column.

(ADD) "Colleges and Universities" as a permitted use in the following designated districts: MXD, HTD, IPD.

AMEND permitted uses in the Village Commercial District (VC) by deleting "Colleges and Dormitories" and adding "Colleges and Universities".

AMEND permitted uses in the CCSD District by deleting "Colleges and Dormitories" and adding "Colleges and Universities".

A full copy of the above referenced application is available for review in the Office of the Land Use Bureau 7th Floor, Government Center Building, 888 Washington Boulevard, Stamford, CT during normal business hours.

At the above time and place all interested persons shall be given an opportunity to be heard. The hearing may be continued to such time and place as will be announced by the Zoning Board. The meeting place is accessible to the physically handicapped. Hearing impaired persons wishing to attend this meeting that require an interpreter may make arrangements by contacting the Department of Social Services administration office at 203-977-4020, at least five (5) working days prior to the meeting.

ATTENT: THOMAS R. MILLS, CHAIRMAN, ZONING BOARD CITY OF STAMFORD, CONN. A.M., of the Project Site.

Dated at the City of Stamford, CT, this 16th day of March 2016

**THE CITY OF STAMFORD  
INVITATION TO BID**

The City of Stamford will receive sealed Request for Proposals/Qualifications and competitive bids for the following projects at the Stamford Government Center, Purchasing Department, 10th Floor, 888 Washington Boulevard, Stamford, Connecticut 06901. All sealed bids will be publicly opened and read.

All Proposal and bid documents, drawings and specifications can be viewed/downloaded from our website at: [stamfordcity.org](http://stamfordcity.org). For questions regarding the RFPs, purchasing or bidding procedures, call or email Beverly Avoni, Purchasing Agent, at (203) 977-4107 or [bavoni@stamfordcity.org](mailto:bavoni@stamfordcity.org).

**Request for Bid No. S-6598, REHABILITATION OF MERREBROOK LANE BRIDGE OVER MIAMIUS RIVER.**  
Bid Opening: April 6, 2016 at 11:30 AM  
Bid Deposit: 5%  
Mandatory Pre-Bid Walk Through: Tuesday, March 22, 2016, at 10:00 A.M., at the Project Site.  
All drawings can also be picked up from County Reproductions, 39 Beiden Street, Stamford, CT 06902, tele: (203) 348-3785; fax: (203) 348-2654. A non-refundable fee will be charged for these documents.  
Contact for Technical Questions: Jeff Grubb, Project Manager - Engineering Bureau at (203) 977-4856 or email [jgrubb@stamfordcity.org](mailto:jgrubb@stamfordcity.org).

**Request for Bid No. S-6527, BRICK RESTORATION AT STAMFORD HIGH SCHOOL, 25 STRAWBERRY HILL AVENUE.**  
Bid Opening: April 15, 2016 at 11:30 AM  
Bid Deposit: 5%  
Mandatory Pre-Bid Walk Through: Tuesday, March 29, 2016, at 3:00 P.M., at Stamford High School, 55 Strawberry Hill Avenue (Meet at the front of the school).  
All drawings can also be picked up from County Reproductions, 39 Beiden Street, Stamford, CT 06902, tele: (203) 348-3785; fax: (203) 348-2654. A non-refundable fee will be charged for these documents.  
Contact for Technical Questions: Jeff Parfitt, Construction Manager - Engineering Bureau at (203) 977-5227 or email [jparfitt@stamfordcity.org](mailto:jparfitt@stamfordcity.org).

Beverly Avoni  
Purchasing Agent

**PUBLIC NOTICES**

**LEGAL NOTICE DIRECTOR OF ADMINISTRATION  
CITY OF STAMFORD NOTICE OF INTENT TO DISCONTINUE  
WATERSIDE PLACE AND UNNAMED HIGHWAY  
AFFECTING PROPERTIES OWNED BY O&G INDUSTRIES, INC.  
AND THE CITY OF STAMFORD CT**

Notice is hereby given that the Director of Administration of the City of Stamford, CT will conduct a Public Hearing on Tuesday, March 22, 2016 at 11:00 AM, Administration Conference Room, 10th Floor, Government Center Building, 888 Washington Boulevard, Stamford, CT, upon application of the City of Stamford and O&G Industries, Inc. to discontinue Waterside Place and Unnamed Highway, Board of Representatives Resolution #3603 stating the intention to discontinue Waterside Place and Unnamed Highway, as well as the Mayor's Report on the discontinuance, are available for public inspection at the Town Clerk's Office, Stamford City Hall, 888 Washington Blvd., Stamford, CT during normal business hours.



The affected property is generally described as follows: Waterside Place and Unnamed Highway begins at land owned by the City of Stamford comprising what is Davenport Street and continues to additional land owned by the City of Stamford comprising what is Pulaski Street in said City of Stamford. The total area of Waterside Place and Unnamed Highway is 18,280.35 square feet (42 acres).

At the above time and place, all interested persons shall be given an opportunity to be heard with respect to the proposed discontinuance or any assessment of benefits or damages as set forth in the Mayor's Report. The meeting is accessible to the physically handicapped. Hearing impaired persons wishing to attend this meeting that require an interpreter may make arrangements by contacting the Dept. of Social Services Administration office at 977-4029 at least five working days prior to the meeting.

For further information, please contact:

Michael E. Handler  
Director of Administration  
City of Stamford  
(203) 977-4182

Dated at the City of Stamford, CT this 16th day of March, 2016

**Request for Quotation #02-1607**

The State of Connecticut Judicial Branch invites qualified contractors to submit quotations to provide Level I Conceivable Ballistic Vests.

Sealed quotations must be received by 11:30 AM, on Wednesday, April 6, 2016. Immediately thereafter all quotations will be publicly opened and prices read aloud.

**BUSINESS SET-ASIDE PROGRAM ARE ENCOURAGED TO BID.**

Bid packages may be picked-up at Judicial Purchasing Services, 90 Washington Street, 4th Floor, Hartford, CT or call 860-766-5200 to request by mail, or access the web site below.

PLEASE CHECK THE JUDICIAL WEB SITE AT:  
[www.jud.ct.gov/external/news/business/](http://www.jud.ct.gov/external/news/business/)

**JUDICIAL BRANCH  
PURCHASING SERVICES  
90 WASHINGTON STREET  
HARTFORD, CT 06106**

An Equal Opportunity/Affirmative Action Employer

**INVITATION TO BID**

The Stamford Community Development Office (SCDO) will be accepting sealed bids from General and Masonry Contractors on behalf of the Food Bank located at 461 Glenbrook Road, Stamford, CT for Exterior Facade Restoration. Contractors must have relationship with a DUNS number, be registered with SAM.gov and be licensed in the State of Connecticut.

On Wednesday, April 20, 2016 at 10:30 AM all bids will be publicly read also at the 10th Floor Community Development Office located in the Government Center. Faxed, Electronic or Late bids will not be accepted.

A mandatory site inspection will be conducted on Wednesday, March 30, 2016, at 10:30 AM.

Bid packages are available at the SCDO office, 10th Floor, 888 Washington Blvd., Stamford, CT 06904 between the hours of 8:30 AM - 4:30 PM Monday thru Friday.

The owner reserves the right to reject any or all bids, or to waive any informalities in the bid(s).

This bid is subject to Community Development Block Grant regulations, Federal Equal Opportunity Laws, Davis Bacon Wage Rates Apply.

**SITUATIONS WANTED**

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**PUBLIC NOTICES**

**LEGAL NOTICE**

Pursuant to Conn. Gen. Stat. §16-262(a), the Public Utilities Regulatory Authority (PURA) will conduct a public hearing at Ten Franklin Square, New Britain, Connecticut, on Wednesday, March 23, 2016, at 10:30 a.m., concerning Docket No. 11-08-07W19 - Application of Avon Water Company for Approval of Water Infrastructure and Conservation Adjustment and Semi-Annual Filing Report Docket W1CA-11-08-07W19. The PURA will continue the hearing. For information and the notice of hearing file with the Secretary of State's Office of Public Utilities REGULATORY AUTHORITY, JEFFREY R. GAUDIOSI, ESQ., EXECUTIVE SECRETARY. The public may call the Authority's office, at 860-527-1853, option 4 (using a touch tone phone), commencing each day from 7:30 a.m. to 4:30 p.m., to be advised as to whether this hearing has been cancelled or postponed due to inclement weather. The Connecticut Department of Energy and Environmental Protection is an Affirmative Action and Equal Opportunity Employer that is committed to complying with the Americans with Disabilities Act. To request an accommodation contact us at (860) 418-5810 or [deap-accommodations@state.ct.gov](mailto:deap-accommodations@state.ct.gov).

**PUBLIC NOTICE**

The Darien Board of Education is requesting sealed bids for the purchase of Chromobooks. Deadline for receiving bids is Thursday, March 31, 2016 at 5:00 p.m. Bids will be opened on that date and time. Specifications may be obtained on the district website at [www.darienps.org](http://www.darienps.org) or call 203-958-7465 to have them emailed. Darien Board of Education reserves the right to reject any and all proposals.

**LEGAL NOTICE**

Advanced Radiology MRI Centers Limited Partnership is applying for Certificate of Need pursuant to Section 19a-638a(1)(G) of the Connecticut General Statutes. Advanced Radiology will request permission to acquire an MRI unit for facility located at 115 Westchester Boulevard, Stamford, CT 06901. The total expenditure associated with this acquisition is \$2,039,442.

**MERCHANDISE FOR SALE**

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**COOKWARE-EMERALD**, new in box, 2 piece Castor of stainless steel, by Fostex. \$60. 203-323-1881

**CUBE REFRIGERATOR**, Brand New Red, Hair Brans \$78.00 Call 203-820-3670  
**DRAPES**, Red, custom made, with pale yellow valance border, 90" x 90". Excl. \$50. 203-323-1881

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**CLASSIFIED INDEX**

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Greenwich Area 203-330-6554

To Place A Legal Ad or Public Notice 203-330-6206  
To Place A Death Notice 203-964-2315  
Facsimile Transmission 203-964-2302  
To Place A Classified Display Ad 203-964-2302

**DEADLINES**

In-Column  
10:00 A.M. each Thursday for Real Estate Sections  
1:00 P.M. Thursday for Friday  
2:30 P.M. day before publication Tues., Wed., Thurs. & Sat.  
4:30 P.M. Friday for Sunday publication  
4:30 P.M. Friday for Monday publication

Classified Display  
1:30 P.M. each Tuesday for The Advocate and Greenwich  
11:00 A.M. two (2) days before publication for Wednesday  
Thursday, Friday and Saturday  
3:30 P.M. Thursday for Saturday publication  
Noon Friday for Monday publication  
4:00 P.M. Friday for Tuesday publication

Obituary Hours  
Monday-Sunday 10:30 a.m. - 5:30 p.m.  
notary: deadlines subject to change

Legal Advertising (in-column and display)  
10:59 a.m. two days before publication for Wednesday, Thursday, Friday and Saturday  
3:00 p.m. Thursday for Sunday publication  
Thursday for Monday publication  
4:00 p.m. Friday for Tuesday publication

Pool deadline is 24 hours prior to space deadline. \*Holiday deadline subject to change.  
Corrections & Cancellations: Responsibility for Errors  
Advertisers are URGED to CHECK their ads on the FIRST day of publication. The Advocate/Greenwich Time staff will be responsible for the correction when in part of any advertisement for any publication error or other error in the event of any omission or error. The Advocate/Greenwich Time liability shall be limited to the amount paid by the advertiser for the first insertion only. In no event shall the Advocate/Greenwich be liable for consequential damages of any kind including damages for lost profits.

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**BUSINESS HOURS**  
The Advocate: Monday-Friday 8:30-5:00  
Greenwich Time: Monday-Friday 8:30-5:00

# Affidavit

Applicant: **Advanced Radiology MRI Centers Limited Partnership**

Project Title: **Acquisition of 3.0 Tesla MRI Unit**

I, Terence Hughes, M.D., Chairman of Advanced Radiology MRI Centers Limited Partnership being duly sworn, depose and state that said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.



Signature



Date

Subscribed and sworn to before me on 6/9/10



Notary Public/Commissioner of Superior Court

My commission expires: \_\_\_\_\_

## Executive Summary

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow.

Advanced Radiology MRI Centers Limited Partnership proposes to acquire a 3.0Tesla MRI unit to augment the 1.5 Tesla services provided at the Stamford office of Advanced Radiology Consultants, LLC. As this CON Application demonstrates, there is a clear public need for additional MRI capacity in Stamford, and at Advanced Radiology's Stamford office in particular. The addition of a second MRI unit in this office will address unmet need going forward while improving the quality, accessibility and cost-effectiveness of MRI services in the area.

The existing MRI unit at Advanced Radiology's Stamford office is operating at 165% capacity based on guidelines set forth in the Statewide Healthcare Facilities and Services Plan. The practice has extended hours as much as practicable to try to meet demand for MRI services. The Stamford office scans patients late into the evening on weekdays and nearly all day on weekends, staying open for up to 92 hours each week.

Acquisition of a second unit is necessary in order to accommodate current MRI volume, to handle urgent/emergent scans in a timely fashion, and to manage future growth in MRI. Significant growth is expected in coming years given the aging population, advances in technology, and Medicaid expansion in Connecticut, to name just a few contributing factors. Planning for MRI growth is a critical part of ensuring that area residents have timely access to MRI services now and in the future.

Acquisition of a 3.0 Tesla unit will improve the quality of MRI services in Stamford by offering advanced imaging techniques not otherwise available in the area. In addition, a second MRI unit at Advanced Radiology's Stamford office will allow more patients to access services during normal business hours, which is important for certain types of scans and certain types of patients. It will also enhance access for the Medicaid recipients and indigent patients that Advanced Radiology is committed to serving. Lastly, as the only private radiology practice in Stamford, Advanced Radiology is one of the most cost-effective MRI providers, charging physician-practice rates without facility fees.

Advanced Radiology MRI has met all relevant criteria for the acquisition of a much-needed second MRI unit for the practice's Stamford office. The scanner will improve the delivery of MRI services in the Stamford area for all patients and this Con Application should therefore be approved.

*Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Care Access is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a “§” indicates it is actual text from the statute and may be helpful when responding to prompts.*

## **Project Description**

1. Provide a detailed narrative describing the proposal. Explain how the Applicant(s) determined the necessity for the proposal and discuss the benefits for each Applicant separately (if multiple Applicants). Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline and why the proposal is needed in the community.

### **RESPONSE:**

Advanced Radiology MRI Centers Limited Partnership (“Advanced Radiology MRI”) proposes to acquire a 3.0Tesla MRI unit to augment MRI services provided at the Stamford office of Advanced Radiology Consultants, LLC (“Advanced Radiology”). As discussed in greater detail below, the existing MRI unit at Advanced Radiology’s Stamford office is operating at 165% capacity and the practice has extended hours as much as practicable to try to meet demand for MRI services. Acquisition of a second unit is necessary in order to accommodate current and projected future volume and to ensure that area residents have timely access to MRI services. It will also make available advanced imaging techniques that are not otherwise available in the Stamford area.

### ***Advanced Radiology – Practice Background, Stamford Office & MRI Services***

Advanced Radiology is a private radiology practice with office locations in Stamford, Fairfield, Stratford, Trumbull, Shelton, and Orange. The practice provides a full range of diagnostic imaging and interventional radiology services, including Magnetic Resonance Imaging (“MRI”). MRI services are provided at each Advanced Radiology office by Advanced Radiology MRI, an affiliated entity that owns and operates the practice’s MRI scanners. Advanced Radiology has a long history of providing the highest quality care to the communities it serves. With more than 110 years of service, Advanced Radiology is one of the oldest independent imaging practices in the state. With 30 subspecialty trained radiologists on staff, it is also one of the largest.

Advanced Radiology has served the Stamford community for more than 15 years, providing MRI, CT, ultrasound, mammography, and general x-ray out of its office at 1315 Washington Boulevard. The practice’s first MRI unit in Stamford was a low-field open unit acquired in 2001. This unit was replaced with a 1.5 Tesla Siemens Espree unit acquired in 2005 (Docket No. 04-30277-CON). This high-field unit has “open” properties and was the first of its kind to operate in Connecticut, the second in the U.S, and just the fourth produced by Siemens worldwide. Advanced Radiology has seen the demand for MRI at its Stamford office increase steadily since the 1.5 Tesla was acquired. In just the last four years Stamford MRI volume has grown by 25%. This growth occurred despite the fact that numerous additional MRI units were

approved and placed into operation in the service area after Advanced Radiology began providing high-field MRI services.

The increase in Advanced Radiology's Stamford MRI volume is a testament to the quality of the practice's services and the strength and breadth of its relationships with area physicians and other providers. In FY 2015, Advanced Radiology received referrals to its Stamford office for MRI services from more than 500 different sources. These include primary care physicians and specialists such as orthopedist, neurologists, gastroenterologists, pulmonologists, ophthalmologist, gynecologists, urologists, and endocrinologists, to name a few. Advanced Radiology also receives a significant number of referrals from podiatrists and chiropractors. The practice provides MRI scan of all types including body, breast, musculoskeletal, neurological, and vascular exams. Advanced Radiology has a sophisticated image sharing network that allows referring physicians access to images regardless of where the scan was performed or where the physician resides. This enhances the timely communication of exam results and minimizes unnecessary repeated imaging. This network also allows the highest level of subspecialty interpretation. Finally, Advanced Radiology's patients are empowered with direct access to their images and results through a patient portal.

The Stamford office provides MRI services to patients who reside primarily in the towns of Stamford, Norwalk, Greenwich, Darien, and New Canaan. However, the overall MRI service area extends throughout Fairfield County and into other parts of Connecticut and New York. Advanced Radiology does not discriminate against patients based upon ability to pay or payer source. The practice participates with most commercial and governmental insurers, including Medicare and Medicaid. In addition, Advanced Radiology provides MRI services for uninsured and indigent persons, reducing rates and assisting with payments whenever necessary.

### ***Increasing MRI Volume & Need for Additional Scanner***

As far back as FY 2011, Advanced Radiology's Stamford unit has been operating at well above optimal capacity.<sup>2</sup> According to the need methodology set forth in the Statewide Healthcare Facilities & Services Plan ("SHP"), the estimated capacity of an MRI unit is 4,000 scans per year (SHP, p. 61). If a provider operates an MRI in the service area, that provider is expected to demonstrate that its existing scanner is operating over 85% capacity (3,400 scans annually) in order to justify the acquisition of an additional unit (SHP, p. 61). The Stamford scanner performed 6,705 scans in FY 2013 (168% capacity based on SHP guidelines); 7,002 scans in FY 2014 (175% capacity based on SHP guidelines); and 6,617 scans in FY 2015 (165% capacity based on SHP guidelines). The decline in volume between FY 2014 and FY 2015 was due to the fact that Advanced Radiology performed upgrades to its Trumbull MRI unit and transitioned certain scans that previously could not be performed in Trumbull from Stamford to that office. The Stamford unit is projected to perform 6,947 scans in FY 2016, bringing utilization back up to 174% capacity based on SHP guidelines.

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<sup>2</sup> The Stamford MRI performed 5,285 scans in FY 2011, which is 132% capacity based upon a SHP standard of 4,000 scans per unit per year. The trend of operating over capacity likely extends beyond FY 2011, but because Advanced Radiology's electronic medical record system changed around that time it is difficult to reliably track MRI volume for earlier years.

By FY 2019, if the existing unit could accommodate all scans requested in Stamford it would be operating at 201% capacity (8,041 scans).<sup>3</sup>

Advanced Radiology has been able to accommodate this significant MRI volume growth by increasing hours and staffing at its Stamford office. Currently, MRI services are available Monday through Friday, from 7 a.m. through 10 p.m. and Saturday and Sunday from 7 a.m. through 3:30 p.m. This has been the case since FY 2010, when the practice began flexing weekend and late evening hours based on patient need. Hours were extended on a regular basis beginning in FY 2011. There are 92 hours of available MRI scanning time each week at the Stamford office. Not all hours are utilized each week due to routine maintenance and other operational factors, as well as patient preference and the need to schedule certain exams during normal business hours.

Notwithstanding Advanced Radiology's willingness to operate its Stamford MRI service 92 hours per week, it has been a challenge for the practice to find MRI technologists willing to work the late night and weekend shifts and the differential in salary is significant (approximately 17% higher than technologists who work during normal business hours). In addition, many patients cannot take advantage of extended hours due to their schedules or because they are unable or unwilling to travel to a medical office on the weekend or late at night (particularly an inner-city office). Furthermore, more complicated scans (i.e. contrast cases and arthrograms) are only performed during normal business hours. For these reasons, Advanced Radiology cannot realistically expand hours further to accommodate more MRI patients in Stamford and, in doing so, fix its capacity issues. Also, Advanced Radiology would like to better serve those patients in need of urgent/emergent MRI scanning who may otherwise wait several hours or days potentiating the risk of a devastating outcome.

Because of the rapid growth in MRI volume in Stamford, Advanced Radiology has been forced to divert MRI patients to its other units. The next closest units operated by the practice are located in Fairfield, Stratford, and Trumbull. In FY 2015, the Fairfield MRI unit performed 6,685 scans and operated at 167% capacity. The Stratford and Trumbull units are operating at 136% capacity and 128% capacity, respectively. Thus the referral of patients from lower Fairfield County to Advanced Radiology's Bridgeport-area MRI units is now impacting the

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<sup>3</sup> Even if capacity is based upon Advanced Radiology's actual hours of operation in Stamford, which total as many as 92 hours per week, the unit will have exceeded 85% capacity by FY 2019. This assumes 30 minutes per scan, 15 hours per day, 5 days per week, 51 weeks per year (one week lost to scheduled down time/maintenance), with 6 holidays per year backed out of available capacity. It also assumes 30 minutes per scan, 8 ½ hours per day, 52 weekends per year. It and does not account for staff breaks, patient cancellations, exams that must be performed during normal business hours, and similar variables that impact capacity. The calculation is as follows:

Weekdays: 15 hours/day x 5 days/week = 75 hours/week x 2 scans/hour = 150 scans/week x 51 weeks/year = 7,650 scans/year – 180 holiday scans/per year (6 days x 30 scans/day) = **7,470 weekday scans/year.**

Weekends: 8 ½ hours/day x 2 days/weekend = 17 hours/weekend x 2 scans/hour = 34 scans/weekend x 52 weekends/year = **1,768 weekend scans/year.**

Total scan capacity per year, assuming all hours of operation are used = **9,238 scans** (more than twice what the SHP considers maximum capacity of an MRI scanner). **85%** of 9,238 scans = **7,852 scans.** Advanced Radiology is projecting **8,041 scans** for its Stamford MRI service by FY 2019 (98% capacity based on 92 hours/week of available scan time).

practice's ability to meet the needs of patients from this area.

Moreover, it appears that a majority of MRI units in the service area are also operating near or above optimal capacity (85%) as described in the SHP (SHP Inventory, Table 8). Greenwich Hospital's main campus units are operating at 117% and 78% capacity, respectively. The Stamford Hospital's main campus unit is operating at 161% capacity and its Tully Center MRI is operating at 109% capacity. Norwalk Hospital's main campus unit is operating at 79% capacity and its off-campus units are operating at 82%, collectively. Orthopaedic & Neurosurgery Specialists' captive unit in Greenwich is operating at 120% capacity. Of the 13 MRI scanners in the service area, 10 are operating at 78% capacity or higher. These units do not have the available capacity to meet existing and projected future demand for MRI services in Stamford and surrounding towns. They should not, therefore, be impacted by the acquisition of a second MRI unit by Advanced Radiology, whose existing MRI unit is the busiest unit in the service area. Nor is the acquisition of a second unit by Advanced Radiology the unnecessary duplication of services.

Note also that these capacity figures do not take into account projected further growth in MRI volume in the Stamford area. Advanced Radiology is near the limits of what it can accommodate on its existing unit. However, the population in the service area continues to grow, as do its MRI needs. According to a G.E. study commissioned by the practice, the population in lower Fairfield County is expected to grow by 2.8% in the next 5 years, with 12.58% growth in the 55-64 age cohort and 15.84% growth in the 65+ age cohort, some of the largest consumers of MRI services (see Exhibit A). MRI scans are expected to increase by 5.92% during the same time period and, according to SG2 projections, MRI volume will increase by 15% nationwide over the next 10 years ("SG2 Report") (see Exhibit A; see also Exhibit B). A 14% growth in Medicaid patients is also anticipated in the area due to healthcare reform-related expansion of program eligibility in Connecticut (see Exhibit A). Advanced Radiology is committed to providing services for these and other low-income individuals and acquiring a second MRI unit for its Stamford office will help to make this possible.

***An Additional MRI Unit Will Meet Increasing Demand & Improve the Quality, Accessibility & Cost-effectiveness of Healthcare in the Stamford Area***

Advanced Radiology's proposal to acquire a second unit for its Stamford office will improve the quality, accessibility and cost effectiveness of MRI service in the area. The practice plans to acquire a G.E. Signa Pioneer 3.0 Tesla MRI unit (see Exhibit C). This technology allows for much higher quality vascular imaging of the head, neck, body, and extremities and may help obviate the need for vascular imaging that requires radiation or may be more invasive. With 3.0 Tesla, high-quality advanced imaging techniques such as diffusion tensor imaging, functional imaging, and brain perfusion will be available in a private practice setting. In addition, the stronger magnet will allow for higher resolution images in cases where added detail is important for diagnosis. A 3.0 Tesla MRI is now the preferred unit for many brain, spine, prostate, and MRA scans.

The new MRI unit in Stamford will accommodate local patients in need of these types of scans who are now referred to the practice's other 3.0 Tesla units in Orange and Fairfield.

Notwithstanding these unique capabilities, overall the scanner has similar throughput and capacity to the existing 1.5 Tesla unit. Therefore, the scanners combined will be able to accommodate approximately 8,000 MRI scans annually. This is roughly the number of scans that Advanced Radiology is projecting for its Stamford office by FY 2019.

Advanced Radiology is hearing from Stamford area physicians that delays in scheduling present challenges for their patients in terms of timely diagnosis and follow-up treatment. The current backlog for MRI services in Advanced Radiology's Stamford office is approximately 7-10 days, but longer for exams that need to be scheduled during weekday hours. A second unit will help to alleviate this backlog. As of now, Advanced Radiology is accommodating significant MRI volume in Stamford with extended hours however these hours are not ideal for many patients. Once the second scanner is up and running Advanced Radiology should be able to accommodate most of its patients during normal business hours. The practice will still offer evening and weekend hours in Stamford, as needed, to accommodate patient preference and any future increases in volume.

Advanced Radiology has a reputation for providing the highest-quality imaging at all of its offices, making it a preferred provider for MRI (and other) services. The availability of subspecialists to interpret MRI scans, and the timeliness with which Advanced Radiology schedules exams and provides referring providers with results (for electronic results less than an hour, on average, once the scan is available to read), has created a demand for the practice's MRI services. Acquiring an additional unit for the Stamford office will ensure that patients and referring physicians have a choice in MRI providers and can choose one with a reputation for excellence. As discussed below, Advanced Radiology meets all of the quality measures set forth in the SHP for MRI services and the second scanner will help to avoid potential delays in timely diagnosis and treatment of patients, as contemplated in the guidelines (SHP, pp. 61-62).

The acquisition of a second unit will also enhance access to MRI services for all service area residents. Advanced Radiology is the only private physician practice in lower Fairfield County that offers MRI services to patients referred by third parties.<sup>4</sup> The MRI scanner will be located in a physician office building with ample free parking and access to public transportation.

A second scanner will also help to avoid serious issues that may arise if Advanced Radiology's existing scanner requires more than routine service or maintenance. Given that the practice provides, on average, 130 scans per week, it is critical that there be back-up in the event of unanticipated or anticipated issues with the existing unit. This includes the inevitable need to overhaul or replace the existing unit, which is now 11 years old. Having a second scanner in place will limit disruption of care and preserve access to a preferred MRI provider while any upgrade takes place.

Moreover, given Advanced Radiology's history of and commitment to servicing Medicaid recipients and indigent persons, adding a second unit will increase access to MRI services for these individuals. A significant percentage of Advanced Radiology's Stamford MRI volume is

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<sup>4</sup> Orthopaedic & Neurosurgery Specialists has an MRI unit in Greenwich, however, it is only for patients referred by physicians within the practice. Moreover, ONS does not participate in the Medicaid program and does not provide MRI services to Medicaid recipients. See Docket No. 16-32063-CON.

Medicaid recipients and uninsured or self-pay patients – 7.66% in FY 2015. Practice-wide, 10.26% of Advanced Radiology’s MRI volume in FY 2015 was Medicaid recipients and uninsured or self-pay patients. Increasing access to services for these individuals is consistent with CON decision criteria and SHP objectives, including a requirement that a provider seeking permission to acquire an MRI unit not deny services to any individual based upon ability to pay or source of payment, including uninsured, underinsured and Medicaid patients (SHP, p. 62).

Advanced Radiology is also one of the more cost-effective options for MRI services in lower Fairfield County. As mentioned above, Advanced Radiology is the only private radiology practice in the service area that offers MRI. Rates paid to physician practices by insurers for MRI services are typically lower than those paid to hospitals. Hospitals account for 11 of the 13 existing MRI units in the primary service area (see OHCA Table 9). In addition, unlike many hospital-based scanners, Advanced Radiology does not charge a facility fee or add-on fees.

For these reasons and as discussed in detail throughout this CON submission, Advanced Radiology MRI has met all CON and SHP criteria for the acquisition of a much-needed second MRI unit for its Stamford office.

2. Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between Applicant(s)? What have the Applicant(s) accomplished so far?).

**RESPONSE:**

MRI volume has been growing at Advanced Radiology’s Stamford office, and throughout the practice, for many years. Lack of adequate MRI capacity is quickly becoming an issue. As mentioned above, the existing Stamford MRI unit has seen relatively steady growth year-over-year since it was acquired in 2005. For the last 3 years it has been operating in excess of 165% capacity. In addition, Advanced Radiology’s Fairfield unit is now operating at 167% capacity, its Stratford unit is operating at 136% capacity, and its Trumbull unit is operating at 128% capacity. Advanced Radiology performed 29,413 scans in FY 2015 using 6 MRI units, which amounts to 123% capacity practice-wide.

Since FY 2015, Advanced Radiology has been having internal discussions about how to handle the significant MRI capacity constraints that it faces as a practice. With respect to Stamford, the practice has expanded hours during the week and on weekends. But these measures cannot keep pace with current demand and the practice determined that it needs to acquire an additional MRI unit. It makes the most sense to locate that unit in Stamford because the existing Stamford MRI unit is one of the busiest in the practice and it is geographically distant from the practice’s other scanners, most of which are located in the greater Bridgeport area. Advanced Radiology’s Fairfield unit is extremely busy as well, but some of this is overflow from Stamford that will hopefully be corrected with the acquisition of a second unit for that office.

To date, Advanced Radiology has signed a quote for purchase of the G.E. Signa Pioneer unit (see Exhibit C). The practice is in the process of assessing build-out costs and planning to site the MRI unit in Stamford. Advanced Radiology anticipates that it will take several months to design and complete construction and to install the second unit once CON approval is received.

3. Provide the following information:

- a. utilizing [OHCA Table 1](#), list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

**RESPONSE:**

See [OHCA Table 1](#).

- b. identify in [OHCA Table 2](#) the service area towns and the reason for their inclusion (e.g., provider availability, increased/decreased patient demand for service, market share);

**RESPONSE:**

See [OHCA Table 2](#).

4. List the health care facility license(s) that will be needed to implement the proposal;

**RESPONSE:**

None.

5. Submit the following information as attachments to the application:

- a. a copy of all State of Connecticut, Department of Public Health license(s) currently held by the Applicant(s);

**RESPONSE:**

Not applicable. Advanced Radiology is a private physician practice. Neither the Applicant Advanced Radiology MRI, nor any of its affiliates, is a DPH licensed entity.

- b. a list of all key professional, administrative, clinical and direct service personnel related to the proposal and attach a copy of their Curriculum Vitae;

**RESPONSE:**

Copies of the Curriculum Vitae of the following individuals are attached as [Exhibit D](#):

Clark G. Yoder, M.B.A., Chief Executive Officer, Advanced Radiology Consultants  
Dennis Condon, Chief Operating Officer, Advanced Radiology Consultants

Terence W. Hughes, M.D., Chairman, Advanced Radiology Consultants  
Gerard J. Muro, M.D., MRI Subspecialist, Advanced Radiology Consultants

- c. copies of any scholarly articles, studies or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles;

**RESPONSE:**

Attached as Exhibit A is a study prepared for Advanced Radiology by G.E. entitled *Market At-a-Glance Report*, dated May 4, 2016 (the “G.E. Study”). The G.E. Study demonstrates the need for a second MRI unit in Stamford based upon anticipated growth in population in the service area and growth in the age cohorts that utilize MRI services most. Specifically, it projects a 2.8% growth in overall population in the service area between FY 2015 and FY 2020.<sup>5</sup> This includes 12.58% growth projected in the 55-64 age cohort and 15.84% growth projected in the 65+ age cohort during this same time period. These individuals are some of the largest consumers of MRI services, representing 21% and 26% of MRI scan volume in the service area, respectively, in FY 2015. The G.E. Study also projects a 5.92% increase in MRI scans over the next 5 years. The SG2 Report, excerpts of which are attached as Exhibit B, projects a 15% increase in MRI nationwide between FY 2015 and FY 2025. In addition, Medicaid Expansion patients are expected to grow by 14% and Advanced Radiology is the only private physician practice in the area that provides MRI services to Medicaid patients.

- d. letters of support for the proposal;

**RESPONSE:**

See Exhibit E.

- e. the protocols or the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet the protocols or guidelines.

**RESPONSE:**

The 3.0 Tesla MRI will be accredited by the American College of Radiology (“ACR”). The ACR MRI Accreditation Program Clinical Image Quality Guide can be found at <http://www.acraccreditation.org/~media/Documents/MRI/ClinicalGuide.pdf?la=en>.

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<sup>5</sup> Note, the service area in the G.E. Study is slightly larger than the Advanced Radiology Stamford office MRI primary service area, but still inclusive of patients who receive MRI services at this location.

- f. copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.

**RESPONSE:**

See G.E. Quotation attached as Exhibit C.

## Public Need and Access to Care

§ *“Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;” (Conn.Gen.Stat. § 19a-639(a)(1))*

6. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.

**RESPONSE:**

DPH has not yet adopted as regulation its policies and standards regarding imaging equipment acquisitions. The SHP sets forth certain standards and guidelines, and Advanced Radiology’s proposal meets each of these as described in greater detail in response to Question 7 below. Advanced Radiology has demonstrated a clear public need for additional MRI capacity in Stamford in accordance with the methodology set forth in the SHP. In addition, the practice meets the SHP quality criteria and is ensuring access to care for all patients regardless of ability to pay or payer source.

§ *“The relationship of the proposed project to the statewide health care facilities and services plan;” (Conn.Gen.Stat. § 19a-639(a)(2))*

7. Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available on [OHCA’s website](#).

**RESPONSE:**

OHCA’s planning and regulatory functions are intended to ensure, among other things, the increased accessibility, continuity and quality of healthcare services, to prevent the unnecessary duplication of services, and to provide financial stability and cost-containment in healthcare service delivery (SHP, p. 2). Several of the Guiding Principles of the SHP relevant to this CON proposal are as follows:

- Ensure that any regulated service will maintain overall access to quality healthcare;
- Promote equitable access to health care services (e.g., reducing financial barriers, increasing availability of physicians) and facilitate access to preventive and medically necessary health care;
- Maintain and improve the quality of healthcare services offered to the state's residents;
- Promote public policy development through measuring and monitoring unmet need; and
- Promote planning or other mechanisms that will achieve appropriate allocation of health care resources in the state.

As discussed in response to Question 1 above, the primary objective of Advanced Radiology's proposal is to ensure that all residents of Connecticut, and particularly those in lower Fairfield County, have adequate, timely access to the highest quality MRI services. This means being able to schedule an MRI scan with a provider of their choosing, including the only private radiology practice in the Stamford area to offer this service. It means being able to access MRI services without unreasonable delay or at the most inconvenient hours. It means having your MRI scan read by a sub-specialty trained radiologist with results communicated promptly and accurately to the physician who referred you so that you can receive a diagnosis and any necessary treatment without delay. It also means being able to access MRI services regardless of your ability to pay. Advanced Radiology's proposal to acquire a second MRI unit for its Stamford office accomplishes all of these objectives. The addition of much-needed MRI capacity in the office will allow for timelier scans, ease of scheduling, and coordination of care. These services will be available to all residents in the greater Stamford area, including indigent persons and Medicaid recipients, without exception.

In addition, as mentioned above, Advanced Radiology has met all of the SHP standards and guidelines for the acquisition of an MRI unit (SHP, pp. 60-62). More specifically, Advanced Radiology has shown that its existing MRI scanner in Stamford is operating at well above the SHP optimal capacity of 85%. Based on SHP guidelines, an MRI scanner has an average annual capacity of 4,000 scans. An applicant that already operates an MRI in the service area is expected to demonstrate that its current unit is operating over 85% capacity or 3,400 scans annually. In FY 2015, Advanced Radiology's existing Stamford scanner performed 6,617 scans, which translates to 165% capacity. This supports a clear public need for the acquisition of an additional unit.

Advanced Radiology has also met all SHP criteria related to quality and accessibility of care. The practice's existing unit is ACR accredited (see [Exhibit F](#)) and the new unit will be accredited as soon as possible once it is placed into operation. A full-time board certified radiologist manages MRI services and interpretation of scans and is available during scans for consultation and adjustment. MRI personnel are adequately trained and the practice has the requisite emergency procedures in place.

Moreover, approving the CON for acquisition of a second MRI unit will allow Advanced Radiology MRI to continue to serve underserved populations (i.e. indigent persons and Medicaid recipients). It will also help to avoid delays in timely diagnosis and treatment that can result from inadequate imaging capacity in a given service area.

*§ “Whether there is a clear public need for the health care facility or services proposed by the applicant;” (Conn.Gen.Stat. § 19a-639(a)(3))*

8. With respect to the proposal, provide evidence and documentation to support clear public need:
- a. identify the target patient population to be served;

**RESPONSE:**

The target population includes individuals, residing primarily in lower Fairfield County, in need of MRI services. These individuals have varying medical conditions and are referred for MRI scans by primary and specialty physicians and other providers (i.e. podiatrists & chiropractors) from the greater Stamford area and beyond. They represent all payer classes, including commercially insured, Medicare and Medicaid recipients, uninsured, and self-pay.

- b. discuss how the target patient population is currently being served;

**RESPONSE:**

The target population is currently being served by Advanced Radiology on its existing Stamford MRI unit. However, because that unit is exceedingly busy (operating at 165% capacity) Advanced Radiology has had to extend its MRI hours to include late evenings and weekends in order to ensure the timely delivery of services. Moreover, Advanced Radiology has had to divert patients from Stamford to other MRI scanners within the practice in offices more distant from where the patients reside. The addition of a second unit Stamford will allow the practice to provide MRI services to its patient base more efficiently.

Moreover, there are a significant number of Medicaid recipients residing in lower Fairfield County. Advanced Radiology treats these recipients currently and intends to accommodate them in increasing numbers as more individuals become eligible for state medical assistance (see Exhibit A).

- c. document the need for the equipment and/or service in the community;

**RESPONSE:**

See response to Question 1, G.E. Study attached as Exhibit A, and SG2 Report excerpts attached as Exhibit B.

- d. explain why the location of the facility or service was chosen;

**RESPONSE:**

Advanced Radiology chose its Stamford office for a second MRI unit because it is one of the practice's busiest offices for MRI services. It is also geographically distant from Advanced Radiology's other scanners, most of which are located in the greater Bridgeport area. MRI scan volume has grown with some consistency since the existing Stamford unit was placed into operation in 2005. Between FY 2011 and FY 2015, MRI volume increased by 25%. Advanced Radiology has extended MRI hours in Stamford until 10:00 p.m. on weeknights and 3:30 p.m. on weekends in an effort to accommodate increasing volume. There is minimal ability to expand hours further given the availability of technologists and patients' unwillingness to schedule exams at earlier or later times. Advanced Radiology has reached the point where it must redirect many patients who want their MRI exams in Stamford to other practice scanners. The practice's Fairfield MRI (the next closest to Stamford) is now as busy as Stamford. The practice's Stratford and Trumbull scanners are also operating over capacity. The patient overflow from Stamford is crowding Advanced Radiology's MRI scanners in the greater Bridgeport area and creating access issues for patients who live there. Accordingly, the practice has decided to acquire a second unit and increase its capacity in Stamford to meet existing and proposed future demand for MRI services in lower Fairfield County.

- e. provide incidence, prevalence or other demographic data that demonstrates community need;

**RESPONSE:**

See G.E. Study attached as Exhibit A; see SG2 Report excerpts attached as Exhibit B; see also response to Question 1 above.

- f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;

**RESPONSE:**

Advanced Radiology has a history of providing services to low-income persons, racial and ethnic minorities and other underserved groups. By way of example, in FY 2015 19.1% of all MRI scans performed at Advanced Radiology offices were of non-Caucasian patients. In addition, 3.09% of all MRI patients practice-wide were uninsured/self-pay and 7.18% were Medicaid recipients during the same time period. Advanced Radiology has always had a policy of including all patients regardless of gender, race, ethnicity, religion, disability, or ability to pay and will continue to do so with approval of a second MRI unit for its Stamford office.

- g. list any changes to the clinical services offered by the Applicant(s) and explain why the change was necessary;

**RESPONSE:**

The only change in clinical services is the increased availability of advanced imaging techniques in Stamford. The 3.0 Tesla scanner is capable of performing certain examinations that cannot be performed on the practice's existing 1.5 Tesla unit. For example, 3.0 Tesla is the preferred MRI unit for brain scans for Lyme disease and Parkinson's disease and certain prostate, spine and MRA scans. There are no other changes to clinical services proposed. This second MRI unit will be staffed by the same technologists that staff the existing unit at Advanced Radiology's Stamford office (with additional technicians hired as necessary) and scans will be interpreted by the same subspecialist radiologists. The same protocols will apply to both units.

- h. explain how access to care will be affected;

**RESPONSE:**

The proposed acquisition of a second MRI unit for Advanced Radiology's Stamford office will enhance access to care for area residents. The existing Stamford unit is operating at 165% capacity, which is only possible because the practice extended hours to include late evenings and nearly full days on the weekends. In order to provide all patients with timely access to MRI services many patients must be willing to have their MRI scans performed during off hours and the practice must be able to find qualified technologists to work these hours. With the addition of a second unit, Advanced Radiology will be able to accommodate its existing MRI scan volume, and projected future growth, in a more timely fashion during normal business hours, early evenings, and weekend mornings (the times that patients tend to favor). This will allow for more expeditious diagnosis and coordination of any necessary follow-up care for MRI patients. The second unit will also serve as a back-up if the existing Stamford MRI unit goes down for service and/or upgrade, ensuring uninterrupted access to care.

In addition, Advanced Radiology provides services to all patients regardless of ability to pay. This includes the uninsured, indigent persons and Medicaid recipients. The fact that the MRI unit will be located in Stamford will enhance access for many indigent persons and Medicaid recipients who live within the city itself. Approving an additional unit in the Stamford area for a provider that takes all patients will improve access for all, as required by the CON statues and SHP.

- i. discuss any alternative proposals that were considered.

**RESPONSE:**

As previously mentioned, Advanced Radiology initially tried to manage increasing demand for MRI services in Stamford by extending hours to accommodate additional patients. Over the course of the last several years weekday hours have been expanded so that scanning begins as

early as 7 a.m., and does not end until 10 p.m., Monday through Friday. In addition, the practice has extended weekend hours, scanning patients from 7 a.m. through 3:30 p.m. on both Saturday and Sunday. The Advanced Radiology MRI unit operates longer hours than any scanner in the service area other than the hospital inpatient units that operate 24 hours (SHP Inventory, Table 8). Notwithstanding the foregoing, the practice is still unable to meet demand for MRI services with a single Stamford unit.

Advanced Radiology also considered whether it should add MRI capacity at an alternate office location. However, Stamford is one of its busiest offices for MRI and it would be even busier if the practice did not divert patients to other offices in order to accommodate all requests for MRI services in Stamford. Also, the Stamford MRI is geographically distant from other practice scanners. It is easier to schedule patients from the greater Bridgeport area among existing units in Fairfield, Stratford, Bridgeport, and Shelton. It is more difficult to ask patients to travel from the greater Stamford area to the greater Bridgeport or New Haven area for scans. In order to ensure access for these patients, a second MRI unit in Stamford is needed.

*§ “Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons; (Conn.Gen.Stat. § 19a-639(a)(5))*

9. Describe how the proposal will:

a. improve the quality of health care in the region;

**RESPONSE:**

The acquisition of a second MRI unit for Advanced Radiology’s Stamford office will improve the quality of healthcare in the region. As previously mentioned, Advanced Radiology employs sub-specialty trained radiologists who are unmatched in their ability to interpret MRI scans. Referring physicians and patients choose Advanced Radiology for MRI services because of its reputation for excellence. Giving patients increased access to Advanced Radiology MRI services in Stamford so that all patients can be accommodated in a timely fashion will improve the quality of healthcare in the area.

Advanced Radiology also has a sophisticated image sharing network that allows referring physicians access to images regardless of where the scan was performed or where the physician resides. This enhances the timely communication of exam results and minimizes unnecessary repeated imaging. This network also allows the highest level of subspecialty interpretation. In addition, Advanced Radiology’s patients are empowered with direct access to their images and results through a patient portal.

Moreover, Advanced Radiology has a track record of providing MRI services in accordance with all applicable standards of care, accreditation requirements, and the quality parameters included

within the SHP (SHP, pp. 61-62). The practice's existing Stamford MRI unit is accredited by the ACR and the second unit will be as well. Practice personnel are trained, consistent with ACR guidance, in the use of the existing MRI scanner and safety procedures in the event of an emergency. They will be similarly trained on the new unit. In addition, board-certified, subspecialty trained physicians oversee the MRI exams and interpret the scans, providing referring physicians with timely results that allow for the diagnosis and treatment of patients without unnecessary delay. All of these factors contribute to the quality of MRI services in the Stamford area.

- b. improve accessibility of health care in the region; and

**RESPONSE:**

As mentioned in response to Questions 1 and 8h above, the proposed acquisition of a second MRI unit for Advanced Radiology's Stamford office will enhance access to care for area residents. It will allow the practice to accommodate its existing MRI scan volume and projected future growth in a more timely fashion during hours that are most accessible for patients. Timely scans mean timely diagnosis and follow-up treatment, which contributes to the overall health of the Stamford area population. The added unit will also better serve those patients in need of urgent/emergent MRI scanning who may otherwise wait several hours or days potentiating the risk of a devastating outcome. Furthermore, approving an additional MRI unit in the Stamford area for a provider that cares for all patients, regardless of ability to pay or payer source, will improve access for all, as required by the CON statutes and SHP.

- c. improve the cost effectiveness of health care delivery in the region.

**RESPONSE:**

As mentioned in response to Question 1 above, the acquisition of a second unit for Advanced Radiology's Stamford office will have a positive impact on the cost-effectiveness of MRI services. Advanced Radiology is the only private radiology practice in the service area that offers MRI, making it one of the most cost-effective all-access provider. Rates paid to physician practices by insurers for MRI services are typically lower than those paid to hospitals. Hospitals account for 11 of the 13 existing MRI units in the primary service area (see [OHCA Table 9](#)). In addition, unlike many hospital-based units, Advanced Radiology does not charge a facility fee or add-on fees.

In addition, increasing Advanced Radiology's scan capacity will allow more patients to receive timely MRI scans and obtain diagnoses and follow-up treatment as quickly as possible. This can help to eliminate the need for more costly care resulting from delays in diagnosis or treatment. This further enhances the cost-effectiveness of healthcare delivery in the region.

10. How will this proposal help improve the coordination of patient care (explain in detail regardless of whether your answer is in the negative or affirmative)?

**RESPONSE:**

The provision of MRI services involves the coordination of care between a referring physician and an imaging provider. In the case of Advanced Radiology, the practice receives referrals from providers of all specialties and conducts a wide variety of MRI examinations. The growth in MRI volume across all of the practice's MRI scanners in recent years is a testament to the quality of services provided by Advanced Radiology and its sub-specialty trained radiologists and the practice's reputation in the communities it serves. One of the reasons why many referring physicians choose Advanced Radiology is because of the practice's commitment to expeditious scheduling and timely communication of MRI results. This coordination of care among different types of providers allows a patient to obtain a diagnosis and any necessary follow-up treatment as quickly as possible. As a general rule, earlier diagnosis and treatment leads to better patient outcomes. The acquisition of a second unit to accommodate Advanced Radiology's existing and growing Stamford MRI volume will help to ensure efficient scheduling and interpretation of exams. In addition, as mentioned previously, Advanced Radiology has a sophisticated image sharing network that allows referring physicians to access images regardless of where the scan was performed or where the physician resides. When possible, Advanced Radiology integrates directly with physician EMRs to facilitate the exchange of important healthcare information.

11. Describe how this proposal will impact access to care for Medicaid recipients and indigent persons.

**RESPONSE:**

Advanced Radiology provides services to all patients regardless of ability to pay or payer source. The practice is proud of its policy of inclusion and its commitment to serving the state's most vulnerable patient populations. Advanced Radiology provides MRI services for Medicaid recipients and indigent persons on its existing Stamford unit. However, as previously mentioned, this unit is operating well over optimal capacity. The unit operates late into the evening on weekdays and throughout the day on weekends. These late/off hours are not always ideal for patients. For example, patients who take public transportation are bound to schedules that often do not run late into the evening or as frequently on weekends. Evening hours are also not the best option for patients who work second or third shift. To the extent that indigent persons and Medicaid recipients have these types of issues, the addition of a second MRI unit, and the ability to accommodate more patients in Stamford during normal business hours, will improve access to care.

12. Provide a copy of the Applicant's charity care policy and sliding fee scale applicable to the proposal.

**RESPONSE:**

See Exhibit G.

*§ "Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;" (Conn.Gen.Stat. § 19a-639(a)(10))*

13. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

**RESPONSE:**

The proposal does not fail to provide or reduce access to services by Medicaid recipients or indigent persons. Advanced Radiology is the only private physicians practice in the greater Stamford area that provides MRI services and is open to Medicaid recipients. In addition, the practice has historically provided services to all patients regardless of ability to pay. In FY 2015, Advanced Radiology provided more than 2,000 MRI scans to Medicaid recipients and nearly 1,000 scans to uninsured patients. The addition of a second MRI unit at Advanced Radiology's Stamford office will enhance, rather than reduce, access to care for these individuals.

*§ "Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care." (Conn.Gen.Stat. § 19a-639(a)(12))*

14. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

**RESPONSE:**

The acquisition of a second MRI unit for Advanced Radiology's Stamford office will not adversely impact patient healthcare costs. In fact, increasing access to MRI services offered by Advanced Radiology will have a positive impact on costs. As discussed in response to Questions 1 and 9c above, the fees charged by private physician practice and the rates or reimbursement for MRI services are typically lower than those of hospitals. In addition, unlike most hospitals, private physician practices do not charge facility fees. A majority of the MRI units in the Stamford area are hospital-based. Advanced Radiology is the only private radiology practice that offers MRI services in the area. Allowing the practice to increase MRI capacity will result

in more patients to be cared for in the most cost-effective manner possible.

## Financial Information

§ “Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;”  
(Conn.Gen.Stat. § 19a-639(a)(4))

15. Describe the impact of this proposal on the financial strength of the state’s health care system or demonstrate that the proposal is financially feasible for the applicant.

### **RESPONSE:**

The acquisition of a second MRI unit for Advanced Radiology’s Stamford office will have a positive impact on the financial strength of the state’s healthcare system. As a private physician practice that is reimbursed at lower rates than hospitals for MRI services, and that does not charge facility fees, Advanced Radiology is one of the most cost-effective providers of MRI in the service area. There is a need for additional MRI capacity in the Stamford area. Allowing Advanced Radiology to acquire a second unit is the best option, financially, for patients, payers and the system as a whole. This is particularly true given that Advanced Radiology is open to all patients regardless of ability to pay or payer source.

In addition, as the Financial Worksheet attached as Exhibit H shows, acquisition of a second MRI unit is financially feasible. Through the initial ramp-up period the second unit shows a declining incremental loss. However, the services provided by Advanced Radiology MRI remain profitable overall even with incremental losses during the first few years of operation of the second Stamford unit. Moreover, Advanced Radiology is confident that with significant volume growth expected over the next 5 to 10 years, the second MRI unit will break even in the near future.

16. Provide a final version of all capital expenditure/costs for the proposal using [OHCA Table 3](#).

### **RESPONSE:**

See [OHCA Table 3](#).

17. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

**RESPONSE:**

See Letter of Interest from Bank of America attached as Exhibit I.

18. Include as an attachment:

- a. audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;

**RESPONSE:**

See Balance Sheet and Income Statement for Advanced Radiology MRI attached as Exhibit J.

- b. completed **Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale)**, available on OHCA's website under OHCA Forms, providing a summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the CON project," and "with the CON project." **Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.**

**RESPONSE:**

See Exhibit H.

19. Complete OHCA Table 4 utilizing the information reported in the attached Financial Worksheet.

**RESPONSE:** See OHCA Table 4.

20. Explain all assumptions used in developing the financial projections reported in the Financial Worksheet.

**RESPONSE:**

See Exhibit K.

21. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.

**RESPONSE:** Initial incremental losses are a result of the fact that MRI volume growth in Stamford will not generate sufficient revenue to cover the cost of a second unit in the first several years of operation. However as MRI volume continues to increase and scans are redistributed between the two units, costs will eventually be covered. Note also that the MRI service practice-wide remains profitable from the first day of operation of a second scanner in Stamford.

22. Indicate the minimum number of units required to show an incremental gain from operations for each projected fiscal year.

**RESPONSE:** The MRI service in Stamford needs to add 1,925 scans per year to show an incremental gain from operations with the acquisition of a second unit.

## Utilization

*§ "The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;"  
(Conn.Gen.Stat. § 19a-639(a)(6))*

23. Complete [OHCA Table 5](#) and [OHCA Table 6](#) for the past three fiscal years ("FY"), current fiscal year ("CFY") and first three projected FYs of the proposal, for each of the Applicant's existing and/or proposed services. Report the units by service, service type or service level.

**RESPONSE:**

See [OHCA Tables 5 & 6](#).

24. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Table 5 and 6.

**RESPONSE:**

Volume is projected to grow at a conservative rate of 5% annually with acquisition of a second MRI unit for Advanced Radiology's Stamford office. This is consistent with, and in some cases less than, historic growth on the practice's existing Stamford magnet. Going back to FY 2012,

the unit saw growth as high as 18% annually and, from FY 2011 through FY 2015, MRI volume in Stamford grew by 25%. In addition, the G.E. Study and SG2 Report project significant growth in MRI volume both in the service area and nationwide. There is also projected growth in population generally and in the older age cohorts that tend to be the largest consumers of MRI services. In addition, the number of Medicaid recipients in Connecticut and Fairfield County is expected to grow, giving more people access to covered MRI services. For these reasons, Advanced Radiology expects to see at least 5% growth of its Stamford MRI service year to year.

25. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal using [OHCA Table 7](#) and provide all assumptions. **Note: payer mix should be calculated from patient volumes, not patient revenues.**

**RESPONSE:**

See [OHCA Table 7](#). Advanced Radiology's current payer mix for Stamford MRI services is approximately 21% governmental payers and approximately 79% non-governmental payers. Governmental payers include Medicaid, which represents approximately 3.9% of MRI scans provided in Stamford in FY 2015. Non-governmental payers include uninsured/self-pay patients, who represent approximately 3.76% of Stamford MRI scans in FY 2015.

The projected payer mix reflects roughly the same distribution of governmental and non-governmental payers, including comparable percentages of Medicaid, uninsured and self-pay scans. With the expansion of Medicaid coverage under the Affordable Care Act, Advanced Radiology has seen growth in Medicaid volume throughout the practice. This includes growth in Medicaid-covered MRI scans at its Stamford office and elsewhere. Advanced Radiology expects to see further increases in the number of Medicaid scans it performs as enrollment continues to expand in Connecticut. The increased numbers are reflected in the projections. However, it is difficult to predict the state's expansion plans and whether those numbers will increase exponentially or to quantify the extent to which they will skew the practice's payer mix towards governmental payers. For now, Advanced Radiology is keeping its percentages consistent. The practice values its mission of caring for patients of all payer classes and will accommodate Medicaid, uninsured and self-pay patients as they present for MRI services. The addition of a second MRI unit in Stamford will ensure that there is sufficient capacity to handle any future increases in MRI demand among these most vulnerable patient populations.

§ “Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;”  
(Conn.Gen.Stat. § 19a-639(a)(7))

26. Describe the population (as identified in question 8(a)) by gender, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. **Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health, CT State Data Center) and document the source.**

**RESPONSE:**

See G.E. Study attached as Exhibit A; see also OHCA Tables 2 & 8 for MRI services by patient town of origin; see also Supplemental CON Application Form, Acquisition of Equipment, Table C for MRI scans by type.

27. Using OHCA Table 8, provide a breakdown of utilization by town for the most recently completed fiscal year. Utilization may be reported as number of persons, visits, scans or other unit appropriate for the information being reported.

**RESPONSE:**

See OHCA Table 8.

§ “The utilization of existing health care facilities and health care services in the service area of the applicant;” (Conn.Gen.Stat. § 19a-639(a)(8))

28. Using OHCA Table 9, identify all existing providers in the service area and, as available, list the services provided, population served, facility ID (see table footnote), address, hours/days of operation and current utilization of the facility. Include providers in the towns served or proposed to be served by the Applicant, as well as providers in towns contiguous to the service area.

**RESPONSE:**

See OHCA Table 9.

29. Describe the effect of the proposal on these existing providers.

**RESPONSE:**

The acquisition of a second MRI unit for Advanced Radiology's Stamford office will have little, if any, impact on existing providers of MRI services in the greater Stamford area. Advanced Radiology's referring provider/patient base is strong enough that its existing Stamford MRI unit is operating at 165% capacity. MRI volume at the Stamford office is projected to exceed 8,000 scans by FY 2019, which based on SHP guidelines is sufficient volume to keep two MRI units operating at 100% capacity. All of this reflects organic growth in the service area population, the number of insured patients and their MRI needs, and not the shifting of patients from any other MRI providers.

Moreover, as mentioned above it appears that a majority of MRI units in the service area are also operating near or above optimal capacity as described in the SHP (85%) (SHP Inventory, Table 8). Greenwich Hospital's main campus units are operating at 117% and 78% capacity, respectively. The Stamford Hospital's main campus unit is operating at 161% capacity and its Tully Center MRI is operating at 109% capacity. Norwalk Hospital's main campus unit is operating at 79% capacity and its off-campus units are operating at 82% capacity, collectively. Orthopaedic & Neurosurgery Specialists' captive unit in Greenwich is operating at 120% capacity. Of the 13 MRI scanners in the service area, 10 are operating at 78% capacity or higher. Based on the foregoing, existing MRI providers appear to have solid referring provider/patient bases as well. They should not, therefore, be impacted by the acquisition of a second MRI unit by Advanced Radiology, whose existing Stamford unit is operating at 165%, making it the busiest unit in the service area.

30. Describe the existing referral patterns in the area served by the proposal.

**RESPONSE:**

Advanced Radiology receives referrals for MRI services at its Stamford office from various physicians, physician practices and other provider entities located primarily in Fairfield County and New York. Referring physicians include primary care physicians and specialists such as orthopedist, neurologists, gastroenterologists, pulmonologists, ophthalmologist, gynecologists, urologists, and endocrinologists. Advanced Radiology also receives a significant number of referrals from podiatrists and chiropractors.

31. Explain how current referral patterns will be affected by the proposal.

**RESPONSE:**

Current referral patterns will be largely unchanged with the approval of a second MRI unit for Advanced Radiology's Stamford office. Referring providers will, however, have increased access to MRI services at this location once additional capacity is added. In addition, their patients will experience greater ease of access with less need for late night and weekend

appointments. The only potential change in referral patterns is the ability of area providers to refer patients to Advanced Radiology's Stamford office if they are in need of a 3.0 Tesla MRI scan rather than sending them to the practice's scanners in Fairfield or Orange. It is likely that there will be many cases where patients who would have been sent out of state or across counties for 3.0 Tesla imaging will be served locally.

§ "Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;" (Conn.Gen.Stat. § 19a-639(a)(9))

32. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.

**RESPONSE:**

The proposal will not result in an unnecessary duplication of services because there is a documented need for additional MRI capacity at Advanced Radiology's Stamford office. According to SHP guidelines, the capacity of an MRI unit is 4,000 scans per year and an applicant can demonstrate need for an additional MRI if it has an MRI in the service area that is operating at 85% capacity (3,400 scans per year). The existing MRI unit in Stamford performed 6,617 scans in FY 2015 and is operating at 165% capacity. In FY 2014, 7,002 MRI scans were performed at Advanced Radiology's Stamford office, meaning the unit operated at 175% capacity during that time period. Adding another MRI unit to this office will barely meet the projected demand for scans through FY 2019. Accordingly, the scanner is not unnecessary, nor would it duplicate services available elsewhere. Note also that this will be the only 3.0 Tesla MRI scanner in the Stamford area. In addition, Advanced Radiology's image sharing network will likely decrease the duplication of patient services through better coordination of care.

§ "Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region;" (Conn.Gen.Stat. § 19a-639(a)(11))

33. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.

**RESPONSE:**

Advanced Radiology is the only private radiology practice that provides MRI services in the Stamford area. The benefits of MRI in a private physician practice include ease of access for patients, lower cost for patients and payers, and no facility fee charged. A majority of the other MRI scanners in the area are hospital-based (11 of 13 units). Hospital-based MRI services are

typically reimbursed at higher rates than scans performed by private physician practices. In addition, hospitals often charge facility fees for MRI services, subject to certain limitations. Moreover, the only other private physician practice with an MRI in the service area is an orthopedic practice that only scans self-referred patients and excludes Medicaid beneficiaries. It is critical that Advanced Radiology be available as an alternative for patients who do not want to use hospital-based MRI services and who are prohibited from using the orthopedic practice's scanner. In order for Advanced Radiology to meet existing and future demand and serve as an alternative for these patients, a second MRI unit is required at its Stamford office.

## Tables

**TABLE 1  
APPLICANT'S SERVICES AND SERVICE LOCATIONS**

| Service | Street Address, Town                            | Population Served   | Days/Hours of Operation   | New Service or Proposed Termination                                   |
|---------|---|---|---|---|
| MRI     | 1315 Washington Boulevard<br>Stamford, CT 06902 | Patients referred by area providers for MRI scans; see OHCA Table 8 for list of patient towns of origin | <p>M.-F., 7 a.m. – 10 p.m.</p> <p>Sat. 7 a.m. – 3:30 p.m.</p> <p>Sun. 7 a.m. – 3:30 p.m.</p> <p>*Note, with the acquisition of a second MRI unit, Advanced Radiology will be able to shorten its hours of operation and still meet patient demand. Advanced Radiology intends to continue providing services on weekdays, weekday early evenings, and weekends on demand, but will likely do away with later evening and/or weekend afternoon hours based on historic utilization patterns.</p> | Proposed acquisition of a second MRI unit to operate at same location |

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**TABLE 2**  
**SERVICE AREA TOWNS**

List the official name of town\* and provide the reason for inclusion.

| <b>Town*</b>   | <b>Reason for Inclusion</b>  |
|--|--|
| Stamford<br>Norwalk<br>Darien<br>New Canaan<br>Greenwich | These towns represent the geographic area consisting of the lowest number of contiguous ZIP codes from which Advanced Radiology draws at least 75% of its patients for MRI services provided at its Stamford office (SHP, p. 60) |

\* Village or place names are not acceptable.

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**TABLE 3  
TOTAL PROPOSAL CAPITAL EXPENDITURE**

| <b>Purchase/Lease</b>                     | <b>Cost</b>        |
|---|--------------------|
| Equipment (Medical, Non-medical, Imaging) | \$2,506,224        |
| Land/Building Purchase*                   |                    |
| Construction/Renovation**                 | \$410,000          |
| Other (specify)                           |                    |
| <b>Total Capital Expenditure (TCE)</b>    | <b>\$2,916,224</b> |
| Lease (Medical, Non-medical, Imaging)***  |                    |
| <b>Total Lease Cost (TLC)</b>             | <b>\$0</b>         |
| <b>Total Project Cost (TCE+TLC)</b>       | <b>\$2,916,224</b> |

\* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.

\*\* If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.

\*\*\* If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

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**TABLE 4  
PROJECTED INCREMENTAL REVENUES AND EXPENSES**

|                                  | <b>FY 2017*</b>    | <b>FY 2018*</b>    | <b>FY 2019*</b>    |
|----------------------------------|--------------------|--------------------|--------------------|
| Revenue from Operations          | \$212,504          | \$431,221          | \$665,464          |
| Total Operating Expenses         | \$836,758          | \$915,310          | \$1,007,818        |
| <b>Gain/Loss from Operations</b> | <b>(\$624,254)</b> | <b>(\$484,089)</b> | <b>(\$342,354)</b> |

\* Fill in years using those reported in the Financial Worksheet attached.

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**TABLE 5  
HISTORICAL UTILIZATION BY SERVICE**

| Service**    | Actual Volume<br>(Last 3 Completed FYs) |               |               | CFY<br>Volume*          |
|--------------|---|---------------|---------------|-------------------------|
|              | FY<br>2013***                           | FY<br>2014*** | FY<br>2015*** | FY 2016*** <sup>6</sup> |
| MRI Scans    | 6,705                                   | 7,002         | 6,617         | 2,825                   |
| <b>Total</b> | <b>6,705</b>                            | <b>7,002</b>  | <b>6,617</b>  | <b>2,825</b>            |

\* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the

method of annualizing. For periods less than 6 months, report actual volume and identify the period covered.

\*\* Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.

\*\*\* Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

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**TABLE 6  
PROJECTED UTILIZATION BY SERVICE**

| Service*     | Projected Volume |              |              |
|--------------|------------------|--------------|--------------|
|              | FY 2017**        | FY 2018**    | FY 2019**    |
| MRI Scans    | 7,294            | 7,658        | 8,041        |
| <b>Total</b> | <b>7,294</b>     | <b>7,658</b> | <b>8,041</b> |

\* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.

\*\* If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

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<sup>6</sup> This includes MRI scan performed between January 1 and May 31, 2016.

**TABLE 7  
APPLICANT'S CURRENT & PROJECTED PAYER MIX**

| Payer                            | Current<br>FY 2015** |               | Projected    |               |              |               |              |               |
|----------------------------------|----------------------|---------------|--------------|---------------|--------------|---------------|--------------|---------------|
|                                  |                      |               | FY 2016**    |               | FY 2017**    |               | FY 2018**    |               |
|                                  | Discharges           | %             | Discharges   | %             | Discharges   | %             | Discharges   | %             |
| Medicare*                        | 1,151                | 17.39%        | 1,208        | 17.39%        | 1,268        | 17.39%        | 1,332        | 17.39%        |
| Medicaid*                        | 258                  | 3.90%         | 270          | 3.89%         | 284          | 3.89%         | 298          | 3.89%         |
| CHAMPUS &<br>TriCare             | 0                    | 0%            | 0            | 0%            | 0            | 0%            | 0            | 0%            |
| <b>Total<br/>Government</b>      | <b>1,409</b>         | <b>21.29%</b> | <b>1,478</b> | <b>21.28%</b> | <b>1,552</b> | <b>21.28%</b> | <b>1,630</b> | <b>21.28%</b> |
| Commercial<br>Insurers           | 4,717                | 71.29%        | 4,952        | 71.28%        | 5,200        | 71.29%        | 5,460        | 71.30%        |
| Uninsured/Self-<br>pay           | 249                  | 3.76%         | 262          | 3.77%         | 275          | 3.77%         | 289          | 3.77%         |
| Workers<br>Compensation          | 242                  | 3.66%         | 255          | 3.67%         | 267          | 3.66%         | 279          | 3.65%         |
| <b>Total Non-<br/>Government</b> | <b>5,208</b>         | <b>78.71%</b> | <b>5,469</b> | <b>78.72%</b> | <b>5,742</b> | <b>78.72%</b> | <b>6,028</b> | <b>78.72%</b> |
| <b>Total Payer<br/>Mix</b>       | <b>6,617</b>         | <b>100%</b>   | <b>6,947</b> | <b>100%</b>   | <b>7,294</b> | <b>100%</b>   | <b>7,658</b> | <b>100%</b>   |

\* Includes managed care activity.

\*\* Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

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**TABLE 8  
UTILIZATION BY TOWN**

| <b>Town</b>         | <b>Utilization<br/>FY 2015**</b> |
|---------------------|----------------------------------|
| Stamford            | 3,648 (55.13%)                   |
| Greenwich           | 661 (9.99%)                      |
| Norwalk             | 652 (9.85%)                      |
| Darien              | 379 (5.73%)                      |
| New Canaan          | 275 (4.16%)                      |
| Other CT            | 623 (9.41%)                      |
| New York            | 327 (4.94%)                      |
| Other               | 52 (0.79%)                       |
| <b><u>Total</u></b> | <b><u>6,617 (100%)</u></b>       |

\* List inpatient/outpatient/ED volumes separately, if applicable

\*\* Fill in most recently completed fiscal year.

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**TABLE 9  
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS<sup>7</sup>**

| <b>Service or Program Name</b>                                  | <b>Population Served</b> | <b>Facility ID*</b>      | <b>Facility's Provider Name, Street Address and Town</b>   | <b>Hours/Days of Operation</b>   | <b>Current Utilization (FY 2014 Scan Volume)</b> |
|---|--------------------------|--------------------------|--|--|--|
| G.E. 450<br>1.5 Tesla<br>Fixed/Closed                           | Not publically available | Not publically available | Greenwich Hospital<br>5 Perry Ridge Road<br>Greenwich, CT<br>06830   | M. – F.,<br>7:15 a.m. –<br>7:00 p.m.<br><br>Sat.-Sun.,<br>7:30 a.m. –<br>5:30 p.m.                                     | 4,693  |
| G.E. Signa<br>Excite<br>3.0 Tesla<br>Fixed/Closed               | Not publically available | Not publically available | Greenwich Hospital<br>5 Perry Ridge Road<br>Greenwich, CT<br>06830   | M. – F.,<br>7:30 a.m. –<br>7:00 p.m.<br><br>Sat.-Sun.,<br>7:00 a.m. –<br>5:00 p.m.                                     | 3,128  |
| Siemens<br>Espree<br>1.5 Tesla<br>Fixed/Closed                  | Not publically available | Not publically available | Greenwich Hospital<br>Diagnostic Center<br>2015 West Main Street<br>Greenwich, Ct<br>06902                           | M. – F.,<br>7:30 a.m. –<br>5:00 p.m.   | 1,991  |
| Philips<br>Ingenia<br>1.5 Tesla<br>Fixed/Closed                 | Not publically available | Not publically available | Norwalk Hospital<br>24 Stevens Street<br>Norwalk, CT<br>06856  | Sun. – Sat.,<br>24 hours   | 3,174  |
| G.E. HDX<br>Twinspeed 8<br>Channel<br>1.5 Tesla<br>Fixed/Closed | Not publically available | Not publically available | Norwalk Hospital<br>d/b/a Norwalk<br>Radiology &<br>Mammography<br>Center<br>184 East Avenue<br>Norwalk, CT<br>06851 | M. – Th.,<br>7:15 a.m. –<br>8:30 p.m.<br><br>F.,<br>7:15 a.m. –<br>4:30 p.m.<br><br>Sat.,<br>7:30 a.m. –<br>11:45 a.m. | 9,797  |

<sup>7</sup> Source: SHP Inventory, Table 8.

| <b>Service or Program Name</b>                                  | <b>Population Served</b> | <b>Facility ID*</b>      | <b>Facility's Provider Name, Street Address and Town</b>   | <b>Hours/Days of Operation</b>  | <b>Current Utilization (FY 2014 Scan Volume)</b> |
|---|--------------------------|--------------------------|--|---|--|
| G.E. HDX<br>Openspeed<br>Excite<br>.7 Tesla<br>Fixed/Open       | Not publically available | Not publically available | Norwalk Hospital<br>d/b/a Norwalk<br>Radiology &<br>Mammography<br>Center<br>184 East Avenue<br>Norwalk, CT<br>06851 | M. – Th.,<br>7:15 a.m. –<br>8:30 p.m.<br><br>F.,<br>7:15 a.m. –<br>4:30 p.m.<br><br>Sat.,<br>7:30 a.m. –<br>11:45 a.m.          | Included in<br>9,797 above                       |
| G.E. HDX<br>Echospeed 8<br>Channel<br>1.5 Tesla<br>Fixed/Closed | Not publically available | Not publically available | Norwalk Hospital<br>d/b/a Norwalk<br>Radiology &<br>Mammography<br>Center<br>184 East Avenue<br>Norwalk, CT<br>06851 | M. – Th.,<br>7:15 a.m. –<br>8:30 p.m.<br><br>F.,<br>7:15 a.m. –<br>4:30 p.m.<br><br>Sat.,<br>7:30 a.m. –<br>11:45 a.m.          | Included in<br>9,797 above                       |
| G.E. Signa<br>HDX   | Not publically available | Not publically available | The Stamford<br>Hospital<br>30 Shelburne<br>Road<br>Stamford, CT<br>06904  | Sun. – Sat.,<br>24 hours  | 6,427  |
| G.E. Horizon<br>LX<br>1.5 Tesla<br>Fixed/Closed                 | Not publically available | Not publically available | Stamford<br>Hospital's Darien<br>Imaging Center<br>6 Thorndale Circle<br>Darien, CT 06820                            | M, W. & F.,<br>8:00 a.m. –<br>4:00 p.m.<br><br>Tu. & Th.,<br>8:00 a.m. –<br>8:00 p.m.<br><br>Sat.,<br>8:00 a.m. –<br>12:00 p.m. | 1,827  |

| <b>Service or Program Name</b>                 | <b>Population Served</b> | <b>Facility ID*</b>      | <b>Facility's Provider Name, Street Address and Town</b>                                 | <b>Hours/Days of Operation</b>  | <b>Current Utilization (FY 2014 Scan Volume)</b> |
|--|--------------------------|--------------------------|--|---|--|
| G.E. Signa 15 HDXT 1.5 Tesla Fixed/Closed      | Not publically available | Not publically available | Stamford Hospital's Tully Health Center<br>32 Strawberry Hill Ct.<br>Stamford, CT 06902  | M. – F.,<br>8:00 a.m. – 8:00 p.m.<br><br>Sat. – Sun.,<br>8:00 a.m. – 4:00 p.m.                                | 4,360  |
| Siemens Magnetom Espree 1.5 Tesla Fixed/Closed | ONS patients only        | Not publically available | Orthopaedic & Neurosurgical Specialists<br>40 Valley Drive<br>Greenwich, CT 06830        | M. – F.,<br>7:00 a.m. – 9:00 p.m.<br><br>Sat.,<br>7:00 a.m. – 5:00 p.m.<br><br>Sun.,<br>7:00 a.m. – 1:00 p.m. | 4,800  |
| G.E. Optima 1.5 Tesla Fixed/Closed             | Not publically available | Not publically available | Hospital for Special Surgery Outpatient Center<br>1 Blatchley Road<br>Stamford, CT 06902 | Not publically available  | 1,981 <sup>8</sup>                               |

\* Provide the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

[\[back to question\]](#)

<sup>8</sup> This figure includes February 2015 through January 2016 (Docket No. 12-31780-CON).



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Supplemental CON Application Form  
**Acquisition of Equipment**  
Conn. Gen. Stat. § 19a-638(a)(10),(11)

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**Applicant:** Advanced Radiology MRI Centers Limited Partnership

**Project Name:** Acquisition of 3.0 Tesla MRI Unit for Stamford Office

**1. Project Description: Acquisition of Equipment**

- a. Provide the manufacturer, model and number of slices/tesla strength of the proposed scanner (as appropriate to each piece of equipment).

**RESPONSE:**

G.E. Signa Pioneer 3.0 Tesla MRI

- b. List each of the Applicant's sites and the imaging modalities currently offered by location.

**RESPONSE:**

See Exhibit L.

**2. Clear Public Need**

- a. Complete **Table A** for each piece of equipment of the type proposed currently operated by the Applicant at each of the Applicant's sites.

**TABLE A**  
EXISTING EQUIPMENT OPERATED BY THE APPLICANT

| Advanced Radiology Office Address                 | Service*             | Days/Hours of Operation **  | FY 2015 Utilization*** |
|---|----------------------|---|------------------------|
| 1055 Post Road<br>Fairfield, CT 06824             | 3.0 Tesla Open MRI   | Mon. – Fri., 7 a.m. – 11 p.m.<br>Sat., 7 a.m. – 3:15 p.m.<br>Sun., 7 am. – 7 p.m. | 6,685                  |
| 297 Boston Post Road<br>Orange, CT 06477          | 3.0 Tesla Open MRI   | Mon. – Fri., 7 a.m. – 10 p.m.   | 2,886                  |
| 4 Corporate Drive, Suite 182<br>Shelton, CT 06484 | 1.5 Tesla Closed MRI | Mon. – Fri., 8:30 a.m. – 5 p.m.   | 2,653                  |
| 1315 Washington Boulevard<br>Stamford, CT 06902   | 1.5 Tesla Closed MRI | Mon. – Fri., 7 a.m. – 10 p.m.<br>Sat. – Sun., 7 a.m. – 3:30 p.m.                  | 6,617                  |
| 2867 Main Street<br>Stratford, CT 06614           | 1.5 Tesla Closed MRI | Mon. – Fri., 7 a.m. – 11 p.m.<br>Sat., 7 a.m. – 7 p.m.                            | 5,433                  |
| 15 Corporate Drive<br>Trumbull, CT 06611          | 1.5 Tesla Open MRI   | Mon. – Fri., 7:15 a.m. – 10 p.m.<br>Sat., 7 a.m. – 3:15 p.m.                      | 5,139                  |

\*Include equipment strength (e.g. slices, tesla strength), whether the unit is open or closed (for MRI)

\*\*Days of the week unit is operational, and start and end time for each day

\*\*\*Number of scans/exams performed on each unit for the most recent 12-month period (identify period).

- b. Provide the rationale for locating the proposed equipment at the proposed site;

**RESPONSE:**

As mentioned in the CON Application Main Form, Advanced Radiology chose its Stamford office for a second MRI unit because it is one of the practice's busiest offices for MRI services. It is also geographically distant from Advanced Radiology's other scanners, most of which are located in the greater Bridgeport area. MRI scan volume has grown with some consistency since the existing Stamford unit was placed into operation in 2005. Between FY 2011 and FY 2015, Stamford MRI volume grew by 25%. Advanced Radiology has extended MRI hours in Stamford until 10:00 p.m. on weeknights and 3:30 p.m. on weekends in an effort to accommodate increasing volume. There is minimal ability to expand hours further given the availability of technologists and patients' unwillingness to schedule exams at earlier or later times. Advanced Radiology has reached the point where it must redirect many patients who want their MRI exams in Stamford to other practice scanners. The practice's Fairfield MRI (the next closest to Stamford) is now as busy as Stamford. The practice's Stratford and Trumbull scanners are also operating over capacity. The patient overflow from Stamford is crowding Advanced Radiology's MRI scanners in the greater Bridgeport area and creating access issues for patients who live there. Accordingly, the practice has decided to acquire a second unit and increase its capacity in Stamford to meet existing and proposed future demand for MRI services in lower Fairfield County.

3. Actual and Projected Volume

- a. Complete the following tables for the past three fiscal years (“FY”), current fiscal year (“CFY”), and first three projected FYs of the proposal, for each of the Applicant’s existing and proposed pieces of equipment (of the type proposed, at the proposed location only). In **Table B**, report the units of service by piece of equipment, and in **Table C**, report the units of service by type of exam (e.g. if specializing in orthopedic, neurosurgery, or if there are scans that can be performed on the proposed scanner that the Applicant is unable to perform on its existing scanners).

**TABLE B**  
HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY EQUIPMENT UNIT

| Equipment***                          | Actual Volume<br>(Last 3 Completed FYs) <sup>1</sup> |                 |                 | CFY<br>Volume* <sup>2</sup> | Projected Volume<br>(First 3 Full Operational FYs)** |                 |                 |
|---------------------------------------|--|-----------------|-----------------|-----------------------------|--|-----------------|-----------------|
|                                       | FY 2013<br>****                                      | FY 2014<br>**** | FY 2015<br>**** | FY 2016<br>****             | FY 2017<br>****                                      | FY 2018<br>**** | FY 2019<br>**** |
| Stamford MRI, Existing 1.5 Tesla Unit | 6,705  | 7,002           | 6,617           | 2,825                       | 3,647  | 3,829           | 4,021           |
| Stamford MRI, Proposed 3.0 Tesla Unit | --   | --              | --              |                             | 3,647  | 3,829           | 4,020           |
| <b>Total</b>                          | <b>6,705</b>   | <b>7,002</b>    | <b>6,617</b>    | <b>2,825</b>                | <b>7,294</b>   | <b>7,658</b>    | <b>8,041</b>    |

\*For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

\*\*If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.

\*\*\*Identify each scanner separately and add lines as necessary. Also break out inpatient/outpatient/ED volumes if applicable.

\*\*\*\*Fill in years. In a footnote, identify the period covered by the Applicant’s FY (e.g., July 1-June 30, calendar year, etc.).

<sup>1</sup> Advanced Radiology’s fiscal year runs from January 1 through December 31.

<sup>2</sup> This includes MRI scan performed between January 1 and May 31, 2016.

**TABLE C**  
HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY TYPE OF SCAN/EXAM

| MRI Scan Type<br>*** | Actual Volume<br>(Last 3 Completed FYs) |                 |                 | CFY<br>Volume*  | Projected Volume<br>(First 3 Full Operational FYs)** |                 |                 |
|----------------------|---|-----------------|-----------------|-----------------|--|-----------------|-----------------|
|                      | FY 2013<br>****                         | FY 2014<br>**** | FY 2015<br>**** | FY 2016<br>**** | FY 2017<br>****                                      | FY 2018<br>**** | FY 2019<br>**** |
| Body                 | 340                                     | 328             | 323             | 166             | 429  | 450             | 473             |
| Breast               | 205                                     | 223             | 168             | 87              | 225  | 236             | 248             |
| Musculoskeletal      | 3,220                                   | 3,284           | 3,059           | 1,226           | 3,166  | 3,324           | 3,490           |
| Neurological         | 2,925                                   | 3,158           | 3,062           | 1,344           | 3,470  | 3,644           | 3,826           |
| Vascular             | 15                                      | 9               | 5               | 2               | 4  | 4               | 4               |
| <b>Total</b>         | <b>6,705</b>                            | <b>7,002</b>    | <b>6,617</b>    | <b>2,825</b>    | <b>7,294</b>   | <b>7,658</b>    | <b>8,041</b>    |

\*For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

\*\*If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.

\*\*\*Identify each type of scan/exam (e.g., orthopedic, neurosurgery or if there are scans/exams that can be performed on the proposed piece of equipment that the Applicant is unable to perform on its existing equipment) and add lines as necessary.

\*\*\*\*Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).

- b. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume by scanner and scan type.

**RESPONSE:**

Volume is projected to grow at a conservative rate of 5% annually with acquisition of a second MRI unit for Advanced Radiology's Stamford office. This is consistent with, and in some cases less than, historic growth on the practice's existing Stamford magnet. Going back to FY 2012, the unit saw growth as high as 18% annually and, from FY 2011 through FY 2015, MRI volume in Stamford grew by 25%. In addition, the G.E. Study and SG2 Report project significant growth in MRI volume both in the service area and nationwide. There is also projected growth in population generally and in the older age cohorts that tend to be the largest consumers of MRI services. In addition, the number of Medicaid recipients in Connecticut and Fairfield County is expected to grow, giving more people access to covered MRI services. For these reasons, Advanced Radiology expects to see at least 5% growth of its Stamford MRI service year to year.

- c. Explain any increases and/or decreases in the volume reported in the tables above.

**RESPONSE:**

The decline in MRI volume between FY 2014 and FY 2015 was due to the fact that the practice performed upgrades to its Trumbull MRI unit and transitioned certain scans that could not previously be performed in Trumbull from Stamford to that office. Advanced Radiology is projecting that this loss of Stamford MRI volume will be recouped between FY 2016 and FY 2017.

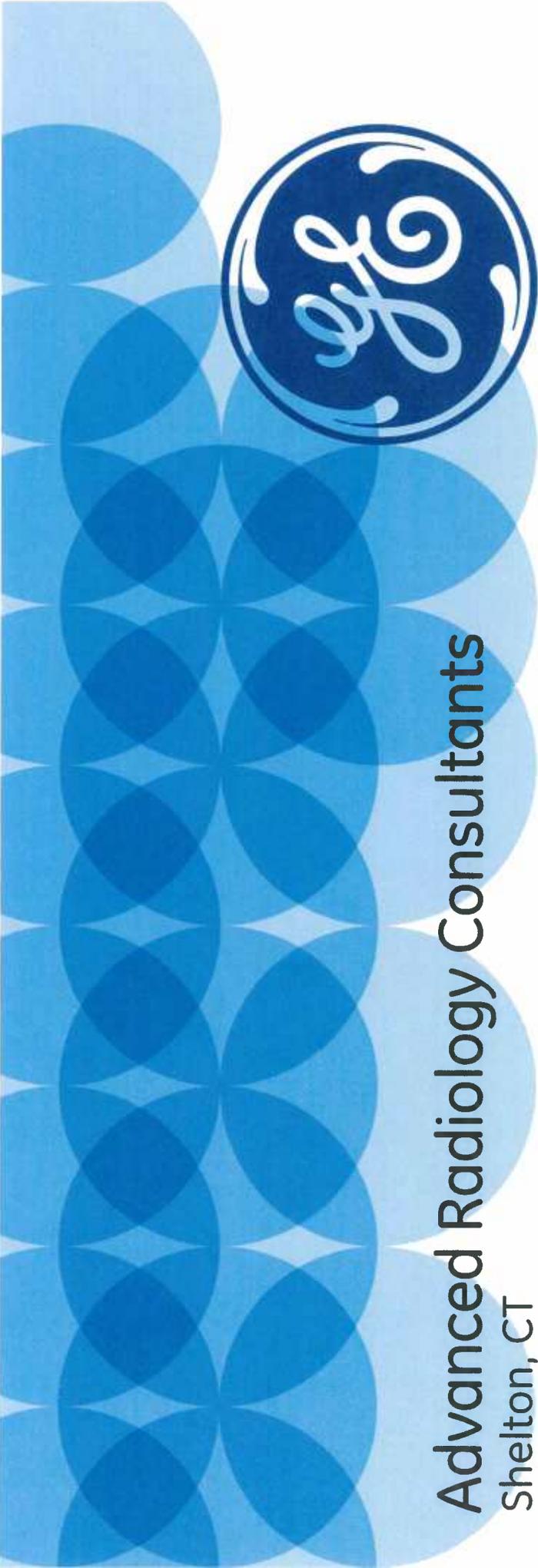
- d. Provide a breakdown, by town, of the volumes provided in **Table C** for the most recently completed FY.

**TABLE D**  
UTILIZATION BY TOWN

| <b>Equipment*</b>                        | <b>Town</b>  | <b>Utilization<br/>FY 2015**</b> |
|--|--------------|----------------------------------|
| Stamford MRI, 1.5 Tesla,<br>Fixed/Closed | Stamford     | 3,648 (55.13%)                   |
|  | Greenwich    | 661 (9.99%)                      |
|  | Norwalk      | 652 (9.85%)                      |
|  | Darien       | 379 (5.73%)                      |
|  | New Canaan   | 275 (4.16%)                      |
|  | Wilton       | 105 (1.59%)                      |
|  | Bridgeport   | 81 (1.22%)                       |
|  | Westport     | 76 (1.15%)                       |
|  | Fairfield    | 73 (1.10%)                       |
|  | Ridgefield   | 36 (0.54%)                       |
|  | Weston       | 31 (0.47%)                       |
|  | Trumbull     | 26 (0.39%)                       |
|  | Stratford    | 23 (0.35%)                       |
|  | Redding      | 20 (0.30%)                       |
|  | Easton       | 18 (0.27%)                       |
|  | Danbury      | 15 (0.23%)                       |
|  | Shelton      | 12 (0.18%)                       |
|  | Monroe       | 11 (0.17%)                       |
|  | Milford      | 10 (0.15%)                       |
|  | Other CT     | 86 (1.30%)                       |
| New York                                 | 327 (4.94%)  |                                  |
| Other                                    | 52 (0.79%)   |                                  |
|  | <b>TOTAL</b> | <b>6,617 (100%)</b>              |

\*Identify each scanner separately and add lines as necessary. Also, break out inpatient/outpatient/ED volumes if applicable and include equipment strength (e.g., slices, tesla strength), whether the unit is open or closed (for MRI). \*\*Fill in year.

# *EXHIBIT A*



# Advanced Radiology Consultants

Shelton, CT



May 4, 2016

Market At-a-Glance Report

This report has been prepared by GE Healthcare based upon research obtained through industry and public sources through Market Expert, a tool developed by Truven Health Analytics. GE Healthcare makes no representation or warranties, express or implied, as to the accuracy or completeness of either the material contained herein or any other written or oral statements or projections made by GE Healthcare.

**Imagination at work.**

# Table of contents

## 1. Report source:

*GE Healthcare leverages data from Truven Health Analytics to create reports based on customers' market reach and needs.*

*Truven Health Analytics has delivered this unbiased third party data, in addition to various analytical tools, benchmarks and services to the healthcare industry for over 30 years.*

## 2. Market reach summary & observations

## 3. Market reach data\*:

- Population Planning
- Outpatient Planning

## 4. Appendices:

- A1-2\*: Detailed procedure level data in your market reach
- B: DRG & CPT reference file, methodologies, insurance categories & glossary



\*In some cases, inpatient planning and /or outpatient planning are not included.



## Market reach observations

- In the next 5 years, population estimates are expected to increase/decrease by 2.8%
- All outpatient encounters projected to increase/decrease 2.4% over the next 5 years, including technology growth



\*Refers to the inpatient and outpatient encounters for the service lines present in this report; additional encounters might exist outside of what's presented in this report. Projections and estimates are based on the most current Truven Health Analytics data collection methodology. Observations are pulled directly from the data and include only the ZIP codes and service lines requested within this report.

# Population Planning

Projections and estimates are based on the most current Truven Health Analytics data collection methodology. Data is available only if the volume is large enough to produce a reportable output. In some cases, market reach data is unavailable. The following volumes are representative of the chosen ZIP codes listed on slide 3.



# Demographic snapshot

| Statistic                          | 2015      | 2020      | 5 year growth |
|------------------------------------|-----------|-----------|---------------|
| Total Population                   | 399,504   | 410,620   | 2.8%          |
| Total Male Population              | 195,477   | 201,148   | 2.9%          |
| Total Female Population            | 204,027   | 209,472   | 2.7%          |
| Females, Child Bearing Age (15-44) | 70,756    | 71,578    | 1.2%          |
| Total Households                   | 149,249   | 153,355   | 2.8%          |
| Average Household Income           | \$169,140 | \$172,978 | 2.3%          |
| Average Effective Buying Income    | \$133,187 |           |               |
| Median Household Income            | \$120,084 | \$123,574 | 2.9%          |
| Median Effective Buying Income     | \$88,472  |           |               |
| % Unemployment                     |           | 4.22%     |               |



Projections and estimates are based on the most current Truven Health Analytics data collection methodology.

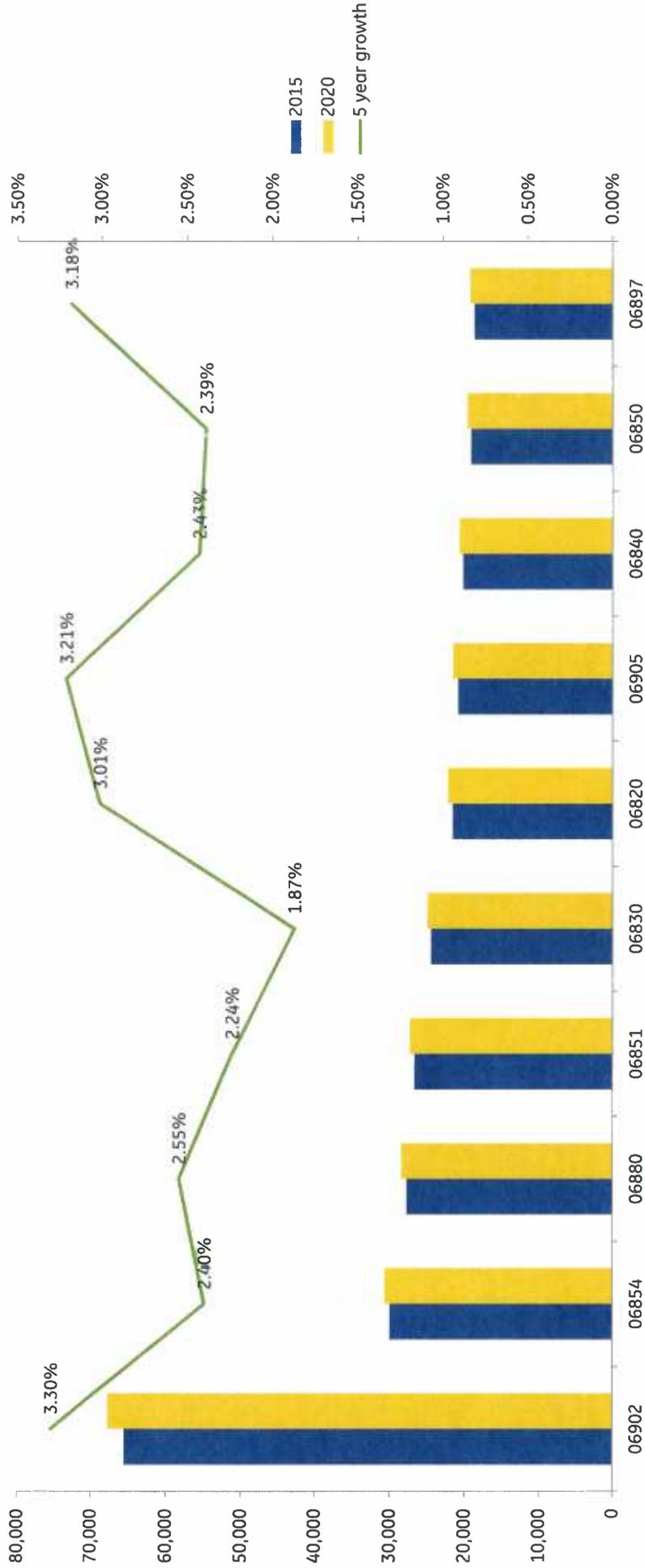
# Population growth Age band & gender split

| Age Band     | 2015           |                | 2020         |            | 5 year growth |        | 2015   |            | 2020       |            | 5 year growth |        |
|--------------|----------------|----------------|--------------|------------|---------------|--------|--------|------------|------------|------------|---------------|--------|
|              | Population     | Population     | Population   | Population | growth        | growth | Gender | Population | Population | Population | Population    | growth |
| 0-14         | 78,911         | 75,692         | -4.08%       | Male       | 40,449        | 38,843 | -3.97% | Male       | 40,449     | 38,843     | -3.97%        |        |
|              |                |                |              | Female     | 38,462        | 36,849 | -4.19% | Female     | 38,462     | 36,849     | -4.19%        |        |
| 15-17        | 17,022         | 17,935         | 5.36%        | Male       | 8,790         | 9,102  | 3.55%  | Male       | 8,790      | 9,102      | 3.55%         |        |
|              |                |                |              | Female     | 8,232         | 8,833  | 7.30%  | Female     | 8,232      | 8,833      | 7.30%         |        |
| 18-24        | 32,705         | 38,408         | 17.44%       | Male       | 17,018        | 19,835 | 16.55% | Male       | 17,018     | 19,835     | 16.55%        |        |
|              |                |                |              | Female     | 15,687        | 18,573 | 18.40% | Female     | 15,687     | 18,573     | 18.40%        |        |
| 25-34        | 42,669         | 44,223         | 3.64%        | Male       | 22,055        | 23,208 | 5.23%  | Male       | 22,055     | 23,208     | 5.23%         |        |
|              |                |                |              | Female     | 20,614        | 21,015 | 1.95%  | Female     | 20,614     | 21,015     | 1.95%         |        |
| 35-54        | 114,603        | 104,523        | -8.80%       | Male       | 55,362        | 50,907 | -8.05% | Male       | 55,362     | 50,907     | -8.05%        |        |
|              |                |                |              | Female     | 59,241        | 53,616 | -9.50% | Female     | 59,241     | 53,616     | -9.50%        |        |
| 55-64        | 53,682         | 60,435         | 12.58%       | Male       | 25,794        | 28,697 | 11.25% | Male       | 25,794     | 28,697     | 11.25%        |        |
|              |                |                |              | Female     | 27,888        | 31,738 | 13.81% | Female     | 27,888     | 31,738     | 13.81%        |        |
| 65+          | 59,912         | 69,404         | 15.84%       | Male       | 26,009        | 30,556 | 17.48% | Male       | 26,009     | 30,556     | 17.48%        |        |
|              |                |                |              | Female     | 33,903        | 38,848 | 14.59% | Female     | 33,903     | 38,848     | 14.59%        |        |
| <b>Total</b> | <b>399,504</b> | <b>410,620</b> | <b>2.78%</b> |            |               |        |        |            |            |            |               |        |



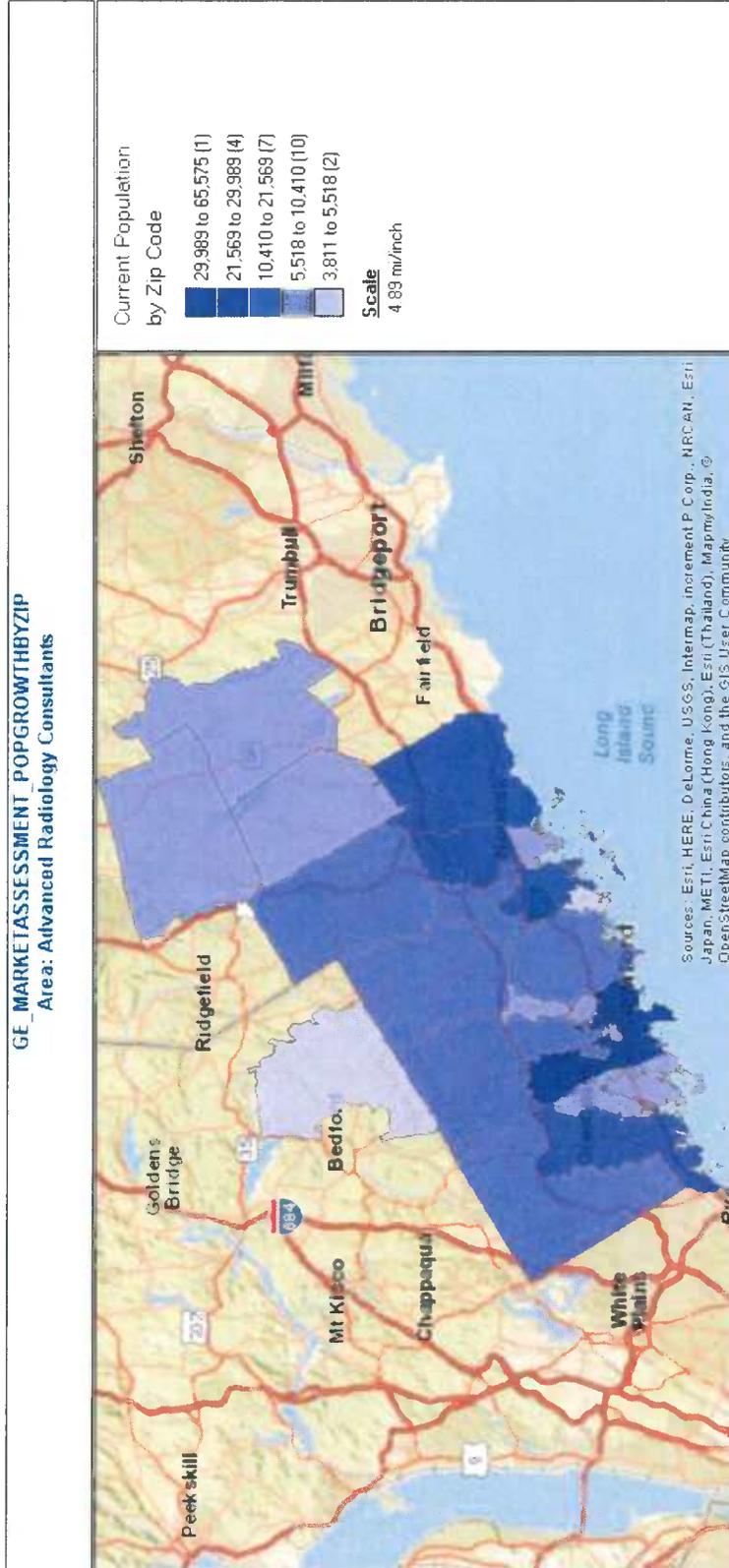
Projections and estimates are based on the most current Truven Health Analytics data collection methodology.

# Population growth Top ZIP codes\*



\*If more than 10 ZIP codes are identified in your Market Reach, than only the top 10 are shown above; Projections and estimates are based on the most current Truven Health Analytics data collection methodology.

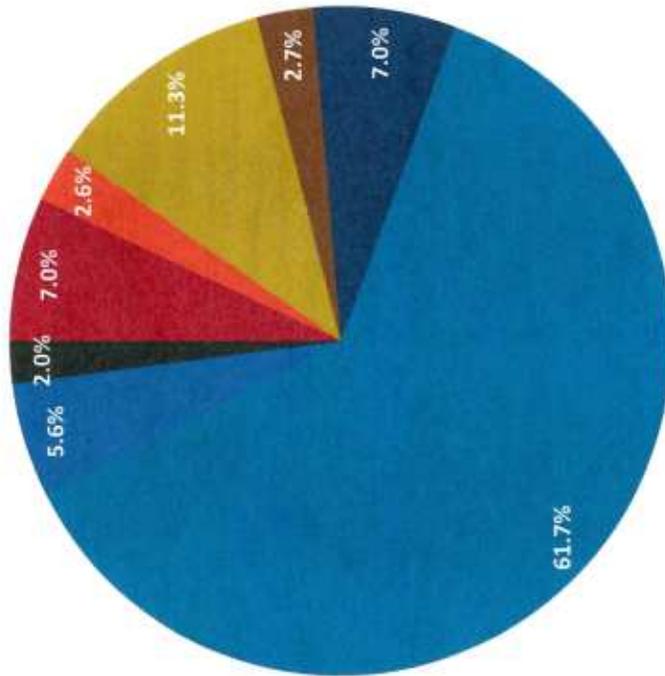
# Population volume



Projections and estimates are based on the most current Truven Health Analytics data collection methodology.

# Insurance coverage

2016  
Payer Mix (% of Total)



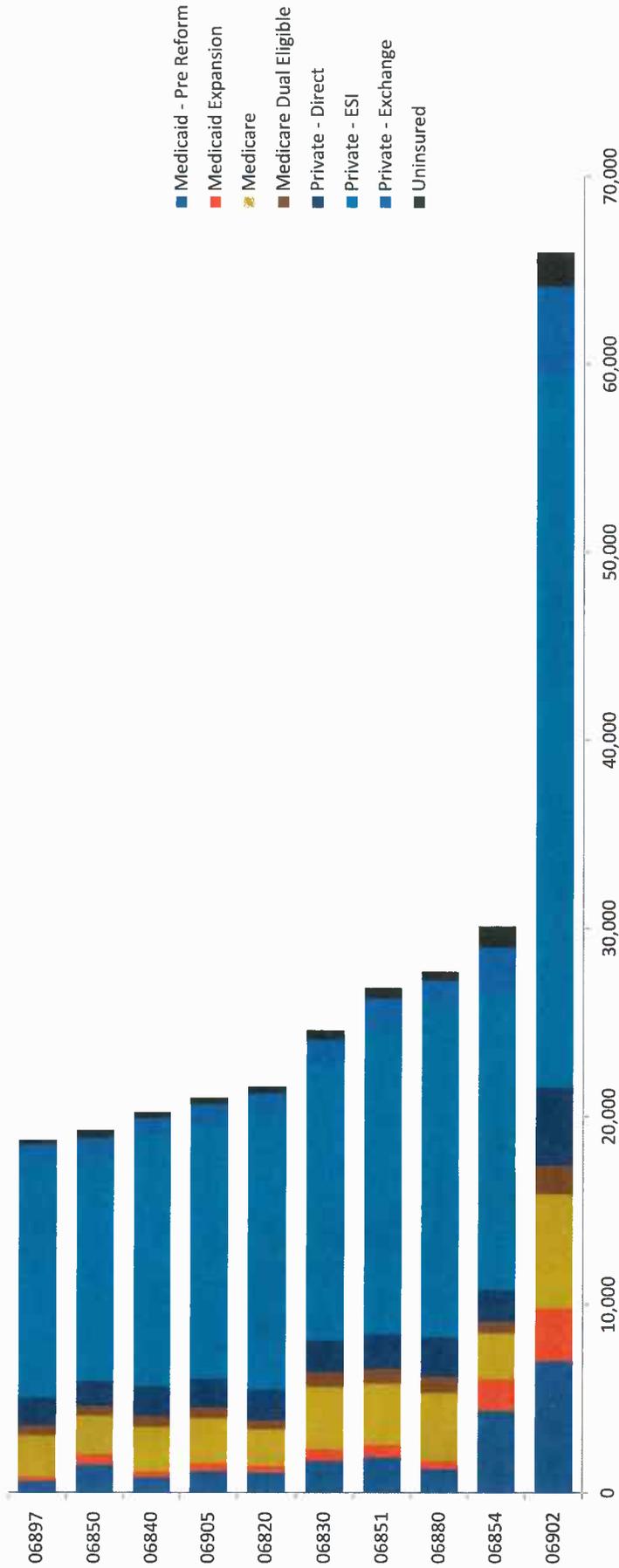
| Payer                  | 2016           | 2021           | 5 year growth |
|------------------------|----------------|----------------|---------------|
| Medicaid - Pre Reform  | 27,924         | 27,528         | -1%           |
| Medicaid Expansion     | 10,569         | 12,014         | 14%           |
| Medicare               | 45,218         | 51,800         | 15%           |
| Medicare Dual Eligible | 10,775         | 12,117         | 12%           |
| Private - Direct       | 28,088         | 27,569         | -2%           |
| Private - ESI          | 247,193        | 249,179        | 1%            |
| Private - Exchange     | 22,415         | 23,963         | 7%            |
| Uninsured              | 8,176          | 8,004          | -2%           |
| <b>Total</b>           | <b>400,359</b> | <b>412,173</b> | <b>2.95%</b>  |



Projections and estimates are based on the most current Truven Health Analytics data collection methodology.

# Insurance coverage Top ZIP codes\*

2016  
Payer Mix (Total lives)



\*If more than 10 ZIP codes are identified in your Market Reach, than only the top 10 are shown above; Projections and estimates are based on the most current Truven Health Analytics data collection methodology.

# Outpatient Planning

Projections and estimates are based on the most current Truven Health Analytics data collection methodology. Data is available only if the volume is large enough to produce a reportable output. In some cases, market reach data is unavailable and detailed procedure level data may not be listed in the appendix. Procedures performed on those who live in the service area, not procedures performed in service area.

For outpatient, the detail is shown at the CPT procedure group level and each service line is displayed for your market reach identified on slide 3.



# Outpatient procedures 5 year projected growth

Outpatient Procedures  
5 year projected growth  
Adjusted & Trended



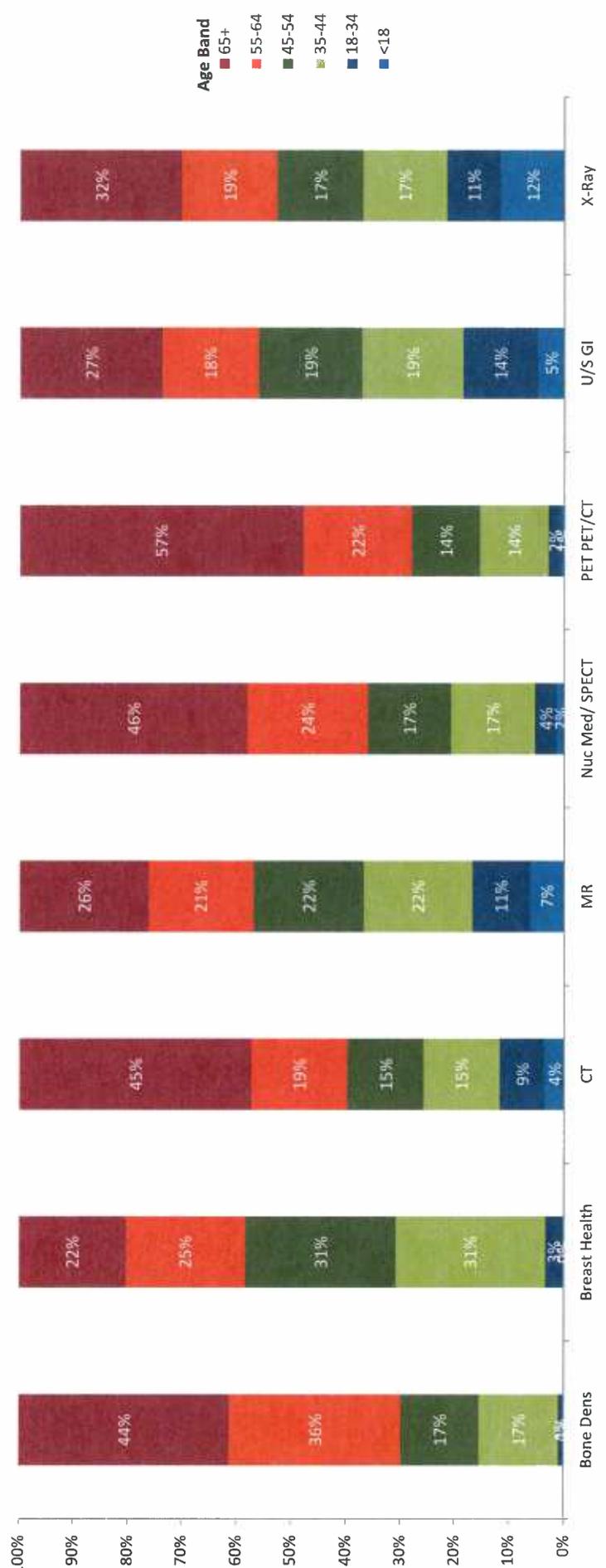
5 year growth:



Projections and estimates are based on the most current Truven Health Analytics data collection methodology.

# 2015 Procedures OP Procedures (% of Total) Age band split Adjusted & Trended

# Outpatient procedures Age band split



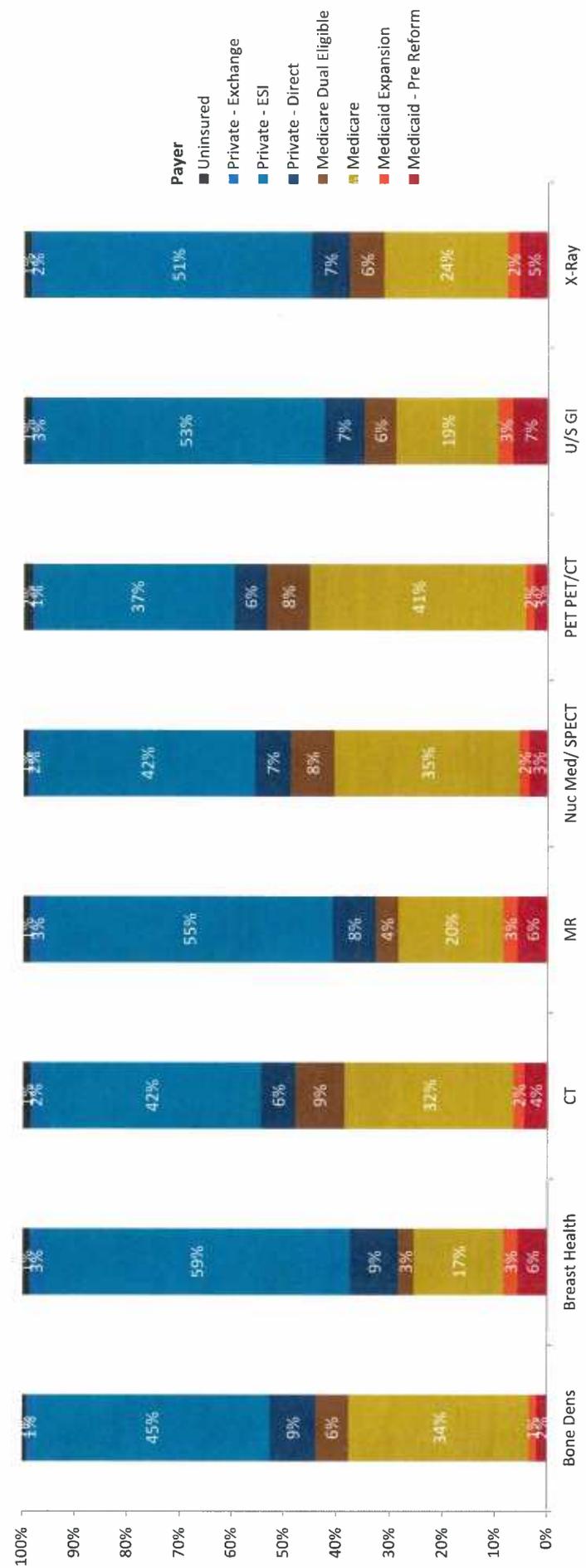
Procedures:



Projections and estimates are based on the most current Truven Health Analytics data collection methodology.

2015 Adjusted Procedures  
OP Procedures (% of Total)  
Payer mix split  
Adjusted & Trended

Outpatient procedures  
Payer mix split



| Procedures: | 13,530 | 102,695 | 62,550 | 38,229 | 12,331 | 2,792 | 63,712 | 253,593 |
|-------------|--------|---------|--------|--------|--------|-------|--------|---------|
|-------------|--------|---------|--------|--------|--------|-------|--------|---------|



Projections and estimates are based on the most current Truven Health Analytics data collection methodology.

## Potential next steps

- **Capital & technology planning**
- **Budget proposals & business cases**
- **Market & share evaluations**
- **Business development**
- **Asset management**
- **Strategic Assessments**

*Ask your GE Healthcare representative for more information to support enterprise solutions with GE Partners and Healthcare Financial Services*



# Appendix A2: All detailed procedure level data in your market reach

## *Outpatient Planning*

Projections and estimates are based on the most current Truven Health Analytics data collection methodology. Data is available only if the volume is large enough to produce a reportable output. In some cases, market reach data is unavailable and detailed procedure level data may not be listed in the appendix. Procedures performed on those who live in the service area, not procedures performed in service area.

For outpatient, the detail is shown at the CPT procedure group level. The top 15 procedure codes for each service line is displayed for your market reach. The top 15 is determined by '5 year' adj procedures.



# 5 year projected Bone Dens growth Outpatient procedures

| Service Line CPT Procedure Code Group | Procedures       |                       |                                |
|---------------------------------------|------------------|-----------------------|--------------------------------|
|                                       | 2015<br>Adjusted | 2020<br>Adj & trended | 5 year adj &<br>trended growth |
| DEXA scan                             | 13,496           | 11,580                | -14.20%                        |
| Ultrasound, bone-density              | 33               | 27                    | -18.60%                        |
| <b>Top procedure groups - total</b>   |                  |                       | <b>-14.21%</b>                 |
|                                       | <b>13,530</b>    | <b>11,607</b>         |                                |



Projections and estimates are based on the most current Truven Health Analytics data collection methodology. Top 15 DRG code descriptions shown; if more than 15 exist, volumes may differ between slides.

# 5 year projected Breast Health growth Outpatient procedures

| Service Line CPT Procedure Code Group | Procedures     |                    |  | 5 year adj & trended growth |
|---------------------------------------|----------------|--------------------|--|-----------------------------|
|                                       | 2015 Adjusted  | 2020 Adj & trended |  |                             |
| Mammography                           | 65,833         | 59,162             |  | -10.10%                     |
| Ultrasound, breast                    | 35,098         | 33,667             |  | -4.10%                      |
| X-ray - breast                        | 820            | 799                |  | -2.60%                      |
| MRI - breast                          | 726            | 688                |  | -5.30%                      |
| Mammographic guidance                 | 218            | 155                |  | -28.90%                     |
| <b>Top procedure groups - total</b>   | <b>102,695</b> | <b>94,471</b>      |  | <b>-8.01%</b>               |



Projections and estimates are based on the most current Truven Health Analytics data collection methodology. Top 15 DRG code descriptions shown; if more than 15 exist, volumes may differ between slides.

# 5 year projected CT growth Outpatient procedures

| Service Line CPT Procedure Code Group | Procedures       |                       |                                |
|---------------------------------------|------------------|-----------------------|--------------------------------|
|                                       | 2015<br>Adjusted | 2020<br>Adj & trended | 5 year adj &<br>trended growth |
| CT - abdomen                          | 20,617           | 22,730                | 10.20%                         |
| CT - head/brain/neck                  | 17,817           | 20,381                | 14.40%                         |
| CT - chest/thorax                     | 12,297           | 13,551                | 10.20%                         |
| CT - guidance                         | 5,632            | 7,846                 | 39.30%                         |
| CT - spine & pelvis                   | 4,629            | 5,003                 | 8.10%                          |
| CT - lower extremities                | 739              | 843                   | 14.10%                         |
| CT - upper extremities                | 430              | 507                   | 18.00%                         |
| CT - other                            | 166              | 170                   | 2.60%                          |
| CT - heart                            | 126              | 126                   | 0.30%                          |
| CT - bone density                     | 52               | 47                    | -10.10%                        |
| CT - colonography                     | 44               | 40                    | -9.10%                         |
| <b>Top procedure groups - total</b>   | <b>62,550</b>    | <b>71,245</b>         | <b>13.90%</b>                  |



Projections and estimates are based on the most current Truven Health Analytics data collection methodology. Top 15 DRG code descriptions shown; if more than 15 exist, volumes may differ between slides.

# 5 year projected MR growth Outpatient procedures

| Service Line CPT Procedure Code Group | Procedures    |                    |               | 5 year adj & trended growth |
|---------------------------------------|---------------|--------------------|---------------|-----------------------------|
|                                       | 2015 Adjusted | 2020 Adj & trended | 2020          |                             |
| MRI - lower extremities               | 10,179        | 11,381             | 11,381        | 11.80%                      |
| MRI - spine, lumbar                   | 7,317         | 7,243              | 7,243         | -1.00%                      |
| MRI - brain                           | 7,073         | 7,389              | 7,389         | 4.50%                       |
| MRI - upper extremities               | 4,030         | 4,562              | 4,562         | 13.20%                      |
| MRI - spine, cervical                 | 3,714         | 3,804              | 3,804         | 2.40%                       |
| MRI - abdomen                         | 1,698         | 1,814              | 1,814         | 6.80%                       |
| MRI - pelvis                          | 1,354         | 1,563              | 1,563         | 15.40%                      |
| MRI - orbit, face, neck               | 1,331         | 1,142              | 1,142         | -14.20%                     |
| MRI - spine, thoracic                 | 1,127         | 1,162              | 1,162         | 3.10%                       |
| MRI - chest/thorax                    | 149           | 124                | 124           | -17.00%                     |
| MRI - cardiac                         | 116           | 144                | 144           | 24.10%                      |
| MRI - other                           | 82            | 97                 | 97            | 18.90%                      |
| MRI - guidance                        | 59            | 68                 | 68            | 14.80%                      |
| <b>Top procedure groups - total</b>   | <b>38,229</b> | <b>40,492</b>      | <b>40,492</b> | <b>5.92%</b>                |



Projections and estimates are based on the most current Truven Health Analytics data collection methodology. Top 15 DRG code descriptions shown; if more than 15 exist, volumes may differ between slides.

# 5 year projected Nuc Med/ SPECT growth Outpatient procedures

| Service Line CPT Procedure Code Group | Procedures    |                    | 5 year adj & trended growth |
|---------------------------------------|---------------|--------------------|-----------------------------|
|                                       | 2015 Adjusted | 2020 Adj & trended |                             |
| SPECT - heart                         | 8,055         | 4,810              | -40.30%                     |
| Musculoskeletal imaging               | 1,156         | 104                | -91.00%                     |
| Gallbladder imaging                   | 978           | 1,007              | 3.00%                       |
| GI imaging                            | 478           | 532                | 11.30%                      |
| Thyroid & parathyroid imaging         | 428           | 255                | -40.50%                     |
| Pulmonary imaging                     | 299           | 327                | 9.40%                       |
| Cardiac blood pool imaging            | 197           | 114                | -42.10%                     |
| Radionuclide therapy                  | 145           | 182                | 25.20%                      |
| Miscellaneous imaging                 | 135           | 114                | -15.40%                     |
| SPECT - bone                          | 117           | 125                | 7.00%                       |
| SPECT - tumor                         | 105           | 138                | 31.40%                      |
| Genitourinary imaging                 | 94            | 53                 | -44.10%                     |
| Myocardial perfusion study            | 39            | 22                 | -44.30%                     |
| SPECT - brain                         | 36            | 39                 | 7.70%                       |
| Pulmonary perfusion imaging           | 23            | 26                 | 10.80%                      |
| <b>Top procedure groups - total</b>   | <b>12,286</b> | <b>7,848</b>       | <b>-36.12%</b>              |



Projections and estimates are based on the most current Truven Health Analytics data collection methodology. Top 15 DRG code descriptions shown; if more than 15 exist, volumes may differ between slides.

# 5 year projected PET PET/CT growth Outpatient procedures

| Service Line CPT Procedure Code Group | Procedures       |                       |                                |
|---------------------------------------|------------------|-----------------------|--------------------------------|
|                                       | 2015<br>Adjusted | 2020<br>Adj & trended | 5 year adj &<br>trended growth |
| Fusion Imaging                        | 2,573            | 2,819                 | 9.60%                          |
| PET scan                              | 219              | 228                   | 4.00%                          |
| <b>Top procedure groups - total</b>   |                  |                       |                                |
|                                       | <b>2,792</b>     | <b>3,046</b>          | <b>9.11%</b>                   |



Projections and estimates are based on the most current Truven Health Analytics data collection methodology. Top 15 DRG code descriptions shown; if more than 15 exist, volumes may differ between slides.

# 5 year projected U/S GI growth Outpatient procedures

| Service Line CPT Procedure Code Group | 2015          |               | Procedures    |               | 5 year adj & trended growth |
|---------------------------------------|---------------|---------------|---------------|---------------|-----------------------------|
|                                       | Adjusted      | 2020          | Adj & trended | 2020          |                             |
| Ultrasound, abdomen                   | 18,120        | 18,719        | 18,719        | 18,719        | 3.30%                       |
| Ultrasound, pelvis                    | 15,264        | 14,935        | 14,935        | 14,935        | -2.20%                      |
| Ultrasound, guidance                  | 12,078        | 15,914        | 15,914        | 15,914        | 31.80%                      |
| Ultrasound, head/neck                 | 10,125        | 10,962        | 10,962        | 10,962        | 8.30%                       |
| Ultrasound, ophthalmic                | 2,875         | 1,679         | 1,679         | 1,679         | -41.60%                     |
| Ultrasound, male genitalia            | 1,992         | 2,115         | 2,115         | 2,115         | 6.10%                       |
| Ultrasound, extremities               | 1,983         | 2,653         | 2,653         | 2,653         | 33.80%                      |
| Ultrasound, other                     | 643           | 657           | 657           | 657           | 2.30%                       |
| Image major misc                      | 278           | 315           | 315           | 315           | 13.30%                      |
| Lymphatics imaging                    | 144           | 155           | 155           | 155           | 7.50%                       |
| Ultrasound, chest                     | 141           | 160           | 160           | 160           | 13.70%                      |
| Ultrasound, spinal                    | 69            | 54            | 54            | 54            | -22.50%                     |
| <b>Top procedure groups - total</b>   | <b>63,712</b> | <b>68,319</b> | <b>68,319</b> | <b>68,319</b> | <b>7.23%</b>                |



Projections and estimates are based on the most current Truven Health Analytics data collection methodology. Top 15 DRG code descriptions shown; if more than 15 exist, volumes may differ between slides.

# 5 year projected X-Ray growth Outpatient procedures

| Service Line CPT Procedure Code Group | Procedures     |                    | 5 year adj & trended growth |
|---------------------------------------|----------------|--------------------|-----------------------------|
|                                       | 2015 Adjusted  | 2020 Adj & trended |                             |
| X-ray - lower extremities             | 82,184         | 90,233             | 9.80%                       |
| X-ray - chest                         | 62,139         | 61,266             | -1.40%                      |
| X-ray - upper extremities             | 46,924         | 51,131             | 9.00%                       |
| X-ray - spine & pelvis                | 36,535         | 36,887             | 1.00%                       |
| X-ray - abdomen                       | 7,328          | 7,588              | 3.50%                       |
| X-ray - guidance                      | 4,992          | 5,488              | 9.90%                       |
| X-ray - head/neck                     | 3,200          | 2,985              | -6.70%                      |
| X-ray - GI tract                      | 1,878          | 1,349              | -28.10%                     |
| Fluoroscopic guidance                 | 1,699          | 1,836              | 8.10%                       |
| Fluoroscopy                           | 1,548          | 1,587              | 2.60%                       |
| Myelography/diskography               | 1,014          | 1,118              | 10.20%                      |
| X-ray - abdomen - additional          | 808            | 571                | -29.40%                     |
| X-ray - orthodontic                   | 720            | 752                | 4.40%                       |
| Injection for arthrography            | 506            | 696                | 37.70%                      |
| Arthrography injection, shoulder      | 424            | 522                | 23.20%                      |
| <b>Top procedure groups - total</b>   | <b>251,899</b> | <b>264,009</b>     | <b>4.81%</b>                |



Projections and estimates are based on the most current Truven Health Analytics data collection methodology. Top 15 DRG code descriptions shown; if more than 15 exist, volumes may differ between slides.

# Appendix B: DRG & CPT reference files, methodologies, insurance categories & glossary

This document defines methodologies, insurance categories & common terms and abbreviations used by Truven Health Analytics MarketDiscovery Planning. All descriptions and definitions are provided by Truven Health.



## DRG & CPT Reference file

- Use this file to identify the exact DRG and CPT codes used in each of the service lines included in your report
- GE Healthcare groups together DRGs and CPT procedural groups\* to develop the inpatient and outpatient service lines
  - \*For outpatient, Truven groups like-CPT codes into procedural groups



# Methodologies & data sources

| Module                         | Description   | Business Questions Module Helps to Answer  | Data Sources   | Database Detail  |
|--------------------------------|---|--|--|--|
| Demographic Expert             | Detailed demographic profiles and projections of any US market; analyze a market's current, historical, and projected population and household counts and characteristics.                            | <ul style="list-style-type: none"> <li>What is the demographic composition and distribution of the population or households within our market (age, gender, race, ethnicity, income, education)?</li> <li>How is that projected to change over time?</li> <li>How does that vary by ZIP? By block group?</li> <li>What are the demographics in the market that may represent target commercial members?</li> </ul>   | Nielsen, PRIZM® Lifestyle Segmentation   | Population, Households, Families, Income, Wealth, Home Value, Age, Gender, Race, Ethnicity, Education, County, ZIP Code, Census Tract, Block Group   |
| Insurance Coverage Estimates   | Annual estimates thru 10 years of forecasts for population by insurance category, patient age, sex, and ZIP Code.   | <ul style="list-style-type: none"> <li>Where are specific payer populations concentrated in our market? How are these populations expected to change over the next 10 years?</li> <li>How large is the uninsured portion of the population?</li> <li>What's the impact of healthcare reform on my local payer mix over the next 10 years?</li> </ul>   | Nielsen, HealthLeaders-InterStudy, Medicare county files, state-supplied Medicaid enrollment, Current Population Survey, American Community Survey, Dual Eligible Enrollment (CMS), Congressional Budget Office (CBO) Report | Payer type, age, sex<br>County, ZIP Code   |
| Inpatient Demand Estimates     | Annual estimates thru 10 years of forecasts of discharges and days by DRG or three-digit ICD-9 diagnosis code, and either payer or patient age and sex. Reform adjusted future trending is available. | <ul style="list-style-type: none"> <li>How are volumes of key inpatient services going to change in my market? How can I capitalize on these key trends?</li> <li>What's the projected impact of technology, practice changes, &amp; reform on my inpatient market over the next 10 years including newly formed healthcare exchanges?</li> <li>What are the future bed needs in the market? For our facility? Do we need to renovate? Expand? Build?</li> <li>What can I use with my internal data to calculate market share for key inpatient services?</li> </ul> | All payer state discharge data from 24 states; Medicare (MEDPAR, SAF-I & HSAF) data, and Truven Health Analytics Insurance Coverage Estimates  | Discharges, Days, Age, Sex, DRG, 3-digit ICD9, service line, payer, ZIP Code. Inpatient utilization rates are by county, age group, sex payer, and DRG or 3 digit ICD9 code for every market in the United States. |
| Outpatient Procedure Estimates | Annual estimates thru 10 years of forecast CPT-based procedure groups by patient age, sex, payer or site of care. Reform adjustments & future trending are included.                                  | <ul style="list-style-type: none"> <li>How are volumes of key outpatient services going to change in my market? By site? By payer?</li> <li>What's the projected impact of reform on my outpatient market over the next 10 years including the newly formed healthcare exchanges?</li> <li>How will changes in technologies and underlying practice patterns affect future volumes?</li> </ul>   | Commercial & Medicare Physician and Facility Claims (650+ million annually), Federal surveys, Truven Health Analytics Insurance Coverage Estimates, Nielsen  | Procedures, Procedure Grouping, Clinical Service Category, Ambulatory Technical Group, Age Group, Gender, Payer, Site of Care County, ZIP Code   |



Source: Truven Health Analytics. Inpatient state data sets available in Market Expert includes the following:  
 • Arizona, California, Colorado, District of Columbia, Florida, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Nevada, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Virginia, Washington and Wisconsin

# Insurance categories

| Insurance Type                     | Description  |
|------------------------------------|--|
| Medicaid – Pre reform              | Includes all individuals in traditional Medicaid and HMO Medicaid who are not also receiving Medicare benefits   |
| Medicaid Expansion Population      | A provision in the ACA called for expanding Medicaid eligibility in order to cover more low-income people. States have the ability to opt-in or out of this expansion. |
| Medicare                           | Includes all individuals in traditional Medicare and Medicare HMO who are not also receiving additional benefits through Medicaid                                      |
| Medicare - Dual Eligible           | The population currently enrolled in traditional Medicare and Medicare HMO who also receive additional benefits through Medicaid                                       |
| Private – ESI (employee sponsored) | Includes all individuals in HMO, Fee for Service (FFS), or PPO plans offered as part of an employment arrangement  |
| Private – Exchange                 | Includes all individuals who purchase insurance through an insurance exchange or insurance market place, not associated with employment                                |
| Private – Direct                   | Includes all individuals who purchase insurance directly from an insurance provider, not through an employment agreement or through an insurance exchange              |
| Uninsured                          | Includes all individuals without any insurance coverage  |



# Glossary

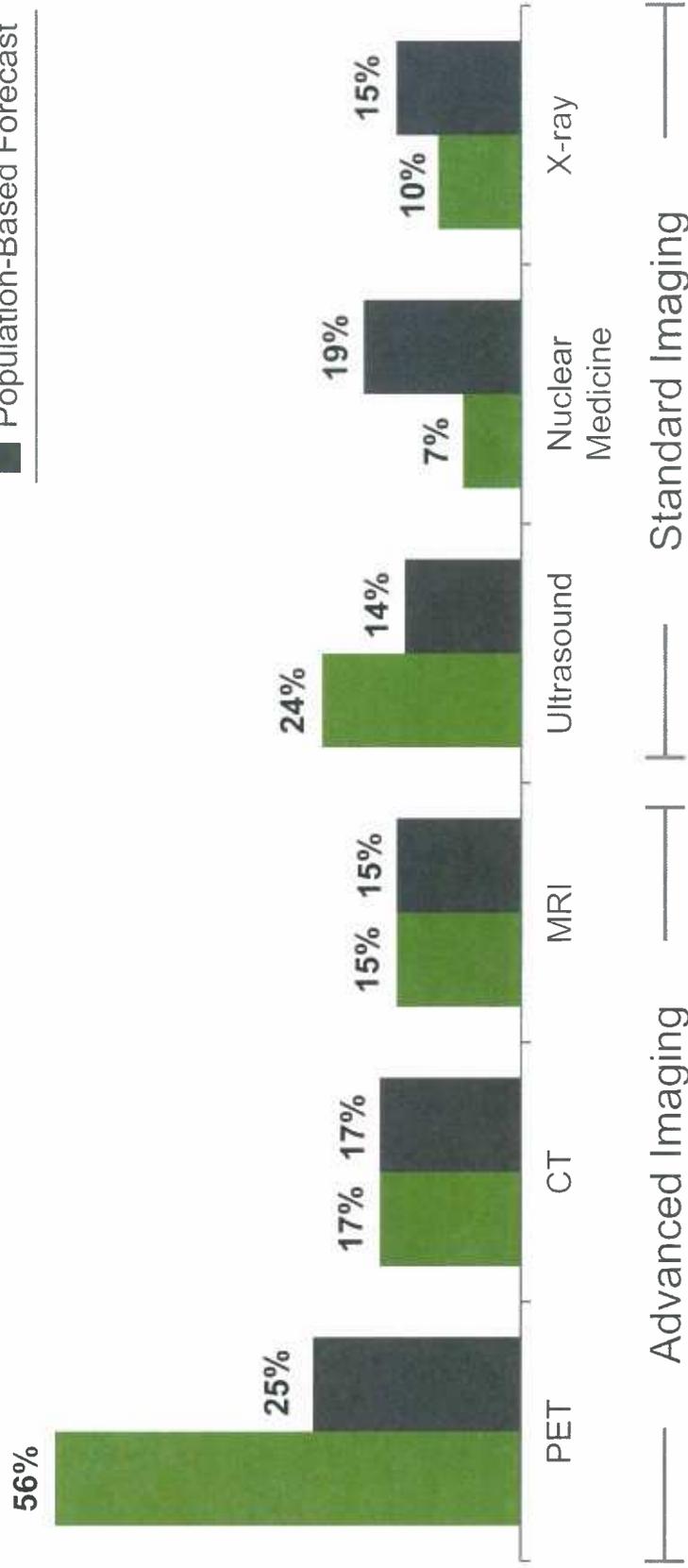
| Term                          | Definition  |
|-------------------------------|---|
| Adjusted                      | Adjusted projections include the impact of the Affordable Care Act (ACA) on utilization rates. In addition these projections incorporate shifts in healthcare coverage due to ACA.  |
| Adjusted & Trended            | Adjusted & Trended projections are the most comprehensive forecast of changes in demand from Truven Health Analytics. In addition, regarding the impact of the ACA on insurance coverage and on utilization, these estimates also incorporate short-term trends in utilization projected from historical trends and long-term trends due to major changes in the prevalence of chronic diseases   |
| Age Band                      | Age bands are age ranges (for example, ages 0-17, 18-45, and 46-85) within an age grouping  |
| Baseline                      | Baseline projections reflect changes in outpatient, physician, and inpatient demand for services expected by demographic shifts alone. Note that these projections do not include any future impact of healthcare reform, but do include any historical impact of reform as based on historic trends. Utilization rates are assumed constant over the 10 years of the projections. These forecasts provide a basis of comparison for the other two forecasts, Adjusted procedures and Adjusted and Trended procedures |
| CPT                           | An abbreviation for Common Procedural Terminology. Physicians' most commonly-used coding scheme of five-digit codes used to identify the medical or surgical procedure that occurred for a patient. Most frequently used for billing by professionals   |
| Data Source                   | The origin of the data used to create reports. Some modules use a single data source, for example, MEDPAR. Other modules use multiple data sources  |
| DRG                           | An abbreviation for Diagnosis Related Groups. Medicare developed this classification to organize how it will pay for inpatient care. DRGs are based on age, type of diagnosis, sex, complications, and anticipated procedures. Providers are paid a flat fee based on expected cost calculations of DRGs; they aim to provide all healthcare services for a patient within the budgeted fee.  |
| Effective Buying Income (EBI) | Effective Buying Income (EBI) reflects income after taxes.  |
| MEDPAR                        | Medicare Provider Analysis and Review data are released annually by the Center for Medicare/Medicaid Services (CMS) for 100% of the discharges for Medicare Fee For Service beneficiaries   |
| Service Lines                 | Service lines are groupings of similar codes, which are designed to combine similar disease processes and surgical procedures.  |
| Trend                         | Trending helps in interpreting data. Based on a time series that consists of a series of measurements, trend estimation can be used to make and justify statements about tendencies in the data. This is done by relating the measurements to the times at which they occurred. In <i>MarketDiscovery Planning</i> reports, trending compares multiple, consecutive quarters or years in a single report  |



# ***EXHIBIT B***

# OP Imaging Forecast by Modality

## Growth in Outpatient Imaging Exam Volumes US Market, 2015–2025



Advanced Imaging | Standard Imaging

**Note:** Analysis excludes 0–17 age group. **Sources:** Impact of Change® v15.0; IMS LifeLink® PharMetrics Health Plan Claims Database, 2011, 2013; The following 2013 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; The Nielsen Company, LLC, 2015; Sg2 Analysis, 2015.

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# *EXHIBIT C*

Quotation Number: PR8-C70846 V 1

Advanced Radiology Consultants LLC  
 3 Enterprise Dr Ste 220  
 Shelton CT 06484-4696

Attn: Dennis Condon

Date: 05-04-2016

| Qty | Catalog No. | Description                     |
|-----|-------------|---------------------------------|
| 1   |             | <b>SIGNA Pioneer 3.0T</b>       |
| 1   | S7550KS     | SIGNA Pioneer 3.0T SP MR System |

The SIGNA Pioneer 3.0T MR system is designed with pioneering technology to maximize your productivity and ROI while delivering unmatched patient comfort, uncompromised clinical performance and streamlined workflow. This configuration includes the system electronics, operating software, imaging software, post-processing software and RF coil suite:

- 97 channel Total Digital Imaging Receive Technology
- Digital Surround Technology
- Ultra-High Efficiency Gradient System
- Quiet Technology (Acoustic Reduction Technology)
- Auto Protocol Optimization
- Multi-Drive Transmit & PERFORM 2.0
- Computing Platform & DICOM
- Comfort Plus Patient Table
- TDI Coil Suite
- Volume Reconstruction Engine
- Computing Platform and DICOM
- Express 2.0 Workflow
- ScanTools

Total Digital Imaging: The SIGNA Pioneer Total Digital Imaging RF architecture delivers 97 channels standard in every SIGNA Pioneer system. This pioneering technology delivers images with greater clarity and up to 25% increased SNR. TDI has three fundamental components:

- Direct Digital Interface (DDI) employs an independent analog-to-digital converter to digitize inputs from each of 97 RF channels. Every input is captured and every signal digitized to deliver high quality 3.0T images.
- Digital Surround Technology (DST) delivers the capability to simultaneously acquire MR signal from the integrated body coil and the surface coil. By combining the digital signal from surface coil elements with the signal from the integrated RF body coil, the superior SNR and sensitivity of the high-density surface coils are combined with the superior homogeneity and deeper signal penetration of the integrated RF Body Coil. This results in richer, higher quality spine and body images.
- Digital Micro Switching (DMS) technology represents a revolutionary advance in RF coil



Quotation Number: PR8-C70846 V 1

| Qty | Catalog No. | Description  |
|-----|-------------|--|
|     |             | <p>design by replacing analog blocking circuits with advanced Micro Electro-Mechanical System (MEMS) based blocking circuits enabling a coil design that supports ultrafast coil switching times for further expansion of zero TE imaging capabilities.</p> <p>Ultra High Efficiency Gradient System: The SIGNA Pioneer gradient coil is 2x more efficient than previous gradient coil designs (i.e. the pioneer gradient coil requires half the amount of current required by previous designs to generate the same gradient field). This eco-friendly design enables the gradients to deliver superior performance while significantly reducing power consumption. Further, the SIGNA Pioneer gradient driver includes Intelligent Gradient Control (IGC) technology which employs a digital control system that utilizes predictive models of the electrical and thermal characteristics of the gradient coil to maximize the performance of the gradient system to deliver exceptional clinical performance.</p> <p>Quiet Technology: The SIGNA Pioneer system features Acoustic Reduction Technology (ART) that delivers an enhanced patient experience by significantly reducing noise levels (up to 99% reduction in sound volume). Acoustic reduction is achieved through:</p> <ul style="list-style-type: none"> <li>• Gradient &amp; RF coil isolation.</li> <li>• Acoustic dampening material.</li> <li>• Vibro-acoustic isolation.</li> <li>• Gradient waveform optimization.</li> </ul> <p>RF Transmit Technology: The SIGNA Pioneer integrates an innovative RF transmit architecture designed to enhance overall image uniformity, and a multi-faceted SAR optimization system. The MultiDrive RF architecture adjusts/optimizes the phase and amplitude of each RF amplifier output channel that is applied to the 4-port drive whole-body RF transmit coil to enhance RF uniformity and signal homogeneity regardless of patient size and body habitus. PERFORM 2.0 combines RF body coil design, optimized pulse sequences, detailed predictive SAR modeling during prescription, and real-time SAR feedback and correction during scanning to help ensure high performance across all applications, tailored for each patient.</p> <p>Computing Platform: The Intel Xeon Nehalem Dual Core Processor computing platform utilizes a parallel, multi-processor design to enable simultaneous scanning, reconstruction, filming, post-processing, archiving, and networking. The keyboard assembly integrates an intercom speaker, microphone, volume controls, and emergency stop switch. Start scan, pause scan, stop scan and table advanced to center hot keys are also included.</p> <ul style="list-style-type: none"> <li>• 32GB DDR3 Memory</li> <li>• 3 x 300GB SAS disk subsystem</li> <li>• 24" flat panel LCD with 1920x1200 resolution</li> <li>• Single tower configuration</li> </ul> |



Quotation Number: PR8-C70846 V 1

| Qty | Catalog No. | Description  |
|-----|-------------|--|
|     |             | <ul style="list-style-type: none"> <li>• DVD interchange</li> </ul> <p>DICOM: The SIGNA Pioneer generates MR Image, Secondary Capture, Structured Report, and Gray Scale Softcopy Presentation State DICOM objects. The DICOM networking supports both send and query retrieve as well as send with storage commit to integrate with PACS archive. Please refer to the DICOM Compliance Statement for SIGNA Pioneer for further details.</p> <p>M70012SK (1 unit included in S7550KS) Comfort Plus Patient Table: The SIGNA Pioneer offers a fully integrated Comfort Plus patient table (also known as TDI patient table), which features the embedded TDI Posterior Array, to help improve exam efficiency, and patient comfort. The Comfort Plus patient table can be lowered to very low heights to facilitate transfer of wheelchair patients. The cradle width has also been increased by 30% from previous generations to enable a more comfortable experience for patients.</p> <ul style="list-style-type: none"> <li>• Maximum patient weight for scanning: 550 lbs</li> <li>• Maximum patient weight mobile: 550 lbs</li> <li>• Maximum patient weight for lift: 550 lbs</li> <li>• Automated vertical and longitudinal power drive</li> <li>• Fast longitudinal speed: 17 cm/sec</li> <li>• Slow longitudinal speed: 1.9 cm/sec</li> <li>• IntelliTouch &amp; laser land-marking</li> <li>• Laser alignment land-marking</li> </ul> <p>TDI Coil Suite: The Total Digital Imaging Suite of coils is designed to enhance patient comfort and image quality while simplifying workflow. The Coil Package includes:</p> <ul style="list-style-type: none"> <li>• Integrated T/R Body Coil</li> <li>• TDI Posterior Array</li> <li>• TDI Head Neck Unit</li> <li>• Anterior Array</li> </ul> <p>M7001KA (1 unit included in S7550KS) The TDI Posterior Array is the first coil to include the Digital Micro Switch. The integrated Posterior Array is symmetrically positioned within the patient supporting cradle, and coil connection ports are located at both ends of the table. This design enables all components of the TDI Coil Suite to support either patient orientation and enable a more comfortable patient position. The PA is designed to provide optimal element geometry for each targeted anatomy by using different element geometries for the cervical-to-thoracic spine transition, thoracic and lumbar spine, and the body.</p> <ul style="list-style-type: none"> <li>• Elements: 32</li> <li>• Length: 120.5 cm; Width: 48.6cm</li> </ul> |



Quotation Number: PR8-C70846 V 1

| Qty | Catalog No. | Description   |
|-----|-------------|---|
|     |             | <ul style="list-style-type: none"> <li>• S/I coverage: 113cm head-first or feet-first</li> <li>• Parallel imaging in all three scan planes</li> <li>• Head-first or feet-first positioning</li> </ul> <p>The TDI Posterior Array is designed to be used in conjunction with the TDI Head Neck Unit, the 3.0T Anterior Array, and the GEM Flex Coils. The TDI PA is invisible to additional surface coils when they are placed directly on top of the surface.</p> <p>M7001KD (1 unit included in S7550KS ) The TDI HNU consists of 3 imaging components: a head base-plate, an anterior neuro-vascular face-array, and the open face adapter. The open-face design provides a patient-friendly feel. The base plate may be used with the open face adaptor to accommodate cervical spine exams in large or claustrophobic patients or for patients with intubation. Improved access and patient comfort may be achieved through elevation of the superior end of the coil.</p> <ul style="list-style-type: none"> <li>• Elements: up to 29 combined with PA and AA</li> <li>• Length: 53 cm; Width: 35 cm</li> <li>• Height with NV Array: 35 cm</li> <li>• Height with Cervical Array: 32.6 cm</li> <li>• Height with Open Array: 25.9 cm</li> <li>• S/I coverage: up to 50 cm with PA and AA</li> <li>• Parallel imaging in all three scan planes</li> </ul> <p>M7001KB (1 unit included in S7550KS) The Anterior Array facilitates chest, abdomen, pelvis, and cardiac imaging. The GEM AA is lightweight, thin and flexible, and pre-formed to conform to the patient's size and shape. With 54 cm of S/I coverage, the GEM AA permits upper abdomen and pelvis imaging without repositioning the coil.</p> <ul style="list-style-type: none"> <li>• Elements: up to 36 combined with PA</li> <li>• Length: 55.6 cm; Width: 67.4 cm</li> <li>• S/I coverage: 54 cm</li> <li>• R/L coverage: up to the full 50 cm FOV</li> <li>• Parallel imaging in all three scan planes</li> <li>• Head-first or feet-first positioning</li> </ul> <p>Express Workflow 2.0: Streamlined workflow on SIGNA Pioneer starts in the magnet room with the dual touch-screen In Room Displays enable interaction with the host computer from the magnet room. The user has direct control or selection of:</p> <ul style="list-style-type: none"> <li>• Display of patient name, ID, study description</li> </ul> |



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| Qty | Catalog No. | Description   |
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|     |             | <ul style="list-style-type: none"> <li>• Display and entry of patient weight</li> <li>• Display and entry of patient orientation and position</li> <li>• Cardiac gating waveform display</li> <li>• EKG lead confirmation with gating control</li> <li>• Respiratory waveform display</li> <li>• IntelliTouch Landmarking</li> <li>• AutoStart</li> <li>• Display of coil connection and status</li> <li>• Display of table location and scan time</li> <li>• Screen saver</li> </ul> <p>Express Exam enables complete control of protocols for prescription, archiving, searching, and sharing. Protocols are organized into two libraries – GE authored and Site authored – and Protocol Notes allow customized notes to be saved with each protocol. ProtoCopy enables a complete exam protocol, from either a library or previous exam, to be shared with a mouse click, and the Modality Worklist provides an automated method of linking exam and protocol information for a patient directly from a DICOM Worklist server.</p> <p>The Workflow Manager controls the execution of scan prescription, acquisition, processing, viewing and networking and may automate these steps, when requested by the user. Auto Coil Prescription automatically selects the optimum subset of elements for scanning, and AutoStart automatically starts the first acquisition as soon as the technologist exits the magnet room. Processing steps are automatically completed with Inline Processing once the data have been reconstructed and the images saved into the database. For certain tasks, the user must accept the results or complete additional steps prior to saving the images. These automatic Inline Processing steps can be saved into the Protocol Library. Inline Viewing allows the user to conveniently view, compare, and analyze images from the Scan Desktop by selecting the desired series from the Workflow Manager.</p> <p>ScanTools: The ScanTools clinical package delivers an expansive portfolio of advanced applications, imaging options, and visualization tools packaged with the system operating software to provide extensive clinical capability and enhanced productivity.</p> <p>Advanced Neuro Applications:</p> <ul style="list-style-type: none"> <li>• PROPELLER 3.0 motion robust radial FSE</li> <li>• PROPELLER 3.0 FSE-based diffusion imaging</li> <li>• 3D Cube 3.0 with Cube DIR</li> <li>• READY Brain</li> </ul> |



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| Qty | Catalog No. | Description  |
|-----|-------------|--|
|     |             | <ul style="list-style-type: none"> <li>• Spin Echo &amp; Fast Spin Echo Suites</li> <li>• T1-FLAIR &amp; T2-FLAIR Suite</li> <li>• Gradient Echo &amp; Fast GRE Suites</li> <li>• Spoiled Gradient Echo &amp; Fast SPGR Suites</li> <li>• Echo Planar, EPI FLAIR &amp; fMRI EPI Suites</li> <li>• EchoPlus with Single Echo and RTFA diffusion imaging</li> <li>• DWI Prep for diffusion imaging</li> <li>• 3D FIESTA &amp; 3D FIESTA-C steady-state imaging</li> <li>• 3D BRAVO IR-prepped fast SPGR imaging</li> <li>• 3D COSMIC modified steady-state imaging</li> <li>• 2D/3D MERGE multi-echo recombined GRE imaging</li> <li>• PROBE PRESS &amp; STEAM single voxel spectroscopy</li> <li>• BrainSTAT GVF and AIF parametric maps</li> </ul> <p>Advanced Spine &amp; MSK Applications:</p> <ul style="list-style-type: none"> <li>• PROPELLER 3.0 motion-robust radial FSE</li> <li>• 3D Cube 2.0</li> <li>• Spin Echo &amp; Fast Spin Echo Suites</li> <li>• Gradient Echo &amp; Fast GRE Suites</li> <li>• 3D COSMIC modified steady-state imaging</li> <li>• 2D/3D MERGE multi-echo recombined GRE imaging</li> <li>• High Bandwidth FSE artifact reduction</li> <li>• Spectral Spatial Fat Suppression</li> </ul> <p>Advanced Body Applications:</p> <ul style="list-style-type: none"> <li>• Auto Navigators pencil-beam diaphragm tracker</li> <li>• PROPELLER 3.0 motion robust radial FSE</li> <li>• Spin Echo &amp; Fast Spin Echo Suites</li> <li>• Gradient Echo &amp; Fast GRE Suites</li> <li>• 3D LAVA T1 DCE imaging with Turbo ARC</li> <li>• 2D/3D Dual Echo Fat-Water Imaging</li> <li>• 3D FRFSE MRCP &amp; HYDRO imaging</li> <li>• Enhanced SSFSE single-shot FSE imaging</li> <li>• 2D FS FIESTA steady-state imaging</li> </ul> |



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| Qty | Catalog No. | Description  |
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|     |             | <ul style="list-style-type: none"> <li>• Multi-phase DynaPlan</li> <li>• SmartPrep automated bolus detection</li> <li>• Fluoro Trigger real-time bolus monitoring</li> <li>• Respiratory Compensation, Gating &amp; Triggering</li> <li>• iDrivePro &amp; iDrivePro Plus real-time imaging</li> <li>• SPECIAL IR Fat Saturation</li> <li>• Auto Protocol Optimization</li> </ul> <p>Advanced Vascular Applications:</p> <ul style="list-style-type: none"> <li>• Auto Navigators pencil-beam diaphragm tracker</li> <li>• 2D/3D Time-Of-Flight &amp; 2D Gated Time-of-Flight</li> <li>• 2D/3D Phase Contrast &amp; Phase Contrast Cine</li> <li>• SmartPrep automated bolus detection</li> <li>• Fluoro Trigger real-time bolus monitoring</li> <li>• Magnetization Transfer&amp; Flow Compensation</li> <li>• Peripheral &amp; EKG Gating &amp; Triggering</li> <li>• Respiratory Compensation, Gating &amp; Triggering</li> </ul> <p>Advanced Cardiac Applications:</p> <ul style="list-style-type: none"> <li>• Double-Triple IR-FSE with spectral fat suppression</li> <li>• FastCine FGRE-based, gated multi-phase imaging</li> <li>• 2D FIESTA Cine steady-state, gated multi-phase imaging</li> <li>• 3D FS FIESTA steady-state coronary imaging</li> <li>• iDrivePro Plus real-time inter-active imaging</li> <li>• Blood Suppression</li> <li>• Cardiac Navigator diaphragm tracker</li> <li>• Cardiac Compensation, Gating &amp; Triggering</li> <li>• Respiratory Compensation, Gating &amp; Triggering</li> <li>• Cine Paging (128 images/4 windows @ 30fps)</li> </ul> <p>Advanced Imaging Tools:</p> <ul style="list-style-type: none"> <li>• ARC &amp; Turbo ARC data-based parallel acceleration</li> <li>• ASSET 3.0 image-based parallel acceleration</li> <li>• Real Time Field Adjustment for DWI</li> <li>• DWI Prep for diffusion imaging</li> </ul> |



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| Qty | Catalog No. | Description  |
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|     |             | <ul style="list-style-type: none"> <li>• Chemical Shift Direction Selection</li> <li>• 2D/3D GradWarp compensation</li> <li>• Acoustic Reduction Technology</li> <li>• IR Prep, DE Prep &amp; T2 Prep</li> <li>• Full Echo Train &amp; Tailored RF</li> <li>• Spectral Spatial Fat Suppression</li> <li>• SPECIAL IR Fat Suppression</li> <li>• ASPIR Fat Suppression</li> <li>• Matrix ZIP 512 &amp; ZIP 1024</li> <li>• 3D Slice 2X ZIP &amp; 4X ZIP</li> <li>• Square Pixel &amp; Rectangular FOV</li> <li>• No Phase Wrap &amp; No Frequency Wrap</li> <li>• Extended Dynamic Range</li> </ul> <p>Advanced Processing &amp; Display:</p> <ul style="list-style-type: none"> <li>• Inline Viewing &amp; Inline Processing</li> <li>• Image Fusion &amp; Image Pasting</li> <li>• SCIC &amp; PURE surface coil intensity correction</li> <li>• Multi-planar Volume Reformat</li> <li>• Interactive Vascular Reformat</li> <li>• ClariView Image Filtering</li> <li>• Compare Mode &amp; Reference Image</li> <li>• Cine Paging (128 images/4 windows @ 30fps)</li> </ul> <p>Advanced FuncTool Analysis:</p> <ul style="list-style-type: none"> <li>• ADC maps &amp; eADC mapping</li> <li>• Correlation Coefficient analysis</li> <li>• NEI Negative Enhancement Integral analysis</li> <li>• MTE Mean Time To Enhance analysis</li> <li>• Positive Enhancement Integral analysis</li> <li>• Signal Enhancement Ratio analysis</li> <li>• Maximum Slope Increase analysis</li> <li>• Maximum Difference Function analysis</li> <li>• Difference Function analysis</li> </ul> |



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| Qty | Catalog No. | Description  |
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| 1   | M7001KT     | <p>SIGNA Pioneer 3.0T Magnet</p> <p>The SIGNA Pioneer is equipped with GE's most-advanced 3.0T magnet design, a spacious 70cm patient bore with bright inner-bore lighting, Total Digital Imaging RF architecture and MultiDrive RF transmit technology delivering performance, productivity and exceptional image quality.</p> <p>GE's Wide-Bore Magnet Design: With GE's active shielding technology and space-age composite design, the lightweight 3.0T magnet minimizes weight while preserving homogeneity and minimizing fringe fields. The result is a 3.0T magnet that does not compromise performance yet can be installed almost anywhere. The magnet's high-homogeneity delivers excellent fat-saturation away from iso-center and ensures image quality over a full 50 cm field-of-view. Coupled with its zero-boil off technology and remote magnet monitoring technology, the SIGNA Pioneer 3.0T magnet is designed to provide years of worry-free, reliable, low-cost operation.</p> <p>The SIGNA Pioneer introduces pioneering RF technology called TDI which stands for Total Digital Imaging and delivers imaging with greater clarity and increased SNR by up to 25%. TDI is built on three fundamental components:</p> <ul style="list-style-type: none"> <li>• GE's Direct Digital Interface (DDI) employs an independent analog-to-digital converter to digitize inputs from each of the RF channels. Every input is captured and every signal digitized, literally redefining the concept of an RF channel. Not only does DDI technology improve SNR of our images, but it also works with legacy GE coils for unmatched flexibility.</li> <li>• Digital Surround Technology (DST) combines the digital signal from every coil element with the signal from the integrated RF body coil. The superior SNR and sensitivity of the high-density surface coils are combined with the superior homogeneity and deeper signal penetration of the integrated RF Body Coil resulting in richer, higher quality spine and body images.</li> <li>• Digital Micro Switching (DMS) technology represents a revolutionary advance in RF coil design by replacing analog blocking circuits with intelligent Micro Electro-Mechanical Switches (MEMS) by enabling coil design that supports ultrafast coil switching times for further expansion of zero TE imaging capabilities.</li> </ul> <p>Dual In-Room Displays (IRD): By consolidating all controls into one place, the Dual In-Room Displays (IDR) provides real-time feedback to the operator to improve exam room efficiency. With an in-room display monitor available at either side of the magnet, the technologist always has all the control he needs at his fingertips, irrespective of which side he is operating from. Further touch-screen capability makes the controls even more intuitive and easy to use. The display provides realtime interaction with the scanner and the host computer. The user has direct control or selection of the following:</p> <ul style="list-style-type: none"> <li>• Display of patient name, ID, study description</li> </ul> |



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| Qty | Catalog No. | Description  |
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|     |             | <ul style="list-style-type: none"> <li>• Display and entry of patient weight</li> <li>• Display and entry of patient orientation and patient position</li> <li>• Cardiac waveform display and ECG/EKG lead confirmation with gating control: trigger select, invert and reset</li> <li>• Respiratory waveform display</li> <li>• IntelliTouch technology landmarking</li> <li>• AutoStart - initiate the scanner to automatically acquire, process, and network images</li> <li>• Display connected coils and coil status</li> <li>• Display of table location and scan time remaining</li> <li>• Screen saver</li> <li>• Control multiple levels of in-bore ventilation and lighting</li> </ul> <p>Ultra High Efficiency (UHE) Gradient System: The SIGNA Pioneer gradient coil is 2x more efficient than previous generation of products (i.e. the pioneer gradient coil requires half the amount of current required by previous designs to generate the same gradient field). This eco-friendly design enables the gradients to deliver superior performance while significantly reducing power consumption. The gradient is non-resonant and actively shielded to minimize eddy currents and mechanical forces within the system. The gradient coil and the RF body coil are integrated into a single module, which is water and air-cooled for optimum duty-cycle performance and patient comfort. Further, the SIGNA Pioneer gradient driver includes Intelligent Gradient Control (IGC) technology which employs a digital control system that utilizes predictive models of the electrical and thermal characteristics of the gradient coil to maximize the performance of the gradient system to deliver exceptional clinical performance. Utilizing a unique acoustic barrier material, acoustic noise levels are reduced for enhanced patient comfort without compromising imaging performance.</p> <p>SIGNA Pioneer MultiDrive RF Whole-Body RF Coil: The SIGNA Pioneer system with GE's MultiDrive RF transmit technology as a standard system feature. This system features a high efficiency 4-port drive RF body coil and independent RF amplitude and phase control to improve RF signal homogeneity across the field of view. The system features a fully automated optimization to adjust the RF settings for each patient to deliver optimal image quality regardless of patient size or shape.</p> |
| 1   | S7525NZ     | <p>Preinstallation Collector</p> <p>The Preinstallation Collector delivers to the site in advance of the magnet and main electronic components. This facilitates the later delivery and installation of supporting electronics. This collector contains the integrated cooling cabinet and the patient comfort and cryo hoses.</p>   |

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| Qty | Catalog No. | Description   |
|-----|-------------|---|
| 1   | M7000VA     | <p>Vibroacoustic Dampening Kit</p> <p>Material in the Vibroacoustic Dampening Kit can significantly attenuate the transmission of gradient-generated acoustic noise through the building structure to nearby areas, including adjacent rooms and floors above or below the MR suite. If this kit is applied during the installation of a new magnet, no additional service charges are necessary. However, installation of the Vibroacoustic Dampening kit under an existing magnet requires special steps. The steps to prepare the site and steps to install, such as modifications to the RF screen room, and other magnet rigging, modifications to the RF screen room, and other finishing work, are not covered in the pricing.</p> |
| 1   | M70012LR    | <p>Pioneer Scan Room Collector - Long</p> <p>The Scan Room Collector contains a collection of cables such as gradient cables and other materials necessary for system interconnections. The long configuration is designed for room configurations that require a long length based on distance between system components.</p>  |
| 1   | M70012LT    | <p>Equipment Room Collector - Long</p> <p>The Equipment Room Collector contains a collection of cables and parts required for interconnections between equipment room system components. The long configuration is designed for room configurations that require a long length based on distance between system components.</p>   |
| 1   | M70012RP    | English Language Kit  |
| 1   | M7000WL     | <p>Main Disconnect Panel</p> <p>The Main Disconnect Panel safeguards the MR system's critical electrical components, by providing complete power distribution and emergency-off control.</p>  |
| 1   | M1000MW     | <p>Operator's Console Table</p> <p>Wide table designed specifically for the color LCD monitor and keyboard.</p>   |
| 1   | R33002AC    | SIGNA Pioneer Standard Service Package  |
| 1   | S7525NE     | <p>Silent Suite Package 3.0T</p> <p>The Silent Suite Package includes a complete set of sequences designed to generate high-resolution images which deliver T1, T2, FLAIR, and PD weighted contrasts. The Silenz imaging sequence delivers 3D isotropic images with T1, PD, and angiographic contrast with sound levels that are within 3dB of the ambient conditions.</p>  |

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| Qty | Catalog No. | Description  |
|-----|-------------|--|
| 1   | S7024CB     | <p>Newly enhanced gradient waveforms have been employed to minimize the acoustic signature of FSE, 3D Cube, and PROPELLER-based acquisitions to generate T2 and T2 FLAIR weighted images. In addition, the localizer, Prescan, and calibration sequences have been optimized as well to deliver a complete neuro exam at nearly silent levels.</p> <p>Silent Suite also includes a set of protocols including PROPELLER based acquisitions with Diffusion for high resolution brain exams with and without fat suppression. This allows a full exam to be conducted with less than 11 dB(A) from ambient room conditions.</p> <p><b>Neuro Expert Package</b></p> <ul style="list-style-type: none"> <li>• eDWI</li> <li>• SWAN</li> <li>• DTI</li> <li>• FiberTrak</li> </ul> <p>The eDWI application includes the acquisition sequence and post-processing tools. It is designed to provide high signal-to-noise-ratio diffusion images of the brain and liver with short-acquisition time. Its multi-B feature is designed to provide measurement of apparent diffusion coefficient (ADC) map with reduced effect of perfusion. In addition, "3 in 1" B value combining technique, applies diffusion weighting to all three gradients simultaneously, helping improve sensitivity. Its smart NEX feature significantly reduces the acquisition time. Inversion recovery has been deployed to provide robust fat suppression.</p> <p>SWAN is a volumetric 3D acquisition technique that is sensitive to differences in susceptibility between different tissues. This technique acquires multiple-echoes at different echo times to highlight regions with increased T2* (susceptibility-induced) decay. Utilizing multiple-echoes, SWAN generates images with higher SNR when compared with similar techniques that rely on a single echo.</p> <p>Diffusion Tensor Imaging (DTI) creates contrast based on the degree of diffusion anisotropy in cerebral tissues such as white matter. The DTI method expands Echo planar imaging capability to include diffusion imaging sequence using motion sensing gradient pulses along 6 to 155 orientations in order to generate tensor component images. With the Express Workflow, fractional anisotropy (FA) and Volume Ratio Anisotropy (VRA) maps may be automatically created after image acquisition without any user intervention.</p> <p>FiberTrak is a host computer post processing tool expands the capability of Diffusion Tensor imaging by generation of 2D color orientation maps, 2D eigenvector maps, and 3D tractography maps from the diffusion tensor image data. The resulting datasets may be easily saved and archived for later use.</p> |
| 1   | S7525HS     | Neuro Elite Package  |

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| Qty | Catalog No. | Description   |
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|     |             | <ul style="list-style-type: none"> <li>• 3D PROMO</li> <li>• 3D ASL</li> </ul> <p>3D PROMO provides a real time 3D navigator based motion correction algorithm correcting for the six rigid body terms where re-acquisition of severely corrupted data provides robust, high quality, motion free, 3D outcomes. 3D PROMO is compatible with both T2 and T2 FLAIR Cube acquisitions.</p> <p>3D ASL utilizes water in arterial blood as an endogenous contrast media to help visualize tissue perfusion and provide quantitative assessment of cerebral blood flow (CBF) in ml/100 g/min. The quantitative CBF maps can be generated and stored in DICOM format.</p> <p>3D ASL deploys stacked spiral FSE readout with modulated flip angle to acquire 3D data with increased SNR and less image distortion compared to conventional 2D EPI-based ASL techniques. A pulsed-continuous labeling is applied to label arterial blood close to the imaging volume thus improving conspicuity of flowing blood. Selective, interwoven pulses are then used to saturate and invert the imaging volume, in order to achieve better background suppression, and reduce sensitivity to motion. The isotropic 3D volume data can be reformatted to axial, sagittal, coronal or oblique planes.</p> <p>3D ASL helps generate robust, reproducible images and perfusion maps with high SNR, reduced motion artifacts and less distortion in high magnetic susceptibility regions.</p> |
| 1   | S7525NC     | <p>Body Expert Package</p> <ul style="list-style-type: none"> <li>• IDEAL &amp; Flex</li> <li>• IDEAL IQ</li> <li>• StarMap</li> <li>• eDWI</li> </ul> <p>The IDEAL acquisition and reconstruction methods can generate a water-only, fat-only, in-phase and out-of-phase data sets for clear tissue differentiation in a single series. In addition susceptibility artifacts common to MR imaging such as incomplete or inaccurate fat saturation, and chemical shift can be eliminated as well. The IDEAL application acquires multiple echoes and uses unique reconstruction routines to generate the four image contrasts and correct for errors due to tissue susceptibility. IDEAL is ideally suited for imaging anatomical regions such as the brachial plexus, neck, spine, chest, foot, ankle, and axilla where inhomogeneous magnetic fields may yield failures with traditional fat saturation techniques. IDEAL is compatible with Fast Spin Echo, 3D Gradient Echo and parallel imaging.</p>   |



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| Qty | Catalog No. | Description   |
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|     |             | <p>For fast T1w multi-phase imaging of the abdomen and pelvis, LAVA Flex acquisition uses 2D ARC parallel imaging to reduce artifacts from breath hold misregistration and incorrect FOV placement while providing up to four types of T1w-based tissue contrasts: water-only, fat-only, in-phase and out-of-phase.</p> <p>IDEAL IQ is an acquisition and reconstruction software package that generates water and fat images, relative fat concentration, and R2* relaxation maps. This technique builds upon GE's IDEAL (Iterative Decomposition of water and fat with Echo Asymmetry and Least-squares estimation) technology by incorporating a fast, volumetric multi-echo imaging sequence and an enhanced reconstruction algorithm to improve the visualization of regional fat deposits in-vivo.</p> <p>IDEAL IQ incorporates the following features and functionality:</p> <ul style="list-style-type: none"> <li>• A fast, multi-echo 3D gradient echo imaging sequence to generate volumetric data.</li> <li>• Parallel imaging to improve acquisition speed and allow breath hold acquisitions.</li> <li>• A low flip angle excitation scheme to reduce T1 bias in the fat, water, and fat fraction maps.</li> <li>• Multi-echo reconstruction processing to calculate R2* decay rate maps.</li> <li>• Magnitude fitting to reduce the influence of phase errors due to system imperfections.</li> <li>• A multi-peak fat model to account for the multiple resonant peaks of fat.</li> <li>• Fully automated, generation and storage of R2* corrected fat and water maps, fat fraction maps, and R2* maps from the data acquired.</li> </ul> <p>The IDEAL IQ reconstruction generates R2* corrected fat and water maps as well as an R2* map depicting the signal decay at each voxel in the image. Water and fat images produce the fat fraction map, a relative measure of the quantity of fat to total signal (water and fat signal combined) at each voxel in the image. The fat fraction image is scaled such that a full-scale value represents a voxel containing only fat while a value of zero represents no fat in that voxel.</p> <p>StarMap enables the acquisition of multiple gradient echo images at each 2D slice at a range of echo-times. The resultant images can be processed using FuncTool to provide T2* maps within the anatomy of interest.</p> <p>The eDWI application includes the acquisition sequence and post-processing tools. It is designed to provide high signal-to-noise-ratio diffusion images of the brain and liver with short-acquisition time. Its multi-B feature is designed to provide measurement of apparent diffusion coefficient (ADC) map with reduced effect of perfusion. In addition, "3 in 1" B value combining technique, applies diffusion weighting to all three gradients simultaneously, helping improve sensitivity. Built in tetrahedral feature applies four different diffusion weighing</p> |

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| Qty | Catalog No. | Description  |
|-----|-------------|--|
| 1   | S7525ND     | <p>combinations of x, y, and z gradients simultaneously to acquire isotropic diffusion weighted images with high signal to noise ratio and shorter TE. Its smart NEX feature significantly reduces the acquisition time. Inversion recovery has been deployed to provide robust fat suppression.</p> <p><b>Breast Expert Package</b></p> <ul style="list-style-type: none"> <li>• VIBRANT</li> <li>• 8-channel Breast Array</li> </ul> <p>VIBRANT (Volume Imaged BReast Assessment) is a fast, high resolution T1 weighted imaging sequence and application optimized for evaluation of breast tissue. VIBRANT uses GE exclusive technology and parallel imaging acceleration to quickly acquire multi-phase data without compromising spatial resolution. This 3D gradient echo technique, optimized for sagittal or axial acquisitions, uses an optimized inversion pulse and dual-shimming technology that yields enhanced image contrast and robust, uniform, bilateral fat suppression. Auto subtraction of the first dataset is also available to further background suppression. For enhanced speed, VIBRANT is compatible with both ASSET and ARC parallel imaging with acceleration factors up to four. As a result, VIBRANT enables reliable, high quality breast imaging.</p> <p>For improved tissue contrast, VIBRANT is compatible with Flex imaging (sold separately). VIBRANT Flex acquisition will provide a water-only, fat-only, in-phase and out of phase data sets in a single acquisition and produce images with significantly reduced chemical shift and susceptibility artifacts. This is critical for evaluation of the axilla and chest wall.</p> <p>The 8-channel Breast Array generates high-definition MR breast images on 3.0T MR systems. Optimized for use with ASSET and VIBRANT for up to 3X acceleration, this 8-element phased-array coil helps ensure excellent temporal and spatial resolution, patient after patient. The array is also compatible with Fast Spin Echo, Fast Gradient Echo, and Diffusion Imaging sequences. It provides uncompromised lateral and medial access. This collector contains a set of MR compatible biopsy grids that are compatible with this coil.</p> |
| 1   | S7024CK     | <p><b>Vascular Expert Package</b></p> <ul style="list-style-type: none"> <li>• Inhance Suite 2.0</li> <li>• TRICKS</li> <li>• Flow Analysis</li> </ul> <p>The Inhance Suite application consists of several sequences designed to provide high-resolution images of the vasculature with short-acquisition times and excellent vessel detail. These sequences include: Inhance Inflow IR: Inhance Inflow IR is an angiographic method, which has been developed to image renal arteries with ability to suppress static</p>  |



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| Qty | Catalog No. | Description  |
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|     |             | <p>background tissue and venous flow. This sequence is based on 3D FIESTA, which improves SNR, as well as produce bright blood images.</p> <p>Inhance 3D Velocity: Inhance 3D Velocity is designed to acquire angiography images in brain and renal arteries with excellent background suppression in a short scan time. By combining a volumetric 3D phase contrast acquisition with parallel imaging, efficient k-space traversal, and pulse sequence optimization, Inhance 3D Velocity is capable of obtaining complete Neurovascular imaging in 5-6 minutes.</p> <p>Inhance 3D Deltaflow is a 3D non-contrast enhanced MRA application for peripheral arterial imaging. Inhance 3D Deltaflow is based on the 3D Fast Spin Echo technique and it utilizes the systolic and diastolic flow differences to help generate arterial signal contrast. A subtraction of the systolic phase from the diastolic phase images results in arterial only images, with venous and background suppression.</p> <p>Inhance 2D Inflow: The Inhance 2D Inflow pulse sequence is designed to acquire angiography images of arteries, which follow almost a straight path, i.e. femoral, popliteal, carotid arteries, etc.</p> <p>TRICKS provides high resolution multi-phase 3D volumes of any anatomy for fast accurate visualization of the vasculature. With segmented complex data recombination, TRICKS can accelerate 3D dynamic vascular imaging without compromising spatial detail. TRICKS also uses elliptic centric data collection for optimized contrast resolution and auto-subtraction for optimized background suppression. The result is time course imaging that does not require timing or triggering, provides high temporal and high spatial resolution, and enables the extraction of optimum phases of data. As a result, TRICKS enables reliable, high quality vascular imaging.</p> <p>Flow Analysis automates the review and analysis of gated phase contrast magnetic resonance (MR) images and generates a report for the referring physician. This version is available on the host computer.</p> <p>Flow Analysis has an automated edge detection algorithm that propagates through all the phases of the cine phase contrast series.</p> <p>The flow analysis measurement tab displays a summary chart of peak velocities in addition to individual velocity results from each phase of the cardiac cycle. A background correction may also be applied which is particularly suited to slow flowing fluid such as cerebrospinal fluid.</p> <p>Customizable Macros are a feature of Flow Analysis 4.0. These Marcos allow the user to quickly write a report specific to the patient being assessed with simple mouse clicks. The macros are customizable to reflect the language used by the reporting physician.</p> <p>Flow Analysis offers the capability to archive reports or cine images as seen in a DICOM format so they may be viewed on any DICOM viewer.</p> |

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 General Electric Company, GE Medical Systems

ARC000102  
 6/14/2016

Quotation Number: PR8-C70846 V 1

| Qty | Catalog No. | Description   |
|-----|-------------|---|
| 1   | S7525CH     | <p data-bbox="526 405 781 436"><b>Cardiac Expert Package</b></p> <ul data-bbox="545 447 781 636" style="list-style-type: none"> <li data-bbox="545 447 756 478">• 2D and PS-MDE</li> <li data-bbox="545 489 651 520">• MDE+</li> <li data-bbox="545 531 662 562">• Cine IR</li> <li data-bbox="545 573 776 604">• Blackblood SSFSE</li> <li data-bbox="545 615 781 646">• FGRE Time Course</li> </ul> <p data-bbox="526 678 1503 814">2D MDE combines a Fast Gradient Echo pulse sequence with an inversion pulse and cardiac gating to enable delayed enhancement imaging of the heart. The technique uses an IR preparation pulse with an inversion time (TI) typically selected to differentiate normal from enhancing myocardial tissue. Image data are collected in a 2D slice mode.</p> <p data-bbox="526 846 1526 982">Phase-sensitive myocardial delayed enhancement (PS-MDE) is a variation of 2D MDE that uses a phase-sensitive inversion recovery reconstruction technique that can improve contrast between tissues with reduced dependency on the user-selected inversion time (TI) compared to conventional magnitude reconstruction. Not compatible with ReportCard 4.0.</p> <p data-bbox="526 1014 1526 1129">MDE+ provides a B1 insensitive inversion pulse to improve the uniformity of the signal for MDE acquisitions. Additionally improved performance for delayed enhancement is introduced through utilization of a fat suppression pulse integrated into the MDE acquisition.</p> <p data-bbox="526 1161 1526 1402">Cine IR is used for approximating the myocardial null point for a subsequent myocardial viability assessment with delayed enhancement (MDE) techniques. Cine IR is a conventional ECG-gated, gradient-recalled echo FastCard or FastCine acquisition sequence with a multi-phase readout and an inversion recovery (IR) preparation. A single adiabatic inversion pulse is generated upon detection of the cardiac R-wave to trigger the multi-phase readout. Multi-phase images are generated within the cardiac cycle, each at a progressively longer TI time.</p> <p data-bbox="526 1434 1526 1654">Black Blood SSFSE is available for either dual or triple inversion pre-pulse single shot FSE based acquisition utilized for morphological imaging of the heart and vessels. The use of inversion pre-pulses allow for nulling of the blood pool for improved visualization of vessels and heart structures. Utilization of single shot acquisitions allows for single breath hold multi-slice coverage which leads to larger volume coverage in fewer breath holds for patient tolerance as well as reduction of overall exam times.</p> <p data-bbox="526 1686 1526 1785">Fast Gradient Recalled Echo Time Course utilizes single-echo acquisition to reduce sensitivity to echo mis-alignment or system calibration variations, resulting in robust image quality with ghosting and artifact reduction. ASSET parallel imaging and shortened RF pulse design are</p> |



Quotation Number: PR8-C70846 V 1

| Qty | Catalog No. | Description  |
|-----|-------------|--|
| 1   | S7024CY     | <p>incorporated to improve temporal resolution and reduce motion related artifacts. In addition to selective notch pulse, it also supports non-selective saturation pulse for excellent background suppression and multi-plane imaging capability.</p> <p><b>Cardiac Elite Package</b></p> <ul style="list-style-type: none"> <li>• 3D Heart</li> <li>• MR Echo</li> <li>• Tagging</li> </ul> <p>3D Heart is a 3D Fat Sat FIESTA sequence (Optimized for 1.5T) or 3D IRPrep FGRE sequence (Optimized for 3T) that provides whole-heart coverage for coronary artery imaging or cardiac chamber imaging. It employs a T2 preparation pulse at 1.5T to provide myocardial suppression for better coronary visualization. A multi-slab localizer allows easy whole-heart prescription, and increase inflow effect for high vessel conspicuity. A navigator echo pulse that detects motion of the diaphragm is utilized to enable free breathing acquisition. The navigator has been optimized to improve robustness, and employs prospective real-time motion correction to improve motion suppression and increase scan efficiency.</p> <p>As this sequence supports 3D IRPrep FGRE acquisition mode on both 1.5T and 3T, it can also be used for 3D MDE acquisition. With the purchase of 3D Heart, three additional options (3D MDE, Cine IR and Cardiac Navigator) are included.</p> <p>MR Echo is a dedicated Cardiac MR interface that eases cardiac workflow and combines leading edge pulse sequences used specifically in cardiac imaging. It includes the following:</p> <ul style="list-style-type: none"> <li>• 2D FIESTA imaging for cardiac wall motion visualization both in classic gated mode and with a real-time ability that needs no gating nor patient breath-holding. The real time imaging combines the resolution of MRI with the ease of use of Echocardiography and hence the product name MR Echo. FIESTA combined with parallel imaging permits acquisition times of approximately 50ms, which results in 20 frames/second in the real time mode.</li> <li>• Time Course imaging includes two pulse sequences to visualize the myocardial tissue at a single phase over a period of time. The first of these is an FGRE pulse sequence which uses a notched saturation pulse to maximize contrast to noise ratio. The second is a FIESTA base time course technique, which permits time course imaging in multiple planes simultaneously.</li> <li>• Myocardial Evaluation, within the MR Echo interface, allows scar tissue assessment of the heart.</li> </ul> <p>With Cardiac Tagging, an even distribution of spatial saturation lines are applied across the myocardium in the FastCINE Gradient Echo pulse sequence to enable cardiac wall motion assessment. Tagging allows the application of 1D diagonal stripes or 2D grid saturation pulses</p> |



Quotation Number: PR8-C70846 V 1

| Qty | Catalog No. | Description  |
|-----|-------------|--|
| 1   | S7525NT     | <p>once per R-R interval immediately following the R-wave trigger. Resulting images demonstrate motion (or lack of motion) effects.</p> <p>MSK Expert Package</p> <ul style="list-style-type: none"> <li>• IDEAL &amp; FLEX</li> <li>• Cartigram</li> </ul> <p>The IDEAL acquisition and reconstruction methods can generate a water-only, fat-only, in-phase and out-of-phase data sets for clear tissue differentiation in a single series. In addition susceptibility artifacts common to MR imaging such as incomplete or inaccurate fat saturation, and chemical shift can be eliminated as well. The IDEAL application acquires multiple echoes and uses unique reconstruction routines to generate the four image contrasts and correct for errors due to tissue susceptibility. IDEAL is ideally suited for imaging anatomical regions such as the brachial plexus, neck, spine, chest, foot, ankle, and axilla where inhomogeneous magnetic fields may yield failures with traditional fat saturation techniques. IDEAL is compatible with Fast Spin Echo, 3D Gradient Echo and parallel imaging.</p> <p>Cartigram is a non-invasive imaging method for early detection of osteoarthritis. It quantifies the T2 relaxation of knee cartilage and can overlay the quantified parametric maps over high resolution images for clear visualization of the anatomy. The imaging results are color mapped to indicate whether or not the cartilage structure is breaking down and, if so, to what extent. This information can be used to determine the best course of treatment for the individual patient. In addition, it can be used to monitor the cartilage post-treatment, obviating the need for follow-up arthroscopic surgeries or biopsies.</p> |
| 1   | M7001SE     | <p>FOCUS</p> <p>FOCUS delivers a highly efficient method for increasing the resolution in Single Shot DW EPI sequences. The outcome delivers robust high resolution results while removing artifacts typically induced from motion, image backfolding or unsuppressed tissue. In addition, with the higher efficiency of the application, the reduced field of view imaging leads to a reduction in blurring that translates into an overall improvement to the image quality result. The sequence utilizes 2D selective excitation pulses in DW-EPI acquisitions to limit the prescribed phase encoded field of view at both 1.5T and 3.0T field strengths.</p>   |
| 1   | M7000PF     | <p>MAVRIC SL</p> <p>MAVRIC SL is an advanced magnetic resonance imaging technique for imaging soft tissue and bone near MR conditional metallic devices. MAVRIC SL is designed to greatly reduce susceptibility artifacts, compared to conventional fast spin echo techniques, and is suitable for use on all patients cleared for MR exams.</p>   |



Quotation Number: PR8-C70846 V 1

| Qty | Catalog No. | Description   |
|-----|-------------|---|
| 1   | M7001KL     | <p>3.0T 18-ch TDI T/R Knee Array</p> <p>The 18-channel Knee Array is a transmit/receive coil that produces high resolution images of the knee and is optimized for parallel imaging in all three directions to reduce acquisition times.</p>  |
| 1   | M7001KM     | <p>3.0T TDI 8-ch Foot/Ankle Array</p> <p>The Foot/Ankle Array produces high-resolution images of the foot and ankle by incorporating an 8-channel phased array design in a unique "ski" boot design. The unique coil design has excellent distal coverage and supports multiple foot positions for optimizing studies. Parallel imaging is supported to reduce acquisition times.</p>   |
| 1   | M7001KE     | <p>3.0T 3-ch Shoulder Array</p> <p>The 3-Channel Shoulder Array takes orthopedic scanning to new performance levels. Designed to fit a large range of patients and optimized for off-center FOV imaging, this shoulder coil delivers homogenous and exquisite image quality.</p>  |
| 1   | M7000SK     | <p>3.0T GEM Flex Suite, Premium - P Connector</p> <p>The GEM Flex Suite is a versatile set of high density 16-channel receive coils designed to give high quality images in a wide range of applications. The high degree of flexibility was achieved by removing all non-essential electronics to an external interface assembly, ensuring reduced weight on the patient and better conformance to the anatomy. The high degree of flexibility is particularly advantageous when imaging patients that do not fit the constraints of rigid coils, improving patient and technologist experience, and enabling most exams to be completed with the same level of image quality expected from dedicated coils.</p> <p>This extended set includes all three sizes of coils, Small, Medium, and Large, and a knee stabilization fixture that is designed for compatibility with the flat GEM table. They cover a broad range of muscular skeletal applications, including hand, wrist, elbow, shoulder, hip (unilateral and bilateral), knee, ankle, and foot. In addition, the coils' versatility has been shown in a range of general purpose applications that include head, neck, and spine exams.</p> <p>This suite of flex coils is compatible with the MR750w + GEM with the flat table top. It is not compatible with the MR750 and MR750w systems configured with the standard curved table top.</p> <p>Includes:</p> <ul style="list-style-type: none"> <li>• 3.0T GEM Flex Coils - Small, Medium, and Large Arrays.</li> <li>• 3.0T GEM Flex Interface Module 16-channel Fixed, P-Connector.</li> <li>• GEM Flex Knee Stabilization fixture for flat table.</li> <li>• GEM Flex GP Strap and Interface Module Cover.</li> </ul> |

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 6/14/2016

Quotation Number: PR8-C70846 V 1

| Qty | Catalog No. | Description  |
|-----|-------------|--|
| 1   | M7005BE     | <ul style="list-style-type: none"> <li>• GEM Flex Cable Take-up Pad and General Purpose Stabilization Pad.</li> </ul> <p>Flex Array Positioner</p> <p>The Flex Array Positioner is a multipurpose support for a broad range of exams including foot, ankle, forefoot, knee, and head. A dedicated forefoot attachment allows the flex array elements to be wrapped tightly around the foot, yielding improved image quality. A repositionable support pad in the foot and ankle attachment allows for selection of a 90 degree position, or a relaxed position of the ankle. The pads and straps included with the stabilizer facilitate rapid setup and allow for flexibility in how the anatomy is secured.</p>  |
| 1   | E8914DB     | <p>GE Healthcare has partnered with the Glen Dimplex Group to offer chillers designed to meet the needs of your MR System.</p> <p>This chiller is highly reliable and is verified to perform with GE Healthcare MR systems. As part of your integrated GE Healthcare solution, you'll work with a single contact throughout the whole installation. A Project Manager of Installation will help with building layout, room designs, delivery and installation - every step until your system is ready to scan. Our team will work seamlessly with architects, contractors and your internal team to help ensure timely, cost-effective completion. Once your cooling system is running, you'll get fast, highly-skilled service support managed through GE Healthcare with the same quality and response time you expect from your MR system.</p> <p><b>FEATURES AND BENEFITS</b></p> <ul style="list-style-type: none"> <li>- Designed to provide stable fully dedicated cooling for your MR system's needs</li> <li>- Compact housing, zinc-plated and powder coated, painted white, suitable for outdoor installation</li> <li>- Water/glycol outdoor-air-cooled chiller to support your highest exam volumes and your full range of diagnostic procedures</li> <li>- Quiet operation between patient exams and overnight - ideal for facilities in residential areas</li> <li>- Comes with installation support, commissioning of the chiller, one preventative maintenance visit, and 12 months of parts and labor warranty</li> <li>- Installation support includes: support through GE's Project Manager of Install, GE's Design Center, technical support from the Glen Dimplex company</li> <li>- Comprehensive and quality service rapidly delivered through our CARES service solution</li> <li>- 300 liters of water-glycol pre-mixture (60/40%)</li> <li>- Remote display panel provides the ability to monitor the system's operation from the control room. When plugged into a LAN connection, system can be remotely monitored and</li> </ul> |



Quotation Number: PR8-C70846 V 1

| Qty | Catalog No. | Description  |
|-----|-------------|--|
|     |             | <p>diagnosed for proactive maintenance.</p> <ul style="list-style-type: none"> <li>- Highly recommended that Vibration Isolation Spring Kit (E8914DG) be added for systems that will be rooftop mounted</li> <li>- Environmental friendly and non-ozone harming refrigerant R134a</li> <li>- Condenser coated for coastal areas with specially treated nano coating to increase resistance against corrosion, salt water and dust</li> </ul> <p>SPECIFICATIONS</p> <ul style="list-style-type: none"> <li>- Net Cooling Capacity: 49 kW at 60Hz, 41kW at 50Hz</li> <li>- Coolant Outlet Temperature: 50 F (10 C)</li> <li>- Max Coolant Pressure : 3.2 Bar</li> <li>- Refrigerant: R134a</li> <li>- Coolant: 60% water and 40% glycol with inhibitors</li> <li>- Ambient Temp Range: -13 to 122 F (-25 to 50 C)</li> <li>- Tank Capacity: 100 liters</li> <li>- Supply Voltage: 460v/3 phase /60 Hz or 400v/3 phase/50 Hz</li> <li>- Overall Size (L x W x H) 855mm x 2295mm x 1930mm</li> </ul> <p>COMPATIBILITY:</p> <ul style="list-style-type: none"> <li>- GE Signa Pioneer 3.0T MR system and GE Signa Voyager 1.5T MR system</li> </ul> <p>NOTES:</p> <ul style="list-style-type: none"> <li>- Chiller is non-returnable and non-refundable.</li> </ul> |
| 1   | E8914DG     | Anti-vibration kit used for uncoupling the chiller from its surface. Typically used for rooftop installations.   |
| 1   | E8804SB     | <p>Medrad Spectris Solaris EP MR Injection System</p> <p>Medrad Spectris Solaris EP MR injector for use use in all MR scanner field strengths up to and including 3.0T. Optimized touch-screen for fewer keystrokes, KVO (keep vein open) allows patient to be prepared before beginning the scan. Larger 115 ml saline syringe for longer KVO or multiple flushes. Includes cables and starter kit...E</p> <p>NOTE: GE is responsible for unpacking, assembly, and installation of equipment. Medrad will be available for technical assistance by phone at (412)767-2400. An additional charge will apply for on-site installation assistance. Medrad will be responsible for operational checkout, final calibration, in-service of the equipment, and initial applications training. Please contact the local Medrad office two weeks in advance of installation.</p>  |
| 1   | E8823MC     | The Genesis Ultra Two-Way Systems are designed to provide Two-Way Communication and Music for GEHC "ONI" style extremity MRIs.   |



Quotation Number: PR8-C70846 V 1

| Qty | Catalog No. | Description  |
|-----|-------------|--|
|     |             | <ul style="list-style-type: none"> <li>• Built-in Two-Way Intercom allows communication to and from the patient and technologist even while the scanner is active</li> <li>• Music provides comfort to the patient even while the scanner is active</li> <li>• Patient choice of FM stereo, CD player, iPod or USB enhance usability</li> <li>• Patient handheld controls with voice feedback offer the patients a sense of control by allowing them to adjust the volume and control the media they are listening to</li> <li>• Magnaset Stethoscope style headsets - 10 included</li> <li>• Magnacap Earplugs - 200 pair included</li> <li>• Technologist control unit is ergonomically designed, microprocessor controlled with backlit Keypad, and LCD display, allowing operation of the entire system with a touch of a button even in low light environments</li> <li>• Active volume stabilization automatically adjusts music level to give a more even flow of sound to the patient, raising the volume level while soft music is playing and reducing the volume level while loud music is playing</li> <li>• Custom transducer amplifiers provide years of trouble free life</li> <li>• Direct input for audio portion of video</li> </ul> |

1 E4502FD

GE Digital Energy 5000 Series 150 KVA - X-Ray, MR450, MR750 Systems

The GE Digital Energy SG Series is one of the best performing and most reliable three-phase UPS systems providing critical power protection for medical imaging systems. The SG Series UPS was developed using GE's Design for Six Sigma methodology ensuring that the product fully meets customer requirements and expectations. It produces extremely low output voltage distortion during step loads from 0-100% thus making it ideal for diagnostic imaging systems. Its superior performance enables GE to correctly size the UPS for the application resulting in significant savings in initial and life cycle costs compared to other systems.

FEATURES/BENEFITS

- The use of uninterruptible power enables the system imaging to be completed after the loss of supply power, and allows for saving of valuable data and orderly system shutdown
- This 3 Phase, Online Double Conversion UPS eliminates all power anomalies such as noise, transients, over-voltage, and under-voltage, which could damage the imaging system's sensitive computer components
- Improves imaging system reliability, reduces service costs, and increases system uptime
- Superior UPS technologies include:
  - Superior dynamic load handling capability offers you a cost-effective solution with reduced lifecycle costs and a reduced footprint
  - Extremely low output voltage distortion reduces the need for over-sizing the UPS

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 6/14/2016

Quotation Number: PR8-C70846 V 1

| Qty | Catalog No. | Description  |
|-----|-------------|--|
|     |             | <p>(up to 14% smaller footprint)</p> <ul style="list-style-type: none"> <li>- Space vector modulation resulting in faster response and higher efficiency</li> <li>- Output isolation transformer separates the utility power from the load providing greater critical power protection</li> <li>- Superior battery management enhances the life of the battery and reduces operational costs</li> <li>- Input 5th harmonic filter reduces the input distortion to less than 7%.</li> </ul> <ul style="list-style-type: none"> <li>• SNMP Card included which allows the UPS to be managed using an existing Network Management System or with GE Digital Energy's exclusive UPS management software</li> <li>• Recommended with 150 KVA Bypass Panel (E4504CH), sold separately</li> </ul> |

SPECIFICATIONS

- Dimensions (H x W): 71" x 47.25"
- Weight: 2161 lbs.
- Voltage: 480VAC, 3 phase, 4 wire + ground
- Frequency: 60 Hz

COMPATIBILITY

- X-Ray Systems, Cath Lab, MR450 1.5T and MR750 3.0T

NOTES:

- Customer is responsible for rigging and arranging for installation with a certified electrician
- ITEM IS NON-RETURNABLE AND NON-REFUNDABLE

|   |         |  |
|---|---------|--|
| 1 | E4504CH | 150 KVA UPS Bypass Panel (Use With E4502FD/ E4505MB) |
|---|---------|--|

FEATURES/BENEFITS

- The 150 kVA UPS Bypass Panel feeds power to the GE Digital Energy 150 kVA UPS in the normal mode and enables an imaging system to operate when the UPS is in the manual bypass mode for routine servicing of the UPS or in the event of UPS failure
- The UPS input and output breakers provide branch overcurrent protection, a disconnection means and OSHA lockout/tagout provisions
- The bypass breaker includes a control contact which interfaces with the UPS to switch into static bypass
- Each circuit breaker is permanently identified by function for ease of operation
- Reduces installation time and cost by providing a pre-designed and tested system eliminating the need to mount and wire a number of individual components



Quotation Number: PR8-C70846 V 1

| Qty | Catalog No. | Description   |
|-----|-------------|---|
| 1   | E4504FM     | <ul style="list-style-type: none"> <li>• Standardized design and testing assures high product quality and system reliability</li> </ul> <p>SPECIFICATIONS</p> <ul style="list-style-type: none"> <li>• Dimensions (H x W x D): 65.87" x 31" x 11.5"</li> <li>• Weight: 350 lbs.</li> <li>• Mounting: Four 0.5" square mounting holes provided</li> </ul> <p>COMPATIBILITY</p> <ul style="list-style-type: none"> <li>• Use with GE Digital Energy 150 kVA UPS (E4502FD)</li> </ul> <p>700 VA Partial System UPS - MR</p> <p>Tested with all MR system computers, the 700VA Partial System UPS provides reliable, clean, consistent power for the data processing portion of the MR imaging system. The use of the double conversion UPS enables the MR system data processing portion electronics to operate when there is a power anomaly or total power loss. Valuable data and the system operating software are protected, if there is an extended outage the UPS allows for an orderly shutdown of the system.</p> <p>FEATURES/BENEFITS</p> <ul style="list-style-type: none"> <li>• True double-conversion, online technology provides reliable operation and uninterrupted glitch free power</li> <li>• Automatic frequency selection eases startup, i.e., 50 or 60 Hz compatible</li> <li>• Integral Electronic Static Bypass switch means zero transfer time</li> <li>• Improves user productivity, system reliability, reduces service costs and increases system uptime</li> <li>• Advanced Battery Management (ABM) software monitors / indicates battery health and improves battery service life</li> </ul> <p>SPECIFICATIONS</p> <ul style="list-style-type: none"> <li>• Dimensions (H x W x D): 9.09" x 6.3" x 13.9"</li> <li>• Weight: 26 lbs.</li> <li>• Input Voltage Range: Single Phase 80-138 V</li> <li>• Input Frequency Range: 47-70 Hz</li> <li>• Rating: 700 VA / 630 W</li> </ul> <p>COMPATIBILITY</p> <ul style="list-style-type: none"> <li>• MR Systems</li> </ul> <p>NOTES</p> |



Quotation Number: PR8-C70846 V 1

| Qty | Catalog No. | Description  |
|-----|-------------|--|
|     |             | <ul style="list-style-type: none"> <li>This is a partial system UPS - it covers only the computer, not the entire MR imaging system. After a power event portions of the system will have to be reset before operation can resume</li> <li>Customer is responsible for rigging and arranging for installation with a certified electrician</li> <li>ITEM IS NON-RETURNABLE AND NON-REFUNDABLE</li> </ul>   |
| 1   | E8823A      | <p>MR Coated Patient Positioning Accessories Kit</p> <p>MR accessories kit consists of a complete set of coated positioning pads in a lightweight tote case that can be a permanent fixture in an MR suite or can be easily carried from room to room. Also provides storage area for other accessories such as earplugs, electrodes, and film leads. The following pads are included: 1 knee rest, 1 knee coil insert, 1 extremity rest, 4 segment table pads, 4 body wedges, 4 rectangle stack pads, and 2 rectangle elbow pads. Sold per kit, but replacement pads can be ordered under separate part numbers...H</p> <p>NOTE:</p> <ul style="list-style-type: none"> <li>This item is not compatible with the GEM patient table</li> </ul>   |
| 1   | E8802MC     | <p>MR Signa Wide Security Strap Set</p> <p>Wide security strap set - includes one strap with Velcro and one strap with plastic buckle; 14 in. wide. For use with GE Signa MR systems..H</p>  |
| 1   | E8802MD     | <p>MR Signa Narrow Security Strap Set</p> <p>Narrow security strap set - includes one strap with Velcro and one plastic buckle; 6 in. wide. For use with GE Signa MR systems..H</p>  |
| 1   | W0105MR     | <p>TiP Discovery and Optima Family Succeed Advance</p> <p>This program is designed for CURRENT GE customers WITH HD/HDx experience who purchase the Discovery or Optima system. Program content focuses on features and differences between HD/HDx and Discovery or Optima. Blended content delivery and design promotes learner retention and more efficient and effective advanced skill development. Extended TVA support ensures learners maintain performance over the long term.</p> <ul style="list-style-type: none"> <li>1 Discovery or Optima HQ Class/session (One class is equivalent to one session.)</li> <li>17 onsite days</li> <li>4 hours TVA</li> </ul> <p>This training program must be scheduled and completed within 24 months after the date of product delivery.</p> |



Quotation Number: PR8-C70846 V 1

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| Qty | Catalog No. | Description |
|-----|-------------|-------------|
|-----|-------------|-------------|

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**Quote Summary:**

**Total Quote Net Selling Price** **\$2,506,223.62**

(Quoted prices do not reflect state and local taxes if applicable)

If you would like to place an order for this equipment, a formal contract document will be prepared for your consideration. This quote is for budgetary use only; only a GE contract can become a binding order.



Quotation Number: PR8-C70846 V 1

### Options

(These items are not included in the total quotation amount)

| Qty | Catalog No. | Description   | Ext Sell Price |         |
|-----|-------------|---|----------------|---------|
| 1   | S7525NG     | Spectroscopy Elite Package <ul style="list-style-type: none"> <li>• PROBE 2D CSI</li> <li>• PROBE 3D CSI</li> </ul> | \$30,138.75    | X _____ |

PROBE 2D CSI expands proton brain spectroscopy capability enabling simultaneous acquisition of multiple in-plane voxels. PROBE 2D CSI uses the PRESS pulse sequence to acquire and display volume-localized, water suppressed 1H spectra in a multi-voxel mode for the non-invasive assessment of in vivo metabolites. Metabolite maps are automatically generated in FuncTool on the operator console.

PROBE 3D CSI extends your PROBE-P 2D CSI spectroscopic capabilities by allowing you to perform 3-dimensional multi-voxel acquisitions. Post-processing, including the creation of metabolite maps, is automatically generated with the FuncTool Performance Package (included as part of ScanTools).

**(Quoted prices do not reflect state and local taxes if applicable)**



# ***EXHIBIT D***

**Clark G. Yoder, MBA**  
1370 Fence Row Drive, Fairfield, CT 06824

**Professional Experience**

**Advanced Radiology Consultants, LLC, Shelton, CT** 2015- Present

**Chief Executive Officer**

**North Shore-LIJ and North Shore-LIJ CareConnect Insurance Company Roslyn, NY** 2014-2015

**Chief Customer Officer and NSLIJ-IPA Vice President**

**WESTMED Practice Partners LLC and WESTMED Medical Group, P.C. – Purchase, NY** 2000- 2013

**Promoted to Chief Operating Officer**

**Promoted to Chief Financial Officer**

**Promoted to Director of Ancillary Services**

**Radiology Manager**

**Salick Healthcare, St. Vincents Cancer Center, New York, NY** 1999-2000  
**Radiology Director**

**Radiologix/HVRA, New City, NY** 1996-1999  
**Director of Operations**

**Greenwich Hospital, Greenwich, CT** 1990-1996  
**Radiology Technologist and Radiologic Technologist Supervisor**

## **Education and Credentials**

**Master of Business Administration (MBA) – University of Connecticut**

**Bachelor of Science, Radiology (BS) - Quinnipiac University**

### ***Professional and Personal Achievements***

Beta Gamma Sigma Business Society Member

Member American College of Healthcare Executives

Member Radiology Business Management Association

Member Radiological Society of North America

Member Healthcare Leaders of New York

ARRT (MR)(CT)(RT)(R)

President: Ridge Homeowners Association, Inc.

Former Board of Director- Bedford Physicians Risk Retention Group, Inc.

Former Board of Director WPP, LLC

Former Managing Member and Treasurer- Rye Ambulatory Surgery Center, LLC

Former Assistant Treasurer- WESTMED PAC

Former Board of Director- Amerinet Northeast Alliance



### **Dennis Condon COO**

Dennis Condon is the chief operating officer of Advanced Radiology. He has served in the role of COO since 2003. With more than 35 years of experience, he is leading the reinvention of Advanced Radiology to strengthen its strategic positioning and value creation for the regional community.

Dennis's responsibilities include senior-level system strategy oversight of regional business development, clinical quality and effectiveness, system service line development and growth, Integrating Advanced Radiology's seven outpatient facilities with multiple hospital partners.

Prior to re-joining Advanced Radiology, he served as the chief operating officer for Jefferson Radiology, an integrated regional multi-campus imaging system in Hartford Connecticut. Prior to his relocation to Connecticut in 1992, Dennis had served in senior leadership roles with the Inova Health System's Alexandria Hospital in Alexandria, Virginia.

Dennis is an active member in the state of Connecticut, serving as Chairman of the Monroe Board of Health as well as serving on multiple local business boards and commissions in the community. Past BOD Chairman of Connecticut's Beardsley Zoo, Past President of Rotary, and Chairman of Emergency Medical Services in Monroe Ct. He is an active member of the (ACHE) American College of Healthcare Executive, (RBMA) Radiology Business Managers Association and (HIMSS) Health Information Management Systems.

Mr. Condon received his bachelor's degree from the Hofstra University and his master's degree in health care administration from the Medical College of Virginia, Virginia Commonwealth University.

305 Sarah Wells Trail  
Campbell Hall, NY 10916  
Home: (845) 291-7110  
Beeper: (845) 346-7420  
Email: thughes328@frontiernet.net

## Terence W. Hughes, M.D.

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**EDUCATION:** State University of New York, Health Science Center at Brooklyn,  
College of Medicine, Brooklyn, New York  
M.D., May 1995

New York University, New York, New York  
B.A., May 1991

### **PROFESSIONAL EXPERIENCE:**

**July 2003 – Present:** Diagnostic and Interventional Radiologist,  
Radiologic Associates, P.C., Middletown, New York

**July 2001 – July 2003:** Assistant Professor of Radiology, The  
Institute for Vascular Health and Disease, Albany Medical College,  
Albany, New York

**August 2000 – April 2001:** Diagnostic Radiologist, locums,  
Flushing Medical Center of Queens, Queens, New York

**April 1999 – April 2001:** Diagnostic Radiologist, locums,  
Manhasset Diagnostic Imaging, Manhasset, New York

### **HOSPITAL STAFF PRIVILEGES:**

**July 2003 - Present:** Orange Regional Medical Center: Horton  
Campus, Middletown, New York; Arden Hill Campus, Goshen,  
New York

**September 2003 - Present:** St. Luke's Hospital, Newburgh,  
New York

**September 2003 - Present:** Cornwall Hospital, Cornwall, New York

## Terence W. Hughes, M.D.

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### GRADUATE TRAINING:

**July 2000 – June 2001:** Fellow, Department of Diagnostic Radiology, Section of Vascular and Interventional Radiology, Westchester Medical Center, Valhalla, New York

**January 1999 – January 2000:** Chief Resident, Department of Diagnostic Radiology, Albert Einstein College of Medicine – Montefiore Medical Center, Bronx, New York

**July 1996 – June 2000:** Resident, Department of Diagnostic Radiology, Albert Einstein College of Medicine – Montefiore Medical Center, Bronx, New York

**July 1995 – June 1996:** Intern, Department of Internal Medicine, Sound Shore Medical Center, New Rochelle, New York

### HONORS AND AWARDS:

**June 2000:** Milton Elkin Outstanding Graduating Resident Award, Department of Radiology, Albert Einstein College of Medicine – Montefiore Medical Center

**1993 – 1995:** SUNY - HSCB Alumni Fund Scholarship

**1990 – 1991:** New York State Assembly Certificate of Merit based on collegiate academic performance

**1989 – 1991:** NYU Premedical Honor Society, The Caducean Society

**1987 – 1991:** NYU Trustee Scholarship

**CERTIFICATION:** **November 2002:** Granted Certificate of Added Qualification in Vascular and Interventional Radiology by The American Board of Radiology

**May 2000:** Granted certification by The American Board of Radiology

**April 1996:** Diplomate, National Board of Medical Examiners

**March 2003:** Certified, Advanced Cardiac Life Support

### LICENSURE:

New York State Medical License No. 205350

Granted, December 1996

Drug Enforcement Agency Registration No. BH5633854, Granted November 1997

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**Terence W. Hughes, M.D.**

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**PROFESSIONAL  
MEMBERSHIPS:**

Society of Cardiovascular and Interventional Radiology  
The Radiological Society of North America  
American Roentgen Ray Society  
New York Roentgen Society

**PUBLICATIONS:**

Siskin GP, Englander M, Roddy S, Dowling K, Dolen EG,  
Quarfordt S, Hughes TW, Mandato K . Results of Iliac Artery  
Stent Placement in Patients Younger than 50 Years of Age. JVIR  
2002; 13: 785-790.

**Hughes TW, Bakal CW: Mesenteric Ischemia: An update of  
treatment techniques.**

**POSTER**

**PRESENTATIONS:** Rozenblit GN, Rundback JH, Poplasky MR, Maddineri S, Crea  
GA, Piper JB, Wolf DC, Hughes TW, et al. Percutaneous Ablation  
of Liver Tumors with Acetic Acid. Poster presentation. The 26<sup>th</sup>  
Annual Scientific Meeting of the Society of Cardiovascular &  
Interventional Radiology, San Antonio, Texas, March, 2001.

**INVITED**

**LECTURE:**

Fenoldopam (Corlopam) : Adjunct Therapy for the High Risk  
Patient Requiring Contrast Dye. Meeting of the Northeast  
Chapter for Vascular Nursing. Albany, New York. September 2002.

**PERSONAL:**

Date of Birth: March 28, 1969  
Place of Birth: Queens, NY  
Social Security No.: ( )  
Marital Status: Married; three children  
Health: Excellent

**REFERENCES:**

Furnished upon request

Gerard J. Muro, M.D.

**WORK HISTORY**

Advanced Radiology Consultants  
Trumbull, Connecticut July 1999 to present

Radiology Consultants, Ltd.  
Reno Nevada July 1998 to June 1999

**EDUCATION**

M.D., State University of New York Health Science Center at Brooklyn, NY May 1991  
B.S., Cornell University, Ithaca, NY June 1987

**POST-GRADUATE TRAINING**

FellowshipNeuroradiology  
The Barrow Neurological Institute/St Joseph's Hospital and Medical Center,  
Phoenix, AZ  
July, 1996 - June 1998

Residency Radiology  
State University of New York Health Science Center, Brooklyn, NY  
July, 1992 – June 1996

Internship Internal Medicine  
Winthrop University Hospital, Mineola, NY  
July 1991 – June 1992

**CERTIFICATION**

Certificate of Added Qualification - Neuroradiology

Diplomate, American Board of Radiology

National Board of Medical Examiners

**AWARDS**

Summa cum laude. Pediatric Cervical Spine Atlas.  
American Society of Neuroradiology 46th Annual Meeting, June 2008

Summa cum laude. Anatomy Wiz – Soft Tissue Neck: An Interactive, Online Reference  
and Educational Tool.  
American Society of Neuroradiology 44th Annual Meeting, June 2006

Summa cum laude. The Anatomy Wiz: An Interactive Internet-Based Anatomy Tutorial –  
MDCT of the Temporal Bone.  
American Society of Neuroradiology 44th Annual Meeting, June 2006

Magna cum laude. American Society of Neuroradiology 39th Annual meeting, 2001  
Computer exhibit: Soft Tissue Neck Anatomy

Summa cum laude. American Society of Neuroradiology 37th Annual Meeting, 1999  
Computer exhibit: Skull Base Anatomy

Magna cum laude. American Society of Neuroradiology 36th Annual meeting, 1998  
Computer exhibit: Head and Neck Anatomy

Roentgen/Fellow Research Award RSNA Research & Education Fund, 1998

## **BOOKS/PUBLICATIONS**

Chapter in the ELC Syllabus for the American Society of Neuroradiology 45th Annual  
meeting.

"High Speed Connectivity for Work and Home". GJ Muro. 2007.

Chapter in the ELC Syllabus for the ASNR 44th Annual meeting. "Broadband and the  
Wireless Technologies

Update 2006". GJ Muro. 2006.

Chapter in the ELC Syllabus for the ASNR 43rd Annual meeting. "Broadband and the  
Wireless Technologies Update 2005".

Gerard J. Muro, M.D., John Pan, M.D. 2005.

Chapter in the ELC Syllabus for the ASNR 42nd Annual meeting. "Broadband and The  
Wireless technologies,

Update 2004". GJ Muro. 2004.

Chapter in the ELC Syllabus for the ASNR 41st Annual meeting.

"Broadband: Fast Internet Connections Update 2003". GJ Muro. 2003.

Chapter in the ELC Syllabus for the ASNR 40th Annual meeting.

"Fast Internet Connections: Broadband". GJ Muro. 2002.

Chapter in the ELC Syllabus for the ASNR 39th Annual meeting.

“Fast Internet Connections: Broadband”. GJ Muro. 2001.

Cerebral Venous Thrombosis: Combined Intrathrombus rt-PA and Intravenous Heparin. JL Frey, GJ Muro, CG McDougall, BL Dean, HK Jahnke. Stroke Jan-Feb 1999.

Chapter for Neuroimaging, William Orrison. “The Aging Brain and Neurodegenerative Disorders”. MR Theobald, GJ Muro, JP Karis. 1999.

Neuroimaging in Temporal Lobe Epilepsy. GJ Muro, JP Karis. CNS Spectrums. The International Journal of Neuropsychiatric Medicine. 1997, 2:31-42

## **RESEARCH/TEACHING EXPERIENCE**

- 1990 State University of New York Health Science Center at Brooklyn, Summer Internship. Developed computer assisted EKG tutorial under F. Kavalier, M.D., Dept. of Physiology and Lucy Squire, M.D., Dept. of Radiology
- 1987 Teaching Assistant - “Intro to Micro-Computers”. Cornell University, Ithaca, NY
- 1983 Cold Spring Harbor Laboratories, Summer Internship. Investigation of transposable elements in corn under Dr. Steve Dellaporta and Dr. Barbara McClintock, Nobel laureate.

## **PROFESSIONAL PRESENTATIONS**

Pediatric CT Cervical Spine Atlas.

Muro, G. Brannan, S. American Society of Neuroradiology 46th Annual Meeting, June 2008

Anatomy Wiz – Soft Tissue Neck: An Interactive, Online Reference and Educational Tool.

Muro, G. Wendorf, K. American Society of Neuroradiology 44th Annual Meeting, June 2006

The Anatomy Wiz: An Interactive Internet-Based Anatomy Tutorial – MDCT of the Temporal Bone.

Muro, G. Raghavan, M. American Society of Neuroradiology 44th Annual Meeting, June 2006

The Anatomy Wiz: An Interactive Internet-based Vascular Anatomy Learning Tool.

Wheeler, S. Muro, GJ. Zinn, K. (Computer exhibit at the RSNA, Chicago 2005)

ELC Lecture: High Speed Connectivity Update. GJ Muro.

American Society of Neuroradiology 43rd Annual Meeting, June 2005

Lecture: High Speed Connectivity. GJ Muro.

American Society of Neuroradiology 42nd Annual Meeting, June 2004

Lecture: High Speed Connectivity. GJ Muro.

American Society of Neuroradiology 41st Annual Meeting, May 2003

MR Anatomy of the Elbow. A Computer-based Tutorial. C Shen, GJ Muro. (Computer exhibit At the 51st Annual Meeting of the Association of University Radiologists, April 2003)

Soft Tissue Neck Anatomy. A computer-based tutorial. GJ Muro.  
(Computer exhibit at the American Society of Neuroradiology 39th Annual Meeting, May 2001)

Skull Base Anatomy. A computer-based tutorial. G Luh, GJ Muro, R Bird.  
(Computer exhibit at the American Society of Neuroradiology 37th Annual Meeting, May 1999)

Orbit and Sinus Anatomy. A computer-based tutorial. GJ Muro, G Luh.  
(Computer exhibit at the RSNA, Chicago 1998)

Head and Neck Anatomy. A stand-alone and Internet-Based tutorial. GJ Muro J Stoane.  
(Computer exhibit at the American Society of Neuroradiology 36th Annual Meeting, May 1998)

Cerebral Angiographic Anatomy: An Internet-Based Tutorial. GJ Muro, JA Hodak  
(Computer exhibit at the Roentgen Ray Society Meeting, April 1998)

The Disconnected Conus. GJ Muro, TP Naidich, EK Fram.  
The Western Neuroradiological Society 29th Annual Meeting, October 1997

Pneumosinus Dilatans In Association with an Arachnoid Cyst. GJ Muro, JP Karis.  
The Western Neuroradiological Society 29th Annual Meeting, October 1997

Dural Sinus Thrombosis: Direct Thrombolysis with TPA. GJ Muro, JL Frey, CG McDougall, et al.  
American Society of Interventional and Therapeutic Neuroradiology, September 1997

NASCET Estimation of Carotid Stenosis by MRA: Error related to Digitization. GJ Muro, JE Heiserman, PJ Keller. American Society of Neuroradiology 35th Annual Meeting, May 1997

## **HOBBIES AND OTHER INTERESTS**

Skiing, Tennis, Fishing, Golf, Bike Riding, Computer Programming

***EXHIBIT E***

ROBERT H. LOVEGROVE, M.D.

June 7, 2016

Hon. Raul Pino M.D.  
Commissioner of Public Health  
Department of Public Health  
410 Capitol Avenue  
Post Office Box 340308  
Hartford, CT 06134-0308

Re: Docket Number: 1215726-CON

Dear Commissioner Pino:

I am writing to express my strong support for the Certificate of Need application filed by Advanced Radiology to acquire a new 3 Tesla MRI.

Advanced Radiology provides high quality imaging services to all of my patients as well as Medicaid members. By approving the application it will provide improved access to high field imaging at a lower cost, which is not only a benefit to my patients but, also to the community.

In addition, the additional MRI scanner will provide for new and enhanced capabilities that are currently unavailable in the outpatient setting in Stamford

I support this project and I urge the Office of Healthcare Access to approve the Certificate of Need application.

Thank you.

Regards,



Robert Lovegrove, M.D.

# ***EXHIBIT F***



# American College of Radiology

Magnetic Resonance Imaging Services of

**Advanced Radiology Consultants - Stamford**

1315 Washington Boulevard  
Stamford, Connecticut 06902

were surveyed by the  
Committee on MRI Accreditation of the  
Commission on Quality and Safety

The following magnet was approved

**Siemens ESPREE 2005**

For

**Head, Spine, Body, MSK, MRA**

Accredited from:

**October 13, 2015 through October 13, 2018**

A handwritten signature in black ink, reading "Anthony J. Sculco, M.D.".

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CHAIRMAN, COMMITTEE ON MRI ACCREDITATION

A handwritten signature in black ink, reading "Paul H. Ellenbogen, M.D.".

---

PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY

MRAP# 03011-02



# American College of Radiology

Breast MR Imaging Services of

**Advanced Radiology Consultants - Stamford**

**1315 Washington Boulevard  
Stamford, Connecticut 06902**

were surveyed by the  
Committee on Breast MRI Accreditation of the  
Commission on Quality and Safety

The following unit was approved  
**SIEC MAGNETOM ESPREE 1.5T 2005**

Accredited from:  
**August 01, 2014 through December 02, 2017**

CO-CHAIR, COMMITTEE ON BREAST MRI  
ACCREDITATION

CO-CHAIR, COMMITTEE ON BREAST MRI  
ACCREDITATION

PRESIDENT, AMERICAN  
COLLEGE OF RADIOLOGY

BMRAP# 00835-01

# ***EXHIBIT G***

## Charity Care Policy

### PURPOSE:

To provide a policy and procedure for the determination and handling of Advanced Radiology's Charity Care. Charity Care is a financial assistance program offered by the Advanced Radiology which provides a reduced cost rate for medically necessary services incurred by State of Connecticut legal residents whose household income does not exceed 250% of the Federal Income Poverty Guidelines for a family unit.

### PROCEDURE:

Patients are required to complete a financial assistance application and provide the following requested documents to verify financial need:

1. Copies of items to support income reported on application
  - Pay stubs , bank statements, tax returns & documentation of Other income - Alimony, Social Security, Disability, Pension, Annuity Payments
  
2. Copies of items to support monthly expenses reported on application:  
Examples:
  - Monthly expenses - Mortgage statement, rent (canceled check), electric, gas, oil, cable, phone, insurance car/home/health, auto payments, alimony
  
3. Number of dependents in household

Advanced Radiology will review the submitted documents and provide a decision timely. A payment plan will be established if the qualifications for charity care are not met.

# ***EXHIBIT H***



**FOR-PROFIT**

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format

**Applicant Name:**  
**Financial Worksheet (B)**

| LINE | Total Entity Description             | (1) FY 2015 Actual Results |              | (2) FY 2016 Projected |              | (3) FY 2016 Projected Incremental |              | (4) FY 2016 Projected With CON |              | (5) FY 2017 Projected |              | (6) FY 2017 Projected Incremental |            | (7) FY 2017 Projected With CON |              | (8) FY 2018 Projected |              | (9) FY 2018 Projected Incremental |            | (10) FY 2018 Projected With CON |              | (11) FY 2019 Projected |          | (12) FY 2019 Projected Incremental |              | (13) FY 2019 Projected With CON |              |              |              |              |              |
|------|--------------------------------------|----------------------------|--------------|-----------------------|--------------|-----------------------------------|--------------|--------------------------------|--------------|-----------------------|--------------|-----------------------------------|------------|--------------------------------|--------------|-----------------------|--------------|-----------------------------------|------------|---------------------------------|--------------|------------------------|----------|------------------------------------|--------------|---------------------------------|--------------|--------------|--------------|--------------|--------------|
|      |                                      | W/out CON                  | With CON     | W/out CON             | With CON     | W/out CON                         | With CON     | W/out CON                      | With CON     | W/out CON             | With CON     | W/out CON                         | With CON   | W/out CON                      | With CON     | W/out CON             | With CON     | W/out CON                         | With CON   | W/out CON                       | With CON     | W/out CON              | With CON | W/out CON                          | With CON     | W/out CON                       | With CON     | W/out CON    | With CON     |              |              |
| C.   | Retained Earnings, beginning of year | \$0                        | \$0          | \$0                   | \$0          | \$0                               | \$0          | \$0                            | \$0          | \$0                   | \$0          | \$0                               | \$0        | \$0                            | \$0          | \$0                   | \$0          | \$0                               | \$0        | \$0                             | \$0          | \$0                    | \$0      | \$0                                | \$0          | \$0                             | \$0          | \$0          |              |              |              |
|      | Retained Earnings, end of year       | \$0                        | \$0          | \$0                   | \$0          | \$0                               | \$0          | \$0                            | \$0          | \$0                   | \$0          | \$0                               | \$0        | \$0                            | \$0          | \$0                   | \$0          | \$0                               | \$0        | \$0                             | \$0          | \$0                    | \$0      | \$0                                | \$0          | \$0                             | \$0          | \$0          |              |              |              |
|      | Principal Payments                   | \$0                        | \$0          | \$0                   | \$0          | \$0                               | \$0          | \$0                            | \$0          | \$0                   | \$0          | \$0                               | \$0        | \$0                            | \$0          | \$0                   | \$0          | \$0                               | \$0        | \$0                             | \$0          | \$0                    | \$0      | \$0                                | \$0          | \$0                             | \$0          | \$0          |              |              |              |
| D.   | <b>PROFITABILITY SUMMARY</b>         |                            |              |                       |              |                                   |              |                                |              |                       |              |                                   |            |                                |              |                       |              |                                   |            |                                 |              |                        |          |                                    |              |                                 |              |              |              |              |              |
| 1    | Hospital Operating Margin            | 46.9%                      | 46.9%        | 49.5%                 | 49.5%        | 0.0%                              | 0.0%         | 0.0%                           | 0.0%         | 48.6%                 | 48.6%        | -293.8%                           | -293.8%    | 33.0%                          | 33.0%        | 47.2%                 | 47.2%        | -112.3%                           | -112.3%    | 33.2%                           | 33.2%        | 0.0%                   | 0.0%     | 0.0%                               | 0.0%         | 45.6%                           | 45.6%        | -51.4%       | -51.4%       | 33.1%        | 33.1%        |
| 2    | Hospital Non Operating Margin        | 0.0%                       | 0.0%         | 0.0%                  | 0.0%         | 0.0%                              | 0.0%         | 0.0%                           | 0.0%         | 0.0%                  | 0.0%         | 0.0%                              | 0.0%       | 0.0%                           | 0.0%         | 0.0%                  | 0.0%         | 0.0%                              | 0.0%       | 0.0%                            | 0.0%         | 0.0%                   | 0.0%     | 0.0%                               | 0.0%         | 0.0%                            | 0.0%         | 0.0%         | 0.0%         | 0.0%         | 0.0%         |
| 3    | Hospital Total Margin                | 46.9%                      | 46.9%        | 49.5%                 | 49.5%        | 0.0%                              | 0.0%         | 0.0%                           | 0.0%         | 48.6%                 | 48.6%        | -293.8%                           | -293.8%    | 33.0%                          | 33.0%        | 47.2%                 | 47.2%        | -112.3%                           | -112.3%    | 33.2%                           | 33.2%        | 0.0%                   | 0.0%     | 0.0%                               | 0.0%         | 45.6%                           | 45.6%        | -51.4%       | -51.4%       | 33.1%        | 33.1%        |
| E.   | FTEs                                 | 4.5                        | 4.5          | ###                   | ###          | ###                               | ###          | ###                            | ###          | 4.5                   | 4.5          | 1.5                               | 1.5        | 6.0                            | 6.0          | 4.5                   | 4.5          | 1.5                               | 1.5        | 6.0                             | 6.0          | 4.5                    | 4.5      | 1.5                                | 1.5          | 6.0                             | 6.0          | 4.5          | 4.5          | 6.0          | 6.0          |
| F.   | <b>VOLUME STATISTICS<sup>d</sup></b> |                            |              |                       |              |                                   |              |                                |              |                       |              |                                   |            |                                |              |                       |              |                                   |            |                                 |              |                        |          |                                    |              |                                 |              |              |              |              |              |
| 1    | Inpatient Discharges                 | 0                          | 0            | 0                     | 0            | 0                                 | 0            | 0                              | 0            | 6,947                 | 6,947        | 347                               | 347        | 7,294                          | 7,294        | 6,947                 | 6,947        | 711                               | 711        | 7,658                           | 7,658        | 0                      | 0        | 6,947                              | 6,947        | 1,094                           | 1,094        | 8,041        | 8,041        | 0            | 0            |
| 2    | Outpatient Visits                    | 6,617                      | 6,617        | 6,947                 | 6,947        | 6,947                             | 6,947        | 6,947                          | 6,947        | 6,947                 | 6,947        | 347                               | 347        | 7,294                          | 7,294        | 6,947                 | 6,947        | 711                               | 711        | 7,658                           | 7,658        | 0                      | 0        | 6,947                              | 6,947        | 1,094                           | 1,094        | 8,041        | 8,041        | 8,041        | 8,041        |
|      | <b>TOTAL VOLUME</b>                  | <b>6,617</b>               | <b>6,617</b> | <b>6,947</b>          | <b>6,947</b> | <b>6,947</b>                      | <b>6,947</b> | <b>6,947</b>                   | <b>6,947</b> | <b>6,947</b>          | <b>6,947</b> | <b>347</b>                        | <b>347</b> | <b>7,294</b>                   | <b>7,294</b> | <b>6,947</b>          | <b>6,947</b> | <b>711</b>                        | <b>711</b> | <b>7,658</b>                    | <b>7,658</b> | <b>0</b>               | <b>0</b> | <b>6,947</b>                       | <b>6,947</b> | <b>1,094</b>                    | <b>1,094</b> | <b>8,041</b> | <b>8,041</b> | <b>8,041</b> | <b>8,041</b> |

<sup>a</sup>Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

<sup>b</sup>Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No 2011-07, July 2011.

<sup>c</sup>Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

<sup>d</sup>Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

# *EXHIBIT I*



June 6, 2016

Carol Friia  
Director of Finance  
Advanced Radiology Consultants  
3 Enterprise Drive, Suite 220  
Shelton, CT 06484

Dear Ms. Friia:

Re: MRI Project Financing Approval Confirmation

This letter is being sent to confirm our credit approval to finance \$2,500,000.00 for an MRI and \$410,000.00 for the associated build out described in the MRI Project Outline provided by ARC.

We look forward to financing this project and working with your organization.

Very truly yours,

Banc of America Public Capital Corp

A handwritten signature in cursive script, appearing to read "Jennifer E. Cunningham".

By: Jennifer E. Cunningham  
Title: Senior Vice President

***EXHIBIT J***

ADVANCED RADIOLOGY MRI CENTERS, LP  
Balance Sheet  
For the Twelve Months Ending Thursday, December 31, 2015

ADVANCED RADIOLOGY MRI CENTERS, LP  
Balance Sheet  
For the Twelve Months Ending Thursday, December 31, 2015

**Current Assets**

|                                   |                     |
|-----------------------------------|---------------------|
| Cash                              | \$104,079.98        |
| Accounts Receivable               | 2,842,468.47        |
| Deposits                          |                     |
| Notes Receivable-Related Entities | 1,993,357.87        |
| Notes Receivable-Partners         | 1,119,400.40        |
| Total Current Assets              | <u>6,059,306.72</u> |

**Plant & Equipment**

|                              |                    |
|------------------------------|--------------------|
| Office Furniture & Equipment | 83,510.09          |
| Leasehold Improvements       | 117,922.41         |
| Reserve for Depreciation     | <u>(97,225.27)</u> |
| Net Capital Equipment        | 104,207.23         |

|                     |                            |
|---------------------|----------------------------|
| <b>Total Assets</b> | <b><u>6,163,513.95</u></b> |
|---------------------|----------------------------|

**Current Liabilities**

|                                      |                     |
|--------------------------------------|---------------------|
| Accounts Payable                     | 332,548.26          |
| Accrued Expenses                     | 24,831.00           |
| Loan Payable-Related Entities        | 6,799,811.37        |
| Accrued Retirement Plan Contribution | 103,319.75          |
| Total Current Liabilities            | <u>7,260,510.38</u> |

**Equity Accounts**

|                                       |                            |
|---------------------------------------|----------------------------|
| Retained Earnings                     | 7,204,677.60               |
| Partners Equity                       | 388,287.90                 |
| Members Distributions                 | (15,680,354.47)            |
| Net Income                            | 6,990,392.54               |
| Total Equity                          | <u>(1,096,996.43)</u>      |
| <b>Total Liabilities &amp; Equity</b> | <b><u>6,163,513.95</u></b> |

**ADVANCED RADIOLOGY MRI CENTERS, LP**  
For the Twelve Months Ending Thursday, December 31, 2015

|                                 | <u>2015</u>          |
|---------------------------------|----------------------|
| <b><u>Revenue</u></b>           |                      |
| Fee Income                      | \$ 39,108,970        |
| Adjustments                     | (21,393,340)         |
| Interest Income                 | 51,552               |
| Gain on Sale of Asset           | (45,806)             |
| Other Income                    | 34,580               |
| Bad Debt Recovery               | 337,346              |
| <b>Total Income</b>             | <b>\$ 18,093,301</b> |
| <br>                            |                      |
| <b><u>Expenses</u></b>          |                      |
| Professional Component          | 3,423,927            |
| Total Employee Expenses         | 2,183,068            |
| Total Medical Supplies          | 327,992              |
| Equipment Cost                  | 2,014,341            |
| Total Facility and Occupancy    | 367,811              |
| Information Technology Services | 264,856              |
| Business Support                | 2,203,931            |
| Billing Services                | 237,657              |
| Total Other Expenses            | 79,248               |
| <br>                            |                      |
| <b>Total Expenses</b>           | <b>\$ 11,102,831</b> |
| <br>                            |                      |
| <b>Net Income</b>               | <b>\$ 6,990,470</b>  |

# ***EXHIBIT K***

Assumptions used in developing the financial projections are as follows:

**2016 Projected Volume**

| PROJECTED VOLUME |         |         |         |
|------------------|---------|---------|---------|
| FY 2016          | FY 2017 | FY 2018 | FY 2019 |
| 6947             | 7,294   | 7,658   | 8,041   |

**STAMFORD MRI**

**2015 Ave. Net Per Procedure**

Net Revenue 638  
 4,432,186  
 Net Rev % Based on 2015 49.8%  
 Gross Revenue Calculated based on net Rev/Net Rev % 8,891,104.12

**Projected incremental volume**

**2015 Ave. Net Per Procedure**

|   | FY 2017    | FY 2018    | FY 2019      | Breakeven    |
|---|------------|------------|--------------|--------------|
| Net Revenue   | 638        | 638        | 638          | 638          |
| Net Rev % Based on 2015   | 221,386.00 | 453,618.00 | 697,972.00   | 1,228,150.00 |
| Gross Revenue Calculated based on net Rev/Net Rev %               | 444,107.26 | 909,971.93 | 1,400,153.72 | 2,463,707.42 |
| Allowances based on Historical Contractual Allowance Average Rate | 222,721.26 | 456,353.93 | 702,181.72   | 1,235,557.42 |
|   | 221,386.00 | 453,618.00 | 697,972.00   | 1,228,150.00 |

The Total Government and Total Non-Government Patient Service Revenue is based on 2015 actual results and projected out to years 2016 through 2019 for current volume and incremental volume.

Bad Debt is based on 2% Historical Rate for all years

A standard 3% annual increase is assumed for employees salaries and benefits without the proposed scanner.

The incremental cost of additional MRI staff for the proposed MRI is based on current employee costs.

Physician fees are based on 19% of net collections on projected volume with or without the Proposed Scanner.

Supplies and Drugs are based on the 2015 actual results and projected out to years 2016 through 2019 for current volume and incremental volume.

The incremental Depreciation and amortization is based on the purchase of the GE 3T MRI depreciated over 7 years on a straight line basis. The estimated construction and installation costs have been estimated at \$410,000 with depreciation over 39 years using the straight line method.

**Projection**

|                   |              |            |  |
|-------------------|--------------|------------|--|
| GE 3T Quote       | 2,500,000.00 | 410,000.00 | Based on 2,000 square feet at \$175/sq. ft. (Average Medical BO Cost) plus 60k for shielding |
| 7 years           | 7            | 39         |  |
| Depreciation      | 357,142.86   | 10,512.82  | 367,655.68 Depreciation  |
| Interest 1st year | 65,000.00    |            |  |

Supplies and drugs are directly related to volume and adjust directly based on projected volume with or without the Proposed Scanner.

Lease expenses are based on the Current MRI lease schedule.

Projected utilization without the Proposed MRI is based on a 0.0% annual Growth. Based on the Practice's current High utilization rate, potential growth is limited. Growth with the proposed MRI is based on 5.0% growth.

"Other Operating Expenses" listed in the Financial Form are inclusive of:

Office Supplies, Dues & Subscriptions, Postage, Accounting, Accreditation Fees, Travel, Billing Services, Business Office Support and IT support. These costs are estimated based on 2015 actual expenses incurred with a 3% increase.

Additional Rent is estimated at \$60,000 per year.

# *EXHIBIT L*

|                                       | CT | Breast Imaging | DEXA Bone Density Screening | MRI | Nuclear Medicine | Pediatric Imaging | PET/CT | Ultrasound | Vascular Imaging & Intervention | X-ray |
|---------------------------------------|----|----------------|-----------------------------|-----|------------------|-------------------|--------|------------|---------------------------------|-------|
| 1055 Post Road, Fairfield             | X  | X              |                             | X   |                  | X                 |        | X          | X                               | X     |
| 297 Boston Post Road, Orange          |    |                |                             | X   |                  | X                 |        | X          | X                               | X     |
| 4 Corporate Drive, Suite 182, Shelton | X  | X              |                             | X   |                  | X                 |        | X          |                                 | X     |
| 1315 Washington Boulevard, Stamford   | X  | X              |                             | X   |                  | X                 |        | X          | X                               | X     |
| 2876 Main Street, Stratford           | X  | X              | X                           | X   |                  | X                 |        | X          | X                               | X     |
| 15 Corporate Drive, Trumbull          |    | X              | X                           | X   | X                | X                 | X      | X          | X                               | X     |



## Internal Medicine of Stamford, PC

David M. Radin, MD

27 Oak Street  
Stamford, CT 06905

203-359-4888 Voice  
203-359-6983 Fax  
dradinmd@gmail.com

June 7, 2016

Hon. Raul Pino M.D.  
Commissioner of Public Health  
Department of Public Health  
410 Capitol Avenue  
Post Office Box 340308  
Hartford, CT 06134-0308



Re: Docket Number: 1215726-CON

Dear Commissioner Pino:

I am writing to express my strong support for the Certificate of Need application filed by Advanced Radiology to acquire a new 3 Tesla MRI.

My patients have used Advanced Radiology for many years. I have always been impressed by the professionalism and dedication of the entire staff. The organization by far is the easiest I have worked with and both the Radiologists and support staff are extremely accessible and helpful. My patients have benefited from the outpatient setting and lower cost without any loss of medical skill or diagnostic value. The use of MRI has expanded and there are specific application of 3 Tesla high field strength magnet that provide better information to reach the correct diagnosis and treatment sooner. Approving this application will have enormous benefits to our community.

I support this project and I urge the Office of Healthcare Access to approve the Certificate of Need application.

Thank you.

Regards,

David M. Radin, M.D.

## Greer, Leslie

---

**From:** Fernandes, David  
**Sent:** Friday, July 08, 2016 2:02 PM  
**To:** jfusco@uks.com  
**Cc:** Greer, Leslie; Lazarus, Steven; Veyberman, Alla; Riggott, Kaila; Martone, Kim  
**Subject:** 16-32093-CON Completeness Letter  
**Attachments:** 16-32093-Final Completeness Letter.docx

Good afternoon Ms. Fusco,

Please see the attached completeness letter in the matter of the proposed acquisition of a 3.0 Tesla MRI by Advance Radiology MRI Center. In responding to the completeness letter questions, please follow the instructions included in the letter and provide the response document as an attachment only (no hard copies required). Please provide your written responses to OHCA as soon as possible.

Email to [OHCA@ct.gov](mailto:OHCA@ct.gov) and cc: [David.Fernandes@ct.gov](mailto:David.Fernandes@ct.gov), [Steven.Lazarus@ct.gov](mailto:Steven.Lazarus@ct.gov) and [Kaila.Riggott@ct.gov](mailto:Kaila.Riggott@ct.gov).

If you have any questions regarding the completeness letter, please contact David Fernandes (860) 418-7032 or Kaila Riggott at (860) 418-7037.

Please confirm receipt of this email and corresponding attachments (completeness letter, main application and financial workbook).

### David Fernandes

Planning Analyst (CCT)  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, Hartford, Connecticut 06134  
P: (860) 418-7032 | F: (860) 418-7053 | E: [David.Fernandes@ct.gov](mailto:David.Fernandes@ct.gov)



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.  
Acting Commissioner

Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Office of Health Care Access

July 8, 2016

VIA EMAIL ONLY

Ms. Jennifer G. Fusco  
Attorney  
Updike, Kelly & Spellacy, P.C.,  
265 Church Street  
New Haven, CT 06510

RE: Certificate of Need Application; Docket Number: 16-32093-CON  
Acquisition of a 3.0 Tesla MRI Unit by Advanced Radiology MRI Center  
Completeness Letter

Dear Ms. Fusco:

On June 14, 2016, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application filing on behalf of Advance Radiology MRI Centers ("ARC"). This proposal requests authorization to acquire a G.E. Signa Pioneer 3.0 Tesla MRI unit with an associated capital expenditure of \$2,916,224.

OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email. **Please email your responses to all of the following email addresses: [OHCA@ct.gov](mailto:OHCA@ct.gov), [David.Fernandes@ct.gov](mailto:David.Fernandes@ct.gov), [Steven.Lazarus@ct.gov](mailto:Steven.Lazarus@ct.gov) and [Kaila.Riggott@ct.gov](mailto:Kaila.Riggott@ct.gov).**

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than **September 6, 2016**, otherwise your application will be automatically considered withdrawn.



Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611  
410 Capitol Avenue, P.O. Box 340308  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 146** and reference "**Docket Number: 16-32093-CON.**"

1. Please submit MRI utilization along with capacity for fiscal year ("FY") 2012, as this information was omitted from page 13 of the application.
2. Explain why more complicated scans such as scans that use contrast and arthrograms are performed only during traditional business hours.
3. Page 31 of the application indicates an additional 1,925 scans would be required to achieve an incremental gain. When is the proposed scanner projected to achieve the 1,925 scans?
4. Please explain in detail ARC's image sharing network and how it anticipates to lessen duplication of patient services as noted on page 35 of the application.
5. Other than the Fairfield location, what other ARC locations have received patients from ARC's Stamford location? Provide patient town of origin by site.
6. Please provide the primary service area for all of ARC's MRI centers.
7. Has an assessment documenting the utilization of all of ARC's scanners, including the possibility of relocating an under-utilized scanner to a high volume area been performed? Please detail the findings and provide a copy.
8. Page 25 of the application lists Bridgeport along with other existing MRI units within the Bridgeport area, but the Bridgeport unit is missing from Table A on page 48. Please add the missing location along with its corresponding information to Table A.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7032, or Kaila Riggott at (860) 418-7037.

## Greer, Leslie

---

**From:** Jennifer Groves Fusco <jfusco@uks.com>  
**Sent:** Friday, July 08, 2016 3:42 PM  
**To:** Fernandes, David  
**Cc:** Greer, Leslie; Lazarus, Steven; Veyberman, Alla; Riggott, Kaila; Martone, Kim  
**Subject:** RE: 16-32093-CON Completeness Letter

Hi, David.

I received this email. The only document attached was the completeness letter. Were other documents supposed to be attached?

We will get you response as soon as possible.

Thanks and have a nice weekend!

Jen

---

**From:** Fernandes, David [<mailto:David.Fernandes@ct.gov>]  
**Sent:** Friday, July 08, 2016 2:02 PM  
**To:** Jennifer Groves Fusco  
**Cc:** Greer, Leslie; Lazarus, Steven; Veyberman, Alla; Riggott, Kaila; Martone, Kim  
**Subject:** 16-32093-CON Completeness Letter

Good afternoon Ms. Fusco,

Please see the attached completeness letter in the matter of the proposed acquisition of a 3.0 Tesla MRI by Advance Radiology MRI Center. In responding to the completeness letter questions, please follow the instructions included in the letter and provide the response document as an attachment only (no hard copies required). Please provide your written responses to OHCA as soon as possible.

Email to [OHCA@ct.gov](mailto:OHCA@ct.gov) and cc:[David.Fernandes@ct.gov](mailto:David.Fernandes@ct.gov), [Steven.Lazarus@ct.gov](mailto:Steven.Lazarus@ct.gov) and [Kaila.Riggott@ct.gov](mailto:Kaila.Riggott@ct.gov).

If you have any questions regarding the completeness letter, please contact David Fernandes (860) 418-7032 or Kaila Riggott at (860) 418-7037.

Please confirm receipt of this email and corresponding attachments (completeness letter, main application and financial workbook).

**David Fernandes**  
Planning Analyst (CCT)  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, Hartford, Connecticut 06134  
P: (860) 418-7032 | F: (860) 418-7053 | E: [David.Fernandes@ct.gov](mailto:David.Fernandes@ct.gov)

## Greer, Leslie

---

**From:** Lazarus, Steven  
**Sent:** Monday, July 18, 2016 7:24 AM  
**To:** Greer, Leslie  
**Cc:** Veyberman, Alla  
**Subject:** FW: Advanced Radiology Docket No. 16-32093-CON -- Completeness Question Responses  
**Attachments:** DOCS-#1318574-v1-ADRAD\_STAMFORD\_CQR\_FINAL\_(PDF2).PDF; DOCS-#1318572-v1-ADRAD\_STAMFORD\_MRI\_CQR\_FINAL.docx

FYI-

Steve

### *Steven W. Lazarus*

Associate Health Care Analyst  
Division of Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue  
Hartford, CT 06134  
Phone: 860-418-7012  
Fax: 860-418-7053



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**From:** Jennifer Groves Fusco [<mailto:jfusco@uks.com>]  
**Sent:** Sunday, July 17, 2016 9:23 AM  
**To:** User, OHCA; Fernandes, David; Lazarus, Steven; Riggott, Kaila  
**Cc:** Martone, Kim  
**Subject:** Advanced Radiology Docket No. 16-32093-CON -- Completeness Question Responses

All:

Attached please find both Word and PDF versions of Advanced Radiology's response to OHCA's July 8<sup>th</sup> completeness questions. Please let me know if you need any additional information.

Thanks,  
Jen

Jennifer Groves Fusco, Esq.  
Principal  
Updike, Kelly & Spellacy, P.C.  
One Century Tower  
265 Church Street

New Haven, CT 06510  
Office (203) 786.8316  
Cell (203) 927.8122  
Fax (203) 772.2037  
[www.uks.com](http://www.uks.com)



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**Advanced Radiology MRI Centers Limited Partnership  
Acquisition of 3.0 Tesla MRI Unit for Stamford Office  
Docket No. 16-32093-CON  
Completeness Question Responses**

1. Please submit MRI utilization along with capacity for fiscal year (“FY”) 2012, as this information was omitted from page 13 of the application.

**RESPONSE:**

The MRI unit operating at Advanced Radiology’s Stamford office performed 6,242 scans in FY 2012. This equates to 156% capacity based upon the SHP estimated capacity of an MRI unit, which is 4,000 scans per year. The FY 2012 MRI volume represents an 18% increase over FY 2011, when the Stamford unit performed 5,285 scans and operated at 132% capacity. As you can see, over the last 5 years the MRI service in Stamford has far exceeded the volume required to justify acquisition of a second unit.

2. Explain why more complicated scans such as scans that use contrast and arthrograms are performed only during traditional business hours.

**RESPONSE:**

There are a number of reasons why complicated scans are only scheduled during normal business hours, mostly having to do with physician coverage. Many of these scans require a physician to be in attendance to perform an ancillary procedure, such as an injection of contrast into a joint. For other scans involving intravenous contrast, a physician must be in attendance in order to provide immediate medical attention in the event that the patient has an untoward reaction. Moreover, if a patient does have an adverse reaction it is easier to access their referring physicians and providers during normal business hours. Lastly, a physician needs to be on-site for certain examinations to oversee the technologist’s selection of technical parameters and/or to determine if the studies are complete or require additional “views.” As Advanced Radiology provides 24-hour coverage at two hospitals, the practice does not have the physician personnel to provide after-hours coverage for its offices as well.

In addition to physician coverage issues, some of the MRI examinations require the coordination of multiple clinical resources and personnel (i.e. the use of multiple rooms staffed by different personnel), which can best be accomplished during normal business hours. Furthermore, in cases where tissue samples are taken it is Advanced Radiology’s practice to have the specimens sent out immediately for pathology review. Scheduling these types of procedures at night or on weekends can delay lab results and diagnoses.

3. Page 31 of the application indicates an additional 1,925 scans would be required to achieve an incremental gain. When is the proposed scanner projected to achieve the 1,925 scans?

**RESPONSE:**

The MRI service in Stamford will need to perform 1,925 incremental scans to see a gain from operations with the acquisition of a second unit. These scans will be roughly evenly distributed between the two scanners. The service expects to reach approximately 1,925 incremental scans by FY 2021, based on projected 5% annual growth.

4. Please explain in detail ARC's image sharing network and how it anticipates to lessen duplication of patient services as noted on page 35 of the application.

**RESPONSE:**

Advanced Radiology has an extensive data network that facilitates the electronic exchange of medical orders and results (reports and images) between several physician groups, healthcare systems (including Yale-New Haven Health System, St. Vincent's Medical Center and The Stamford Hospital) and Advanced Radiology. This electronic exchange of medical orders and results minimizes scheduling effort, data entry redundancies and errors, duplicative procedures performed, and time spent waiting on results. Further, Advanced Radiology shares medical imaging and reports in real time with thousands of physicians in Connecticut and beyond via an Internet-enabled clinical viewer, physician web portal and mobile apps. Both physicians and patients can securely share images with anyone for whom they have an e-mail address, allowing continuity of care as patients see a range of healthcare professionals in Connecticut and beyond. Advanced Radiology's patient portal currently has 120,000 active patient users while new patients are registering at a rate of approximately 3,000 patients per month.

This type of image sharing is critically important to patient care and "ownership" of their healthcare. This is particularly relevant in a state like Connecticut where hospitals and providers are located in close proximity and patients may see multiple physicians, or visit multiple facilities, that do not utilize the same EMR systems. The network that Advanced Radiology has created allows patients and all of these physicians and providers to access patient images and reports regardless of the EMR systems in place and to do it from anywhere. An image sharing network is also beneficial to Connecticut residents who choose to travel to major medical centers in New York and Boston for second opinions and for the many residents who travel out of state during the winter months.

Advanced Radiology is at the forefront of private physician practices nationwide in the implementation of EMR and a comprehensive image sharing network. The practice was one of two radiology practices in the country to receive accreditation in the first month of the EMR Meaningful Use program. Dr. Alan Kaye, the practice's former President, has given presentations on image sharing and patient portals to the American College of Radiology and in connection with a Connecticut State Innovation Model (SIM) grant. Advanced Radiology was also the first private practice selected to participate in a Radiology Society of North America

collaborative on image sharing that involved major academic medical centers such as Johns Hopkins, Massachusetts General, Mt. Sinai, and several others.

The image sharing network that Advanced Radiology pioneered differs from traditional EMR systems. EMR systems allow communication between physicians and have traditionally been utilized to document the information required to support payment. But many EMR systems exclude images or handle them in a proprietary way. Having an image sharing network that allows physicians to access a patient's records anywhere, at any time, from almost any mobile device empowers those physicians with the information necessary to provide timely and appropriate treatment for their patients. Advanced Radiology is aware of one physician who was able to view his patients records while on vacation in Europe and to arrange for necessary follow-up care. Similarly, the portal aspect of the image sharing network empowers patients through the ownership and portability of their images and reports. Advanced Radiology often receives inquiries from patients looking for clarification of information in their records or a comparison of information received from multiple providers. This type of interoperability and data sharing is consistent with the goals of the Affordable Care Act and recently passed State of Connecticut legislation aimed at the free flow of electronic health information.

Advanced Radiology's image sharing network lessens the duplication of services by ensuring that a patient's exam results and images are available to any care provider who needs them. This avoids the need for a patient to have a repeat MRI scan if they are living in Florida for the winter, for example, and a local physician needs diagnostic information. That physician can simply access the results of the patient's MRI scan through Advanced Radiology's image sharing network and avoid the increased cost and exposure, and delay in diagnosis and treatment, associated with duplicating the study. In addition, as mentioned in the CON application, this network enhances quality of care by ensuring timely diagnosis and rapid clinical decision making and allowing for coordination of care among a patient's many healthcare providers.

This commitment to enabling and empowering patients and physicians with health information is one of the reasons why they chose Advanced Radiology and why the practice's MRI units are consistently busy. Advanced Radiology offers high-quality, cost-effective MRI services with access to subspecialty trained radiologists and full portability of images and reports. These reasons also support approving the acquisition of a second MRI for Advanced Radiology's Stamford office where the entire community will be ensured of access, not just select patients.

5. Other than the Fairfield location, what other ARC locations have received patients from ARC's Stamford location? Provide patient town of origin by site.

**RESPONSE:**

Advanced Radiology uses a centralized scheduling system to schedule all types of exams and procedures, including those involving MRI. Through this system a patient or the patient's physician if the patient requests that the physician's office handle scheduling, calls and requests an MRI scan at the office of his or her choosing. If a patient requests an MRI scan in Stamford

he or she will be given the next available appointment time at which the type of scan ordered can be performed. If a patient cannot be accommodated in a timely fashion in Stamford, either because they do not want to wait for the next available appointment or the physician wants the patient to be seen before the next available appointment, the scheduler will begin checking availability at other Advanced Radiology offices.

MRI patient overflow from Stamford – meaning patients who express a preference to have their scans performed in Stamford but who cannot be accommodated in that office in a timely fashion – is handled at all of Advanced Radiology’s other MRI locations. Many of the patients who request scans in Stamford are from lower Fairfield County and likely opt for the Fairfield office as it is the next closest Advanced Radiology office that offers MRI. Keep in mind, however, that the Fairfield office is very busy, as are the Advanced Radiology MRI services in Stratford and Trumbull. This means that patients who want to be examined in Stamford might be referred as far as Orange or Shelton, 30 to 40 miles from Stamford, for their MRI scans. Asking patients from the Stamford area to travel to the Fairfield/Bridgeport area for their scans can be a significant hardship given the traffic congestion on I-95 and the Merritt Parkway in Fairfield County, which is unrelenting for all but a few hours each day. Asking these patients to travel farther, to Advanced Radiology’s offices in Orange and Shelton, can be even more of a hardship with added traffic in the greater New Haven area. Given that Governor Malloy is tasked with reducing automobile traffic on our roads and highways this is incongruent with his goal.

Advanced Radiology does not keep track of the number of patients who request Stamford as their first choice for MRI, the offices to which they are ultimately referred if they cannot be accommodated in Stamford, or where those patients reside. Anecdotally, Advanced Radiology is aware that there are a significant number of patients who cannot be accommodated in Stamford due to how busy the MRI unit has become. Given historical referral patterns, many of these patients originate from the greater Stamford area.

6. Please provide the primary service area for all of ARC’s MRI centers.

**RESPONSE:**

These towns represent the lowest number of contiguous ZIP codes that comprised at least 75% of MRI volume at each Advanced Radiology office location in FY 2015.

| <b>ARC MRI LOCATION</b>                       | <b>PRIMARY SERVICE AREA</b>   |
|---|---|
| <p>1055 Post Road<br/>Fairfield, CT 06824</p> | <p>Fairfield (32.85%)<br/>Bridgeport (21.30%)<br/>Westport (8.24%)<br/>Trumbull (5.04%)<br/>Weston (2.50%)<br/>Easton (2.36%)<br/>Stratford (2.33%)<br/>Shelton (2.31%)</p> |

| <b>ARC MRI LOCATION</b>                                   | <b>PRIMARY SERVICE AREA</b>  |
|---|--|
| <p>297 Boston Post Road<br/>Orange, CT 06477</p>          | <p>Milford (21.20%)<br/>West Haven (14.14%)<br/>Orange (7.24%)<br/>Stratford (6.20%)<br/>Shelton (4.64%)<br/>Trumbull (3.57%)<br/>Ansonia (2.60%)<br/>Monroe (2.32%)<br/>Derby (2.11%)<br/>Seymour (2.01%)<br/>East Haven (1.94%)<br/>Bridgeport (1.80%)<br/>New Haven (1.56%)<br/>Woodbridge (1.39%)<br/>Fairfield (1.35%)<br/>Westport (1.21%)</p> |
| <p>4 Corporate Drive, Suite 182<br/>Shelton, CT 06484</p> | <p>Shelton (38.56%)<br/>Seymour (7.39%)<br/>Ansonia (7.16%)<br/>Trumbull (5.77%)<br/>Derby (4.86%)<br/>Oxford (3.88%)<br/>Stratford (3.69%)<br/>Monroe (3.43%)<br/>Bridgeport (2.98%)</p>  |
| <p>2867 Main Street<br/>Stratford, CT 06614</p>           | <p>Stratford (32.56%)<br/>Bridgeport (27.74%)<br/>Milford (5.98%)<br/>Shelton (5.21%)<br/>Trumbull (3.77%)</p>   |
| <p>15 Corporate Drive<br/>Trumbull, CT 06611</p>          | <p>Trumbull (26.64%)<br/>Monroe (16.42%)<br/>Shelton (10.33%)<br/>Bridgeport (10.08%)<br/>Fairfield (5.55%)<br/>Stratford (4.50%)<br/>Easton (2.55%)</p>   |

7. Has an assessment documenting the utilization of all of ARC's scanners, including the possibility of relocating an under-utilized scanner to a high volume area been performed? Please detail the findings and provide a copy.

**RESPONSE:**

Advanced Radiology has performed various internal analyses of the utilization and capacity of the MRI units operating at each of its office locations. This includes a determination of when "flex capacity" is required at any given site, where hours are extended as practicable to meet increased MRI demand in an office on any given week. Based on these analyses, and considering the ability to flex hours and staffing as required to ensure that patients are being served as expeditiously as possible, none of Advanced Radiology's MRI units is presently underutilized.

As mentioned in the CON application the Fairfield, Stratford and Trumbull units are operating in excess of 100% capacity based on SHP benchmarks. The Fairfield MRI unit performed 6,685 scans in FY 2015, which translates to 167% capacity, making it the busiest unit in the practice for that year. The Stratford MRI unit performed 5,433 scans (136% capacity) in FY 2015 and the Trumbull unit performed 5,139 scans (128% capacity). Each of these units has far exceeded the 85% capacity threshold that justifies acquisition of an additional MRI unit for use in its primary service area. In fact, Advanced Radiology is currently assessing whether and to what extent it needs to add MRI capacity in and around these markets. So relocating one of these units is not a viable option.

The Orange and Shelton MRI units perform fewer scans on an annual basis however neither is underutilized. The Orange unit performed 2,886 scans in FY 2015, which is 72% of available capacity based on SHP standards. The Shelton unit performed 2,653 scans, which is 66% of available capacity. Both units are well-utilized and serve a broad array of referring physicians and providers in their respective service areas. To relocate either one of these units would result in a reduction in access for these communities. The Orange and Shelton units serve communities that are not served in large part by the practice's other MRI units, including the Greater New Haven area (i.e. West Haven, New Haven, East Haven, & Woodbridge) and the Valley (i.e. Ansonia, Derby, Seymour, & Oxford). Note also that since June of 2014, Advanced Radiology has served 387 Medicaid and uninsured MRI patients in Orange and 365 Medicaid and uninsured MRI patients in Shelton. The significant number of scans performed at the Orange and Shelton offices could not be absorbed by other Advanced Radiology units, which are already operating well above optimal capacity. Nor could the volume from the Orange and Shelton offices be combined on a single unit, because that unit would have to perform 5,539 scans or operate at 138% capacity to accommodate just current volume.

The analyses performed by Advanced Radiology have never been compiled into a document or summarized in a form that is producible to OHCA. They are ongoing internal business analyses and discussions among Advanced Radiology physicians and administrative staff.

8. Page 25 of the application lists Bridgeport along with other existing MRI units within the Bridgeport area, but the Bridgeport unit is missing from Table A on page 48. Please add the missing location along with its corresponding information to Table A.

**RESPONSE:**

The reference to a Bridgeport MRI unit on page 25 of the CON application is a typographical error. The sentence was referring to a Trumbull MRI unit and should have read: “It is easier to schedule patients from the greater Bridgeport area among existing units in Fairfield, Stratford, *Trumbull*, and Shelton.” Advanced Radiology’s Trumbull unit is listed on Table A at p. 48 of the application.

## Greer, Leslie

---

**From:** Fernandes, David  
**Sent:** Thursday, July 21, 2016 8:30 AM  
**To:** Jennifer Groves Fusco  
**Cc:** Riggott, Kaila; Lazarus, Steven; Veyberman, Alla; Greer, Leslie  
**Subject:** CON-32093 Deemed Complete  
**Attachments:** 15-32093-CON Notification of Application Deemed Complete.docx

Good Morning Ms. Fusco:

Please see the attached letter deeming complete the above reference application. Please confirm receipt of this correspondence as soon as possible.

If you have any questions, do not hesitate to contact me.

Thanks,

### David Fernandes

Planning Analyst (CCT)  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, Hartford, Connecticut 06134  
P: (860) 418-7032 | F: (860) 418-7053 | E: [David.Fernandes@ct.gov](mailto:David.Fernandes@ct.gov)



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.  
Commissioner



Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Office of Health Care Access

July 21, 2016

Via Email Only

Ms. Jennifer G. Fusco  
Attorney  
Updike, Kelly & Spellacy, P.C.,  
265 Church Street  
New Haven, CT 06510

RE: Certificate of Need Application; Docket Number: 16-32093-CON  
Acquisition of a 3.0 Tesla MRI Unit by Advanced Radiology MRI Centers  
Completeness Letter

Dear Ms. Fusco:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of July 20, 2016.

If you have any questions concerning this letter, please feel free to contact Kaila Riggott or me at (860) 418-7001.

Sincerely,

*David Fernandes*

David Fernandes  
Planning Analyst (CCT)



Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611  
410 Capitol Avenue, P.O. Box 340308  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

## Greer, Leslie

---

**From:** Jennifer Groves Fusco <jfusco@uks.com>  
**Sent:** Friday, July 22, 2016 8:29 AM  
**To:** Fernandes, David  
**Cc:** Riggott, Kaila; Lazarus, Steven; Veyberman, Alla; Greer, Leslie  
**Subject:** RE: CON-32093 Deemed Complete

Received, thank you.

Jen

---

**From:** Fernandes, David [David.Fernandes@ct.gov]  
**Sent:** Thursday, July 21, 2016 8:30 AM  
**To:** Jennifer Groves Fusco  
**Cc:** Riggott, Kaila; Lazarus, Steven; Veyberman, Alla; Greer, Leslie  
**Subject:** CON-32093 Deemed Complete

Good Morning Ms. Fusco:

Please see the attached letter deeming complete the above reference application. Please confirm receipt of this correspondence as soon as possible.

If you have any questions, do not hesitate to contact me.

Thanks,

**David Fernandes**

Planning Analyst (CCT)  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, Hartford, Connecticut 06134  
P: (860) 418-7032 | F: (860) 418-7053 | E: [David.Fernandes@ct.gov](mailto:David.Fernandes@ct.gov)



---

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# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.  
Commissioner

Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

### Office of Health Care Access

TO: Kevin Hansted, Hearing Officer

FROM: Raul Pino M.D., M.P.H., Commissioner 

DATE: July 25, 2016

RE: Certificate of Need Application; Docket Number: 16-32093-CON  
Advance Radiology MRI Center  
Acquisition of a 3.0 Tesla MRI Unit

---

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.



Phone: (860) 418-7001 • Fax: (860) 418-7053  
410 Capitol Avenue, MS#13HCA  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

## Greer, Leslie

---

**From:** Greer, Leslie  
**Sent:** Friday, August 05, 2016 9:08 AM  
**To:** michelemlvolpe@aol.com  
**Cc:** Lazarus, Steven; Veyberman, Alla; Fernandes, David; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Olejarz, Barbara  
**Subject:** DN: 16-32063-CON Hearing Notice and Order  
**Attachments:** 32063 Hearing Notice.pdf; 32063 and 32093 Order.pdf

Attorney Volpe,

Attached is the hearing notice for Orthopaedic & Neurosurgery Specialists, P.C. and the Order by the Department of Public Health, Office of Health Care Access dated August 5, 2016.

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
*Website:* [www.ct.gov/ohca](http://www.ct.gov/ohca)



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.  
Commissioner



Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

### Office of Health Care Access

August 5, 2016

Jennifer G. Fusco, Esq.  
Updike, Kelly & Spellacy, P.C.  
265 Church Street  
New Haven, CT 06510

RE: Certificate of Need Application Docket Number 16-32093-CON  
Advanced Radiology MRI Centers  
Acquisition of a Second Magnetic Resonance Imaging Scanner  
Applicant Hearing Notice

Dear Attorney Fusco,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Advanced Radiology MRI Centers ("Applicant") on July 20, 2016 the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant: Advanced Radiology MRI Centers

Docket Number: 16-32093-CON

Proposal: Acquisition of a Second Magnetic Resonance Imaging Scanner



Phone: (860) 418-7001 • Fax: (860) 418-7053  
410 Capitol Avenue, MS#13HCA  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: August 30, 2016

Time: 10:00 a.m.

Place: Department of Public Health, Office of Health Care Access  
470 Capitol Avenue, Conference Room A/B  
Hartford, CT 06134

The Applicants are designated as parties in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in *The Advocate* pursuant to General Statutes § 19a-639a (f).

All Applicants and Intervenors are reminded that The Office of Health Care Access division of the Department of Public Health follows the Rules of Practice under section 19a-9-1, et seq., of the Regulations of Connecticut State Agencies.

Sincerely,



Kimberly R. Martone  
Director of Operations  
Enclosure

cc: Henry Salton, Esq., Office of the Attorney General  
Antony Casagrande, Department of Public Health  
Kevin Hansted, Department of Public Health  
Wendy Furniss, Department of Public Health  
Maura Downes, Department of Public Health  
Jill Kentfield, Department of Public Health  
Chris Stan, Department of Public Health  
DeVaughn Ward, Department of Public Health  
Marielle Daniels, Connecticut Hospital Association

KRM:DF:SWL:img

# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.  
Commissioner

Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Office of Health Care Access

August 5, 2016

P.O. #54772

The Advocate  
75 Tresser Boulevard  
Stamford, CT 06904

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than Monday, **August 8, 2016**. Please provide the following within 30 days of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

A handwritten signature in black ink, appearing to read "Kim Martone".

---

Kimberly R. Martone  
Director of Operations

Attachment

cc: Danielle Pare, DPH  
Marielle Daniels, Connecticut Hospital Association

KRM:DF:SWL;lmg



Phone: (860) 418-7001 • Fax: (860) 418-7053  
410 Capitol Avenue, MS#13HCA  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearings

Statute Reference: 19a-638

Applicant(s): Orthopedic and Neurosurgery Specialists, PC  
Advanced Radiology MRI Centers

Town: Stamford

Docket Number(s): 16-32063-CON and 16-32093-CON

Proposal: Acquisition of a Second Magnetic Resonance Imaging Scanner

Date: August 30, 2016

Time: 10:00 a.m.

Place: Department of Public Health, Office of Health Care Access  
470 Capitol Avenue, Conference Room A/B  
Hartford, CT 06134

Any person who wishes to request status in the above listed public hearing may file a written petition no later than August 25, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at [www.ct.gov/ohca](http://www.ct.gov/ohca) for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

**From:** [Jennifer Groves Fusco](#)  
**To:** [Greer, Leslie](#)  
**Cc:** [Lazarus, Steven](#); [Fernandes, David](#); [Veyberman, Alla](#); [Riggott, Kaila](#); [Hansted, Kevin](#); [Martone, Kim](#); [Olejarz, Barbara](#)  
**Subject:** RE: DN: 16-32093-CON Hearing Notice and Order  
**Date:** Friday, August 05, 2016 9:28:37 AM

---

Thanks, Leslie.

Jennifer Groves Fusco  
Principal  
Updike, Kelly & Spellacy, P.C.

---

**From:** Greer, Leslie  
**Sent:** Friday, August 05, 2016 9:11:26 AM  
**To:** Jennifer Groves Fusco  
**Cc:** Lazarus, Steven; Fernandes, David; Veyberman, Alla; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Olejarz, Barbara  
**Subject:** DN: 16-32093-CON Hearing Notice and Order

Attorney Fusco,

Attached is the hearing notice for Advanced Radiology MRI Centers and the Order by the Department of Public Health, Office of Health Care Access dated August 5, 2016.

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
*Website:* [www.ct.gov/ohca](http://www.ct.gov/ohca)



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Updike, Kelly & Spellacy, P.C.

## Greer, Leslie

---

**From:** ADS <ADS@graystoneadv.com>  
**Sent:** Friday, August 05, 2016 11:50 AM  
**To:** Greer, Leslie  
**Subject:** Re: Hearing Notices DN's 16-32063-CON and 16-32093-CON

Good day!

Thanks so much for your ad request.  
We will be in touch shortly and look forward to serving you.

***As a reminder, Graystone offers a wide range of diversity sources, don't hesitate to ask for options for this or future requests.***

PLEASE NOTE: New Department of Labor guidelines allow web based advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for \$115.00/web site. If required, notify Graystone when ad placement is approved.

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We sincerely appreciate your business.

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Bridgeport, CT 06604  
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Fax: 203-549-0061

**E-mail new ad requests to:** [ads@graystoneadv.com](mailto:ads@graystoneadv.com)  
<http://www.graystoneadv.com/>

---

**From:** "Greer, Leslie" <[Leslie.Greer@ct.gov](mailto:Leslie.Greer@ct.gov)>  
**Date:** Friday, August 5, 2016 at 8:55 AM  
**To:** Ads Desk <[ads@graystoneadv.com](mailto:ads@graystoneadv.com)>  
**Cc:** "Olejarz, Barbara" <[Barbara.Olejarz@ct.gov](mailto:Barbara.Olejarz@ct.gov)>  
**Subject:** Hearing Notices DN's 16-32063-CON and 16-32093-CON

Please run the attached hearing notice in The Advocate by 8/8/16. For billing purposes, please refer to P.O. 54772. In addition, when the "proof of publication" becomes available, please forward me a copy.

Thank you,

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
**Website:** [www.ct.gov/ohca](http://www.ct.gov/ohca)

## Greer, Leslie

---

**From:** Robert Taylor <RTaylor@graystoneadv.com>  
**Sent:** Friday, August 05, 2016 5:30 PM  
**To:** Greer, Leslie  
**Cc:** Olejarz, Barbara  
**Subject:** FW: Hearing Notices DN's 16-32063-CON and 16-32093-CON  
**Attachments:** 16-32063 and 16-32093 The Advocate.docx

Hello,

This notice is set to publish on Monday.  
\$180.91

Thanks,

Robert Taylor

Graystone Group Advertising  
[www.graystoneadv.com](http://www.graystoneadv.com)  
2710 North Avenue, Suite 200  
Bridgeport, CT 06604  
Phone: [203-549-0060](tel:203-549-0060)  
Toll Free: [800-544-0005](tel:800-544-0005)  
Fax: [203-549-0061](tel:203-549-0061)

---

**From:** ADS <[ADS@graystoneadv.com](mailto:ADS@graystoneadv.com)>  
**Date:** Fri, 5 Aug 2016 11:49:32 -0400  
**To:** Microsoft Office User <[rtaylor@graystoneadv.com](mailto:rtaylor@graystoneadv.com)>  
**Subject:** FW: Hearing Notices DN's 16-32063-CON and 16-32093-CON

---

**From:** "Greer, Leslie" <[Leslie.Greer@ct.gov](mailto:Leslie.Greer@ct.gov)>  
**Date:** Friday, August 5, 2016 at 8:55 AM  
**To:** Ads Desk <[ads@graystoneadv.com](mailto:ads@graystoneadv.com)>  
**Cc:** "Olejarz, Barbara" <[Barbara.Olejarz@ct.gov](mailto:Barbara.Olejarz@ct.gov)>  
**Subject:** Hearing Notices DN's 16-32063-CON and 16-32093-CON

Please run the attached hearing notice in The Advocate by 8/8/16. For billing purposes, please refer to P.O. 54772. In addition, when the "proof of publication" becomes available, please forward me a copy.

Thank you,

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health

# SCOREBOARD

## ON THE AIR

- BASEBALL**
- ▶ Little League World Series, Southeast Regional semifinal (ESPN) 7 p.m.
  - ▶ Little League World Series, Southwest Regional (ESPN) 9 p.m.
- HORSE RACING**
- ▶ Cab Calloway Stakes (FS2) 4 p.m.
- MAJOR LEAGUE BASEBALL**
- ▶ San Francisco Giants at Miami Marlins (MLB) 7 p.m.
- RIO SUMMER OLYMPICS**
- ▶ Women's Field Hockey: U.S. vs. Australia; Women's Fencing; Women's Basketball: U.S. vs. Spain; Women's Fencing; Women's Rugby; Table Tennis; Women's Fencing; Archery; Men's Basketball: U.S. vs. Venezuela; Men's Water Polo; Weightlifting; Women's Volleyball; Boxing (NBCSN) 9 a.m.
  - ▶ Equestrian; Table Tennis; Beach Volleyball; Women's Handball 9 a.m.
  - ▶ Tennis (BRAVO) 9:30 a.m.
  - ▶ Rowing; Men's Water Polo: U.S. vs. Spain; Swimming: Qualifying Heats; Canoe/Kayak; Women's Volleyball: U.S. vs. Netherlands; Men's Beach Volleyball: Gibb/Patterson (U.S.) vs. Huber/Seidl (Austria) (NBC) 10 a.m.
  - ▶ Women's Beach Volleyball: Brazil vs. Argentina; Boxing; Basketball; Boxing (TELEMUNDO) 10:30 a.m.
  - ▶ Beach Volleyball; Women's Volleyball; Men's Basketball; Men's Shooting; Judo; Sailing (MSNBC) Noon
  - ▶ Volleyball; Men's Basketball: U.S. vs. Venezuela; Boxing (NBC UNIVERSO) 2 p.m.
  - ▶ Men's Water Polo; Women's Rugby; Beach Volleyball; Table Tennis (CNBC) 5 p.m.
  - ▶ Men's Diving; Men's Gymnastics; Team Gold Medal Finals; Swimming: Gold Medal finals: Men's 200m Freestyle & 100m Backstroke, Women's 100m Backstroke & 100m Breaststroke; Women's Beach Volleyball; Walsh Jennings/Ross (U.S.) vs. Wang/Yue (China) (NBC) 8 p.m.
  - ▶ Canoe/Kayak; Whitewater qualifying (NBC) 12:35 a.m. (Tuesday)

- Listings subject to change by station and networks**
- AUTO RACING**
- NASCAR-Sprint Cup**
- CHEEZ-IT 355**
- At Watkins Glen International Watkins Glen, N.Y.  
Lap length: 2.45 miles  
(Start position in parentheses)
- (6) Denny Hamlin, Toyota, 90.
  - (7) Joey Logano, Ford, 90.
  - (12) Brad Keselowski, Ford, 90.
  - (9) AJ Allmendinger, Chevrolet, 90.
  - (5) Kyle Busch, Toyota, 90.
  - (14) Martin Truex Jr., Toyota, 90.
  - (10) Jamie McMurray, Chevrolet, 90.
  - (32) Trevor Bayne, Ford, 90.
  - (4) Matt Kenseth, Toyota, 90.
  - (17) Kurt Busch, Chevrolet, 90.
  - (20) Casey Mears, Chevrolet, 90.
  - (16) Chase Elliott, Chevrolet, 90.
  - (21) Jeff Gordon, Chevrolet, 90.
  - (1) Carl Edwards, Toyota, 90.
  - (8) Ryan Newman, Chevrolet, 90.
  - (11) Michael McDowell, Chevrolet, 90.
  - (28) Clint Bowyer, Chevrolet, 90.
  - (19) Ryan Blaney, Ford, 90.
  - (23) Casey Khirnis, Chevrolet, 90.
  - (31) Danica Patrick, Chevrolet, 90.
  - (22) Paul Menard, Chevrolet, 90.
  - (40) Landon Cassill, Ford, 90.
  - (37) Boris Said, Ford, 90.
  - (30) Brian Scott, Ford, 90.
  - (15) Josh Wise, Chevrolet, 90.
  - (34) Aric Almirola, Ford, 90.
  - (22) Cole Whitt, Toyota, 90.
  - (2) Kyle Larson, Chevrolet, 90.
  - (25) Chris Buescher, Ford, 89.
  - (18) Austin Dillon, Chevrolet, 89.
  - (15) Kevin Harvick, Chevrolet, Accident, 83.
  - (26) David Ragan, Toyota, Accident, 83.
  - (35) Matt DiBenedetto, Toyota, Accident, 83.
  - (29) Regan Smith, Chevrolet, 77.
  - (36) Alex Kennedy, Chevrolet, Engine, 76.
  - (38) Michael Annett, Chevrolet, 74.
  - (30) Ricky Stenhouse Jr., Ford, Accident, 52.
  - (24) Greg Biffle, Ford, Accident, 52.
  - (13) Jimmie Johnson, Chevrolet, Accident, 52.

**Race Statistics**

Average Speed of Race Winner: 89.513 mph.; Time of Race: 2 hrs., 27 min., 7.30 p.m.  
2:06.5 Seconds; Caution Flags: 8 for 20 laps.; Lead Changes: 9 among 8 drivers.

**Leaders Summary (Driver, Times Lead, Laps Led):** B. Keselowski 2 times for 28 laps; C. Edwards 1 time for 25 laps; D. Patrick 1 time for 11 laps; D. Hamlin 1 time for 10 laps; J. Logano 2 times for 8 laps; Kyle Busch 1 time for 4 laps; Kurt Busch 1 time for 3 laps; M. Truex Jr. 1 time for 1 lap.

**Top 16 in Points:** B. Keselowski, 727; K. Harvick, 718; Kurt Busch, 689; Kyle Busch, 670; C. Edwards, 653; J. Logano, 652; D. Hamlin, 620; M. Truex Jr., 612; M. Kenseth, 600; J. Johnson, 578; R. Newman, 562; C. Elliott, 561; A. Dillon, 559; J. McMurray, 550; K. Larson, 520; T. Bayne, 512.

**BASEBALL**

**Atlantic League**

| FREEDOM DIVISION |    |    |      |    |
|------------------|----|----|------|----|
|                  | W  | L  | Pct. | GB |
| Sugar Land       | 18 | 12 | .600 | —  |
| York             | 17 | 12 | .586 | ½  |
| Lancaster        | 13 | 17 | .433 | 5  |
| Southern Md.     | 12 | 18 | .400 | 6  |

| LIBERTY DIVISION |    |    |      |    |
|------------------|----|----|------|----|
|                  | W  | L  | Pct. | GB |
| Long Island      | 16 | 12 | .571 | —  |
| Bridgeport       | 17 | 13 | .567 | —  |
| Somerset         | 14 | 15 | .483 | 2½ |
| New Britain      | 11 | 19 | .367 | 6  |

**Sunday's Results**

Bridgeport 3, Long Island 1  
New Britain 8, Lancaster 1  
York 6, Southern Maryland 3  
Somerset at Sugar Land, late

**Today's Games**

New Britain at York, 6 p.m.  
Somerset at Long Island, 6 p.m.

**AMERICA'S LINE**

**BASEBALL**

**Favorite** ..... **Odds** ..... **Underdog**

**American League**

BLUE JAYS ..... -\$140 (9) ..... Rays  
Astros ..... -\$138 (9) ..... TWINS  
Orioles ..... -\$110 (9) ..... A'S  
MARINERS ..... -\$107 (7½) ..... Tigers

**National League**

MARLINS ..... -\$150 (6½) ..... Giants  
BREWERS ..... -\$165 (9) ..... Braves  
CARDINALS ..... -\$185 (9) ..... Reds  
DODGERS ..... -\$200 (8) ..... Phillies

**Interleague**

Rangers ..... -\$120 (10½) ..... ROCKIES  
NOTE: The number inside the bracket is the over/under run total for the game.

**NFL PRESEASON**

**Favorite** ..... **Points** ..... **Underdog**

**Open** ..... **Close** ..... **OU**

**Thursday**

WASHINGTON ..... 3 3 (37) ..... Falcons  
EAGLES ..... 3 3 (37½) ..... Buccaneers  
JETS ..... 1½ 2½ (36½) ..... Jaguars  
RAVENS ..... 1 1 (36½) ..... Panthers  
PATRIOTS ..... 4 3½ (39½) ..... Saints  
GIANTS ..... 1½ 1½ (35) ..... Broncos

**Friday**

BEARS ..... 3 3 (36½) ..... Dolphins  
STEELERS ..... 4 3½ (35½) ..... Lions  
BENGALS ..... 3 3 (35) ..... Vikings  
PACKERS ..... NL NL (NL) ..... Browns  
CARDINALS ..... 3 3 (37½) ..... Raiders

**Saturday**

CHEFS ..... 1½ 2½ (35½) ..... Seahawks  
BILLS ..... NL NL (NL) ..... Colts  
RAMS ..... 3 3½ (35½) ..... Cowboys  
TITANS ..... 3 3 (35½) ..... Chargers

**Sunday**

49ERS ..... 3 3 (36) ..... Texans

**OLYMPIC BASKETBALL**

**Favorite** ..... **Points** (O/U) ..... **Underdog**

Serbia ..... 6 (159½) ..... Australia  
France ..... 24½ (149½) ..... China  
USA ..... 50½ (167) ..... Venezuela  
Home Team in CAPS

## GOLF

### PGA

#### TRAVELERS CHAMPIONSHIP

At TPC River Highlands Cromwell, Conn.  
Purse: \$6.6 million  
Yardage: 6,841; Par: 70

**Final**

|                               |       |                 |
|-------------------------------|-------|-----------------|
| Russell Knox, \$1,188,000     | ..... | 67-67-64-68=266 |
| Jerry Kelly, \$712,000        | ..... | 67-66-65-71=269 |
| Patrick Rodgers, \$382,800    | ..... | 68-66-66-68=268 |
| Justin Thomas, \$382,800      | ..... | 68-69-69-62=268 |
| Daniel Berger, \$231,825      | ..... | 66-67-62-74=269 |
| Jim Furyk, \$231,825          | ..... | 73-66-72-58=269 |
| Robert Garrigus, \$231,825    | ..... | 67-67-68-67=269 |
| T. Van Aswegen, \$231,825     | ..... | 67-66-65-71=269 |
| Brice Knopka, \$135,300       | ..... | 67-70-64=270    |
| Marc Leishman, \$184,800      | ..... | 65-68-71-66=270 |
| Alex Cejka, \$135,300         | ..... | 68-69-69-65=271 |
| Russell Henley, \$135,300     | ..... | 68-65-65-73=271 |
| Spencer Levin, \$135,300      | ..... | 69-67-68-67=271 |
| Patrick Reed, \$135,300       | ..... | 70-67-68-66=271 |
| Shawn Stefani, \$135,300      | ..... | 71-68-67-65=271 |
| D. Sumnerhayes, \$83,490      | ..... | 68-69-65-69=271 |
| Paul Casey, \$83,490          | ..... | 68-67-66-71=272 |
| Andres Gonzales, \$83,490     | ..... | 70-68-65-69=272 |
| Tyrell Hatton, \$83,490       | ..... | 71-65-70-66=272 |
| Matt Kuchar, \$83,490         | ..... | 69-67-71-65=272 |
| Ryan Moore, \$83,490          | ..... | 70-66-66-70=272 |
| Louis Oosthuizen, \$83,490    | ..... | 68-71-67-66=272 |
| Carlos Ortiz, \$83,490        | ..... | 66-71-69-66=272 |
| Brendan Steele, \$83,490      | ..... | 70-69-69-64=272 |
| Blayne Barber, \$47,227       | ..... | 71-64-70-68=273 |
| Keegan Bradley, \$47,227      | ..... | 67-72-67-67=273 |
| Tony Finau, \$47,227          | ..... | 69-68-69-67=273 |
| Charley Hoffman, \$47,227     | ..... | 69-68-69-67=273 |
| Si Woo Kim, \$47,227          | ..... | 69-70-67-67=273 |
| Henrik Norlander, \$47,227    | ..... | 71-68-70-64=273 |
| Scott Brown, \$47,227         | ..... | 68-70-67-68=273 |
| Jon Rahm, \$47,227            | ..... | 65-70-69-69=273 |
| Bubba Watson, \$47,227        | ..... | 67-70-68-68=273 |
| Aaron Baddeley, \$34,815      | ..... | 73-65-67-69=274 |
| Jason Kokrak, \$34,815        | ..... | 69-68-72-66=274 |
| Webb Simpson, \$34,815        | ..... | 70-69-66-70=274 |
| Cameron Smith, \$34,815       | ..... | 70-67-69-68=274 |
| Derek Ernst, \$25,740         | ..... | 68-69-70-68=275 |
| Lucas Lee, \$25,740           | ..... | 68-69-72-66=275 |
| Seung-Yul Noh, \$25,740       | ..... | 69-70-68-68=275 |
| Rod Pamplig, \$25,740         | ..... | 69-68-72-66=275 |
| Chris Stroud, \$25,740        | ..... | 70-69-66-70=275 |
| Brian Stuard, \$25,740        | ..... | 70-65-69-71=275 |
| Hudson Swafford, \$25,740     | ..... | 64-71-70-70=275 |
| Vaughn Taylor, \$25,740       | ..... | 64-71-70-70=275 |
| Gary Woodland, \$25,740       | ..... | 67-70-67-71=275 |
| Greg Chalmers, \$16,573       | ..... | 69-69-72-66=276 |
| Enze Els, \$16,573            | ..... | 72-67-70-67=276 |
| Retief Goosen, \$16,573       | ..... | 69-69-69-69=276 |
| Stuart Appleby, \$16,573      | ..... | 68-68-69-71=276 |
| Bryson DeChambeau, \$16,573   | ..... | 72-66-68-70=276 |
| Zach Johnson, \$16,573        | ..... | 67-71-68-70=276 |
| Francesco Molinari, \$16,573  | ..... | 71-67-65-73=276 |
| Abram Percy, \$16,573         | ..... | 69-69-67-71=276 |
| Ben Reavie, \$16,573          | ..... | 70-67-70-71=276 |
| Cameron Tringoli, \$14,718    | ..... | 68-68-68-73=277 |
| Miguel A. Carballo, \$14,718  | ..... | 73-66-71-67=277 |
| Bryce Molder, \$14,718        | ..... | 69-70-66-72=277 |
| Rory Sabbatini, \$14,718      | ..... | 67-72-73-65=277 |
| John Senden, \$14,718         | ..... | 69-68-72-69=277 |
| Vijay Singh, \$14,718         | ..... | 67-67-69=277    |
| Zar Larsson, \$14,190         | ..... | 70-68-69-71=278 |
| Martin Laird, \$14,190        | ..... | 68-69-68-73=278 |
| Padrraig Harrington, \$13,794 | ..... | 70-69-65-75=279 |
| Matt Jones, \$13,794          | ..... | 69-69-71-70=279 |
| Soren Kjeldsen, \$13,794      | ..... | 68-69-69-73=279 |
| Nick Taylor, \$13,794         | ..... | 68-71-68-72=279 |
| Ricky Barnes, \$13,332        | ..... | 67-68-71-72=280 |
| Scott Pinckney, \$13,332      | ..... | 68-67-74-72=281 |
| Bud Cauley, \$13,068          | ..... | 68-71-69-74=282 |
| Sung Kang, \$13,068           | ..... | 70-67-75-70=282 |
| Hunter Mahan, \$13,068        | ..... | 68-71-76-67=282 |
| David Toms, \$12,804          | ..... | 67-71-70-75=283 |

### Champions Tour

#### 3M CHAMPIONSHIP

Sunday  
At TPC Twin Cities  
Blaine, Minn.  
Purse: \$1.75 million  
Yardage: 7,114; Par: 72

**Final**

(x=won on 1st playoff hole)

|                                 |       |                 |
|---------------------------------|-------|-----------------|
| x-Joe Durant, \$262,500         | ..... | 70-64-63=197-19 |
| Miguel Angel Jimenez, \$154,000 | ..... | 67-63-67=197-19 |
| Bernhard Langer, \$115,063      | ..... | 67-68-64=199-17 |
| Kevin Sutherland, \$115,063     | ..... | 67-64-68=199-17 |
| Glen Day, \$76,563              | ..... | 65-67-68=200-16 |
| David Frost, \$76,563           | ..... | 70-65-66=200-16 |
| Woody Austin, \$59,500          | ..... | 67-68-66=201-15 |
| Jeff Maggert, \$59,500          | ..... | 66-67-68=201-15 |
| Joe Coceres, \$49,000           | ..... | 70-65-67=202-14 |
| Mike Goodes, \$40,250           | ..... | 69-67-67=203-13 |
| Colin Montgomerie, \$40,250     | ..... | 66-67-70=203-13 |
| Steve Pate, \$40,250            | ..... | 69-68-66=203-13 |
| Glenn Alan, \$40,250            | ..... | 71-65-67=203-13 |
| Stephen Ames, \$32,375          | ..... | 68-69-67=204-12 |
| Mark O'Meara, \$32,375          | ..... | 68-66-70=204-12 |
| Olin Browne, \$29,750           | ..... | 71-67-67=205-11 |
| Michael Allen, \$22,641         | ..... | 72-69-65=206-10 |
| Scott Dunlap, \$22,641          | ..... | 67-70-69=206-10 |
| Paul Goydos, \$22,641           | ..... | 69-69-68=206-10 |
| Mike Grob, \$22,641             | ..... | 69-70-67=206-10 |
| Mark Brooks, \$22,641           | ..... | 68-68-70=206-10 |
| Bart Bryant, \$22,641           | ..... | 67-69-70=206-10 |
| Todd Hamilton, \$22,641         | ..... | 69-68-69=206-10 |
| Scott Hoch, \$22,641            | ..... | 68-69-69=206-10 |
| Michael Bradley, \$14,919       | ..... | 69-68-70=207-9  |
| Brad Bryant, \$14,919           | ..... | 71-65=207-9     |
| Tommy Armour III, \$11,288      | ..... | 72-69-69=207-9  |
| Marco Dawson, \$14,919          | ..... | 72-67-68=207-9  |
| Carlos Franco, \$14,919         | ..... | 67-70-70=207-9  |
| Doug Garwood, \$14,919          | ..... | 73-62-72=207-9  |
| Lee Janzen, \$14,919            | ..... | 69-71-67=207-9  |
| Brandt Jobe, \$14,919           | ..... | 69-65-73=207-9  |
| Wes Short, Jr., \$14,919        | ..... | 71-65=207-9     |
| Tommy Armour III, \$11,288      | ..... | 72-69-69=207-9  |
| Russ Cochran, \$11,288          | ..... | 72-69-67=208-8  |
| Tom Pernice Jr., \$11,288       | ..... | 73-66-69=208-8  |
| Jean-Francois Remesy, \$11,288  | ..... | 67-70-71=208-8  |
| Jay Haas, \$8,925               | ..... | 70-70-69=209-7  |
| Jeff Hart, \$8,925              | ..... | 71-68-70=209-7  |
| Wayne Levi, \$8,925             | ..... | 69-70-70=209-7  |
| Larry Mize, \$8,925             | ..... | 68-69-72=209-7  |
| Kenny Perry, \$8,925            | ..... | 73-68-68=209-7  |
| Steve Scheinert, \$8,925        | ..... | 68-69-72=209-7  |
| Rod Spittle, \$8,925            | ..... | 66-74-69=209-7  |
| Joey Sindelar, \$6,825          | ..... | 73-67-70=210-6  |
| Mike Small, \$6,825             | ..... | 71-69-70=210-6  |
| Esteban Toledo, \$6,825         | ..... | 72-69-69=210-6  |
| Duffy Waldorf, \$6,825          | ..... | 73-70-67=210-6  |
| Willie Wood, \$6,825            | ..... | 73-70-67=210-6  |
| Jay Don Blake, \$5,250          | ..... | 73-69-69=211-5  |
| Steve Lowery, \$5,250           | ..... | 70-70-71=211-5  |
| Rocco Mediate, \$5,250          | ..... | 69-66-76=211-5  |
| Gene Sauers, \$5,250            | ..... | 71-71=211-5     |
| Clark Dennis, \$4,113           | ..... | 73-68-71=212-4  |
| John Inman, \$4,113             | ..... | 71-73-68=212-4  |
| Larry Nelson, \$4,113           | ..... | 68-70-74=212-4  |
| Kirk Triplett, \$4,113          | ..... | 73-71-68=212-4  |
| Tom Byrum, \$3,500              | ..... | 75-70-68=213-3  |
| Scott McCarron, \$3,500         | ..... | 72-68-73=213-3  |
| Carolina Ballester, \$3,500     | ..... | 69-71-73=213-3  |
| Billy Andrade, \$2,888          | ..... | 69-72-73=214-2  |
| Tom Lehman, \$2,888             | ..... | 73-73-68=214-2  |
| Loren Roberts, \$2,888          | ..... | 75-71-68=214-2  |
| Hal Sutton, \$2,888             | ..... | 71-73-70=214-2  |
| Jean Van de Velde, \$2,450      | ..... | 72-69-74=215-1  |
| Scott Verplank, \$2,275         | ..... | 76-71-73=215-1  |
| Jerry Smith, \$2,100            | ..... | 73-70-74=217-1  |
| Neal Lancaster, \$1,715         | ..... | 74-68-76=218-2  |
| Craig Parry, \$1,715            | ..... | 70-71-77=218-2  |
| Tom Purtzer, \$1,715            | ..... | 72-73-73=218-2  |
| Bob Tway, \$1,715               | ..... | 73-74-71=218-2  |
| John Daly, \$1,383              | ..... | 72-72-75=219-3  |
| John Harris, \$1,383            | ..... | 76-71-72=219-3  |
| Dan Forsman, \$1,190            | ..... | 71-77-72=220-4  |
| Gil Morgan, \$1,190             | ..... | 76-71-73=220-4  |
| Mike Springer, \$1,085          | ..... | 76-72-73=221-5  |

### European Tour

**PAUL LAWRIE MATCH PLAY**

At Archerfield Links Golf Club North Berwick, Scotland  
Purse: \$1.11 million  
Yardage: 6,978; Par: 72  
Championship

Anthony Wall, England, def. Alex Noren, Sweden, 1 up.

**Third Place**

James Morrison, England, def. Oliver Fisher, England, 4 and 2.

**NFL**

**Preseason Schedule**

Sunday's Game  
Green Bay vs. Indianapolis at Canton, Ohio, ccd., field conditions

**Thursday's Games**

Washington at Atlanta, 7 p.m.  
Tampa Bay at Philadelphia, 7 p.m.  
Carolina at Baltimore, 7:30 p.m.  
New Orleans at New England, 7:30 p.m.  
Jacksonville at New York Jets, 7:30 p.m.  
Denver at Chicago, 8 p.m.

**Friday's Games**

Miami at New York Giants, 7 p.m.  
Detroit at Pittsburgh, 7 p.m.  
Minnesota at Cincinnati, 7:30 p.m.  
Cleveland at Green Bay, 8 p.m.  
Oakland at Arizona, 10 p.m.

**Saturday's Games**

Seattle at Kansas City, 4:30 p.m.  
Indianapolis at Buffalo, 7 p.m.  
Dallas at Los Angeles, 8 p.m. (ESPN)  
San Diego at Tennessee, 8 p.m.

**Sunday, Aug. 14**

Houston at San Francisco, 7 p.m.

**SOCCER**

**MLS**

Sunday's Results  
Portland 3, Sporting Kansas City 0  
Seattle 3, Orlando City 1  
New York at Los Angeles, late

**Friday's Game**  
San Jose at Vancouver, 11 p.m.

## OLYMPICS ROUNDUP

### Winds affect day 2

ASSOCIATED PRESS

RIO DE JANEIRO — The whipping gusts that disrupted athletes and spectators alike were just a prelude to the winds of change that roared through Rio de Janeiro on Sunday night: Serena and Venus Williams lost an Olympic doubles match for the first time.

Day two of the Rio Games proved quite the breeze for some athletes and much too windy for others. The gusts ripped apart a large decorative panel on the swimming venue and even shut down shopping at the megastore — essentially an enormous tent — inside the Olympic Park.

Then, the tempest: the Williams sisters were stunned in the opening round by the Czech Republic's Lucie Safarova and Barbora Strycova 6-3, 6-4 after entering Sunday's match with a 15-0 mark in the Olympics.

China won yet another medal in air rifle on a day nasty winds sent the clay targets in the trap event bobbing and bouncing through the air, forced delays on the tennis courts and whipped up treacherous waves in the Rodrigo de Freitas Lagoon.

The rowing regatta was called off after a two-hour delay when the choppy seas didn't let up. Race officials said winds gusting up to 34 mph pushed buoys into the lanes and capsized two boats during morning practice.

There were 14 golds up for grabs, including four swimming finals, where Katie Ledecky is the overwhelming favorite in the 400-meter freestyle.

Other highlights from Day 2 of the Rio Games: ▶ **KOSOVO FIRST**: Majlinda Kelmendi won Kosovo's first Olympic medal, taking gold in the women's 52-kilogram judo division. ▶ **BAD BREAK**: A day after gruesomely breaking his left leg while vaulting during men's preliminaries, French gymnast Samir Air Said posted a Facebook video from his hospital bed on Sunday thanking people for their support and pledging to shoot for



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

IN THE MATTERS OF:

Orthopaedic & Neurosurgery Specialists, P. C.  
Advanced Radiology MRI Centers Limited Partnership

Docket Number: 16-32063-CON  
Docket Number: 16-32093-CON

**ORDER**

Pursuant to Conn. Gen. Stat. § 19a-639a(f), the above-referenced Dockets are hereby consolidated for purposes of conducting a public hearing. All other proceedings pertaining to the Dockets shall remain separate, including the issuance of a decision in each Docket.

Date

8/5/16

Kevin T. Hansted  
Hearing Officer

*An Equal Opportunity Employer*

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308

Telephone: (860) 418-7001 Toll-Free: 1-800-797-9688

Fax: (860) 418-7053

## Greer, Leslie

---

**From:** Kathleen Gedney <kgg@bvmlaw.com>  
**Sent:** Monday, August 08, 2016 2:59 PM  
**To:** User, OHCA; Veyberman, Alla; Riggott, Kaila; Lazarus, Steven; Fernandes, David  
**Cc:** Michele Volpe; Jennifer O'Donnell  
**Subject:** Docket No. 16-32063 and Docket No. 16-32093  
**Attachments:** 201608081453.pdf

Please see the attached request in regards to the above-captioned matters.

Kathleen Gedney-Tommaso  
Attorney at Law  
Bershtein, Volpe & McKeon P.C.  
105 Court Street, 3<sup>rd</sup> Floor  
New Haven, CT 06511  
Tel: (203) 859-6238  
Fax: (203) 777-5806  
Email: [kgg@bvmlaw.com](mailto:kgg@bvmlaw.com)

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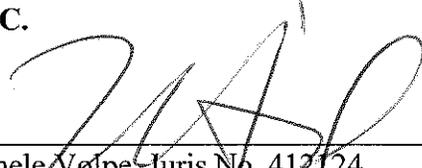
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**DEPARTMENT OF PUBLIC HEALTH** :  
**DIVISION OF OFFICE OF** :  
**HEALTH CARE ACCESS** :  
 :  
**IN RE: ORTHOPAEDIC & NEUROSURGERY** : **DOCKET NO. 16-32063-CON**  
**SPECIALISTS, P.C.** :  
**ACQUISITION OF MAGNETIC** :  
**RESONANCE IMAGING SCANNER** :  
 :  
**IN RE: ADVANCED RADIOLOGY MRI** : **DOCKET NO. 16-32093-CON**  
**CENTERS LIMITED PARTNERSHIP** :  
**ACQUISITION OF MRI UNIT FOR** :  
**STAMFORD OFFICE** : **AUGUST 8, 2016**

**REQUEST TO RECEIVE COPIES OF ALL CORRESPONDENCE**

Orthopaedic & Neurosurgery Specialists, P.C. (“ONS”) and Advanced Radiology MRI Centers Limited Partnership (the “ARC”), the applicants in the above-captioned matters, are subject to a consolidated hearing on August 30, 2016. As ONS and ARC are subject to a consolidated hearing, ONS respectfully requests the Department of Public Health division of Office of Health Care Access grant ONS the right to receive a copy of any and all correspondence with respect to ARC Docket No. 16-32093-CON.

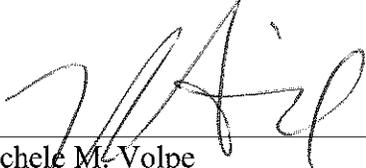
**ORTHOPAEDIC & NEUROSURGERY  
SPECIALISTS, P.C.**

**BY:**   
 Its Attorney: Michele Volpe, Juris No. 412124  
 Bershtein, Volpe & McKeon P.C.  
 105 Court Street, 3<sup>rd</sup> Floor  
 New Haven, Connecticut 06511  
 Tel. No. 203 777-5800  
 Fax No. 203 777-5806

**CERTIFICATION**

I hereby certify that a copy of the foregoing has been sent via electronic mail, this 8th day of August, 2016 to the following:

Jennifer Groves Fusco  
Attorney  
Updike, Kelly & Spellacy, P.C.  
One Century Tower  
265 Church Street  
New Haven, CT 06510  
jfusco@uks.com

  
\_\_\_\_\_  
Michele M. Volpe  
Bershtein, Volpe & McKeon P.C.

## User, OHCA

---

**From:** Fernandes, David  
**Sent:** Wednesday, August 10, 2016 9:31 AM  
**To:** Jennifer Groves Fusco  
**Cc:** User, OHCA; Riggott, Kaila; Lazarus, Steven; Greer, Leslie; Veyberman, Alla  
**Subject:** Docket # 16-32093 CON: Request for Prefiled Testimony & Issues  
**Attachments:** Request for Prefiled Testimony and Issues 16-32093.pdf

Dear Attorney Fusco,

Attached please find a Request for Profile Testimony and Issues related to the hearing scheduled for August 30, 2016 (docket number 16-32093). Submit responses as an e-mail attachment, in both Word and .pdf format, and reply to all recipients of this e-mail by August 23, 2016. Additionally, confirm receipt of this e-mail with me as soon as possible.

Please feel free to contact me or Steve Lazarus at [steven.lazarus@ct.gov](mailto:steven.lazarus@ct.gov) if you have any questions.

Sincerely,

**David Fernandes**

Planning Analyst (CCT)

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue, Hartford, Connecticut 06134

P: (860) 418-7032 | F: (860) 418-7053 | E: [David.Fernandes@ct.gov](mailto:David.Fernandes@ct.gov)



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.  
Commissioner



Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

### Office of Health Care Access

August 10, 2016

Via Email Only

Jennifer G. Fusco, Esq.  
Updike, Kelly & Spellacy, P.C.,  
265 Church Street  
New Haven, CT 06510

RE: Certificate of Need Application Docket Number: 16-32093-CON  
Acquisition of Second Magnetic Resonance Imaging Scanner

Dear Attorney Fusco:

The Office of Health Care Access ("OHCA") will hold a public hearing on the above docket number on August 30, 2016. The hearing is at 10:00 a.m. at the Department of Public Health, Office of Health Care Access, 470 Capitol Avenue, Conference Room A/B in Hartford, CT 06134. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29(e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. OHCA requests that Advance Radiology MRI Centers ("Applicant") submit prefiled testimony by 4:00 p.m. on **August 23, 2016**.

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find attached OHCA's Issues. Please respond to the attached Issues in writing to OHCA by 4:00 p.m. on **August 23, 2016**.

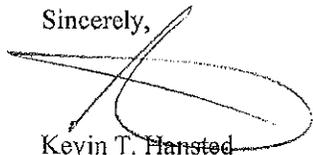


Phone: (860) 418-7001 • Fax: (860) 418-7053  
410 Capitol Avenue, MS#13HCA  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

*Affirmative Action/Equal Opportunity Employer*

Please contact David Fernandes or Steven W. Lazarus at (860) 418-7001 if you have any questions concerning this request.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin T. Hansted". The signature is stylized with a large, sweeping loop that extends to the left and then curves back to the right, crossing over itself.

Kevin T. Hansted  
Hearing Officer

Attachment

## Office of Health Care Access

### Public Hearing Issues

**Docket Number: 16-32093-CON:** Acquisition of a second magnetic resonance imaging scanner  
by Advanced Radiology MRI Centers

**The Applicant should be prepared to present and discuss supporting evidence on the following issues:**

1. The clear public need for of the proposal
2. Patient population and payer mix
3. Utilization at the Orange and Shelton offices
4. Patient referrals pattern for ARC's existing offices
5. Options to relocate existing MRI scanners
6. Capacity of the proposed second unit
7. MRI capacity/availability (including all existing providers in this service area)

**When responding to the issues above, please refer to the links below:**

1. [http://www.ct.gov/dph/lib/dph/ohca/hc\\_facilities\\_advisory\\_body/inventory/2014/table\\_8\\_\(mri\).xlsx](http://www.ct.gov/dph/lib/dph/ohca/hc_facilities_advisory_body/inventory/2014/table_8_(mri).xlsx)
2. <http://www.ct.gov/dph/cwp/view.asp?a=3902&q=557562>
3. <http://www.ct.gov/dph/cwp/view.asp?a=3902&q=469574>

## Greer, Leslie

---

**From:** Jennifer Groves Fusco <jfusco@uks.com>  
**Sent:** Wednesday, August 10, 2016 9:48 AM  
**To:** Fernandes, David  
**Cc:** User, OHCA; Riggott, Kaila; Lazarus, Steven; Greer, Leslie; Veyberman, Alla  
**Subject:** RE: Docket # 16-32093 CON: Request for Prefiled Testimony & Issues

Good morning, David.

This is to confirm receipt of the attached Request for Prefiled Testimony & Hearing Issues. I will review and let you know if I have any questions.

Thanks,  
Jen

---

**From:** Fernandes, David [<mailto:David.Fernandes@ct.gov>]  
**Sent:** Wednesday, August 10, 2016 9:31 AM  
**To:** Jennifer Groves Fusco  
**Cc:** User, OHCA; Riggott, Kaila; Lazarus, Steven; Greer, Leslie; Veyberman, Alla  
**Subject:** Docket # 16-32093 CON: Request for Prefiled Testimony & Issues

Dear Attorney Fusco,

Attached please find a Request for Prefile Testimony and Issues related to the hearing scheduled for August 30, 2016 (docket number 16-32093). Submit responses as an e-mail attachment, in both Word and .pdf format, and reply to all recipients of this e-mail by August 23, 2016. Additionally, confirm receipt of this e-mail with me as soon as possible.

Please feel free to contact me or Steve Lazarus at [steven.lazarus@ct.gov](mailto:steven.lazarus@ct.gov) if you have any questions.

Sincerely,

**David Fernandes**  
Planning Analyst (CCT)  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, Hartford, Connecticut 06134  
P: (860) 418-7032 | F: (860) 418-7053 | E: [David.Fernandes@ct.gov](mailto:David.Fernandes@ct.gov)



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in this e-mail is unauthorized and may be unlawful. If you are not an addressee, please inform the sender immediately and permanently delete and/or destroy the original and any copies or printouts of this message. Thank you. Updike, Kelly & Spellacy, P.C.

## Greer, Leslie

---

**From:** Jennifer Groves Fusco <jfusco@uks.com>  
**Sent:** Wednesday, August 10, 2016 10:51 AM  
**To:** Fernandes, David; Veyberman, Alla; Lazarus, Steven  
**Cc:** User, OHCA; Michele Volpe (mmv@bvmlaw.com); Michelemvolpe@aol.com  
**Subject:** Docket Nos. 16-32063-CON & 16-32093-CON -- Objection to Request to Receive Copies of All Correspondence  
**Attachments:** Objection to Request for Copies of Correspondence .pdf

Attached please find Advanced Radiology MRI Centers Limited Partnership's Objection to Orthopaedic and Neurosurgery Specialists, P.C.'s Request to Receive Copies of Correspondence, dated August 8, 2016.

Thanks,  
Jen

Jennifer Groves Fusco, Esq.  
Principal  
Updike, Kelly & Spellacy, P.C.  
One Century Tower  
265 Church Street  
New Haven, CT 06510  
Office (203) 786.8316  
Cell (203) 927.8122  
Fax (203) 772.2037  
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**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION**

|                                 |   |                         |
|---------------------------------|---|-------------------------|
| .....                           | ) |                         |
| IN RE: ADVANCED RADIOLOGY MRI   | ) | DOCKET NO. 16-32093-CON |
| CENTERS LIMITED PARTNERSHIP     | ) |                         |
| ACQUISITION OF MRI UNIT FOR     | ) |                         |
| STAMFORD OFFICE                 | ) |                         |
|                                 | ) | DOCKET NO. 16-32063-CON |
| IN RE: ORTHOPAEDIC &            | ) |                         |
| NEUROSURGERY SPECIALISITS, P.C. | ) |                         |
| ACQUISTION OF MAGENTIC          | ) |                         |
| RESONANCE IMAGING SCANNER       | ) | AUGUST 10, 2016         |
| .....                           | ) |                         |

**OBJECTION TO REQUEST TO RECEIVE COPIES OF ALL CORRESPONDENCE**

Advanced Radiology MRI Centers Limited Partnership (“ARC”) hereby objects to Orthopaedic & Neurosurgery Specialists, P.C.’s (“ONS”) Request to Receive Copies of All Correspondence, dated August 8, 2016. The Office of Healthcare Access (“OHCA”) has consolidated the above-referenced dockets for hearing purposes only and a joint public hearing is scheduled for August 30, 2016. ONS has requested the right to receive copies of “any and all correspondence” with respect to Docket No. 16-32093-CON, ARC’s request for permission to acquire a second MRI unit for its Stamford office. ONS has provided no legal basis for its request and it should, therefore, be denied.

ARC and ONS have filed Certificate of Need (“CON”) applications for the acquisition of MRI units to be located in Stamford and Greenwich, respectively. On August 5, 2016, OHCA issued an Order, pursuant to Conn. Gen. Stat. § 19a-693a(f), consolidating the dockets for purposes of conducting a public hearing. Section 19a-639a(f) allows OHCA to “hold hearings

on applications of a similar nature at the same time” in the interest of efficiency. However as OHCA’s Order clearly states, “[a]ll other proceedings pertaining to the Dockets shall remain separate, including the issuance of a decision in each Docket.”

Consolidation of the ONS and ARC CON applications for hearing purposes only does not confer special rights on either applicant. The mere fact that two CON applications are heard jointly does not entitle either applicant to receive information or participate in any way in the other applicant’s docket. The right to participate, which typically includes the right to receive copies of correspondence through the issuance of a Final Decision, is reserved for intervenors and parties to a proceeding. Without being designated a party or intervenor, ONS has no greater right of access to the information in Docket No. 16-32093-CON than the general public.

In addition, all public documents in Docket No. 16-32093-CON will be available to ONS, either on the OHCA website or through the filing of a Freedom of Information Act request, in advance of the August 30<sup>th</sup> hearing. An order that ARC share these documents is, therefore, unnecessary. If however OHCA does order that ARC share documents from Docket No. 16-32093-CON with ONS, ARC requests that its obligation to provide copies of “any and all correspondence” be limited to standard hearing submissions (i.e. appearances, written testimony, responses to hearing issues, etc.). Moreover, if ARC is ordered to share documents with ONS then ARC requests identical access to information from Docket No. 16-32063-CON.

Respectfully Submitted,

ADVANCED RADIOLOGY MRI CENTERS  
LIMITED PARTNERSHIP

By:

  
JENNIFER GROVES FUSCO, ESQ.

Updike, Kelly & Spellacy, P.C.

265 Church Street

One Century Tower

New Haven, CT 06510

Tel: (203) 786-8300

Fax (203) 772-2037

**CERTIFICATION**

This is to certify that a copy of the foregoing was sent via electronic mail this 10<sup>th</sup> day of August, 2016 to the following parties:

Michele M. Volpe, Esq,  
Bershtein, Volpe & McKeon, P.C.  
105 Court Street, 3<sup>rd</sup> Floor  
New Haven, CT 06511  
michelemvolpe@aol.com

  
\_\_\_\_\_  
JENNIFER GROVES FUSCO, ESQ.  
Updike, Kelly & Spellacy, P.C.



STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION

|                                |   |                         |
|--------------------------------|---|-------------------------|
| .....                          | ) |                         |
| IN RE: ADVANCED RADIOLOGY MRI  | ) | DOCKET NO. 16-32093-CON |
| CENTERS LIMITED PARTNERSHIP    | ) |                         |
| ACQUISITION OF MRI UNIT FOR    | ) |                         |
| STAMFORD OFFICE                | ) |                         |
|                                | ) | DOCKET NO. 16-32063-CON |
| IN RE: ORTHOPAEDIC &           | ) |                         |
| NEUROSURGERY SPECIALISTS, P.C. | ) |                         |
| ACQUISITION OF MAGNETIC        | ) |                         |
| RESONANCE IMAGING SCANNER      | ) | AUGUST 10, 2016         |
| .....                          | ) |                         |

**OBJECTION TO REQUEST TO RECEIVE COPIES OF ALL CORRESPONDENCE**

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on applications of a similar nature at the same time” in the interest of efficiency. However as OHCA’s Order clearly states, “[a]ll other proceedings pertaining to the Dockets shall remain separate, including the issuance of a decision in each Docket.”

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Respectfully Submitted,

ADVANCED RADIOLOGY MRI CENTERS  
LIMITED PARTNERSHIP

By:



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JENNIFER GROVES FUSCO, ESQ.

Updike, Kelly & Spellacy, P.C.

265 Church Street

One Century Tower

New Haven, CT 06510

Tel: (203) 786-8300

Fax (203) 772-2037

**CERTIFICATION**

This is to certify that a copy of the foregoing was sent via electronic mail this 10<sup>th</sup> day of August, 2016 to the following parties:

Michele M. Volpe, Esq,  
Bershtein, Volpe & McKeon, P.C.  
105 Court Street, 3<sup>rd</sup> Floor  
New Haven, CT 06511  
michelemvolpe@aol.com

  
\_\_\_\_\_  
JENNIFER GROVES FUSCO, ESQ.  
Updike, Kelly & Spellacy, P.C.

## Greer, Leslie

---

**From:** Jennifer Groves Fusco <jfusco@uks.com>  
**Sent:** Tuesday, August 23, 2016 3:39 PM  
**To:** User, OHCA  
**Cc:** Fernandes, David; Lazarus, Steven; Hansted, Kevin; Riggott, Kaila; Greer, Leslie; Michele Volpe (mmv@bvmlaw.com); Kathleen Gedney  
**Subject:** Advanced Radiology MRI Centers Limited Partnership -- Docket No. 16-32093-CON  
**Attachments:** Acquisition of MRI.PDF

All:

Attached please find Advanced Radiology MRI Centers Limited Partnership's submissions in connection with the August 30, 2016 public hearing in Docket No. 16-32093-CON. Please confirm receipt of this email at your convenience. Originals are being sent to OHCA via overnight mail.

Thanks,

Jen

Jennifer Groves Fusco, Esq.  
Principal  
Updike, Kelly & Spellacy, P.C.  
One Century Tower  
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Jennifer Groves Fusco  
(t) 203.786.8316  
(f) 203.772.2037  
jfusco@uks.com

August 23, 2016

**VIA ELECTRONIC & OVERNIGHT MAIL**

Hon. Janet Brancifort, M.P.H.  
Deputy Commissioner  
Office of Health Care Access Division  
Department of Public Health  
410 Capitol Avenue  
Post Office Box 340308  
Hartford, CT 06134-0308

***Re: Advanced Radiology MRI Centers Limited Partnership  
Acquisition of MRI Unit for Stamford Office  
Docket No. 16-32093-CON***

Dear Deputy Commissioner Brancifort:

This office represents Advanced Radiology MRI Centers Limited Partnership (“ARC MRI”) in connection with the above-referenced docket. Enclosed are an original and four (4) copies of the following:

- Notice of Appearance of Updike, Kelly & Spellacy, P.C.;
- Prefiled Testimony of Clark G. Yoder, M.B.A., Chief Executive Officer, Advanced Radiology Consultants;
- Prefiled Testimony of Gerard J. Muro, M.D., Neuroradiology Section Director & Chief Medical Information Officer, Advanced Radiology Consultants;
- Prefiled Testimony of Alan D. Kaye, M.D., former Chief Executive Officer, Advanced Radiology Consultants; and
- Responses to Public Hearing Issues.

These documents are being submitted in connection with the public hearing on the above matter scheduled for August 30, 2016 at 10:00 a.m. Mr. Yoder and Drs. Muro and Kaye will be present at the hearing to adopt their prefiled testimony under oath and for cross-examination.

Hon. Janet Brancifort, M.P.H.  
August 23, 2016  
Page 2

Should you require anything further, please feel free to call me at (203) 786-8316.

Very truly yours,



Jennifer Groves Fusco

Enclosures

cc: Clark G. Yoder (*w/enc*)  
Michele M. Volpe, Esq. (*w/enc*)

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION**

..... )  
IN RE: ADVANCED RADIOLOGY MRI ) DOCKET NO. 16-32093-CON  
CENTERS LIMITED PARTNERSHIP )  
ACQUISITION OF MRI UNIT FOR )  
STAMFORD OFFICE )  
..... )  
AUGUST 23, 2016

**NOTICE OF APPEARANCE**

In accordance with Section 19a-9-28 of the Regulations of Connecticut State Agencies, please enter the appearance of Updike, Kelly & Spellacy, P.C. ("Firm") in the above-captioned proceeding on behalf of Advanced Radiology MRI Centers Limited Partnership ("ARC"). The Firm will appear and represent ARC at the public hearing on this matter, scheduled for August 30, 2016.

Respectfully Submitted,

ADVANCED RADIOLOGY MRI CENTERS  
LIMITED PARTNERSHIP

By:  \_\_\_\_\_  
JENNIFER GROVES FUSCO, ESQ.

Updike, Kelly & Spellacy, P.C.  
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Fax (203) 772-2037

**CERTIFICATION**

This is to certify that a copy of the foregoing was sent via electronic mail this 23<sup>rd</sup> day of August, 2016 to the following parties:

Michele M. Volpe, Esq,  
Bershtein, Volpe & McKeon, P.C.  
105 Court Street, 3<sup>rd</sup> Floor  
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michelemvolpe@aol.com

  
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JENNIFER GROVES FUSCO, ESQ.  
Updike, Kelly & Spellacy, P.C.

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION**

..... )  
IN RE: ADVANCED RADIOLOGY MRI ) DOCKET NO. 16-32093-CON  
CENTERS LIMITED PARTNERSHIP )  
ACQUISITION OF MRI UNIT FOR )  
STAMFORD OFFICE )  
..... )  
AUGUST 23, 2016

**PREFILED TESTIMONY OF CLARK G. YODER, M.B.A.,  
CHIEF EXECUTIVE OFFICER OF ADVANCED RADIOLOGY CONSULTANTS, LLC,  
ON BEHALF OF ADVANCED RADIOLOGY MRI CENTERS  
LIMITED PARTNERSHIP**

Good morning Hearing Officer Hansted and members of the Office of Health Care Access (“OHCA”) staff. My name is Clark Yoder and I am the Chief Executive Officer (“CEO”) of Advanced Radiology Consultants, LLC (“ARC”). ARC is a private radiology practice with six offices located along the Connecticut shoreline from Stamford to Orange. The practice provides a full range of diagnostic imaging and interventional radiology services including MRI, which is offered at each of our locations. ARC has been in business for more than 100 years and is one the largest and most well-respected radiology practices in our state. I have been with ARC since 2015, leading an executive team responsible for the growth and development of a practice committed to providing its patients and referring physicians with state-of-the-art technology and the highest quality care.

Thank you for this opportunity to speak in support of Advanced Radiology MRI Centers Limited Partnership’s (“ARC MRI”) request for Certificate of Need (“CON”) approval to acquire a second MRI unit for ARC’s Stamford office. My testimony today will focus on how we determined the need for this additional unit, why we are choosing to locate the unit in

Stamford, and how it will improve the accessibility and cost-effectiveness of care for an all-inclusive patient population.

With me today is Dr. Gerard Muro, a board certified neuroradiologist with ARC who will be testifying about the benefits of 3.0 Tesla MRI. Dr. Muro also serves as ARC's Chief Medical Information Officer and he will speak to you about how our practice is at the forefront of health IT advances in Connecticut and nationwide. Also with me is Dr. Alan Kaye, former CEO of ARC. Dr. Kaye will offer testimony about the cost-effectiveness of introducing additional MRI capacity in a private radiology office setting. We have other ARC physicians and executive staff here today as well, with the hope that we can provide OHCA all of the information it needs to rule favorably on our CON request.

#### Clear Public Need for Additional MRI Capacity at ARC's Stamford Office

As technology evolves and applications for MRI expand, practices like ours have been experiencing an increased demand for MRI services. Over the course of the last several years ARC has been evaluating MRI capacity at each of its office locations, flexing hours and repurposing staff in order to meet demand at the places and during the times when it is greatest, evaluating market conditions, and planning for the acquisition of additional MRI units as necessary. What we found is that all of our MRI units are well-utilized and a majority of them are over-utilized. We found that in order to accommodate the demand for our MRI services we need to operate some of our units for an unsustainable amount of hours and schedule exams at times that are inconvenient for patients and more costly to staff. We also found that each of our units serves a unique patient population and we cannot simply relocate scanners that are serving patients to meet the greater demand that exists in different parts of our service area.

The following information helps to demonstrate the capacity issues that ARC MRI services are experiencing:

- ARC performed 29,413 scans among its six MRI units in FY 2015. Per the Statewide Healthcare Facilities and Services Plan (“SHP”) guidelines the practice’s total MRI capacity is 24,000 scans per year (4,000 scans per year x 6 units). This means in FY 2015 ARC’s MRI service was operating at 123% capacity (29,413 ÷ 24,000) (CON Application, p. 48).
- In FY 2015, four of the six ARC units were operating over capacity. This included Fairfield (6,685 scans ÷ 4,000 or 167% capacity); Stamford (6,617 scans ÷ 4,000 or 165% capacity); Stratford (5,433 scans ÷ 4,000 or 136% capacity); and Trumbull (5,139 scans ÷ 4,000 or 128% capacity) (CON Application, p. 48). Technically speaking, each of these offices could justify the acquisition of an additional MRI unit based on the SHP capacity benchmark (SHP, p. 61).
- The Orange MRI unit performed 2,886 scans in FY 2015, putting it at 72% capacity (CON Application, pp. 48 & 151). This unit performed 2,355 scans in the first 7 months of FY 2016 and is expected to reach capacity in the near future.
- The Shelton MRI unit performed 2,653 scans in FY 2015, which equates to 66% capacity (CON Application, pp. 48 & 151). Recent software upgrades will expand the types of exams that can be performed on this unit and, as a result, volume is expected to grow.
- The Stamford MRI unit has seen largely steady growth since FY 2011. MRI scan volume from FY 2011 through FY 2015 increased by 1,332 scans or 25% (CON Application, p. 13).

- The Stamford MRI unit operates as many as 92 hours per week. Even if capacity is gauged based on these unrealistically long hours, the existing Stamford unit will reach 87% capacity by FY 2019 (CON Application, p. 14).<sup>1</sup>
- Several other ARC locations offer similarly long or longer MRI service hours. Fairfield, for example, provides MRI services up to 100 hours per week. Stratford offers MRI services up to 92 hours per week. And Trumbull's MRI unit operates as many as 82 hours each week. Even with extended hours each of these units is operating well-above 100% capacity.

The MRI volumes and hours described above are not sustainable from either an operations or patient care perspective. As mentioned in our CON submissions, it is extremely difficult to find qualified MRI technologists who are willing to work the extended hours required to accommodate all of the practice's requests for MRI scans (CON Application, p. 14). In Stamford, for example, the service operates until 10:00 p.m. on weekdays and starts as early as 7:00 a.m. on weekdays and weekends (CON Application, p. 14). In order to get technologists to work these hours we need to pay a significant salary differential, thus reducing the cost-effectiveness of our services (CON Application, p. 14).

These hours are not always convenient for patients either. Although we understand that convenience does not equate to need, when you have an inner-city office such as our Stamford office you have to consider whether patients will be comfortable scheduling a scan late at night. In addition, there are certain scans and procedures that must be performed during the day in order to ensure sufficient physician coverage and availability of services in the event of an emergency (CON Application, p. 146). The only way to solve these problems is to add MRI

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<sup>1</sup> There is a typographical error in footnote 3 on page 14 of the CON Application. The last paragraph should state that the existing Stamford MRI service will reach 87% capacity based on 92 hours per week, not 98% capacity.

capacity so that more patients can be scanned or have their procedures performed during normal business hours.

As previously mentioned, there is a need for additional MRI capacity in several of ARC's offices. We are requesting permission to acquire a second MRI unit for the Stamford office in particular for several reasons. First, Stamford is one of our busiest offices for MRI services (CON Application, p. 48). Stamford is the most geographically distant MRI from other scanners in the practice, which also factored into the decision. If patients from the greater Stamford area cannot be accommodated at ARC's Stamford office they need to travel to our offices in upper Fairfield and New Haven Counties.<sup>2</sup> Given how busy the Fairfield MRI service has been this could mean traveling to Stratford, Trumbull, or as far as Orange or Shelton. Traffic congestion in Fairfield County, as well as the greater New Haven area, can make this travel an extreme hardship. The trip from Stamford to Orange could take several hours during peak travel times and patients making the trip are often in pain that is aggravated by sitting and driving (i.e. back pain).

In addition, the practice commissioned a study by General Electric that showed growth factors supporting the acquisition of a second MRI for ARC's Stamford office (CON Application, pp. 54-84). This includes a projected 2.8% growth in population in the greater Stamford area over the next five years, including 12.58% growth in the 55-64 age cohort and 15.84% growth in the 65+ age cohort, some of the largest consumers of MRI services (CON Application, p. 60). G.E. also projects a 5.92% increase in MRI volume over the same time period and healthcare consulting firm SG2 projects a 15% nationwide increase in MRI volume over the next 10 years (CON Application, pp. 66 & 85). In addition, 14% growth in the

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<sup>2</sup> Other MRI providers in the Stamford area are equally busy, with 10 of the 12 non-ARC units operating above 78% capacity and some operating as high as 161% capacity (see SHP, Table 8).

Medicaid population is expected to increase in lower Fairfield County as a result of healthcare reform-related expansion of program eligibility in Connecticut (CON Application, p. 63). Given ARC's commitment to serving these patients, it makes sense to increase MRI capacity in an area where Medicaid growth is expected.

#### Approving a Second Unit for ARC's Stamford Office Will Positively Impact Access and Cost

Adding more MRI capacity at ARC's Stamford office will increase access to these services for the broadest possible population of patients. From a geographic perspective, it will meet a growing demand for MRI services among residents of the greater Stamford area. These are patients who choose to obtain MRI services at ARC and if the existing Stamford MRI cannot accommodate them, they will have to travel anywhere from 20 to 40 miles down I-95 to obtain a scan. That is not adequate access.

The question has been asked whether ARC can relocate one of its lower-volume MRI units to Stamford to address capacity constraints. The answer is no, for several reasons. The only MRI units that are operating under 85% capacity per SHP standards are the Orange and Shelton units. This simply means is that they have not yet met the utilization threshold above which ARC could request permission for a second unit for either office. These units are operating at 72% and 66% capacity, respectively (CON Application, p. 151). Each unit performed between 2,500 and 3,000 scans in FY 2015 (CON Application, p. 48). As noted above, the Orange unit performed 2,355 scans in the first 7 months of FY 2016 and is expected to reach capacity in the near future. Growth is expected for the Shelton MRI service as well as a result of recent software upgrades to that office's unit.

The Orange and Shelton units are well-utilized and serve towns not covered by ARC's other MRI locations. For example, the primary service areas ("PSA") for the Shelton and Orange units include many Valley towns (i.e. Ansonia, Derby, Seymour & Oxford) that are not included in the PSAs of ARC's other MRIs (CON Application, p. 150). The Orange unit also serves patients from the greater New Haven area (i.e. West Haven, New Haven, East Haven & Woodbridge) who are not served in large numbers by other ARC units (CON Application, p. 150). Relocating either of these units would leave thousands of patients in these communities without access to ARC's MRI services. There are no other units located in Orange and the only other unit in Shelton is a hospital-based unit (CON Application, pp. 43-45). Hospital-based MRI services are often more costly for patients and payers. Note also that the Orange MRI unit is a 3.0 Tesla with certain clinical enhancements over other MRIs in the practice. Moreover, the Orange and Shelton MRI services provided scans to more than 750 Medicaid and uninsured/underinsured patients over the last two years (CON Application, p. 151). Relocating either scanner could therefore decrease access to care for these vulnerable patient populations.

The acquisition of a second MRI unit for ARC's Stamford office will also increase access to care for patients with all types of conditions, referred by all types of providers, regardless of their payer status or ability to pay. Unlike "captive" MRI units owned by specialty physician groups, ARC's MRI unit is available for referrals from physicians of any specialty, as well as ancillary providers. ARC participates with Medicaid and provides services to uninsured and underinsured patients. In FY 2015, Medicaid and uninsured/underinsured patients made up nearly 8% of Stamford MRI volume and more than 10% of MRI volume practice-wide (approximately 3,000 scans) (CON Application, p. 17). ARC's commitment to care for

Medicaid recipients in particular is critical with the expansion of participation due to healthcare reform.

The MRI services that we provide in Stamford are also more cost-effective than others in the area because ARC is the only private radiology practice offering MRI. Private practices are typically reimbursed at lower rates than their hospital counterparts. In addition, patients are not charged facility fees in connection with ARC's MRI services. Lastly, because ARC physicians do not self-refer for MRI services there is no risk of overutilization at an increased cost to patients and payers.

### Conclusion

There is a clear public need for an additional MRI unit at ARC's Stamford office based on the standards developed by OHCA as part of the SHP. The existing unit is operating an unsustainable amount of hours and servicing thousands more patients each year than the SHP says it should. The Stamford MRI is just a few hundred scans short of operating at *twice* the capacity required to justify a second unit. There is a growing demand for MRI services in the greater Stamford area as is evidenced by third-party studies and the relative utilization of the many units operating in the region. ARC cannot continue to expand hours and expect to be able to provide quality services to patients in a cost-effective manner. Nor can ARC relocate other units within the practice to meet its needs in Stamford without causing significant access issues in other communities.

Approval of a second MRI unit for ARC's Stamford office presents the best option for adding much-needed capacity and increasing access for all patients. This includes patients with

varying conditions receiving treatment from different types of referring physicians and providers. It also includes all patients regardless of ability to pay.

Thank you again for giving us the opportunity to speak with you about this important project. We urge you to approve ARC's CON request.

I will now turn the presentation over to Dr. Muro. At the conclusion of his presentation Drs. Muro and Kaye and I, along with our colleagues, will be available to answer any question that you have.

The foregoing is my sworn testimony.

A handwritten signature in blue ink, appearing to read 'Clark G. Yoder', is written above a horizontal line. The signature is stylized and cursive.

Clark G. Yoder, M.B.A.

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION**

..... )  
IN RE: ADVANCED RADIOLOGY MRI ) DOCKET NO. 16-32093-CON  
CENTERS LIMITED PARTNERSHIP )  
ACQUISITION OF MRI UNIT FOR )  
STAMFORD OFFICE )  
..... )  
AUGUST 23, 2016

**PREFILED TESTIMONY OF GERARD J. MURO, M.D.,  
NEURORADIOLOGY SECTION DIRECTOR & CHIEF MEDICAL INFORMATION  
OFFICER, ADVANCED RADIOLOGY CONSULTANTS, LLC,  
ON BEHALF OF ADVANCED RADIOLOGY MRI CENTERS  
LIMITED PARTNERSHIP**

Good morning Hearing Officer Hansted and members of the Office of Health Care Access (“OHCA”) staff. My name is Dr. Gerard Muro. I am a fellowship-trained, board-certified neuroradiologist and director of the neuroradiology section at Advanced Radiology Consultants, LLC (“ARC”). In this capacity I oversee the practice’s use of 3.0 Tesla MRI to provide the highest quality brain, spine and head and neck imaging. I am also ARC’s Chief Medical Information Officer responsible for the practice’s implementation of healthcare information technology, including our groundbreaking image sharing network. Thank you for this opportunity to speak in support of Advanced Radiology MRI Centers Limited Partnership’s (“ARC MRI”) request for Certificate of Need (“CON”) approval to acquire a second MRI unit for ARC’s Stamford office. My testimony today will focus on the quality of MRI services provided by ARC and how this increases patient demand, the benefit of introducing 3.0 Tesla technology in Stamford, and the added value that our health information technology innovations bring to the referring physicians and patients we serve.

### Advanced Radiology MRI Services

As mentioned in our CON submissions and in Mr. Yoder's testimony, ARC is one of the oldest, largest and most well-respected private radiology practices in the State of Connecticut. All of our radiologists are subspecialists. This means that in addition to having American Board of Radiology certification, we have all had additional years of training in various radiology subspecialties. All of our modalities are accredited by the American College of Radiology ("ACR") for quality and safety and several of our radiologists are fellows of the ACR. Our physicians are on staff at both Bridgeport Hospital and St. Vincent's Medical Center and we participate in residency training at both hospitals. Because of our relationships with these hospitals our radiologists are subject to Joint Commission standards regarding appointment and reappointment of professional staff based on performance and quality measures. And as discussed below, ARC is committed to enabling and empowering patients and physicians through innovations in health information technology.

Our extensive training and experience, and our commitment to excellence and empowerment, set us apart from other diagnostic imaging and interventional radiology providers. It is a testament to the quality of care we provide that many of our services, including MRI, are in such demand. There are 20 physicians, including myself, who are specially trained to read MRI scans. The practice is committed to providing state-of-the-art MRI services, which is why we are requesting permission to acquire a 3.0 Tesla unit to be the first of its kind in Stamford.

### Acquisition of a 3.0 Tesla MRI Will Improve Quality of Care

Our decision to acquire a 3.0 Tesla MRI unit was driven by our desire to bring state-of-the-art MRI services to Stamford (CON Application, p. 15). This technology allows for much better quality vascular imaging of the head, neck, body, and extremities and may help obviate the need for vascular imaging that requires radiation or may be more invasive. With 3.0 Tesla, high-quality advanced imaging techniques such as diffusion tensor imaging, functional imaging, and brain perfusion will be available in a private practice setting. In addition, the stronger magnet will allow for higher resolution images in cases where added detail is important for diagnosis. A 3.0 Tesla MRI is now the preferred unit for many brain scans (including scans for Lyme disease and Parkinson's disease), as well as spine, prostate, and MRA scans. Making this technology available in Stamford – in a private practice setting where all patients are welcomed regardless of ability to pay – will enhance the quality, accessibility and cost-effectiveness of MRI services.

### Benefits of ARC's Image Sharing Network

ARC has been at the forefront of health information technology for radiology practices in Connecticut and nationally. As discussed in our Completeness Question Responses (CON Application, pp. 147-48), we have an extensive data network that facilitates the electronic exchange of medical orders and results between healthcare systems and physician groups such as Yale-New Haven Health, St. Vincent's and Stamford Medical Group, and ARC. This electronic exchange of medical orders and results minimizes scheduling effort, data entry redundancies and errors, duplicative procedures, and time spent waiting on results. Further, ARC shares medical images and reports in real time with thousands of physicians in Connecticut and beyond via an

Internet-enabled clinical viewer, physician web portal and mobile apps. Both physicians and patients can securely share images with anyone for whom they have an e-mail address, allowing continuity of care as patients see a range of healthcare professionals in Connecticut and beyond. ARC's patient portal currently has 120,000 active patient users while new patients are registering at a rate of approximately 3,000 patients per month.

As we mentioned in our CON submission, this type of image sharing empowers patients. It allows them to consult effortlessly with providers at different hospitals and facilities within and outside of Connecticut, whereas previously this would not have been possible if the providers had different electronic medical record ("EMR") systems. This flexibility is particularly important in an area where many patients travel to New York and Boston for second opinions or travel out of state in the winter months.

This "portability" of images and reports can avoid the need for repeat scans if a patient finds himself or herself out of state and in need of MRI results to provide to a physician, for example. That physician can simply access the results of the patient's MRI scan through ARC's image sharing network and avoid the increased cost and exposure, and delay in diagnosis and treatment, associated with duplicating the study. In addition, this network enhances quality of care by ensuring timely diagnosis and rapid clinical decision making and allowing for coordination of care among a patient's many healthcare providers.

The image sharing network that our practice pioneered differs from traditional EMR systems. EMR systems allow communication between physicians and have traditionally been utilized to document the information required to support payment. But many EMR systems exclude images or handle them in a proprietary way. Having an image sharing network that allows physicians to access a patient's records anywhere, at any time, from almost any mobile

device empowers those physicians with the information necessary to provide timely and appropriate treatment for their patients. Similarly, the portal aspect of the image sharing network empowers patients through the ownership and portability of their images and reports. This type of interoperability and data sharing is consistent with the goals of the Affordable Care Act and recently passed State of Connecticut legislation aimed at the free flow of electronic health information.

### Conclusion

Approving the acquisition of a 3.0 Tesla MRI unit for ARC's Stamford office will undeniably enhance the quality of MRI service in the area. A provider that is committed to excellence, that employs the services of only subspecialty trained radiologists, will be able to offer state-of-the-art MRI to anyone in need. Because of ARC's practice of inclusion of all patients regardless of ability to pay, this unit will enhance access to care for the most vulnerable patients in our state. Finally, there will be the added value of integrating the new MRI into a secure regional image sharing network facilitating the exchange of vital healthcare information between patients, physicians and hospitals. For these reasons we urge you to approve ARC's CON request.

Thank you and we are available to answer any questions that you have.

The foregoing is my sworn testimony.

A handwritten signature in black ink, appearing to read 'G. Muro', with a long horizontal flourish extending to the right.

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Gerard J. Muro, M.D.

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION**

..... )  
IN RE: ADVANCED RADIOLOGY MRI ) DOCKET NO. 16-32093-CON  
CENTERS LIMITED PARTNERSHIP )  
ACQUISITION OF MRI UNIT FOR )  
STAMFORD OFFICE )  
..... )  
AUGUST 23, 2016

**PREFILED TESTIMONY OF ALAN D. KAYE, M.D.,  
FORMER CHIEF EXECUTIVE OFFICER OF  
ADVANCED RADIOLOGY CONSULTANTS, LLC,  
ON BEHALF OF ADVANCED RADIOLOGY MRI CENTERS  
LIMITED PARTNERSHIP**

Good morning Hearing Officer Hansted and members of the Office of Health Care Access (“OHCA”) staff. My name is Dr. Alan Kaye and I am the former Chief Executive Officer of Advanced Radiology Consultants, LLC (“ARC”). Thank for your allowing me this opportunity to provide brief remarks in support of Advanced Radiology MRI Centers Limited Partnership’s (“ARC MRI”) request for a Certificate of Need (“CON”) to acquire a second MRI unit for ARC’s Stamford office. In addition to my work with ARC, which has spanned more than 30 years, I have been actively involved with organized medicine and advocacy efforts on behalf of radiologists on a state and national level for most of my career. As such, I have had an opportunity to witness the evolution of imaging “self-referral” and the impact that it has had on healthcare consumers, payers and providers such as ARC.

My remarks today will focus on how providing imaging services, in this case MRI, in a private radiology office setting is more cost-effective than providing these same services in an office where the providers themselves both decide whether a patient needs an exam and make referral for that exam to a unit in which they have a financial interest. Thus, ARC MRI’s

proposal presents the most cost-effective option for adding much-needed MRI capacity in the Stamford area.

#### Impact of Self-Referral on Cost-effectiveness, Quality & Accessibility of Imaging Services

Put simply, self-referral is when a provider refers a patient to a facility for healthcare services and that provider has a financial interest in, or arrangement with, the facility that allows the potential for financial gain from the referral. An example is the ownership of an MRI unit by an orthopedic group and the referral of patients for “in-office” MRI services by physicians in that group. In this case, the physicians who make the referrals stand to benefit from the revenues generated by the MRI unit. They therefore have a financial incentive to maximize referrals to their captive scanner.

Compare this with private radiology practices such as ARC, which only perform examinations referred by providers not affiliated with the group. These providers refer patients to ARC’s MRI units (and other equipment) for one reason only, their need for information, including preventative, interventional, diagnostic, and staging studies, as well as determinations of efficacy of treatment, to guide their patients’ care. There is no personal incentive on the part of these referring providers to send patients for MRI scans and there is certainly no financial gain realized by the referrers.

On the other hand, as our experience demonstrates and study after study unequivocally show, the volume and cost of imaging increases substantially when providers who refer patients for imaging tests own the machines on which the examinations are performed. Early studies, which led to initial attempts at curtailing self-referral, showed that providers engaged in self-referral ordered imaging studies at a much higher rate than their colleagues who sent patients to

dedicated imaging facilities and that self-referral increased the cost of care considerably (Exhibit A). Many subsequent studies showed similar results. For example, analysis of Medicare data published in 2002 showed that growth in the use of radionuclide myocardial perfusion imaging between 1996 and 1998 was 10 times higher among cardiologists (self-referred) than radiologists (Exhibit B).

There is no obvious explanation for the higher rate of use except the financial benefits of self-referral for providers making the referrals. Self-referral accounts for a majority of imaging growth. The issues regarding self-referral and its adverse impact on cost of care are so well known that many advocacy groups (i.e. American Association of Retired Persons<sup>1</sup>), the GAO (Exhibit D), and President Obama's 2017 budget (Exhibit E) have all called for reform of the system to close loopholes in the law that allow it.

There is an undisputed need for additional MRI capacity in Stamford. As others have testified, the ARC Stamford MRI unit is operating at 165% capacity and volume is projected to grow at a rate of 5% annually (CON Application, pp. 13 & 40). By allowing ARC MRI to acquire a second unit for the practice's Stamford office, OHCA can be assured that the scanner will be used to fulfill the legitimate healthcare needs of all area patients, regardless of the type of insurance they have. None of the more than 500 providers who referred patients to ARC's Stamford office for nearly 7,000 MRI scans in FY 2015 has a financial interest in our MRI unit or in any ARC equipment for that matter. Our referring providers have nothing to gain financially from ordering MRI scans for their patients. We know, therefore, that every scan

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<sup>1</sup> In a 2014 letter to U.S. Rep. Speier, the AARP stated as follows: "The in-office ancillary services exception was intended to allow physicians to perform services which can be completed in the physician's office while the patient is present and which aid in the diagnosis of the patient in order to minimize delays in patient care. Unfortunately, the exception has contributed to overutilization and rapid growth of certain services, particularly in radiation oncology, anatomic pathology, advanced imaging, and physical therapy. Closing the loophole will better serve patients and preserve Medicare's resources by saving approximately \$6 billion over ten years for these services" (Exhibit C).

referred to ARC's Stamford office has been deemed necessary in the clinical judgment of the referring provider, further supporting the validity of our volume projections. ARC's independent status helps to minimize unnecessary scans, thereby helping to keep healthcare costs down. The acquisition of an MRI unit by ARC is therefore a more cost-effective means of adding MRI capacity than any proposals by self-referring providers.

Note also that self-referral can have an adverse impact on both the quality and accessibility of imaging services. As Dr. Muro mentioned in his testimony, the quality of ARC's MRI services are unparalleled. Every single one of our MRI scans is interpreted by a board certified radiologist with additional training in the specific type of examination for that particular patient – i.e., neuroradiologists for MRI's of the brain and spine and musculoskeletal radiologists for bones and joints. Thus, patients scanned by ARC have their expert clinical referring physician plus a sub-specialized imaging physician consultant - a built-in second opinion. The former editor of the prestigious New England Journal of Medicine wrote that self-referral situations deprive patients of independent judgment on the part of their doctor and of peer review, factors that are inherent in any exam referred from one physician to another, and thereby undermine the integrity and trust of the medical profession and its social contract with patients (Exhibit F).

In addition, ARC's health information technology systems are cutting edge, allowing web-based sharing of images and reports with referring physicians, consulting physicians, and patients. The private radiology office setting affords the presence of an on-site radiologist and ARC's technology infrastructure means that a sub-specialized radiologist is always only a click away. All of this provides a level of oversight that is not always available in offices where MRI scans are self-referred. Why does ARC continue to invest so heavily in high-end scanners (i.e.

3.0 Tesla MRI) and technology and sub-specialized radiologists? Specifically because we have to compete for their patronage, the only incentives we can provide our referring physicians and patients are quality and service.

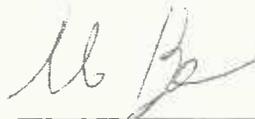
Lastly, self-referral providers often limit the payers they accept and “skim the cream” of commercially insured patients, leaving private radiology offices and hospitals to care for Medicaid recipients and uninsured patients to our financial detriment. This ultimately impacts the viability of our practices and facilities and potentially our ability to continue to provide access for all patients regardless of their financial means.

### Conclusion

Thank you again for this opportunity to speak in support of ARC MRI’s request for permission to acquire a second MRI unit for Stamford. None of the thousands of MRI scans that ARC performs each year results in any financial gain to the referring provider. This removes any specter of conflict of interest, ensuring that each referred scan is needed and that it is not artificially adding to the cost of health care, making ARC’s proposal cost-effective. The absence of self-referral also enhances the quality and accessibility of MRI services for the benefit of all patients. For these reasons, I urge OHCA to approve ARC MRI’s CON request.

I am available to answer any questions that you have.

The foregoing is my sworn testimony.

A handwritten signature in cursive script, appearing to read 'Alan Kaye', written in dark ink.

---

Alan Kaye, M.D.

***EXHIBIT A***



# The NEW ENGLAND JOURNAL of MEDICINE

## SPECIAL ARTICLE

## Frequency and Costs of Diagnostic Imaging in Office Practice — A Comparison of Self-Referring and Radiologist-Referring Physicians

Bruce J. Hillman, M.D., Catherine A. Joseph, B.A., Michael R. Mabry, B.A., Jonathan H. Sunshine, Ph.D., Stephen D. Kennedy, Ph.D., and Monica Noether, Ph.D.

N Engl J Med 1990; 323:1604-1608 | December 6, 1990 | DOI: 10.1056/NEJM199012063232306

Share:

### Abstract

#### Abstract

To assess possible differences in physicians' practices with respect to diagnostic imaging, we compared the frequency and costs of imaging examinations as performed by primary physicians who used imaging equipment in their offices (self-referring) and as ordered by physicians who always referred patients to radiologists (radiologist-referring).

Using a large, private insurance-claims data base, we analyzed 65,517 episodes of outpatient care by 6419 physicians for acute upper respiratory symptoms, pregnancy, low back pain, or (in men) difficulty urinating. The respective imaging procedures studied were chest radiography, obstetrical ultrasonography, radiography of the lumbar spine, and excretory urography, cystography, or ultrasonography.

For all four clinical presentations, the self-referring physicians obtained imaging examinations 4.0 to 4.5 times more often than the radiologist-referring physicians ( $P < 0.0001$  for all four). For chest radiography, obstetrical ultrasonography, and lumbar spine radiography, the self-referring physicians charged significantly more than the radiologists for imaging examinations of similar complexity ( $P < 0.0001$  for all three). The combination of more frequent imaging and higher charges resulted in mean imaging charges per episode of care that were 4.4 to 7.5 times higher for the self-referring physicians ( $P < 0.0001$ ). These results were confirmed in a separate analysis that controlled for the specialty of the physician.

Physicians who do not refer their patients to radiologists for medical imaging use imaging examinations more frequently than do physicians who refer their patients to radiologists, and the charges are usually higher when the imaging is done by the self-referring physician. From our results it is not possible to determine which group of physicians uses imaging more appropriately. (N Engl J Med 1990; 323:1604–8.)

### Article

THE potential for conflicts of interest and higher costs for health care arising from the ownership by physicians of the diagnostic facilities to which they refer patients has attracted considerable attention recently in the medical literature<sup>1 2 3 4 5</sup> and lay press<sup>6 7</sup> and has been the subject of government study and legislation.<sup>8 9 10</sup> The ownership of imaging centers by physicians has received much of the media attention. However, most self-referral for medical imaging — in which physicians perform and interpret diagnostic imaging examinations of their own patients rather than refer them to imaging specialists — takes place in the physician's office.

The few previous studies investigating the effect of self-referral on the use and costs of imaging have been limited by methodologic flaws, small study populations, and lack of controls. To overcome these limitations, we analyzed a large data base of private insurance claims and evaluated the imaging done in physicians' offices during episodes of outpatient medical care. After controlling for differences in patients' clinical presentations and physicians' specialties, we compared the frequencies

with which the patients underwent imaging examinations during episodes of medical care for acute conditions, according to whether their physicians could perform those imaging examinations themselves. We also compared the resultant charges for the imaging examinations.

We purchased access to a data base (Medstat Systems, Ann Arbor, Mich.) comprising all the health insurance claims of 403,458 employees and dependents of several large American corporations. The insurance programs provided comprehensive coverage, including outpatient imaging services, with no copayments required. The data base was selected for its uniformity and completeness. Seventy-nine percent of the study population lived in the north central United States, 6 percent in the Northeast, 11 percent in the South, and 4 percent in the West. Fifty-one percent were female, and 49 percent male. Fifty-five percent were 0 to 34 years old, 33 percent were 35 to 54 years old, and 12 percent were 55 or older. Ninety-three percent of the physicians making claims for care provided to these patients practiced in metropolitan areas.

Using this data base, we compared the frequency of imaging and the charges for imaging among self-referring physicians and among physicians who instead referred patients to radiologists (radiologist-referring physicians) for four clinical presentations, selected for their variety and the volume of associated imaging procedures. The presentations, with the associated diagnostic inquiry, were as follows: acute upper respiratory symptoms (Was chest radiography performed?), pregnancy (Was obstetrical ultrasonography performed to assess fetal size and gestational age?), low back pain (Was radiography of the lumbar spine performed?), and (in men) difficulty urinating (Was excretory urography, cystography, or ultrasonography performed?).

We surveyed the *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)*,<sup>11</sup> selecting all codes that might reasonably represent diagnoses that would be entered by physicians whose patients presented with symptoms related to any of the four clinical presentations. A detailed tabulation of the codes is available elsewhere.\*

We developed and applied to the claims data base a computer algorithm, modeled on previous methods, for defining episodes of outpatient medical care occurring in physicians' offices.<sup>12</sup> The date of a claim for an index ICD-9-CM code in an office setting was used to define the starting date of an episode. Episodes were considered to have ended after specified periods — four weeks for upper respiratory infection, nine months for pregnancy, six weeks for low back pain, and six weeks for difficulty urinating. Claims made between the initiation and termination dates of an episode were eligible for inclusion in that episode. Depending on the clinical presentation, a lag period of two to eight weeks followed the termination of each episode, so that follow-up visits for the original episode would not be counted as new episodes of care. The length of the episodes and lag periods was initially proposed on the basis of medical experience. We ensured that these durations were appropriate by evaluating the completeness of 600 randomly selected episodes and determining that the use of alternate durations for the episodes of up to two-thirds longer affected the number of episodes by only 1 to 6 percent in the case of the clinical presentations studied.

To be included in the study, episodes of care had to begin after January 1, 1986, and end before June 1, 1988. Episodes were excluded if the only physician involved in the episode was a radiologist or if the specialty of any physician involved was unknown. Within valid episodes, we deleted any claims for which no charge or payment was made, any claims for supplemental payments, and any claims for which the age or sex of the patient or the physician's identification number was unknown. We also excluded claims that were unrelated in terms of ICD-9-CM coding to the clinical presentations under investigation and claims made by physicians whose specialty codes indicated practices unrelated to the clinical presentations under study. A list of the specialties of the physicians included in the analysis is available elsewhere.\*

The physicians who filed the claims included in the episodes studied were distinguished by their physician identification numbers; these numbers were coded to protect confidentiality. With regard to each clinical presentation, the physicians were grouped, according to their involvement in episodes for which they were the only nonradiologist physician to file a claim (one-physician episodes), into the following categories: self-referring physicians, who charged at least once for an index imaging examination; radiologist-referring physicians, who never charged for an index imaging examination and who were involved in at least one one-physician episode in which a radiologist performed such an examination; and physicians whose patients had no imaging in any one-physician episodes. One-physician episodes comprised 92 percent of all valid episodes.

We considered the possibility that some physicians categorized as radiologist-referring might actually be self-referring physicians who happened not to have performed any imaging in the episodes in our sample. We performed a correction to account for this possibility (details available elsewhere\*). Since this correction did not alter the results, we report only our unadjusted data here.

The categorization of the physicians who participated in the one-physician episodes was used to develop six categories of similar and dissimilar pairs of physicians for the 7 percent of valid episodes in which two different physicians, neither a radiologist, cared for the patient (two-physician episodes). The 471 valid episodes (0.7 percent) in which more than two nonradiologist physicians were involved were not included in the analysis. We performed separate classifications of the one-physician and two-physician episodes on the basis of the categorization of the physicians and whether a claim for a related imaging examination was filed during the episode, as evidenced by the encountering of an appropriate diagnostic-imaging-procedure code (CPT-4 code; the table of index codes is available elsewhere\*).

\*See NAPS document no. 04816 for 16 pages of supplementary material. Order from NAPS c/o Microfiche Publications, P.O. Box 3513, Grand Central Station, New York, NY 10163-3513. Remit in advance (in U.S. funds only) \$7.75 for photocopies or \$4 for microfiche. Outside the U.S. and Canada add postage of \$4.50 (\$1.50 for microfiche postage).

For the one-physician episodes, our estimates of the frequency of imaging by the self-referring physicians and the radiologist-referring physicians were based on the observed frequencies for these two categories of physicians. Applying maximum-likelihood methods to the information we derived from our data about the imaging practices of self-referring and radiologist-referring physicians, we adjusted these observed frequencies to account for the episodes attributable to the physicians who had performed no imaging. This adjustment was based on the assumption that the imaging practices of the physicians within each category were homogeneous. However, this was almost certainly not the case. As a result, the correct adjustment of the observed frequencies is uncertain. For this reason, we report here the most likely estimates of the imaging frequencies for the self-referring and the radiologist-referring physicians. In addition, to account for heterogeneity in the physicians' imaging practices, we developed estimates biased upward and downward that show that our results are not affected qualitatively by the choice of the adjustment for the episodes involving the physicians who performed no imaging over the entire range of possible adjustments. The methods we employed, the initial categorization of the physicians and classification of episodes, and the upward- and downward-biased estimations of imaging frequencies are available elsewhere.\*

For the analyses of both the one-physician and the two-physician episodes, we assessed the differences between self-referring and radiologist-referring physicians in terms of the proportion of episodes that involved imaging, the charges for imaging performed, and the average imaging charges per episode. To calculate the results for the group, we weighted the results for individual physicians according to the number of episodes in which they were involved. The significance of the differences between self-referring and radiologist-referring physicians was determined by the usual t-statistic for the difference in means between the two groups. We conducted a similar analysis based on the specialties of the physicians involved in the episodes, to compare differences within specialties. The null hypothesis of no difference was rejected at a P level of <0.05.

For each clinical presentation, we compared the complexity of the imaging examinations performed by the self-referring physicians with that of the examinations performed by the radiologists by calculating the mean ( $\pm$ SD) relative values of their procedures (i.e., a measure of the complexity of the procedure).<sup>13</sup>

The data base generated 62,880 one-physician episodes for the four study groups. After exclusions (see Methods), there were 60,829 valid episodes involving 6419 physicians. One-physician episodes represented 92 percent of all valid episodes. These were distributed as follows: upper respiratory symptoms, 47,794 episodes involving 3452 physicians; normal pregnancy, 1377 episodes involving 468 physicians; back pain, 9634 episodes involving 2001 physicians; men with difficulty urinating, 2024 episodes involving 498 physicians.

Table 1 shows the frequencies with which imaging was used during the episodes, the charges for imaging, and the charges for imaging per episode for self-referring and radiologist-referring physicians. The mean imaging charges of the self-referring physicians were significantly higher (P for all comparisons, <0.0001) than those of the radiologists for all clinical presentations except difficulty urinating. Depending on the clinical presentation, the episodes involving self-referring physicians resulted in imaging 4.0 to 4.5 times as frequently, with average imaging charges per episode 4.4 to 7.5 times higher than those for the episodes involving radiologist-referring physicians (P<0.0001 for each clinical presentation, for both frequency of imaging and average imaging charges per episode).

There were 4688 valid two-physician episodes, or 7 percent of all episodes. The results for these episodes support the findings in the one-physician episodes. Depending on the clinical presentation, the episodes involving two self-referring physicians were 1.7 to 3.7 times as likely to result in imaging as episodes involving two radiologist-referring physicians (P<0.01 for each presentation). Complete results for all six categories of physician pairs are available elsewhere.\*

**TABLE 1**

Categories of Physicians and Episodes, Frequencies of Imaging, and Imaging Costs in One-Physician Episodes.\*

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For each specialty and each clinical presentation, the self-referring physicians performed imaging 2.4 to 11.1 times as often as the radiologist-referring physicians, and at a cost per episode for imaging that was 3.0 to 17.1 times higher, depending on the specialty and clinical presentation (Table 2) ( $P < 0.01$  for each specialty studied with regard to each clinical presentation).

The mean ( $\pm$ SD) complexity score for chest films was  $3.02 \pm 0.14$  for self-referring physicians, and  $3.00 \pm 0.20$  for radiologist-referring physicians. For obstetrical ultrasonography, the comparison was  $11.24 \pm 1.14$  versus  $11.35 \pm 0.96$ ; for lumbar spine films,  $3.98 \pm 0.63$  versus  $4.14 \pm 0.52$ ; and for the combination of urography, cystography, and ultrasonography,  $8.46 \pm 0.70$  versus  $8.35 \pm 0.43$ . Thus, the differences in complexity ranged from 1 to 4 percent and do not account for the differences identified in the charges for imaging.

For the clinical presentations we studied, patients with similar sets of symptoms were at least four times as likely to have diagnostic imaging performed as part of their evaluation if they sought care from a physician who performed imaging examinations in the office rather than from one who referred patients to a radiologist. Because self-referring physicians performed imaging studies more frequently and generally charged more than radiologists for similar imaging procedures, patients seeking care from self-referring physicians incurred considerably higher charges for diagnostic imaging than patients whose physicians referred them to radiologists. These effects cannot be attributed to differences in the mix of patients, the specialties of the physicians, or the complexity of the imaging examinations performed.

Previously, Childs and Hunter<sup>14</sup> found that physicians other than radiologists who provided imaging services used imaging more frequently than their peers in caring for elderly patients in Northern California. In a 1978 survey of 5447 physicians, Radecki and Steele<sup>15</sup> determined that nonradiologist physicians with imaging facilities either in their offices or at the same site have higher rates of use than physicians without such facilities. A similar study of the effect of the site of imaging facilities used by family practitioners produced a similar result.<sup>16</sup>

The differences between our study and those performed previously include the relatively large number of patients and physicians we studied and the emphasis on specific clinical situations and episodes of medical care. Analyzing episodes of care permitted us to focus directly on the issue that seemed most pertinent — whether individual patients with specific symptoms were more likely to receive imaging examinations when their physicians operated imaging equipment. As compared with the global measures used in previous studies, this method controls better for other variables — physicians' specialization, the complexity of examinations, differences in the types of patients seen by physicians, and the number of patient—physician encounters that might occur during the course of a patient's medical care. Finally, the focus on episodes as the unit of analysis allows a more accurate assessment of the activities and costs of medical care, the chief focus of our study.<sup>12</sup>

We have attempted to account for what we perceive to be the major possible biases of our study. After assessing the effect of correcting our results to account for the small percentage of physicians who had probably been miscategorized, and evaluating alternative probabilistic models for assigning the episodes involving physicians whom we could not categorize definitively, we found that these considerations did not affect the results qualitatively (details of these assessments and the adjusted results are available elsewhere\*). Our population of patients did not represent the American population, geographically or according to age. However, the geographic concentration tended to lessen the effects of regional differences in practice patterns, and it seems implausible that the large differences we identified in the use of imaging would be related to age. Although there is no assurance that the clinical presentations we studied represent the imaging practices of physicians in other clinical settings, the dimensions and consistency of our findings with regard to four very different clinical presentations and types of imaging examinations suggest that this practice pattern may be widespread.

We based our methods on those used by previous investigators,<sup>12, 17, 18</sup> but with adaptations to account for the large number of physicians and patients in our data base. Doubtless, the initial visits to physicians that triggered episodes of outpatient care occurred in an undefined context of patients' seeing their personal physicians, being referred by one physician to another, and seeking the specialist they believed to be appropriate. Although the manner in which the patients ended up seeing the physicians they did might potentially have affected the results, it is important to note that the results were uniformly sustained in our analysis of individual specialties. Also, with regard to our means of defining the index symptoms, determining the start of episodes, and including claims in episodes, there is nothing to suggest that our choices unequally biased the probability of imaging or the imaging charges in favor of either self-referring or radiologist-referring physicians. We believe that the differences between these two groups of physicians are so considerable that such issues have little relevance to the results.

TABLE 2

Frequency of Imaging and Costs per Episode in One-Physician Episodes, According to the Specialty of the Physician.\*

Our findings of increased use of imaging and increased costs attributable to nonradiologist physicians who operate their own imaging equipment should be of interest to regulatory and reimbursement agencies. It is impossible to determine from our results whether the imaging practices of the self-referring physicians or those of the radiologist-referring physicians represent the more appropriate care. Nor is it possible to determine the extent to which financial incentives are responsible for the higher levels of use and charges among the self-referring physicians. These physicians may perform imaging more frequently because they have financial incentives to do so, because imaging is more convenient when performed in a physician's office, or because physicians who perform imaging more often are more likely to acquire imaging equipment. Nonetheless, the differences between the self-referring and radiologist-referring physicians in the use of imaging are so large that some concern over the role of financial incentives must be invoked. Schroeder and Showstack<sup>19</sup> have detailed the potent financial incentives for a physician to incorporate imaging into an office practice. More recently, Hemenway et al.<sup>20</sup> validated this concern by showing an increase in the use of imaging when a group of ambulatory clinics changed to a method of compensation that used the frequency with which physicians ordered imaging examinations as the basis for paying them.

The American Medical Association has stated that the referral of patients to facilities in which physicians have an ownership interest is permissible, provided that patients are apprised of this relation and have other choices, and provided that physicians always act in their patients' best interests.<sup>21</sup> With respect to diagnostic imaging, however, it is unlikely that patients, even if so apprised, will be able to assess the appropriateness of such referrals accurately or seek imaging elsewhere. Particularly in the office setting, patients cannot be said to have a meaningful choice when their physicians advise them to undergo imaging. The potential to self-refer patients for imaging must surely complicate physicians' decisions and perhaps jeopardize their obligation to place their patients' interests above their own.

\*See NAPS document no. 04816 for 16 pages of supplementary material. Order from NAPS c/o Microfiche Publications, P.O. Box 3513, Grand Central Station, New York, NY 10163-3513. Remit in advance (in U.S. funds only) \$7.75 for photocopies or \$4 for microfiche. Outside the U.S. and Canada add postage of \$4.50 (\$1.50 for microfiche postage).

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# Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population

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**Objectives and Rationale.**—For 10 common clinical presentations, we assessed differences in physicians' utilization of and charges for diagnostic imaging, depending on whether they performed imaging examinations in their offices (self-referral) or referred their patients to radiologists (radiologist-referral).

**Methods.**—Using previously developed methodologies, we generated episodes of medical care from an insurance claims database. Within each episode, we determined whether diagnostic imaging had been performed, and if so, whether by a self-referring physician or a radiologist. For each of the 10 clinical presentations, we compared the mean imaging frequency, mean imaging charges per episode of care, and mean imaging charges for diagnostic imaging attributable to self- and radiologist-referral.

**Results.**—Depending on the clinical presentation, self-referral resulted in 1.7 to 7.7 times more frequent performance of imaging examinations than radiologist-referral ( $P < .01$ , all presentations). Within all physician specialties, self-referral uniformly led to significantly greater utilization of diagnostic imaging than radiologist-referral. Mean imaging charges per episode of medical care (calculated as the product of the frequency of utilization and mean imaging charges) were 1.6 to 6.2 times greater for self-referral than for radiologist-referral ( $P < .01$ , all presentations). When imaging examinations were performed—including those performed in both physicians' offices and hospital outpatient departments—mean imaging charges were significantly greater for radiologists than for self-referring physicians in seven of the clinical presentations ( $P < .01$ ). This result is related to the high technical charges of hospital outpatient departments; in office practice, radiologists' mean charges for imaging examinations were significantly less than those of self-referring physicians for seven clinical presentations ( $P < .01$ ).

**Conclusions.**—Nonradiologist physicians who operate diagnostic imaging equipment in their offices perform imaging examinations more frequently, resulting in higher imaging charges per episode of medical care. These results extend our previous research on this subject by their focus on a broader range of clinical presentations; a mostly elderly, retired population; and the inclusion of higher-technology imaging examinations.

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DURING the last decade, direct payments for physicians' services tripled, from \$41.9 billion to \$125.7 billion.<sup>1</sup> In large part, this has been due to an increase in the number of services provided to patients.<sup>2,3</sup> One phenomenon promoting greater intensity of care is physicians increasingly adopting more and more complex technologies into their office practices.<sup>3</sup> Physicians then can "self-refer" their patients to these technologies. Self-referral has been shown to be associated with higher-technology utilization than when physicians refer their patients to specialists employing these same technologies.<sup>4,7</sup>

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See also p 2055.

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Previously, we demonstrated that, for each of four common clinical presentations, self-referring physicians employed diagnostic imaging at least four times as frequently as their colleagues who referred imaging examinations to radiologists. Self-referring physicians also charged significantly more for performing and interpreting imaging studies in their offices than did radiologists.<sup>7</sup> This investigation employs similar methodology to expand upon our previous work assessing physicians' utilization of and charges for diagnostic imaging by studying a mostly elderly, chronically ill patient population that is of particular interest with regard to Medicare reimbursement; evaluating a broader array of imaging technologies and clinical presentations; more extensively portraying imaging charges; and assessing

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patients with 10 common clinical presentations, including three of the four presentations investigated in our previous research.

## METHODS

### Insurance Claims Database and Clinical Presentations

Access to the insurance claims database used in this investigation was provided without charge by the United Mine Workers of America Health and Retirement Funds (Funds). Reimbursement for physicians' claims and the claims database are administered for the Funds by Alta Health Strategies, Inc (Alta). We investigated the portion of the database representing all physicians' claims for all Funds beneficiaries, regardless of age, rendered during the 2-year period January 1, 1988, through December 31, 1989. The claims history file records the billed charge for all line items for each claim.

Funds beneficiaries and their dependents receive full reimbursement, with no copayments, for outpatient diagnostic imaging examinations. The Funds administers both the Medicare and supplemental insurance components of physician reimbursements for Funds beneficiaries (84% of Funds beneficiaries are covered by Medicare Part B).

The Funds database details the health insurance coverage for their approximately 119 000 beneficiaries. Of these, 79% are 65 years or older. Thirty-four percent are male. Eighty percent live in the Appalachian coal-mining region.

Using this database, we compared the frequency of imaging and the imaging charges accrued during episodes of acute care of self-referring physicians with those of radiologist-referring physicians for 10 clinical presentations. The clinical presentations and their associated imaging examinations were chosen to obtain a broad distribution of anatomic locations, variety of imaging examinations, and sophistication of imaging technology, as well as for their frequency of appearance in the Funds' claims database and the imaging costs they represented to the Funds.

The 10 clinical presentations selected included three of the four clinical presentations investigated in our earlier research,<sup>7</sup> including (with the associated imaging examinations) acute upper respiratory tract symptoms (plain films, fluoroscopy), men with trouble urinating (excretory urography, cystourethrography, sonography), and low-back pain (plain films, myelography, diskography, computed tomography [CT], magnetic resonance [MR]). Additional clinical presentations investigated in this study

were headache (CT, MR), transient cerebral ischemia (CT, MR, sonography including Doppler studies, angiography), upper gastrointestinal bleeding (plain films, barium studies), knee pain (plain films, arthrography, CT, MR), urinary tract infection (plain films, excretory urography, cystourethrography, sonography, CT, MR), chest pain (plain films, barium studies, radionuclide studies), and congestive heart failure (plain films, echocardiography, real-time and Doppler sonography, angiography, radionuclide studies). A complete list of the radiologic procedure (CPT-4) codes<sup>8</sup> counted in the analysis for each clinical presentation can be obtained from the National Auxiliary Publications Service (NAPS).

### Development of Episodes of Medical Care

We previously have detailed the methods employed to define episodes of outpatient care.<sup>7</sup> Briefly, for each of the 10 clinical presentations, we defined all diagnostic (ICD-9) codes<sup>9</sup> that physicians reasonably might enter on their claims for services to these patients. The ICD-9 codes selected for each clinical presentation (index ICD-9 codes) can be obtained from NAPS. Each of the 10 clinical presentations was analyzed separately.

We applied to the database a version of the computerized algorithm we employed in our earlier work.<sup>7</sup> Briefly, an episode was initiated by a physician's claim for a service related to an index ICD-9 code. The date of this service represented the starting date of the episode; the episode concluded after a fixed period of time, the amount of time depending on the clinical presentation. All claims from physicians with specialties relevant to the clinical presentation (see NAPS deposit), for office and hospital outpatient services, encountered between the beginning and end dates for the episode were eligible for inclusion in the episode. A lag period was observed immediately following each episode, during which neither an index ICD-9 code nor index CPT-4 code either counted as part of the previous episode or initiated a new episode. This restriction prevented the misclassification of a follow-up service as the initiation of a new episode. The durations of episodes and lag periods for each clinical presentation can be obtained from NAPS. The appropriateness of the durations of episodes and lag periods was established and tested by the same methods we have previously described.<sup>7</sup>

Episodes were eligible for inclusion in the analysis if they were triggered by an appropriate index ICD-9 code, with

a service date on or after January 1, 1988, and were completed by December 31, 1989. Because we were unable to determine which of two or more physicians decides whether to perform an imaging examination, we excluded episodes where multiple nonradiologist physicians cared for the patient or where services other than laboratory or radiology were provided in a hospital outpatient department (10% of episodes). Since we could not reliably categorize imaging services as self- or radiologist-referral when multispecialty group practices provided both radiologic and other services, we excluded episodes occurring in clinics and when a provider was involved in numbers of episodes greater than 2 SD from the mean. Following these exclusions, the episode files included 50% to 75% of the original episodes for the 10 clinical presentations.

Individual claims within valid episodes were excluded if the services were unrelated to the clinical indication or provided in nondesignated settings or if there was no charge for the claim.

### Designation of Physicians as Self-referring or Radiologist-Referring

Each nonradiologist provider (defined by their primary specialty code and/or having less than 75% of their claims being for imaging procedures) was designated individually as "self-referring," "radiologist-referring," or "unknown," separately, for each clinical presentation in which he or she participated. A self-referring physician was one who at least once during the 2-year period submitted a claim for performing an index imaging study, even if he or she also referred a patient to a radiologist. A radiologist-referring physician never submitted a claim for an index imaging study and at least once participated in a valid episode in which the patient was referred to a radiologist for imaging. An unknown physician did not participate in a valid episode during which either he or a radiologist performed an index imaging examination.

### Classification of Episodes and Estimation of the Frequency of Imaging

We classified the episodes of self- and radiologist-referring physicians on the basis of whether imaging was performed. This provided us with the observed frequencies of imaging for these two groups. These observed frequencies overestimate the actual imaging rates of self- and radiologist-referring physicians, since they do not account for physicians who were not involved in episodes where imaging occurred (the "unknown"

Table 1.—Primary Estimates of Imaging Frequency for Self-referring and Radiologist-Referring Physicians\*

| Clinical Presentation             | Imaging Frequencies†                        |  | Ratio (95% Confidence Interval) |
|-----------------------------------|---|--|---------------------------------|
|                                   | Self-referring Physicians (No. of Episodes) | Radiologist-Referring Physicians (No. of Episodes) |                                 |
| Chest pain                        | 0.31 (4389)                                 | 0.16 (12 842)                                      | 1.9 (1.8-2.1)                   |
| Congestive heart failure          | 0.25 (13 588)                               | 0.09 (24 840)                                      | 2.7 (2.5-2.8)                   |
| Difficulty urinating              | 0.11 (1111)                                 | 0.05 (5990)  | 2.2 (1.5-2.9)                   |
| Gastrointestinal bleeding         | 0.23 (1159)                                 | 0.13 (12 074)                                      | 1.7 (1.5-2.0)                   |
| Headache                          | 0.30 (275)                                  | 0.07 (6674)  | 4.3 (3.3-5.4)                   |
| Knee pain                         | 0.40 (2898)                                 | 0.05 (5191)  | 7.7 (6.6-8.7)                   |
| Low-back pain                     | 0.21 (7381)                                 | 0.06 (21 179)                                      | 3.6 (3.4-3.9)                   |
| Transient cerebral ischemia       | 0.60 (334)                                  | 0.13 (2531)  | 4.7 (3.9-5.4)                   |
| Upper respiratory tract infection | 0.30 (10 781)                               | 0.13 (21 552)                                      | 2.3 (2.2-2.4)                   |
| Urinary tract infection           | 0.11 (1731)                                 | 0.05 (18 280)                                      | 2.4 (1.9-2.8)                   |

\*Estimates were rounded to the nearest percentage. All differences between self- and radiologist-referring physicians are statistically significant,  $P < .01$ .  
†Imaging frequency is the number of episodes containing one or more imaging claims divided by the total number of episodes.

group). To correct for this deficiency, we employed the same method of maximum likelihood estimation as in our previous study<sup>7</sup> (detailed in the NAPS deposit) to estimate the imaging frequencies for all self-referring and radiologist-referring physicians, including those in the unknown group, as the proportion of episodes for each physician group in which imaging was performed. Our method of maximum likelihood estimation is based on the expectation that, within physician designations as self- or radiologist-referring, physicians' imaging practices are uniform. However, this may not strictly be the case. Thus, as in our previous study,<sup>7</sup> we performed upward and downward biased estimates to represent "worse case" scenarios, embodying the maximum departures from the primary estimate that could result if there were no similarities among the practices of self-referring or radiologist-referring physicians (described in the NAPS deposit).

#### Comparison of Physicians' Charges and Correction for the Complexity of Imaging Examinations

Our analysis of charges for imaging examinations included all global, professional, and technical charges in both the office and hospital outpatient settings.

We compared the total charges for imaging for all episodes in the database, whether or not imaging occurred. The result, termed "mean imaging charges per episode," is calculated as the product of the mean charges for diagnostic imaging claimed during episodes in which imaging occurred and the frequency of imaging.

To assess the influence of differences in the complexity of examinations on differences in mean imaging charges per episode, we assigned to each imaging service its relative value (in relative value units [RVU]), according to the relative value scale used through 1991 for

payment for imaging services provided to Medicare patients.<sup>10</sup> Dividing the mean charge by the mean RVU provided the measurement "mean charge per RVU," which we used to compare the charges of self- and radiologist-referring physicians for comparable work. Because hospitals apply high technical charges to imaging performed in their hospital outpatient departments and because financial incentives to perform imaging examinations usually differ in office and hospital outpatient practice, we performed this analysis separately for episodes involving imaging solely in physicians' offices.

#### Analysis

Differences between self- and radiologist-referring physicians' estimated frequency of imaging and imaging charges were tested for statistical significance by unpaired *t* tests of the difference in means between the two groups. Differences were considered statistically significant at  $P < .01$ .

We also conducted an analysis of imaging utilization for selected individual physician specialties, investigating the imaging practices of a specialty for a clinical presentation if the number of episodes was large enough that the error of the estimate of the frequency of imaging for all physicians of that specialty was less than one fourth the magnitude of the estimate and there were at least 25 self-referring and 25 radiologist-referring physicians in the sample for each such analysis.

#### RESULTS

The claims database yielded 174 800 episodes for the 10 clinical presentations (Table 1).

#### The Frequency of Diagnostic Imaging

The primary estimates of imaging frequencies for self-referring physicians were significantly greater than the im-

aging frequencies of radiologist-referring physicians for all 10 clinical presentations (all presentations,  $P < .01$ ). The ratios of the frequency of imaging varied considerably with the clinical presentation. Self-referring physicians employed imaging 7.7 times as frequently as radiologist-referring physicians for knee pain but only 1.7 times as often for gastrointestinal bleeding (Table 1).

Upward biased estimates sustained the essential result of significantly greater imaging by self-referring physicians for all clinical presentations ( $P < .01$ ). However, in three clinical presentations, the downward biased estimate resulted in differences between self- and radiologist-referral that were not statistically significant (difficulty urinating, gastrointestinal bleeding, and transient cerebral ischemia). In two other clinical presentations, the downward biased estimates indicated imaging utilization by radiologist-referring physicians significantly greater than that of self-referring physicians (headache and urinary tract infection). A table of biased estimates is available from NAPS.

Twenty-one clinical presentation-physician specialty combinations met the screening criteria for investigation of specialty-related imaging practices. Six clinical presentations were represented in general practice, four each in internal medicine and family practice, two in general surgery, cardiology, and orthopedic surgery, and one in pulmonology. In all cases, the primary estimates indicated that self-referring physicians employed imaging significantly more frequently than radiologist-referring physicians (all specialty-clinical presentation pairs,  $P < .01$ ) (Table 2). The ratio of the frequencies of imaging (self-referring/radiologist-referring) ranged from 1.5:1 to 4.8:1 for different clinical presentations and specialties. The finding that self-referring physicians employ imaging significantly more frequently than radiologist-referring physicians was sustained

Table 2.—Primary Estimates of Imaging Frequency by Selected Physician Specialties\*

| Physician Specialty and Clinical Presentation | Imaging Frequencies†                        |  | Ratio (95% Confidence Interval) |
|---|---|--|---------------------------------|
|   | Self-referring Physicians (No. of Episodes) | Radiologist-Referring Physicians (No. of Episodes) |                                 |
| Cardiology                                    |   |  |                                 |
| Chest pain                                    | 0.38 (390)                                  | 0.19 (1327)  | 2.0 (1.6-2.4)                   |
| Congestive failure                            | 0.30 (2195)                                 | 0.13 (1314)  | 2.4 (2.0-2.5)                   |
| Family practice                               |   |  |                                 |
| Chest pain                                    | 0.30 (784)                                  | 0.16 (2442)  | 1.8 (1.5-2.1)                   |
| Congestive failure                            | 0.20 (2472)                                 | 0.10 (5036)  | 2.1 (1.8-2.3)                   |
| Low-back pain                                 | 0.20 (1289)                                 | 0.05 (4475)  | 3.8 (3.1-4.6)                   |
| Upper respiratory tract infection             | 0.31 (2834)                                 | 0.13 (4216)  | 2.3 (2.1-2.5)                   |
| General practice                              |   |  |                                 |
| Chest pain                                    | 0.30 (2025)                                 | 0.16 (5058)  | 1.9 (1.7-2.1)                   |
| Congestive failure                            | 0.25 (4985)                                 | 0.09 (10458)                                       | 2.7 (2.5-3.0)                   |
| Gastrointestinal bleeding                     | 0.20 (618)                                  | 0.13 (4081)  | 1.5 (1.2-1.8)                   |
| Knee pain                                     | 0.25 (691)                                  | 0.05 (1946)  | 4.8 (3.5-6.1)                   |
| Low-back pain                                 | 0.19 (2542)                                 | 0.05 (8448)  | 3.5 (3.0-4.0)                   |
| Upper respiratory tract infection             | 0.28 (4352)                                 | 0.11 (8721)  | 2.4 (2.2-2.7)                   |
| General surgery                               |   |  |                                 |
| Low-back pain                                 | 0.23 (545)                                  | 0.07 (1350)  | 3.1 (2.3-3.9)                   |
| Upper respiratory tract infection             | 0.30 (726)                                  | 0.15 (1660)  | 1.9 (1.6-2.3)                   |
| Internal medicine                             |   |  |                                 |
| Chest pain                                    | 0.33 (990)                                  | 0.14 (3633)  | 2.3 (2.0-2.6)                   |
| Congestive failure                            | 0.25 (3715)                                 | 0.09 (7866)  | 2.8 (2.6-3.1)                   |
| Low-back pain                                 | 0.16 (1274)                                 | 0.05 (5693)  | 2.9 (2.3-3.5)                   |
| Upper respiratory tract infection             | 0.33 (2030)                                 | 0.16 (4581)  | 2.0 (1.8-2.2)                   |
| Orthopedic surgery                            |   |  |                                 |
| Low-back pain                                 | 0.28 (1666)                                 | 0.12 (511)   | 2.3 (1.6-3.0)                   |
| Knee pain                                     | 0.58 (1307)                                 | 0.30 (135)   | 1.9 (1.3-2.5)                   |
| Pulmonology                                   |   |  |                                 |
| Upper respiratory tract infection             | 0.34 (360)                                  | 0.20 (184)   | 1.7 (1.1-2.4)                   |

\*Estimates were rounded to the nearest percentage. All differences between self- and radiologist-referring physicians are statistically significant,  $P < .01$ .  
†Imaging frequency is the number of episodes containing one or more imaging claims divided by the total number of episodes.

in all 21 upward biased estimates and 19 of 21 downward biased estimates ( $P < .01$ ). In two cases—general practitioners seeing patients for gastrointestinal bleeding and internists for patients with low-back pain—the differences in the downward biased estimates were not significantly different.

### Imaging Charges

Mean imaging charges per episode—for all episodes, including both office and hospital outpatient department settings and regardless of whether an imaging examination occurred—are detailed in Table 3. For all 10 clinical presentations, mean imaging charges per episode were 1.6 to 6.2 times greater for self-referral than for radiologist-referral ( $P < .01$ , all clinical presentations).

When all episodes with imaging were considered—including office and hospital outpatient examinations—charges per RVU for self-referral were 0.8 to 1.0 of the charges per RVU referable to radiologist-referral, depending on the clinical presentation. However, the comparison of charge per RVU for examina-

Table 3.—Imaging Charges per Episode of Care\*

| Clinical Presentation             | Charges per Episode, \$† |                      | Ratio |
|-----------------------------------|--------------------------|----------------------|-------|
|                                   | Self-referral            | Radiologist-Referral |       |
| Chest pain                        | 29                       | 19                   | 1.6   |
| Congestive heart failure          | 41                       | 7                    | 6.2   |
| Difficulty urinating              | 19                       | 8                    | 2.3   |
| Gastrointestinal bleeding         | 38                       | 24                   | 1.6   |
| Headache                          | 117                      | 36                   | 3.3   |
| Knee pain                         | 31                       | 5                    | 6.2   |
| Low-back pain                     | 34                       | 13                   | 2.5   |
| Transient cerebral ischemia       | 242                      | 65                   | 3.7   |
| Upper respiratory tract infection | 19                       | 9                    | 2.2   |
| Urinary tract infection           | 32                       | 13                   | 2.4   |

\*Charges were rounded to the nearest dollar.  
†Charges were calculated as the product of the percentage of episodes in which imaging occurred (ie, imaging frequency) and the mean imaging charge in episodes with imaging.

tions performed in office practice indicates that these differences are attributable to the technical charges billed by hospitals and the fact that almost all imaging examinations in hospital outpatient departments are performed by radiologists. For examinations performed in office practice, self-referral results in charges per RVU 0.9 to 1.3 times the charges per RVU of radiologists.

### COMMENT

This investigation both extends and confirms our previous research into how physicians' ownership of diagnostic imaging technology in their office practices affects imaging utilization and charges. The major differences between our previous and current research include the nature of the patient and physician

populations. Also, the present investigation evaluates a broader range of clinical presentations and assesses utilization of both conventional and more advanced imaging technologies. Finally, we were able to extend our evaluation of charges for imaging examinations to include the hospital outpatient setting. Despite these differences, the essential result remains unchanged: physicians who own imaging technology employ diagnostic imaging in the evaluation of their patients significantly more often and, as a result, generate 1.6 to 6.2 times higher average imaging charges per episode of care than do physicians who refer imaging examinations to radiologists. This result is reinforced by the consistent result of significantly greater utilization associated with self-referral in our specialty-based analysis.

In this study, differences in imaging utilization between self- and radiologist-referring physicians were more varied with respect to clinical presentation than in our previous research. Almost certainly, this is attributable to characteristics of the patient population. The Funds' beneficiaries are, overwhelmingly, elderly and, because of their work histories, prone to a variety of chronic ailments. As such, they are very different from the generally healthy, younger, working individuals we evaluated in our initial research.

The large differences between self- and radiologist-referring physicians' mean imaging charges per episode are almost entirely attributable to differences in utilization. Differences in charges for imaging examinations and the complexity of examinations are largely referable to the setting in which the examinations were performed. Examinations performed by radiologists in hospital outpatient departments usually generate higher overall charges be-

cause of the high technical charges filed by hospitals. Medicare, on average, pays 58% of these charges.<sup>11</sup> In office practice, self-referring physicians generally charge higher fees than radiologists for comparable examinations.

In recent years, physicians' referral of their patients to medical technologies in which they have a financial interest has gained increasing attention as a significant problem promoting increasing health care costs. Investigations demonstrating that self-referral promotes greater frequency of technology utilization,<sup>4,7</sup> studies indicating that a financial incentive may motivate the higher frequency of self-referral,<sup>12-15</sup> and articles in the lay press discussing these findings have negatively affected public perceptions about the medical profession (*Wall Street Journal*, March 1, 1989; *Christian Science Monitor*, December 8, 1988). Although it is difficult to determine what proportion of the higher utilization associated with self-referral might be inappropriate, it has not been shown that more frequent application of office-based ancillary technologies provides a consonant benefit in improving patients' health.

These considerations motivated the United Mine Workers of America Health and Retirement Funds to participate in our continuing research into the costs associated with self-referral for diagnostic imaging. The Funds face a difficult financial future. While the cost of health care for the Funds' beneficiaries continues to increase, contributions to the Funds' financial base from the participating coal companies are declining. Thus, the Funds must identify means of controlling their expenditures that still sustain the high quality of care their beneficiaries receive. This research has provided information that may guide the Funds and other payers in developing

new policies with respect to payment for self-referred imaging. One possible policy would be to deny payment for self-referred imaging, or to deny payment to specific specialties or individual physicians shown to utilize imaging technology at significantly higher rates than other specialties or their peers. The Funds could choose to reduce financial incentives for self-referral by reimbursing self-referred imaging at a lower level than it pays for referred examinations or bundling payment for imaging as part of the reimbursement for an office visit. Alternatively, the Funds might develop standards for image quality and physician training for different examinations, much as standards have been developed for reimbursing claims for mammography under Medicare. Nonqualified practices would become ineligible for reimbursement of their claims.

Each of these alternatives is accompanied by potential political consequences and might potentially affect patient care. The activation of policies regarding self-referral by a payer such as the Funds may provide a demonstration for government and other payers of the effects of restricting self-referral on patient access to diagnostic imaging, the quality of care patients receive, and imaging-related expenditures.

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# ***EXHIBIT B***

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### Index terms:

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### Abbreviations:

CPT-4 = Current Procedural  
Terminology, 4th Edition  
EF = ejection fraction  
HCFA = Health Care Financing  
Administration  
MPI = myocardial perfusion imaging  
WM = wall motion

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Guarantors of integrity of entire study, all authors; study concepts and design, all authors; literature research, D.C.L.; data acquisition, L.P., J.H.S.; data analysis/interpretation, all authors; statistical analysis, L.P.; manuscript preparation, D.C.L.; manuscript definition of intellectual content, editing, revision/review, and final version approval, all authors.

# Recent Rapid Increase in Utilization of Radionuclide Myocardial Perfusion Imaging and Related Procedures: 1996-1998 Practice Patterns<sup>1</sup>

**PURPOSE:** To evaluate cardiac nuclear medicine practice patterns in different physician specialty groups to better understand a recent rapid increase in utilization of radionuclide myocardial perfusion imaging (MPI) and certain supplementary examinations.

**MATERIALS AND METHODS:** National Medicare Part B databases from 1996 and 1998 were used to evaluate utilization of four primary procedure codes for radionuclide MPI and two supplementary codes (add-on left ventricular wall motion or left ventricular ejection fraction). Utilization rates were calculated for cardiologists, radiologists, and other physicians. Other cardiac imaging for which radionuclide imaging might be substituted was similarly studied.

**RESULTS:** Overall utilization rate of radionuclide MPI per 100,000 Medicare beneficiaries increased 19.1%, from 4,046 in 1996 to 4,820 in 1998 ( $P < .001$ ). However, for cardiologists the rate increased from 1,771 to 2,413 (36.3%), whereas for radiologists it increased from 1,958 to 2,031 (3.7%) ( $P < .001$  for both changes). Overall utilization rate of add-on codes increased 264% from 1,006 to 3,657 ( $P < .001$ ). By 1998, the ratio of these add-on examinations to primary MPI was 0.94 among cardiologists compared with 0.53 among radiologists (relative risk, 1.77; 95% CI: 1.76, 1.78). Cardiologist-performed stress echocardiography and cardiac catheterization and coronary angiography increased by 24.2% and 8.7%, respectively.

**CONCLUSION:** Growth in utilization of radionuclide MPI between 1996 and 1998 was almost 10 times higher among cardiologists than radiologists. Utilization of the two add-on codes increased even more dramatically. The greater use of MPI is not a substitute for other cardiac imaging.

In recent years, radionuclide myocardial perfusion imaging (MPI) has become the principal method of noninvasively imaging suspected coronary artery disease. This technique provides greater sensitivity and specificity than does exercise electrocardiographic stress testing alone (1,2). The addition of electrocardiographic gating and technetium 99m-labeled radioisotopes, such as <sup>99m</sup>Tc sestamibi and <sup>99m</sup>Tc tetrofosmin, have brought further improvements. An important advantage of <sup>99m</sup>Tc-labeled compounds, aside from providing better counting statistics for MPI, is that they also allow determination of regional and global left ventricular wall motion (WM) and left ventricular ejection fraction (EF) (2). In 1992, largely as a result of this development, two new codes were incorporated into the nuclear medicine section of the Current Procedural Terminology, 4th Edition (CPT-4) coding manual (3). Codes 78478 and 78480 for left ventricular WM and left ventricular EF, respectively, were specifically designated as "add-on" codes. That is, users of the manual were instructed that these two codes were to be used only in conjunction with one of the four primary codes (78460, 78461, 78464, or 78465) for radionuclide MPI. Although there is little doubt about the utility of assessing myocardial perfusion and left

**TABLE 1**  
**Cardiac Radionuclide Imaging Codes in 1998**

| CPT-4 Code | Descriptor   | Global Relative Value Units* | No. of Examinations Performed† |
|------------|--|------------------------------|--------------------------------|
| 78460      | MPI; (planar) single study, at rest or stress  | 3.75                         | 11,740                         |
| 78461      | MPI; (planar) multiple studies, at rest and/or stress, and redistribution and/or rest injection            | 6.80                         | 55,955                         |
| 78464      | MPI; tomographic (SPECT), single study at rest or stress   | 9.09                         | 139,644                        |
| 78465      | MPI; tomographic (SPECT), multiple studies, at rest and/or stress and redistribution and/or rest injection | 14.67                        | 1,329,884                      |
| 78478      | WM (in addition to primary procedure)  | 2.57                         | 673,050                        |
| 78480      | EF (in addition to primary procedure)  | 2.57                         | 493,064                        |
| 78472      | CBPI, gated equilibrium; single study at rest or stress, WM plus EF  | 7.30                         | 100,957                        |
| 78473      | CBPI, gated equilibrium; multiple studies at rest and stress, WM plus EF                                   | 10.89                        | 16,403                         |
| 78481      | CBPI, first pass; single study at rest or stress, WM plus EF   | 6.99                         | 43,126                         |
| 78483      | CBPI, first pass; multiple studies at rest and stress, WM plus EF  | 10.53                        | 18,252                         |

Note.—CBPI = cardiac blood-pool imaging, SPECT = single photon emission computed tomography.

\* Refers to Medicare relative value units in 1998.

† 1998 values.

ventricular WM and EF by using radionuclide imaging techniques, concern has been raised about overutilization. The fiscal year 2000 work plan of the Office of Inspector General of the Department of Health and Human Services identified MPI as a medical service undergoing unusually rapid expansion in utilization, with a 23% increase in billing to the Health Care Financing Administration (HCFA), the administrator of the Medicare program, in just 1 year (4). Among the many thousands of physician services offered to patients, it was the only one specifically targeted by the Office of Inspector General for assessment for medical appropriateness.

The goal of this study was to evaluate cardiac nuclear medicine practice patterns among different physician specialty groups to better understand the rapid increase in utilization of these examinations.

## MATERIALS AND METHODS

Our data sources were the HCFA Physician/Supplier Procedure Summary Master Files for 1996 and 1998. These files contain all Medicare Part B services performed nationwide by physicians for beneficiaries enrolled in the traditional fee-for-service Medicare program. In 1996 there were 38.1 million Medicare beneficiaries in the United States—33.2 million in traditional fee-for-service Medicare and an-

other 4.9 million enrolled in Medicare health maintenance organizations, or HMOs. In 1998 there were 38.5 million Medicare beneficiaries—31.9 million in traditional fee-for-service and 6.6 million others in Medicare HMOs. Because services to Medicare HMO patients are generally capitated and not handled directly by Medicare fiscal intermediaries, their records are not included in these files and were therefore not included in this study.

In the files, each physician service is classified in a number of ways. The first is by type of service by using the CPT-4 codes. A second classification is by the location where the service is performed by using one of 27 HCFA location codes. A third classification is by specialty of the physician provider by using one of 107 HCFA specialty codes. For the purposes of this study, physicians were categorized as cardiologists, radiologists (including nuclear medicine physicians), or other physicians.

Table 1 lists the CPT-4 codes that were analyzed and brief descriptors from the coding manual. The first four (78460, 78461, 78464, 78465) are the primary codes used for radionuclide MPI. The next two (78478 and 78480) are the add-on codes for determination of left ventricular WM or EF when used in conjunction with a primary MPI examination. The last four codes (78472, 78473, 78481, and 78483) are "freestanding" codes for WM and EF determination

when these examinations are performed separately and not in conjunction with an MPI. These four codes are used less frequently, usually in patients with some form of heart disease other than coronary disease; aside from determining the total number of these examinations performed, we did not analyze these codes further.

For each of the four primary MPI CPT-4 codes and the two add-on WM and EF codes, we first compared utilization rates during 1996 and 1998 among radiologists, cardiologists, and all other physicians. The difference in proportions for 1996 rates versus 1998 rates was calculated by using the z test. Since the rates are complete counts of the entire Medicare population rather than a sample, it might be argued that no inferential statistics are required. However, the particular counts obtained in 1996 and 1998 can be considered theoretically as samples of a superpopulation of samples influenced by various random factors and traditional sampling statistics, such as the z test, and can be calculated. Of course, population parameters change systematically from year to year in ways that may be associated with increased utilization—such as the aging of the Medicare population. While it would have been desirable to adjust for age differences, the data set utilized does not contain demographic information, and no adjustment was possible. Because the points are close in time, changes in such parameters are not great, and it is reasonable to treat these years as samples of a superpopulation. Since this confounder could not be eliminated, we caution that our inferential statistics should be considered descriptive rather than true tests of significance. We also calculated the percentages of the examinations performed by each of the three physician groups. We further analyzed the physician utilization rates according to location of the examinations. For this, we used the location codes for (a) hospital inpatient settings, (b) hospital outpatient settings, (c) private offices, and (d) a final group encompassing all other locations. Utilization rates were calculated as the number of examinations per 100,000 Medicare fee-for-service beneficiaries that year. We then calculated the ratios of the add-on WM and EF studies to the primary MPI studies according to physician specialty and location to determine if these variables influenced the utilization of WM and EF studies. The ratios were measures of the risk that a patient undergoing MPI would have a WM and/or EF

**TABLE 2**  
Changes in Utilization Rates of Cardiac Radionuclide Imaging between 1996 and 1998 among Cardiologists, Radiologists, and Other Physicians in All Places of Service

| Examination Type and Physician Category | 1996* | 1998* | Change* (%) |
|---|-------|-------|-------------|
| MPI†                                    |       |       |             |
| Cardiologists                           | 1,771 | 2,413 | 36.3        |
| Radiologists                            | 1,958 | 2,031 | 3.7         |
| Other physicians                        | 317   | 376   | 18.6        |
| Total                                   | 4,046 | 4,820 | 19.1        |
| Add-on WM or EF‡                        |       |       |             |
| Cardiologists                           | 603   | 2,275 | 277         |
| Radiologists                            | 330   | 1,080 | 227         |
| Other physicians                        | 73    | 302   | 314         |
| Total                                   | 1,006 | 3,657 | 264         |

Note.—For all differences between 1996 and 1998 rates,  $P < .001$  (z test).

\* Utilization per 100,000 Medicare beneficiaries.

† Four codes.

‡ Two codes.

study added. Relative risks (one ratio divided by another) and CIs were calculated separately for 1996 and 1998 utilization of add-on WM and/or EF studies in all places of service for cardiologists and other physicians versus radiologists.

Because increases in utilization of diagnostic studies like cardiac radionuclide imaging might be offset by decreases in utilization of other imaging tests that provide comparable or supplementary information, we also assessed stress echocardiography and cardiac catheterization. Cardiologists perform the majority of these procedures. We therefore compared 1996 and 1998 utilization rates among cardiologists for stress echocardiography (code 93350) and the seven codes encompassing adult cardiac catheterization and coronary angiographic procedures (codes 93510, 93511, 93526, 93539, 93540, 93543, and 93545).

HCFA uses eight "specialty" codes in which it is not actually possible to determine the medical specialty of the physician who provides the service—multispecialty clinic or group practice, ambulatory surgical center, portable x-ray supplier, clinical laboratory, independent physiological laboratory, skilled nursing facility, intermediate care nursing facility, and other nursing facility. We excluded claims filed under these specialty codes; they ac-

**TABLE 3**  
Cardiac Radionuclide Imaging Performed by Radiologists, Cardiologists, and Other Physicians during 1996 and 1998 in All Places of Service

| Examination Type and Physician Category | 1996*         | 1998*         |
|---|---------------|---------------|
| MPI†                                    |               |               |
| Cardiologists                           | 1,771 (43.8)  | 2,413 (50.1)  |
| Radiologists                            | 1,958 (48.4)  | 2,031 (42.1)  |
| Other physicians                        | 317 (7.8)     | 376 (7.8)     |
| Total                                   | 4,046 (100.0) | 4,820 (100.0) |
| Add-on WM or EF‡                        |               |               |
| Cardiologists                           | 603 (59.9)    | 2,275 (62.2)  |
| Radiologists                            | 330 (32.8)    | 1,080 (29.5)  |
| Other physicians                        | 73 (7.3)      | 302 (8.3)     |
| Total                                   | 1,006 (100.0) | 3,657 (100.0) |

Note.—Data in parentheses are percentages.

\* Utilization per 100,000 Medicare beneficiaries (specialty percentage).

† Four codes.

‡ Two codes.

counted for only 4% of all Medicare fee-for-service claims in 1998.

## RESULTS

Data are presented in the Tables. Table 2 demonstrates 1996 and 1998 utilization rates per 100,000 Medicare beneficiaries among cardiologists, radiologists, and other physicians. Total utilization per 100,000 of the four MPI codes increased 19.1% from 4,046 in 1996 to 4,820 in 1998. However, the utilization rate increased 36.3% among cardiologists compared with only 3.7% among radiologists. Utilization of these codes by other physicians was considerably lower but increased 18.6% during the 2-year interval. The total utilization rate of the two add-on WM and EF codes increased 264% from 1,006 in 1996 to 3,657 in 1998. The growth in utilization of the latter two codes during the 2 years was high for all three physician groups—277% among cardiologists, 227% among radiologists, and 314% among other physicians. Differences in utilization rates between 1996 and 1998 reported in Table 2 all show probabilities of less than .001 by using the z-test. As we noted in the Materials and Methods section, these probabilities are to be interpreted descriptively rather than as customary significance tests.

Table 3 is derived from Table 2 and shows the percentages of MPI and add-on WM and/or EF examinations performed by radiologists, cardiologists, and other physicians during 1996 and 1998. During 1996, radiologists performed 48.4% of MPI examinations, while cardiologists performed 43.8%. By 1998, the cardiologists' share had increased to 50.1% while

radiologists' share had decreased to 42.1%. However, during the 2-year interval, the utilization rate among radiologists increased (from 1,958 to 2,031). The shift to the greater utilization proportion by cardiologists thus appears to be due to a much more rapid increase in their utilization (from 1,771 to 2,413), rather than to a shift in procedure volume from radiologists to cardiologists.

Table 4 further demonstrates overall physician utilization by categorizing it according to the place where the service was performed. The three principal places of service where imaging is performed are hospital inpatient settings, hospital outpatient settings, and private offices. All other locations were grouped together as a fourth category, but the table shows that utilization in this category was much less than in the three principal locations. The numeric columns in Table 4 show utilization rates per 100,000 beneficiaries for both 1996 and 1998, as well as the percentage change between them. For hospital inpatients, the utilization rate of MPI increased 21.8% between 1996 and 1998 among cardiologists (from 252 to 307) compared with 6.0% among radiologists (from 581 to 616). In hospital outpatient settings, where the utilization of MPI was considerably higher, the rate increased 18.2% between 1996 and 1998 among cardiologists (from 396 to 468) compared with 2.2% among radiologists (from 1,109 to 1,133). In private offices, cardiologist utilization increased 45.8% (from 1,115 to 1,626) during the period, whereas radiologist utilization increased 8.1% (from 223 to 241). The utilization of the add-on WM and/or EF codes between 1996 and 1998

**TABLE 4**  
Changes in Rates of Utilization of Cardiac Radionuclide Imaging between 1996 and 1998  
by Physician Category and Place of Service

| Examination Type and Physician Category | Hospital Inpatient | Hospital Outpatient | Office              | Other Locations | Total per Physician Category |
|---|--------------------|---------------------|---------------------|-----------------|------------------------------|
| <b>MPI</b>                              |                    |                     |                     |                 |                              |
| Cardiologists                           | 252/307 (+21.8)    | 396/468 (+18.2)     | 1,115/1,626 (+45.8) | 9/12 (+33.3)    | 1,771/2,413 (+36.3)          |
| Radiologists                            | 581/616 (+6.0)     | 1,109/1,133 (+2.2)  | 223/241 (+8.1)      | 45/41 (-8.9)    | 1,958/2,031 (+3.7)           |
| Other physicians                        | 67/64 (-4.5)       | 113/115 (+1.8)      | 134/193 (+44.0)     | 3/3 (0)         | 317/376 (+18.6)              |
| Total                                   | 900/987 (+9.7)     | 1,618/1,716 (+6.1)  | 1,472/2,060 (+39.9) | 57/56 (-1.8)    | 4,046/4,820 (+19.1)          |
| <b>Add-on WM or EF</b>                  |                    |                     |                     |                 |                              |
| Cardiologists                           | 45/182 (+304)      | 87/302 (+247)       | 466/1,781 (+282)    | 5/9 (+80)       | 603/2,275 (+277)             |
| Radiologists                            | 79/301 (+281)      | 152/550 (+262)      | 95/206 (+117)       | 4/24 (+500)     | 330/1,080 (+227)             |
| Other physicians                        | 11/38 (+245)       | 14/54 (+286)        | 48/207 (+331)       | 1/2 (+100)      | 73/302 (+314)                |
| Total                                   | 135/521 (+286)     | 253/906 (+258)      | 609/2,194 (+260)    | 10/35 (+250)    | 1,006/3,657 (+264)           |

Note.—For all numbers in table, utilization per 100,000 Medicare beneficiaries for 1996/1998; data in parentheses are percentage change.

**TABLE 5**  
Changes in Ratios of Add-on WM and/or EF Studies to Primary MPI Studies between 1996 and 1998

| Physician Category | Hospital Inpatient | Hospital Outpatient | Office    | Other Locations | Total      |
|--------------------|--------------------|---------------------|-----------|-----------------|------------|
| Cardiologists      | 0.18/0.59          | 0.22/0.65           | 0.42/1.10 | 0.56/0.75       | 0.34/0.94* |
| Other physicians   | 0.16/0.59          | 0.12/0.47           | 0.36/1.07 | 0.33/0.67       | 0.23/0.80† |
| Radiologists       | 0.14/0.49          | 0.14/0.49           | 0.43/0.85 | 0.09/0.59       | 0.17/0.53  |
| Total              | 0.15/0.53          | 0.16/0.53           | 0.41/1.07 | 0.18/0.63       | 0.25/0.76  |

Note.—For all numbers in table, utilization ratios for 1996/1998.

\* Relative risk is 2.02 (95% CI: 2.00, 2.04)/1.77 (95% CI: 1.76, 1.78) for cardiologists vs radiologists for all places of service.

† Relative risk is 1.38 (95% CI: 1.35, 1.40)/1.51 (95% CI: 1.49, 1.52) for other physicians vs radiologists for all places of service.

increased proportionately among cardiologists and radiologists in the hospital inpatient and outpatient settings. However, in private offices, utilization of these codes increased 282% among cardiologists compared with 117% among radiologists.

Table 5 shows the 1996 and 1998 ratios of add-on WM and EF studies to primary MPI studies. This ratio indicates the proportion of MPI examinations to which a WM or EF examination is appended. Since the physician performing the examination can elect to add both WM and EF studies to a basic MPI study, the ratio can range from 0 to 2.0. Ratios are shown for cardiologists, radiologists, and other physicians in each of the four place of service categories. The ratios in this table are derived from Table 4. For example, Table 4 shows that in 1996, the total utilization rate of WM or EF studies was 1,006 per 100,000 Medicare beneficiaries, while the total utilization rate of MPI that year was 4,046. The ratio is 1,006/4,046, or 0.25. Because the WM or EF codes can be used only in conjunction with MPI, this indicates that approximately 25% of all MPI studies were accompanied by a WM or EF determination in 1996. In 1998, this ratio was 3,657/4,820, or 0.76, indicating that by then

more than three-fourths of all MPI studies were accompanied by a WM or EF determination. In 1996, the ratio among cardiologists was 0.34 versus 0.17 among radiologists. By 1998, the ratio among cardiologists was 0.94 compared with 0.53 among radiologists. Analysis by location shows that the highest ratios were generally found in private offices. By 1998, the ratios among cardiologists and other physicians in private offices exceeded 1.0. Table 5 shows that for both 1996 and 1998, the relative risk of a patient undergoing WM and/or EF studies is higher for cardiologists and other physicians compared with radiologists.

We noted a different utilization pattern for the four freestanding WM and EF codes (78472, 78473, 78481, and 78483) than for the add-on codes. Claims under the freestanding codes were much less frequent than claims for the WM and EF studies. In 1996 there were 194,585 claims for the four freestanding codes and 333,820 for the two add-on codes; in 1998 there were 178,738 claims for the former and 1,166,114 for the latter. Thus, WM or EF determinations were much more commonly performed along with MPI as part of the evaluation of suspected coronary disease.

The utilization rate for stress echocardiography among cardiologists increased 24.2%, from 727 per 100,000 Medicare beneficiaries in 1996 to 903 in 1998. For the seven cardiac catheterization and/or coronary angiographic codes, the utilization rate among cardiologists in 1996 was 7,318 per 100,000 beneficiaries. By 1998, this rate had increased 8.7% to 7,958. Cardiologists performed 85.3% of all stress echocardiograms and 91.7% of all cardiac catheterization/coronary angiographic procedures in 1998.

## DISCUSSION

Our data provide interesting insight into the concerns expressed about MPI in the Medicare program. Between 1996 and 1998 there was a substantial increase (19.1%) in the overall utilization rate of MPI. However, there was a striking difference between the practice patterns of radiologists and cardiologists. The utilization rate increased 3.7% among radiologists during the 2-year interval compared with 36.3% among cardiologists. As shown in Table 4, the most dramatic MPI increase among cardiologists occurred in private offices, with a 45.8%

increase in 2 years. In hospital settings, the utilization increase among cardiologists was more modest (21.8% for inpatients and 18.2% for outpatients). It is thus apparent that a major contributing factor in the increase in Medicare billing for radionuclide myocardial perfusion codes was the rapid increase in utilization of MPI by cardiologists.

Overall utilization of the add-on WM and EF codes increased far more rapidly (264%) than MPI between 1996 and 1998. This is perhaps not surprising, since these studies rely on the use of radioisotopes, nuclear camera improvements, and billing codes that have been developed relatively recently. As shown in the listing of relative value units in Table 1, these studies are considerably less costly than the primary MPI studies. Increases in rates of the WM and/or EF studies during the 2-year period were 277% among cardiologists, 227% among radiologists, and 314% among other physicians. The ratios shown in Table 5 represent a more direct measure of the tendency to utilize these supplementary procedures. This table shows that the ratios for cardiologists were considerably higher than for radiologists in both 1996 and 1998, in all locations. By 1998, the overall ratio for cardiologists was 0.94 compared with 0.53 for radiologists. The relative risk that patients undergoing an MPI examination performed by a cardiologist would also undergo an add-on WM and/or EF exam was 1.77 compared with the risk if the patient was referred for an MPI examination to a radiologist.

The rapid increase in use of cardiac radionuclide imaging might be justified if it was being substituted for other examinations for coronary artery disease. However, at the same time the increases in utilization of cardiac radionuclide imaging were occurring, cardiologists' use of stress echocardiography increased by 24.2%, and their use of cardiac catheterization and coronary angiography increased by 8.7%. Thus there was no evidence that the growth in utilization of radionuclide examinations resulted in lower utilization of these other related diagnostic studies.

MPI and the associated add-on WM and EF studies performed by cardiologists are often self-referred. The opportunity for physicians to self refer has been shown to be a potent stimulus to increased utilization of imaging studies. Hillman et al (5,6) demonstrated that self-referring physicians who operated their own imaging equipment used 2–8 times as many imaging studies as did

physicians who referred their patients to radiologists. Findings of a large-scale General Accounting Office study (7) of the Medicare population in Florida showed substantially the same results. These findings have been confirmed by other study findings as well (8–11). It is not clear whether the increased utilization of imaging among self-referring physicians is due to a belief that their patients are sicker than the norm, to an enthusiasm for technology, to a desire to maximize income, or to some other motivation, but the net effect is increased cost to the health care system.

Some limitations of our study should be noted. First, although it is possible that the MPI utilization increase among cardiologists may be due to self referral within a single practice or group, our database does not allow precise determination of the degree of self referral. Second, we cannot determine whether the rapid growth resulted from higher utilization among a small group of cardiologists, or whether a larger number of cardiologists acquired nuclear cameras and began performing the examinations. Third, the data do not allow us to assess the appropriateness of the imaging examinations. However, there is no reason to assume that the populations of patients studied by radiologists, cardiologists, or other physicians are inherently different or that the latter two populations have greater need for cardiac nuclear imaging examinations. It would be difficult to ascertain whether the increased utilization detected in this study was medically necessary or not. Fourth, this study was conducted among the Medicare population only and may not exactly reflect events occurring in other health insurance databases. Fifth, there are small year-to-year changes in the underlying Medicare population demographics, which may contribute to small changes in utilization and which we are unable to adjust for. Consequently, as noted earlier, probability levels reported should be interpreted as descriptive rather than as traditional significance tests. Finally, the 107 HCFA physician specialty codes are self designated by physician providers and this may lead to minor inaccuracies. For example, in a given hospital, a cardiologist may work in the nuclear medicine section of the department of radiology, and his billings to HCFA might be classified as being from a "radiologist."

In summary, this study has provided insight into the concerns expressed in the Office of Inspector General work plan for 2000 (4). There was sharp growth be-

tween 1996 and 1998 in the utilization rate of MPI; this growth was almost entirely due to increased utilization by cardiologists, particularly in the office setting. There was an even more striking increase in the use of add-on WM and/or EF codes; however, this can be at least partially explained by the fact that these were still relatively new codes, which had been available only for 4 years in 1996. Although the increase in utilization of the add-on WM and/or EF codes was high among all physicians, by 1998 the probability that a patient would undergo one of these examinations was substantially higher if the primary MPI examination was performed by a cardiologist than if it was referred to a radiologist. The recent higher utilization seen in cardiac radionuclide imaging is not being offset by declines in use of other related imaging studies.

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# *EXHIBIT C*



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December 11, 2014

The Honorable Jackie Speier  
House of Representatives  
211 Cannon Office Building  
Washington, DC 20515

Dear Representative Speier:

On behalf of AARP's nearly 38 million members and the millions more with Medicare, thank you for your continued work to close provider reimbursement loopholes. AARP agrees that restrictions on physician self-referral and provider-kickback schemes must be strengthened. Closing the in-office ancillary services exception for certain services will save taxpayers and Medicare beneficiaries money and reduce unnecessary care.

As you know, the in-office ancillary services exception was intended to allow physicians to perform services which can be completed in the physician's office while the patient is present and which aid in the diagnosis of the patient in order to minimize delays in patient care. Unfortunately, the exception has contributed to overutilization and rapid growth of certain services, particularly in radiation oncology, anatomic pathology, advanced imaging, and physical therapy. Closing the loophole will better serve patients and preserve Medicare's resources by saving approximately \$6 billion over ten years for these services.

We look forward to working with you and your colleagues in both parties to improve Medicare and reduce health care spending. If you have any questions, please contact me or have your staff contact Ariel Gonzalez of our Government Affairs team, at [agonzalez@aarp.org](mailto:agonzalez@aarp.org) or 202-434-3770.

Sincerely,

Joyce A. Rogers  
Senior Vice President  
Government Affairs

# ***EXHIBIT D***



Highlights of GAO-12-966, a report to congressional requesters

## MEDICARE

# Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions

### Why GAO Did This Study

Medicare Part B expenditures—which include payment for advanced imaging services—are expected to continue growing at an unsustainable rate. Questions have been raised about self-referral's role in this growth. Self-referral occurs when a provider refers patients to entities in which the provider or the provider's family members have a financial interest. GAO was asked to examine the prevalence of advanced imaging self-referral and its effect on Medicare spending. This report examines (1) trends in the number of and expenditures for self-referred and non-self-referred advanced imaging services, (2) how provision of these services differs among providers on the basis of whether they self-refer, and (3) implications of self-referral for Medicare spending. GAO analyzed Medicare Part B claims data from 2004 through 2010 and interviewed officials from the Centers for Medicare & Medicaid Services (CMS) and other stakeholders. Because Medicare claims lack an indicator identifying self-referred services, GAO developed a claims-based methodology to identify self-referred services and expenditures and to characterize providers as self-referring or not.

### What GAO Recommends

GAO recommends that CMS improve its ability to identify self-referral of advanced imaging services and address increases in these services. The Department of Health and Human Services, which oversees CMS, stated it would consider one recommendation, but did not concur with the others. GAO maintains CMS should monitor these self-referred services and ensure they are appropriate.

View GAO-12-966. For more information, contact James C. Cosgrove at (202) 512-7114 or [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov).

### What GAO Found

From 2004 through 2010, the number of self-referred and non-self-referred advanced imaging services—magnetic resonance imaging (MRI) and computed tomography (CT) services—both increased, with the larger increase among self-referred services. For example, the number of self-referred MRI services increased over this period by more than 80 percent, compared with an increase of 12 percent for non-self-referred MRI services. Likewise, the growth rate of expenditures for self-referred MRI and CT services was also higher than for non-self-referred MRI and CT services.

GAO's analysis showed that providers' referrals of MRI and CT services substantially increased the year after they began to self-refer—that is, they purchased or leased imaging equipment, or joined a group practice that already self-referred. Providers that began self-referring in 2009—referred to as switchers—increased MRI and CT referrals on average by about 67 percent in 2010 compared to 2008. In the case of MRIs, the average number of referrals switchers made increased from 25.1 in 2008 to 42.0 in 2010. In contrast, the average number of referrals made by providers who remained self-referrers or non-self-referrers declined during this period. This comparison suggests that the increase in the average number of referrals for switchers was not due to a general increase in the use of imaging services among all providers. GAO's examination of all providers that referred an MRI or CT service in 2010 showed that self-referring providers referred about two times as many of these services as providers who did not self-refer. Differences persisted after accounting for practice size, specialty, geography, or patient characteristics. These two analyses suggest that financial incentives for self-referring providers were likely a major factor driving the increase in referrals.

Change in Average Number of MRI Services Referred, 2008 and 2010

|                    | Average 2008 referred MRI services | Average 2010 referred MRI services | Percentage change |
|--------------------|------------------------------------|------------------------------------|-------------------|
| Switchers          | 25.1                               | 42.0                               | 67.3              |
| Non-self-referrers | 20.6                               | 19.2                               | -6.8              |
| Self-referrers     | 47.0                               | 45.4                               | -3.4              |

Source: GAO analysis of Medicare data.

Note: Pattern observed for MRI services was similar for CT services. GAO defines switchers as those providers that did not self-refer in 2007 or 2008, but did self-refer in 2009 and 2010.

GAO estimates that in 2010, providers who self-referred likely made 400,000 more referrals for advanced imaging services than they would have if they were not self-referring. These additional referrals cost Medicare about \$109 million. To the extent that these additional referrals were unnecessary, they pose unacceptable risks for beneficiaries, particularly in the case of CT services, which involve the use of ionizing radiation that has been linked to an increased risk of developing cancer.

# ***EXHIBIT E***

## White House Releases FY 2017 Budget Proposal

On February 9, President Obama released his proposed federal budget for the 2017 fiscal year (FY). The FY 2017 budget will be the last of his presidency. The budget is comprised of \$4.1 trillion in spending on receipts of \$3.6 trillion, resulting in a \$503 billion deficit for the year. Although several provisions in the Obama budget may be included throughout the year as separate policies to congressional legislation, due to the Republican majority in Congress, the vast majority of the president's proposals contained in his budget will not be considered or debated.

The President's budget is chock-full of various Medicare-related changes that present both opportunities and threats to radiologists. The American College of Radiology (ACR) is encouraged that the Administration, once again, included provisions to close the in-office ancillary services (IOAS) exception to the Ethics in Patient Referrals Act, commonly referred to as the Stark law, after its author, former Congressman Fortney "Pete" Stark. The budget stipulates that, starting in 2018, advanced imaging, radiation therapy, anatomic pathology and physical therapy services would be removed from the IOAS exception. The Obama Administration would only permit these four services to be self-referred within clinically integrated practices that are required to demonstrate cost containment. In total, closure of the IOAS exception is expected to produce slightly more than \$4.9 billion in savings over 10 years.

However, the ACR continues to be frustrated by the Obama Administration's annual effort to establish a Medicare prior authorization program. Although the Administration did not specifically cite a prior authorization policy strictly for advanced imaging services as it has in past budgets, the president did call for a broader, prior authorization policy that affects all Medicare fee-for-service procedures. The ACR is puzzled as to why the Administration would pursue such a policy for imaging services in light of the passage of a mandatory imaging appropriate use criteria (AUC) consultation policy specifically designed to reduce imaging overutilization. Furthermore, the ACR remains deeply skeptical that a prior authorization policy would generate any savings for Medicare because of the considerable administrative costs associated with implementing the policy. Above all, the ACR continues to hold strong reservations about prior authorization programs limiting patient access to lifesaving imaging services.

In addition to some of the more specific policies the ACR monitors within the President's budget, The White House's medical research funding included a \$33.1 billion budget for the National Institutes of Health (NIH) in fiscal year 2017. Some of the Administration's research priorities include:  
**Cancer Moonshot**

The budget provides \$680 million to the NIH to expand clinical trials for health disparity populations, pursue new vaccine technology and fund exceptional opportunities in cancer research. These investments will drive scientific advances that aim to understand the causes of cancer, discover new prevention strategies, improve early detection and diagnosis and cultivate effective treatments.

**Advances the Precision Medicine Initiative**

The budget provides the Department of Health and Human Services with \$309 million to continue scaling up the Precision Medicine Initiative. Recent breakthroughs in genomics, computing and molecular medicine have created extraordinary opportunities to advance health care into a new era when many more treatments are based on the genetic characteristics of each patient. Research based on this cohort will lay the foundation for findings for many diseases that can lead to new prevention strategies, novel therapeutics and medical devices.

**BRAIN Initiative**

The budget provides \$195 million within NIH, \$45 million more than FY2016, for the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. Increased funds in FY 2017 will continue to support basic neuroscience research, human neuroscience, neuroimaging and training initiatives. The funding is also expected to be used on potential projects to collaborate with industry to test novel devices in the human brain, new ways to address big data from the brain, and to develop devices for mapping and tuning brain circuitry.

The ACR will continue to monitor the budget process as it progresses through the legislative process and evaluate any policies that emerge from it that may impact imaging services and/or the practice of radiology.

# ***EXHIBIT F***

not detected by current assays may yet be found in both serum and cryoprecipitates.

The possibility that HCV infection is responsible for many or perhaps most cases of Type II and Type III cryoglobulinemia has therapeutic implications. In the past, treatment with plasmapheresis or plasma exchange plus corticosteroids or cytotoxic drugs was reserved for patients with severe manifestations, such as vascular insufficiency, renal failure, and progressive involvement of the peripheral nerves. Combined treatment was often remarkably effective under these circumstances, but it was less effective in patients with smoldering renal or neurologic involvement or painful episodes of cutaneous vasculitis. The favorable results of treatment of mixed cryoglobulinemia with interferon alfa are encouraging<sup>9</sup>; this drug should be subjected to multicenter controlled therapeutic trials to determine its efficacy in mixed cryoglobulinemia due to HCV infection.

Several viruses have also been implicated in the pathogenesis of Sjögren's syndrome,<sup>10</sup> but there is no rigorous proof of an etiologic role for any of them. The finding of HCV RNA in the serum of three of four patients raises this issue anew. Possibly, HCV will prove to be the etiologic agent of Sjögren's syndrome, or perhaps HCV is merely another virus capable of infecting salivary and lacrimal glands to produce a clinical and histologic picture resembling idiopathic Sjögren's syndrome.

Meticulous adherence to the proper methods of collecting and processing samples is essential to the detection of cryoprecipitable substances in serum. At least 20 ml of blood (large amounts enhance the likelihood of detecting small amounts of cryoprecipitate) should be taken from a fasting patient (lipids may interfere with the test by precipitating in the cold). The blood (not treated with an anticoagulant) is placed in tubes in warm water and transported promptly to the laboratory. Once there, it is allowed to clot at 37°C for 1 hour and then separated in a warm centrifuge; the clear serum supernatant is removed and stored at 4°C for 72 hours. The serum is examined daily for cryoprecipitate. If any is detected, the amount of cryoprecipitate (the cryocrit) is determined, and the carefully washed cryoprecipitate is dissolved by warming. Its constituents are then identified by immunodiffusion. Delay in the transport or refrigeration of the sample before processing will lead to the loss of cryoprecipitable substances in the clot, which is discarded when serum is obtained. Hence, in most instances, blood to be examined for cryoprecipitable substances should not be drawn when the laboratory is closed or about to close.

Finally, in view of the demonstration of HCV RNA in the cryoprecipitate from many patients with Type II and Type III cryoglobulinemia, the term "cryoglobulin" no longer accurately describes the cold-precipitable substances recoverable from serum. The phenomenon is once again in search of a name.

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## "SELF-REFERRAL" — WHAT'S AT STAKE?

"SELF-REFERRAL" is the term used to describe a physician's referral of patients to an outside facility in which he or she has a financial interest but no professional responsibility. This practice has become particularly prevalent in certain parts of the country, where for-profit imaging centers, diagnostic laboratories, home health care services, radiotherapy centers, physiotherapy units, and other free-standing facilities have been soliciting investments by physicians who can refer patients to them. Self-referral is a prime example of the current and growing encroachment of commercialism on medical practice. The contentious and emotional debate that has been waged over this issue reflects the increasing tension between professional and business values in medicine.<sup>1</sup>

In December 1991, the American Medical Association (AMA) seemed finally to have ended years of ambivalence and uncertainty about self-referral when its House of Delegates approved without dissent a report from the Council on Ethical and Judicial Affairs.<sup>2</sup> Taking a strong stand on the side of professional values, the council advised physicians to avoid self-referral, except when there is a demonstrated need in the community for the facility and alternative financing is not available. The council acknowledged the mounting evidence of excessive costs and rates of use in jointly owned for-profit facilities but emphasized that it was primarily concerned about the integrity of the profession. The following passage from the report expresses its essential message:

At the heart of the Council's view of this issue is its conviction that, however others may see the profession, physicians are not simply business people with high standards. Physicians are engaged in the special calling of healing, and, in that calling, they are the fiduciaries of their patients. They have different and higher duties than

even the most ethical business person. . . . There are some activities involving their patients that physicians should avoid whether or not there is evidence of abuse.<sup>2</sup>

This admirable statement supports a position I have repeatedly advocated for more than a decade<sup>3-6</sup> — one that was also strongly recommended by the Institute of Medicine in its 1986 report on for-profit enterprise in health care.<sup>7</sup>

Coming on the heels of recent similar statements on self-referral by such other major medical organizations as the American College of Physicians, the American College of Surgeons, and the American College of Radiology, the council's report and its endorsement by the AMA's House of Delegates seemed to have settled the debate once and for all. Unfortunately, that did not prove to be the case. Six months later, in June of this year, the House of Delegates reversed its position. By a close margin, the delegates approved a new resolution introduced by the New Jersey delegation that declared self-referral to be ethical as long as the patient is fully informed about the physician's financial interest in the facility. Although the vote could not change the council's report, which remains part of the AMA's code of ethics, this sudden about-face reveals the confusion and the conflicting interests that still prevent many physicians from recognizing their professional obligations.

The justification offered for the new resolution was unconvincing. Proponents argued that the policy recommended by the council would limit the access of many patients to necessary health services. They also claimed that the great majority of self-referring physicians, who do not abuse their patients' trust, were being penalized because of concern over the few who did. One delegate from New Jersey was quoted in the press as saying, "Sanctions should be applied [to "overutilizers"] when appropriate. . . . But must we always punish the innocent along with the guilty?"<sup>8</sup>

These arguments are transparently spurious. As already noted, the council's report allows for self-referral if the facility is clearly needed by the community and could not be built without physician-investors. As for distinguishing between physicians who abuse self-referral and those who do not, there would be no way to do that without prohibitively expensive and intrusive surveillance of the private practices of all physicians who practice self-referral. Besides, the argument that self-referring physicians should be trusted unless they can be proved to have abused that trust misses an essential point about fiduciary responsibility: people in important positions of trust should not put themselves in situations that inevitably raise questions about their motives and priorities, regardless of whether they actually behave in accordance with that trust.

Physicians are trusted to act as medical purchasing agents for their patients. A doctor who thinks there should be no concern about self-referral as long as it is disclosed and the referrals are monitored is analogous to a purchasing agent for a large corporation who dis-

closes to the chief executive officer (CEO) that he has a vested interest in certain vendors with whom he does business, and who thinks that this disclosure, plus careful surveillance of his purchases by management, should assuage the CEO's concerns. Obviously, it would not do so. In fact, the CEO would probably fire the purchasing agent on the spot. Why should physicians want to apply a lower standard of fiduciary responsibility to themselves than is generally accepted in business?

Two articles in this issue of the *Journal* add to the growing body of evidence that self-referral leads to the overuse of services and excessive cost.<sup>9,10</sup> In a study of free-standing radiation-therapy facilities in Florida, where at least 40 percent of all practicing physicians are involved in some kind of self-referral,<sup>11</sup> Mitchell and Sunshine<sup>9</sup> report that none of the joint-venture facilities were located in inner-city neighborhoods or rural areas, thus refuting the suggestion that joint ventures often bring needed services to otherwise underserved communities. These authors also found that self-referral in radiation therapy, as already reported for other services, was associated with increased use and costs.<sup>9</sup> The second study, by Swedlow et al.,<sup>10</sup> reports on self-referral to three different kinds of outside services in California's workers' compensation system. They found that self-referral increased the rate of use and the cost per case of physiotherapy and increased the cost per case of psychiatric evaluation. Even more interesting, they report that the inappropriate use of magnetic resonance imaging was more frequent among the patients cared for by self-referring physicians, although there was no difference in the cost per case. None of this new evidence is particularly surprising, but taken together with the results of earlier studies cited in the council report, it convincingly demonstrates that self-referral adds to the cost of medical care.

No wonder that government has begun to take restrictive action. In September 1991 the U.S. Department of Health and Human Services issued so-called safe-harbor regulations, which allow physicians to refer Medicare and Medicaid patients to facilities in which they have a financial interest only under limited conditions.<sup>12</sup> These regulations are new interpretations of a Medicare and Medicaid anti-kickback statute that has been on the books since 1972, but they may soon become moot as a result of new, more comprehensive laws at the federal and state levels. A law passed by Congress in 1989 that took effect this year bans the referral of Medicare and Medicaid patients to clinical laboratories owned by their physicians. There is discussion about extending the ban to other kinds of facilities, a move favored by the Bush administration as a means of restraining Medicare expenses. The Internal Revenue Service, reversing its previous stance, has announced that not-for-profit hospitals may lose their tax-exempt status if they enter into certain types of financial arrangements with physicians, including those that involve self-referral. The Federal Trade Commission, which had formerly en-

dorsed self-referral as enhancing competitiveness, now thinks the practice may be anticompetitive because it tends to limit the referring physician's choice to the facility in which he or she has invested, and because it keeps prices up. There has also been much activity at the state level. Florida and New Jersey recently banned most self-referrals, and several other states, including California and New York, are considering similar legislation. Thus, it seems evident that still more legislative restrictions are in the offing.

Those who say that ethics cannot and should not be legislated<sup>13</sup> are right, but for government the issue is clearly economic, not ethical. Voluntary ethical guidelines, although essential for the morale of the profession and for its public image and self-image, cannot establish firm national policy. That requires legislation. Some medical organizations oppose legislation because they fear the indiscriminate banning of referrals to all facilities with which the referring physician has any financial connection — even when the arrangement is in the interest of patients and necessary for good medical practice. This concern is legitimate, but the problem can easily be solved if professional groups work constructively with government to develop laws and regulations that are appropriate. Attempts simply to obstruct corrective legislation are, in my opinion, ill advised. They merely strengthen the public's impression that physicians are more interested in pursuing their own economic interests than in preserving their good name or helping to keep costs down. In any case, as recent history has shown, most efforts to prevent legislative action are likely to fail, leaving a residue of public cynicism and ill will toward organized medicine.

The AMA is worried about the erosion of professionalism in a system of medical care that is becoming increasingly commercialized, and its concern is justified. The reputation of medicine as a trusted profession is at stake, as is the profession's own view of its basic values. The AMA has wisely chosen to make the promulgation and enforcement of ethical standards a major strategic goal. It has sought help from state and local organizations in this task and has asked the Federal Trade Commission to allow physicians more flexibility in self-regulation. These initiatives deserve support, but there is still much more to be done in the profession's struggle against commercialization. In addition to self-referral, the AMA should look closely at the sale of drugs by office-based physicians,<sup>14</sup> deals between physicians and the manufacturers of devices and prostheses, and a wide variety of other kinds of

joint ventures between physicians and the facilities in which they treat their patients.<sup>5</sup>

It would be a major victory for professional values if the AMA could once again endorse a simple precept that stood as one of the beacons of its pre-1980s ethical code: "In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients."<sup>15</sup> In today's chaotic market, doctors need a few clear guidelines. This is one of the best.

It is hard to predict what our health care system will look like in the year 2000, or what the conditions of medical practice will be. What seems clear, however, is that physicians will have little opportunity to help shape the future if they do not retain their public credibility. That is the real importance of the self-referral debate. If physicians choose to act from self-interest, or even if they merely put themselves in positions that suggest self-interest, they risk damaging their most precious possessions — the trust and respect of their patients and the esteem of the general public.

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**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION**

..... )  
IN RE: ADVANCED RADIOLOGY MRI )  
CENTERS LIMITED PARTNERSHIP )  
ACQUISITION OF MRI UNIT FOR )  
STAMFORD OFFICE )  
..... )

DOCKET NO. 16-32093-CON

AUGUST 23, 2016

**RESPONSES TO PUBLIC HEARING ISSUES**

Advanced Radiology MRI Centers Limited Partnership (“ARC MRI”) hereby submits the following responses to the Office of Health Care Access’ (“OHCA”) Public Hearing Issues, dated August 10, 2016.

1. The clear public need for the proposal

**RESPONSE:**

There is a clear public need for the acquisition of a second MRI unit for Advanced Radiology Consultants, LLC’s (“ARC”) Stamford office. Information regarding this need is set forth in detail in the CON Application and Completeness Question Responses submitted in connection with this matter and is summarized below.

First and foremost, acquisition of a second MRI unit is justified based on the need methodology set forth in the Statewide Healthcare Facilities and Services Plan (“SHP”). The SHP states that the current estimated capacity of an MRI unit is 4,000 scans per year (SHP, p. 61). In order for an applicant to justify the acquisition of an MRI unit one of two criteria must be met. In the case of ARC’s Stamford CON request, it is the following:

*If the applicant has an MRI scanner in the Primary Service Area, the applicant is expected to demonstrate that its Percent Utilization of Capacity exceeds 85% (SHP, p. 61).*

With the capacity of an MRI unit being 4,000 scans per year, ARC must demonstrate that its existing Stamford unit performs at least 3,400 scans annually (4,000 x .85) in order to establish need for an additional unit.

In FY 2015, ARC performed 6,617 MRI scans at its Stamford office (CON Application, p. 40). This equates to 165% capacity ( $6,617 \div 4,000$ ) and is nearly two times the 3,400 scans required to demonstrate need for another unit. In order to accommodate the MRI volume projected for ARC's Stamford office by FY 2019, which is 8,041 scans, the existing unit would need to operate at 201% capacity (CON Application, p. 135). This is impossible. Hours of operation have already been extended to 92 per week and there is still a 7 to 10 day backlog for MRI services (CON Application, pp. 14 & 16). Hours cannot practicably be extended further. A second unit is needed in order to meet patient demand in as timely a fashion as possible. The second unit is also needed to ensure that when an exam needs to be performed during normal business hours, whether because of the type of exam or the patient's schedule, this can be done.

In addition, and as discussed in greater detail below, ARC cannot relocate any of its existing MRI units to Stamford to meet growing patient demand. The practice's units in Fairfield, Stratford and Trumbull are operating in excess of 100% capacity (CON Application, p. 48). Its Orange unit operated at 72% capacity in FY 2015, and is projected to reach capacity in the near future based on an increasing demand for 3 Tesla MRI services, which continue to evolve and expand (CON Application, p. 48). ARC's Shelton MRI is operating at 66% capacity, but recent software upgrades have enhanced the unit's capabilities and ARC expects Shelton MRI volume to begin to grow (CON Application, p. 48). These units are well-utilized and cannot be relocated without significantly and adversely impacting access to care in the communities they presently serve.

Moreover, there is a clear public need for an additional MRI unit in ARC's Stamford office so that patients from the area will not have to travel unreasonably long distances to obtain MRI services from the provider of their choosing. ARC's Stamford office is geographically distant from its other offices. If a patient from the area cannot be accommodated in Stamford, he or she would be referred to another ARC location. The next closest offices are in Fairfield, Stratford and Trumbull, but these MRI units are operating above capacity (128% - 167%) and cannot accommodate significant overflow. This means that patients from the Stamford area could be referred to an office as far away as Shelton or Orange. A patient could be asked to travel anywhere from 20 to 40 miles to access ARC MRI services. Given the traffic congestion on I-95 at almost all hours of the day, this could mean several hours of commuting each way. This is a significant issue, particularly when the person traveling for the scan has a condition causing them pain.

The SHP allows OHCA to consider other information in support of clear public need as well, including the following (SHP, pp. 61 & 62):

- The capabilities of the proposed scanner as compared to existing scanners. As discussed in the CON submission (p. 16), 3.0 Tesla MRI allows for better quality vascular imaging of the head, neck, body, and extremities than a 1.5 Tesla or other unit. It will allow ARC to perform such advanced imaging techniques as diffusion tensor imaging, functional imaging and brain perfusion. The stronger magnet allows for higher resolution images in cases where added detail is important for diagnosis. 3.0 Tesla MRI is now the preferred unit for many brain scan (including scans for Lyme disease and Parkinson's disease), and spine, prostate, and MRA scans. This would be the first 3.0 Tesla MRI in Stamford. It

would also be the first 3.0 Tesla MRI in the service area in a private practice setting. ARC would therefore be making this state-of-the art technology available to all patients, regardless of ability to pay, in one of the most cost-effective practice settings.

- The ability of the applicant to serve an underserved population and not jeopardize the financial viability of the project. ARC provides MRI services to all patients regardless of payer source or ability to pay. This includes underserved populations such as Medicaid recipients and the uninsured and underinsured. In FY 2015, 7.66% of ARC's Stamford MRI volume and 10.26% of its overall MRI volume were Medicaid and uninsured/self-pay patients (CON Application, p. 17). ARC remains committed to serving these patient populations, likely in increasing numbers as Medicaid coverage expands in coming years. Provision of services to these populations does not jeopardize the financial viability of the project. Although the Stamford MRI service will not breakeven with acquisition of the second unit until FY 2021, ARC MRI remains profitable throughout (CON Application, p. 134). All other ARC services are expected remain profitable as well, making the practice financially viable and the project financially feasible.
- The impact on existing services, including avoiding delays in timely diagnosis and treatment. Acquisition of a second MRI unit for ARC's Stamford office will have a favorable impact on the practice's existing MRI services. It will help to alleviate capacity constraints in Stamford, as well as other offices where MRI overflow patients are being referred. It will allow ARC to reduce MRI hours of operation and accommodate more patients during normal business hours, which tend to be the most convenient for patients and least costly to staff. It will also allow ARC to reduce the 7 to 10 day backlog (longer for exams that need to be performed during normal business hours) it is experiencing for MRI services in Stamford and ensure timely diagnosis and follow-up treatment for patients, many of whom are in pain while awaiting their exams (CON Application, p. 16). ARC's EMR system and image sharing network will also allow for the rapid (< 1 hour) relay of exam results to referring providers, patient access to records and portability of images and results (CON Application, pp. 147-48). A second MRI can also serve as back-up in the event that the existing unit, which is 11 years old, is down for service or upgrade (CON Application, p. 16). This is critically important from an access perspective given how busy the Stamford MRI service is on a daily basis. Note also that there will be no adverse impact on existing MRI providers in the area. A majority of MRI units in the Stamford area are operating at or over capacity (CON Application, p. 15). They have their own referral bases that will not be influenced by the acquisition of an additional unit to meet ARC's existing MRI volume and projected future growth (CON Application, p. 134).
- The history of the applicant in running accredited, financially successful facilities. ARC has a long history of running accredited and financially successful facilities. Each ARC modality is accredited by the American College of Radiology, including the practice's MRI service (Exhibit A). The proposed 3.0 Tesla will be accredited as well. These accreditations are in addition to the subspecialty training of all ARC physicians and the licensure and enhanced training of its technicians. ARC has been in operation for more than 100 years. The practice has grown considerably since its inception and has always

been profitable despite the lower fee structure for private physician practices. The ARC MRI service is profitable as well. As noted above, although the MRI service in Stamford will show some short-term operating losses through FY 2021 with the acquisition of a second MRI unit, ARC MRI as a whole remains profitable throughout.

2. Patient population and payer mix

**RESPONSE:**

Patients of the ARC Stamford MRI service originate primarily from lower Fairfield County. The Primary Service Area includes Stamford, Greenwich, Norwalk, Darien, and New Canaan (CON Application, p. 38). Patients originating from these towns comprised approximately 85% of Stamford MRI volume in 2015 (with the largest ZIP codes within these towns generating the 75% of MRI volume that resulted in inclusion of the towns within the Stamford MRI PSA) (CON Application, pp. 38 & 42). None of the PSA towns for the Stamford MRI service overlap with PSA towns for other ARC MRI services (CON Application, pp. 149-150). The next closest MRI unit is in Fairfield, which is approximately 20 miles north of Stamford. Without traffic it would take approximately 25 minutes to travel between the Stamford and Fairfield ARC offices. With traffic it could take upwards of an hour. The Stamford and Orange offices are approximately 40 miles apart with similar travel concerns.

The patient population for the proposed MRI unit will include (but not be limited to) patients who can benefit specifically from the technology of 3.0 Tesla. As mentioned above, 3.0 Tesla is now the preferred MRI for many brain, spine, prostate, and MRA scans.

The Stamford MRI service accepts virtually all payers. In FY 2015, 21.29% of MRI scans in Stamford were for governmentally insured patients (CON Application, p. 41). This included 3.90% Medicaid (258 scans) (CON Application, p. 41). The ARC Stamford MRI service also saw 249 uninsured patients in FY 2015, representing 3.76% of MRI volume for that year (CON Application, p. 41). For ARC MRI services as whole in FY 2015, 10.26% of patients were Medicaid recipients and uninsured/self-pay patients (CON Application, p. 17).

Per the G.E. Study commissioned by ARC, Medicaid recipients in the service area are expected to grow by 14% in the next 5 years (CON Application, p. 63). ARC is committed to caring for these patients. ARC participates in the Medicaid program and provides services to beneficiaries at all of its office locations. ARC is also committed to providing services for the uninsured and underinsured. The practice works with any and all patients who request help with payment of an invoice for services not covered by insurance.

Allowing ARC to acquire a second MRI unit for its Stamford office will increase access to services for vulnerable patient populations. ARC is committed to serving underserved patients and the practice does not, and will not, deny access to MRI or any service to patients due to payer source or an inability to pay (SHP, p. 62).

### 3. Utilization at the Orange and Shelton offices

#### RESPONSE:

The Orange and Shelton offices of ARC provide comprehensive services and are well-utilized by patients in their respective communities. With respect to MRI services, these offices are busy and are projected to get busier in the near future. MRI services in Orange are provided with a 3.0 Tesla open unit and services in Shelton are provided with a 1.5 Tesla closed unit.

The Orange MRI scanner performed 2,886 scans in FY 2015, which equals 72% capacity based on SHP guidelines (CON Application, pp. 48 & 151; SHP, p. 61). For the first seven months of FY 2016, ARC provided 2,355 MRI scans in Orange. The MRI unit in Orange is a 3.0 Tesla that has the same unique and evolving capabilities as the unit being proposed for Stamford. This unit also has a larger bore to accommodate obese and claustrophobic patients and it is used for DynaCad 3D imaging, certain knee protocols (i.e. Zimmer Chondrofix), and research studies. ARC anticipates that its Orange MRI unit will reach capacity in the near future as uses and demand for 3 Tesla expand and increase.

The Shelton MRI scanner performed 2,653 scans in FY 2015 (66% capacity) (CON Application, pp. 48 & 151). The scanner recently underwent software upgrades that will increase its functionality and expand the types of MRI exams that can be performed in Shelton. As a result, ARC expects to see Shelton MRI volume grow in coming years.

Based on the foregoing, the Orange scanner is fully utilized and will soon exceed the threshold for approval of the acquisition of a second unit for that office. The Shelton scanner has not yet reached this threshold, but it remains busy. If either unit were to be relocated it would have a significant adverse impact on MRI services in the community. These scanners serve towns not served by other ARC MRI offices (i.e. the greater New Haven area & the Valley) (CON Application, p. 151). They also serve a considerable number of Medicaid and uninsured/underinsured patients (CON Application, p. 151). ARC is the only non-hospital provider of MRI services in Orange and Shelton (SHP Table 8; CON Application, pp. 43-45). Without one or both of these scanners thousands of individuals in these and surrounding towns would lose access to a high-quality, cost-effective MRI service provider. For those patients who still want to receive their MRI services from ARC, this could mean an arduous commute in the opposite direction on I-95 where traffic congestion can be just as bad.

4. Patient referral patterns for ARC's existing offices

**RESPONSE:**

ARC has six offices located in Stamford, Fairfield, Stratford, Trumbull, Shelton, and Orange. Each office offers MRI services. The MRI equipment located at each office is as follows:

| <b>Office Location</b> | <b>MRI Unit Type</b>           |
|------------------------|--------------------------------|
| Stamford               | Siemens 1.5 Tesla, Fixed, Open |
| Fairfield              | Siemens 3.0 Tesla, Fixed, Open |
| Stratford              | G.E. 1.5 Tesla, Fixed, Closed  |
| Trumbull               | Siemens 1.5 Tesla, Fixed, Open |
| Shelton                | G.E. 1.5 Tesla, Fixed, Closed  |
| Orange                 | Siemens 3.0 Tesla, Fixed, Open |

Referral patterns for MRI services vary based upon a number of factors. These include patient towns of origin and employment – some patients prefer to receive their MRI scans closer to where they work versus where they live. Referrals are also dependent on the type of exam or procedure ordered (some are better suited for 3.0 Tesla vs. 1.5 Tesla), referring physician preference for a particular scanner, and the urgency of the scan (urgency might cause a patient to be referred to a less-convenient office with a sooner “next available appointment” time). Referrals are also impacted by patient limitations (i.e. obesity, claustrophobia) and special populations (i.e. women’s or pediatric imaging). Obese and claustrophobic patients tend to do better on the “open” units located in Stamford, Fairfield, Trumbull, and Orange. Women’s imaging is done primarily in Trumbull and Stamford where the practice has specialized equipment and a variety of imaging services can be provided at a single location.

In terms of patient towns of origin, there is no overlap between the PSA of the Stamford MRI services and other ARC offices. It is the most geographically distant of the ARC office, separated from the others by 20 to 40 miles in one of the worst traffic corridors in the country. The Fairfield, Stratford and Trumbull offices (greater Bridgeport area) have some overlap in PSAs and all of these units are extremely busy. And as mentioned previously, the Orange and Shelton offices serve patients from the Valley and greater New Haven area in larger numbers than other ARC offices.

All ARC MRI offices receive referrals from a wide array of healthcare providers. These include physicians of many different specialties, podiatrists and chiropractors. The Stamford office received referrals from more than 500 different providers in FY 2015 (CON Application, p. 13). Other ARC offices have similar referral bases.

## 5. Options to relocate existing MRI scanners

### RESPONSE:

ARC is not able to relocate any of its existing scanners to meet the pressing demand for additional MRI capacity at its Stamford office. As previously mentioned, the ARC units in Fairfield, Stratford and Trumbull are operating at 167% capacity, 136% capacity and 128% capacity, respectively (CON Application, p. 14). These scanners are averaging between 5,000 and 7,000 scans per year (CON Application, p. 48). Relocating one of these units out of its existing market would have a significant adverse impact on access to care for these communities. Instead of reducing access, ARC continues to evaluate the ways in which it can meet the increasing demand for services in and around these offices.

OHCA has asked specifically about the ability to relocate either the Orange or the Shelton MRI unit to lower Fairfield County to alleviate capacity constraints in Stamford. This is not a viable option for several reasons. First, with respect to the Orange unit, which is operating at 72% capacity, a recent increase in MRI volume has the scanner projected to reach capacity in the near future. This is a 3.0 Tesla unit that has unique and evolving capabilities and exists as a clinical resource for referring physicians in this community. The Shelton unit is operating at 66% capacity (CON Application, p. 151). However, a recent software upgrade is expected to expand the uses of this unit and increase MRI volume in Shelton going forward. The Orange and Shelton offices serve towns located in the Valley and greater New Haven area that are not served by other ARC offices (CON Application, p. 151). ARC is the only non-hospital MRI provider in Orange and Shelton, which impacts favorably on cost (SHP, Table 8; CON Application pp. 43-45). The Orange and Shelton offices also provide MRI and other services to a significant number of Medicaid and uninsured/underinsured patients (CON Application, p. 151). Relocating either one of these units would reduce access for thousands of patients, including many of the state's most vulnerable patients.

## 6. Capacity of the proposed second unit

### RESPONSE:

ARC needs to operate the 3.0 Tesla MRI and evaluate the patient and demand mix before it can determine the capacity of this scanner (and the Stamford MRI service as a whole) and finalize hours of operation for each unit. Initially, ARC will operate the second unit from 7:30 a.m. to 3:30 p.m. daily, which should allow the Stamford office to reduce some late evening and "off hours" shift work. The 1.5 Tesla hours will remain the same initially, subject to the aforementioned reductions. Eventually ARC anticipates having the 3.0 Tesla operational from 7:30 a.m. to 3:30 p.m. daily and the 1.5 Tesla scheduled for extended shifts at different times and on different days each week as needed.

With the acquisition of a second unit for Stamford, ARC anticipates having sufficient capacity to meet the MRI volume projected for this office in its CON submissions. By FY 2019, the Stamford MRI service is projected to perform 8,041 scans (CON Application, p. 135). Per

the SHP, both the 3.0 Tesla MRI and the 1.5 Tesla MRI have a capacity of 4,000 scans per year (SHP, p. 61). This brings the total capacity of the ARC Stamford MRI service to 8,000 scans per year.

7. MRI capacity/availability (including all existing providers in this service area)

**RESPONSE:**

See below for a revised version of Table 9 from the CON Application (pp. 43-45), which includes calculations of utilization/capacity ratios for each unit. The utilization data is based on Table 8 of the SHP. Capacity per unit is assumed to be 4,000 scans per the SHP (p. 61). As you can see, a vast majority of MRI providers in the service area are operating near or over (well-over in some cases) the 85% threshold for acquisition of an additional MRI unit. As a whole, providers in the service area are operating at 92% capacity. This is based on there being 13 units with a capacity of 4,000 scan each, for an annual service area capacity of 52,000 scans. In FY 2013, these providers conducted a total of 47,662 scans ( $47,662 \div 52,000 = .92$ ).

| Type of MRI Unit                                  | Provider's Name & Address  | Provider Type | FY 2013 Scan Volume | Capacity of MRI Unit | % Capacity Utilized |
|---|--|---------------|---------------------|----------------------|---------------------|
| G.E. 450<br>1.5 Tesla<br>Fixed/Closed             | Greenwich<br>Hospital<br>5 Perry Ridge<br>Road<br>Greenwich, CT<br>06830                         | Hospital      | 4,693               | 4,000                | 117%                |
| G.E. Signa<br>Excite<br>3.0 Tesla<br>Fixed/Closed | Greenwich<br>Hospital<br>5 Perry Ridge<br>Road<br>Greenwich, CT<br>06830                         | Hospital      | 3,128               | 4,000                | 78%                 |
| Siemens<br>Espree<br>1.5 Tesla<br>Fixed/Closed    | Greenwich<br>Hospital<br>Diagnostic Center<br>2015 West Main<br>Street<br>Greenwich, Ct<br>06902 | Hospital      | 1,991               | 4,000                | 50%                 |
| Philips<br>Ingenua<br>1.5 Tesla<br>Fixed/Closed   | Norwalk Hospital<br>24 Stevens Street<br>Norwalk, CT<br>06856                                    | Hospital      | 3,174               | 4,000                | 79%                 |

| Type of MRI Unit  | Provider's Name & Address  | Provider Type                    | FY 2013 Scan Volume                          | Capacity of MRI Unit                            | % Capacity Utilized |
|---|--|----------------------------------|--|---|---------------------|
| G.E. HDX<br>Twinspeed 8<br>Channel<br>1.5 Tesla<br>Fixed/Closed<br><br>G.E. HDX<br>Openspeed<br>Excite<br>.7 Tesla<br>Fixed/Open<br><br>G.E. HDX<br>Echospeed 8<br>Channel<br>1.5 Tesla<br>Fixed/Closed | Norwalk Hospital<br>d/b/a Norwalk<br>Radiology &<br>Mammography<br>Center<br>184 East Avenue<br>Norwalk, CT<br>06851 | Hospital                         | 9,797<br>(combined<br>volume for 3<br>units) | 12,000<br>(combined<br>capacity for<br>3 units) | 82%                 |
| G.E. Electric<br>Signa HDX<br>1.5 Tesla<br>Fixed/Closed   | The Stamford<br>Hospital<br>30 Shelburne<br>Road<br>Stamford, CT<br>06904  | Hospital                         | 6,427  | 4,000   | 161%                |
| G.E. Horizon<br>LX<br>1.5 Tesla<br>Fixed/Closed   | Stamford<br>Hospital's Darien<br>Imaging Center<br>6 Thorndale<br>Circle<br>Darien, CT 06820                         | Hospital                         | 1,827  | 4,000   | 46%                 |
| G.E. Signa<br>15 HDXT<br>1.5 Tesla<br>Fixed/Closed  | Stamford<br>Hospital's Tully<br>Health Center<br>32 Strawberry<br>Hill Ct.<br>Stamford, CT<br>06902                  | Hospital                         | 4,360  | 4,000   | 109%                |
| Siemens<br>Espree<br>1.5 Tesla<br>Fixed/Open  | Advanced<br>Radiology<br>Consultants<br>1315 Washington<br>Boulevard<br>Stamford, CT<br>06902                        | Private<br>Radiology<br>Practice | 5,484  | 4,000   | 137%                |

| <b>Type of MRI Unit</b>                        | <b>Provider's Name &amp; Address</b>  | <b>Provider Type</b>        | <b>FY 2013 Scan Volume</b> | <b>Capacity of MRI Unit</b> | <b>% Capacity Utilized</b> |
|--|---|-----------------------------|----------------------------|-----------------------------|----------------------------|
| Siemens Magnetom Espree 1.5 Tesla Fixed/Closed | Orthopaedic & Neurosurgical Specialists<br>40 Valley Drive<br>Greenwich, CT 06830           | Private Orthopedic Practice | 4,800                      | 4,000                       | 120%                       |
| G.E. Optima 1.5 Tesla Fixed/Closed             | Hospital for Special Surgery<br>Outpatient Center<br>1 Blatchley Road<br>Stamford, CT 06902 | Hospital                    | 1,981 <sup>1</sup>         | 4,000                       | 50%                        |
| <b>TOTAL:</b>                                  |   |                             | <b>47,662</b>              | <b>52,000</b>               | <b>92%</b>                 |

<sup>1</sup> This figure includes February 2015 through January 2016 (Docket No. 12-31780-CON). The HSS unit was not in operation during FY 2013, so the only available numbers were used for sake of completeness.

# *EXHIBIT A*



ACR Accreditations



## Greer, Leslie

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**From:** Jennifer Groves Fusco <jfusco@uks.com>  
**Sent:** Wednesday, August 24, 2016 11:58 AM  
**To:** User, OHCA; Fernandes, David; Lazarus, Steven; Hansted, Kevin  
**Cc:** Michele Volpe (mmv@bvmlaw.com)  
**Subject:** Advanced Radiology MRI Centers Limited Partnership -- Docket No. 16-32093-CON  
**Attachments:** DOCS-#1347501-v1-ADRAD\_CORRECTED\_Q\_7.pdf

Attached please find a revised version my client's response to Public Hearing Issue #7. I inadvertently reported 5,484 as the number of MRI scans performed at ARC's Stamford office in FY 2013. Per Table 8 of the SHP, that is the number of patient visits. The number of scans was 6,705, which is consistent with our historical volume as reported in the CON Application at p. 40. The narrative and table have been revised to reflect the correct number of ARC scans and the correct number of total service area scans, with utilization percentages adjusted accordingly.

Thanks,  
Jen

Jennifer Groves Fusco, Esq.  
Principal  
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7. MRI capacity/availability (including all existing providers in this service area)

**RESPONSE:**

See below for a revised version of Table 9 from the CON Application (pp. 43-45), which includes calculations of utilization/capacity ratios for each unit. The utilization data is based on Table 8 of the SHP. Capacity per unit is assumed to be 4,000 scans per the SHP (p. 61). As you can see, a vast majority of MRI providers in the service area are operating near or over (well-over in some cases) the 85% threshold for acquisition of an additional MRI unit. As a whole, providers in the service area are operating at 94% capacity. This is based on there being 13 units with a capacity of 4,000 scan each, for an annual service area capacity of 52,000 scans. In FY 2013, these providers conducted a total of 48,883 scans ( $48,883 \div 52,000 = .94$ ).

| <b>Type of MRI Unit</b>                           | <b>Provider's Name &amp; Address</b>   | <b>Provider Type</b> | <b>FY 2013 Scan Volume</b> | <b>Capacity of MRI Unit</b> | <b>% Capacity Utilized</b> |
|---|--|----------------------|----------------------------|-----------------------------|----------------------------|
| G.E. 450<br>1.5 Tesla<br>Fixed/Closed             | Greenwich<br>Hospital<br>5 Perry Ridge<br>Road<br>Greenwich, CT<br>06830                         | Hospital             | 4,693                      | 4,000                       | 117%                       |
| G.E. Signa<br>Excite<br>3.0 Tesla<br>Fixed/Closed | Greenwich<br>Hospital<br>5 Perry Ridge<br>Road<br>Greenwich, CT<br>06830                         | Hospital             | 3,128                      | 4,000                       | 78%                        |
| Siemens<br>Espree<br>1.5 Tesla<br>Fixed/Closed    | Greenwich<br>Hospital<br>Diagnostic Center<br>2015 West Main<br>Street<br>Greenwich, Ct<br>06902 | Hospital             | 1,991                      | 4,000                       | 50%                        |
| Philips<br>Ingenua<br>1.5 Tesla<br>Fixed/Closed   | Norwalk Hospital<br>24 Stevens Street<br>Norwalk, CT<br>06856                                    | Hospital             | 3,174                      | 4,000                       | 79%                        |

| <b>Type of MRI Unit</b>   | <b>Provider's Name &amp; Address</b>  | <b>Provider Type</b>       | <b>FY 2013 Scan Volume</b>             | <b>Capacity of MRI Unit</b>               | <b>% Capacity Utilized</b> |
|---|---|----------------------------|--|---|----------------------------|
| G.E. HDX Twinspeed 8 Channel<br>1.5 Tesla<br>Fixed/Closed<br><br>G.E. HDX Openspeed Excite<br>.7 Tesla<br>Fixed/Open<br><br>G.E. HDX Echospeed 8 Channel<br>1.5 Tesla<br>Fixed/Closed | Norwalk Hospital<br>d/b/a Norwalk Radiology & Mammography Center<br>184 East Avenue<br>Norwalk, CT<br>06851 | Hospital                   | 9,797<br>(combined volume for 3 units) | 12,000<br>(combined capacity for 3 units) | 82%                        |
| G.E. Electric Signa HDX<br>1.5 Tesla<br>Fixed/Closed  | The Stamford Hospital<br>30 Shelburne Road<br>Stamford, CT<br>06904   | Hospital                   | 6,427                                  | 4,000                                     | 161%                       |
| G.E. Horizon LX<br>1.5 Tesla<br>Fixed/Closed  | Stamford Hospital's Darien Imaging Center<br>6 Thorndale Circle<br>Darien, CT 06820                         | Hospital                   | 1,827                                  | 4,000                                     | 46%                        |
| G.E. Signa 15 HDXT<br>1.5 Tesla<br>Fixed/Closed   | Stamford Hospital's Tully Health Center<br>32 Strawberry Hill Ct.<br>Stamford, CT<br>06902                  | Hospital                   | 4,360                                  | 4,000                                     | 109%                       |
| Siemens Espree<br>1.5 Tesla<br>Fixed/Open   | Advanced Radiology Consultants<br>1315 Washington Boulevard<br>Stamford, CT<br>06902                        | Private Radiology Practice | 6,705                                  | 4,000                                     | 168%                       |

| <b>Type of MRI Unit</b>                              | <b>Provider's Name &amp; Address</b>   | <b>Provider Type</b>        | <b>FY 2013 Scan Volume</b> | <b>Capacity of MRI Unit</b> | <b>% Capacity Utilized</b> |
|--|--|-----------------------------|----------------------------|-----------------------------|----------------------------|
| Siemens Magnetom Espree<br>1.5 Tesla<br>Fixed/Closed | Orthopaedic & Neurosurgical Specialists<br>40 Valley Drive<br>Greenwich, CT<br>06830           | Private Orthopedic Practice | 4,800                      | 4,000                       | 120%                       |
| G.E. Optima<br>1.5 Tesla<br>Fixed/Closed             | Hospital for Special Surgery<br>Outpatient Center<br>1 Blatchley Road<br>Stamford, CT<br>06902 | Hospital                    | 1,981 <sup>1</sup>         | 4,000                       | 50%                        |
| <b><u>TOTAL:</u></b>                                 |  |                             | <b>48,883</b>              | <b>52,000</b>               | <b>94%</b>                 |

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<sup>1</sup> This figure includes February 2015 through January 2016 (Docket No. 12-31780-CON). The HSS unit was not in operation during FY 2013, so the only available numbers were used for sake of completeness.

## Greer, Leslie

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**From:** Alise Emerson <aemerson@pppclaw.com>  
**Sent:** Thursday, August 25, 2016 11:22 AM  
**To:** mmv@bvmlaw.com; jfusco@uks.com; Lazarus, Steven; Greer, Leslie; david.fernands@ct.gov  
**Cc:** Patrick J. Monahan II; maryheffernan@optonline.net  
**Subject:** WESTMED -  
**Attachments:** OHCA complete package 08.25.16.pdf

Please see the attached documents, which we submitted to OHCA today.



**ALISE EMERSON, Legal Assistant**

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ATTORNEYS AT LAW  
August 25, 2016



**Via Hand-Delivery and Electronic Mail**

Ms. Kimberly Martone  
Director of Operations  
Office of Health Care Access Division  
Department of Public Health  
410 Capitol Avenue, MS#13HCA  
Hartford, CT 06134-0308

**Re: Certificate of Need Application Docket No. 32093-CON  
Advanced Radiology MRI Centers  
Acquisition of Second MRI Unit for Stamford Office**

Dear Director Martone:

This firm represents Westchester Medical Group, P.C. ("WESTMED"). On behalf of WESTMED, I attach the following documents (an original and four copies) in connection with WESTMED's Petition to be Designated as an Intervenor with Full Rights in the above-referenced proceeding, which is scheduled for hearing on August 30, 2016:

- My firm's Notice of Appearance on behalf of WESTMED
- WESTMED's Petition to be Designated as Intervenor
- The Pre-filed Testimony of Dr. Richard Morel
- The Pre-filed Testimony of Dr. Jonathan Weiss

Dr. Morel and Dr. Weiss will be present at the hearing on August 30, 2016 to adopt their written testimony under oath and for cross-examination.

On behalf of WESTMED, and for the reasons presented in the attached documents, I respectfully request that OHCA grant WESTMED Intervenor status with full rights in this proceeding.

Thank you for your consideration.

Sincerely,

Patrick J. Monahan II  
pmonahan@pppclaw.com

Enclosures

cc: Mr. Steven Lazarus, OHCA via Electronic Mail  
Leslie Greer, OHCA via Electronic Mail  
Jennifer Fusco Groves, Esq. via Electronic Mail  
Michele Volpe, Esq. via Electronic Mail  
Mr. David Fernandes via Electronic Mail

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION**

IN RE CERTIFICATE OF NEED APPLICATION : DOCKET NO. 163-32093-CON  
OF ADVANCED RADIOLOGY MRI CENTERS :  
LIMITED PARTNERSHIP TO ACQUIRE A :  
3.0 TESLA MRI UNIT FOR STAMFORD OFFICE : AUGUST 25, 2016

**NOTICE OF APPEARANCE**

In accordance with Section 19a-9-28 of the Regulations of Connecticut State Agencies, please enter the appearance of Parrett, Porto, Parese & Colwell, P.C. ("Firm") in the above-captioned proceeding on behalf of Westchester Medical Group, P.C. d/b/a WESTMED ("WESTMED"). The Firm, through undersigned counsel, will appear and represent WESTMED at the public hearing in this matter scheduled for August 30, 2016.

Respectfully Submitted,  
WESTCHESTER MEDICAL GROUP, P.C. d/b/a  
WESTMED

By: 

\_\_\_\_\_  
PATRICK J. MONAHAN II, Its Attorney  
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2319 Whitney Avenue, Suite 1D  
Hamden, CT 06518  
Tel: (203) 281-2700  
Fax: (203) 281-0700

**CERTIFICATION**

I hereby certify that a copy of the foregoing has been sent via First Class, U.S. Mail, postage prepaid, and electronic mail, this 25<sup>th</sup> day of August, 2016 to:

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PATRICK J. MONAHAN II  
Commissioner of the Superior Court

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION**

IN RE CERTIFICATE OF NEED APPLICATION : DOCKET NO. 16-32093-CON  
OF ADVANCED RADIOLOGY MRI CENTERS :  
LIMITED PARTNERSHIP TO ACQUIRE A :  
3.0 TESLA MRI UNIT FOR STAMFORD OFFICE : AUGUST 25, 2016

**PETITION OF WESTCHESTER MEDICAL GROUP, P.C. (d/b/a WESTMED  
MEDICAL GROUP) TO BE DESIGNATED AS AN INTERVENOR WITH FULL  
RIGHTS, INCLUDING THE RIGHT TO CONDUCT CROSS-EXAMINATION**

**I. Introduction**

Pursuant to Section 4-177a of the Connecticut General Statutes and Section 19a-9-27 of the Regulations of Connecticut State Agencies, Petitioner Westchester Medical Group, P.C. (“WESTMED”), with a principal office at 2700 Westchester Avenue, Purchase, New York 10577, and with additional offices in New York and in Greenwich, Stamford and Darien, Connecticut, hereby petitions the Office of Health Care Access Division of the Department of Public Health (“OHCA”) to be designated an Intervenor in this proceeding with full rights as permitted by the referenced statute and regulation. This proceeding involves the Certificate of Need Application (“Application”) of Advanced Radiology MRI Centers Limited Partnership (“Advanced Radiology”) to acquire a second MRI Unit, and to be specific, a 3.0 Tesla MRI, for its Stamford office.

As explained in more detail below and in the accompanying pre-filed testimony of Richard Morell, M.D., MMM, Co-Medical Director of WESTMED and Jonathan Weiss, M.D., WESTMED Diagnostic Radiology, WESTMED requests Intervenor status in order to provide pertinent information demonstrating that the Application should be denied. WESTMED intends to present evidence that: (i) Advanced Radiology relies on a flawed methodology that has produced inaccurate, or at the very least, speculative, projections; (ii) Advanced Radiology fails

in its Application to demonstrate a clear public need for the 3.0 Tesla MRI; and (iii) the Application, if granted, would not be cost-effective and would not improve the quality of healthcare in the affected region; granting the Application instead would create incentive for over-utilization of MRI imaging and would be inconsistent with the rapidly advancing Medicare policy and objectives of tying physician reimbursement to quality and efficiency. For these reasons, WESTMED would be adversely affected by the granting of the Application, and as further detailed below, WESTMED believes that its participation as an Intervenor would furnish significant assistance to OHCA through its presentation of relevant market, clinical and other data, all of which is pertinent to the proceeding and which has not been presented in the Application.

## **II. Overview of WESTMED and its Polyclinic Model of Care**

WESTMED respectfully suggests that its basis for this Petition and its objection to the Application may be better understood if WESTMED provides essential points about its practice model, as well as details about its current and expanding practice locations in Connecticut.

WESTMED is a physician-owned and physician-managed multispecialty group practice of more than 330 physicians and approximately 1,300 employees. As a comprehensive multispecialty group with a large primary care base (more than 70 internists, 25 pediatricians, 36 OB/GYNs, and additional physicians in most medical, surgical and pediatric specialties), WESTMED provides advanced medical care to more than 330,000 patients in Connecticut and New York.

Founded in 1996 in Rye Brook, New York, WESTMED operates large multispecialty offices in New York State with onsite clinical laboratory, pathology laboratory and imaging services provided in White Plains, Rye, Yonkers, Purchase and New Rochelle, and additional services are provided in West Harrison, Hartsdale, and Scarsdale. In Connecticut, WESTMED

presently serves patients in four office locations: one in Stamford (resulting from the physician shareholders of Orthopaedic Associates of Stamford, P.C. becoming practicing physician shareholders and employees of WESTMED as of July 11, 2016); two in Greenwich; and one in Darien. WESTMED's Connecticut physicians currently focus on internal medicine, pediatrics, OB/GYN, ENT, plastic surgery, cardiology, pulmonary, orthopedics and physical medicine. WESTMED's laboratory and imaging services are available to any WESTMED patient who chooses to utilize such services, regardless of the location of the WESTMED physician or office from which a referral or order for a laboratory or imaging service is made.

WESTMED serves a diverse population both from an economic and social perspective. The multispecialty practice serves a large senior population over the age of 65, with approximately 25% of its patient visits comprising Medicare patients. WESTMED also is an active participant in Medicaid, with approximately 4% of its patient base constituting Medicaid recipients.

Declaring as its mission "to improve the health of those we serve" and its vision "to be the future of health care today," WESTMED is committed to a constant effort at being the best place for patients to receive care, for physicians to practice medicine and for employees to work. Its success as a multispecialty provider of high-quality, coordinated and efficient healthcare and overall commitment to excellence are evidenced by the awards and recognition WESTMED has received. WESTMED is certified as a National Committee for Quality Assurance ("NCQA") Level 3 Medical Home (the highest achievable level), is one of more than 250 Medicare Accountable Care Organizations (ACOs) nationwide and one of the less than 100 successful Medicare Shared Savings Plans ("MSSP") for 2014 (which is the last year for which information has been finalized). WESTMED is ranked 20<sup>th</sup> nationally among MSSP participants for quality.

WESTMED set its sights from its beginnings on becoming what is now recognized as a “high-performing multispecialty practice.” This was accomplished in large part by being an early adopter of state of the art health information technology in order to redesign care for capitation while focusing on measures of quality and cost of care along with patient population management. WESTMED regularly analyzes over 2,200 processes and procedures to provide clinicians with information to improve practices and patient health. The entire WESTMED practice has been on a common Electronic Medical Record (“EMR”) platform since 2002. Being an early implementer of a successful EMR system was instrumental in WESTMED becoming in 2004 the first large practice in New York State to apply for and receive NCQA recognition for diabetes care for all of its adult primary care physicians. Additional NCQA recognitions followed in 2005 and 2006.

Over the years, WESTMED’s commitment to patient population management, cost efficiency and superior patient outcomes led WESTMED to a become a fully integrated polyclinic model. This “polyclinic” model goes well beyond physical infrastructure. As used by WESTMED and recognized by health sector supporters of concrete measures to improve the quality of care in the most cost-effective way, the polyclinic model refers to vertically and horizontally integrated centers of patient care provision, linked by a common EMR and a philosophy of patient-centered care at the right time with the right treatment with the right resources. In addition to primary care and specialty care, these polyclinics provide diagnostic imaging, clinical laboratory, pathology, chiropractic, audiology, behavioral health, pain management, palliative care, cardiac testing, physical therapy, occupational therapy, optometry and an optical shop.

In addition to the proven benefits to patient care, the WESTMED polyclinic model is in line with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the significant federal legislation that advances Medicare's development of policy and practices of tying physician reimbursement to quality and efficiency. WESTMED operates polyclinics in White Plains, Rye, Yonkers, Purchase and New Rochelle and is in the process of opening its first Connecticut polyclinic location in Stamford, Connecticut at 1281 East Main Street.<sup>1</sup>

Comprehensive radiology services – including CT, MRI, PET-CT and TomoTherapy Hi-Art - are integral to the WESTMED polyclinic model. The practice opened its first CT scanner in 2000 and its first MRI in 2004. The majority of WESTMED's polyclinics have full radiology with x-ray, mammography, bone density, ultrasound, CT and MRI. WESTMED also has CT/PET at the Purchase location and TomoTherapy at the Rye location. By providing full service radiology and diagnostic testing services in addition to multispecialty care in single locations, WESTMED patients receive comprehensive, integrated and timely care at a significantly lower cost than hospital based systems and traditional single specialty private practices.

WESTMED's judicious use of imaging services, in particular, has been externally validated by independent sources. Cigna's Advanced Imaging Summary reports that WESTMED's MRI use rate per 1,000 is 74% of the market average, meaning WESTMED orders fewer MRIs than other providers in the region. MVP Medicaid, a New York State managed Medicaid plan, measures the percentage of members with a new primary diagnosis of low back pain who did not have an imaging study within 28 days of diagnosis. In this measurement

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<sup>1</sup> Given the importance of factual accuracy and in the spirit of full and fair disclosure, WESTMED notes that even though its polyclinics with imaging and radiology services just over the NY-CT border are available to and being used by Connecticut patients, WESTMED is contemplating seeking OHCA approval as necessary to acquire and employ MRI imaging and radiology services in its Stamford office to better serve its growing patient population.

system, a higher rate is more desirable and WESTMED achieved a 77% rate compared to a market rate of 72%. MVP Medicaid also tracks GI CT scans per 1,000 members. In this measurement of GI CT scans, a lower rate is more desirable and WESTMED's rate is 229 scans per 1,000 members versus the market rate of 250 scans per 1,000 members. Further, WESTMED completed more of these studies in its polyclinics instead of a hospital outpatient department, providing additional cost savings to Medicaid and the State of New York (an achievement it is striving to replicate in Connecticut). According to CMS 2014 MSSP data, WESTMED's MRI use rate is 260 per thousand versus the overall MSSP rate of 269 per 1000. These data points demonstrate that a horizontally integrated polyclinic can properly reduce imaging utilization more effectively than the traditional external radiology referral model that is currently common practice in the pertinent region in Connecticut affected by the Advanced Radiology Application.

### **III. The Reasons for WESTMED's Objection to the Application**

Advanced Radiology proposes to acquire a second MRI (3.0 Tesla) for its Stamford office on the basis that the existing MRI in the Stamford office exceeds 4,000 scans per year. WESTMED objects for the following reasons:

#### **A. Applicant has employed a flawed methodology to forecast volume and therefore has failed to demonstrate a clear public need for the 3.0 Tesla MRI.**

OAS had been a large – if not the largest – source of referrals for Applicant's Stamford office. In calendar year 2015, OAS made 2767 MRI referrals of which greater than 95% were completed by Applicant's Stamford office, representing 40% of the 2015 volume reported by Applicant. (See Application at ARC000040). As of July 11, 2016, the OAS shareholders became WESTMED shareholders and employees. Because WESTMED operates on a polyclinic model, it offers its patients the opportunity to have imaging services performed by WESTMED. In

practical terms, and based on WESTMED experience as it has acquired practice locations and developed its successful polyclinic model, the historical pattern of patients going from OAS to Advanced Radiology for MRI imaging that occurred before July 11, 2016 will naturally diminish and likely end, if not completely, then nearly completely, to a modest, or even nominal level, as WESTMED can refer patients internally for imaging services and readily complete its patients' MRIs within the WESTMED practice. In fact, since July 11, 2016, patients initially seen in the WESTMED Stamford office (formerly OAS's office) have already begun to choose to have their imaging done in the nearby WESTMED offices. Although these MRI scans presently occur in New York, the radiologists in the practice are duly licensed Connecticut physicians.

WESTMED is actively recruiting primary care and specialty physician practices for the Stamford polyclinic, which, based on the historical patterns of the polyclinic model, will inevitably, and naturally, further erode the referral base upon which Applicant has relied for its Stamford office and purports to rely for projections in its Applications. Even though the Fairfield County medical community has been well aware of WESTMED's impending and now definitive arrival in Stamford for months, Applicant fails to acknowledge this important factor and the inevitable decrease in OAS-based referrals in its projections.

Even assuming for the sake of argument that sources of referrals to Applicant remained the same, Applicant applies a 5% annual growth factor to its volume projections. This projection is not credible, as Applicant's Stamford growth history over the 4 years from 2012 through 2015 has only been 6%.

Applicant MRI Utilization

|          | 2012 | 2013 | 2014 | 2015   | 4 Year<br>Growth |
|----------|------|------|------|--------|------------------|
| Scans    | 6242 | 6705 | 7002 | 6617   |                  |
| Variance |      | 7.4% | 4.4% | (5.5%) | 6%               |

Source: Application at pages 40 and 146.

Further, the GE Study, attached as Applicant’s Exhibit A, does not support Applicant’s projected annual growth rate of 5%. According to the GE Chart on page ARC000074 of the Application, GE projects Applicant’s service area to experience a total outpatient MRI growth rate of 5.92% *over a 5-year period*. GE’s five-year projection simply does not square with Applicant’s annual 5% projection, as the logical extension of Applicant’s projection in the absence of any elaboration or explanation of conditions on its assumptions, would result in more than 25% growth predicted over 5 years, in contrast to GE’s 5.92%.

Similarly, the SG2 study, attached as Applicant’s Exhibit B, fails to support the 5% annual growth rate applied by Applicant. The chart located on page ARC000085 of the Application projects a 10-year national outpatient MRI growth rate of 15%. Applicant fails to substantiate with its own evidence that a 5% growth rate is reasonable or achievable, and the very studies on which it relies undermine its projections.

Finally, from a clinical perspective, it is WESTMED’s clinical opinion, as a high-volume high-quality provider, that 3.0 Tesla MRI scanners are best suited for the acute care hospital environment and that state-of-the-art 1.5 Tesla MRIs are properly suited for the vast majority of standard, orthopedic, neuro and body exams, producing excellent quality imaging in a more cost-

effective manner. There are relatively few outpatient MRI scans that materially benefit from being performed on a 3.0 Tesla MRI versus a 1.5 Tesla MRI. And despite Applicant's assertions on page ARC000015 of the Application that the 3.0 Tesla MRI "*allows for much higher quality vascular imaging of the head, neck, body and extremities and may obviate the need for vascular imaging that requires radiation or is more invasive*", Applicant's projections on page ARC000051 demonstrate no growth in vascular MRI.

**B. Applicant's proposal is not cost effective or in the best interest of healthcare consumers or the statewide healthcare system.**

The cost of the Applicant's proposed 3.0 Tesla MRI is \$2,506,224 according to Table 3 on page ARC000030 of the Application. WESTMED represents that it has obtained a vendor quote for a 1.5 Tesla MRI that is capable of performing all studies appropriate to an outpatient setting. The cost of a comparable new 1.5 Tesla MRI is \$1,206,751 which is \$1,299,473 less than what Applicant proposes to spend with no clear clinical benefit and no clear demonstration of need. Even with Applicant's overly ambitious volume projections, Applicant projects that it will not experience an incremental gain on the project until 2021. In view of the likely decrease in volume of at least 40% due to loss of WESTMED referrals, for which Applicant has not accounted, Applicant's losses will certainly extend beyond 2021.

Further, Applicant has failed to provide any evidence that an unmet clinical need exists that necessitates a 3.0 Tesla MRI in its practice. Given the fundamental purpose of OHCA's planning and regulatory functions to, among other things, prevent unnecessary duplication of health services and provide financial stability and cost-containment of health care services, saddling the Connecticut healthcare system with a device that is more than double the cost of a more appropriate 1.5 Tesla MRI does not benefit the statewide system or consumers.

**C. The Granting of Advanced Radiology's Application would be inconsistent with the policy, goals and objectives of MACRA.**

WESTMED's model of care is aligned with the evolving healthcare system's current public policy as reflected in Medicare statutes and regulations. To be more specific, rather than paying providers on a fee-for-service basis in a manner that has great potential to incentivize over-utilization, Medicare payments are rapidly shifting to payment structures that tie reimbursement to patient outcomes and efficient use of resources. To date, the focus of those efforts have been related ACOs and acute care hospitals. However, with the passage of MACRA, physician reimbursement will be tied to quality and efficiency. Without pouring into the details of the law in this Petition, it is clear that the statute provides that quality tracking will begin in 2017, and beginning in January 2019, payments to physicians – including interventional and diagnostic radiology – will be based on quality and efficiency with two paths for payment.

The first track is called the Merit-based Incentive Payment System ("MIPS"). MIPS is a budget neutral program where financial incentives and penalties are intended to balance according to quality achievement, resource use, practice improvement and meaningful use of EMR. Most independent physician practices will be paid under MIPS, and Medicare physician fee-for-service reimbursement is expected to freeze by 2019 until 2026. The second track is named Advanced Alternate Payment Models ("APMs"). Those eligible for payment under APMs include ACOs, patient-centered medical homes and participants in certain bundled payment models. From 2019 to 2024, qualifying APM participants will receive an annual 5% lump sum incentive payment. Beginning in 2026, APMs will receive .75% annual fee schedule updates while MIPS will receive .25% annual fee schedule updates.

MACRA makes it clear that CMS prefers the model of care utilized by WESTMED and is providing incentives for horizontal integration of physician practice. The new reimbursement

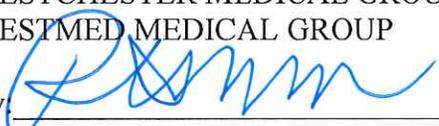
model motivates APMs to question every referral outside its own practice. As a result, single-specialty MIPS provider will likely experience a reduction in Medicare referrals under MACRA. And based on historical market trends, commercial payors tend to follow Medicare payment practices in their private contracting and adjudication practices.

With this in mind, WESTMED respectfully suggests that OHCA's evaluation of the Application in this instance on the basis of volume threshold guidelines should be weighed against the policy that the federal government is in effect implementing in connection with the measure of quality and efficiency and related reimbursement practices, a policy which unquestionably bears on and provides guidance to our state healthcare system practices. In short, CMS is linking payments to value and performance and seeking to reduce incentives for volume-based reimbursement. WESTMED believes that viewing the Application in light of its contribution to quality of care, clinical practice improvement and resource utilization, demonstrates that it is insufficient to satisfy the requirements for the granting of the requested Certificate of Need.

Based on the foregoing, and the accompanying documents and pre-filed testimony, WESTMED seeks Intervenor status with full rights for the purpose of opposing the Application.

Respectfully Submitted,

WESTCHESTER MEDICAL GROUP, P.C. d/b/a  
WESTMED MEDICAL GROUP

By: 

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ITS ATTORNEYS

**CERTIFICATION**

I hereby certify that a copy of the foregoing has been sent via First Class, U.S. Mail, postage prepaid, and electronic mail, this 25<sup>th</sup> day of August, 2016 to:

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PATRICK J. MONAHAN II  
Commissioner of the Superior Court

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION**

IN RE CERTIFICATE OF NEED APPLICATION : DOCKET NO. 16-32093-CON  
OF ADVANCED RADIOLOGY MRI CENTERS :  
LIMITED PARTNERSHIP TO ACQUIRE A :  
3.0 TESLA MRI UNIT FOR STAMFORD OFFICE : AUGUST 24, 2016

**PREFILED TESTIMONY OF RICHARD P. MOREL, M.D., M.M.M. OF  
WESTCHESTER MEDICAL GROUP, P.C.**

Good afternoon Hearing Officer Hansted and staff of the Office of Health Care Access (“OHCA”). My name is Richard Morel and I am the Co-Medical Director of the Westchester Medical Group, P.C. (“WESTMED”). Thank you for the opportunity today to testify in opposition to the Certificate of Need Application (“the Application”) filed by Advanced Radiology MRI Centers Limited Partnership (“Advanced Radiology”) to acquire a 3.0 Tesla MRI for its Stamford office.

WESTMED has filed a Petition for Intervenor Status because we believe, for the reasons stated in the Petition, and in my testimony and in the testimony of my colleague, Dr. Jonathan Weiss, that we have important information to offer to OHCA to provided material assistance in its review and determination of the merit of the Application. We believe that the information that we are providing demonstrates that the Application should be denied because: (i) Advanced Radiology relies on a flawed methodology that has produced inaccurate, or at the very least, speculative, projections; (ii) Advanced Radiology fails in its Application to demonstrate a clear public need for the 3.0 Tesla MRI; and (iii) the Application, if granted, would not be cost-effective and would not improve the quality of healthcare in the region affected by the Application. On the contrary, we believe the evidence supports the conclusion that granting the Application instead would create incentive for over-utilization of MRI imaging and would be

inconsistent with the implementation of Medicare policy objectives of tying physician reimbursement to quality and efficiency.

### **I. Overview of WESTMED**

As WESTMED is relatively new to Connecticut, I would like to briefly start by discussing who we are, how we practice and how we are growing. This overview will provide essential context for WESTMED's objection to the Application.

WESTMED is a physician-owned and physician-managed multispecialty group practice of more than 330 physicians and approximately 1,300 employees. As a comprehensive multispecialty group with a large primary care base, we provide advanced medical care to more than 330,000 patients in Connecticut and New York. We presently employ more than 70 internists, 25 pediatricians, 36 OB/GYNs, and additional physicians in most medical, surgical and pediatric specialties.

Founded in 1996 in Rye Brook, New York, WESTMED operates large multispecialty offices in New York State with onsite clinical laboratory, pathology laboratory and imaging services provided in White Plains, Rye, Purchase, Yonkers and New Rochelle, and additional services are provided in West Harrison, Hartsdale, and Scarsdale. In Connecticut, WestMed presently serves patients in four office locations: one in Stamford, resulting from the physician shareholders of Orthopaedic Associates of Stamford, P.C. ("OAS") becoming practicing physician shareholders and employees of WESTMED as of July 11, 2016; two offices in Greenwich; and one office in Darien. WESTMED's Connecticut physicians currently focus on internal medicine, pediatrics, OB/GYN, ENT, plastic surgery, cardiology, pulmonary, orthopedics and physical medicine. WESTMED's laboratory and imaging services are available to any WESTMED patient who chooses to use such services, regardless of the location of the

WESTMED physician or office from which a referral or order for a laboratory or imaging service is made.

We serve a diverse population both from an economic and social perspective. Our multispecialty practice serves a large senior population over the age of 65, with Medicare patients accounting for approximately 25% of our patient visits. WESTMED also is an active participant in Medicaid, with approximately 4% of our patient base constituting Medicaid recipients.

We take pride in being committed to a constant effort at being the best place for patients to receive care, for physicians to practice medicine and for employees to work. Our success as a multispecialty provider of high-quality, coordinated and efficient healthcare and overall commitment to excellence has been recognized in the form of awards and other types of favorable recognition. For example, WESTMED is certified as a National Committee for Quality Assurance (“NCQA”) Level 3 Medical Home (the highest achievable level), is one of more than 250 Medicare Accountable Care Organizations (ACOs) nationwide and one of the less than 100 successful Medicare Shared Savings Plans (“MSSP”) for 2014 (which is the last year for which information has been finalized). We are ranked 20<sup>th</sup> nationally among MSSP participants for quality.

From our beginnings, we have been determined to become what is now recognized as a “high-performing multispecialty practice.” This was accomplished in large part by being an early adopter of state of the art health information technology in order to redesign care for capitation while focusing on measures of quality and cost of care along with population management. We regularly analyze over 2,200 processes and procedures to provide clinicians with information to improve practices and patient health. The entire WESTMED practice has

been on a common Electronic Medical Record (“EMR”) platform since 2002. Being an early implementer of a successful EMR system was instrumental in WESTMED becoming in 2004 the first large practice in New York State to apply for and receive NCQA recognition for diabetes care for all of its adult primary care physicians. Additional NCQA recognitions followed in 2005 and 2006.

Over the years, our commitment to patient population management, cost efficiency and superior patient outcomes led WESTMED to become a fully integrated polyclinic model. As you may know, a true “polyclinic” model goes well beyond physical infrastructure. The polyclinic model refers to vertically and horizontally integrated centers of patient care provision, linked by a common EMR and a philosophy of patient-centered care at the right time with the right treatment with the right resources. In addition to primary care and specialty care, effective polyclinics provide diagnostic imaging, clinical laboratory, pathology, chiropractic, audiology, behavioral health, pain management, palliative care, cardiac testing, physical therapy, occupational therapy, optometry and optical services.

In my role I am certainly familiar with Medicare policies and practices, and I make it a point to gain an understanding of the direction and public policy of the federal healthcare system, especially through Medicare. In addition to the proven benefits to patient care, the WESTMED polyclinic model is, in my opinion, very much in line with the policy and objectives of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the federal legislation that advances Medicare’s development of policy and practices of tying physician reimbursement to quality and efficiency.

WESTMED operates polyclinics in White Plains, Rye, Yonkers, Purchase and New Rochelle; and is in the process of opening its first Connecticut polyclinic location in Stamford, Connecticut at 1281 East Main Street. To that end, we are actively recruiting primary care physicians for 1281 East Main Street and are in the process of leasing additional space. Our Connecticut patients recognize the benefits of using our imaging services in our convenient and nearby New York office locations, however, in the spirit of full and fair disclosure, and in keeping with our polyclinic model objectives, we are considering seeking OHCA approval for an MRI in radiology in our expanding Stamford office location.

I point out, too, that comprehensive radiology services – including CT, MRI, PET-CT and TomoTherapy Hi-Art - are integral to the WESTMED polyclinic model. We have offered CT Scanning since 2000 and MRI since 2004. The majority of our polyclinics have full radiology with x-ray, mammography, bone density, ultrasound, CT and MRI. We offer CT/PET at the Purchase location and TomoTherapy at the Rye location. By providing full service radiology and diagnostic testing services in addition to multispecialty care in single locations, WESTMED patients receive comprehensive, integrated and timely care at a significantly lower cost than hospital based systems and traditional single specialty private practices.

## **II. The Reasons for WESTMED's Objection to the Advanced Radiology Application**

Advanced Radiology proposes to acquire a second MRI (3.0 Tesla) for its Stamford office. WESTMED objects for the following reasons:

### **A. Advanced Radiology has employed a flawed methodology to forecast volume and therefore has failed to demonstrate a clear public need for the 3.0 Tesla MRI.**

OAS had been a large – if not the largest – source of referrals for Advanced Radiology's Stamford office. According to the Application, in calendar year 2015, OAS made 2767 MRI referrals of which greater than 95% were completed by Advanced Radiology's Stamford office,

representing 40% of the 2015 volume reported by Advanced Radiology. (See Application at ARC000040). As of July 11, 2016, the OAS shareholders became WESTMED shareholders and employees. Because WESTMED operates on a polyclinic model, it offers its patients the opportunity to have imaging services performed by WESTMED. In practical terms, and based on my personal experience and involvement in the details of WESTMED's development of the polyclinic model through practice acquisitions, the historical pattern of patients going from OAS to Advanced Radiology for MRI imaging that occurred before July 11, 2016 will undoubtedly diminish and likely end, if not completely, perhaps to a truly minimal level. This is because WESTMED can refer patients internally for imaging services and readily complete its patients' MRIs efficiently and effectively within the WESTMED practice. In fact, since July 11, 2016, patients initially seen in the WESTMED Stamford office (formerly OAS's office) have already begun to choose to have their imaging done in the nearby WESTMED offices, and that pattern is likely to develop further in relatively short order. Although these MRI scans presently occur in New York, the radiologists in the practice are duly licensed Connecticut physicians.

We are actively recruiting primary care and specialty physician practices for the Stamford polyclinic, which, based on the historical patterns of the polyclinic model, will inevitably, and naturally, further erode the referral base upon which Advanced Radiology has relied for its Stamford office and purports to rely for projections in its Applications. Even though the Fairfield County medical community has been well aware of WESTMED's anticipated and now definitive arrival in Stamford for months, it is my understanding that Advanced Radiology fails to acknowledge this fact and the inevitable decrease in referrals in its projections.

As stated in our Petition, even assuming for the sake of argument that sources of referrals to Advanced Radiology remained the same, I see that Advanced Radiology applies a 5% annual growth factor to its volume projections. Based on my experience, training and expectations of this market region, this projection is not credible, as Advanced Radiology's Stamford growth history over the 4 years from 2012 through 2015 has only been 6%.

Advanced Radiology MRI Utilization

|          | 2012 | 2013 | 2014 | 2015   | 4 Year Growth |
|----------|------|------|------|--------|---------------|
| Scans    | 6242 | 6705 | 7002 | 6617   |               |
| Variance |      | 7.4% | 4.4% | (5.5%) | 6%            |

(See Application at pages ARC000040 and ARC0000146).

Further, the GE Study, attached to Advanced Radiology's Application, in my opinion does not support Advanced Radiology's projected annual growth rate of 5%. According to the GE Chart on page ARC000074 of the Application, GE projects Advanced Radiology's service area to experience a total outpatient MRI growth rate of 5.92% over a five-year period. GE's five-year projection simply does not match up with Advanced Radiology's annual 5% projection and Advanced Radiology has failed to provide adequate explanation for its assumed growth rate, which if we understand it correctly, is more than 25% growth predicted over 5 years, in contrast to GE's 5.92%.

Similarly, the SG2 study, attached as Advanced Radiology's Exhibit B, in my opinion fails to support the 5% annual growth rate applied by Advanced Radiology. The chart located on page ARC000085 of the Application projects a 10-year national outpatient MRI growth rate of

15%. Advanced Radiology fails to substantiate with its own evidence that a 5% growth rate is reasonable or achievable, and the very studies on which it relies undermine its projections.

**B. Advanced Radiology's proposal is not cost effective or in the best interest of healthcare consumers or the statewide healthcare system.**

The cost of the Advanced Radiology's proposed 3.0 Tesla MRI is \$2,506,224 according to Table 3 on page ARC000030 of the Application. WESTMED has obtained a vendor quote for a 1.5 Tesla MRI that is capable of performing all studies appropriate to an outpatient setting. The cost of a comparable new 1.5 Tesla MRI is \$1,206,751 which is \$1,299,473 *less* than what Advanced Radiology proposes to spend with no clear clinical benefit and no clear demonstration of need. Even with Advanced Radiology's overly ambitious volume projections, Advanced Radiology projects that it will not experience an incremental gain on the project until 2021. In view of the likely decrease in volume of at least 40% due to loss of WESTMED referrals, for which Advanced Radiology has not accounted, Advanced Radiology's losses will almost certainly extend beyond 2021.

Further, in my review of the Application, I do not see any evidence that an unmet clinical need exists that necessitates a 3.0 Tesla MRI in its practice. With WESTMED becoming increasingly active in Connecticut in the provision of high quality and cost-effective care, I have become more familiar with some of the fundamental purposes of OHCA's planning and regulatory functions to, among other things, prevent unnecessary duplication of health services and provide financial stability and cost-containment of health care services. With those purposes in mind, saddling the Connecticut healthcare system with a device that is more than double the cost of a more appropriate 1.5 Tesla MRI does not in my opinion benefit the statewide system or consumers.

**C. The Granting of Advanced Radiology's Application would be inconsistent with the policy, goals and objectives of MACRA.**

As I stated above, WESTMED is aligned with the evolving healthcare system's public policy as reflected in Medicare statutes and regulations. To be more specific, rather than paying providers on a fee-for-service basis in a manner that has great potential to incentivize over-utilization, Medicare payments are shifting to payment structures that tie reimbursement to patient outcomes and efficient use of resources. To date, the focus of those efforts have been related ACOs and acute care hospitals. However, with the passage of MACRA, it is my understanding that physician reimbursement will ultimately be tied to quality and efficiency. My understanding is that physician quality tracking will begin in 2017 and payments to physicians – including interventional and diagnostic radiology – will be based on quality and efficiency with two paths for payment in 2019.

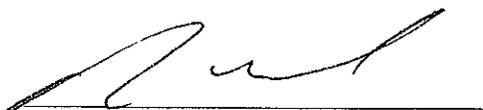
The first track is called the Merit-based Incentive Payment System (“MIPS”). MIPS is a budget neutral program where financial incentives and penalties appear to be intended to balance according to quality achievement, resource use, practice improvement and meaningful use of EMR. Most independent physician practices will be paid under MIPS, and Medicare physician fee-for-service reimbursement is expected to freeze by 2019 until 2026. The second track is named Advanced Alternate Payment Models (“APMs”). Those eligible for payment under APMs include ACOs, patient-centered medical homes and participants in certain bundled payment models. From 2019 to 2024, qualifying APM participants are expected to receive an annual 5% lump sum incentive payment. Beginning in 2026, APMs are expected to receive .75% annual fee schedule updates while MIPS will receive .25% annual fee schedule updates.

From my and WESTMED's perspective, MACRA makes it clear that CMS prefers the model of care utilized by WESTMED and is providing incentives for horizontal integration of physician practice. The new reimbursement model motivates APMs to question every referral outside its own practice. As a result, single-specialty MIPS provider will likely experience a reduction in Medicare referrals under MACRA. And it is our experience is that commercial payors tend to follow Medicare payment practices.

We respectfully suggest that OHCA's evaluation of the Application in this instance on the basis of volume threshold guidelines should be weighed against the policy that the federal government is implementing in connection with the measure of quality and efficiency and related reimbursement practices, a policy which unquestionably bears on and provides guidance to this state healthcare system practices. In short, CMS is linking payments to value and performance and seeking to reduce incentives for volume-based reimbursement. WESTMED believes that viewing the Application in light of its contribution to quality of care, clinical practice improvement and resource utilization, demonstrates that it is insufficient to satisfy the requirements for the granting of the requested Certificate of Need.

Thank you for your time and consideration. I am available to answer any questions you may have.

The foregoing is my sworn testimony.



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Richard P. Morel, M.D.

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION**

IN RE CERTIFICATE OF NEED APPLICATION : DOCKET NO. 16-32093-CON  
OF ADVANCED RADIOLOGY MRI CENTERS :  
LIMITED PARTNERSHIP TO ACQUIRE A :  
3.0 TESLA MRI UNIT FOR STAMFORD OFFICE : AUGUST 24, 2016

**PREFILED TESTIMONY OF JONATHAN D. WEISS, M.D. OF WESTCHESTER  
MEDICAL GROUP, P.C.**

Good afternoon Hearing Officer Hansted and staff of the Office of Health Care Access (“OHCA”). My name is Jonathan Weiss and I am a board certified diagnostic radiologist specializing in MRI. I am in practice with the Westchester Medical Group, P.C. (“WESTMED”). Thank you for the opportunity today to testify in opposition to the Certificate of Need Application (“the Application”) filed by Advanced Radiology MRI Centers Limited Partnership (“Advanced Radiology”) to acquire a 3.0 Tesla MRI for its Stamford office.

As my colleague, Dr. Richard Morel, has testified, WESTMED is a large multispecialty practice that provides care in polyclinics, serving more than 330,000 patients and growing. We provide comprehensive radiology services in our polyclinics and have offered MRI since 2004. In calendar year 2015, we completed 11,770 MRI scans for our patients.

***ADVANCED RADIOLOGY FAILS TO PROVE CLEAR PUBLIC NEED FOR A 3.0 TESLA MRI:***

It is my clinical opinion based on my education, training, and experience, including my substantial experience with WESTMED, a high-volume high-quality provider, that 3.0 Tesla MRI scanners are best suited for the acute care hospital environment and that state-of-the-art 1.5 Tesla MRIs are more properly suited for the vast majority of standard, orthopedic, vascular, neuro and body exams, producing excellent quality imaging in a more cost-effective manner.

There are relatively few outpatient MRI scans where a 3.0 Tesla MRI produces a clinically significant better result than a 1.5 Tesla MRI. And despite Advanced Radiology’s assertions on page ARC000015 of the Application that the 3.0 Tesla MRI “allows for much higher quality vascular imaging of the head, neck, body and extremities and may obviate the need for vascular imaging that requires radiation or is more invasive”, I do not see in Advanced Radiology’s projections on page ARC000051 any demonstration of growth in vascular MRI; nor do I see evidence of any specific service line growth attributable to those few procedures that require the finest detail of a 3.0 Tesla MRI.

I think it is important, too, to understand that while a 3.0 Tesla MRI can produce images in exquisite detail, it can also produce increased problems with susceptibility-based artifacts. To say it more plainly, different tissues and various implants react differently to magnetic fields. The larger the magnet, the greater the potential for local field distortion.

Another concern with the 3.0 Tesla is the increased specific absorption rate (“SAR”). Human tissue absorbs the radiofrequency generated by MRI which can cause tissue heating and subsequent tissue damage. The higher the Tesla strength, the higher the SAR. The doubling of field strength from 1.5 Tesla MRI to 3.0 Tesla MRI leads to a quadrupling of SAR.

For these reason, the vast majority of MRIs installed nationally in academic centers, hospitals and outpatient facilities are 1.5 Tesla MRI. The same is true in Connecticut.

Connecticut MRIs

|                   | < 1.5T |         | 1.5T  |         | 2.0T  |         | 3.0T  |         | Total |         |
|-------------------|--------|---------|-------|---------|-------|---------|-------|---------|-------|---------|
|                   | Count  | Percent | Count | Percent | Count | Percent | Count | Percent | Count | Percent |
| Hospital Operated | 5      | 4%      | 61    | 46%     | 0     | 0%      | 13    | 10%     | 79    | 60%     |
| Private Practice  | 16     | 12%     | 29    | 22%     | 4     | 3%      | 4     | 3%      | 53    | 40%     |
| Total             | 21     | 16%     | 90    | 68%     | 4     | 3%      | 17    | 13%     | 132   | 100%    |

Source: [http://www.ct.gov/dph/lib/dph/ohca/hc\\_facilities\\_advisory\\_body/inventory/2014/table\\_8\\_\(mri\).xlsx](http://www.ct.gov/dph/lib/dph/ohca/hc_facilities_advisory_body/inventory/2014/table_8_(mri).xlsx)

Of the thirteen hospital-operated 3.0 Tesla MRIs, two are dedicated to psychiatric research and three are dedicated to the Smilow Cancer Center at Yale-New Haven. WESTMED also would like to point out that there is a 3.0 Tesla MRI located in Greenwich and operated by Greenwich Hospital that has capacity to accommodate those few patients who truly benefit from the larger magnet.

***ADVANCED RADIOLOGY'S STATEMENTS LINKING SELF-REFERRAL OF MRIs TO EXCESSIVE REFERRALS AND OVER-UTILIZATION IS A SPECIOUS ARGUMENT***

In Advanced Radiology's prefiled testimony, Dr. Kaye asserts that practices that own MRIs for their own practice's use engage in over-referrals because of a financial incentive to do so. I see no current data supplied by Advanced Radiology to support this assertion. Rather, Advanced Radiology points to several significantly outdated articles to support its claim, all of which predate the Affordable Care Act and MACRA. While these articles were substantive when published pre-2002, they are no longer compelling in a health care reimbursement environment that focuses on accountability, quality, efficiency and cost reduction. The only current exhibit provided by Advanced Radiology is Exhibit E on page ARC000199. However, this exhibit supports what WESTMED has asserted, which is that integrated medical practices yield superior results. In addition, the proposed 2018 budget as described in Exhibit E to Dr. Kaye's Prefiled Testimony reports that the STARK exemption will be allowed to continue for integrated practices like WESTMED.

WESTMED can prove that integrated practices work to reduce MRI utilization. We are a private practice that owns MRIs for our own patients. And the fact is, we are a highly responsible referrer to our own MRI. Independent, external sources validate WESTMED's judicious use of MRI. Cigna's Advanced Imaging Summary reports that WESTMED's MRI use

rate per 1,000 is 74% of the market average, meaning our physicians order fewer MRIs than other providers in the region. MVP Medicaid, a New York State managed Medicaid plan, measures the percentage of members with a new primary diagnosis of low back pain who did not have an imaging study within 28 days of diagnosis. In this measurement system, a higher rate is more desirable and WESTMED achieved a 77% rate compared to a market rate of 72%. MVP Medicaid also tracks GI CT scans per 1,000 members. In this measurement of GI CT scans, a lower rate is more desirable and WESTMED's rate is 229 scans per 1,000 members versus the market rate of 250 scans per 1,000 members. According to CMS 2014 MSSP data, WESTMED's MRI use rate is 260 per thousand versus the overall MSSP rate of 269 per 1000. These data points demonstrate that a horizontally integrated polyclinic can properly reduce imaging utilization more effectively than the traditional external radiology referral model that is currently common practice in the pertinent region in Connecticut affected by the Advanced Radiology Application.

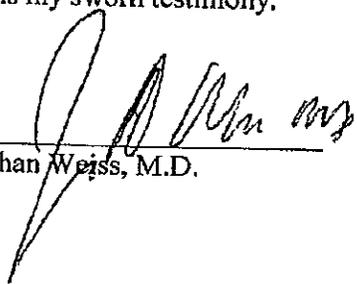
***ADVANCED RADIOLOGY'S PROPOSAL WILL NOT IMPROVE PATIENT CARE***

Advanced Radiology has provided no evidence that a 3.0 Tesla MRI, which will show operating losses until at least 2021 (assuming that all of the Applications assertions are accepted as fact) will improve patient care. There is no data that I have seen that verifies that patients are turned away. There is no data that I have seen showing that patients experience an untoward delay in service. There also is no data presented showing that that images captured on the existing 1.5 Tesla MRI are inadequate. All that is provided as argument is a reliance on OHCA guidelines regarding device utilization. My colleague has already testified that a more in-depth review of this Application is warranted, especially in view of the fact that WESTMED's presence in Stamford will erode Advanced Radiology's volume to a material extent.

WESTMED is presently located in Stamford, Greenwich and Darien. My experience is that after our new practices integrate back office functions, change to our EMR and redesign their workflow, both physicians and patients see increased value associated with receiving comprehensive medical services under the WESTMED umbrella. All tests immediately load to the EMR and patient portal. Physicians can walk to each other's offices within the same building to have real-time consultations. Patients can receive all services in one location and know that each provider associated with his/her care has an entire record a mouse-click away. Our patients receive team care in a coordinated, cost-effective manner that yields superior outcomes. Advanced Radiology's proposal and its related negative assertions against the internal referrals that occur in a polyclinic model are dated artifacts of a practice model that do not accurately reflect the superior quality and cost-effective benefits associated with the current multispecialty and polyclinic physician practice models.

Thank you for your time and consideration. I am available to answer any questions you may have.

This is my sworn testimony.

  
Jonathan Weiss, M.D.

## Greer, Leslie

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**From:** Kathleen Gedney <kgg@bvmlaw.com>  
**Sent:** Thursday, August 25, 2016 3:40 PM  
**To:** Hansted, Kevin; Lazarus, Steven; Riggott, Kaila; Fernandes, David; Greer, Leslie; User, OHCA  
**Cc:** Jennifer Groves Fusco; pmonahan@pppclaw.com; Michele Volpe; Jennifer O'Donnell  
**Subject:** Docket No. 16-32093 - Advanced Radiology MRI Centers Limited Partnership Acquisition of 3.0 Tesla MRI Unit for Stamford Office - August 30, 2016 Hearing  
**Attachments:** Docket No. 16-32093 - ONS Intervenor Filings (8.25.16).pdf

All:

Please see attached with respect to the above-captioned matter.

Regards,

Kathleen Gedney-Tommaso  
Attorney at Law  
Bershtein, Volpe & McKeon P.C.  
105 Court Street, 3<sup>rd</sup> Floor  
New Haven, CT 06511  
Tel: (203) 859-6238  
Fax: (203) 777-5806  
Email: [kgg@bvmlaw.com](mailto:kgg@bvmlaw.com)

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**BERSHTEIN, VOLPE & McKEON, P.C.**  
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TELEPHONE: (203) 777-5800  
FACSIMILE: (203) 777-5806

Michele M. Volpe  
[mmv@bvmlaw.com](mailto:mmv@bvmlaw.com)  
203-777-5802

August 25, 2016

Kevin Hansted  
Department of Public Health  
Office of Health Care Access  
410 Capitol Avenue  
MS #13HCA  
Hartford, Connecticut 06134-0308

RE: Docket No. 16-32093-CON  
Advanced Radiology MRI Centers Limited Partnership Acquisition of MRI Unit for Stamford  
Office

Mr. Hansted:

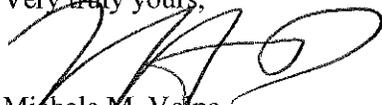
This firm represents Orthopaedic & Neurosurgery Specialists, P.C. ("ONS"). On behalf of ONS, enclosed please find the following documents in connection with ONS's petition for intervenor status in the above-referenced proceeding scheduled for August 30, 2016:

- Notice of Attorney Appearance;
- ONS's Petition to be Designated as an Intervenor; and
- The Pre-Filed Testimony of Dr. Mark Camel.

Dr. Camel will be present at the hearing on August 30, 2016 to adopt his pre-filed testimony under oath. An original, signed copy of the pre-filed testimony will be submitted at the hearing.

If you have any questions or need anything further, please do not hesitate to contact me at 203-777-5802. Thank you.

Very truly yours,

  
Michele M. Volpe

Enclosures

Cc: Mr. Steven Lazarus, OHCA via email  
Ms. Kaila Riggot, OHCA via email  
Mr. David Fernandes, OHCA via email  
Ms. Leslie Greer, OHCA via email  
Jennifer Groves Fusco, Updike, Kelly & Spellacy, P.C. via email  
Patrick J. Monahan, II, Parrett, Porto Parese & Colwell, P.C. via email

DEPARTMENT OF PUBLIC HEALTH :  
DIVISION OF OFFICE OF :  
HEALTH CARE ACCESS : DOCKET NO. 16-32093-CON  
:  
IN RE: ADVANCED RADIOLOGY MRI :  
CENTERS LIMITED PARTNERSHIP :  
ACQUISITION OF MRI UNIT FOR :  
STAMFORD OFFICE : AUGUST 25, 2016

NOTICE OF APPEARANCE

In accordance with §19a-9-28 of the Conn. Agencies Reg., please enter the appearance of Michele Volpe, of Bershtein, Volpe & McKeon, P.C., on behalf of Orthopaedic & Neurosurgery Specialists, P.C. in the above-captioned matter.

I will attend and participate in the hearing on August 30, 2016 on behalf of Orthopaedic & Neurosurgery Specialists, P.C.

Respectfully Submitted,

ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.

BY:

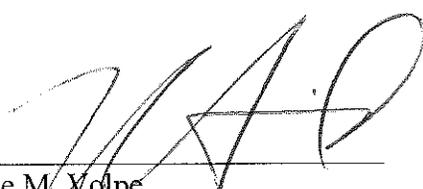
  
\_\_\_\_\_  
Michele M. Volpe, Juris No. 412124  
Bershtein, Volpe & McKeon P.C.  
105 Court Street, 3<sup>rd</sup> Floor  
New Haven, Connecticut 06511  
Tel. No. 203 777-5800  
Fax No. 203 777-5806  
[mmv@bvmlaw.com](mailto:mmv@bvmlaw.com)  
Its Attorney

**CERTIFICATION**

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 25th day of August 2016 to the following:

Jennifer Groves Fusco  
Attorney  
Updike, Kelly & Spellacy, P.C.  
One Century Tower  
265 Church Street  
New Haven, CT 06510  
jfusco@uks.com

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\_\_\_\_\_  
Michele M. Volpe  
Bershtein, Volpe & McKeon P.C.

DEPARTMENT OF PUBLIC HEALTH :  
DIVISION OF OFFICE OF :  
HEALTH CARE ACCESS : DOCKET NO. 16-32093-CON  
:  
IN RE: ADVANCED RADIOLOGY MRI :  
CENTERS LIMITED PARTNERSHIP :  
ACQUISITION OF MRI UNIT FOR :  
STAMFORD OFFICE : AUGUST 25, 2016

**PETITION OF ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.  
FOR INTERVENOR STATUS WITH FULL PROCEDURAL RIGHTS  
INCLUDING RIGHT OF CROSS-EXAMINATION  
AT AUGUST 30, 2016 HEARING**

Pursuant to Conn. Gen. Stat. §§4-166 *et seq.* and §19a-9-27 of the Regulations of Connecticut State Agencies, Othopaedic & Neurosurgery Specialists, P.C. (“ONS” or the “Petitioner”) respectfully petitions the Department of Public Health division of Office of Health Care Access (“OHCA”) for intervenor status in the above-referenced proceeding with full rights, including the right to inspect and copy records, receive a copy of any and all correspondence submitted to OHCA, present written and oral testimony, evidence and argument, and to cross-examine the Applicants, Advanced Radiology MRI Centers Limited Partnership (“Advanced Radiology” or “the Applicant”) and any witnesses in the above captured matter.

**I. Preliminary Statement**

Petitioner is a private physician practice with offices at 6 Greenwich Office Park, 40 Valley Drive, Greenwich, CT 06831 and 5 High Ridge Park, Stamford, CT 06905. Pursuant to Docket Number 08-31150-CON, ONS operates a fixed 1.5T MRI at its Greenwich office location.

Petitioner will present evidence and is available to serve as a resource to OHCA relating to the public need in the service area and whether or not Advanced Radiology has established a public need, whether or not Advanced Radiology's proposed services are duplicative, and whether or not Advanced Radiology's proposed project is financially feasible.

**II. Manner in Which the Petitioner's Interest is Affected by the Proposal**

The Petitioner's interests are greatly affected by the proposal to establish additional MRI services in ONS's service area. If OHCA were to approve Advanced Radiology's application, such approval will have an impact on need in the service area and therefore an impact on the Petitioner. Petitioner and Advanced Radiology both provide private physician practice based MRI services in the same service area. The Petitioner is a limited referral source for MRI services. The Petitioner's interests are affected because the Petitioner and Advanced Radiology are both requesting a second MRIs at their practice locations.

**III. Manner and Extent to Which ONS Proposes to Participate**

The Petitioner will participate in this proceeding as follows:

A. The Petitioner proposes to present documentary evidence, direct testimony and arguments at the public hearing. The Petitioner will provide OHCA with information regarding public need from a provider and referral source perspective of Advanced Radiology MRI services.

B. The Petitioner requests that it be granted permission to cross-examine representatives of Advanced Radiology (and any other parties, intervenors and/or informal participants) on issues, including but not limited to, the impact of this proposal

on ONS, whether or not Advanced Radiology has demonstrated public need for this proposal and other issues related to the services that the Petitioner has specific knowledge.

C. The Petitioner requests that it be granted permission to inspect and copy any and all documents in the record of this matter and that it be copied on all future submissions and correspondence. The Petitioner further requests that it be granted permission to participate in any formal or informal meetings or discussions involving the Applicant and OHCA staff.

**IV. The Manner in which ONS's Participation Will Assist OHCA**

A. As an existing provider of MRI services in the area as well as a limited referral source of such services, the Petitioner is in a unique position to provide OHCA with information not otherwise available to the agency. The Petitioner can offer insight regarding the accessibility of MRI services currently in the service area and the impact of the proposal on existing providers.

B. The Petitioner will provide the evidence summarized in this petition as well as related points at the public hearing through the pre-filed testimony from witnesses and consultants employed by and/or retained by the Petitioner. As an existing provider of MRI services, the Petitioner will furnish assistance to OHCA and serve as a provider resource in resolving the issues in this contested case.

C. The Petitioner's participation in the proceedings is in the interest of justice and will not impair the orderly conduct of these proceedings.

**V. Summary of Anticipated Evidence**

The Petitioner will present evidence regarding Advanced Radiology and whether it has met its burden under Conn. Gen. Stat. 19a-639(a). The following is a summary of the evidence that ONS will offer at the public hearing.

A. Whether Advanced Radiology Has Established Public Need

Advanced Radiology represents that it has established need for a second MRI in the service area and ONS will present evidence and can serve as a resource regarding such public need, as well as the utilization of other MRI scanners in the service area, including ONS's own MRI scanner.

B. Whether Advanced Radiology's Proposed Services Are Duplicative

Advanced Radiology represents that its proposed services are not duplicative. ONS will present evidence regarding the utilization of MRI scanners in the service area, including ONS's own MRI scanner. ONS can serve as a resource to OHCA relating to capacity and utilization of MRI scanners by a private practice located in the same service area as the Applicant.

C. Whether Advanced Radiology Has Proven the Proposal is Financially Feasible

Advanced Radiology represents it will have incremental losses and "will not generate sufficient revenue to cover the cost of a second unit."<sup>1</sup> ONS will present evidence regarding the financial feasibility of MRI ownership by a private practice in the

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<sup>1</sup> Application at 31.

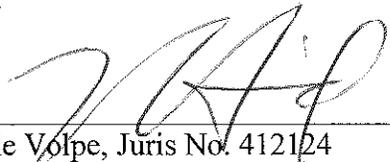
service area. ONS can serve as a resource to OHCA relating to operational costs of MRI scanners in the service area.

**Conclusion**

The Petitioner will demonstrate, through evidence, testimony, documentation and established industry standards, along with information presented in rebuttal and cross-examination, whether Advanced Radiology has or has not meet its burden to establish a clear public need for the proposed MRI. For the foregoing reasons, the Petitioner respectfully requests Intervenor Status with full rights, including the right of cross-examination, pursuant to Section 19a-9-27 of the OHCA regulations.

**THE PETITIONER  
ORTHOPAEDIC & NEUROSURGERY  
SPECIALISTS, P.C.**

**BY:**

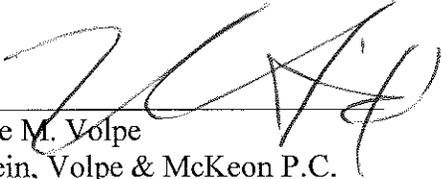
  
\_\_\_\_\_  
Michele Volpe, Juris No. 412124  
Bershtein, Volpe & McKeon P.C.  
105 Court Street, 3<sup>rd</sup> Floor  
New Haven, Connecticut 06511  
Tel. No. 203 777-5800  
Fax No. 203 777-5806

**CERTIFICATION**

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 25th day of August 2016 to the following:

Jennifer Groves Fusco  
Attorney  
Updike, Kelly & Spellacy, P.C.  
One Century Tower  
265 Church Street  
New Haven, CT 06510  
jfusco@uks.com

---

  
Michele M. Volpe  
Bershtein, Volpe & McKeon P.C.

**DEPARTMENT OF PUBLIC HEALTH** :  
**DIVISION OF OFFICE OF** :  
**HEALTH CARE ACCESS** : **DOCKET NO. 16-32093-CON**  
:  
**IN RE: ADVANCED RADIOLOGY MRI** :  
**CENTERS LIMITED PARTNERSHIP** :  
**ACQUISITION OF MRI UNIT FOR** :  
**STAMFORD OFFICE** : **AUGUST 25, 2016**

**PRE-FILE TESTIMONY OF MARK CAMEL, M.D.**

My name is Mark Camel, M.D. and I am the Vice President of Othopaedic & Neurosurgery Specialists, P.C. (“ONS” or the “Petitioner”). ONS is a petitioner in the above-captioned matter. I am here today to speak in opposition of Advanced Radiology MRI Centers Limited Partnership (“Advanced Radiology” or “ARC”) Certificate of Need (“CON”) application (the “Application”) to add a 3.0 Tesla MRI unit at its Stamford location.

My testimony will address that: (1) Advanced Radiology has not demonstrated there is clear public need as it is not sending patients to other facilities (such as its Fairfield location) but is managing all its patients’ MRI needs in Stamford; (2) Advanced Radiology has significant service area overlap of its existing MRI machines and two such machines are underutilized; (3) Advanced Radiology can relocate an existing underutilized MRI in its practice to Stamford; (4) Advanced Radiology has not demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery to Medicaid recipients and indigent persons because the Application has not properly accounted for its own projected increased Medicaid population; (5) the Applicant fails to satisfactorily demonstrate how the proposal will improve quality, accessibility and cost effectiveness of health care delivery because the Applicant utilizes an inferior image sharing network; (6) the Application fails to identify the population to be

served because the Applicant fails to provide evidence that it is referring Stamford patients to another MRI; (7) the Application fails to identify the population to be served because the application has not properly accounted for its own projected increased population; (8) the Application fails to address the utilization of existing 3.0T Scanners in the service area as there is adequate 3.0T capability in the service area and excess capacity of its own 3.0T in Orange; (9) the project is not financially feasible; (10) Advanced Radiology relies on outdated and improper studies to argue that self-referred MRI results in overutilization and increased costs to patients and payors; and (11) Advanced Radiology has a history of being reactionary and failing to be proactive in upgrading technology or even adding imaging capacity until other providers spend resources and come forward for CON approval to meet the public need. Specifically, Advanced Radiology has been at excess capacity in Stamford for years yet it only commenced the CON process for an additional MRI after the ONS application was deemed complete. Further, Advanced Radiology failed to upgrade its Stamford MRI to a 3.0T when it sought and received approval for such upgrade in 2008.<sup>1</sup>

### Professional Background

My professional background is described in the Curriculum Vitae attached as Attachment A to my testimony.

#### **I. The Application Fails to Identify a Clear Public Need**

Approval of a CON requires that the applicant satisfy a clear public need for the proposed services.<sup>2</sup> Advanced Radiology has failed to demonstrate there is public need for any additional MRI services in its practice. Further, OHCA has repeatedly found that patient convenience is

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<sup>1</sup> OHCA Docket No. 08-31188-WVR “*Request to Waive CON Requirements for the Replacement of the Existing 1.5 Tesla MRI Scanner with a 3.0 Tesla Scanner in Stamford*” (Final Decision issued July 8, 2008).

<sup>2</sup> CGS 19a-639(a)(3).

not a compelling need factor therefore Advanced Radiology's claim that patient convenience should be considered is not appropriate.

Advanced Radiology claims it has had to relocate other patients to its Fairfield, Stratford and Trumbull locations but Advanced Radiology's own data contradicts this assertion. In the Application, Advanced Radiology states "because of the rapid growth of MRI volume in Stamford, Advanced Radiology has been forced to divert MRI patients to its other units. The next closest units operated by the practice are located in Fairfield, Stratford and Trumbull."<sup>3</sup>

However, Advanced Radiology's 2015 patient draw data for its other locations does not include any patients from Stamford or from towns that are closer to Stamford.<sup>4</sup> Thus, Advanced Radiology's claim that it cannot manage all its patients' MRI needs in Stamford is unfounded. The Applicant relies on the argument that public need is shown by the fact that Advanced Radiology must refer patients to Fairfield, Stratford and Trumbull to accommodate its overloaded patient demand in Stamford. However, Advanced Radiology has previously testified in OHCA hearings that it "uses a 'Centralized Scheduling System' and when patients call in they call into a 'Call Center'" and that Advanced Radiology does "not view the referral to us as a referral to a machine or a coil, but to us as a practice or a physician group."<sup>5</sup> As important, Advanced Radiology has previously touted it has the capability to adequately address imaging utilization among all its locations but does not utilize this capability to resolve and spread out capacity among its MRIs.

Additionally, there are three hospitals in the service area that operate numerous scanners and accept any patients. While ONS does not have capacity there are two providers right in

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<sup>3</sup> Application at 14.

<sup>4</sup> Application at 149.

<sup>5</sup> OHCA Docket No. 07-30983, "*Acquisition of Three 1.5 Tesla Magnetic Resonance Imaging Scanners for Offices Located in the Towns of Trumbull, Orange and Shelton, Connecticut*" Final Decision at 5 (February 27, 2008).

Stamford who accept referrals and have excess capacity. Hospital for Special Surgery (“HSS”) and Greenwich Hospital’s off campus MRI both have excess capacity.<sup>6</sup>

Lastly, Advanced Radiology bases the need for an additional scanner in its practice for reasons of patient convenience.<sup>7</sup> Advanced Radiology states “there is a clear public need for additional MRI unit in ARC’s Stamford office so that patients from the area will not have to travel unreasonably long distances to obtain MRI services from the provider of their choosing.”<sup>8</sup> Advanced Radiology is stating that patient convenience should prove public need. However, OHCA has stated that patient convenience does not equate to need.<sup>9</sup>

## **II. Advanced Radiology Has Significant Service Area Overlap of Its Existing MRI Machines and Two Such Machines Are Underutilized**

Advanced Radiology has significant service overlap between its existing MRI locations. See Attachment B. Advanced Radiology has two (2) MRIs that are underutilized and that service many of the same cities and towns as its MRIs operating at or above capacity. As important, the Applicant’s underutilized MRIs can service patients from any over-utilized MRI because the Applicant’s underutilized 1.5T Closed MRI is the same strength and capability as the Applicant’s two (2) over-utilized 1.5T Closed MRI and the other underutilized MRI is a 3.0T Open MRI. The Applicant’s underutilized 3.0T Open MRI can accommodate any MRI patient as it has the same and additional capability as a 1.5T MRI and is able to do anything that a 1.5T MRI can do.

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<sup>6</sup> Statewide Healthcare Facilities and Services Inventory – 2014, Table 8 (“Magnetic Resonance Imaging (MRI) Scanning Providers”) published by the Department of Public Health (2014). [http://www.ct.gov/dph/lib/dph/ohca/publications/2014/final\\_2014\\_facilities\\_plan\\_-\\_2\\_24\\_15.pdf](http://www.ct.gov/dph/lib/dph/ohca/publications/2014/final_2014_facilities_plan_-_2_24_15.pdf); OHCA Docket No. 12-32780-CON, Attachment 6 to Agreed Settlement Annual Report dated April 15, 2016.

<sup>7</sup> Applicant’s Pre-Filed Testimony at 158 and 206.

<sup>8</sup> Applicant’s Pre-Filed Testimony at 206.

<sup>9</sup> See, OHCA Docket No. 12-31780-CON “*Acquisition of a Magnetic Resonance Imaging Scanner to be Located in Stamford, Connecticut*” Final Decision at 10 (June 14, 2013). (“OHCA’s determination on the acquisition of an MRI is based, in part, on the demonstrated need for the acquisition, not whether an MRI may provide a more convenient location for the patient...”)

Further, the Applicant's underutilized 3.0T MRI is the same strength requested in the Application – the Applicant already has an underutilized high level MRI. The Applicant's overlapping service areas indicate that Advanced Radiology can accommodate its patients at its numerous locations with its existing scanners.

### **III. The Applicant Can Relocate an Existing Underutilized 3.0T Scanner to Stamford**

As stated above, Advanced Radiology has previously testified in OHCA hearings that it “uses a ‘Centralized Scheduling System’ and when patients call in they call into a ‘Call Center’” and that Advanced Radiology does “not view the referral to us as a referral to a machine or a coil, but to us as a practice or a physician group.”<sup>10</sup> The Applicant's centralized scheduling system and its overlapping service areas indicate that Advanced Radiology can accommodate its patients at its numerous locations with its existing scanners by relocating to Stamford underutilized MRI.

In addition, another provider (“COS”) is seeking approval to place an MRI in Orange to address overutilization on its existing MRIs that already services the same population as Advanced Radiology in the greater Orange area.<sup>11</sup> The Applicant's service area in Orange and COS's proposed service area are substantially similar; the Applicant's Orange service area<sup>12</sup> includes all of the COS cities and towns.<sup>13</sup> With the introduction of additional capacity in Orange pursuant to the COS CON application, the Applicant's scanner in Orange may face decreasing utilization. The Applicant's machine in Orange is already underutilized. In addition, the COS CON application points out the many providers that are already in existence in the

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<sup>10</sup> OHCA Docket No. 07-30983, “*Acquisition of Three 1.5 Tesla Magnetic Resonance Imaging Scanners for Offices Located in the Towns of Trumbull, Orange and Shelton, Connecticut*” Final Decision at 5 (February 27, 2008).

<sup>11</sup> OHCA Docket No. 16-32117- CON, “*Acquisition of a 1.5 Tesla MRI Mobile Unit*” (Application filed August 22, 2016) (hereinafter the “COS Application”)

<sup>12</sup> Application at 150.

<sup>13</sup> COS Application at 40.

Orange service area can accommodate additional volume (including, but not limited to, Milford Hospital main campus, Griffin Hospital main campus, Griffin Hospital Ivy Brook off campus, seven (7) MRIs at the Yale York Street campus, two (2) MRIs at the Yale Chapel Street campus, Yale Temple Radiology; St. Raphael's MRI Center, and Bridgeport Hospital Stratford campus).<sup>14</sup> As such, relocating Advanced Radiology's underutilized Orange MRI is a viable option as there is sufficient capacity to adopt the Applicant's current Orange patients and an additional provider is currently seeking approval to provide additional capacity to the Orange service area.

**IV. The Applicant Fails to Satisfactorily Demonstrate How the Proposal Will Improve Quality, Accessibility and Cost Effectiveness of Health Care Delivery to Medicaid Recipients and Indigent Persons Because the Application Has Not Properly Accounted for Its Own Projected Increased Medicaid Population**

Approval of a CON requires that the applicant satisfactorily demonstrate how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, provision of or any change in the access to services for Medicaid recipients and indigent persons.<sup>15</sup> Although Advanced Radiology indicates that it has a "history of and commitment to servicing Medicaid recipients and indigent persons..." its Medicaid patient population is only 3.9% of its Stamford location.<sup>16</sup> The Applicant's commitment to serving Medicaid populations is also questionable as it anticipated a much higher percentage of Medicaid patient population in a previous Stamford MRI OHCA filing. Specifically, Advanced Radiology anticipated it would serve approximately 6% Medicaid

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<sup>14</sup> COS Application at 45-47.

<sup>15</sup> CGS 19a-639(a)(7).

<sup>16</sup> Application at 32.

patients.<sup>17</sup> Currently, Advanced Radiology serves less than its previously projected Medicaid population. Advanced Radiology has decreased its percentage of Medicaid patients over the years undermining the statements put forth by Advanced Radiology regarding its commitment to serving Medicaid beneficiaries.

Further, Advanced Radiology does not anticipate taking on a higher percentage of Medicaid patients even though the analysis from GE claims there will be more Medicaid patients in the next five years.<sup>18</sup> The GE survey commissioned by Advanced Radiology indicates that growth in the next five years. However, the Medicaid volume in Advanced Radiology's patient population projections for 2016-2019 remain stagnant at the same percentage.<sup>19</sup> Advanced Radiology spends considerable attention and outlines in detail that Medicaid populations in the service area will increase. However, it does not reflect that same position in its projected patient populations and Advanced Radiology does not show any increase in its projected Medicaid patient population.

The MRI located at the Stamford campus of the HSS has done considerable outreach to attract Medicaid patients in the same service area.<sup>20</sup> HSS's efforts to attract Medicaid recipients to its Stamford MRI have only resulted in 1.9% percent of its total patient population.<sup>21</sup> With respect to its Stamford MRI, HSS has enrolled in Medicaid, sent letters to providers informing area providers of its Medicaid participation status, offered clinic hours, hosted community education events, and taken many other steps to increase its Medicaid population. In spite of these efforts, HSS's Medicaid patient population remains under 2%. Considering HSS's efforts

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<sup>17</sup> OHCA Docket No. 04-30277-CON, "*Acquire a High Field Open MRI Unit for Stamford Radiology Practice Location*" Final Decision at 7 (November 18, 2004).

<sup>18</sup> Application at 134.

<sup>19</sup> Application at 41.

<sup>20</sup> OHCA Docket No. 12-32780-CON, Agreed Settlement Annual Report dated April 15, 2016.

<sup>21</sup> OHCA Docket No. 12-32780-CON, Table 6 to Agreed Settlement Annual Report dated April 15, 2016.

to specifically attract Medicaid patients, query whether Advanced Radiology intentionally overestimates the Medicaid population need in the service area.

**V. The Applicant Fails to Satisfactorily Demonstrate How the Proposal Will Improve Quality, Accessibility and Cost Effectiveness of Health Care Delivery Because the Applicant Utilizes an Inferior Image Sharing Network**

The Applicant emphasizes the benefits of its MRI imaging sharing network, however, the network is inferior compared to existing systems in the area and the State. Upon information and belief, the system is often down and is not compatible with hospital systems. As a result, surgeons are unable to pull up the images during surgery.

**VI. The Application Fails to Identify the Population to Be Served Because the Applicant Fails to Provide Evidence That it is Referring Stamford Patients to Another MRI**

Approval of a CON requires that the applicant satisfactorily identify the population to be served by the proposed project and satisfactorily demonstrates that the identified population has a need for the proposed services.<sup>22</sup> Advanced Radiology has indicated there are many individuals who prefer to receive services in the Stamford location but are forced to go to Fairfield due to capacity issues. However, Advanced Radiology cannot provide any factual evidence.<sup>23</sup> This presents an inconsistency with Advanced Radiology's centralized scheduling system. Contrary to what Advanced Radiology states in its application that "[g]iven historical referral patterns, many of those patients originate from the greater Stamford area," the Fairfield, Stratford or Trumbull primary service area patient draw does not include any Stamford residents.<sup>24</sup> Nor do the Fairfield, Stratford or Trumbull location draw patients from towns that

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<sup>22</sup> CGS 19a-639(a)(7).

<sup>23</sup> "Advanced Radiology does not keep track of the number of patients who request Stamford as their first choice for MRI, the offices to which they are ultimately referred if they cannot be accommodated in Stamford, or where those patients reside." Application at 149.

<sup>24</sup> Application at 149.

are closer to Stamford than the respective town.<sup>25</sup> Without any clear evidence that Advanced Radiology is turning patients away from its Stamford location, the patient population to be served has not been identified.

**VII. The Application Fails to Identify the Population to Be Served Because the Application Has Not Properly Accounted for Its Own Projected Increased Medicaid Population.**

Approval of a CON requires that the applicant satisfactorily identify the population to be served by the proposed project and satisfactorily demonstrates that the identified population has a need for the proposed services.<sup>26</sup> Advanced Radiology has failed to identify the population to be served because the Application has not properly accounted for its own projected increased Medicaid population. Advanced Radiology presents an estimate in its GE survey that shows a growth of 14% in Medicaid Expansion and 15% in Medicare.<sup>27</sup> However, these drastic projected increases in Medicaid and Medicare populations are not factored into Advanced Radiology's projected payor mix presented in its Application.<sup>28</sup> Specifically, Advanced Radiology has not calculated any additional anticipated Medicaid population into its projected payor mix; in its financial projections, there are no additional allocations for uninsured patients.<sup>29</sup> Advanced Radiology continues to represent it will have a Medicaid patient population of 3.89% in 2016 and until 2019.<sup>30</sup> In fact, Advanced Radiology's Medicaid population slightly decreases from

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<sup>25</sup> *Id.*

<sup>26</sup> CGS 19a-639(a)(7).

<sup>27</sup> Application at 63.

<sup>28</sup> Application at 134.

<sup>29</sup> *Id.*

<sup>30</sup> Application at 41.

2015 to 2016.<sup>31</sup> Advanced Radiology has not properly identified its future patient base as it presents payor projections conflict with the GE report it presents as support of its Application.

**VIII. The Application Fails to Address the Utilization of Existing 3.0T Scanners in the Service Area or Acknowledge that 3.0T Technology is Adequately Available in the Service Area**

Approval of a CON requires that OHCA consider the utilization of existing health care facilities and health care services in the service area of the applicant.<sup>32</sup> Advanced Radiology asserts it needs a 3.0 Tesla MRI,<sup>33</sup> however, there already exists a 3.0T scanner in the service area.<sup>34</sup> Additionally, Advanced Radiology has an underutilized 3.0T scanner in its practice. Greenwich Hospital already has a 3.0T with excess capacity and Advanced Radiology has a 3.0T in Orange with excess capacity. As such, Advanced Radiology can accommodate a potential patient's need for 3.0T technology with its current scanners. Advanced Radiology has not adequately addressed the excess capacity of existing 3.0T scanners in the area.

**IX. The Project is Not Financially Feasible**

Approval of a CON requires that OHCA consider whether or not the project is financially feasible for the applicant.<sup>35</sup> By Advanced Radiology's own admission, the proposal is not financially feasible. Even after three years of operation Advanced Radiology is still projecting a net income loss for the proposed scanner.<sup>36</sup> Losses of approximately \$625,000 are anticipated in the first year of operations.<sup>37</sup> Advanced Radiology cannot predict when its scanner will become

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<sup>31</sup> Application at 41.

<sup>32</sup> CGS 19a-639(a)(8).

<sup>33</sup> Application at 15.

<sup>34</sup> Greenwich Hospital operates at GE Signa Excite 3.0T at its main campus.

<sup>35</sup> CGS 19a-639(a)(4).

<sup>36</sup> Application at 134.

<sup>37</sup> *Id.*

financially feasible; it is only represented that it expects its proposed MRI to “break even.”<sup>38</sup>

Advanced Radiology presents its GE study to show continued population growth but does not use that same population study to determine and follow that the population growth will be enough to achieve financial feasibility. It is not financially feasible for Advanced Radiology to undertake this project when it only has negative financial predictions. Running a financially unstable operation could present risk to patients as a provider may need to make financial cuts to staffing or maintenance to limit the negative financial impact; and this may also have an adverse impact on quality. As such, Advanced Radiology has not met the financial feasibility criteria. Therefore, query whether even if the MRI is approved Advanced Radiology will acquire the approved second MRI since it is saying it is not financially feasible.

**X. Advanced Radiology Relies On Outdated and Improper Studies to Argue That Self- Referred MRI Results in Overutilization and Increased Costs to Patients and Payors**

In the Applicant’s pre-filed testimony, Advanced Radiology puts forth a statement that in-office imaging has a negative impact to the system and patients because there are financial incentives to over utilize in-office imaging.<sup>39</sup> However, the evidence supporting this statement is extremely outdated. The Applicant relies on studies that that are approximately 25, 30 and 20 years old and, as important, such studies are not specific to MRI or orthopedic or neurosurgical practice. Federal and state regulations relating to in-office imaging have evolved substantially in the past 20-30 years and thus these articles no longer present persuasive arguments. Further, the cited studies do not take into account the appropriateness of use of imaging: “it is not possible to determine which group of physicians [self-referring and radiologist-referring] uses imaging more

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<sup>38</sup> Application at 29.

<sup>39</sup> Applicant’s Pre-Filed Testimony at 172.

appropriately.”<sup>40</sup> Therefore, the Applicant’s reliance on these studies is misplaced because the studies are outdated, improper and do not address the appropriateness of the use of imaging. Lastly, the Applicant’s assertion regarding the 2018 budget<sup>41</sup> does not reflect current law.

**XI. Advanced Radiology Has a History of Being Obstructionist and Failing to be Proactive Until Other Providers Seek Approval to Meet the Public Need**

Advanced Radiology has a pattern of not seeking CON approval for technology upgrades and equipment until other providers have come forward first to serve the need. Advanced Radiology claims it has been operating over capacity in Stamford since 2011 yet it is just now filing its CON. Query whether Advanced Radiology is using the CON process as a means to prevent other providers from obtaining MRIs in the service area.

With regard to the Application at hand, Advanced Radiology waited to file its own CON application for an additional MRI scanner until the ONS application was deemed complete even though Advanced Radiology has been over capacity at its Stamford MRI since FY 2011.<sup>42</sup> Advanced Radiology states it had annual growth of 18% as early as FY 2012.<sup>43</sup> Pursuant to its own data, in FY 2013 Advanced Radiology’s capacity was 167%, in FY 2014 it was 175%, and in FY 2015 it was 165%.<sup>44</sup> Advanced Radiology states in the Application that “As far back as 2011, Advanced Radiology’s Stamford unit has been operating at will above optimal capacity.”<sup>45</sup> Despite Advanced Radiology’s own representation indicating that it has been operating well over capacity for many years, Advanced Radiology did not submit a CON until ONS submitted a CON to acquire an MRI in the same service area. It is questionable whether or not Advanced

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<sup>40</sup> Applicant’s Pre-Filed Testimony at 178 quoting Hillman, M.D., Bruce, et al, N Eng J. Med 1990: 323:1604-1608 (December 6, 1990).

<sup>41</sup> Applicant’s Pre-Filed Testimony at 199.

<sup>42</sup> Application at 13.

<sup>43</sup> Application at 51.

<sup>44</sup> Application at 13.

<sup>45</sup> Application at 13.

Radiology is in need of an additional MRI when it has been operating at its current capacity for years without filing a CON to acquire another MRI or is whether Advanced Radiology will expend resources to purchase an additional MRI.

The most compelling evidence and fact is that Advanced Radiology received OHCA approval to upgrade its Stamford scanner but Advanced Radiology never implemented. In 2008, Advanced Radiology requested a waiver and was approved to upgrade the Stamford MRI to a 3.0 MRI.<sup>46</sup> In its Waiver Request, Advanced Radiology stated an upgrade was required because “advanced neurological studies are best performed on the proposed scanner, including spectroscopy, functional MRI, tractography, imaging of multiple sclerosis and other white matter diseases; and the new scanner will allow the Applicant to perform cardiac applications for its patients.”<sup>47</sup> Further, Advanced Radiology stated that the upgrade “may allow more examinations to be performed in the same number of hours, which is critical as the current unit is over capacity and even though it operates seven days (92 to 104 hours) per week, backlogs persist.”<sup>48</sup> Advanced Radiology was approved for the upgrade and although Advanced Radiology stated it intended to start operations of the new scanner in June 2009,<sup>49</sup> Advanced Radiology never implemented the technology upgrade. It is questionable if this Waiver Request was put forth to be obstructionist to other CON filings in the same time frame, specifically ONS’s request to upgrade its own MRI in Greenwich.<sup>50</sup> It is also questionable if Advanced Radiology is committed to providing the best options for patients since its modus operandi is to obstruct other providers from serving their patients. Advanced Radiology has only been pushed to upgrade its technology or acquire additional imaging capability when another provider comes forth in the

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<sup>46</sup> OHCA Docket No. 08-31188-WVR.

<sup>47</sup> OHCA Docket No. 08-31188-WVR Final Decision at 3.

<sup>48</sup> OHCA Docket No. 08-31188-WVR, Waiver Request at 5 (June 12, 2008).

<sup>49</sup> OHCA Docket No. 08-31188-WVR, Final Decision at 4 (July 8, 2008).

<sup>50</sup> OHCA Docket No. 08-31120-CON (“Acquisition of a 1.5 Tesla Magnetic Resonance Imaging Scanner”).

service area to acquire new technology and upgrade equipment for the benefit of the population in the service area.

Unlike Advanced Radiology's reactive strategy, ONS has always taken the proactive approach to upgrade to the best technology for its patients. To address its patient's needs, ONS went through a CON process to upgrade its MRI.<sup>51</sup> It should be noted that shortly after ONS was required to go through the lengthy and expensive regulatory process to upgrade its existing MRI from a 1.0T to a 1.5T, the law was updated to only require notice as opposed to a CON in order to upgrade imaging equipment.<sup>52</sup>

Based on Advanced Radiology's history of delayed or unimplemented CON and Waiver Request approvals and Advanced Radiology's own admission that the MRI will not be profitable, it is questionable whether or not Advanced Radiology will even implement the CON if it is approved.

Additionally, it is not certain that Advanced Radiology (even if approved) will retain an additional MRI in the Stamford location because an MRI may be relocated anywhere within the state. There is no guarantee that Advanced Radiology intends to expand access and capacity for the patients of the greater Stamford service area since it already has been afforded the regulatory approval to do so but has elected not to implement.<sup>53</sup> Advanced Radiology has many offices across the state and may choose to relocate an approved scanner at any time yet it has not done so for Stamford. As important, Advanced Radiology can now take a new approved MRI and move it anywhere in Connecticut.

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<sup>51</sup> *Id.*

<sup>52</sup> Conn. Gen. Stat. 19a-638(b)(18); Conn. Agencies Reg. 19a-638-3.

<sup>53</sup> OHCA Docket No. 08-31188-WVR.

## **XII. Conclusion**

In conclusion, Advanced Radiology's Certificate of Need Application fails to meet the OHCA criteria for approval. OHCA should carefully consider the deficiencies in Advanced Radiology's application. Advanced Radiology has not demonstrated there is clear public need, has not demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery to Medicaid recipients and indigent patients, fails to identify the population to be served in numerous ways, fails to address the utilization of existing 3.0T scanners in the service area; acknowledge that the project is not financially feasible; and has a history of not upgrading its technology or seeking CON for additional capacity or technology until other providers in the service area come forward to meet the needs of the patient population. For all the forgoing reasons, the Advanced Radiology CON for the acquisition of MRI unit for Stamford should be denied.

**Attachment A**  
**CV**

# CURRICULUM VITAE

## MARK H. CAMEL, M.D.

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Personal Married: Linda Chiswick, May 3, 1987  
Children: Andrew, Matthew, Edward

### EDUCATION AND PROFESSIONAL TRAINING

1977 Bachelor of Arts: Political Science and Biology  
University of Rochester  
Rochester, New York

1981 Doctor of Medicine  
Washington University School of Medicine  
Saint Louis, Missouri

1981-1982 Internship: General Surgery  
Barnes Hospital  
Saint Louis, Missouri

1982-1985 Resident: Neurological Surgery  
Barnes Hospital  
Saint Louis, Missouri

1985-1986 Chief Resident: Neurological Surgery  
Barnes Hospital  
Saint Louis, Missouri

1986-1987 Fellowship: Neurological Surgery  
Washington University School of Medicine  
Saint Louis, Missouri

## BOARD CERTIFICATION

1990 American Board of Neurological Surgery

## LICENSURE

Missouri  
Connecticut  
New York

## PROFESSIONAL EMPLOYMENTS

1987-1998 Neurological Surgeon  
Private Practice  
Stamford, Connecticut

1998-Present Neurological Surgeon  
Private Practice  
Greenwich, Connecticut

## PROFESSIONAL SOCIETIES

Congress of Neurological Surgeons  
American Association of Neurological Surgeons  
The New England Neurosurgical Society  
The Physician's Scientific Society

## PROFESSIONAL ACTIVITIES

1995-1996 Vice President, Congress of Neurological Surgeons

1992-2000 Member, Executive Committee, Congress of Neurological Surgeons

1999-2000 Chairman, Strategic Financial Planning Committee,  
Congress of Neurological Surgeons

1993-1995 Chairman, Membership Committee, Congress of Neurological Surgeons

1992-1995 Chairman, Exhibits Committee, Congress of Neurological Surgeons

1991-1992 Member, Editorial Board, Clinical Neurosurgery

1993-1995 Member, Professional Conduct Committee,  
Congress of Neurological Surgeons

### PROFESSIONAL ACTIVITIES (Continued)

- 1993-1994 Member, Guidelines and Outcomes Committee,  
American Association of Neurological Surgeons
- 1991-1992 Member, Executive Committee, Greenwich Hospital
- 1996-1997 Member, Credentials Committee, Greenwich Hospital

### ACADEMIC AFFILIATIONS

- 2010-2011 Clinical Assistant Professor of Neurological Surgery, Weill Cornell Medical  
College

**Attachment B**  
**Service Area Overlap**

| <u>Office</u>                               | <u>Service</u>              | <u>Days/Hours of Operation</u>           | <u>FY 2015 Utilization</u> | <u>2015 PSA</u>  |
|---|-----------------------------|--|----------------------------|--|
| 1055 Post Road,<br>Fairfield                | 3.0T Open<br>MRI            | M-F 7a-11p<br>Sa – 7a-3:15p<br>Su- 7a-7p | 6,685                      | Bridgeport<br>Easton<br>Fairfield<br>Shelton<br>Stratford<br>Trumbull<br>Weston<br>Westport  |
| 297 Boston Post<br>Road, Orange             | 3.0T Open<br>MRI            | M-F 7a-10p                               | 2,886                      | Ansonia<br>Bridgeport<br>Derby<br>East Haven<br>Fairfield<br>Milford<br>Monroe<br>New Haven<br>Orange<br>Seymour<br>Shelton<br>Stratford<br>Trumbull<br>West Haven<br>Westport<br>Woodbridge                               |
| 4 Corporate<br>Drive, Suite 182,<br>Shelton | 1.5T Tesla<br>Closed<br>MRI | M-F 8:30a-5p                             | 2,653                      | Ansonia<br>Bridgeport<br>Derby<br>Monroe<br>Oxford<br>Seymour<br>Shelton<br>Stratford<br>Trumbull  |
| 1315<br>Washington<br>Bldv, Stamford        | 1.5T<br>Closed<br>MRI       | M-F 7a-10p<br>Sa-Sun 7a-3:30p            | 6,617                      | Bridgeport<br>Danbury<br>Darien<br>Easton<br>Fairfield<br>Greenwich<br>Monroe<br>Milford<br>Norwalk<br>New Canaan<br>Redding<br>Ridgefield<br>Stamford<br>Stratford<br>Shelton<br>Trumbull<br>Weston<br>Westport<br>Wilton |
| 2867 Main<br>Street, Stratford              | 1.5T<br>Closed<br>MRI       | M-F 7a-11p<br>Sa-Sun 7a-7p               | 5,433                      | Bridgeport<br>Milford<br>Shelton<br>Stratford<br>Trumbull  |
| 15 Corporate<br>Drive, Trumbull             | 1.5T Open<br>MRI            | M-F 7:15a-10p<br>Sa-Sun 7a-3:15p         | 5,139                      | Bridgeport<br>Easton<br>Fairfield<br>Monroe<br>Shelton<br>Stratford<br>Trumbull  |

## Greer, Leslie

---

**From:** Jennifer Groves Fusco <jfusco@uks.com>  
**Sent:** Friday, August 26, 2016 11:34 AM  
**To:** User, OHCA; Fernandes, David; Lazarus, Steven; Hansted, Kevin; Riggott, Kaila  
**Cc:** Michele Volpe (mmv@bvmlaw.com)  
**Subject:** Advanced Radiology Docket No. 16-32093-CON -- ONS Objection  
**Attachments:** DOCS-#1349318-v1-ADRAD\_STAMFORD\_MRI\_ONS\_OBJECTION.PDF

Attached please find an objection to ONS's request for intervenor status.

Thanks,  
Jen

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**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION**

..... )  
IN RE: ADVANCED RADIOLOGY MRI )  
CENTERS LIMITED PARTNERSHIP )  
ACQUISITION OF MRI UNIT FOR )  
STAMFORD OFFICE )  
..... )

DOCKET NO. 16-32093-CON

AUGUST 26, 2016

**OBJECTION TO PETITION OF ORTHOPAEDIC & NEUROSURGERY  
SPECIALISTS, P.C. FOR INTERVENOR STATUS WITH FULL PROCEDURAL  
RIGHTS INCLUDING RIGHT OF CROSS-EXAMINATION AT  
AUGUST 30, 2016 HEARING**

Advanced Radiology MRI Centers Limited Partnership (“ARC”), applicant in the above-referenced CON proceeding under Docket No. 16-32093-CON, hereby objects to Orthopaedic & Neurosurgery Specialists, P.C.’s (“ONS”) Petition For Intervenor Status With Full Procedural Rights Including Right of Cross-Examination, dated August 25, 2016 (the “Petition”). ONS has not established that its interests will be affected by these proceedings in any way that would justify its request to participate (Regulations of Connecticut State Agencies (“RCSA”), §19a-9-27(b)(2)). Nor has ONS established that its participation in this proceeding will add evidence or arguments on relevant issues that would not otherwise be available to OHCA (RCSA, §§19a-9-27(b)(4)). As the testimony of Marc Camel, M.D. makes abundantly clear, ONS wants to participate in this CON proceeding in order to levy unfounded accusations, to speculate about ARC’s plans and motivations, and to fill the docket with irrelevant and inaccurate information intended to confuse the issues before OHCA. ONS’s participation is not in the interest of justice and will certainly impair the orderly conduct of the proceedings (Conn. Gen. Stat. §4-177a(b)). For these reasons, the Petition should be denied.

The above-referenced proceeding concerns a request by ARC to acquire a second MRI unit for its office in Stamford. This matter has been consolidated with a request by ONS for permission to acquire a second MRI unit for its Greenwich office, for hearing purposes only (Docket No. 16-32063-CON). The proposed ONS unit and its existing MRI unit are captive scanners that serve ONS patients who are self-referred by the practice's physicians and ancillary provider. ARC has petitioned to intervene in that proceeding because ONS refers MRI scans to its Stamford unit presently, and approval of a second unit for ONS will result in the loss of referrals to ARC's financial detriment. In addition, ONS's refusal to participate with the Medicaid program or provide a meaningful amount of MRI services to indigent persons has an adverse impact on ARC as well. Because ARC has sought to intervene in Docket No. 16-32063-CON, ONS now seeks to intervene in Docket No. 16-32093-CON.

#### ONS's Interests Are Not Affected By ARC's Proposal

There is no basis for the Petition and it is nothing more than an attempt by ONS to obstruct ARC's CON proceeding. ONS's claimed "interests" in these proceedings are spurious. ONS states as follows:

- "If OHCA were to approve Advanced Radiology's application, such approval will have an impact on need in the service area and therefore an impact on the Petitioner." ONS is presumably arguing that the addition of capacity by ARC would increase the total market capacity for MRI making it more difficult for another provider to obtain CON approval. This argument lacks merit in that ONS already has a CON pending to add capacity. ONS claims that the need for its proposal is based on the utilization of its existing unit and that

a market analysis is unnecessary. Regardless, even if a market analysis is necessary that has already been completed by ONS and an ARC approval would not alter it.

- “Petitioner and Advanced Radiology both provide private physician practice based MRI services in the same service area.” This alone does not qualify ONS as an intervenor. ONS’s MRI services are 100% self-referred (“Petitioner is a limited referral source for MRI services.”). ONS does not compete with other area MRI providers such as ARC for outside referrals. Therefore, the addition of MRI capacity by ARC does not have any potential adverse impact on ONS.
- “The Petitioner’s interests are affected because the Petitioner and Advanced Radiology are both requesting a second MRIs (sic) at their practice locations.” Again, the fact that each provider is requesting a second MRI unit does not mean that ONS’s interests are affected by ARC’s CON. As ONS itself states, its existing unit is a “limited referral source” scanner. ONS has complete control over referrals and purports to have established need for a second scanner through existing MRI volume within the practice. ARC’s proposal to acquire a second MRI unit will in no way impact the number of ONS’s self-referrals or scans completed on their unit(s).

OHCA has consolidated the ARC and ONS CON proceedings for hearing purposes only. The applications remain separate for all other purposes. ONS should not be allowed to participate in ARC’s CON proceedings simply because it will be present at the hearing. Nor should ONS be allowed to participate simply because ARC has requested status in its CON. ONS has not shown any legitimate reason why it should be granted intervenor status and the Petition should therefore be denied.

ONS Is Offering Irrelevant And Inaccurate Evidence; ONS's Participation Will Impair Orderly Conduct Of Proceedings

ONS does not have any information relevant to ARC's CON that is not otherwise available to OHCA. Much of the information that ONS proposes to present is irrelevant, inaccurate and misleading. ONS should not be allowed to interfere with the orderly conduct of ARC's CON by offering up misinformation. Some examples are as follows:

- ONS claims that ARC's non-Stamford MRIs do not serve any patients from the Stamford area (Camel Testimony, p. 3). This is entirely inaccurate. ONS mistakes primary service area data, which was requested by OHCA, for a complete list of patient towns of origin. This misinformation, which could have easily been avoided by a more careful reading of ARC's submission, has no place in the record.
- ONS accuses ARC of stating that "patient convenience should prove public need" (Camel Testimony, p. 3). ARC says nothing of the sort and in fact the testimony of Clark Yoder says the exact opposite *on the very same page that ONS has cited*: "Although we understand that convenience does not equate to need ..." (Yoder Testimony, p. 158). ONS's statements in this regard are intentionally false and misleading.
- ONS claims that OHCA should consider the proposed acquisition of an MRI unit by Connecticut Orthopaedic Specialists ("COS"), to be used part-time in Orange, as justification for the denial of ARC's request for a second scanner for Stamford (Camel Testimony, p. 5). The idea being that the COS request will be approved (although it was only just filed this week), that ARC can move its well-utilized 3.0 Tesla unit out of Orange, and leave that community to be treated by a mobile orthopedic scanner and various more costly hospital units. This is nonsensical and a perfect example of why ONS should not be allowed to participate in these proceeding.

- ONS claims that “upon information and belief” ARC has an inferior information sharing network to others in the area and that surgeons have difficulty using it. ONS provides no basis whatsoever for these hearsay assumptions. They are meant to stir controversy, but are not grounded in facts.

These are just a few examples of the inaccurate, irrelevant and intentionally misleading information that ONS proposes to present in ARC’s CON hearing. Based on what it has provided to OHCA thus far, ONS’s participation will bring nothing beneficial to these proceedings. To the extent that OHCA has any questions of ARC with respect to the need for its proposal, its financial feasibility, or its impact on the quality, accessibility and cost-effectiveness of care, ARC stands ready and willing to respond. ONS does not need to participate in order for OHCA to properly vet ARC’s CON Application.

### Conclusion

For these reasons, and in order to ensure a fair and orderly hearing, ARC respectfully requests that ONS’s Petition be denied and that its testimony be stricken from the record. If the Petition is approved, ARC requests that ONS be denied the right to conduct cross-examination as a means to further proffer misinformation. ARC also requests that OHCA deny ONS’s unusual request to participate in any formal or informal meetings or discussions between ARC and OHCA staff.

Respectfully Submitted,

ADVANCED RADIOLOGY  
MRI CENTERS LIMITED PARTNERSHIP

By:  \_\_\_\_\_

JET. NIFER GROVES FUSCO, ESQ.

Updike, Kelly & Spellacy, P.C.

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**CERTIFICATION**

This is to certify that a copy of the foregoing was sent via electronic mail this 26<sup>th</sup> day of August, 2016 to the following parties:

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JENNIFER GROVES FUSCO, ESQ.  
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## Greer, Leslie

---

**From:** Jennifer Groves Fusco <jfusco@uks.com>  
**Sent:** Friday, August 26, 2016 11:36 AM  
**To:** User, OHCA; Fernandes, David; Lazarus, Steven; Hansted, Kevin; Riggott, Kaila  
**Cc:** Michele Volpe (mmv@bvmlaw.com); pmonahan@pppclaw.com  
**Subject:** Advanced Radiology Docket No. 16-32093-CON -- WestMed Objection  
**Attachments:** DOCS-#1349321-v1-ADRAD\_STAMFORD\_MRI\_WESTMED\_OBJECTION.PDF

Attached please find an objection to WestMed's request for intervenor status.

Thanks,  
Jen

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**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION**

..... )  
IN RE: ADVANCED RADIOLOGY MRI ) DOCKET NO. 16-32093-CON  
CENTERS LIMITED PARTNERSHIP )  
ACQUISITION OF MRI UNIT FOR )  
STAMFORD OFFICE )  
..... )  
AUGUST 26, 2016

**OBJECTION TO PETITION OF WESTCHESTER MEDICAL GROUP, P.C. (d/b/a WESTMED MEDICAL GROUP) TO BE DESIGNATED AS AN INTERVENOR WITH FULL RIGHTS, INCLUDING THE RIGHT TO CONDUCT CROSS-EXAMINATION**

Advanced Radiology MRI Centers Limited Partnership (“ARC”), applicant in the above-referenced CON proceeding under Docket No. 16-32093-CON, hereby objects to Westchester Medical Group, P.C.’s (“WestMed”) Petition To Be Designated As An Intervenor With Full Rights, Including The Right To Conduct Cross-Examination, dated August 25, 2016 (the “Petition”). WestMed has not established that it has *any* interest affected by these proceedings that would justify its request to participate (Regulations of Connecticut State Agencies (“RCSA”), §19a-9-27(b)(2)). Nor has WestMed established that its participation in this proceeding will add evidence or arguments on relevant issues that would not otherwise be available to OHCA (RCSA, §§19a-9-27(b)(4)) or that its participation is in the interest of justice and will not impair the orderly conduct of the proceedings (Conn. Gen. Stat. §4-177a(b)). WestMed is opposing this CON request for one reason only – to preserve its opportunity to apply for and acquire an MRI unit for use in the Stamford market at some undetermined time in the future. This is not a legitimate basis for intervening in an OHCA proceeding and WestMed’s participation should not be allowed.

### WestMed's Interests Are Not Affected by the Proceeding

Although WestMed devotes a considerable amount of its submission to a description of its "Polyclinic Model of Care" and discussion of its benefits, nowhere does WestMed explain how its interests are impacted by this CON proceeding (RCSA, §19a-9-27(b)(2)). That is because WestMed's interests are *not* impacted by this proceeding. WestMed is a New York multispecialty practice attempting to make inroads into the wealthiest region of our state. WestMed has several physician offices in Connecticut, but besides x-ray and ultrasound at one of its Greenwich offices WestMed provide no in-state imaging services. WestMed does not own an MRI unit operating in Connecticut. Nor does it have a CON Application noticed or pending for the acquisition of an MRI unit to be operated in Connecticut. ARC's request for permission to acquire an MRI unit for its Stamford office will have no impact on WestMed whatsoever given that it is not an existing provider of MRI services.

Rather, WestMed stands before this state's healthcare planning agency asking it to deny a proposal to add much-needed MRI capacity in Stamford for the benefit of Connecticut resident. WestMed threatens to redirect thousands of Connecticut patients away from local units to WestMed MRI units located in the state of New York. It suggests that for these patients, traveling out of state through one of the busiest traffic corridors in the nation to a WestMed scanner is in their best interest.

But WestMed knows this is not the case. This is why the practice is considering an application for its own MRI unit in Stamford to service the patients referred by Orthopaedic Associates of Stamford, P.C. ("OAS"), which just became a part of WestMed. WestMed understands that as a new entrant to the market it will need to establish an unmet need for MRI services in the area. If ARC is authorized to acquire an additional scanner there will be less

unmet need and less of a chance that WestMed's request will be approved. WestMed does not have a legitimate interest to protect by way of its participation in this CON proceeding. Rather, WestMed is attempting to intervene for anti-competitive reasons, based on speculative future plans, and in doing so it potentially jeopardizes access to care for Connecticut residents. OHCA should deny the Petition for this reason alone.

WestMed's Evidence Is Irrelevant and Otherwise Available Without WestMed's Participation; WestMed Will Impair the Orderly Conduct of the Proceedings

The evidence that WestMed proposes to present will not furnish assistance to OHCA in deciding the issues in the contested case – namely, whether there is a clear public need for ARC's proposal, whether it is financially feasible, and whether it will improve the quality, accessibility and cost-effectiveness of MRI services in the Stamford area. In fact, much of the information offered by WestMed is irrelevant and speculative and should be excluded. By way of example:

- More than half of WestMed's intervenor submission is dedicated to a discussion of WestMed and its practice model. WestMed does not have an application pending before OHCA. The issue in this proceeding is not whether the WestMed model is better than the ARC model or any other model for the provision of MRI services. The issue is whether there is a clear public need for additional MRI capacity in Stamford and whether ARC's proposal meets that need while improving the quality, accessibility and cost-effectiveness of care for all patients, which it does. None of the "essential points about its practice model" offered by WestMed are relevant to this proceeding and if WestMed is allowed to participate its testimony should be limited in this regard.

- WestMed proposes to present testimony about how OAS physicians will now direct thousands of patients in need of MRI services away from ARC and other Stamford providers to WestMed units in New York. WestMed claim that ARC will see the loss of 40% of its Stamford MRI business as a result and that this should have been disclosed in the CON. As WestMed mentions, its deal with OAS has been in the works for many months. ARC arguably should have seen an appreciable drop in MRI referrals by OAS as a result, but it has not. Patients have a choice in providers and ARC suspects that many will want to stay local to minimize travel inconvenience and because of the exceptional care they have received historically from ARC and other area providers. So WestMed's suggestion that ARC has failed to disclose a significant referral shift to OHCA is inaccurate and a distraction from the real issues in this proceeding.
- WestMed wants to point out supposed flaws in ARC's MRI volume projections. ARC stands by its projections and will answer any questions that OHCA has about how they were derived. WestMed's participation in this regard is not necessary.
- WestMed allegedly has some unique knowledge about capabilities of 3.0 Tesla MRI and how it should be deployed in Connecticut. Again, WestMed's participation in this regard is unnecessary. ARC's board-certified neuroradiologists, with decades of experience, are more than capable of explaining the benefits of the proposed MRI unit. And ARC will answer any question that OHCA has about its capabilities or limitations.
- WestMed's claims about financial feasibility are also misleading. As a provider of MRI services they are well-aware that when purchasing a unit the quoted price is never the purchase price. Options are selected and price is negotiated before a contract is signed. ARC anticipates that the 3.0 Tesla MRI will cost far less than quoted when all is said and

done. WestMed also draws incorrect conclusions about the feasibility of the proposal based on incremental financials for the new unit. They intentionally disregard the financial viability of ARC's MRI service as a whole, which is clearly stated in the CON. Again, their testimony in this regard is misleading and more confusing than helpful.

None of the information offered by WestMed will assist OHCA in deciding this CON. And WestMed is not in a unique position to provide OHCA with any information relevant to ARC's proposal. To the extent that OHCA requires any additional information from ARC, ARC will provide it. The Petition is nothing more than a play to preserve what WestMed sees as its future market share of MRI in lower Fairfield County. WestMed has no legitimate interest in this proceeding and justice certainly does not dictate that it be allowed to participate. WestMed's participation will surely impair the orderly conduct of the proceeding and it should not be permitted.

### Conclusion

In light of the foregoing, ARC respectfully requests that the Petition be denied and that WestMed's proposed filings be stricken from the record. If WestMed is allowed to participate, ARC request that its participation be limited to written filings on relevant issues and that WestMed not be given the opportunity to cross-examine ARC or any other participants.

Respectfully Submitted,

ADVANCED RADIOLOGY MRI CENTERS  
LIMITED PARTNERSHIP

By: 

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**CERTIFICATION**

This is to certify that a copy of the foregoing was sent via electronic mail this 26<sup>th</sup> day of August, 2016 to the following parties:

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**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION**

IN RE CERTIFICATE OF NEED APPLICATION : DOCKET NO. 16-32093-CON  
OF ADVANCED RADIOLOGY MRI CENTERS :  
LIMITED PARTNERSHIP TO ACQUIRE A :  
3.0 TESLA MRI UNIT FOR STAMFORD OFFICE : AUGUST 26, 2016

**WESTCHESTER MEDICAL GROUP, P.C. (d/b/a WESTMED) REPLY TO ADVANCED  
RADIOLOGY'S OBJECTION TO WESTMED'S PETITION TO BE DESIGNATED AS  
AN INTERVENOR WITH FULL RIGHTS, INCLUDING THE RIGHT TO CONDUCT  
CROSS-EXAMINATION**

Westchester Medical Group, P.C. ("WESTMED") submits this Reply to the specious objection filed by Advanced Radiology MRI Centers Limited Partnership ("ARC") in opposition to WESTMED's Petition for Intervenor status.

It is disconcerting that ARC would go to the length of asking OHCA to preclude WESTMED, a current medical provider in the relevant market and a significant MRI provider and referral source for patients in the affected region, from presenting and expanding upon critical information that has been submitted in the WESTMED Petition for OHCA's consideration.

ARC's objection is on its face disingenuous in claiming that WESTMED's participation is irrelevant and a "play" on the market, when it is ARC itself that is attempting to monopolize a proceeding in which it has submitted information that WESTMED has demonstrated and will confirm to be false and misleading. In a relatively naïve display of market and patient patterns, ARC ignores WESTMED's multispecialty presence in Fairfield County, Connecticut, and pretends that WESTMED has said something outlandish by stating the truth that patients close to the CT/NY border do in fact travel to and from each state to the other for high quality, accessible care. Moreover, ARC suggests that WESTMED has no

other provider options in Fairfield County to whom to refer patients in need of MRIs. That implication is wrong, as WESTMED has every right and opportunity to refer patients to MRI providers other than ARC who provide MRI access.

Further, ARC distorts the point of WESTMED's disclosure about a possible MRI application in the future. No such application is before OHCA, but the candid and frank disclosure demonstrates WESTMED's above-board and transparent approach to interacting with OHCA. Such an approach in fact facilitates an orderly proceeding, with OHCA receiving all relevant information from all relevant sources, in contrast to ARC's myopic approach of saying that OHCA should box WESTMED out so that ARC can spin its supporting information, much of which has been demonstrated as flawed as explained in the WESTMED Petition.

In short, this is not a proceeding about Connecticut vs. New York as ARC tries to imply – it is about a determination on an Application that directly bears on WESTMED and Connecticut patients whom it serves. WESTMED is indeed impacted by this proceeding and would be adversely impacted if silenced as ARC requests. Without reiterating the Petition in its entirety, WESTMED's involvement would provide critical information to demonstrate that ARC is relying on incorrect and exaggerated assumptions, all of which have the potential to unjustifiably effect Connecticut patients served by WESTMED and other providers in the region. WESTMED respectfully suggests that what underlies a fair and orderly proceeding is OHCA's ability to hear from relevant providers affected by ARC's Application, especially one such as WESTMED, which is an accurate supplier of information that can demonstrate the unreliability of the Application's foundation.

If ARC's confidence in its position and projections submitted to OHCA was unwavering, there would be no need for it to try to foreclose a relevant market provider, namely WESTMED, from being heard. WESTMED respectfully submits that OHCA, not ARC, should determine WESTMED's relevance and credibility during a full and fair proceeding.

For these reasons, and the reasons supplied in its Petition, WESTMED respectfully maintains its request for Intervenor status with full rights.

Respectfully Submitted,

WESTCHESTER MEDICAL GROUP, P.C. d/b/a  
WESTMED MEDICAL GROUP

By: \_\_\_\_\_

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ITS ATTORNEYS

**CERTIFICATION**

I hereby certify that a copy of the foregoing has been sent via First Class, U.S. Mail, postage prepaid, and electronic mail, this 26<sup>th</sup> day of August, 2016 to:

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PATRICK J. MONAHAN II  
Commissioner of the Superior Court

## Greer, Leslie

---

**From:** Jennifer Groves Fusco <jfusco@uks.com>  
**Sent:** Monday, August 29, 2016 9:43 AM  
**To:** User, OHCA; Fernandes, David; Lazarus, Steven; Hansted, Kevin; Riggott, Kaila  
**Cc:** Michele Volpe (mmv@bvmlaw.com); pmonahan@pppclaw.com  
**Subject:** Advanced Radiology -- Docket No. 16-32093-CON -- Rebuttal Testimony  
**Attachments:** DOCS-#1349780-v1-ADRAD\_STAMFORD\_MRI\_WESTMED\_REBUTTAL.PDF; DOCS-#1349766-v1-ADRAD\_STAMFORD\_MRI\_ONS\_REBUTTAL.PDF

Attached please find Advanced Radiology MRI Centers rebuttal testimony in the above-referenced docket.

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**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION**

----- )  
IN RE: ADVANCED RADIOLOGY MRI ) DOCKET NO. 16-32093-CON  
CENTERS LIMITED PARTNERSHIP )  
ACQUISITION OF MRI UNIT FOR )  
STAMFORD OFFICE )  
 )  
 )  
----- ) AUGUST 26, 2016

**REBUTTAL OF ADVANCED RADIOLOGY MRI CENTERS LIMITED  
PARTNERSHIP IN RESPONSE TO TESTIMONY OF  
ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.**

Advanced Radiology MRI Centers Limited Partnership (“ARC”), applicant in the above-referenced CON proceeding under Docket No. 16-32093-CON, hereby submits the following rebuttal to the testimony of Mark Camel, M.D., submitted on behalf of Orthopaedic & Neurosurgery Specialists, P.C.’s (“ONS”) and dated August 26, 2016 (“Camel Testimony”). This testimony is the combined effort of ARC’s witnesses, but will be adopted by Clark G. Yoder at the public hearing for addition into the record.

ONS has made the following inaccurate, irrelevant and/or intentionally misleading statements through the testimony of Dr. Camel, which ARC rebuts as follows:

- ONS claims that ARC has not proven a “public need for any additional MRI services *in its practice*” (Camel Testimony, p. 2) (emphasis added). As ONS is well-aware, this is not the standard for MRI need as set forth in the Statewide Healthcare Facilities & Services Plan (“SHP”). The SHP states that if an applicant has an MRI unit operating *in the primary service area* of its proposed scanner it must demonstrate that *the existing unit* is operating at 85% capacity based on a benchmark of 4,000 scans per year (SHP, p.61). ARC’s existing Stamford unit is the only unit it operates in the Stamford MRI

service PSA of Stamford, Norwalk, Darien, New Canaan, and Greenwich (“Stamford PSA”) (CON Application, p. 38). This unit performed 6,617 scans in FY 2015 and is operating at 165% capacity ( $6,617 \div 4,000$ ) (CON Application, p. 40). It is, in fact, the busiest MRI unit in the service area based on publically available information (SHP, Table 8).

- ONS claims that ARC has not provided services to any patients who reside in the Stamford PSA on ARC MRI units other than the Stamford unit (Camel Testimony, p. 3). This is patently false. In support of its contention, ONS states that “Advanced Radiology’s 2015 patient draw data for its other locations does not include any patients from Stamford or from towns that are closer to Stamford.” The basis of this claim is a chart found at pages 149-150 of the CON Application that lists the *primary service areas* for each of the other ARC MRI services, per OHCA’s request (“Please provide the primary service area for all ARC MRI centers ...”). The narrative response above the chart states clearly that the towns “represent the lowest number of contiguous ZIP codes that comprised at least 75% of MRI volume at each Advanced Radiology Office location in FY 2015” (CON Application, p. 149). ARC provides MRI services for many patients who reside in the Stamford PSA at its other office locations. As the chart on the next page shows, patients from the Stamford PSA received **537 scans** at ARC MRI locations other than Stamford in FY 2015, including 61 who had to travel as far as Shelton or Orange.

|            | FAIRFIELD MRI | ORANGE MRI | SHELTON MRI | STRATFORD MRI | TRUMBULL MRI | Total |
|------------|---------------|------------|-------------|---------------|--------------|-------|
| DARIEN     | 25            | 2          | 2           | 1             | 3            | 33    |
| GREENWICH  | 8             | 1          | 0           | 3             | 1            | 13    |
| NEW CANAAN | 21            | 5          | 2           | 1             | 6            | 35    |
| NORWALK    | 236           | 14         | 6           | 26            | 26           | 308   |
| STAMFORD   | 87            | 19         | 10          | 18            | 14           | 148   |
| Total      | 377           | 41         | 20          | 49            | 50           | 537   |

In addition, as ONS will certainly agree, patients often choose to access MRI services closer to where they work than where they live if, for example, they want to get the scan on their lunch hour or after they leave work for the day. ARC has no way of tracking patients who request a scan in Stamford because they work in or around Stamford, but are then referred elsewhere due to capacity constraints in Stamford. ARC is aware, through its schedulers that this happens and this makes the number of patients who cannot be accommodated in Stamford for MRI services even higher. ONS also mischaracterizes ARC's Centralized Scheduling System. Just because we have the ability to coordinate MRI scheduling among our many locations does not mean that patients will not express a preference for a certain office (Camel Testimony, p. 3). The point of ONS's testimony in this regard is to suggest that ARC should be sending its Stamford-area patients as far as Orange, 40 miles down I-95, for MRI scans. Dr. Camel is well-aware of the traffic issues in Fairfield County and the time it would take to complete a round-trip from Stamford to Orange, or even Stamford to Fairfield, at certain times of the day. In addition, as a physician we hope he understands that this type of travel is not in the best interest of patients who may be in pain or have limited mobility.

- ONS claims that there are hospital-based MRI units in the Stamford area with excess capacity, suggesting that there is no need for ARC's proposal (Camel Testimony, pp. 3-4). This is contrary to the guidelines set forth in the SHP regarding calculation of need for the addition of capacity, as cited by ONS in its own CON docket (SHP, p. 61; Docket No. 16-32063-CON). ONS itself states that not one but *two MRI units* could be acquired for the Stamford area without reducing the utilization ratio below 82% (Docket No. 16-32063-CON, Camel Testimony, p. 28). In addition, as ONS also concedes in its own submission, hospital-based MRI is more costly, generally, than physician-office-based MRI (Docket No. 16-32063-CON, p. 21).
- ARC does not take the position that "patient convenience should prove need," as ONS claims (Camel Testimony, p. 4). ONS arrives at this conclusion based upon ARC's statement that acquisition of second unit is justified, in part, by the difficulties patients from the Stamford area have traveling 20 to 40 miles to ARC's other MRI units for services. However, ONS neglects to reference the following *from the exact page of Mr. Yoder's testimony that they have cited*: "Although we understand that convenience does not equate to need ..." (Yoder Testimony, p. 158). Again, ARC is well aware that patient convenience is not the standard. But surely Dr. Camel does not advocate for making patients in need of MRI services travel hours each way to receive them? Moreover, ONS references "convenience" as a basis for approving its own CON throughout Docket No. 16-32063-CON (i.e. CON Application, p. 18 "...in-office imaging ... offers more convenient and appropriate levels of care ...," p. 28; "... ONS will be able to offer all expanding patient base the choice to receive MRI services at its convenient office based location").

- ONS suggests that ARC can simply shift its MRI patients among units to accomplish an even distribution of scans and, as a result, all of its capacity issues will be solved (Camel Testimony, pp. 4-5). This is not true. First, the mere fact that two units are of the same tesla strength does not mean that they provide the exact same services. Different units have different applications. In addition, different ARC offices have different subspecialties targeted at particular groups of patients (i.e. women's services, pediatrics). ARC has six offices among which it needs to share and coordinate staff, a process that involves flexing hours to ensure appropriate coverage when and where it is needed. Not to mention the fact that this "shifting" of volume that ONS suggests does not take into account patient towns of origin or ability to travel. ONS's process suggestions are oversimplified, which is a luxury they have given that they operate just one MRI unit and coordinate examinations for their patients only. Notwithstanding the foregoing, ARC continues to refer Stamford area patients to other unit where capacity exists. However, the practice has gotten to the point where the majority of its MRI units are operating over capacity. The only ones that are not (yet) are nearly 40 miles from Stamford, which for reasons discussed herein creates access issues for patients.
- ONS states unequivocally that ARC can and should relocate its Orange 3.0 Tesla scanner to Stamford (Camel Testimony, pp. 5-6). As mentioned above and as is evident on pages 5 to 6 of Dr. Camel's testimony, ONS misunderstands the concept of centralized scheduling. It does not mean that patients can be sent to any scanner for any reasons without considering patient preference, referring physicians preference, type of exam, special patient characteristics (i.e. claustrophobia, obesity), and the like. In addition, the

Orange MRI unit performed 2,355 MRI scans for the first seven months of FY 2016, putting it on track to reach capacity in the near future (Hearing Issues, p. 209). The unit serves a significant number of Medicaid and uninsured patients and is likely more cost-effective than the hospital units in the area that ONS says can accommodate the thousands of patients who would be left without access if ARC relocated the Orange unit (Camel Testimony, pp. 5-6; Hearing Issues, p. 209). The only non-hospital unit operating in the Orange area is the Diagnostic Imaging of Milford MRI, a 13-year-old 0.7 Tesla open unit (SHP, Table 8). ONS also suggests that ARC's patients can be served by a new part-time mobile MRI scanner, proposed by Connecticut Orthopedic Specialists in a CON request filed just last week. This proposal, which has not yet been and may never be approved, is not a reasonable alternative to the high-quality full-time 3.0 Tesla MRI unit that ARC has operated for the benefit of all patients in the greater Orange community for many years. Patients have a right to choose their MRI provider and they should not be forced into treatment situations that are more costly and in some instances of lesser quality.

- ONS claims that ARC has “decreased its percentage of Medicaid patients over the years” because its current 3.9% Medicaid MRI payer mix in Stamford does not equal the 6% Medicaid MRI payer mix that ARC projected in a 2004 CON filing. This argument is entirely without merit. First, Medicaid MRI volume in Stamford has grown steadily since FY 2012, increasing from 181 scans or 2.9% of volume in FY 2012 to 258 scans or 3.9% of volume in FY 2015. If ARC could accommodate all of the patients in the Stamford PSA who presently request MRI services at its Stamford office, that number would be over 4%. Second, the CON filing to which ONS refers is now 12 years old.

The projections that ARC made were just that, projections. By way of comparison, in ONS's 2008 CON request for permission to acquire its existing MRI unit the practice projected that it would perform 6.6% of its MRI scans on workers compensation patients, but its payer mix shows that it in fact performs only 2% of its scans on workers compensation patients, and Dr. Camel testified that workers' compensation does not even allow patients to be scanned at ONS (Docket No. 08-31120-CON; CON Application, p. 33; Camel Testimony, p. 31). In fact, the only payer projection in the ONS 2008 CON that proved to be accurate was the projection that 0% of ONS's scans would be of Medicaid patients (Docket No. 08-31120).

- ONS questions ARC's payer mix projections in that they do not include growth of Medicaid volume despite our assertions that Medicaid volume will in fact grow in the coming years (Camel Testimony, p. 7). As noted in our CON Application at page 32, ARC anticipates an increase in Medicaid MRI volume in Stamford and that is reflected in our total projected volume. However, because it is difficult to predict the state's expansion plans we did not quantify the shift in payer mix at this time (CON Application, p. 32). Regardless, ARC remains committed to serving any and all Medicaid patients in need of MRI or any other service at any of its office locations.
- ONS claims that the Hospital for Special Surgery's ("HSS") failure to attract Medicaid patients to its newly approved MRI is indicative of a low Medicaid MRI population in Fairfield County that is being adequately served (Camel Testimony, pp. 7-8). It is equally possible that HSS is marketing its MRI service more towards commercially insured patients in accordance with its initial CON proposal. As noted in Mr. Yoder's

testimony in Docket No. 16-32063-CON, Stamford has a 9% Medicaid population that is expected to grow to 13% with Medicaid expansion and Norwalk has an 11% Medicaid population that is expected to grow to 15% with Medicaid expansion (Yoder Testimony, p. 19).

- ONS claims, without providing any verifiable evidence to support its claims, that ARC's image sharing network is inferior to others in the service area, incompatible with hospital systems and that surgeons have difficulty accessing images (Camel Testimony, p. 8). They offer this testimony "upon information and belief," however without substantiating evidence or testimony from hospitals or surgeons who have in fact had difficulty accessing the system it is no more than hearsay. Advanced Radiology offers several methods for accessing images by healthcare systems, referring physicians and patients, and continues to exhibit leadership in this space. Advanced Radiology's Intelrad PACS imaging platform has long provided industry-leading uptime, with no unscheduled service interruptions in nearly four years. St. Vincent's Medical Center has relied on it 24 hours a day, 7 days a week, 365 days a year, since 2010, for their in-house clinical image storage and retrieval. Advanced Radiology offers the same clinical diagnostic viewer, called IntelViewer, which our own radiologists use, to any referring physician in Connecticut that wants it, free of charge. The total number of user accounts stands at 3,859. Earlier in 2016, our marketing liaisons worked with ONS to deploy IntelViewer for most or all of their physicians at their Greenwich office. Dr. Scott Simon at ONS's Stamford office has used IntelViewer for many years, as have a great many healthcare providers in Connecticut. In 2012, Advanced Radiology partnered with a software company to provide a first-of-its-kind mobile access to images and reports through a

platform known as ARConnect. With ARConnect, any referrer can look up their patient's images and reports from an iOS or Android device through an application freely available on Apple and Google's application stores, or via a web browser. ARConnect also includes the ability to securely share images and reports with anyone else involved in a patient's care. While ARConnect delivered a new level of mobility in medical imaging, it did not always exhibit the same level of reliability that the Intelrad PACS does. Advanced Radiology had a period through the summer and fall of 2015 where ARConnect developed a backlog in retrieval weekly. Those issues were resolved, and the platform has been highly available ever since. Also in 2012, Advanced Radiology was the first private practice to participate in the RSNA Image Share network pilot project. Ultimately ARC found this platform too cumbersome for many patients to use, and went on to later add image access and image sharing to their own patient portal. In 2013, Advanced Radiology began providing images to the Yale New Haven Health System via the lifeIMAGE sharing network. Today Advanced Radiology receives requests from the Yale New Haven Health System several times per week, and provides images quickly via a direct upload from their Intelrad PACS to lifeIMAGE. In 2014, Advanced Radiology began offering patients access to their images via a web-based patient portal. Advanced Radiology remains one of the few private practices nationally to offer patients the ability to access their images online, and to share them other providers at their own discretion. While all of the items described herein are securely accessible via the public Internet, various tools have been blocked by some hospitals and healthcare groups in Connecticut at certain points in the past, possibly creating the impression that images were inaccessible by any of the above means. Contrary to ONS's

assertion, Advanced Radiology is a leader in image sharing, and is proud of the many steps taken to make patients' images available to the patients themselves, as well as all who participate in a patient's care, here in Connecticut and beyond.

- ONS's claims regarding the availability of 3.0 Tesla for Stamford area residents are flawed (Camel Testimony, p. 10). The Greenwich Hospital unit is not a private office-based unit and, thus, does not offer as cost-effective MRI services as an ARC unit. ONS acknowledges this cost differential throughout its submissions in its own docket (Docket No. 16-32063, CON Application, pp. 18 & 21) And as discussed above, relocating ARC's 3.0 Tesla unit from Orange to Stamford is not feasible and would create significant, unnecessary access issues in that community.
- ARC dispute's ONS's contention that this proposal is not financially feasible (Camel Testimony, p. 10). Despite the incremental losses in the first few years after the acquisition, Advanced Radiology MRI Centers Limited Partnership remains profitable throughout. Per the financial worksheet on page 134 of our CON Application, despite the incremental loss in FY 2017, ARC MRI realizes net income of \$1,543,125. Nor is ARC a "financially unstable operation" as ONS suggests. As the new Stamford MRI ramps up, even before it breaks even, the company will realize a net income of \$1,697,851 in FY 2019. Advanced Radiology Consultants has been in existence for 111 years. The practice has a reputation for excellent service and we will not make investments that we do not believe are financially sound. We take this approach so that we may ensure the availability of service for all of our patients for years to come.

- Laws and policy positions regarding self-referral have evolved over the course of the last 25 years. Despite ONS's suggestion otherwise, the evidence that ARC provides regarding self-referral is not outdated and irrelevant (Camel Testimony, pp. 11-12). Rather, the initial results of early studies were provided for reference and to show how thinking on the subject has progressed. ARC also provided recent information from the GAO (2012) and this year's Federal budget proposals as part of Dr. Alan Kaye's testimony, which is some of the most updated information available.
- ARC does not have a history of obstructing CONs and failing to take proactive steps to upgrade technology to meet the needs of its patients, as ONS suggests (Camel Testimony, p. 12). This "pattern" of not seeking CON approval to undertake projects until a competitor applies for a CON is a fallacy. ONS claims that ARC waited to file its request to upgrade its Stamford MRI by waiver in 2008 until ONS filed a CON for its own upgrade. There is no truth to this assertion. And regardless the ONS CON was approved, without opposition from ARC. Nor is ARC's filing of a CON Application for a second MRI unit for its Stamford office an attempt to obstruct ONS in its 2016 filing. As ONS acknowledges, ARC has been experiencing MRI capacity issues in its Stamford office for many years. These same capacity constraints exist in other ARC offices as well. Planning for the addition of MRI capacity among a six-unit practice is a complex process. Acquiring new technology is an expensive proposition and one that ARC undertakes gladly, but not lightly, for the benefit of its patients. It is not uncommon for providers to request waivers and then, as the CON laws change and operations evolve, pursue other options. Thus, ONS's evidence regarding ARC's failure to implement an

almost decade-old waiver to upgrade its existing unit to 3.0 Tesla is a red herring.<sup>1</sup> Note also that ARC has not requested permission to intervene in any CON proceeding since 2008, eight years ago, which does not support a “pattern” of obstructing competitors (Docket No. 07-31023-CON).

- Similarly, there is no merit to ONS’s claim that ARC only upgrades technology when pushed to do so by a competitive proposal (Camel Testimony, p. 13). OHCA has upgraded virtually all of its MRI equipment over the course of the last six years. This includes upgrading its Fairfield MRI unit to 3.0 Tesla in 2008 (Docket No. 07-30917-WVR); upgrading its Orange MRI unit to a 3.0 Tesla in 2010 (Docket No. 09-31434-WVR); upgrading its Trumbull unit to a 1.5 Tesla open unit in 2014; completing a software upgrade of its 1.5 Tesla Shelton unit in 2016; and its proposed acquisition of 3.0 Tesla MRI unit for Stamford.

Based on the foregoing, ONS’s claims regarding ARC’s failure to meet CON statutory decision criteria are unfounded. ARC has demonstrated a clear public need for its proposal; ARC’s MRI service areas do not overlap in the way, or to the extent, that ONS suggests and ARC cannot simply relocate its existing 3.0 Tesla MRI from Orange to Stamford; this proposal will favorably impact the quality, accessibility and cost-effectiveness of MRI services in the Stamford area and will increase access for Medicaid recipients and indigent persons; the acquisition of a second MRI unit is financially feasible; ARC properly identifies all relevant

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<sup>1</sup> Another reason ARC did not implement the 2008 CON upgrade waiver was difficulties it encountered siting the proposed unit at its 1315 Washington Boulevard office and its inability to find another suitable office location within the city of Stamford. ARC has since found an appropriate space and anticipates relocating its Stamford office to 1259 East Main Street in Stamford early next year. The practice just signed a 10-year lease for this space, which evidences its commitment to moving forward with the MRI acquisition and continuing to serve the Stamford community, which it has served for the last 15 years.

populations; ARC accounts for the utilization of other service area scanners; ARC's claims regarding self-referral and its impact on cost-effectiveness of care are current, accurate and relevant; and ARC is not in any way obstructionist in its planning for, and deployment of, advanced imaging equipment.

Thank you for allowing us the opportunity to submit this rebuttal.

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS DIVISION**

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IN RE: ADVANCED RADIOLOGY MRI ) DOCKET NO. 16-32093-CON  
CENTERS LIMITED PARTNERSHIP )  
ACQUISITION OF MRI UNIT FOR )  
STAMFORD OFFICE )  
 )  
 )  
----- ) AUGUST 26, 2016

**REBUTTAL OF ADVANCED RADIOLOGY MRI CENTERS LIMITED  
PARTNERSHIP IN RESPONSE TO TESTIMONY OF  
WESTCHESTER MEDICAL GROUP, P.C. (d/b/a WESTMED MEDICAL GROUP)**

Advanced Radiology MRI Centers Limited Partnership (“ARC”), applicant in the above-referenced CON proceeding under Docket No. 16-32093-CON, hereby submits the following rebuttal to the testimony of Richard P. Morel, M.D., M.M.M. and Jonathan D. Weiss, M.D., submitted on behalf of Westchester Medical Group, P.C. (“WestMed”) and dated August 26, 2016 (“Morel Testimony” or “Weiss Testimony”). This testimony is the combined effort of ARC’s witnesses, but will be adopted by Clark G. Yoder at the public hearing for addition into the record.

WestMed has made the following inaccurate, irrelevant and/or intentionally misleading statements through the testimony of Drs. Morel and Weiss, which ARC rebuts as follows:

- As a threshold matter, ARC would like to bring to OHCA’s attention testimony by WestMed that makes it abundantly clear the practice (i) advocates directing Connecticut residents to MRI units in New York, and (ii) intends to apply for permission to operate its own MRI unit in the Stamford area. In his testimony, Dr. Morel states that WestMed’s “Connecticut patients recognize the benefits of using our imaging services in our

convenient and nearby New York Office locations ...” and that “patients initially seen in the WESTMED Stamford office (formerly OAS’s office) have already begun to choose to have their imaging done in the nearby WESTMED offices ... [and] these MRI scans presently occur in New York.” Nowhere in Dr. Morel’s testimony does he propose redirecting patients currently referred to ARC’s Stamford office to other Connecticut-based MRI providers. Only after ARC raised this issue in its objection to WestMed’s request for status did counsel suggest the possibility that such referrals could occur (Reply, pp. 1-2). Although given how much time Dr. Morel devotes to advocating for the integrated delivery model, we must assume that WestMed’s physicians are strongly encouraged to make referrals for MRI to practice scanners. WestMed further touts the benefits of “providing full service radiology and diagnostic testing services in addition to multispecialty care in single locations” (Morel Testimony, p. 5). Therefore, unless WestMed has plans to affiliate with a practice like Orophpaedic & Neurosurgery Specialists, P.C. (“ONS”) with an existing MRI unit in the Stamford area (a possibility given that it has not opposed ONS’s request to add MRI capacity under Docket No. 16-32063-CON), it is doing more than “considering” an application for a new scanner at the former Orthopedic Associates of Stamford, P.C. (“OAS”) office (Morel Testimony, p. 5). OHCA should therefore view any testimony provided by WestMed through the lens of a potential economic competitor and weigh it accordingly.

- WestMed’s claims regarding referrals made to ARC’s Stamford MRI service are inaccurate and misleading and do not support a lack of need for, or the feasibility of, ARC’s proposal. WestMed states that in FY 2015 OAS, which is now part of WestMed,

“made 2,767 MRI referrals of which greater than 95% were completed by Advanced Radiology’s Stamford office, representing 40% of the 2015 volume reported by Advanced Radiology” (Morel Testimony, pp. 5-6). This testimony is false. According to Dr. Morel, OAS referred greater than 2,629 MRI scans to ARC’s Stamford office in FY 2015 (2,767 x .95) (p. 11). In fact, OAS referred only 2,175 MRI scans to ARC in FY 2015. Moreover, only 2,016 of those scans were performed in ARC’s Stamford office. This represents 71% of OAS referrals and just 30% of ARC’s FY 2015 Stamford office MRI volume. Notably, the fact that 159 OAS referrals were performed outside of Stamford, mostly in Fairfield (75), supports ARC’s claim that it lacks sufficient capacity to accommodate patient demand on its existing Stamford unit. In addition, given that providers in the Fairfield medical community have supposedly known about the WestMed/OAS affiliation for months, you might expect to have seen a decline in OAS referrals to ARC in FY 2016 (Petition, p. 7). Instead, from January through May of FY 2016, ARC experienced an *increase* in MRI referrals from OAS over FY 2015, and in June and July saw only a minor decrease in these referrals.

- WestMed cannot credibly state that all of the 2,000 referrals that OAS makes to ARC each year, or that even a vast majority of these referrals, will be redirected elsewhere. First, as mentioned above, redirecting patients to WestMed’s New York offices for MRI scans presents access issues for Connecticut residents. As Dr. Morel concedes, patients have a choice in where they receive MRI services (Morel Testimony, pp. 2 & 6) and there are a multitude of MRI units located in Stamford and surrounding towns (Statewide Healthcare Facilities & Services Plan (“SHP”), Table 8). He says that based on his

“personal experience” with development of the polyclinic model through practice acquisition, OAS referrals will be redirected to WestMed MRI units in New York and, presumably, patients will go along with this (Morel Testimony, p. 6). However, query whether Dr. Morel’s “personal experience” includes practices located in areas where patients might have to travel hours round trip to access care due to heavy traffic congestion. ARC has experienced first hand the reluctance of patients from the Stamford area to want to travel as far as Fairfield for their scans, let alone to New York. Looking at OAS referrals for FY 2016 there are close to 200 patients who reside to the north and east of the ARC’s Stamford PSA who would likely not travel to New York. Nor would many who live in the ARC PSA towns of Stamford, Darien, and New Canaan, in our experience. OAS referrals from these towns totaled more than 1,600 in FY 2015. We believe that many of OAS’s patients will chose to remain in Connecticut, and to obtain their scans at ARC, not just for convenience but for the quality of MRI services that they have historically received from our practice (note that WestMed does not have its MRI scans read by subspecialist radiologist). Second, so that the record is clear, WestMed does not own an MRI unit operating in Connecticut, nor has it noticed or filed a CON Application requesting permission to acquire an MRI to operate in Connecticut. Therefore, WestMed itself cannot offer Connecticut-based MRI services to patients of the former OAS practice. WestMed’s counsel makes reference to the practice’s ability to redirect MRI patients away from ARC to other Fairfield County providers (Reply, pp. 1-2). This begs the question whether WestMed’s “expanding practice locations in Connecticut” and its active recruiting of “specialty physician practices for the Stamford

polyclinic” potentially include physician practices in the Stamford area that own MRI units (Petition, p. 2; Morel Testimony, p. 7).

- Even if ARC’s Stamford MRI service were to lose every one of its referrals from the OAS office of WestMed, our existing unit would still be operating at 115% capacity. In FY 2016 ARC’s Stamford MRI performed 6,617 examinations (CON Application, p. 40). Assuming the loss of 2,016 scans, the unit’s volume would have been 4,601. Based the SHP benchmark capacity of an MRI unit (4,000 scans), this represents 115% capacity ( $4,601 \div 4,000$ ) well above the 85% capacity threshold required for acquisition of a second MRI unit by ARC. The ARC Stamford unit is the busiest unit operating in the service area, and would remain one of the busiest even with the redirection of some of the OAS referrals to New York (SHP, Table 8).
- WestMed claims that ARC’s volume projections for its Stamford MRI services, which show 5% annual growth, are overstated (Morel Testimony, pp. 7-8). First, ARC does not claim that the G.E. Study alone supports its projected 5% annual growth. The G.E. Study supports the notion that there will be growth in MRI generally, as well as growth in the older age cohorts that use MRI services at a higher rate and the Medicaid population, in the Stamford area (CON Application, pp. 54-83). Note, ARC is the only private MRI provider in the Stamford area that participates with Medicaid, thus, as Medicaid MRI demand grows we will undoubtedly see an increase in volume. Moreover, ARC bases its volume projections in part on its historical volume growth in Stamford. WestMed cites ARC’s MRI volume growth for the last four year (Morel Testimony, p. 7), conveniently omitting FY 2011 to FY 2012 when ARC’s Stamford MRI service saw an 18% increase

in MRI volume, from 5,285 scans to 6,242 scans, bringing the office's five-year MRI volume growth to 25% (CON Application, pp. 13, 40 & 146). And as previously noted ARC does not expect to lose as many OAS referrals as WestMed claims. We are confident that if patients are afforded the right to choose their MRI service provider, which WestMed claims will be the case, they will opt to stay with ARC and obtain their services locally rather than traveling to New York for scans. All this being said, ARC's Stamford MRI unit is operating at 165% capacity and performing *nearly twice the number of scans required to justify the acquisition of a second unit*. The need is present and immediate and is not dependent upon the addition of any MRI volume going forward. Even with the loss of some referrals and/or a slightly slower growth in MRI volume, the unit remains well above capacity and the acquisition of a second unit is clearly justified. And despite WestMed's concerns about the financial feasibility of the proposal, our financials show that Advanced Radiology MRI Centers Limited Partnership is profitable and will remain so even with any projected incremental losses from initial operations (CON Application, p. 134).

- WestMed is incorrect in stating that 3.0 Tesla MRI is better suited for the acute care hospital environment (Weiss Testimony). In fact, the opposite is true. A 3T can be difficult to operate in a hospital environment and is often contraindicated because of the acute care type of equipment attached to the patient or difficulty obtaining an adequate history. WestMed state "relatively few outpatient MRI scans that materially benefit from being performed on a 3.0 Tesla MRI". First, what does "relatively" mean? Second, why does it matter? ARC wishes to provide the added benefits of a 3.0 Tesla MRI rather than

adding another 1.5 Tesla unit to its inventory despite it being less profitable for the practice (although still financially feasible). The fact is there are patients who will benefit clinically from a 3.0 Tesla unit. We choose to provide this enhanced technology because, unlike self-referral practices, ARC competes for the business of its referring physicians and patients based on the quality of our services. WestMed does not have to compete for referrals, so it has no incentive to acquire a more expensive and less profitable MRI unit, even if it would benefit patients to do so. Contrary to WestMed's assertions, 3.0 Tesla works very well in an outpatient environment of elective cases. Our neuro-oncologists and radiation oncologists prefer it when following brain tumor patients. Our pediatric neurologists prefer it when evaluating their pediatric patients for seizures. We have neurologists specializing in headaches that require the advanced diffusion MRI techniques 3.0 Tesla makes possible. Dr. Muro was recently interviewed by Channel 12 News before the movie *Concussion* was released because we are the only provider in Fairfield County performing DTI on 3.0 Tesla MRI and it provides the only definitive MRI tool to see white matter changes in the brain. 3.0 Tesla is clearly better when following the stability of very small brain aneurysms as well. We currently participate in several clinical trials related to very important medical conditions such as traumatic brain injury, multiple sclerosis, and Alzheimer's where 3.0 Tesla is required for the study. In addition, Prostate imaging is much better. In fact, we can image the prostate without putting a device (coil) in the patient's rectum. All of our extremity imaging is performed at higher resolution and the image quality is much better. We would do all such cases on a 3.0 Tesla if it were possible. Imaging the feet is especially beneficial. We can differentiate tendinosis from tendon tears in the shoulder better as well. Moreover, there is no added cost to patients or

payers with 3.0 Tesla MRI. ARC is reimbursed the same for scans on its 3.0 and 1.5 Tesla machines. The only other 3.0 Tesla MRI in the service area is at Greenwich Hospital. As a hospital-based unit it is less cost-effective than the same unit in a private physician practice setting. In addition, according to Table 8 of the SHP, the Greenwich Hospital 3.0 Tesla unit is operating at 82%, just 3% below the threshold for consideration of another unit.

- Contrary to WestMed's assertions, ARC's proposal is financially feasible. First, WestMed challenges the cost of the 3.0 Tesla MRI and whether that cost impacts negatively on the viability of ARC. WestMed suggests that ARC should not purchase a \$2.5 million 3.0 Tesla MRI unit when a 1.5 Tesla unit can be acquired for \$1.2 million and will be perfectly adequate for ARC's purposes (Morel Testimony, p. 8). As mentioned above, the acquisition of a 3.0 Tesla unit will enhance the quality of MRI services in Stamford, despite WestMed's opinions to the contrary. Moreover, ARC has submitted evidence to show that even with the acquisition of a \$2.5 million MRI unit, and incremental losses that are expected during the ramp-up period, Advanced Radiology MRI Centers Limited Partnership remains profitable throughout, with projected net income in FY 2017 (the first year of operation of the new Stamford unit) of \$1,543,125 (CON Application, p. 134). In addition, as WestMed should know, the quoted price of an MRI unit is never the price that a purchaser ultimately pays. Once options are negotiated, ARC expects to pay approximately \$1.9 million for the 3.0 Tesla MRI. At this price, ARC's net income in FY 2017 increases to \$1,628,840. Moreover, as WestMed is well aware, multi-service practices often invest in one service or location that is less

profitable, but that benefits patients, and help to cover the cost of that services, in this case over the short term, with revenues from other services. All MRI services at Advanced Radiology Consultants are provided through Advanced Radiology MRI Centers Limited Partnership, the applicant in this matter. The revenue and expenses associated with all MRI services produce sufficient income to support our investment in additional, enhanced MRI technology for Stamford, at a short-term incremental loss, for the benefit of our patients.

- This CON is not about which model of service delivery is best, because as we mention previously, WestMed does not have an application pending before OHCA. However, WestMed’s suggestions that our application creates an incentive or overutilization of MRI and would be inconsistent with the implementation of Medicare policy objectives of tying physician reimbursement to quality and efficiency cannot go unanswered (Morel Testimony, pp. 1-2). Please note the following with respect to ARC:
  - ARC has always been fully and successfully involved with the various CMS initiatives to improve quality and control costs. We were the first radiology practice in the country to successfully implement and attest to Meaningful Use and continue with Meaningful Use 2 despite a program not well suited for radiology.
  - We have been active participants with the Physician Quality Reporting System (“PQRS”) and preparing for the upcoming Merit-Based Incentive Payment System (“MIPS”) program where we will participate with complete success.

- It is important to note that our hospital-based contracts in fact fall under the Alternate Payment Model (“APM”) as boasted by Westmed.
- We also participate and collaborate with Community Medical Group (“CMG”) which is an Accountable Care Organization (“ACO”), initiated in New Haven but now extends well into Fairfield County. Several of our physicians are on the Board, the Executive Committee and in other leadership positions. CMG is in the Medicare Shared Savings Program (“MSSP”), and it has gain-sharing arrangements with Anthem, Cigna, Aetna, and is in discussions with others. As such, CMG has experience with alternative payment models, which has found that working with independent radiology providers is a cost-effective way of providing care. CMG is instituting technology solutions to allow integration of care among providers with disparate information systems and to facilitate coordination of care and population management. These are designed to, in effect, provide a "virtual integration" until we can apply for specific designation as an Integrated Delivery Network.
- We also participate with the St. Vincent’s Health Partners (“SVHP”) ACO and we strive to provide cost-effective value to Medicare participants. As part of SVHP, we participate with bundled payment models to lower the cost of care for Connecticut Medicare residents.
- We are currently preparing for the Clinical Decision Support (“CDS”) mandate under CMS, which came about with the Protecting Access to Medicare Act of 2014 (“PAMA”). With this mandate, ARC will be making clinical decision support tools available to our referring community in order to help them choose

the best imaging study for a given clinical condition and at the same time reduce overutilization.

Particularly in view of ARC's reliable and robust image sharing capability, there is no reason why Westmed, ONS or any practice or aggregation of providers would not benefit from ARC's geographic footprint of high-quality, subspecialized, service-oriented, technologically sophisticated imaging services. The above circumstances are not "accidental" or "random." They are a result of a carefully crafted, longstanding strategy to be able to provide unparalleled imaging service and expertise to all referring physicians and patients in Southwest Connecticut, no matter the practice model of the physician or type of insurance the patient has. Indeed, as OHCA considers new applications for CON, it must adapt to new circumstances, at the same time as following one of the criteria of the CON process, whereby effect on existing providers is considered. The above examples of ARC's willingness to adapt to, and concrete evidence of successful implementation of, a variety of care delivery models will be important in OHCA's considerations. Note WestMed has never approached ARC to explore options for collaboration. Yet, it opposes ARC's application, but does not oppose ONS's request for similar technology in the service area. One plausible explanation is that WestMed is now or plans to be in talks with ONS, leading to a stealth acquisition of MRI.

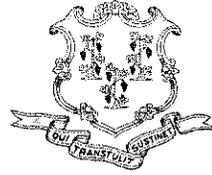
WestMed makes the incredible claim that “[a]ll that [ARC] provided as argument [in support of its CON request] is reliance on OHCA guidelines regarding device utilization” (Weiss Testimony, p. 4). This could not be further from the truth. ARC has presented an exhaustive

CON submission that shows, unequivocally, that the practice meets all statutory decision criteria and SHP guidelines for a CON to acquire an MRI unit. Based on the foregoing, ARC has demonstrated a clear public need for its proposal; the financial feasibility of the proposed acquisition; and that it will improve the quality, accessibility and cost-effectiveness of MRI services in the Stamford area. Any assertions by WestMed to the contrary are unfounded.

Thank you for allowing us the opportunity to submit this rebuttal.

# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.  
Commissioner

Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Office of Health Care Access

### IN THE MATTER OF:

A Certificate of Need Application by  
Advanced Radiology MRI Centers Limited Partnership  
Notice to Petitioner re: Request for Status

Docket Number: 16-32093-CON

### **RULING ON A PETITION FILED BY ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C. TO BE DESIGNATED AS AN INTERVENOR**

By petition dated August 25, 2016, Orthopaedic & Neurosurgery Specialists, P.C. ("Petitioner") requested Intervenor status in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") application of Advanced Radiology MRI Centers Limited Partnership ("Applicant") filed under Docket Number: 16-32093-CON.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with full rights of cross-examination at the hearing scheduled for August 30, 2016 at 410 Capitol Avenue, Hartford, Connecticut. As an Intervenor with full rights of cross-examination, the Petitioner may participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 16-32093-CON and shall be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicant until the issuance of a final decision by OHCA. As an Intervenor with full rights of cross-examination, the Petitioner may be cross-examined by the Applicant and the Petitioner has the right to cross-examine the Applicant.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

August 29, 2016  
Date

Kevin T. Hansted  
Kevin T. Hansted  
Hearing Officer

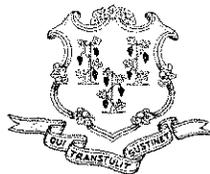


Phone: (860) 418-7001 • Fax: (860) 418-7053  
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Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

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# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.  
Commissioner

Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

Office of Health Care Access

### IN THE MATTER OF:

A Certificate of Need Application by  
Advanced Radiology MRI Centers Limited Partnership  
Notice to Petitioner re: Request for Status

Docket Number: 16-32093-CON

### **RULING ON A PETITION FILED BY WESTCHESTER MEDICAL GROUP, P.C. TO BE DESIGNATED AS AN INTERVENOR**

By petition dated August 25, 2016, Westchester Medical Group, P.C. ("Petitioner") requested Intervenor status in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") application of Advanced Radiology MRI Centers Limited Partnership ("Applicant") filed under Docket Number: 16-32093-CON.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with limited rights at the hearing scheduled for August 30, 2016 at 410 Capitol Avenue, Hartford, Connecticut. As an Intervenor with limited rights, the Petitioner may participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 16-32093-CON and shall be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicant until the issuance of a final decision by OHCA. As an Intervenor with limited rights, the Petitioner may be cross-examined by the Applicant but the Petitioner may not cross-examine the Applicant.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

August 29, 2016  
Date

Kevin T. Hansted  
Kevin T. Hansted  
Hearing Officer



Phone: (860) 418-7001 • Fax: (860) 418-7053  
410 Capitol Avenue, MS#13HCA  
Hartford, Connecticut 06134-0308  
[www.ct.gov/dph](http://www.ct.gov/dph)

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## Olejarz, Barbara

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**From:** Lazarus, Steven  
**Sent:** Monday, August 29, 2016 2:12 PM  
**To:** Karen Wackerman (kwackerman@Jeffers-Law.com); Michele Volpe (mmv@bvmlaw.com); Kathleen Gedney (kgg@bvmlaw.com); Patrick J. Monahan II (pmonahan@pppclaw.com); Jennifer Groves Fusco (jfusco@uks.com)  
**Cc:** Veyberman, Alla; Fernandes, David; Riggott, Kaila; Olejarz, Barbara; Greer, Leslie; Hansted, Kevin  
**Subject:** Docket Numbers: 16-32063-CON and 16-32093-CON  
**Attachments:** 16-32063- Ruling re Intervenor Status Advanced Rad.docx; 16-32063- Ruling re Intervenor Status Stamford.docx; 16-32093- Ruling re Intervenor Status ONS.docx; 16-32093- Ruling re Intervenor Status WestMed.docx

Good Afternoon,

Please see the attached rulings in the above referenced public hearing to be held tomorrow morning. If you have any questions, please feel free to Alla Veyberman (@860-418-7007) or me directly.

Thank you,

Steve

*Steven W. Lazarus*

Associate Health Care Analyst  
Division of Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue  
Hartford, CT 06134  
Phone: 860-418-7012  
Fax: 860-418-7053



## Greer, Leslie

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**From:** Lazarus, Steven  
**Sent:** Tuesday, September 06, 2016 7:15 AM  
**To:** Greer, Leslie  
**Cc:** Martone, Kim  
**Subject:** FW: Advanced Radiology -- Docket No. 16-32093-CON (Late File #1)  
**Attachments:** DOCS-#1354675-v1-ADRAD\_STAMFORD\_MRI\_LATE\_FILE\_#1.PDF

Please add to the original file.

Thank you,

Steve

### *Steven W. Lazarus*

Associate Health Care Analyst  
Division of Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue  
Hartford, CT 06134  
Phone: 860-418-7012  
Fax: 860-418-7053



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**From:** Jennifer Groves Fusco [<mailto:jfusco@uks.com>]  
**Sent:** Friday, September 02, 2016 3:49 PM  
**To:** User, OHCA; Fernandes, David; Lazarus, Steven; Hansted, Kevin; Riggott, Kaila; Veyberman, Alla  
**Cc:** Michele Volpe ([mmv@bvmlaw.com](mailto:mmv@bvmlaw.com)); [pmonahan@pppclaw.com](mailto:pmonahan@pppclaw.com)  
**Subject:** Advanced Radiology -- Docket No. 16-32093-CON (Late File #1)

Attached please find Applicant's Late File #1.

Thanks,  
Jen

**Jennifer Groves Fusco, Esq.**  
**Principal**  
**Updike, Kelly & Spellacy, P.C.**  
**One Century Tower**  
**265 Church Street**  
**New Haven, CT 06510**  
**Office (203) 786.8316**  
**Cell (203) 927.8122**

Fax (203) 772.2037

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**LEGAL NOTICE:** Unless expressly stated otherwise, this message is confidential and may be privileged. It is intended for the addressee(s) only. If you are not an addressee, any disclosure, copying or use of the information in this e-mail is unauthorized and may be unlawful. If you are not an addressee, please inform the sender immediately and permanently delete and/or destroy the original and any copies or printouts of this message. Thank you. Updike, Kelly & Spellacy, P.C.

**Advanced Radiology MRI Centers Limited Partnership  
Docket No. 16-32093-CON  
Late File #1 – Stamford MRI Scans by Type**

|                                | <b>Body</b> | <b>Breast</b> | <b>Musculoskeletal</b> | <b>Neurological</b> | <b>Vascular</b> | <b>TOTAL</b> |
|--------------------------------|-------------|---------------|------------------------|---------------------|-----------------|--------------|
| <b>FY 2013</b>                 | 340         | 205           | 3,220                  | 2,794               | 146             | <b>6,705</b> |
| <b>FY 2014</b>                 | 328         | 223           | 3,284                  | 3,042               | 125             | <b>7,002</b> |
| <b>FY 2015</b>                 | 323         | 168           | 3,059                  | 2,954               | 113             | <b>6,617</b> |
| <b>YTD 2016<br/>1/1 – 8/29</b> | 269         | 119           | 1,929                  | 2,031               | 73              | <b>4,421</b> |
| <b>FY 2017</b>                 | 429         | 225           | 3,166                  | 3,323               | 151             | <b>7,294</b> |
| <b>FY 2018</b>                 | 450         | 236           | 3,324                  | 3,489               | 159             | <b>7,658</b> |
| <b>FY 2019</b>                 | 473         | 248           | 3,490                  | 3,663               | 167             | <b>8,041</b> |

**RESPONSE:**

Above is a revised table showing historic, current and projected Stamford MRI scans by type. This information was initially reported at page 51 of the CON Application. In preparing a response to OHCA’s Late File request, Advanced Radiology MRI Centers Limited Partnership (“ARC”) noticed that its historic and projected vascular scan numbers were inaccurate. The practice’s MRIS categorizes scans by body part, which resulted in an artificially low number of scans being reported as vascular. In fact, a significant number of Magnetic Resonance Angiograms (“MRA”) and Magnetic Resonance Venography (“MVA”) were categorized as neurological scans and should more appropriately have been classified as vascular. ARC has adjusted both its historic and projected numbers in this regard. As you can see, the practice provides a significant number of vascular scans that will be triaged to the new 3 Tesla unit and the numbers continue to increase incrementally going forward. ARC expects its referring physicians to send more of these types of scans to the Stamford office given the superior imaging quality of the proposed unit.

## Olejarz, Barbara

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**From:** Olejarz, Barbara  
**Sent:** Monday, August 29, 2016 3:01 PM  
**To:** Karen Wackerman (kwackerman@Jeffers-Law.com); Michele Volpe (mmv@bvmlaw.com); Kathleen Gedney (kgg@bvmlaw.com); Patrick J. Monahan II (pmonahan@pppclaw.com); Jennifer Groves Fusco (jfusco@uks.com)  
**Cc:** Veyberman, Alla; Fernandes, David; Riggott, Kaila; Greer, Leslie; Hansted, Kevin  
**Subject:** Hearing scheduled for August 30, 2016  
**Attachments:** Directions to the Office of Health Care Access revised.doc; 32063 table.doc; 32093 table.doc; 16-32063 16-32093 Combined Agenda KH.docx

| <b>Tracking:</b> | <b>Recipient</b>                             | <b>Delivery</b>              |
|------------------|--|------------------------------|
|                  | Karen Wackerman (kwackerman@Jeffers-Law.com) |                              |
|                  | Michele Volpe (mmv@bvmlaw.com)               |                              |
|                  | Kathleen Gedney (kgg@bvmlaw.com)             |                              |
|                  | Patrick J. Monahan II (pmonahan@pppclaw.com) |                              |
|                  | Jennifer Groves Fusco (jfusco@uks.com)       |                              |
|                  | Veyberman, Alla                              | Delivered: 8/29/2016 3:01 PM |
|                  | Fernandes, David                             | Delivered: 8/29/2016 3:01 PM |
|                  | Riggott, Kaila                               | Delivered: 8/29/2016 3:01 PM |
|                  | Greer, Leslie                                | Delivered: 8/29/2016 3:01 PM |
|                  | Hansted, Kevin                               | Delivered: 8/29/2016 3:01 PM |

8/29/16

Attached are the Table of Records and Tentative Agenda for tomorrow's hearing. Also attached are directions to the Office, if there is not a visitor parking space in the back lot when you arrive the guard will direct you to where you can park.

Barbara K. Olejarz  
Administrative Assistant to Kimberly Martone  
Office of Health Care Access  
Department of Public Health  
Phone: (860) 418-7005  
Email: [Barbara.Olejarz@ct.gov](mailto:Barbara.Olejarz@ct.gov)



## **Directions to the Office of Health Care Access**

### **From I-91 North or South and from East of the River:**

In Hartford take I-84 westbound. Exit at Asylum Street, exit 48.

At the signal at the bottom of the ramp, make a gradual right, staying to the left of the fork in the road.

At the first light, take an immediate left onto Broad Street.

Travel on Broad Street to the light at the first four-way intersection; take a right onto Capitol Avenue. OHCA (tan brick building at 410 Capitol Avenue) is two blocks down on the right.

\* Pass 410 and enter in the driveway between 410 and 450 Capitol Avenue. Turn right into the parking lot behind the building and proceed to the Security building in the lot. You will be directed to available parking.

### **From the West:**

Take I-84 East to Capitol Avenue, Exit 48B. Bear right on the exit ramp. At the end of the ramp, turn right onto Capitol Avenue. OHCA is 3 blocks down on the right (tan brick building at 410 Capitol Avenue).

Proceed from \* above





**STATE OF CONNECTICUT**  
 DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

**TABLE OF THE RECORD**

**APPLICANT:**                    **Advanced Radiology MRI Centers Limited Partnership**

**DOCKET NUMBER:**        **16-32093-CON**

**PUBLIC HEARING:**         **August 30, 2016 at 10:00 am**

**PLACE:**                      **Department of Public Health, Office of Health Care Access**  
**470 Capitol Avenue, Conference Room A/B**  
**Hartford, CT 06134**

| <b>EXHIBIT</b> | <b>DESCRIPTION</b>   |
|----------------|--|
| <b>A</b>       | Letter from Advanced Radiology MRI Centers Limited Partnership (Applicant) dated June 14, 2016 enclosing the Certificate of Need (CON) application for the Acquisition of a 3.0 Tesla MRI Unit under Docket Number 16-32093, received by OHCA on June 14, 2016. (145 Pages)  |
| <b>B</b>       | Letters from the public in the matter of the CON application under Docket Number 16-32093.(2 Pages)  |
| <b>C</b>       | OHCA's letter to the Applicants dated July 8, 2016, requesting Additional information and/or clarification in the matter of the CON application under Docket Number 16-32093.(2 Pages)   |
| <b>D</b>       | Applicants responses to OHCA's letter of July 8, 2016, dated July 18, 2016 in the matter of the CON application under Docket Number 16-32093, received by OHCA on July 18, 2016. (7 Pages)   |
| <b>E</b>       | OHCA's letter to the Applicants dated July 21, 2016 deeming the application complete in the matter of the CON application filed under Docket Number 16-32093. (1 page)   |
| <b>F</b>       | Designation of Hearing Officer in the in the matter of the CON application under Docket Number 16-32093, dated July 25, 2016. (1 page)   |
| <b>G</b>       | OHCA's request for legal notification in <i>The Advocate</i> of OHCA's Notice to the Applicants of the public hearing scheduled for August 30, 2016, and an order consolidating this hearing with Docket Number 16-32063 for hearing purposes in the matter of the CON application under Docket Number 16-32093, dated August 5, 2016. (5 pages) |

|          |  |
|----------|--|
| <b>H</b> | Letter from Orthopaedic & Neurosurgery Specialists, P.C. (Docket Number 16-32063-CON) to OHCA dated August 8, 2016 requesting to receive copies of all correspondence from the Applicant in the matter of the CON application under Docket Number 16-32093, received by OHCA on August 8, 2016. (2 pages)              |
| <b>I</b> | OHCA's letter to the Applicant dated August 10, 2016 requesting prefile testimony and enclosing issues in the matter of the CON application under Docket Number 16-32093. (3 pages)  |
| <b>J</b> | Letter from the Applicant to OHCA dated August 10, 2016 objecting to the request to receive copies of correspondence by Orthopaedic & Neurosurgery Specialists, P.C. in the matter of the CON application under Docket Number 16-32093-CON, received by OHCA on August 10, 2016.(8 pages)                              |
| <b>K</b> | Letter from the Applicants to OHCA dated August 23, 2016 enclosing Prefile Testimony, responses to issues and noticing the appearance of Updike, Kelly and Spellacy, P.C. in the matter of the CON application under Docket Number 16-32093, received by OHCA on August 23, 2016. (61 pages)                           |
| <b>L</b> | Letter from the Applicants to OHCA dated August 24, 2016 enclosing revised response to issue #7 in the matter of the CON application under Docket Number 16-32093, received by OHCA on August 24, 2016. (4 pages)  |
| <b>M</b> | Letter from Westchester Medical Group P.C. (WESTMED) ("Petitioners") to OHCA dated August 25, 2016 requesting intervenor status in the matter of the CON application under Docket Number 16-32093, received by OHCA on August 25, 2016. (30 pages)   |
| <b>N</b> | Letter from Orthopaedic & Neurosurgery Specialists, PC ("Petitioner") to OHCA dated August 25, 2016 requesting intervenor status and enclosing notice of attorney appearance and prefile testimony in the matter of the CON application under Docket Number 16-32093, received by OHCA on August 25, 2016. ( 21 pages) |
| <b>O</b> | Letter from the Applicant to OHCA dated August 26, 2016 enclosing their objection to Orthopaedic & Neurosurgery Specialists, PC request for intervenor status in the matter of the CON application under Docket Number 16-32093, received by OHCA on August 26, 2016. ( 6 pages)                                       |
| <b>P</b> | Letter from the Applicant to OHCA dated August 26, 2016 enclosing their objection to WESTMED's request for intervenor status in the matter of the CON application under Docket Number 16-32093, received by OHCA on August 26, 2016. ( 6 pages)  |
| <b>Q</b> | Letter from WESTMED to OHCA dated August 26, 2016 replying to the Applicants objection to their request for intervenor status in the matter of the CON application under Docket Number 16-32093, received by OHCA on August 26, 2016. ( 3 pages)   |

|          |   |
|----------|---|
| <b>R</b> | Letter from the Applicant to OHCA dated August 26, 2016 enclosing their rebuttal in response to the testimony of WESTMED Medical Group in the matter of the CON application under Docket Number 16-32093, received by OHCA on August 29, 2016. (24 pages) |
| <b>S</b> | OHCA's Ruling on a Petition filed by Orthopaedic & Neurosurgery Specialists, P.C. to be designated as an Intervenor in the matter of the CON application under Docket Number 16-32093, dated August 29, 2016. (1 page)                                    |
| <b>T</b> | OHCA's Ruling on a Petition filed by Westchester Medical Group, P.C. to be designated as an intervenor in the matter of the CON application under Docket Number 16-32093, dated August 29, 2016. (1 page)   |

Administrative Notice:

- Administrative notice is taken of Docket Number: 16-32063-CON, Orthopaedic & Neurosurgery Specialists, P. C.



**STATE OF CONNECTICUT**  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

**TENTATIVE AGENDA**

**Docket Number: 16-32063-CON**  
**Orthopaedic & Neurosurgery Specialists, P. C.**  
**Acquisition of Magnetic Resonance Imaging Scanner**

**And**

**Docket Number: 16-32093-CON**  
**Advanced Radiology MRI Centers**  
**Acquisition of a 3.0 Tesla MRI Unit**

**August 30, 2016 at 10:00 am**

- I. Convening of the Public Hearing**
- II. Docket Number: 16-32063-CON**
  - A. Applicant's Direct Testimony**
  - B. Intervenors' Direct Testimony**
  - C. Applicant cross-examination of Intervenors**
  - D. Advanced Radiology MRI Centers' cross-examination of Applicant**
- III. Docket Number: 16-32093-CON**
  - A. Applicant's Direct Testimony**
  - B. Intervenors' Direct Testimony**
  - C. Applicant cross-examination of Intervenors**
  - D. Orthopaedic & Neurosurgery Specialists, PC's cross-examination of Applicant**
- IV. OHCA Questions**
- V. Closing Remarks**
- VI. Public Hearing Adjourned**

*An Equal Opportunity Provider*

*(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)*  
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308  
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov



**STATE OF CONNECTICUT**  
DEPARTMENT OF PUBLIC HEALTH  
*Office of Health Care Access*

**TENTATIVE AGENDA**

**Docket Number: 16-32063-CON**  
**Orthopaedic & Neurosurgery Specialists, P. C.**  
**Acquisition of Magnetic Resonance Imaging Scanner**

**And**

**Docket Number: 16-32093-CON**  
**Advanced Radiology MRI Centers**  
**Acquisition of a 3.0 Tesla MRI Unit**

**August 30, 2016 at 10:00 am**

- I. Convening of the Public Hearing**
- II. Docket Number: 16-32063-CON**
  - A. Applicant's Direct Testimony**
  - B. Intervenors' Direct Testimony**
  - C. Applicant cross-examination of Intervenors**
  - D. Advanced Radiology MRI Centers' cross-examination of Applicant**
- III. Docket Number: 16-32093-CON**
  - A. Applicant's Direct Testimony**
  - B. Intervenors' Direct Testimony**
  - C. Applicant cross-examination of Intervenors**
  - D. Orthopaedic & Neurosurgery Specialists, PC's cross-examination of Applicant**
- IV. OHCA Questions**
- V. Closing Remarks**
- VI. Public Hearing Adjourned**

*An Equal Opportunity Provider*

*(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)*

410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308  
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov



Office of Health Care Access

~~APPLICANT~~ *Intervenor*

(Only persons speaking on behalf of Applicants must sign in)

PUBLIC HEARING-SIGN UP SHEET

August 30, 2016

10:00 am

Docket Number: 15-32063-CON *432093*  
Orthopaedic & Neurosurgery Specialists, P. C.  
Acquisition of Magnetic Resonance Imaging Scanner

| PRINT NAME           | Phone               | Email | Title                                 |
|----------------------|---------------------|-------|---------------------------------------|
| <i>Ruth Cardullo</i> |                     |       | <i>U.R. Enterprise Dist Mgr.</i>      |
| <i>Alan Key</i>      | <i>203 694-6125</i> |       | <i>Member</i>                         |
| <i>Clark Yoben</i>   |                     |       | <i>CEO - Adrad</i>                    |
| <i>IAN KAROL</i>     |                     |       | <i>ARC - Advanced Rad Consultants</i> |
| <i>Gerard Moro</i>   |                     |       | <i>Physician - Advanced Robotics</i>  |

## Docket 06:32093 ARC

| PRINT NAME           | Phone        | Email                    | Title   |
|----------------------|--------------|--------------------------|---|
| Mary Heffernan       | 203 858 5840 | mheffernan@optonline.net | Principal, Turnney Lane Partners                  |
| Pat Monahan          | 203-988-6018 | pmmonahan@ppplaw.com     | Attorney PPPIC for West Med                       |
| Richard Morel        | 914-831-6864 | rmorel@westmedgroup.com  | Westmed Medical Group                             |
| PAT GERNER           | 860 794-1907 | KLGI@ad.com              | PRINCIPAL, LAW OFFICE OF PATRICIA A. GERNER, LLC. |
| Jan Weiss MD         | 914 682 6431 | jweiss@westmedgroup.com  | Westmed   |
| Dennis Cordon        | 203 696 3611 | dennis.cordon@adrad.com  | COO Advanced Redology                             |
| Carol Fria           | 203 696 3609 | carol.fria@adrad.com     | Dir of Finance Advanced Redology                  |
| Jan Jusco            | 203 786 8316 | jjusco@utken             | ARC   |
| Dr. Mark Carroll DMS |              |                          |   |
|                      |              |                          |   |



*Office of Health Care Access*

**APPLICANT**  
(Only persons speaking on behalf of Applicants must sign in)  
**PUBLIC HEARING-SIGN UP SHEET**  
August 30, 2016  
10:00 am

Docket Number: 16-32093-CON + 32063  
Advance Radiology MRI Centers  
Acquisition of a 3.0 Tesla MRI Unit

| PRINT NAME       | Phone | Email | Title                    |
|------------------|-------|-------|--------------------------|
| michole volpe    |       |       | BVM, for ONS             |
| Mark Camel, M.D. |       |       | ONS                      |
| Kathleen Tommaso |       |       | BVM, for ONS             |
| CLARK YODER      |       |       | CEO - Advanced Radiology |
| IAN KAROL        |       |       | Advanced Radiology       |

| PRINT NAME         | Phone        | Email                      | Title                             |
|--------------------|--------------|----------------------------|-----------------------------------|
| Gerard Muro        |              |                            | Physician of Advanced Radiology   |
| Dennis Conda       | 2036963611   | dennis.conda<br>@adrad.com | Adv. RAD                          |
| Alan Kage          | 203 696-6125 |                            |                                   |
| Carol Fria         | 2036963609   | Carol.fria<br>@adrad.com   | Advanced Radiology Dir of Financg |
| Jennifer Jusco     | 2037800831   | jtusco@uks.com             | ARC                               |
| Dr. Scott Sullivan |              |                            | General Radiology                 |
|                    |              |                            |                                   |
|                    |              |                            |                                   |
|                    |              |                            |                                   |
|                    |              |                            |                                   |

STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
OFFICE OF HEALTH CARE ACCESS

ORTHOPAEDIC & NEUROSURGERY SPECIALISTS, P.C.  
ACQUISITION OF MAGNETIC RESONANCE IMAGING SCANNER

DOCKET NO. 16-32063-CON

AND

ADVANCED RADIOLOGY MRI CENTERS  
ACQUISITION OF A 3.0 TESLA MRI UNIT

DOCKET NO. 16-32093-CON

AUGUST 30, 2016

10:00 A.M.

DEPARTMENT OF PUBLIC HEALTH  
410 CAPITOL AVENUE  
HARTFORD, CONNECTICUT

POST REPORTING SERVICE  
HAMDEN, CT (800) 262-4102

ORTHOPAEDIC/NEUROSURGERY SPECIALISTS & ADVANCED RADIOLOGY  
AUGUST 30, 2016

1 . . .Verbatim proceedings of a hearing  
2 before the State of Connecticut, Department of Public  
3 Health, Office of Health Care Access, in the matter of  
4 Orthopaedic & Neurosurgery Specialists, P.C., acquisition  
5 of Magnetic Resonance Imaging scanner and Advanced  
6 Radiology MRI Centers, acquisition of a 3.0 Tesla MRI  
7 unit, held at the Department of Public Health, 410  
8 Capitol Avenue, Hartford, Connecticut, on August 30, 2016  
9 at 10:00 a.m. . . .

10  
11  
12

13 HEARING OFFICER KEVIN HANSTED: Good  
14 morning, everyone. This public hearing before the Office  
15 of Health Care Access is being held on August 30, 2016 to  
16 consider applications by Orthopaedic & Neurosurgery  
17 Specialists, P.C. for the acquisition of an MRI, which  
18 has been identified as Docket No. 16-32063-CON, and an  
19 application by Advanced Radiology MRI Centers, Limited  
20 Partnership, for the acquisition of an MRI, which has  
21 been identified as Docket No. 16-32093-CON.

22 This public hearing is being held pursuant  
23 to Connecticut General Statutes, Section 19a-639a(f)2,  
24 and will be conducted as a contested case, in accordance

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1 with the provisions of Chapter 54 of the Connecticut  
2 General Statutes.

3 My name is Kevin Hansted, and I have been  
4 designated as the Hearing Officer for these matters.

5 The staff members assigned to assist today  
6 are Kaila Riggott, Steven Lazarus and Alla Veyberman.  
7 The hearing is being recorded by Post Reporting Services.

8 In making its decision, OHCA will consider  
9 and make written findings concerning the principles and  
10 guidelines set forth in Section 19a-639 of the  
11 Connecticut General Statutes.

12 Orthopaedic & Neurosurgery Specialists,  
13 P.C. and Advanced Radiology MRI Centers, Limited  
14 Partnership, have been designated as parties under their  
15 respective docket numbers.

16 Advanced Radiology MRI Centers, Limited  
17 Partnership has been granted Intervenor status with full  
18 rights in Docket No. 16-32063-CON, and Orthopaedic &  
19 Neurosurgery Specialists, P.C. has been granted  
20 Intervenor status with full rights in Docket No. 16-  
21 32093-CON.

22 The Stamford Hospital has been granted  
23 Intervenor status with limited rights in Docket No. 16-  
24 32063-CON, and Westchester Medical Group, P.C. has been

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1 granted Intervenor status with limited rights in Docket  
2 No. 16-32093-CON.

3 At this time, I will ask staff to read  
4 into the record those documents already appearing in  
5 OHCA's Table of the Record in these matters.

6 All documents have been identified in the  
7 Table of the Record for reference purposes. Mr. Lazarus?

8 MR. STEVEN LAZARUS: Good morning. Steven  
9 Lazarus. First, I will read the exhibits that we're  
10 going to be entering in Docket No. 16-32063. That's for  
11 the Orthopaedic & Neurosurgery Specialists, P.C. We're  
12 entering into the exhibit, into the record, Exhibit A  
13 through U, and, also, we're going to be noticing a filing  
14 that was received this morning that was for the rebuttal  
15 of Orthopaedic & Neurosurgery Specialists, P.C. in  
16 response to the Stamford Hospital reply to the objection  
17 of ONS.

18 HEARING OFFICER HANSTED: Thank you.  
19 Counsel, are there any objections or any corrections that  
20 need to be made? I understand, Attorney Volpe, there may  
21 be one?

22 MS. MICHELE VOLPE: Yes. Michele Volpe,  
23 legal counsel for Orthopaedic & Neurosurgery Specialists.  
24 We have one correction. Exhibit G, a

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1 letter from the public in the matter of the CON  
2 application, that should not be in this record. That is  
3 for Connecticut Orthopaedic Specialists, and it is Town  
4 of Essex letter from the Selectman's office, from the  
5 First Selectman. That belongs in a different docket for  
6 COS.

7 HEARING OFFICER HANSTED: So that should  
8 be in 16-32093-CON?

9 MS. VOLPE: If that's Connecticut  
10 Orthopaedic Specialists docket, yes.

11 HEARING OFFICER HANSTED: That is.

12 MS. VOLPE: Yes.

13 HEARING OFFICER HANSTED: Yes, okay.

14 MS. VOLPE: Yes.

15 MS. JENNIFER GROVES FUSCO: No. Actually,  
16 32093 is our docket in this case. I think Michele has a  
17 letter that belongs in the application that was just  
18 filed by Connecticut Orthopaedic Specialists.

19 MS. VOLPE: The Specialists, COS, yes.

20 HEARING OFFICER HANSTED: Okay, not the  
21 one before us right now?

22 MS. GROVES FUSCO: Neither one.

23 MS. VOLPE: Correct.

24 HEARING OFFICER HANSTED: Okay. Thank

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1 you. We'll have that removed.

2 MS. VOLPE: Okay.

3 MR. LAZARUS: And then we have Table of  
4 the Record for Docket No. 16-32093.

5 MR. STEPHEN COWHERD: Excuse me, Steven.

6 MR. LAZARUS: Yes?

7 COURT REPORTER: I'm sorry.

8 HEARING OFFICER HANSTED: Steve, can you  
9 come up to a microphone, please?

10 MR. COWHERD: Sure. This is an objection  
11 to the record on the ONS application. Stephen Cowherd on  
12 behalf of Stamford Hospital.

13 Hearing Officer Hansted, members of OHCA  
14 staff, I'm interposing an objection to the rebuttal that  
15 ONS submitted to the response of Stamford Hospital's  
16 reply to their objection for Intervenor status.

17 That was not testimony. That was a reply  
18 to an ONS objection. The Office of Health Care Access  
19 made its ruling on Intervenor status at 2:12 p.m. That's  
20 when I received it.

21 The rebuttal was submitted at 5:46 p.m.,  
22 so the whole issue was moot. This is not rebuttal to  
23 testimony that Stamford Hospital supplied. It is  
24 rebuttal to our reply to their objection.

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1                   The Office of Health Care Access already  
2 ruled on that matter at 2:00 p.m. for ONS to submit at  
3 5:46 p.m. A rebuttal to that objection is wholly  
4 improper. It's not testimony, so we'd ask first that it  
5 be stricken from the record, and, secondly, since you  
6 can't unring the bell that it's been submitted to the  
7 agency, in Stamford Hospital's closing remarks, we'd like  
8 to address those issues.

9                   HEARING OFFICER HANSTED: If it's a  
10 rebuttal to an objection, based upon the Intervenor  
11 status, then it's moot, since the Intervenor order has  
12 already been sent out, so, with that respect, I won't  
13 strike it, but it's moot. We'll give it any weight it's  
14 due, which, at this point, is due none.

15                   With respect to responding to it at the  
16 end of this hearing, I'm not going to allow that,  
17 because, as I just stated, it's a moot filing anyway at  
18 this point.

19                   MR. COWHERD: I'd still like to reserve  
20 our ability on closing remarks to address the  
21 application.

22                   HEARING OFFICER HANSTED: All right.

23                   MR. COWHERD: Thank you.

24                   MS. VOLPE: Hearing Officer Hansted, thank

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1 you. Just for point of clarification on that, from our  
2 perspective, when it does come time for the Intervenor to  
3 make a statement, if they are making false statements in  
4 the record, we don't want to disrupt the proceedings, but  
5 we do want to object and not allow them to make false  
6 statements in the record.

7 HEARING OFFICER HANSTED: Well, counsel,  
8 you have the ability to Cross-Examine the Intervenor,  
9 okay? So if they make any statements, which you feel are  
10 incorrect, you can Cross-Examine on those.

11 MS. VOLPE: But they'll be allowed to make  
12 false statements in the record --

13 HEARING OFFICER HANSTED: Well I don't  
14 know if they're necessarily false statements.

15 MS. VOLPE: Okay.

16 HEARING OFFICER HANSTED: I mean that's  
17 why we're here. They're going to present their evidence,  
18 and you're going to present your evidence to rebut that,  
19 okay?

20 MS. VOLPE: Right, but just for point of  
21 clarification, our clients have had to attest to the  
22 testimony and the pre-file, whereas the Intervenor just  
23 has their lawyer making a statement, so, in terms of  
24 Cross, they haven't submitted pre-filed testimony by an

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1 individual.

2 Some of the false statements were made by  
3 an attorney in a filing.

4 HEARING OFFICER HANSTED: Attorney  
5 Cowherd, do you have any witnesses here, who are going to  
6 make a statement?

7 MR. COWHERD: I do. I expect that the  
8 witness will be Cross-Examined on the testimony, the pre-  
9 filed testimony that was submitted by Stamford Hospital,  
10 and that's perfectly appropriate.

11 Beyond the scope of that testimony,  
12 Stamford Hospital will object.

13 HEARING OFFICER HANSTED: Okay, counsel,  
14 so he has witnesses he'll present to make statements, and  
15 you can Cross-Examine those witnesses at the appropriate  
16 time.

17 MS. VOLPE: Understand and appreciate  
18 that. Our concern is with false statements that were  
19 made by legal counsel, without an opportunity to address  
20 those. That's why we asked that they be stricken from  
21 the record.

22 HEARING OFFICER HANSTED: Well and you've  
23 submitted a motion in that respect?

24 MS. VOLPE: Yes, we have.

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1 HEARING OFFICER HANSTED: Okay and I'll  
2 reserve ruling on that. I'll make a written ruling on  
3 that, but, for today, I'll accept those statements.

4 MS. VOLPE: Okay.

5 MR. COWHERD: I'm sorry. What's the  
6 motion?

7 MS. VOLPE: Attorney Cowherd is pointing  
8 out that the title of the motion should have been a  
9 request to strike false statements that were submitted in  
10 a filing by Intervenor, as opposed to pre-filed  
11 testimony, just for point of clarification, and that was  
12 the filing that was submitted last night, just so there's  
13 no confusion.

14 HEARING OFFICER HANSTED: So just for the  
15 record, that is Exhibit V, V, as in Victor.

16 MR. COWHERD: Hearing Officer Hansted, I'm  
17 confused. I haven't seen a motion. Where is the motion  
18 of ONS?

19 HEARING OFFICER HANSTED: I don't believe  
20 it's specifically titled a motion.

21 MS. VOLPE: Correct.

22 HEARING OFFICER HANSTED: It's within that  
23 filing they made the request.

24 MS. VOLPE: Correct.

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1 MR. COWHERD: But I believe that, again,  
2 the way we started was, and I don't want to belabor the  
3 point, is that they submitted a rebuttal to the reply to  
4 their objection for Intervenor status.

5 Where we started was that that issue was  
6 mooted by the ruling of the agency at 2:12 p.m., and  
7 correct me if I'm wrong, but we were told that that will  
8 be given no weight.

9 HEARING OFFICER HANSTED: Well it's moot  
10 at this point. Why don't we do this, just to clean up  
11 the record and to settle this issue?

12 Attorney Volpe, if you would put a motion  
13 in writing?

14 MS. VOLPE: Can I propose that we just  
15 rename what's before you, and we could submit it?

16 HEARING OFFICER HANSTED: Well what I'd  
17 like to you to do is submit a new motion.

18 MS. VOLPE: Sure.

19 HEARING OFFICER HANSTED: And I'll allow  
20 Attorney Cowherd time to respond to that motion. I think  
21 that's only appropriate. And if you could submit that  
22 motion -- how long do you need for that motion?

23 MS. VOLPE: We could have it over to you  
24 this morning, now, during the proceedings.

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1 HEARING OFFICER HANSTED: I mean by the  
2 end of this week.

3 MS. VOLPE: Oh, sure.

4 HEARING OFFICER HANSTED: And then,  
5 Attorney Cowherd, I'll give you until the end of the  
6 following week to respond.

7 MR. COWHERD: Thank you.

8 HEARING OFFICER HANSTED: You're welcome.  
9 And just before we go forward, I would -- I mean, you  
10 know, we're all professionals here, and I would  
11 appreciate it, if any counsel feels that another counsel  
12 may be making statements that are incorrect, whether on  
13 purpose or in error, please reach out to each other ahead  
14 of time.

15 I would rather not have to deal with those  
16 issues at a hearing. It takes up time at the hearing,  
17 and I just don't like -- as professionals, I like to give  
18 each other a professional courtesy. I don't like people  
19 saying that there are lies being told before a Hearing  
20 Officer, so if we could, in the future, handle that in  
21 that respect, I'd appreciate it.

22 Mr. Lazarus, if you want to proceed?

23 MR. LAZARUS: All right. Moving on to the  
24 Table of the Record for Docket No. 16-32093, that's for

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1 Advanced Radiology MRI Centers, Limited Partnership,  
2 we're taking into the record Exhibits A through T, and  
3 also taking administrative notice of Docket No. 16-32063  
4 in this matter.

5 And going back to the other docket, 16-  
6 32063, the application of ARC that was filed under 16-  
7 32093, is also being administrative notice in that  
8 record.

9 HEARING OFFICER HANSTED: Okay. Counsel,  
10 any objections? Any concerns?

11 MS. GROVES FUSCO: This is Jennifer Fusco,  
12 counsel for Advanced Radiology. No objections, but  
13 similar to Attorney Volpe, I have a question, a  
14 clarification question, on Exhibit B, which is letters  
15 from the public in this matter.

16 I think it may be that our letters of  
17 support were sent -- we attached with our CON  
18 application, but may have been delivered to OHCA, as  
19 well. If it's something, other than that, I have not  
20 seen those letters. I couldn't figure out what that was  
21 referencing, so if you could just verify that for me? It  
22 doesn't have to be right now.

23 HEARING OFFICER HANSTED: Okay, we'll take  
24 a look at that and contact you.

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1 MS. GROVES FUSCO: Not a problem. Thank  
2 you.

3 HEARING OFFICER HANSTED: You're welcome.

4 MS. GROVES FUSCO: Other than that, no  
5 objections.

6 HEARING OFFICER HANSTED: Okay. Any  
7 other, counsel? Any other issues concerning this?

8 MS. VOLPE: No.

9 HEARING OFFICER HANSTED: Thank you.  
10 Okay, with respect to today's hearing, what we're going  
11 to do is we'll first hear from the Applicants regarding  
12 Docket No. 16-32063-CON.

13 After that, the Intervenors may present  
14 their position on that particular project, followed by  
15 Cross-Examination by the Applicant in that matter.

16 Then we will hear from the Applicant  
17 regarding the second project under Docket No. 16-32093-  
18 CON, again followed by the Intervenor statements and  
19 Cross-Examination by the Applicant of the Intervenors.

20 Upon completion of those, OHCA will ask  
21 its questions on each project, and then, after that has  
22 concluded, we will hear any public comment.

23 And just before we proceed, are there any  
24 members of the public here at this point? I don't hear

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1 or see anyone, so we'll move on.

2 And would all those individuals, who are  
3 going to testify on behalf of either the Applicants and  
4 the Intervenors, please stand, raise your right hand and  
5 be sworn in by the court reporter?

6 (Whereupon, the parties were duly sworn  
7 in.)

8 HEARING OFFICER HANSTED: Okay. Just as a  
9 reminder for those of you who submitted pre-filed  
10 testimony, after you give your testimony -- I'm sorry.  
11 Before you give your testimony, please identify  
12 yourselves for the record and adopt your pre-filed  
13 testimony on the record.

14 And those individuals, who were just sworn  
15 in, I know space is tight, but if each of you could come  
16 up to the microphone and identify yourselves, I'd  
17 appreciate it at this time.

18 MR. CLARK YODER: Clark Yoder, CEO,  
19 Advanced Radiology.

20 HEARING OFFICER HANSTED: Thank you.

21 DR. ALAN KAYE: Alan Kaye, former CEO,  
22 Advanced Radiology, now a member.

23 DR. GERARD MURO: Dr. Gerard Muro with  
24 Advanced Radiology, Chief Medical Information Officer and

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1 Neuroradiologist.

2 MR. DENNIS CONDON: Dennis Condon, COO for  
3 Advanced Radiology.

4 DR. JONATHAN WEISS: John Weiss, Medical  
5 Director of Radiology for WESTMED.

6 DR. IAN KAROL: Dr. Ian Karol,  
7 Radiologist, Radiology Executive Committee, Advanced  
8 Radiology.

9 MS. CAROL FRIIA: Carol Friia, Advanced  
10 Radiology, Director of Finance.

11 MS. RUTH CARDIELLO: Ruth Cardiello, Vice  
12 President Enterprise Risk Management for Stamford  
13 Hospital.

14 DR. RICHARD MOREL: Dr. Richard Morel,  
15 Medical Director for WESTMED Medical Group.

16 HEARING OFFICER HANSTED: Okay, do we have  
17 everyone?

18 DR. SCOTT SULLIVAN: Dr. Scott Sullivan,  
19 Neuroradiologist and President of Greenwich Radiology  
20 Group.

21 HEARING OFFICER HANSTED: Thank you. And  
22 anyone else on this side of the room? We got everyone,  
23 who was sworn in? You identified yourselves? Okay. All  
24 right, thank you very much, everyone.

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1                   And, at this point, we are ready to begin  
2 the hearing, and, as I stated before, we'll start with  
3 Docket No. 16-32063-CON, and the Applicant may proceed.

4                   MS. VOLPE: Thank you. Michele Volpe,  
5 legal counsel for Orthopaedic & Neurosurgery Specialists.

6                   I have here with me this morning Dr. Mark  
7 Camel, who would like an opportunity to speak before you  
8 and introduce Dr. Sullivan, who is with him.

9                   HEARING OFFICER HANSTED: Thank you. Good  
10 morning.

11                  DR. MARK CAMEL: Good morning. My name is  
12 Dr. Mark Camel, and I am the Vice President of  
13 Orthopaedic & Neurosurgery Specialists, P.C. I adopt my  
14 pre-filed testimony.

15                  HEARING OFFICER HANSTED: Thank you.

16                  DR. CAMEL: I'd like to begin by thanking  
17 you, Hearing Officer Hansted and all of the staff, for  
18 its consideration of our application to acquire an  
19 additional MRI scan to service, scanner, to service our  
20 patients in the region.

21                  Here with me today is Dr. Scott Sullivan  
22 of Greenwich Radiology. Dr. Sullivan is a fellowship-  
23 trained neuroradiologist with decades of experience.

24                  Dr. Sullivan and Dr. Kapil(phonetic)

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1 decide, who is a fellowship-trained bone and joint  
2 radiologist, interpret and supervise the MRI services  
3 that we provide.

4 Dr. Sullivan, Dr. Desai are another  
5 radiologist that's physically present at ONS's office to  
6 interpret all MRI scans.

7 ONS has demonstrated a clear public need  
8 for an additional MRI scanner. ONS has met all of the  
9 standards and guidelines for approval of an additional  
10 MRI, based on a statewide health plan, as well as the  
11 statutory and regulatory requirements for CON approval.

12 Specifically, under any need methodology  
13 applied, as well as the statewide benchmarks, ONS is  
14 utilizing its existing scanner well above 85 percent  
15 capacity.

16 Therefore, based on this criteria alone in  
17 the statewide health plan, ONS's application should be  
18 approved. This is where the need review should end, and  
19 the ONS application should be approved.

20 But taking the needs analysis further and  
21 applying ONS's internal growth, as well as the lack of  
22 current capacity in the service area of the existing MRI  
23 providers, who are collectively operating well above 85  
24 percent capacity limits, the result is the same. This

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1 also shows tremendous need in the service area.

2 Utilizing OHCA's standard of 4,000 scans  
3 outlined in the statewide health plan, the capacity of  
4 the existing ONS scanner is operating at 132 percent  
5 capacity for 2015.

6 Every other provider of MRI services in  
7 the region is operating at above capacity or close to  
8 capacity, and they cannot be relied upon to absorb ONS  
9 patients.

10 For example, Stamford Hospital is  
11 operating at 161 percent of capacity, based on the last  
12 available data.

13 Looking to ONS's internal data, we are  
14 operating at 92 capacity, based on the number of slots we  
15 have available. To meet current patient demand, ONS  
16 operates its scanner far beyond normal business hours,  
17 which opens up availability to more than the OHCA  
18 standard of 4,000 scans per year.

19 Even with ONS's additional scan capacity,  
20 ONS is still operating well above 85 percent. The MRI  
21 volumes and hours described in ONS's application are not  
22 sustainable on an ongoing basis from either an operations  
23 or patient care perspective.

24 ONS has clearly demonstrated with its

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1 recent growth and with its projected growth in our  
2 practice size, based on the growth and the number of  
3 physicians, as well as the growing patient demand for our  
4 services, this provides the need for an additional MRI  
5 scan.

6 As detailed in our application and my pre-  
7 filed testimony, ONS has grown considerably in both  
8 recent and past years and so has our MRI volume.

9 ONS is actively recruiting physicians to  
10 keep up with demand, and it follows that our patient  
11 numbers will grow, as we've demonstrated and they have  
12 done.

13 ONS has two new physicians starting this  
14 fall and is recruiting for two more physicians for the  
15 summer.

16 ONS's proposed MRI will positively impact  
17 access and, also, quality in the region. Adding more MRI  
18 capacity to ONS practice will increase access to the  
19 patient population serviced by ONS.

20 Approval of the ONS application will have  
21 a positive impact on the diversity of health care  
22 providers and patient choice in the region.

23 ONS is a private physician practice in a  
24 region heavily dominated by institutional facilities

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1 providing imaging services.

2 Approval of the ONS application before  
3 OHCA will have no impact on the existing providers and  
4 will not create duplication of services.

5 Nearly all of the providers are at  
6 capacity or close to reaching capacity. ONS's additional  
7 scanner will not impact other providers.

8 ONS anticipates all of its additional  
9 volume will derive from ONS physicians, who, upon joining  
10 the practice, and physicians, who are still growing their  
11 own practice, as they ramp up to a full patient load, as  
12 well accommodate additional intrinsic volume that comes  
13 along with further time.

14 ONS is actively recruiting, as I  
15 mentioned, and will continue to employ more professionals  
16 as demand grows.

17 Further, I refer OHCA to the detail needs  
18 analysis spelled out in my pre-filed testimony outlining  
19 all of the MRIs performed by all of the providers in the  
20 region, as well as our application to the methodology, as  
21 outlined in the statewide health plan.

22 Therefore, there will be no unnecessary  
23 duplication of MRI services when the proposed MRI is  
24 approved.

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1                   The number of scans required for our ONS  
2 patients will always be more than the number of MRIs  
3 performed in ONS, because, for example, some patients  
4 require an MRI on a 3T scanner.

5                   Many of our patients work not in our  
6 service region, but work either in New York City or  
7 further in upstate Connecticut. They choose to have  
8 their MRIs closer to home or closer to where they work  
9 for convenience.

10                  Certain patients, for example, head injury  
11 patients, may require scans that are best done on a 3  
12 Tesla scanner, which can provide diffusion tensor  
13 imaging, which is currently under study as an adjunct for  
14 assessing patients, especially those who have repetitive  
15 concussions.

16                  As already stated, some New York patients  
17 receive their scans at New York providers for both  
18 professional and residential geographic preference.

19                  There is tremendous consolidation in the  
20 health care marketplace. ONS works hard to position the  
21 practice to stay independent and physician-owned.

22                  ONS offers patients a community-based  
23 private practice that is owned by physicians, offering a  
24 cost-effective alternative to institutional care.

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1                   Approval of the ONS CON application before  
2 you will allow ONS to continue to provide a community-  
3 based and independent service. Community-based practices  
4 offer more cost-effective services and options for payers  
5 in the marketplace, as well as more reasonable cost to  
6 patients, who are not otherwise required to absorb  
7 facility fees.

8                   ONS complies with all of the policies and  
9 regulations adopted by the Department of Public Health.  
10 OHCA's approval of ONS's CON application will ensure  
11 access to needed MRI in the service area.

12                   Approval of the CON will improve quality,  
13 accessibility and cost effectiveness for health care, as  
14 delivered in our region.

15                   Advanced Radiology and Stamford Hospital  
16 would want OHCA to believe that ONS doesn't serve the  
17 Medicaid population. In fact, nothing could be further  
18 from the truth.

19                   ONS has been serving the Medicaid and  
20 indigent population for decades. ONS provides hundreds  
21 of thousands of dollars of free care to Medicaid  
22 patients, uninsured, and other patients, who arrive in  
23 our area in need of care. ONS has never denied any  
24 service, including MRI, to a Medicaid patient.

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1                   ONS and Greenwich Hospital work together  
2 and have established, many decades before now, a  
3 successful coordination of care for the Medicaid and  
4 uninsured population.

5                   This coordinated effort should not be  
6 interrupted or interfered with, as it has been effective  
7 and continues to meet the need of the Medicaid population  
8 in Greater Greenwich and surrounding communities.

9                   The Medicaid and poorly or underinsured  
10 population usually presents for health care either at the  
11 Greenwich Hospital emergency room or to the Greenwich  
12 Hospital medical clinic, where they're first evaluated by  
13 a primary care physician.

14                   Once that primary care physician  
15 determines that imaging or an MRI is warranted and that  
16 MRI gives a diagnosis warranting consultation by an ONS  
17 subspecialist, then the patient is seen by an ONS  
18 physician.

19                   Denying the ONS CON could have a negative  
20 impact on the diversity of health care providers and  
21 patient choice in the service area.

22                   The fact that MRIs are obtained at  
23 Greenwich Hospital prior to referral to ONS should not be  
24 an impediment to approving a second MRI scanner at ONS.

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1                   Most important, if OHCA does not approve  
2 the ONS application, it could adversely impact the free  
3 orthopaedic and neurosurgical care provided currently to  
4 Medicaid and indigent patients by ONS.

5                   ONS, though, also sees Medicaid and  
6 uninsured patients in its office, the Greenwich Hospital  
7 Emergency Room and the Orthopaedic Clinic at Greenwich  
8 Hospital.

9                   ONS sees hundreds of Medicaid and indigent  
10 patients a year in these settings. Neurosurgery  
11 patients, whether they're Medicaid or uninsured patients,  
12 are seen in our private office.

13                   The government patient volume and indigent  
14 patient numbers have all been outlined in detail in our  
15 application.

16                   In 2015, for example, ONS saw 1,476  
17 patients with Medicaid as their primary or secondary  
18 insurance. ONS writes off hundreds of thousands of  
19 dollars in care provided to these patients. All of the  
20 detailed numbers of the care have been provided by ONS  
21 and its physicians.

22                   Finally, ONS also works with the ONS  
23 Foundation, a 5013c entity committed to orthopaedic  
24 research, community education and service.

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1                   Orthopaedic research, for both studies  
2                   that have already been published in peer review journals  
3                   and research, which is ongoing, MRI data is utilized to  
4                   evaluate normal surgical approaches.

5                   ONS produces better quality MRIs by having  
6                   longer scan time for our patients, because longer scan  
7                   time, both for individual sequences and additional  
8                   sequences, can result in better quality images and more  
9                   information for the surgeons making a decision whether to  
10                  operate and then planning the surgery that's required.  
11                  This is crucial when the doctor has to utilize these  
12                  images particularly during surgery.

13                  ONS patients are better served in-house,  
14                  as patients will benefit from the enhanced communication  
15                  coordination that occurs with our current in-office  
16                  imaging.

17                  Additionally, we can measure, monitor and  
18                  guide treatment on an ongoing basis.

19                  Lastly, ONS's proposal is financially-  
20                  feasible. We're a financially-sound practice and  
21                  anticipate that the new scanner will be cash flow  
22                  positive in the very first year of operation.

23                  This financial performance will allow us  
24                  to continue to provide hundreds of thousands of dollars

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1 in free care to Medicaid and uninsured patients.

2 In conclusion, ONS has demonstrated a  
3 clear need for an additional MRI scanner in its office,  
4 as well as demonstrating that the proposed MRI meets all  
5 of the requirements of OHCA guidelines and principles,  
6 including, but not limited to, the proposed MRI is  
7 consistent with the statewide Health Care Facilities and  
8 Services Plan.

9 ONS's proposed MRI will positively impact  
10 access and quality in the region and have no impact on  
11 existing providers.

12 ONS has demonstrated that the proposed MRI  
13 strengthens the health care system and cost  
14 effectiveness. ONS has demonstrated that the proposed  
15 MRI will improve accessibility.

16 ONS has demonstrated that the proposed MRI  
17 improves quality and, finally, demonstrates that this CON  
18 is financially-feasible.

19 We respectfully request that the  
20 application be approved. Thank you for your time.

21 HEARING OFFICER HANSTED: Thank you.  
22 Attorney Volpe, do you have anything further?

23 MS. VOLPE: No. That concludes our  
24 presentation. Thank you.

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1 HEARING OFFICER HANSTED: Okay, thank you.  
2 At this point, Attorney Fusco, if you want to Cross-Exam,  
3 or, I'm sorry, give a presentation at this point on this  
4 application? I'm sorry. I'm ahead of myself.

5 MS. GROVES FUSCO: Yes, we would. On  
6 behalf of Advanced Radiology, I'd like to introduce Clark  
7 Yoder, the practice's CEO, who is going to begin our  
8 presentation, and he will introduce our other witnesses.

9 HEARING OFFICER HANSTED: Okay, thank you.

10 MR. YODER: Good morning.

11 HEARING OFFICER HANSTED: Good morning.

12 MR. YODER: My name is Clark Yoder. I'm  
13 the CEO of Advanced Radiology.

14 I would like to adopt my pre-filed  
15 testimony, including rebuttal testimony submitted in  
16 response to testimony of ONS and WESTMED, for the record.

17 HEARING OFFICER HANSTED: Thank you.

18 MR. YODER: I would like to thank Hearing  
19 Officer Hansted and the OHCA staff for their dedication  
20 and time in hearing our case here. I appreciate that.

21 I joined Advanced Radiology in 2005 as  
22 CEO. Prior to Advanced Radiology, I spent 13 years  
23 working for Westchester Medical Group in varying  
24 capacities, including Director of Ancillary Services, CFO

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1 and Chief Operating Officer.

2 I hold an MBA and a BS in Radiology, and I  
3 am a member of various professional organizations,  
4 including the American College of Health Care Executives,  
5 Radiology Business Management Association and the  
6 Radiological Society of North America.

7 As you know, Advanced Radiology is a  
8 multi-site, full-service diagnostic and interventional  
9 radiology outpatient provider.

10 They have offices located in Stamford,  
11 Fairfield, Stratford, Trumbull, Shelton and Orange and  
12 provide advanced imaging, including MRI, at each site.

13 My testimony in opposition to ONS's  
14 request for a second self-referral MRI unit for Greenwich  
15 will focus on two issues, the first being the adverse  
16 impact that acquisition will have on ARC, and, two, ONS's  
17 failure to provide access to MRI services for Medicaid  
18 recipients, an appreciable number of indigent persons,  
19 and the impact that this has on the providers, like ARC,  
20 who serve both those populations.

21 With respect to the adverse impact on ARC,  
22 ONS has been a long refer of MRI services, primarily to  
23 our Stamford office.

24 Last year, we performed nearly 80 scans

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1 referred by ONS physicians, and, this year, we are on  
2 track to perform 110 ONS-referred MRI exams. The value  
3 of these referrals to our practice is approximately 70 to  
4 \$100,000.

5 We have very sophisticated business  
6 intelligence tools and systems that do track referrals,  
7 and we manage referrals throughout our practices in our  
8 offices down to the physician level.

9 ONS's projected volumes show a 1,200-scan  
10 or 22 percent increase in the first year of operation.  
11 This is entirely inconsistent with the historic MRI  
12 growth in that practice, and it is too large of a gain to  
13 be attributable to the recruitment of just two new  
14 physicians in that year.

15 It is clear from the projections,  
16 themselves, as well as the statements made by ONS in its  
17 CON submissions, that the practice intends to redirect  
18 the majority of scans it refers out back to the ONS  
19 units.

20 They typically refer out around 1,500  
21 scans a year. Out of those, there are few that need to  
22 be referred outside. The rest will be directed back to  
23 ONS.

24 Note, also, there is nothing precluding

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1 ONS from relocating the second MRI unit to its Stamford  
2 office, just miles away from the ARC office, without  
3 further OHCA approval. Although we are asking that this  
4 CON be denied, we join with Stamford Hospital's request  
5 that, if it is approved, ONS's right to relocate either  
6 of its units outside of Greenwich be limited.

7 This will mean a loss of revenue for ARC  
8 and other providers by approving this CON. Because ONS  
9 treats primarily commercial-insured patients, we assume  
10 that the majority of those scans we will lose from ARC  
11 are insured commercially-insured scans, and that they  
12 reimburse at a far higher rate than governmental payers  
13 do.

14 This will also further skew our payer mix  
15 towards governmental payers, making ARC less viable  
16 financially.

17 Many of the ONS patients for whom we  
18 provide MRI services are longstanding ARC patients. We  
19 have served them and continue to serve these patients,  
20 despite our own capacity constraints.

21 Please remember that our Stamford office  
22 is a full-service radiology center, providing mammography  
23 services and ultrasound services, as well as CAT scan  
24 services to the community.

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1                   Because ARC and the area hospitals are  
2                   serving these patients already, an acquisition by ONS of  
3                   a second unit is unnecessarily duplicative.

4                   With respect to access for vulnerable  
5                   populations, ONS does not provide access for Medicaid  
6                   recipients and treats a minimal number of uninsured or  
7                   self-pay patients.

8                   As conspicuously absent on the ONS  
9                   website, ONS does not participate with the Medicare  
10                  program and has not provided a single MRI scan to a  
11                  Medicaid recipient since its first open scanners eight  
12                  years ago. No Medicaid scans are projected going forward  
13                  in ONS's pro forma.

14                  ONS states that it occasionally provides  
15                  free care to Medicaid beneficiaries in its office. In  
16                  fiscal year 2015, ONS saw 23 Medicaid patients out of  
17                  almost 52,000 patients seen by the practice that year.

18                  Compare that in ARC, where, in Stamford,  
19                  3.9 percent of our MRI payer mix is Medicaid. Practice-  
20                  wide indicate MRI payer mix is more than seven percent.

21                  ONS claims that it provides service call  
22                  and clinical coverage for Medicaid members at Greenwich  
23                  Hospital, however, as stated in the last rebuttal, they  
24                  refer Medicaid patients, who need an MRI, only to the

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1 Greenwich Hospital and not to their office.

2           ARC assumes that ONS does not participate  
3 with Medicaid, due to the lower rates of reimbursement.  
4 They allude to the fact that the Medicaid population of  
5 Fairfield County is low, but in states, like Stamford and  
6 Norwalk, it is growing to double-digit percentages, due  
7 to health care-related reform and Medicaid expansion.

8           The statewide health plan prohibits a  
9 provider from denying access to Medicaid recipients, and  
10 by failing to participate with Medicaid or to self-refer  
11 Medicaid patients for MRI scans, ONS is, de facto,  
12 denying these individuals access.

13           ONS's uninsured self-pay MRI percentages  
14 are less than one percent. They state that they will try  
15 to work with individuals, who cannot pay their bills, but  
16 their minimal historic and projected percentage on  
17 uninsured scans suggests that this does not happen often.

18           Compare that with ARC's Stamford MRI and  
19 the three percent uninsured and self-pay. By the  
20 numbers, ARC Stamford put forth 15 times as many  
21 uninsured self-pay scans as ONS, and ARC MRI overall  
22 provided nearly 57 times as many uninsured and self-pay  
23 scans as ONS.

24           We are proud of our commitment to serve

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1 our individuals, regardless of their ability to pay. To  
2 allow a provider into a market that doesn't accept a full  
3 range of payers and patients is both unfair, injurious to  
4 ARC and to other providers that do.

5 In conclusion, ARC is asking that you deny  
6 ONS's CON request for permission to acquire a second MRI  
7 unit. They have failed to meet statutory decision  
8 criteria and State Health Plan guidelines around  
9 unnecessary duplication of services and access for  
10 Medicaid recipients and indigent persons.

11 Adding more self-referral MRI capacity to  
12 the Stamford market will be a detriment of ARC and to  
13 every other provider in the area committed to providing a  
14 full range of services to all patients, regardless of  
15 their ability to pay.

16 I want to thank you for allowing me to  
17 present. I would like to introduce my colleague, Dr.  
18 Alan Kaye.

19 DR. KAYE: My name is Dr. Alan Kaye.  
20 First, I'd like to thank you very much for the  
21 opportunity to present here, and I'd like to adopt my  
22 pre-filed testimony.

23 HEARING OFFICER HANSTED: Thank you.

24 DR. KAYE: I have been -- I am the former

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1 CEO of Advanced Radiology Consultants since last year,  
2 and I have a long history of leadership in the practice,  
3 where I was the Chairman of the Department of Radiology  
4 at Bridgeport Hospital, the managing member of the LLC,  
5 and have also been involved in organized medicine,  
6 organized radiology, and state radiological issues, as  
7 well as state governmental relations.

8 I am currently the President, I'm sorry,  
9 the Legislative Chair of the Radiological Society of  
10 Connecticut, and I am on the Board of Chancellors of the  
11 American College of Radiology and serve on the Economics  
12 Commission, the Government Relations Commission, the  
13 Future Trends Committee, and the Radiology Integrated  
14 Care Network at the American College of Radiology.

15 My pre-filed testimony was largely devoted  
16 to the issue of self-referral and how that affects  
17 patient care and utilization and cost, and I would like  
18 to summarize that here.

19 What is imaging self-referral? Imaging  
20 self-referral is essentially when a physician in position  
21 to refer patients is also an owner in the equipment and  
22 gains financially from that referral.

23 Study after study has shown, have shown  
24 that this increases the utilization of imaging and

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1 increases the cost of care, without any increase in the  
2 improvement in the quality.

3 Many of the studies cited are early on,  
4 but every time it has been -- early on, meaning in the  
5 1980s and 1990s, but every time it has been duplicated,  
6 with the latest one being 2012 by the General Accounting  
7 Office, which I've shown, and to quote, or to paraphrase  
8 the title of the General Accounting Office report, self-  
9 referral of advanced medical imaging costs the -- raises  
10 utilization and costs Medicare millions of dollars.

11 As a result of that, President Obama in  
12 his 2014 budget asked that the ability, the loophole that  
13 allows in-office imaging by physicians, who own the  
14 equipment and refer patients, to be banned, and that is  
15 that it be closed.

16 The Office of Management and Budget has  
17 put a cost savings on that just for Medicare of \$6  
18 billion, recently revised down to \$5 billion. We can get  
19 into that, if you'd like, as to why.

20 And, remember, that's just for Medicare,  
21 which is, A, only 25 percent of, in general, 25 percent  
22 of MRI volumes, and, B, at approximately one half to one  
23 quarter of the fees, so if you multiply by four, since  
24 it's 25 percent, if you adopted that nationally and

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1 extrapolate that to Connecticut, you will have four times  
2 the \$6 billion or \$5 billion, which would be \$20 billion,  
3 and then multiply that by the commercial general  
4 reimbursement, which is generally two to four times  
5 greater, you can imagine we're close to 75 to \$100  
6 billion of savings if that were adopted nationally and we  
7 could extrapolate that to Connecticut, so it does cost --  
8 every study has shown that it increases utilization and  
9 costs a lot more money.

10 So what has been the policy reaction? I  
11 can go through that. I've gone through that in my pre-  
12 filed testimony. I'm willing to answer further questions  
13 on that, but the general reaction, at least in  
14 Connecticut, has been that the CON laws have been  
15 strengthened rather than attenuated, and, of course, the  
16 Obama budget and the GAO documents are very important in  
17 showing that this is a current contemporary issue and not  
18 a relic of the past.

19 What is the role of the CON process in  
20 this, and how does self-referral affect the CON process?  
21 Well the first thing we always talk about is need, and  
22 what everybody talks about is the volume.

23 First, let me just say that, having served  
24 on the Task Force for the State Health Plan for imaging,

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1 the issue of volume is only one aspect of need. It is a  
2 necessary hurdle to reach, but not necessarily sufficient  
3 to be a criterion that one is entitled to a Certificate  
4 of Need approval.

5 So with respect to volumes, with all of  
6 the data that I've talked about and have submitted and  
7 will submit more if you'd like, the volume of an existing  
8 self-referring provider has to be called into question,  
9 at least as a valid number, or at least as the most cost-  
10 effective way, and I point you to the General Accounting  
11 Office study, as well. So with respect to volume, which  
12 is the big one, I think we have a question there.

13 With respect to quality and access, with  
14 respect to quality, a referral to an outside provider,  
15 who is not necessarily captive to that practice or  
16 dependent upon that practice for a reimbursement for an  
17 interpretation, creates an automatic second opinion, a  
18 virtual second opinion on the condition of that patient.  
19 That's one aspect of quality.

20 The other is that, in every one of our  
21 offices, we have a physician on site, a radiologist on  
22 site when the scans are being done. That's both a safety  
23 issue with respect to problems that might occur, but,  
24 also, it's a situation to be able to triage and modify

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1 the scan criteria or answer technologists' questions  
2 during the course of exam, an important oversight. Part  
3 of what we get paid for is the oversight of the process  
4 and the technologies.

5 If you look at the CPT codes and the list  
6 of the things that we get paid for, imaging providers get  
7 paid for, it includes the oversight of the technologists  
8 and of the equipment and things like that.

9 The next thing is access. Well, as a  
10 full-service provider for imaging, we need to -- and, by  
11 that, I mean not only taking care of patients within our  
12 practice, which we do none of, we take care of patients  
13 from all types of referring practices, whether it be  
14 orthopedists, neurosurgeons, internal medicine,  
15 obstetricians, pediatricians, the whole list.

16 They rely on us to provide state-of-the-  
17 art services, and we need to make sure that we do provide  
18 that and that we don't make patients wait too long.

19 We also need to provide services to the  
20 broad range, the entire range of payer classes. That  
21 includes Medicaid.

22 We do not say we don't accept Medicaid.  
23 We do not say -- we do not discourage Medicaid patients  
24 from coming to us. We take care of all payers, and

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1 access, particularly with the, A, the sharp rise of  
2 Medicare, of Medicaid beneficiaries in the state, and,  
3 particularly, in view of the recent reductions in  
4 Medicaid reimbursement that occurred in 2015, we need to  
5 make sure that we provide services to them, but, also,  
6 provide services to all payers, so that we cannot go out  
7 of business, which, if we only did Medicaid, we would, or  
8 if our Medicaid percentage went up, that's what would  
9 happen to us.

10 In addition, not only do we accept  
11 Medicaid, we have relationships with the clinics,  
12 federally qualified clinics, and they refer, as well, so  
13 we provide access to all payers.

14 So I think the last point has to do with  
15 competition, and we need to be competitive. Because we  
16 rely on referring physicians for referrals and not  
17 internally, we need to provide the best service.

18 That is a competitive situation, and to  
19 the extent that ONS and other vertically-integrated  
20 providers create their own volume, much like the trusts  
21 for the railroad in the old oil and railroad days and  
22 much like the Microsoft antitrust litigation, we need --  
23 we are disadvantaged by vertically integrated, and we  
24 will additionally be disadvantaged the effect on existing

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1 providers, component of CON, we will be at a further  
2 disadvantage if we lose referrals from community  
3 physicians, like ONS and others.

4 I want to thank you very much for the  
5 opportunity to do this, to present this, and I ask you to  
6 deny ONS's application, and that concludes my comments.

7 HEARING OFFICER HANSTED: Thank you,  
8 Doctor. Attorney Fusco, do you have anyone else?

9 MS. GROVES FUSCO: No, not for this  
10 proceeding.

11 HEARING OFFICER HANSTED: Can I ask you to  
12 -- we're going to have to do a little bit of musical  
13 tables here today. Can I ask you to vacate that table,  
14 so Attorney Cowherd and his witnesses can come up?

15 MS. CARDIELLO: Good morning.

16 HEARING OFFICER HANSTED: Good morning.

17 MS. CARDIELLO: Thank you for the  
18 opportunity to address the Office of Health Care Access  
19 in the CON application of Orthopaedic & Neurosurgery  
20 Specialists, P.C. to acquire a second MRI scanner.

21 My name is Ruth Cardiello. I am the Vice  
22 President of Enterprise Risk Management for Stamford  
23 Hospital, and I also hereby adopt my pre-filed testimony.

24 Stamford's position is that this

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1 application does not promote the long-term viability of  
2 the health care system in lower Fairfield County. As  
3 outlined in my pre-trial testimony, there is an abundance  
4 of established high-quality MRI providers. This is about  
5 fairness in providing services to Medicaid and uninsured  
6 patients.

7                   Stamford Hospital is one of the largest  
8 providers of charity care and other uncompensated care in  
9 the state. If the application is approved and ONS  
10 follows through on its ability to relocate, it will add  
11 unnecessary capacity and raise the risk of diluting the  
12 pool of commercially-insured and Medicare populations  
13 that the established providers are able to serve.

14                   The Stamford, Darien and Rowayton market  
15 does not need another MRI provider, who does not increase  
16 access to health care for the underserved populations in  
17 the region in any meaningful way.

18                   For these reasons and those outlined in my  
19 pre-filed testimony, Stamford Hospital respectfully urges  
20 OHCA, if it decides to approve the application of ONS, to  
21 impose as a condition that ONS may not relocate either of  
22 its MRIs to the Stamford Hospital service area of  
23 Stamford, Darien and Rowayton.

24                   Thank you, and I'm happy to answer any

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1 questions you may have.

2 HEARING OFFICER HANSTED: Thank you.  
3 Attorney Cowherd, do you have anything else at this  
4 point?

5 MR. COWHERD: Nothing further.

6 HEARING OFFICER HANSTED: Okay. Attorney  
7 Volpe, as long as they're up at this table, do you have  
8 any Cross-Examination?

9 MS. VOLPE: No, I don't.

10 HEARING OFFICER HANSTED: Okay, thank you.  
11 You're welcome to return to your seat, and, Attorney  
12 Fusco, if you want to bring your folks back up? We don't  
13 have any questions for you.

14 MR. COWHERD: Can I ask, respectfully?  
15 Counsel will stay until the end of the hearing, but if  
16 there are OHCA questions for Ms. Cardiello, is there a  
17 way that she might be able to answer those questions now  
18 rather than stay until OHCA's question?

19 HEARING OFFICER HANSTED: OHCA does not  
20 have any questions for your witness. Is there any  
21 objection from any of the other counsel to her leaving?

22 MS. VOLPE: None from us.

23 HEARING OFFICER HANSTED: Okay. Counsel,  
24 your witness is released.

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1 MR. COWHERD: Thank you.

2 HEARING OFFICER HANSTED: You're welcome.  
3 Attorney Volpe, if you want to proceed with Cross-  
4 Examining a witness, you may do so.

5 MS. VOLPE: Yes. We're going to have an  
6 opportunity to make a presentation after ARC makes theirs  
7 on their application, so we're going to allow our time  
8 for that, and then we have an opportunity to Cross them  
9 on their application, so we don't have any questions for  
10 them as an Intervenor in our application.

11 HEARING OFFICER HANSTED: Okay.

12 MS. GROVES FUSCO: You'll do your Cross in  
13 ours?

14 MS. VOLPE: Correct.

15 MS. GROVES FUSCO: Okay, because we'll do  
16 the same. We'll do most of ours in this one.

17 MS. VOLPE: Correct.

18 MS. GROVES FUSCO: Would it just make it  
19 easier? Okay.

20 MS. VOLPE: Yeah. I think that is what's  
21 scheduled for D for you.

22 HEARING OFFICER HANSTED: Okay, so, you're  
23 all set, Attorney Volpe. Attorney Fusco, do you have  
24 Cross for the Applicant?

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1 MS. GROVES FUSCO: I do.

2 HEARING OFFICER HANSTED: Okay. You may  
3 proceed.

4 MS. VOLPE: And, Hearing Officer Hansted,  
5 in terms of procedurally, when they ask Cross, in terms  
6 of our opportunity to Redirect --

7 HEARING OFFICER HANSTED: I would do it at  
8 this point.

9 MS. VOLPE: Okay.

10 HEARING OFFICER HANSTED: When they're  
11 done with their Cross, otherwise, it's going to get too  
12 confusing.

13 MS. VOLPE: Yes. Agree. I just wanted to  
14 confirm.

15 HEARING OFFICER HANSTED: Okay. Just make  
16 sure you speak into the microphone, so she picks you up.

17 MS. VOLPE: Yes. Attorney Fusco had the  
18 professional courtesy to state that she's going to direct  
19 her Cross to Dr. Camel, but if we have other witnesses  
20 that are better or more appropriate to answer, and we  
21 may. We have Dr. Sullivan, who is a radiologist, here  
22 with us today, and we'd like to take Attorney Fusco up on  
23 that, to the extent that they're technical --

24 HEARING OFFICER HANSTED: That's fine. I

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1 think that works best. Also, if you could just let me  
2 know if you present any witnesses that have not been  
3 sworn in? Just let me know, so they could be sworn in  
4 before they testify.

5 MS. VOLPE: Sure. They both have been  
6 sworn in.

7 HEARING OFFICER HANSTED: Okay. You may  
8 proceed, Attorney Fusco.

9 MS. GROVES FUSCO: And we'll certainly do  
10 the same on Cross. We'll make all of our employees  
11 available to you, too.

12 Good morning, Dr. Camel.

13 DR. CAMEL: Good morning.

14 MS. GROVES FUSCO: I would like to start.  
15 I'm going to jump around a little bit, because there are  
16 so many filings in this matter.

17 MS. VOLPE: I'm just going to have him get  
18 it in front of him, in case you're going to reference  
19 pages.

20 MS. GROVES FUSCO: Okay, Dr. Camel. I  
21 would like to start with the rebuttal testimony, dated  
22 August 29th, which was admitted yesterday. Do you have  
23 that?

24 MS. VOLPE: Yes.

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1 MS. GROVES FUSCO: In your rebuttal  
2 testimony --

3 MS. VOLPE: Can you just let him get  
4 there?

5 MS. GROVES FUSCO: Sure. Absolutely.

6 MS. VOLPE: Okay.

7 MS. GROVES FUSCO: In your rebuttal  
8 testimony on pages five and six, I believe are where the  
9 references are --

10 HEARING OFFICER HANSTED: Can you come up  
11 to a microphone, please?

12 MR. PATRICK MONAHAN: I don't mean to  
13 interfere. Pat Monahan, counsel for WESTMED, an  
14 Intervenor in this proceeding.

15 If I might just kindly, because there's a  
16 little trouble hearing in the back, ask you to both pull  
17 your microphones as close as you can?

18 MS. VOLPE: Sure.

19 MR. MONAHAN: Thank you very much.

20 MS. VOLPE: Is that what we entered into  
21 your file? Correct?

22 MS. GROVES FUSCO: No. It's a rebuttal.  
23 It's a rebuttal in your -- it was the rebuttal to my  
24 response, and you filed it yesterday. It should be in

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1 your docket. It's dated August 29th. It says rebuttal  
2 of Orthopaedic & Neurosurgery Specialists in response to  
3 testimony of Advanced Radiology.

4 MS. VOLPE: Okay. I think we have it.  
5 Thank you. What page were you referencing?

6 MS. GROVES FUSCO: Pages five and six.  
7 So, Dr. Camel, on pages five and six of the rebuttal  
8 testimony submitted yesterday, you state several times,  
9 actually, that ONS does not refer patients to ARC, due to  
10 inferior scan quality, and, on page six, you say, as  
11 stated above, ONS does not refer scans to ARC, correct?

12 DR. CAMEL: ONS does not directly refer  
13 scans to ARC. Patients from ONS go to ARC to get their  
14 scans, either by their choice or because of a narrow  
15 network. For example, in certain workmen's comp  
16 networks, ONS patients have to go to ARC, based on their  
17 insurance. That's correct.

18 MS. GROVES FUSCO: Okay.

19 DR. CAMEL: But my statement, as I said  
20 it, stands otherwise.

21 MS. GROVES FUSCO: Okay, but you do order  
22 the scans for your patients? You write the prescription  
23 for the scan, correct?

24 DR. CAMEL: Correct.

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1 MS. GROVES FUSCO: And then the patient  
2 gets that order filled at Advanced Radiology's office,  
3 correct?

4 DR. CAMEL: But that's different than  
5 saying I referred the patient or we referred the patient.

6 MS. GROVES FUSCO: Okay, well, I have some  
7 more questions. I mean, in our opinion, a referral is an  
8 order that is completed, and then images and results are  
9 sent back to you to use. That's what I mean a referral  
10 to be.

11 I'm not asking if you recommend one  
12 provider over another. I'm asking do you make a  
13 referral? Do you order a scan, for an MRI scan, which is  
14 then filled at my client's practice, and then you get  
15 those results?

16 MS. VOLPE: Just a point of clarification.  
17 You're using referral and order interchangeably, and I  
18 think that's what Dr. Camel is trying to clarify.

19 MS. GROVES FUSCO: Okay, yeah.  
20 Understood. I'm not asking whether you recommend  
21 Advanced Radiology over another provider. I'm just  
22 asking do you order MRI scans for your patients that are  
23 completed at Advanced Radiology and then receive the  
24 results of those scans?

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1 DR. CAMEL: Yes.

2 MS. GROVES FUSCO: Okay and, in fact, our  
3 records indicate that, in 2012, 64 of those orders were  
4 completed at ARC. In 2013, 80 of those orders were  
5 completed at ARC. In 2014, 64 were completed at ARC. In  
6 2015, 79 were completed at ARC. And, in 2016, year-to-  
7 date, 79 have been completed at ARC. Do you have any  
8 reason to doubt that those numbers are accurate?

9 DR. CAMEL: I have no information either  
10 way.

11 MS. GROVES FUSCO: Okay, so, you don't  
12 keep track of where your patients go for their scans,  
13 other than getting the report back and putting it in  
14 their patient file?

15 DR. CAMEL: We have no method of tracking.

16 MS. GROVES FUSCO: Okay.

17 DR. CAMEL: Once we recommend a patient to  
18 have an MRI scan, there's no tracking method to know how  
19 many were done at which place, other than our own, of  
20 course.

21 MS. GROVES FUSCO: But would you agree  
22 that a radiology practice that relies on outside  
23 referrals, such as my client, might have a system to  
24 track those, so they can be aware of who their referral

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1 sources are and make sure they're providing quality care  
2 to those referring physicians?

3 DR. CAMEL: I have no way of knowing if  
4 Advanced Radiology has a system, but I would presume, as  
5 the basis of a sound business practice, they would want  
6 to know that.

7 MS. GROVES FUSCO: Okay. If you say you  
8 don't refer, and maybe we'll use the word recommend  
9 instead of refer, if you say you don't recommend  
10 patients, based upon poor image quality at ARC, how is it  
11 that you've allowed for the last four years several  
12 hundred patients to get scans there, without ever raising  
13 those quality issues with Advanced Radiology?

14 DR. CAMEL: Well, actually, we have,  
15 actually, and one of the questions, and I don't know what  
16 we referred to Advanced Radiology before those dates,  
17 because I don't even know about the dates you speak of,  
18 but we do have.

19 It's not only the quality of the images,  
20 but it's the access to the images, and, so, as I said in  
21 my earlier testimony, we are very selective about where  
22 we can be and where we mostly are selective about who  
23 does our imaging in a way that's done in the way that  
24 provides us with the information that we need.

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1                   And one of our issues is, and I can only  
2                   speak to the spine imaging, because I'm the neurosurgeon,  
3                   I can't speak to orthopedic imaging in general, which is  
4                   the bulk of our imaging, but, in spine imaging, we do  
5                   more sequences, and we do continuous actual imaging, both  
6                   in T-1 and T-2, and, traditionally, while ARC does that  
7                   sometimes, it doesn't routinely do that, so that's an  
8                   issue for us, in terms of planning our surgery.

9                   The second issue is access to the scan,  
10                  notwithstanding the quality, so, as surgeons, we require  
11                  of each other, all of us, that, when we're operating, no  
12                  matter where we're operating, those images are available.

13                  And the issue is that, in the past and  
14                  currently, from time-to-time, we have a difficulty  
15                  accessing images from ARC. Even when the patient in the  
16                  exam room gives us their access information to try and  
17                  access those images, we're not able to see them, and, so,  
18                  we ask those patients to go back to ARC to bring us a CD.

19                  But, secondly, when we operate at  
20                  Greenwich Hospital, there is no mechanism for, excuse the  
21                  expression, pulling up those images on the computer in  
22                  the operating room. We need those and won't operate  
23                  without them, so, for both of those reasons, both access  
24                  and quality, we refer elsewhere.

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1 MS. GROVES FUSCO: Okay, so, a couple of  
2 things. I mean you raised the issue of the image sharing  
3 network having issues, and, in our response, we said that  
4 we were aware that there were some downtimes, some  
5 retrieval issues back in 2015. You're saying those are  
6 still current issues?

7 DR. CAMEL: Well it's not so much an issue  
8 for me, as I sit here right now, because I really have  
9 very few patients, who go there, and, when I go, when a  
10 patient goes there, before they come back, we ask them to  
11 go to the office, it's usually in Stamford, but sometimes  
12 it's in, I think, your Fairfield or Bridgeport office,  
13 and retrieve a CD, so we can upload the images into our  
14 system, so we take care of the access issue.

15 MS. GROVES FUSCO: Understood, but you're  
16 not personally aware of any current?

17 DR. CAMEL: No, I'm personally aware,  
18 based on my partner saying the same thing.

19 MS. GROVES FUSCO: And you continue to  
20 allow, whether you recommend or not, you continue to  
21 allow your patients, if that's what they want to do, to  
22 have their scans done at Advanced Radiology?

23 DR. CAMEL: That's an incorrect  
24 characterization, to say we allow it. We don't have any

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1 control over it.

2 MS. GROVES FUSCO: Okay, well, understood.

3 MS. VOLPE: Can she let the witness answer  
4 the question?

5 DR. CAMEL: So, as I said before, the  
6 patients that I'm aware of that go to ARC in Stamford of  
7 mine, which I am very comfortable saying this, go,  
8 because of a narrow insurance network usually related to  
9 Workmen's Comp, so I have no ability to control or allow.  
10 That implies I have volitional control using the word  
11 allow. That's incorrect.

12 I don't allow it. The patients need their  
13 scans. It's the only place they can go, because of their  
14 insurance.

15 MS. GROVES FUSCO: Do you advise those  
16 scans, those patients that they're going to be getting  
17 inferior scan quality that might impact their treatment?

18 DR. CAMEL: I have no -- first of all, I  
19 don't speak badly when the patients come back directly to  
20 patients. That's number one.

21 Number two is I write an order on a  
22 Workmen's Comp patient for an MRI scan. This is how it  
23 works in real life. That patient then gets that MRI  
24 approved by Workmen's Comp, and Workmen's Comp refers

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1 them to Advanced Radiology, not me. I neither allow, nor  
2 do I participate in that decision.

3 MS. GROVES FUSCO: Okay, so, even though  
4 you believe that you might be getting images that are not  
5 diagnostically sufficient, you will allow them to go  
6 there, based upon their interest? Is there no -- let me  
7 finish asking my question, Michele, please.

8 Are there no other providers in the  
9 service area, outside the service area, further in  
10 Fairfield County, you're telling me that there are  
11 situations, where ARC is the only provider that can  
12 provide the imaging to patients?

13 DR. CAMEL: For those patients --

14 MS. GROVES FUSCO: The only one. None of  
15 the hospitals?

16 DR. CAMEL: Okay. I'll answer it this  
17 way. One is I don't know what the Workmen's Comp  
18 carrier's network actually is. It's probably because  
19 that may be that you may be the closest one, since our  
20 patients, as you know, are focused in the  
21 Greenwich/Stamford area and the New Canaan/Norwalk area,  
22 which is our service area, so it may be the most  
23 convenient for the patient, and it may be the most  
24 convenient for the one that's allowed in that narrow

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1 network.

2 MS. GROVES FUSCO: And you're saying that  
3 -- so you think the majority of these patients that  
4 continue to go to ARC, the 80 a year that go to ARC, are  
5 Worker's Comp patients?

6 MS. VOLPE: No.

7 DR. CAMEL: I have no way of knowing that.

8 MS. GROVES FUSCO: Okay, so, it can be for  
9 more than reasons of Worker's Comp limiting a place where  
10 they can get their scans?

11 DR. CAMEL: But it's a patient choice  
12 issue.

13 MS. GROVES FUSCO: Understood.

14 DR. CAMEL: Because, unlike certain  
15 networks, our patients choose where they go, just like  
16 they choose to come to us, so patients have a choice to  
17 go to ARC, and they may choose to do so themselves.

18 We don't sit and direct patients in the  
19 way that you're suggesting, like we sent them to ARC, or  
20 we send them to some other institution.

21 As I said in my testimony, patients  
22 choose, based on geography, and the geography is related  
23 to residence and related to work, related to hours and  
24 other ways of I guess other service, perhaps.

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1                   It may be related to cost. Those are all  
2 reasons why patients choose a provider.

3                   MS. GROVES FUSCO: I do understand that.

4                   DR. CAMEL: And, in fact, it's a very  
5 small number of patients percentage-wise, so even  
6 stipulating to your number of 90 it's a small percentage  
7 number, and it represents --

8                   MS. GROVES FUSCO: Understood.

9                   DR. CAMEL: -- only a percent --

10                  MS. GROVES FUSCO: Dr. Camel, you're going  
11 beyond answering my question.

12                  DR. CAMEL: Okay.

13                  MS. GROVES FUSCO: What I just want you to  
14 tell me is that there are instances in which you've  
15 raised concerns with this agency about the quality of MRI  
16 images that my client provides.

17                  You're saying that those images are not  
18 sufficient to be used during complicated surgeries, yet  
19 you let your patients, you let them do it. Whether they  
20 have to go there are not, that is the image they're  
21 giving you to use during surgery.

22                  DR. CAMEL: Well that brings up -- that's  
23 a great question. Here's why it's a great question.

24                  MS. GROVES FUSCO: It's really a yes/no

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1 question. I'm not here to give you more opportunity.

2 DR. CAMEL: Well it's not, because you  
3 said a couple of different things in that lengthy  
4 question.

5 You said we let them go, despite knowing  
6 that it's going to be an inferior image. In fact, when  
7 we receive an image back that's not sufficient, we write  
8 a second referral for an MRI, and we call Workmen's Comp  
9 and have it done on another machine, and we will not  
10 operate, based on an inferior image.

11 Now sometimes, as you know, or you may  
12 know, or the radiologists know, that there are images  
13 that are good enough and there are images that are  
14 outstanding, and sometimes good enough images are okay,  
15 and sometimes those images are okay and, many times,  
16 they're not, but they don't represent the highest quality  
17 that are done routinely in the area.

18 MS. GROVES FUSCO: Do you agree that a 3  
19 Tesla unit improves the quality of an image, generally  
20 speaking, over a 1.5?

21 DR. CAMEL: No.

22 MS. GROVES FUSCO: You don't think that a  
23 3.5 Tesla provides better definition and image quality  
24 than a 1.5 Tesla?

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1 DR. CAMEL: It can in certain  
2 circumstances.

3 MS. GROVES FUSCO: It can.

4 DR. CAMEL: But, in bone and joint  
5 imaging, and maybe Dr. Sullivan wants to comment on that,  
6 it hasn't been shown to provide better quality.

7 In fact, the comment from the bone and  
8 joint people and my orthopedic colleagues is that, often  
9 times, they prefer a 1.5 Tesla machine.

10 MS. GROVES FUSCO: What about with respect  
11 to neurological exams, to brain exams, to vascular exams,  
12 those things?

13 DR. CAMEL: Okay, so, for certain kinds of  
14 imaging, like diffusion tensor imaging, I think you need  
15 a 3 Tesla machine, so it's not possible to do it on a  
16 1.5.

17 I'd like to ask Dr. Sullivan to comment,  
18 please.

19 DR. SULLIVAN: My comment would simply be  
20 that it's a complicated issue. You need to have an  
21 experienced technologist and patients, who cooperate,  
22 but, ideally, 3 Tesla imaging can do more robust imaging  
23 than a 1.5.

24 MS. GROVES FUSCO: Okay, thank you. Have

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1 you ever communicated any of your concerns about quality  
2 directly to any radiologist at Advanced Radiology?

3 DR. CAMEL: Yes. I've called, but I can't  
4 speak of a specific instance, again, because --

5 MS. GROVES FUSCO: Okay, you can't say who  
6 or when?

7 DR. CAMEL: No.

8 MS. GROVES FUSCO: But you've spoken to  
9 radiologists there about it?

10 DR. CAMEL: Sure.

11 MS. GROVES FUSCO: Have you ever asked ARC  
12 whether they can work a certain protocol if the protocols  
13 they're doing don't fit your needs during surgery, like  
14 the ones that you do?

15 DR. CAMEL: Yes. Early on, we ask if they  
16 can do continuous actual imaging.

17 MS. GROVES FUSCO: And who did you ask?

18 DR. CAMEL: It was years ago.

19 MS. GROVES FUSCO: Again, you can't  
20 remember?

21 DR. CAMEL: No, I can't.

22 MS. GROVES FUSCO: You can't provide me  
23 any specifics. With respect to your ability to pull up  
24 images in the hospital setting when you're operating, is

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1 it -- have you asked the hospital to help facilitate  
2 access, because, as you know, sometimes it's the hospital  
3 systems that block access, although legally now they're  
4 not supposed to, so have you asked the hospital to try to  
5 coordinate access for ARC images?

6 DR. CAMEL: I have not personally asked  
7 the hospital.

8 MS. GROVES FUSCO: In terms of sort of  
9 image quality issues, you're aware that Advanced  
10 Radiology operates the exact same MRI unit that you do,  
11 right, the 1.5 Tesla?

12 DR. CAMEL: Yes, I am.

13 MS. GROVES FUSCO: And, in fact, when you  
14 got your CON approval in 2008, the one you claim that ARC  
15 tried to obstruct, you asked if you could come to their  
16 office and see that unit, correct, before you purchased  
17 yours?

18 DR. CAMEL: I actually don't remember  
19 that, no.

20 MS. GROVES FUSCO: Okay. Someone else in  
21 your office was involved in that?

22 DR. CAMEL: That may be.

23 MS. GROVES FUSCO: Someone from ONS came  
24 to Advanced Radiology's office to see the unit, and are

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1 you aware that they asked for and were given protocols  
2 for that unit for you to use on your own unit?

3 DR. CAMEL: No. I don't know who went. I  
4 know that Dr. Sullivan and Dr. Desai have designed the  
5 protocols at ONS.

6 MS. GROVES FUSCO: Okay, well, I can -- so  
7 you can't confirm, but I can tell you that someone from  
8 your office did come over to look at the unit and ask for  
9 those.

10 Moving on to some questions about patient  
11 access, I want to move on to some patient access issues.  
12 To confirm, and I think this has been confirmed in the  
13 CON application, but ONS does not participate with the  
14 Medicaid program for either physician services or MRI,  
15 correct?

16 DR. CAMEL: No. Correct.

17 MS. GROVES FUSCO: In your testimony, I  
18 think it's in the rebuttal testimony at page 11 -- maybe  
19 I have that wrong, because there is no page 11. Maybe it  
20 was your actual testimony on page 11. Oh, I'm sorry.  
21 It's in the rebuttal at page one. I can't even read my  
22 own notes.

23 In the rebuttal testimony at page one, you  
24 cite some of the CON decision criteria, the statutes that

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1 include those decision criteria, and one of those  
2 statutes that you cite is 19a-639(5), which basically  
3 requires OHCA to consider how a CON proposal will improve  
4 the quality, accessibility and cost effectiveness of  
5 health care, including access to services for Medicaid  
6 recipients, correct?

7 DR. CAMEL: Yes.

8 MS. GROVES FUSCO: Okay and what the  
9 statute actually says is that OHCA needs to determine  
10 whether the Applicant has satisfactorily demonstrated how  
11 the proposal will improve the quality, accessibility and  
12 cost effectiveness of health care delivery, including  
13 access to services for Medicaid and indigent persons,  
14 correct?

15 DR. CAMEL: Correct.

16 MS. GROVES FUSCO: Okay. The CON proposal  
17 that you have before OHCA right now is a proposal to  
18 acquire an MRI unit, correct?

19 DR. CAMEL: It is.

20 MS. GROVES FUSCO: And it's a proposal for  
21 nothing more than to acquire an MRI unit to provide MRI  
22 services. Okay.

23 Is it fair to say that you have not  
24 provided a single MRI scan to a Medicaid patient on the

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1       ONS scanner either through the Medicaid program or for  
2       free since 2008?

3                     DR. CAMEL:   It's correct, but not fair.

4                     MS. GROVES FUSCO:   Pardon?

5                     DR. CAMEL:   It's correct, but not fair.

6                     MS. GROVES FUSCO:   Okay, well, all I need  
7       to know is if it's correct.  You have not provided a  
8       single MRI scan on your scanner to a Medicaid patient.  
9       Okay and you aren't projecting any Medicaid scans going  
10      forward on your scanner?

11                    DR. CAMEL:   Not unless the health care  
12      delivery system at Greenwich changes, that's right.

13                    MS. GROVES FUSCO:   Okay, but you've  
14      predicted in your payer mix projections you're projecting  
15      zero Medicaid scans?

16                    DR. CAMEL:   I'm not making a prediction  
17      about whether or not Greenwich Hospital will no longer  
18      provide it, so we will do it directly.

19                    MS. GROVES FUSCO:   Okay.  You claim in  
20      your rebuttal testimony, and I think it's at page three,  
21      that, when you see Medicaid patients, and correct me if  
22      I'm wrong, but the number of Medicaid patients --

23                    DR. CAMEL:   Is this it?  I'm just trying  
24      to get the right thing.

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1 MS. GROVES FUSCO: Yeah, it's the same  
2 document we've been looking at, the rebuttal from  
3 yesterday.

4 DR. CAMEL: Okay. Sorry.

5 MS. GROVES FUSCO: That's okay. So you  
6 claim in your rebuttal at page three that, when you see  
7 Medicaid patients for physician services -- and just so I  
8 can confirm, last year, in terms of Medicaid patients,  
9 who you provided physician services for, where you wrote  
10 off their care, with Medicaid as their primary insurance,  
11 that was 23 patients, correct?

12 MS. VOLPE: That's in your office, but not  
13 in the clinic.

14 MS. GROVES FUSCO: In the office. ONS  
15 physician services in the office.

16 DR. CAMEL: But that misstates --

17 MS. GROVES FUSCO: But does it --

18 DR. CAMEL: It misrepresents the facts.

19 MS. GROVES FUSCO: It's Cross-Examination.  
20 You have to answer my question. It was a number that was  
21 put in your document. Is it correct that you provided --  
22 that physician office services in your office you treated  
23 23 Medicaid patients out of the 51,500 patient visits you  
24 had that year or patients you had that year?

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1 DR. CAMEL: Yes.

2 MS. GROVES FUSCO: Okay, probably more  
3 visits than patients. Okay. And, so, you claim in your  
4 rebuttal that you see Medicaid patients for physician  
5 services, who may have previously received an MRI at  
6 Greenwich Hospital, correct?

7 DR. CAMEL: Yes.

8 MS. GROVES FUSCO: Okay. If Greenwich  
9 Hospital -- I assume, if Greenwich Hospital provides the  
10 MRI service, they get reimbursed by Medicaid, correct?

11 DR. CAMEL: I'm not aware of how they're  
12 reimbursed.

13 MS. GROVES FUSCO: Okay, but, certainly,  
14 if Greenwich Hospital is providing the MRI, you don't  
15 have to write off any costs associated with that MRI,  
16 because you didn't provide it, correct?

17 DR. CAMEL: I don't understand the  
18 question.

19 MS. GROVES FUSCO: The question is you're  
20 not providing -- when an MRI is done by Greenwich  
21 Hospital before that patient gets to you, you didn't have  
22 to provide MRI services to them and then write the cost  
23 off. Someone else did it for you.

24 DR. CAMEL: The MRIs that are done

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1 elsewhere across the entire United States we don't write  
2 off the cost, so why does it matter whether Greenwich  
3 Hospital --

4 MS. GROVES FUSCO: It doesn't matter why  
5 it matters.

6 DR. CAMEL: -- in Boston.

7 MS. GROVES FUSCO: It doesn't matter why  
8 it matters. I'm asking the question. You don't incur  
9 any costs in association with an MRI provided by  
10 Greenwich Hospital before that Medicaid patient gets to  
11 you?

12 DR. CAMEL: So those are the patients that  
13 we -- those are those Medicaid patients that we see for  
14 free for Greenwich Hospital to which you're referring  
15 that haven't already had an MRI?

16 MS. GROVES FUSCO: I'm asking about costs  
17 specifically related to an MRI.

18 DR. CAMEL: Of course not. I mean that's  
19 a silly question.

20 MS. GROVES FUSCO: Okay, well, I  
21 apologize. If those individuals were scanned at ONS, you  
22 would either have to, I mean, if you participated in  
23 Medicaid, you could be reimbursed from Medicaid, but if  
24 they were scanned at ONS, you would have to write off the

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1 cost of the scan, right?

2 DR. CAMEL: Well, before a patient gets  
3 scanned at ONS, they have to be referred to ONS, and  
4 patients can't be referred to ONS before they have a  
5 diagnosis.

6 Imaging, radiology, is what often gives  
7 the primary care physician in the clinic or the emergency  
8 room the diagnosis and provides the reason for the  
9 referral in the first place. We also --

10 MS. GROVES FUSCO: But you diagnose plenty  
11 of patients and then refer them for the scans afterwards.

12 DR. CAMEL: The clinic service and the  
13 emergency room doesn't do that. They don't diagnose  
14 things without imaging and then refer them. That's  
15 incorrect.

16 MS. GROVES FUSCO: Okay, but you're  
17 suggesting that's how it always works. One of these  
18 patients could have presented at your office for services  
19 versus the emergency room or a primary care clinic.

20 They could have presented at your office  
21 services if you were a Medicaid provider. You could have  
22 evaluated and diagnosed and referred them to your own  
23 scanner, correct?

24 DR. CAMEL: Yes.

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1 MS. GROVES FUSCO: Okay. That's all I  
2 needed to know. You say you intend to site the new unit  
3 in Greenwich where the existing unit is, correct?

4 DR. CAMEL: Yes.

5 MS. GROVES FUSCO: One of the reasons why  
6 -- is one of the reasons why you don't take Medicaid,  
7 from what your counsel has said in submissions, because  
8 you don't believe the Medicaid population in Greenwich is  
9 substantial?

10 DR. CAMEL: No.

11 MS. GROVES FUSCO: That's not why you  
12 don't take Medicaid?

13 MS. VOLPE: He answered the question.

14 MS. GROVES FUSCO: Okay.

15 DR. CAMEL: That is correct. My answer is  
16 as it stands.

17 MS. GROVES FUSCO: If you have no  
18 intention of moving the Greenwich MRI unit out of  
19 Greenwich, why are you fighting the request by Stamford  
20 Hospital to have a limiting condition in your CON,  
21 telling you you need to keep it exactly where you say you  
22 --

23 DR. CAMEL: That's actually a great  
24 question. I can't really anticipate the future of health

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1 care. Maybe everybody else in the room can, but I think  
2 putting a limitation on it arbitrarily for reasons that  
3 Stamford Hospital may be worried about, it seems, given  
4 the fact that all of these scanners are full anyway, I  
5 don't know how putting another, even if we were going to  
6 do that, why it matters, but we have no intention of  
7 doing that, but you're asking a question that says I  
8 should agree, without objection, to forever a limitation  
9 going forward, no matter what happens in the health care  
10 system, no matter how health care becomes provided in the  
11 future, and I'm just not smart enough to make that  
12 prediction and agree, without objection, to Stamford  
13 Hospital's request to OHCA.

14 MS. GROVES FUSCO: Do you participate with  
15 any of the Connecticut Health Exchange plans?

16 DR. CAMEL: We do, actually. We do  
17 ConnectiCare. You can check. ConnectiCare and it's  
18 either Aetna or Anthem.

19 MS. GROVES FUSCO: We looked at your  
20 website, and we couldn't find any reference to you taking  
21 those Health Exchange patients.

22 DR. CAMEL: Well I can very clearly tell  
23 you, since I was the one who negotiated those contracts,  
24 that we do, and we have a separate rate schedule I know

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1 for ConnectiCare exchange, as opposed to their  
2 ConnectiCare commercial that we agreed to participate in  
3 both.

4 We're currently in negotiations with  
5 Deremius Williams, who is the Vice President for  
6 Contracting for Aetna, excuse me, for Anthem to do the  
7 same.

8 MS. GROVES FUSCO: Well it isn't  
9 advertised on your website.

10 DR. CAMEL: It's not done yet.

11 MS. GROVES FUSCO: Okay, but might that  
12 limit people, who have those plans, who are looking for  
13 providers, might look at your website and pass you over?

14 DR. CAMEL: Well we can change the  
15 website. That's easy.

16 MS. GROVES FUSCO: Okay, well, maybe you  
17 should, because I know that there are plenty of --

18 MS. VOLPE: Okay. I think he's answered  
19 the question.

20 HEARING OFFICER HANSTED: Counsel? I  
21 would remind everyone it's Cross-Examination. Let's not  
22 get argumentative, either counsel or the witness. Let's  
23 just get to these questions.

24 MS. GROVES FUSCO: Okay. In your hearing

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1 submission, so going back to your actual testimony here,  
2 the initial testimony, not the rebuttal --

3 MS. VOLPE: Pre-filed testimony?

4 MS. GROVES FUSCO: Yes, dated August 23rd.  
5 I think it's page 31. It's attachment D.

6 MS. VOLPE: Almost there.

7 MS. GROVES FUSCO: That's it. So in your  
8 hearing submissions on page 31, it shows that  
9 approximately 78 percent of the scans that you refer are  
10 done internally, correct? So, if I'm reading this  
11 correctly, you refer or order, let's use the word order,  
12 you order 6,769 scans, and, of those, 5,262 are done on  
13 the ONS scanner? Am I reading that correctly?

14 DR. CAMEL: Right. I think those are the  
15 '15 numbers.

16 MS. GROVES FUSCO: Yeah, I think those are  
17 the 2015 numbers. Okay, so, this means that you referred  
18 out, for lack of a better word, 1,507 scans, so 1,507 of  
19 the scans that you ordered could not be performed at ONS  
20 or were not performed?

21 DR. CAMEL: For our Connecticut patients,  
22 that's right.

23 MS. GROVES FUSCO: Okay. This is specific  
24 to Connecticut patients?

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1 DR. CAMEL: To our service area.

2 MS. GROVES FUSCO: Okay, so, is this the  
3 total practice, or is this just the service area?

4 DR. CAMEL: It's the total. It's the  
5 total. I'm sorry.

6 MS. GROVES FUSCO: Okay, so, that would  
7 include patients from both states, okay.

8 DR. CAMEL: Yeah.

9 MS. GROVES FUSCO: You state, at several  
10 points in your pre-file, and I won't necessary bring us  
11 to the pages, but that, you know, one of ONS's goals is  
12 to increase MRI capacity, so that you can give all of  
13 your patients the opportunity to be scanned on your  
14 scanner, if that's what they choose, correct?

15 DR. CAMEL: Yes.

16 MS. GROVES FUSCO: So, arguably, you would  
17 want to scan any patient, except ones for which your  
18 scanner is clinically contraindicated, or who want to get  
19 their scan in New York, because they live there, or, you  
20 know, somewhere else, because they work somewhere else,  
21 correct? Everyone else you would like to do --

22 DR. CAMEL: Or for insurance reasons, as  
23 you pointed out.

24 MS. GROVES FUSCO: For insurance reasons,

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1 okay. Approximately, how many patients each year fit  
2 into that category? How many scans a year do you say,  
3 would you say have to go out for those various reasons?

4 DR. CAMEL: You know, it's hard to know.

5 MS. GROVES FUSCO: Okay.

6 DR. CAMEL: We have no way of keeping that  
7 data.

8 MS. GROVES FUSCO: Is it all 1,500 scans  
9 you referred out?

10 DR. CAMEL: I would have to know why they  
11 went, because I don't know why the ones stayed, who  
12 stayed, so it's a combination factor, right? So maybe  
13 somebody from far away stayed, and maybe somebody from  
14 far away left, but I have no way of knowing that.

15 MS. GROVES FUSCO: Okay, so, you can't  
16 tell us whether those 1,500 patients have all gone  
17 elsewhere for the reasons you've indicated, meaning they  
18 can't be scanned on the ONS scanner?

19 DR. CAMEL: As I've already said, I have  
20 no data, because no patient gives us a reason why they  
21 weren't scanned at ONS.

22 MS. GROVES FUSCO: Are you referring  
23 patients elsewhere now, because you can't do the scans?  
24 You just don't have enough capacity to do the scans?

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1 DR. CAMEL: That's an interesting  
2 question. I don't know that, because I don't know why  
3 they left, again, because patients choose, you know, many  
4 patients choose their provider for different reasons, and  
5 some patients choose us, and some patients don't, so I  
6 don't really know. We do have more capacity.

7 MS. GROVES FUSCO: Okay.

8 DR. CAMEL: Not much, but we have some.

9 MS. GROVES FUSCO: Okay, so, on page 32 of  
10 the CON, so you're projecting, in the first year of the  
11 unit, you're projecting an incremental increase, so  
12 between 2016 and 2017, you're projecting an incremental  
13 increase of 1,201 scans, correct?

14 DR. CAMEL: We are, yeah.

15 MS. GROVES FUSCO: And that's a 22 percent  
16 increase that year?

17 DR. CAMEL: The math is correct.

18 MS. GROVES FUSCO: Correct? Historically,  
19 and I did this math, so you can check it, or you can  
20 trust me, historically, your growth has been between four  
21 and a half and five percent a year, correct?

22 DR. CAMEL: For MRI imaging?

23 MS. GROVES FUSCO: For MRI.

24 DR. CAMEL: Yes.

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1 MS. GROVES FUSCO: Okay, so, would you  
2 agree that a 22 percent increase is entirely inconsistent  
3 with historical growth at four to five percent or four  
4 and a half to five percent?

5 DR. CAMEL: I wouldn't agree. You're  
6 missing some of the facts, which you don't know, so I can  
7 explain that if you want.

8 MS. GROVES FUSCO: Okay, well, I have some  
9 questions that may get us to the answer, but I'm just  
10 asking, if you look just at the percentages going forward  
11 and you have four and a half, five, four and a half,  
12 five, 22, four and a half, five, that 22 is kind of an  
13 outlier, correct?

14 DR. CAMEL: I disagree.

15 MS. GROVES FUSCO: Okay.

16 DR. CAMEL: Am I allowed to say why it's  
17 not an outlier?

18 MS. GROVES FUSCO: I'm going to ask you  
19 some more questions now. You've answered my question.  
20 Thank you.

21 You claim your projections and how you  
22 arrive at that 6,675 number is based on 265, I'm sorry,  
23 267 scans per physician, and you say that's your  
24 historical per physician average. Can you show me how

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1 you arrived at that number?

2 DR. CAMEL: Sure. So here's what I was  
3 trying to say before, but I didn't get to say. So you  
4 have to go backwards a little bit to get to the growth  
5 number, okay?

6 Let's start back going back to the fall of  
7 2014. I'll just have to walk through this in my head.  
8 We had a Dr. Sahler, who is a physiatrist. In March, we  
9 had a Dr. Kowalsky, who is an orthopedic surgeon. In  
10 September, we had a Dr. Wei, who is a hand surgeon. This  
11 September, we're adding Dr. Kaplan, who hasn't joined us  
12 yet, but he's coming in a couple of weeks.

13 We just made an offer to a new  
14 physiatrist, and we have an offer out to a joint  
15 replacement surgeon, so, when you look at the first  
16 person, so let's go back to Dr. Sahler, who started in  
17 '14 --

18 MS. GROVES FUSCO: With all due respect, I  
19 don't want to cut you off, because I know you want to --

20 DR. CAMEL: I just want to explain the  
21 math.

22 MS. VOLPE: He's answering. (Multiple  
23 conversations)

24 HEARING OFFICER HANSTED: Hold on. Hold

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1 on.

2 MS. VOLPE: -- on the 22 percent growth.

3 MS. GROVES FUSCO: No, no. That's not the  
4 question. I didn't ask another question. I asked him  
5 how he arrived at 267 scans per physician, where he got  
6 that number. Are you going to do the math for me?

7 MS. VOLPE: And he's explaining it.

8 HEARING OFFICER HANSTED: I believe that's  
9 what he's explaining.

10 MS. GROVES FUSCO: Okay. Okay.

11 HEARING OFFICER HANSTED: Sort of the long  
12 way.

13 MS. GROVES FUSCO: I mean I'm looking for  
14 math.

15 DR. CAMEL: I'm a little bit known for  
16 that.

17 MS. GROVES FUSCO: I appreciate the story.

18 DR. CAMEL: I apologize, but you can ask a  
19 lot of people about that. So when you go back, and those  
20 numbers are derived probably from the 2014 data, because  
21 you don't count Dr. Sahler, because he just started,  
22 right?

23 So, if you do the math and go -- I can't  
24 do it in my head, but, before Dr. Sahler came, we had --

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1 Dr. Crowe(phonetic) left, so we had an even number of  
2 doctors, so it was 22. You take 22 and do what the  
3 number is. You can do that math. I can't do it in my  
4 head.

5 Now the reason why we have this great  
6 projection is, when the '15 numbers were done, Dr. Sahler  
7 was just beginning his practice. He came at the end of  
8 '14. He's just ramping up. He's now full, and that's  
9 why we're hiring another physiatrist. He's a  
10 physiatrist.

11 We then added Dr. Kowalsky, who is a  
12 shoulder specialist, who joined us from Lenox Hill, and  
13 he is just now full. He's now been with us, well, since  
14 March of '15, whatever that is, 18, 17 months, and I  
15 talked about the other people we're about to add.

16 So we looked at what it takes to go from a  
17 zero practice to a 90 percent, 85, 90 percent, not 100,  
18 and we look at that, and we go, okay, if it takes 18  
19 months and this process takes a certain length of time,  
20 we expect this many more MRI scans are going to be  
21 ordered, and the numbers work when you do the math, but  
22 you don't have all that information --

23 MS. GROVES FUSCO: Okay, well --

24 DR. CAMEL: -- and why we're growing.

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1 MS. GROVES FUSCO: You're correct, but  
2 what I have is the information you put in the CON  
3 application, and that's what OHCA has, as well, and, so,  
4 if you look at your completeness question responses on  
5 page 94, I think it's page 94, it says, right at the  
6 bottom of the page, in 2012, the average number of scans  
7 for per physician was 267, okay?

8 So you're telling me that your story  
9 begins with this number being derived from Dr. Sahler  
10 coming in 2014.

11 DR. CAMEL: No, I didn't.

12 MS. GROVES FUSCO: Okay. In your own  
13 submission, you're saying, in 2012, the average number of  
14 scans per physician was 267, and now I will show you  
15 where I did the math. If you look at our submission --

16 MS. VOLPE: Is there a question for the  
17 witness?

18 MS. GROVES FUSCO: There's going to be a  
19 follow-up question.

20 HEARING OFFICER HANSTED: She's just  
21 setting up the question.

22 MS. GROVES FUSCO: I'm trying to figure  
23 out how we got to this math. I mean you've based your  
24 projections on a scan per physician number that you have

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1 no basis for that I can find in your application.

2 MS. VOLPE: She's offering testimony.

3 Please ask your question.

4 MS. GROVES FUSCO: My question to your  
5 client was can he show me how the math was done? I'm  
6 going to take him to the section in my client's  
7 testimony, where it shows that scans, divided by number  
8 of physicians, does not come out at 267 in 2012 or any  
9 year thereafter, so I would like him to show me how he  
10 arrived at the 267 scan per physician number that you  
11 were using to justify your projections. That's my  
12 question.

13 DR. CAMEL: So, in order to answer the  
14 question, you have to know how many physicians we had in  
15 the practice in 2012.

16 MS. GROVES FUSCO: Which I have.

17 DR. CAMEL: How many?

18 MS. GROVES FUSCO: Your attorney reported  
19 that it was 19.

20 DR. CAMEL: Okay and what was the number  
21 of scans?

22 MS. GROVES FUSCO: 4,565.

23 DR. CAMEL: And how does that work?

24 MS. GROVES FUSCO: That's 240 scans per

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1 physician.

2 DR. CAMEL: What's the next year?

3 MS. GROVES FUSCO: Am I being Cross-  
4 Examined? Can you go to page 22 of our submission?

5 HEARING OFFICER HANSTED: Why don't you  
6 look at the document that she's --

7 MS. GROVES FUSCO: Page 22 of our  
8 submission.

9 MS. VOLPE: Which submission?

10 MS. GROVES FUSCO: Of Mr. Yoder's pre-  
11 file.

12 DR. CAMEL: I have the piece of paper.

13 MS. GROVES FUSCO: Okay.

14 DR. CAMEL: I'm on it.

15 MS. GROVES FUSCO: Okay, so, you have page  
16 22? I'm asking how, and you can double-check my numbers,  
17 but I took these from your attorney's submission, each  
18 year, 2012 through 2016, the number of physicians you  
19 reported in the scan per physician volume, and nowhere in  
20 there does it show 267, and, in fact, as of 2016, it's  
21 238, so 31 scans less per physician.

22 Multiplied by the number of physicians you  
23 have, that significantly skews your projections, doesn't  
24 it?

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1 DR. CAMEL: I have to read. Can I have a  
2 minute to do the math?

3 MS. GROVES FUSCO: Yup. Sure.

4 DR. CAMEL: All right. Well there are a  
5 couple of skews here that go wrong with the projection,  
6 because, and this is the point I was trying to make  
7 before, so, in 2015, we added Dr. Kowalsky and Dr. Wei.

8 Dr. Kowalsky started in March, so he  
9 starts at zero, so for the first -- I think he started on  
10 March 20th or 15th, but I don't remember the exact date,  
11 so, for the first two months, he didn't refer any, and,  
12 for the next few months afterwards, he doesn't refer any,  
13 so it does change it, because it depends how you want to  
14 do the math.

15 If you take the absolute number, including  
16 people, who started yesterday, who refer zero, then it  
17 drops the number for a physician.

18 MS. GROVES FUSCO: I --

19 DR. CAMEL: And if you look at it on a  
20 mature physician basis, that is a physician, who has been  
21 with us for 18 months, who is now referring scans, and  
22 that's how we do our projections, because that's really  
23 what you want to know.

24 What about the guy that did zero when the

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1 day started? It's not a meaningful statistic.

2 MS. GROVES FUSCO: Okay, so, how do you  
3 account for the fact that you say in 2012, because,  
4 again, you're talking about docs that joined in '14 and  
5 '15? You based the 267 number on 2012. In 2012, the  
6 average scan per physician was 267, and here it says 240.

7 DR. CAMEL: I think this says 240.

8 MS. VOLPE: That's theirs. That's theirs.

9 DR. CAMEL: Well --

10 MS. VOLPE: -- by the number of doctors.  
11 If you do the 267, multiplied by the number of doctors  
12 you have, that's an average per doctor.

13 DR. CAMEL: I have to go backwards to 2012  
14 and look at who was hired when to get their real number.

15 MS. GROVES FUSCO: I understand.

16 DR. CAMEL: I just don't know that off the  
17 top of my head.

18 MS. GROVES FUSCO: The only question I'm  
19 asking and the only point I'm trying to make is that  
20 you're basing your projections on what you said to be an  
21 average number of scans per physician of 267 that  
22 occurred in 2012, and I'm saying, if you look at the  
23 information I put on page 22 of our filing, that the  
24 numbers don't add up. I can't get to 267 per physician

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1 with the numbers you've given.

2 DR. CAMEL: I agree.

3 MS. GROVES FUSCO: Now, going back to your  
4 rebuttal document at page four -- actually, I'm sorry.  
5 It's page four and page five. So, on page four, you  
6 specifically state in the first full bullet point on that  
7 page that ONS is not taking back volume, okay? You're  
8 not taking back anything that currently goes elsewhere.

9 And, on the next page, in response to the  
10 questions we raised about the 22 percent increase in scan  
11 volume, you say the 27 projections are based on the fact  
12 that ONS will be accommodating backlogs for its own  
13 patients, okay?

14 So we're talking about a 1,200-scan jump  
15 that year. Are you saying you have 1,200 patients, a  
16 1,200-patient backlog?

17 DR. CAMEL: With the projections, based on  
18 the new doctors, yes, so it won't affect ARC or other  
19 local providers, because that increase in scan -- if you  
20 think about it this way, if ARC sees 80 or something a  
21 year now and everybody else sees whatever they see and  
22 then we grow, then that growth accounts for that 1,200,  
23 and this stays the same while this grows.

24 MS. GROVES FUSCO: Okay.

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1 DR. CAMEL: Now that may grow, as well.  
2 I'm not suggesting that. I'm just saying this grows.  
3 This stays the same.

4 MS. GROVES FUSCO: That raises two issues,  
5 one being sort of -- you keep referencing and you've  
6 referenced in here the growth, based on adding new  
7 physicians, right?

8 DR. CAMEL: Yeah.

9 MS. GROVES FUSCO: Okay, but at a 267 per  
10 physician scan volume, if you add two new physicians that  
11 year, that's not -- that doesn't give you your 1,000 scan  
12 jump.

13 DR. CAMEL: Well that's correct --

14 MS. GROVES FUSCO: Okay, that's --

15 DR. CAMEL: -- but it's not correct on  
16 what we're doing and what we've already done, so it's  
17 incorrect factually and correct math-wise.

18 MS. GROVES FUSCO: Listen to me. So it's  
19 correct math-wise that, if each new physician brings 267,  
20 that doesn't get you to 1,000, okay? And --

21 DR. CAMEL: How many physicians are you  
22 including in that?

23 MS. GROVES FUSCO: Two.

24 DR. CAMEL: Well that's not correct,

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1        though.  I don't want to stipulate to a fact that's not  
2        true.

3                        MS. GROVES FUSCO:  You say you're getting  
4        two new physicians.

5                        DR. CAMEL:  Again, you didn't hear  
6        everything I said.

7                        MS. GROVES FUSCO:  I did hear everything  
8        you said.

9                        MS. VOLPE:  Okay.

10                      MS. GROVES FUSCO:  I'm asking a different  
11        question, so maybe you're not hearing what I'm saying.  
12        I'm asking you your -- you've said, throughout your CON  
13        submissions, that the growth in volume is due to the  
14        addition of physicians to your practice, okay?

15                      DR. CAMEL:  Correct.

16                      MS. GROVES FUSCO:  Fair enough.  In 2016  
17        to 2017, you state that you will be bringing in two  
18        additional physicians.

19                      DR. CAMEL:  That's incorrect.

20                      MS. GROVES FUSCO:  Well that's what it  
21        states in your CON filing.

22                      MS. VOLPE:  Well for 2016, and he's  
23        talking about in 2017.

24                      MS. GROVES FUSCO:  I'm asking about that

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1 one year. The growth for one year will be bringing in  
2 two new physicians.

3 DR. CAMEL: For --

4 MS. GROVES FUSCO: I'm asking --

5 DR. CAMEL: We don't do --

6 HEARING OFFICER HANSTED: Stop, stop,  
7 stop. Let her ask her question, and then try to answer.  
8 If you can't answer it, then do the best you can, and  
9 then she'll follow-up with another question.

10 DR. CAMEL: Okay.

11 MS. VOLPE: Just a point of clarification  
12 on the facts. When this was filed, okay, we provided the  
13 information on the number of doctors that were already  
14 committed to coming.

15 What Dr. Camel testified today is they've  
16 made offers to a doctor, who is starting in two weeks,  
17 and another doctor, so they have projected volume for the  
18 number of doctors they're going to have, and it was a per  
19 patient, per doctor scan volume.

20 Remember, this machine is not going to be  
21 implemented in 2016.

22 HEARING OFFICER HANSTED: So what you're  
23 saying is the number of physicians that you put in your  
24 application initially has changed, and that's going to go

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1 up, based upon new information?

2 DR. CAMEL: Yeah. Based on our current  
3 offers and our projected offers that we're going to make.

4 HEARING OFFICER HANSTED: Okay.

5 DR. CAMEL: We're actively interviewing,  
6 and you can check.

7 HEARING OFFICER HANSTED: So two is no  
8 longer the accurate number?

9 DR. CAMEL: Correct.

10 HEARING OFFICER HANSTED: It's maybe four?  
11 Is that fair?

12 DR. CAMEL: For this year, I tried to  
13 outline. I'll do it really quickly one more time. We  
14 added one in the fall of '15. We count that as a '16  
15 add, because they don't do anything in '15 from a  
16 production.

17 HEARING OFFICER HANSTED: Right. I get  
18 that.

19 DR. CAMEL: We're now adding a second hand  
20 surgeon and a physiatrist. That makes three for '16.  
21 For '17, we're recruiting, have ads out that anybody can  
22 check for a joint replacement surgeon and a neurosurgeon.

23 We are contemplating, but have not begun  
24 the recruitment process, for an additional foot and ankle

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1 surgeon and another physiatrist. Until we finish, we  
2 can't recruit, because of our scale. We just can't  
3 recruit that quickly, so those are our current plans  
4 going forward.

5 MS. GROVES FUSCO: Okay, but at the time  
6 you filed your CON, you were justifying a 1,000 scan  
7 increase that year, based on the addition of two  
8 physicians, because that's all you knew at that time?

9 DR. CAMEL: Well it was in part that, but  
10 we also we filed that I think in, and I don't really know  
11 the date we filed it, February or March when it went back  
12 to, but here's what we -- so we already began to see '16  
13 over '15.

14 What we saw was our patient volume was  
15 increasing by 20 percent, and, partly, that's because we,  
16 at the end of '15, we chose to go in network with Cigna,  
17 ConnectiCare and, to a degree, with Anthem.

18 And, so, we saw early, at the time, I  
19 think at the time of this filing, but I'm not sure what  
20 the date was, so whatever it is, it is, that's a matter  
21 of the record, we started to see this very large increase  
22 in our patient volume in the office, which has sustained  
23 itself now through July, which is the last place I have  
24 numbers for, and that rate of increase is tracking on a

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1 year-to-date basis of 20 percent, so if scanning is  
2 proportional to patient volume and the 20 percent is, in  
3 fact, accurate, whether it is, in fact, proportional, I  
4 don't know, because you could envision it could be more  
5 or less, but it is a very reasonable estimate, which is  
6 all that represents.

7 MS. GROVES FUSCO: Okay, but you've done -  
8 - so this has all been going on in the last month, and,  
9 as of yesterday, when you submitted this document to  
10 OHCA, this rebuttal, you explained none of this.

11 Like, in fact, on page five of your  
12 rebuttal, you say that 22 percent increase is to  
13 accommodate backlogs for your own patients. That's what  
14 you say.

15 MS. VOLPE: It should say and growth.

16 MS. GROVES FUSCO: Okay, well, it doesn't.  
17 It says backlog.

18 MS. VOLPE: Okay, but he's correcting it.

19 HEARING OFFICER HANSTED: Right. He's  
20 correcting the record.

21 MS. GROVES FUSCO: Okay, so, you don't  
22 have a 1,000-patient backlog?

23 MS. VOLPE: We appreciate the correction  
24 on the record.

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1 MS. GROVES FUSCO: Will you continue,  
2 going forward, so, last year, you referred 1,500 scans to  
3 area providers for whatever, you ordered scans. Can you  
4 attest that those 1,500 scans or thereabouts will remain  
5 where they are?

6 DR. CAMEL: Well, again, those scans  
7 really are people. They're not scans. To you, they're  
8 scans. To me, they're patients. Those patients we will  
9 have a whole new group of patients that come this year  
10 and next year, and I don't know what our volume is going  
11 to be, which I've just said to you.

12 I don't know where exactly those patients  
13 are going to come from, so if those patients come from  
14 further and further away, we will continue to refer those  
15 patients out, based on all the reasons I've already  
16 stated more than once.

17 But for me to make a prediction about  
18 patients and their choice and their insurance coverage  
19 and where they work and where they live, it is foolish,  
20 at best, maybe foolhardy is the better word, to  
21 speculate.

22 And there's no reason, as Michele was  
23 reminding me, there's no reason our distribution patients  
24 where they come from is going to change, so, assuming it

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1 just gets bigger with the same kind of geography, so to  
2 speak, a market share increase, which is what we think  
3 we're seeing, not a zip code change, then the proportion  
4 should stay the same.

5 MS. GROVES FUSCO: Okay.

6 DR. CAMEL: Or perhaps even go up. I mean  
7 I don't know.

8 MS. GROVES FUSCO: Just one more question,  
9 then we'll wrap this line of questioning up.

10 DR. CAMEL: Sure.

11 MS. GROVES FUSCO: So this market shift is  
12 going to show a 20 percent growth the year you get a new  
13 unit, but then everything is going to level out again?

14 DR. CAMEL: No.

15 MS. GROVES FUSCO: Well that's how your  
16 projections go, so let's look at your projections,  
17 because your projections show a big jump from 16 to 17,  
18 and then they go back down to four to five percent.

19 This isn't a consistent 20 percent, 20  
20 percent. It's a 20 percent jump the year you get the new  
21 unit, and then back to the historic averages, so how do  
22 you account for that, if you're going to have this growth  
23 going forward?

24 DR. CAMEL: So I've actually answered this

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1 question already. We filed this application the  
2 beginning of '16. We expected to put the application --  
3 we expected to see the new MRI machine by the end of '16.  
4 Maybe hoped would be a better word.

5 We, then, changed our growth pattern,  
6 based on what was happening in the office, which we  
7 couldn't have predicted either at the end of '15 or very  
8 early in '16 before that increase happened, because, as  
9 you correctly point out, we've never seen a growth rate  
10 of this rate at ONS, not of imaging, but of the services  
11 we provide.

12 And as you also have clearly stated, this  
13 is an ancillary service, which we provide to our  
14 patients, so the volume is driven by our patient volume.  
15 It is not where you guys may market, or drop a price, or  
16 get in with an insurance company. All of the volume  
17 derives first from those patients, who show up at the  
18 office.

19 And it is reasonable to assume, maybe not  
20 correct, but reasonable to assume, as the patient volume  
21 grows in the office, our MRI requirements will grow at a  
22 similar ratio. Now that's all I can say.

23 MS. GROVES FUSCO: Okay, so, before -- I  
24 do have one last question, even though I said that was my

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1 last. Before you knew about all of this, which you said  
2 you just found out now in the last month or so --

3 DR. CAMEL: That's not true.

4 MS. GROVES FUSCO: Okay. Did you know  
5 about this before you filed your CON application?

6 DR. CAMEL: Yes, because remember what I  
7 said already, just a few minutes ago. I said, after we  
8 signed these deals with Cigna and ConnectiCare and partly  
9 with Anthem, we began to see a very early rise at the end  
10 of '15 and early in '16 at numbers we had never seen  
11 before in the office, so, when we were preparing this,  
12 the question to me is what do you think your growth will  
13 be, and I said to Michele I don't know for sure, because  
14 I only have this much.

15 Over these few months, a rate of growth of  
16 office patients is about 20 percent, so you'd have to go  
17 with that projection.

18 MS. GROVES FUSCO: But you don't expect  
19 that same rate of growth in 2018 and 2019, based upon  
20 your projections in the CON?

21 MS. VOLPE: Well, because they're just  
22 becoming --

23 HEARING OFFICER HANSTED: Let your client  
24 testify.

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1 DR. CAMEL: I actually disagree with that.  
2 I can see a pathway to grow that, to grow, because we're  
3 continuing to expand.

4 MS. GROVES FUSCO: Well, then, your  
5 projections are incorrect, because your projections show  
6 modest growth in those subsequent years.

7 DR. CAMEL: Well --

8 MS. GROVES FUSCO: Okay. We'll leave  
9 that. If you look at your testimony on page --

10 MS. VOLPE: Is this the pre-file?

11 MS. GROVES FUSCO: You had mentioned in  
12 your comments and Dr. Kaye just noted to me that one of  
13 the docs you said you're recruiting is a joint  
14 replacement surgeon?

15 DR. CAMEL: Yes.

16 MS. GROVES FUSCO: Correct? In our  
17 experience, joint replacement surgeons don't order a lot  
18 of MRI scans, so are you expecting that joint replacement  
19 surgeon to order at least 267 scans?

20 DR. CAMEL: We are, for the following  
21 reason. This particular person, who we have an offer to,  
22 is training at the Rothman Institute in Philadelphia, and  
23 he is actually an expert on ambulatory joint replacement,  
24 especially those patients, who need unicondylar knees or

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1 reconstructive procedures of their hip at a younger age,  
2 and most of those patients undergo an MRI scan.

3 I think you're correct. In the Medicare  
4 population, most of those are treated without an MRI  
5 scan, because --

6 MS. GROVES FUSCO: I mean Advanced  
7 Radiology's docs do those, too, and they don't always  
8 result in MRIs. I'm wondering if the self-referral  
9 nature of the unit is going to bring up that MRI, that  
10 number of MRIs.

11 MS. VOLPE: He answered the question you  
12 asked.

13 DR. CAMEL: May I take that?

14 MS. GROVES FUSCO: Never mind.

15 DR. CAMEL: No, that's fine.

16 MS. GROVES FUSCO: I withdraw my question.  
17 Page 28 of your pre-filed testimony, on page 28, which is  
18 the section on the needs analysis, based upon population,  
19 would you agree that this analysis that you've done shows  
20 that, even with the addition of two new scanners in the  
21 Stamford service area, the entire service area would  
22 still be at 82 percent utilization, which is just three  
23 percent below the threshold for needing additional MRI  
24 capacity?

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1 DR. CAMEL: Yes.

2 MS. GROVES FUSCO: Okay. You claim in  
3 your testimony on page 18, and you said this in a number  
4 of places, but this is just where I was able to find it,  
5 that the number of ONS ordered scans that ARC performs,  
6 which is, you know, was 79 scans, \$55,000, and about one  
7 percent of our Stamford volume, it says in here that that  
8 is a I think the wording used is extremely minimal and  
9 insignificant number. Is that what it says?

10 DR. CAMEL: Do you want me to read it?

11 MS. GROVES FUSCO: I'm just asking if  
12 you've said that that's an extremely minimal and  
13 insignificant number.

14 DR. CAMEL: Well it says these referred  
15 patients barely account for one percent of annual MRI  
16 volume at the Stamford office of Advanced Radiology.

17 In our opinion, that is economically and  
18 insignificant or minimal. It's both minimal and  
19 insignificant.

20 MS. GROVES FUSCO: The --

21 DR. CAMEL: One percent.

22 MS. GROVES FUSCO: The number of scans and  
23 the percent, okay.

24 DR. CAMEL: Yes.

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1 MS. GROVES FUSCO: So, then, would you  
2 agree, and this is a yes/no question, that providing zero  
3 scans, zero MRI scans to Medicaid patients is an  
4 extremely minimal and insignificant number of MRI scans  
5 for Medicaid patients?

6 DR. CAMEL: Yes.

7 MS. GROVES FUSCO: Would you agree that  
8 treating 23 Medicaid patients out of more than 51,000 in  
9 your practice at .0004 percent and writing off \$88,000 is  
10 extremely minimal and insignificant?

11 DR. CAMEL: I would disagree.

12 MS. GROVES FUSCO: Is the number extremely  
13 minimal and insignificant?

14 DR. CAMEL: No. The amount of service we  
15 provide to Medicaid patients is much greater than that,  
16 and to ignore that misrepresents to OHCA what we actually  
17 do.

18 MS. GROVES FUSCO: I'm not ignoring that.  
19 I'm asking a specific question about the 23 patients and  
20 the \$88,000. You've put the other information in your  
21 pre-file. Are the 23 patients as a percentage of your  
22 51,500 patients an extremely minimal and insignificant  
23 number?

24 DR. CAMEL: I would never describe 23

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1 people as insignificant.

2 MS. GROVES FUSCO: But you described the  
3 79 patients that got scans at MRI as insignificant.

4 DR. CAMEL: That is incorrect. I  
5 described the economic impact on ARC as insignificant.  
6 You described the 23 patients as insignificant.

7 MS. GROVES FUSCO: Okay, well, in the  
8 filings, it lists the number and the percent of our total  
9 scans. Seventy-nine is a percentage of our total scans  
10 as being insignificant, and those scans, you said to me  
11 before, are not scans, they're people, correct?

12 DR. CAMEL: I said our patients are  
13 people. You referred to your business as scans.

14 MS. GROVES FUSCO: Okay. You cite the  
15 fact that, and I think it's on page 16 of your testimony,  
16 that 1.9 percent of the hospital for special surgery's  
17 MRI volume was Medicaid patients, despite the outreach  
18 efforts it's made, and you use that as proof that there's  
19 a low Medicaid MRI need in Fairfield County, correct?

20 DR. CAMEL: Yes, the number is correct.

21 MS. GROVES FUSCO: Okay, but you didn't  
22 reach out to any local FQHCs to see whether they report a  
23 need for MRI services for Medicaid patients, did you?

24 DR. CAMEL: I'm not aware of that

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1 abbreviation.

2 MS. GROVES FUSCO: Federally Qualified  
3 Health Centers, like Optimus.

4 DR. CAMEL: Did I personally reach out?

5 MS. GROVES FUSCO: Yes.

6 DR. CAMEL: No.

7 MS. GROVES FUSCO: And you didn't reach  
8 out to any community health centers in the area to see  
9 whether they report a Medicaid MRI need?

10 DR. CAMEL: In Greenwich?

11 MS. GROVES FUSCO: In your service area,  
12 which includes Stamford and Norwalk.

13 DR. CAMEL: I did not reach out.

14 MS. GROVES FUSCO: High Medicaid  
15 populations. When you order an MRI, and this gets back  
16 to an issue we discussed earlier, about patient choice,  
17 in offering your patients a choice, do you provide them,  
18 do you actually hand them a list of alternate providers  
19 in the service area of MRI with contact information?

20 DR. CAMEL: We do.

21 MS. GROVES FUSCO: Okay. Do you disclose  
22 to your patients before they receive a scan on the ONS  
23 unit that you have a financial interest in that  
24 equipment?

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1 DR. CAMEL: We actually do it better than  
2 that. We say we own it.

3 MS. GROVES FUSCO: Okay and you do that  
4 verbally or in writing?

5 DR. CAMEL: It's actually I think on that  
6 same piece of paper, but I don't have that with me.

7 MS. GROVES FUSCO: Okay. I have just a  
8 few more questions. Just a quick question about Worker's  
9 Compensation. I looked back at your CON for your  
10 original unit in 2008, where you had projected 6.6  
11 percent Worker's Comp, and you have a payer mix in this  
12 CON. I think it's on page -- it's on page 33 that shows  
13 two percent MRI Worker's Comp, but then you state in your  
14 remarks that you can't refer Worker's Comp patients to  
15 your scanner, so how do you have scans and volume?

16 DR. CAMEL: I think that's maybe unclear  
17 language, and that actually goes, actually makes the  
18 point, so I think we do, and I don't have the exact  
19 number at my fingertips, but I think you're correct when  
20 you say that about six percent of our patient volume is  
21 Workmen's Comp, but, as I previously said, many Workmen's  
22 Comp carriers have narrow networks to which patients are  
23 referred, but not all of them do, so we actually can scan  
24 some Workmen's Comp patients, but we can't scan most of

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1       them or the majority of them, and that's the discrepancy  
2       of MRIs, Workmen's Comp MRIs versus Workmen's Comp.  
3       patients.

4                       MS. GROVES FUSCO:   Okay, because you say  
5       in your filings that you cannot refer Worker's Comp. to  
6       your scanner.   That's not correct?

7                       DR. CAMEL:   That's an overstatement.

8                       MS. GROVES FUSCO:   Okay.   With respect to  
9       your rebuttal testimony about self-referral, you state  
10      that the studies we cite are older and that there are no  
11      new studies, but are you aware of the GAO study that Dr.  
12      Kaye cited in his testimony from 2012 that shows self-  
13      referral in advanced imaging is costing the Medicare  
14      program millions of dollars every year?

15                      DR. CAMEL:   I'm aware of that study.

16                      MS. GROVES FUSCO:   Okay, and are you aware  
17      of any recent studies that find self-referral for  
18      advanced imaging by orthopedists and neurosurgeons does  
19      not increase utilization or cost?

20                      DR. CAMEL:   We have the best study  
21      locally, because we actually can look at what we referred  
22      to before we put in our --

23                      MS. GROVES FUSCO:   Well, with all due  
24      respect, I'm asking published studies.

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1 DR. CAMEL: I'm not aware of all --

2 MS. GROVES FUSCO: Peer reviewed published  
3 studies.

4 DR. CAMEL: I'm not aware.

5 MS. GROVES FUSCO: Okay. In terms of your  
6 physician recruitment efforts, have you had conversations  
7 with any other orthopedic or physician practices about  
8 joining ONS?

9 DR. CAMEL: You mean groups?

10 MS. GROVES FUSCO: Yes.

11 DR. CAMEL: No.

12 MS. GROVES FUSCO: Okay. In particular,  
13 have you spoken with Orthopaedic Associates of Stamford,  
14 now part of WESTMED?

15 DR. CAMEL: Never about joining.

16 MS. GROVES FUSCO: Okay. Have you had any  
17 conversations with WESTMED about joining their integrated  
18 delivery network?

19 DR. CAMEL: Can I just go backwards on  
20 that?

21 MS. GROVES FUSCO: Um-hum.

22 DR. CAMEL: They actually called us to  
23 have us start a conversation. We declined, so I'm not  
24 sure if that's a conversation.

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1 MS. GROVES FUSCO: And that was OAS or  
2 WESTMED?

3 DR. CAMEL: WESTMED has not had a  
4 conversation with us.

5 MS. GROVES FUSCO: Okay, so, you've had no  
6 conversations with WESTMED about joining their integrated  
7 delivery network?

8 DR. CAMEL: No. No, not at all.

9 MS. GROVES FUSCO: Okay. Are you part of,  
10 along with any other orthopedists in the state, any  
11 national organization or group, like an MSO or similar  
12 contracting entity?

13 DR. CAMEL: No.

14 MS. GROVES FUSCO: Are you affiliated with  
15 or a member of any organization that might include other  
16 orthopedic practices in the state?

17 DR. CAMEL: I'm not sure what you mean.

18 MS. GROVES FUSCO: Are you in affiliation  
19 with any of the other orthopedic practices in the state,  
20 part of any joint membership association or things like  
21 that?

22 DR. CAMEL: Well there is the Connecticut  
23 Orthopaedic Associates, which is a professional group.  
24 They're professional groups. They're members of

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1 professional groups.

2 MS. GROVES FUSCO: You don't have any sort  
3 of, other than professional entities like that, you don't  
4 have any sort of professional affiliation with any  
5 orthopedic groups in the Hartford area, and I mean for  
6 the service of patients?

7 DR. CAMEL: You mean like business  
8 entities?

9 MS. GROVES FUSCO: Yes, business.

10 DR. CAMEL: No, we have not.

11 MS. GROVES FUSCO: You're not in  
12 conversations about any of those?

13 DR. CAMEL: No.

14 MS. GROVES FUSCO: Okay, that's it. Thank  
15 you.

16 HEARING OFFICER HANSTED: All set?

17 MS. GROVES FUSCO: Yeah, we're all set.  
18 Thank you.

19 HEARING OFFICER HANSTED: Okay. Do you  
20 have any Redirect?

21 MS. VOLPE: I do. Do you want us to do it  
22 now, or would you like to break?

23 HEARING OFFICER HANSTED: How long do you  
24 think you'll be?

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1 MS. VOLPE: Half hour, 40 minutes, maybe.  
2 Maybe less.

3 HEARING OFFICER HANSTED: Let's proceed  
4 now.

5 MS. VOLPE: Okay. Dr. Camel, can you --  
6 it was represented that you see an insignificant number,  
7 I think that was ARC's, of Medicaid patients. Can you  
8 discuss your Medicaid service to the population in the  
9 region?

10 DR. CAMEL: Well, as I said in my original  
11 statement and I'll try not to be repetitive, because of  
12 the lunch hour, is that ONS and Greenwich Hospital, and  
13 Greenwich Hospital does this with all other  
14 subspecialists, as well, work together to provide care  
15 for Medicaid, indigent and underinsured patients in  
16 Greenwich, and there are, you know, significant numbers,  
17 and that's the reason every Thursday afternoon from 1:00  
18 to 4:00 there's an orthopedic clinic that takes place at  
19 Greenwich Hospital, three out of four, staffed by ONS  
20 orthopedists.

21 Now there is no neurosurgery clinic, and,  
22 so, those patients to which the attorney referred are the  
23 neurosurgery patients from the clinic that are taken care  
24 of by the clinic, who are referred to us for care.

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1                   We choose to see them in our office,  
2                   because along the spectrum of incidence of disease  
3                   neurosurgical issues are far fewer than orthopedic  
4                   issues, and, so, those 20-some patients you mentioned  
5                   were probably all neurosurgery patients, but there may be  
6                   other patients, who were operated on as emergencies  
7                   without insurance, who are seen in follow-up as part of  
8                   their routine postoperative care, when the scheduling  
9                   with the clinic doesn't work out.

10                   We also see a commensurate amount of  
11                   emergency room call, and, like in most communities and  
12                   not as much as Stamford, certainly, but, in Greenwich,  
13                   there's a significant amount of trauma call that occurs,  
14                   again, more on the orthopedic side and the neurosurgery  
15                   side.

16                   Some of those patients are insured. Some  
17                   of those patients are not insured. We take all comers.  
18                   And, in fact, we have orthopedists and neurosurgeons on  
19                   call 365 days a year, period, whether we're on duty for  
20                   the emergency room, and, most recently, I got called to  
21                   see a patient from the New Haven area, which was not a  
22                   trauma case, an intracerebral hemorrhage, and they called  
23                   me it was literally 4:45 in the morning.

24                   I woke up, I took the call, and I went in,

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1 and then I went I'm not even on call. They called by  
2 error. This has gone on all the time, and our doctors  
3 take care of all of these patients in and around the  
4 Greenwich community, and that care, the in-office space  
5 delivery of care, it's correct. It was 88,000, but there  
6 was an additional hundreds and thousands of dollars of  
7 both office space care done at the hospital for  
8 professional services, surgery that was done, and  
9 postoperative care.

10 MS. VOLPE: Will the physician general  
11 practice always need to -- will you ever be able to  
12 accommodate all of the scans on your patients that are  
13 required in your practice?

14 DR. CAMEL: No. Again, we're being  
15 repetitive a little bit, but we don't for all those  
16 reasons that we haven't been in the past. We can't,  
17 because of geography. We can't, because of insurance.  
18 We can't, because of technological need and, also,  
19 patient choice.

20 So, for all of those reasons, which we've  
21 already been over, we won't and can't.

22 MS. VOLPE: So there is a discussion on  
23 self-referral and the studies and national studies. Has  
24 ONS conducted its own studies to determine its

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1 utilization prior to acquisition of an MRI and after  
2 acquisition of an MRI?

3 DR. CAMEL: Yes. So we looked at that,  
4 because we've had discussions. At some point, I had a  
5 discussion with the Vice Chairman of Radiology at the  
6 Massachusetts General Hospital, and because this issue  
7 has been raised by radiologists, because it's a sort of  
8 driven question about self-referral, because the more  
9 self-referral there is there are fewer MRIs going to  
10 radiologists, who own their own their own imaging  
11 centers, so I understand the economic impact.

12 So we -- I, actually, through a  
13 connection, came into contact with a guy, who is the Vice  
14 Chairman of Radiology at Mass General, and we proposed a  
15 couple of different ways to do it.

16 We asked him to audit our indications,  
17 because Mass General has a list of proper indications for  
18 ordering studies.

19 We are all subspecialists in our group.  
20 Everybody is fellowship trained. It's an old fashioned  
21 system, where we are true partners. We're not  
22 individuals practicing together.

23 So, after a back and forth discussion, he  
24 sort of declined to be hired as the auditing person to

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1 actually look at the charts and do the indication, so  
2 what we said, then, sort of we thought the next best  
3 thing is what was our number of scans done before we had  
4 our first MRI, and what are our number of scans per  
5 physician done after, and you can see, as our number of  
6 scans in the data that's already been presented and  
7 referred to by the other attorney, in 2012, the number  
8 was 240, and the latest year of that table, five years  
9 later, was 238. Intervening years were in the 220s, so  
10 we are actually doing -- our scan ordering per physician  
11 is perfectly stable and has been stable even when  
12 compared to before we owned our own MRI machine.

13 Why do we order so many? We're all  
14 subspecialists. By the time we see patients, if they  
15 haven't already been scanned, many of them get them, but  
16 many patients, as I said before, whether it's from the  
17 clinic, private physician's office, general orthopedists  
18 or general neurosurgeons, refer patients fully evaluated.

19 And, so, they come with their imaging  
20 already. Patients, who come primarily, are imaged at our  
21 office or surrounding scanners.

22 MS. VOLPE: Okay. One of the 12 factors  
23 for determining a CON, number 10, can you read that? Can  
24 you read what that says into the record?

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1 DR. CAMEL: Yeah. Number 10?

2 MS. VOLPE: Yes.

3 DR. CAMEL: "Whether an Applicant, who has  
4 failed to provide or has reduced access to services by  
5 Medicaid recipients or indigent patients, has  
6 demonstrated good cause for doing so."

7 MS. VOLPE: Now would you state that your  
8 cooperation and coordination of that Medicaid population  
9 with Greenwich Hospital and the fact that it's been  
10 working for decades, is that good cause in your opinion?

11 DR. CAMEL: We provide really the same  
12 level of service to Medicaid and uninsured patients as we  
13 do to patients with the best insurance, or, you know, in  
14 our community, you can pay privately.

15 And what's fascinating, when you talk to  
16 people, who have insurance and have plenty of money, of  
17 which there are plenty in our community, make no doubt  
18 about that, they ask what happens to patients without  
19 insurance, because of the discussion in the news  
20 regarding President Obama's health care initiative about  
21 guaranteeing access to care, and I make the point all the  
22 time, I said, you know, the care you're getting from ONS  
23 is the same as everybody gets, and it doesn't matter what  
24 kind of car you drive, or how big your house is, or what

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1 kind of insurance you have. We're all obligated, as are  
2 the radiologists, to provide the same level of service,  
3 no matter what the level of insurance.

4 And in Greenwich, at least, and I can't  
5 speak to all communities throughout the state, which I  
6 know is your charge, Greenwich Hospital and all of the  
7 private physician groups have provided this service since  
8 I arrived, well before I arrived in 1987, and it's worked  
9 great, and I would argue all of those patients have had  
10 access to some of the best physicians you can find  
11 anywhere, not just at ONS, but all throughout our  
12 community.

13 They're trained often in New York and  
14 Boston and other great places, so it's a fabulous level  
15 of care, and it's very different than you're going to see  
16 in more urban communities, just because the communities  
17 differ.

18 MS. VOLPE: We don't have any additional  
19 Redirect for Dr. Camel.

20 HEARING OFFICER HANSTED: Okay. All  
21 right, at this point, we're going to break for lunch.  
22 It's 10 after 12:00 now. Please come back here at 12:40.  
23 I want to get started right at 12:40. Thank you.

24 (Lunch recess)

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1 HEARING OFFICER HANSTED: Back on the  
2 record, and we're going to begin with the Applicant's  
3 presentation on Docket No. 16-32093-CON.

4 MR. YODER: Good afternoon. My name is  
5 Clark Yoder. I'm the CEO of Advanced Radiology. I would  
6 like to adopt my pre-filed testimony, including rebuttal  
7 testimony submitted in responses to the testimony of ONS  
8 and WESTMED, for the record.

9 With me today are my colleagues, Dr.  
10 Gerard Muro, ARC's Neurology Section Director and Chief  
11 Medical Information Officer, and Dr. Alan Kaye, a former  
12 CEO of Advanced Radiology.

13 I joined ARC in 2015 as CEO. Prior to  
14 joining ARC, I spent 13 years working for Westchester  
15 Medical Group in varying capacities, including Director  
16 of Ancillary Services, Chief Financial Officer and Chief  
17 Operating Officer.

18 I hold an MBA and a Bachelor's of Science  
19 in Radiology. I'm a member of various professional  
20 organizations, including the American College of Health  
21 Care Executives, Radiology Business Management  
22 Association, and the Radiological Society of North  
23 America.

24 As you know, ARC is a multi-site, full-

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1 service diagnostic imaging and interventional radiology  
2 provider. We have office locations in Stamford,  
3 Fairfield, Stratford, Trumbull, Shelton and Orange and  
4 provide advanced imaging, including MRI, at each site.

5 Our machines, including MRI, are fully  
6 accredited by the American College of Radiology, and our  
7 radiologists are subspecialty trained in various systems  
8 of the human body.

9 Over the course of the last year, we have  
10 been actively involved in the planning for an upgrade of  
11 ARC's technology. This has included ongoing evaluation  
12 of MRI capacity and planning for the acquisition of new  
13 equipment, as necessary.

14 One of the Intervenors criticized ARC for  
15 being slow to move on adding MRI capacity in Stamford,  
16 given how high our volumes have been since 2011, but, as  
17 mentioned in written testimony, we are deliberate on how  
18 we decide to upgrade and to add new equipment while  
19 making prudent business decisions in the best interest of  
20 the communities we serve and, also, take into  
21 consideration the 200 employees and their families.

22 Advanced imaging equipment is particularly  
23 expensive, and we want to make sure that we are expending  
24 our resources in ways that will benefit our patients, as

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1 well.

2                   The decision to add MRI in Stamford comes  
3 at a point where a majority of our MRI units are  
4 operating well over capacity; Stamford, 6,617 scans in  
5 2015, which is 165 percent capacity, based on the  
6 statewide health plan; Fairfield, 6,685 scans, 167  
7 percent capacity; Stratford, 5,433 scans, 136 percent  
8 capacity; and Trumbull scans 5,139, 128 percent capacity.

9                   Our practice, in totality in 2015,  
10 performed 29,413 exams, which equates to 123 percent  
11 capacity.

12                   We have worked hard to add capacity and to  
13 accommodate the increase in demand for our services by  
14 increasing hours and office locations, including  
15 Stamford.

16                   Stamford MRI service now operates up to 92  
17 hours a week, including weeknights and both weekends,  
18 weekend days. We pay technologists on average 17 percent  
19 more to work nights and weekends than we pay for daytime  
20 coverage, and, even so, we cannot easily find staff to  
21 work these hours.

22                   We are limited, in terms of the types of  
23 exams that can be performed after hours, and patients are  
24 often reluctant to come to an inner city office, such as

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1 Stamford, late at night.

2 Our Stamford office is the most  
3 geographically-distant of our scanners with the primary  
4 service towns that do not overlap with our other offices.

5 Stamford is located in the Southwestern  
6 most corner of our state, and I'm sure, as you know,  
7 traffic congestion from the Connecticut border through  
8 Stamford can continue to New Haven as some of the worst  
9 in the nation.

10 There are several reasons why we decided  
11 to MRI capacity our Stamford office at this time.

12 Despite the noise being made by our  
13 Intervenors about the validity of our projections and an  
14 unsubstantiated potential loss of some orthopedic  
15 referrals, there is, without question, a clear public  
16 need for this proposal.

17 The statewide health plan puts a capacity  
18 of an MRI unit at 4,000 scans per year and says an  
19 existing provider can upgrade once they fill 85 percent  
20 or 3,400 scans.

21 ARC performed 6,617 scans at Stamford last  
22 year, almost twice the amount required to justify an  
23 upgrade.

24 Based on the most recent available data

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1 from OHCA, ARC's Stamford MRI is the busiest MRI of the  
2 13 units operating in the service area.

3 This is especially significant,  
4 considering that at least one of these units is a  
5 hospital magnet that operates 24/7.

6 There has been a question raised about  
7 whether ARC can relocate its Shelton or Orange MRI  
8 scanner to Stamford, and the answer is no.

9 The units are well-utilized, and  
10 relocating them will cause great access issues in those  
11 communities. Although they are not as busy as our  
12 Greater Bridgeport area and Stamford MRI units, the ARC  
13 Shelton and Orange scanners are still busier than several  
14 of the MRI units operating in the Stamford area for  
15 purposes of comparison.

16 The Orange unit, which is a 3 Tesla unit,  
17 has seen a recent increase in volume and will reach  
18 capacity in the near future, and we've just upgraded the  
19 software on our Shelton scanner, so they can perform  
20 additional exams, which will result in increased volume  
21 on this unit, as well.

22 Furthermore, the Shelton and Orange  
23 offices have additional complimentary modalities,  
24 including ultrasound, x-ray, CAT scan, fluoroscopy and

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1 mammography. By removing these services, it would affect  
2 the viability of these offices.

3 Adding a 3 Tesla scanner in the private  
4 practice setting in Stamford will, without question,  
5 increase the quality of MRI services in the area.

6 Dr. Muro will talk to you more about the  
7 benefits of 3 Tesla MRI and address the issues raised by  
8 WESTMED and refuted by ARC about whether this type of  
9 scanner can or should be used in an outpatient setting.

10 Dr. Muro can also tell you everything that  
11 there is to tell about health information advances and  
12 how these afford our physicians and patients  
13 unprecedented access to their images and reports and how  
14 ultimately this enhances the quality of care for so many.

15 More generally, I can tell you, by adding  
16 MRI capacity in Stamford, will reduce our now seven to  
17 10-day backlog for MRI services, allowing more patients  
18 to receive their MRI scans sooner, leading to more timely  
19 diagnosis and treatment.

20 There is an additional need for MRI  
21 services in the Stamford area, generally, and adding this  
22 capacity at ARC is one of the most cost-effective  
23 solutions.

24 As a private physician practice, ARC is

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1 typically reimbursed for MRI services at much lower rates  
2 than hospitals, health systems, large multi-specialty  
3 groups, and making our units more cost-effective than  
4 most.

5 We also don't charge facility fees.  
6 Moreover, as Dr. Kaye will discuss in greater detail, we  
7 do not self-refer patients to our scanner.

8 This ensures that all referrals are  
9 clinically-necessary and that overutilization has not  
10 artificially driven up the cost of care.

11 I know that both Intervenors have question  
12 of financial feasibility of this proposal. Just because  
13 there are initial incremental losses associated with  
14 acquisition of a second unit doesn't mean the project  
15 isn't feasible.

16 Advanced imaging often requires a ramp up  
17 period before it becomes profitable on its own.  
18 Fortunately, our practice has six MRIs spread among our  
19 offices and run through advanced MRI centers limited  
20 partnerships, which remains profitable, even with the  
21 projected incremental losses of the first few years of  
22 operation. For example, in fiscal year 2017, following  
23 the acquisition, ARC MRI will have a net income in excess  
24 of \$1.5 million.

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1                   Lastly, I would like to touch on the very  
2 important issue of access. The addition of MRI capacity  
3 will increase access to our patients generally, which is  
4 critically important, but it will also increase access  
5 for some of the State's most vulnerable patients,  
6 including Medicaid recipients and indigent persons.

7                   We are the only private non-hospital MRI  
8 provider in the Stamford area that participates in the  
9 Medicaid program.

10                   Medicaid accounted for nearly four percent  
11 of Stamford MRI volume and more than seven percent  
12 overall ARC MRI volume.

13                   We are also committed to serving the  
14 uninsured and underinsured. We remain committed to  
15 serving these patients in growing numbers in the future,  
16 unlike some of our competitors.

17                   In conclusion, ARC has met all the CON  
18 statutory decision criteria for its Stamford MRI. Volume  
19 far exceeds the 3,400 scans required to justify  
20 acquisition of a second unit for the office.

21                   We have shown that, without a doubt, this  
22 proposal will improve the quality of MRI services in our  
23 area, the cost effectiveness of these services, and the  
24 accessibility of MRI for underserved populations, such as

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1 Medicaid beneficiaries.

2                   ARC is proud of its commitment to  
3 providing the highest quality of care to all patients,  
4 regardless of their ability to pay.

5                   We urge you to approve this CON, so we can  
6 adequately serve the Stamford community's MRI needs.

7                   Thank you for allowing me to present, and  
8 I would like to ask my colleague, Dr. Muro, to come to  
9 the microphone.

10                   DR. MURO: Good afternoon. I'm Dr. Gerard  
11 Muro, and I'd like to thank you for giving me this  
12 opportunity to speak this afternoon.

13                   I'd like to adopt my pre-filed testimony,  
14 and I'd like to start just by introducing myself. I  
15 think it's relevant to my discussion.

16                   I have been with Advanced Radiology for 17  
17 years. I am a fellowship-trained neuroradiologist, two  
18 years of fellowship training, senior member of the  
19 American Society of Neuroradiology. I'm Director of our  
20 Neuro Section, and I read 3T MRI scans on a regular  
21 basis, so, based on that, I'm certainly qualified to  
22 speak on the benefits of 3T, as well as answer any  
23 questions anyone has.

24                   I'm also the Chief Medical Information

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1 Officer for the organization. ARC makes a huge  
2 investment in health care IT technology.

3 We believe it's one key to improving  
4 quality, service and controlling costs. It's certainly  
5 in keeping with many of the CMS initiatives, such as  
6 within the Affordable Care Act, MACRA, PAMA, and, for  
7 myself, it's just a personal passion of mine.

8 In fact, I'm just completing my Master's  
9 degree in Health Care Information Technology at  
10 Northwestern.

11 So I'd like to discuss two issues; our  
12 decision to acquire a 3T in Stamford, as well as talk  
13 about our mobile imaging sharing network and other health  
14 care IT technologies that is relevant to our 3T  
15 acquisition.

16 First, regarding the decision to acquire a  
17 3T in Stamford, it's part of our commitment to providing  
18 the highest quality possible in a private physician  
19 office setting in the Stamford area.

20 We acknowledge the fact that Greenwich  
21 Hospital has a 3T MRI, however, it is on campus and less  
22 convenient than a private office.

23 It's less cost effective, due to the  
24 higher reimbursement and facility fees. It's currently -

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1 - I'm sorry. Based on 2013 filings, it was at 82 percent  
2 capacity and likely above 85 percent, which is the  
3 threshold for acquiring a new MRI.

4 So what are the benefits of 3T? The  
5 higher strength of the magnet provides more signal, which  
6 translates into a higher definition image, just like the  
7 high definition televisions, so it's not just the  
8 resolution, but it's also temporal resolution, which  
9 means imaging changes over time, such as a beating heart,  
10 and there are certain applications or certain clinical  
11 conditions where this is very helpful.

12 It also allows us to provide some advanced  
13 imaging techniques that are not really feasible or  
14 practical with the 1.5 Tesla, and that includes diffusion  
15 tensor imaging, where there's a lot of interest in  
16 neurodegenerative disorders and traumatic brain injury.

17 Also, it allows us to perform functional  
18 MRI, which is basically imaging the physiology of the  
19 brain.

20 It also provides us with higher definition  
21 vascular imaging, imaging of the blood vessels, and this  
22 is particularly important with such diseases as brain  
23 aneurisms. They're more accurately characterized and  
24 easier to detect with 3T. We can better detect blockages

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1 in blood vessels with 3T, and I think that anyone, who  
2 had a family member or themselves with a brain aneurysm,  
3 would rather have a 3T MRI, if it was possible.

4 It could also obviate the need for a CT  
5 scan, which would require the injection of dye and  
6 entails radiation.

7 I should also mention that we partake in  
8 several clinical trials, most of which are related to  
9 Alzheimer's disease, multiple sclerosis, and traumatic  
10 brain injury. These are performed at our Orange and  
11 Fairfield MRI units. All require 3 Tesla magnetic  
12 imaging, and it would be certainly a benefit to make  
13 these trials available in the Stamford area, as well, not  
14 just for the patients, but, also, for physicians, who  
15 want to engage in some of these clinical trials outside  
16 the academic centers.

17 I should also mention that it's much  
18 better for prostate imaging. There's better definition.  
19 The definition is so much better that we no longer  
20 require the placement of a probe in the rectum, which you  
21 can imagine is uncomfortable for the patient.

22 With extremities and joints, there is  
23 better definition and image quality, which can be a  
24 factor in certain situations, such as with the feet and

1       shoulders. And our physicians, many of our physicians or  
2       specialists, demand 3T imaging for certain clinical  
3       indications, and I'll just give one example.

4                       We have a pediatric neurologist, who will  
5       only have his children imaged on the 3T magnets for  
6       seizure evaluation, looking for very subtle defects in  
7       the brain that could impact treatment and prognosis.

8                       I would like to address some inaccurate  
9       assertions provided by Dr. Weiss of WESTMED, and we  
10      stated that 3T MRI is more appropriate in the acute care  
11      setting, and it's actually the contrary.

12                      In an acute care setting, it's much more  
13      difficult to adequately screen patients for a 3T MRI.  
14      Often, there's attached devices, catheters, wires,  
15      etcetera, that are a contraindication to 3T MRI, and the  
16      truth is there's little added value with 3T in the acute  
17      setting, however, we, I think, we have proof that 3T MRIs  
18      in Orange and Fairfield that there is a huge benefit to a  
19      3T in the outpatient setting. We offer almost the entire  
20      gambit of possibilities or capabilities of 3T at those  
21      units.

22                      It was also mentioned by Dr. Weiss that  
23      there's issues with SAR. Basically, that's tissue  
24      heating that can occur with the MR, whether it's 1.5 or

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1 3T. It is more problematic with 3T, however, our  
2 technologists are experienced, well-trained, and they  
3 could make subtle adjustments in the techniques, so it's  
4 not really an issue.

5 Dr. Weiss also made mention of  
6 susceptibility artifact as a problem. It's true that,  
7 with a stronger magnet, you get more artifacts from  
8 metallic devices, such as implants, hip replacement, for  
9 example, however, with careful screening, if we think  
10 it's a problem, some patients do the 1.5T, and, in fact,  
11 it's actually the susceptibility artifact is one of the  
12 benefits of 3T, because it allows us to -- provides more  
13 sensitivity in detecting micro-hemorrhages, old micro-  
14 hemorrhages in the brain that you might find with  
15 traumatic brain injury, metastatic disease, and other  
16 pathology.

17 I also would like to talk about ARC's  
18 state-of-the-art image and report sharing network. We  
19 call it AR Connect. It's the forefront of health care IT  
20 technology, both within our state and nationally.

21 Sort of central to it is our Inteleraad  
22 PACS imaging platform. Inteleraad is an industry leader  
23 when it comes to PACS, and we have a 100 percent up time.

24 Inteleraad has their own viewer that the

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1 radiologists use for their interpretations, however, we  
2 also provide that same viewer to our referring  
3 physicians. It's very powerful, yet intuitive and easy  
4 to use.

5 We have 3,800 physicians using this  
6 viewer, and there are frequent accolades from our  
7 referring community regarding this particular viewer,  
8 however, to enhance that access to images and reports, we  
9 have developed internally our mobile sharing platform  
10 that's now available nationwide through another vendor,  
11 not through us, but we did develop it, and this makes  
12 images and reports available from mobile devices, such as  
13 an iPad or iPhone.

14 It also includes a zero footprint viewer,  
15 and what that means a zero footprint viewer is a viewer  
16 that you can launch within your Internet Explorer,  
17 Firefox, Safari, without having to download software, and  
18 that's very important, because some of our physicians are  
19 in environments where they're not allowed to download  
20 software, so, basically, we've kind of done everything  
21 possible to increase access to images and reports for  
22 physicians. It kind of fulfills one of our missions,  
23 which is to provide access to images and reports anytime  
24 from anywhere.

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1 I should also mention our patient portal,  
2 which is very unique nationwide. Not only do our  
3 patients have access to their reports within two days  
4 after the report is completed, but they have access to  
5 their images, and there are probably very, very few  
6 people or practices in the country that allow that or  
7 have that technology that we developed.

8 With that, they can not only view their  
9 images. They can share those images, so, if they have a  
10 physician in New York, they could share those images with  
11 that physician, so it's a very powerful patient  
12 empowerment tool.

13 And just some of our integration and  
14 collaboration technologies. We integrate -- our  
15 electronic medical record system integrates with several  
16 other EMRs throughout our service area. It's an HL-7  
17 integration, where we can automatically insert reports  
18 into the front positions of EMR, and they could order  
19 directly from their EMR into our system.

20 It's a more timely, efficient and accurate  
21 exchange of information, and just one notable example is  
22 our integration with the Yale Epic system, where a  
23 physician, who is ordering out of Epic, their studies, if  
24 we perform those studies, those reports will be

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1 automatically uploaded into the Epic EMR, and, with some  
2 very recent collaboration with Yale, we've upgraded that  
3 functionality, where it now appears in their inbox, that  
4 this report is now ready for review.

5 And I should mention that, you know,  
6 Greenwich is part of that Yale system and on Epic, so  
7 those physicians would also see that benefit, and we  
8 have, again, several of these types of integrations,  
9 including the Stamford area.

10 And just one last comment about  
11 integration. We host the PACS for St. Vincent's  
12 Hospital, and our two systems are very tightly  
13 integrated, where we each have an awareness of each  
14 other's studies and instant access to those studies, so  
15 if I'm reading an MRI at St. Vincent's, I will know  
16 instantly if there were prior studies at Advanced  
17 Radiology and vice versus, so you're less likely to have  
18 unnecessary repeat examinations.

19 The quality is better, because you have  
20 access to those prior examinations, and more timely,  
21 because you're not waiting for someone to deliver a CD.

22 So, in conclusion, I would urge OHCA to  
23 please approve ARC's request for permission to acquire a  
24 3T MRI for the Stamford office. It will result in more

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1 timely appointments, diagnosis and treatment, and, at the  
2 same time, bring state-of-the-art imaging technology to  
3 the Stamford area in a private setting that's not  
4 currently available, and it will be backed by our cutting  
5 edge image and report sharing network, which is patient  
6 empowering, enables our physicians with information in a  
7 timely and meaningful manner, and it's also a  
8 collaborative tool with our hospitals.

9 So thank you, again, for allowing me to  
10 speak, and I would like to now introduce my colleague,  
11 Dr. Alan Kaye.

12 DR. KAYE: Hello, again. Alan Kaye, Dr.  
13 Alan Kaye, former CEO of Advanced Radiology and now a  
14 member of the Radiology Executive Committee, like Drs.  
15 Muro and Karol, who are also here.

16 Much of what I have to say is somewhat  
17 duplicative of my remarks regarding the ONS application,  
18 and I will just mention the general category and then  
19 expand on some additional points.

20 Let me just introduce myself again, in  
21 terms of what some of my additional credentials are. As  
22 I've told you, I've been the Legislative Chairperson for  
23 the Radiological Society of Connecticut for now my 23  
24 years. I have been the -- I am on the Board of

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1 Chancellors of the American College of Radiology and  
2 serve on commissions that they are the committees of the  
3 Board, the Commissions for Economics, Government  
4 Relations, the Future Trends Committee, which deals with  
5 the future of alternative payment models and quality  
6 metrics, and the Radiology Integrated Care Network, which  
7 is a way of helping foster, move radiology and to  
8 participate in integrated models.

9                   What I didn't mention before was that I'm  
10 also on the Executive -- I'm on the Board and the  
11 Executive Committee Board and now on the Contracting  
12 Committee for Community Medical Group, which is an  
13 association. It's a conglomeration of IPAs, Independent  
14 Practice Associations, that encompass physicians from  
15 Greenwich, the state border, to the eastern shore of  
16 Connecticut.

17                   There are 1,100 providers participating,  
18 and we are involved in gain sharing models, in Medicare  
19 savings program, and are in the process of getting our  
20 Integrated Care Delivery Network designation, which is a  
21 fairly robust process.

22                   One of the reasons that I serve on that is  
23 because, as a member of Advanced Radiology, they are  
24 impressed with our preparation for those alternative care

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1 models, and we help guide them, not only with respect to  
2 radiology, but with respect to other ways that  
3 independent practices can participate in integrated care.

4 Now, that said, you don't have to be a  
5 single tax identification number one practice to become  
6 an integrated delivery network.

7 In fact, much of that has to do with  
8 technology, and that's why what Dr. Muro said, about how  
9 advanced we are, that's one of the reasons we're at the  
10 table with Community Medical Group.

11 And what Dr. Muro didn't say is that we  
12 have integrated with over 100, maybe even over 130  
13 electronic medical records for over 130 physicians, and,  
14 actually, if you include the now Epic one, it's over  
15 1,000 physicians, so we are technologically advanced, as  
16 well, and willing to provide a virtual integrated  
17 delivery network to our patients and to our referring  
18 physicians.

19 Now I've talked a lot about self-referral  
20 before and in my pre-file, and I'd like to adopt that  
21 pre-filed testimony, and, so, I won't repeat a lot of  
22 that, but I will just reiterate two things about it and  
23 then expand on it.

24 The two things I want to reiterate about

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1 it are, number one, that it does cause increased  
2 utilization relative to those that I refer. Study after  
3 study shows it, and there have even been studies,  
4 multiple studies, that show, when a physician acquires  
5 the imaging technology, he or she changes his or her  
6 behavior, and those are peer reviewed studies,  
7 statistically significant, not anecdotal, although I  
8 could probably give you plenty of anecdotal examples.

9 And the other thing about it is that it  
10 does affect referral relationships, affect on other  
11 providers and competition, but let me just give you some  
12 examples and types of things that are not necessarily  
13 right on the surface of what self-referral does, which  
14 are among the things I mentioned before.

15 When a physician owns his or her own unit,  
16 there is clearly an incentive to do that. Much of the  
17 time, it's stated to be the convenience of the patient,  
18 and we've debunked that in our submissions, but, also,  
19 you don't necessarily try to overcome some of the  
20 obstacles in referring to another practice, even though  
21 there may be enhancements of it.

22 So, for example, let's take, quote,  
23 "quality issues." As the CEO and lead physician of  
24 Advanced Radiology for 22 years, I received hundreds of

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1 requests for changing the way we do things, issues with  
2 respect to types of imaging, sometimes quality, which we  
3 address immediately, and, in fact, I had two employees,  
4 whose main job was to let us -- to canvas our referring  
5 physicians to help make us better and to help them take  
6 care of their patients better, so we might not hear about  
7 quality issues from a self-referring physician.

8                   We might not hear about protocols that  
9 they would prefer, and I can tell you that we have  
10 structured reports. When you get a report from Advanced  
11 Radiology, it has structure, and the way that works is  
12 there are fields to be completed.

13                   One of the fields is technique of the  
14 examination, and there are multiple neuro, orthopedic,  
15 urology, ENT, ophthalmologic protocols that we customize,  
16 as per the request of the referring physician.

17                   Now if you have your own unit and you  
18 aren't going to send anyway, you're not going to tell us  
19 what those protocols are, so that's one way that self-  
20 referral affects the general care of the population, and  
21 the incentives drive the behavior.

22                   Not asking your hospital to provide access  
23 to a radiology, independent radiology practice's  
24 electronic images in the operating room or on their work

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1 stations might be another, so, for example, just to use  
2 the Stamford, OSSM, Orthopaedic Specialty and Sports  
3 Specialists of Sports Medicine, and OAS, Orthopaedic  
4 Associates of Stamford, both had problems in Stamford  
5 seeing our imaging tests in the operating room, and, as  
6 you can imagine, that would create significant issues.

7           They petitioned and asked Stamford  
8 Hospital to allow it, and guess what? Stamford Hospital  
9 allows it, so they have access to it, but before we were  
10 able to get the technology in place, that was the impetus  
11 for the app that you could download on the Apple Store  
12 the app for allowing access.

13           So anyplace you have an internet or even a  
14 cellular connection, you can see our images and our  
15 reports and comparisons with prior ones, so a self-refer  
16 might not be inclined to ask for those things or ask  
17 their hospital to facilitate that.

18           You might not be so inclined to use a 3  
19 Tesla magnet, which, even by Dr. Sullivan's admission, is  
20 the state-of-the-art way to image in many ways that are  
21 probably not being done in places that don't have 3  
22 Tesla, so the gray zone expands for benefit of, I'm  
23 sorry, contracts for the benefits of 3 Tesla.

24           If you're a patient, and, as Dr. Muro

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1 said, somebody in his family he would send to a 3 Tesla,  
2 unless there was a contraindication to it, that's what  
3 happens with self-referral.

4 Now with respect to integrated delivery  
5 networks and sending patients to New York from Darien  
6 for, you know, inconveniencing them to do that, so that  
7 they could be part of the integrated delivery network, as  
8 I've told you, as I've asserted before and as Dr. Muro  
9 has testified, we have an effective integrated delivery  
10 network, and, in fact, our strategy, a lot of the things  
11 we told you about how we provide service in our  
12 electronic strategy and our large footprint, geographic  
13 footprint and our diversity of types of scanners is based  
14 upon what we perceive may be the new paradigm for care,  
15 and that is larger entities covering a larger, and we  
16 believe that an independent radiology practice, who is an  
17 expert in one thing imaging, who has a large footprint,  
18 who has multiple types of imaging services available, and  
19 who is electronically integrated with Cerner, with Epic,  
20 with Allscripts, with almost all of the big ones, is the  
21 way to go, and we can do it more cost effectively,  
22 without inflating the utilization.

23 Now if an integrated delivery network says  
24 that it does fewer, does fewer, that can be -- I'm not

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1 sure it's fewer than what we're doing. I think the 267  
2 is probably larger than what we're doing, but if it has,  
3 they should talk to us about providing the services more  
4 economically and available to a wider geographic  
5 population, and we stand ready to do that, we have been  
6 doing that, and that's one of the reasons why we're at  
7 CMG, and we plan to do that from the state line all the  
8 way up to and past Essex and are ready to do that now.

9 So we urge you to please consider our  
10 application favorably. We are positioning ourselves to  
11 be the preferred provider for imaging services in the  
12 most cost-effective and high-quality way, and I thank you  
13 for the opportunity for hearing myself, Clark Yoder and  
14 Dr. Muro. Thank you.

15 HEARING OFFICER HANSTED: Anything  
16 further?

17 MS. GROVES FUSCO: Oh, I'm sorry. That  
18 concludes our presentation.

19 HEARING OFFICER HANSTED: Okay. All  
20 right. Attorney Volpe, if you want to proceed with your  
21 presentation?

22 MS. VOLPE: Sure. I'm going to introduce  
23 Dr. Camel again.

24 HEARING OFFICER HANSTED: Good afternoon.

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1 DR. CAMEL: Well, hi. It's me again. I'm  
2 Dr. Mark Camel, as you know, and I adopted my pre-filed  
3 testimony in the docket. I'm here to speak in opposition  
4 to Advanced Radiology's CON application, and I will, in  
5 fact, keep my comments brief.

6 As outlined in the pre-filed testimony,  
7 Advanced Radiology has failed to meet the CON criteria.  
8 First, ARC has not demonstrated there's a clear public  
9 need in its practice for an additional MRI machine.

10 ARC has the ability to move underutilized  
11 scanners anywhere in the state, but it has chosen not to  
12 address the needs for individuals presenting for MRI at  
13 its Stamford location.

14 ARC scanners and its practice have  
15 significant service area overlap, and ARC, itself, has  
16 stated that it does not view the referral to us as a  
17 referral to a machine or a coil, but to us, as a practice  
18 or physician group.

19 ARC's assertion, that it's being forced to  
20 send Stamford area patients to Fairfield, is unfounded,  
21 as its Fairfield service area does not include the  
22 Stamford area.

23 ARC can manage the patients' needs by  
24 relocating an existing scanner. ARC already has an

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1 underutilized 3T scanner in its own practice. OHCA  
2 should carefully consider whether ARC has appropriately  
3 identified a need for an additional 3T MRI in its  
4 practice.

5 Further, Greenwich Hospital last week  
6 opened its 3T MRI machine on Long Ridge Road, raising the  
7 question -- I'm sorry. In Stamford, raising the question  
8 whether we need a second 3T MRI in Stamford.

9 As indicated in the WESTMED pre-filed  
10 testimony, WESTMED is seeking to redirect its own  
11 patients in the region, who require MRI scans, away from  
12 Advanced Radiology, presumably to WESTMED scanner in New  
13 York, as well as to other underutilized MRI providers  
14 right in Stamford, owned by Greenwich Hospital, Hospital  
15 for Special Surgery, and Stamford Hospital's scanner in  
16 Darien.

17 This will significantly affect the  
18 projected numbers that ARC has set forth in its  
19 application. OHCA should carefully review the impact on  
20 ARC's projections, since WESTMED will no longer serve as  
21 a referral source to ARC and will not continue to send  
22 thousands of WESTMED patients to its Stamford location.

23 Further, the second, or I should say one  
24 other orthopedic group in Stamford, OSSM, has now

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1       undergone dissolution. Two of those orthopedic surgeons  
2       have joined New England Medical Group, which is part of  
3       the Yale system, and will have offices on Long Ridge.

4                 The physiatrist has joined the Hospital  
5       for Special Surgery at their Chelsea Piers Exit 9  
6       location on 95, and the remaining two orthopedic surgeons  
7       I think have not yet decided what they're doing.

8                 As previously stated, ARC can relocate its  
9       existing scanner. ARC has an underutilized high-level  
10      scanner in its Orange location, which can be moved within  
11      its practice to any address it needs.

12                As important, another MRI referral source  
13      in Orange is seeking approval to expand its MRI services  
14      in Orange, which will bring additional capacity to the  
15      Orange location and will also impact the referrals to  
16      ARC's underutilized Orange MRI.

17                As outlined in detail in my pre-filed  
18      testimony, as well as WESTMED's filing, ARC has put forth  
19      the GE study, which shows significant proposed Medicare  
20      growth, but does not properly account for its own  
21      projected increase in Medicaid population.

22                In its 2004 application to OHCA, they  
23      projected a Medicare percentage population, Medicaid,  
24      excuse me, of 5.92 percent, but recently showed that its

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1 current Medicaid percentage population is about 3.9.

2 The ARC MRI is not -- the Advanced  
3 Radiology MRI is not proposed to be profitable. OHCA is  
4 required to consider the financial feasibility for a  
5 proposed CON. Advanced Radiology does not anticipate a  
6 profit.

7 Furthermore, it is questionable whether an  
8 additional MRI in Stamford will be profitable now that  
9 WESTMED, which accounts for over 2,000 referrals, is  
10 actively working towards redirecting those referrals to  
11 other underutilized MRI providers.

12 OHCA argues that self-referred MRIs are  
13 not beneficial and create overutilization. This cannot  
14 be further from the truth, and we've already reviewed the  
15 data.

16 Dr. Kaye noted national peer reviewed  
17 studies and journal, also noting anecdotal reports, but  
18 he discounts the anecdotal evidence that ONS has,  
19 demonstrating, and it's in this record, showing a stable  
20 to slightly decreasing number of MRIs referred per  
21 surgeon or physician at ONS.

22 Outside MRIs are not always beneficial to  
23 surgeons, and I'm here today to provide detail, as to how  
24 Advanced Radiology's technologists, for purposes of

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1 sharing MRI images, has not worked, as stated.

2 I previously discussed this earlier this  
3 morning and won't review this piece-by-piece, but we find  
4 it often, not seldom, difficult to access using their  
5 online platform.

6 As I've also said before, ONS slot times  
7 are now 40 minutes. More sequences are done, which allow  
8 us to see anatomic detail in ways that we often don't see  
9 from outside imaging devices with much shorter scan  
10 times, even when the machines are identical.

11 Finally, this is not Advanced Radiology's  
12 first time seeking approval concurrent with other  
13 providers in the service area. Advanced Radiology has a  
14 history of being reactionary and failing to be proactive  
15 in upgrading technology or even adding imaging capacity  
16 until other providers spend resources, like we have, and  
17 come forward for CON approval to meet the public need.

18 Advanced Radiology received OHCA approval  
19 to upgrade its Stamford MRI nearly nine years ago, but it  
20 chose not to implement that approval.

21 Further, Advanced Radiology states it has  
22 been overcapacity for years, but just coincidentally  
23 commenced the CON process for an additional MRI after the  
24 ONS application was deemed complete.

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1                   OHCA should question whether Advanced  
2 Radiology will even implement on an approved CON, since  
3 it never implemented on the waiver approval nine years  
4 ago.

5                   In conclusion, Advanced Radiology has  
6 failed to demonstrate a need for an additional MRI  
7 scanner.

8                   For all of the aforementioned reasons, we  
9 respectfully request that you decline Advanced  
10 Radiology's application.

11                   HEARING OFFICER HANSTED: Thank you,  
12 Doctor. Is that all?

13                   MS. VOLPE: Yeah, that concludes our  
14 Intervenor presentation.

15                   HEARING OFFICER HANSTED: Okay and if you  
16 and your client would take seats in the back, or  
17 somewhere back there, so Attorney Monahan and his witness  
18 can use that table, please?

19                   MS. VOLPE: Sure.

20                   HEARING OFFICER HANSTED: Good afternoon.

21                   MR. MONAHAN: Good afternoon, Hearing  
22 Officer Hansted and members of the OHCA panel. I'm  
23 Patrick Monahan. I represent Westchester Medical Group,  
24 PC in an Intervenor capacity.

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1                   On behalf of WESTMED, we do appreciate the  
2 opportunity to offer what we believe is pertinent  
3 evidence.

4                   I, as our Direct, am going to ask both  
5 witnesses to adopt their pre-filed testimony, and then  
6 ask Dr. Morel to my right to provide oral testimony in  
7 brief fashion, and, to facilitate the orderly proceeding  
8 of the hearing, we will rely on the written testimony of  
9 Dr. Weiss, however, to the extent there is any Cross-  
10 Examination of either witness that requires in my  
11 judgment Redirect, I would respectfully request the right  
12 to do some Redirect, if necessary.

13                   HEARING OFFICER HANSTED: Yes.

14                   MR. MONAHAN: Thank you. With that, I  
15 will introduce Dr. Richard Morel and ask him to identify  
16 himself, tell you a little bit about WESTMED and why we  
17 are here. Thank you.

18                   DR. MOREL: Hello. My name is Dr. Richard  
19 Morel, and I am both Medical Director and Vice President  
20 for WESTMED Medical Group, and I want to thank you for  
21 giving me the opportunity to speak today.

22                   I thought it would be helpful, since  
23 WESTMED is new to Connecticut, if I just give you a  
24 little background of who we are.

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1                   So we are a physician-owned and physician-  
2                   run multi-specialty practice. We originated 20 years ago  
3                   with 16 physicians. We've now grown to more than 420  
4                   providers. We have over 1,300 employees. We take care  
5                   of 330,000 patients in both New York and Connecticut.

6                   We operate on what's called a polyclinic  
7                   model, so our average office size is between 70 and  
8                   110,000 square feet, in which we have a primary care  
9                   base, with internal medicine pediatrics, OBGYN.

10                  We have an urgent care system for extended  
11                  access. We have pretty much every subspecialty under our  
12                  care system right now, other than maybe cardiothoracic  
13                  surgery, and we have onsite laboratory, pathology and  
14                  full imaging radiology, including MRI and CT-PET.

15                  That has really allowed us to provide the  
16                  new model of health care, which is the value-based model,  
17                  where we provide the highest quality care at the lowest  
18                  cost.

19                  We've been a successful MSSP through the  
20                  CMS program, have multiple ACO like products with the  
21                  commercial carriers.

22                  About a year ago, we entered into  
23                  Connecticut. We are quickly growing in Fairfield County.  
24                  We now have 20 providers as members of WESTMED here in

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1 Connecticut in four offices. We have two offices in  
2 Greenwich, we have an office in Darien, and we have the  
3 office in Stamford.

4 As of July 11th, Orthopaedic Associates of  
5 Stamford became members of WESTMED Medical Group. It's a  
6 large orthopedic group, with orthopedic, orthopedic spine  
7 pain management.

8 The reason that we are here today is we  
9 felt it was our duty to represent some information that  
10 was presented in ARC's application that we feel is not  
11 accurate, and that is the fact on their projected volume  
12 for MRIs as part of their application.

13 OAS, which is now part of WESTMED,  
14 formally in 2015 referred over 2,000 MRI scans to ARC.  
15 That is a major portion of their current volume.

16 It has been our experience and our growth  
17 from 16 providers to over 430 providers that those type  
18 of external referrals start to dissipate as time goes by.

19 The reason for that is we truly provide  
20 one coordinated network of care, so if you ask patients  
21 what's important to them and their health care, one of  
22 the things that they will tell you is I want my providers  
23 to talk to each other.

24 Most of health care right now is provided

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1 in silos, so you get your radiology images here, you have  
2 your internists here, your orthopedist in another  
3 location, and you're lucky if there's communication  
4 between them.

5                   Within WESTMED, we operate on one system.  
6 Your entire team is talking to each other. We have one  
7 EMR. We have a communication system within our EMR.  
8 Every provider can see what everyone else is doing, and  
9 that leads to higher quality and lower cost.

10                   In addition, one of the things patients  
11 want you to be is respectful for their time.  
12 Traditionally, we've made patients wait too long in  
13 medicine, a lot of unnecessary waiting, right?

14                   You get your mammogram done. You get a  
15 letter in the mail a week later what the results are.  
16 You're called back for additional imaging. You've got to  
17 schedule that a week later. You're told you need a  
18 biopsy. It's two weeks to see a breast surgeon, then you  
19 wait another week for biopsy results. That's five weeks  
20 of time, where you're nervous and you're worried about  
21 what your results will be, so we don't provide that for  
22 patients. We're respectful of their care. We take  
23 patients from screening mammogram to biopsy results in 48  
24 hours.

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1 I still see patients part-time. The  
2 patient that I saw last week was a 70-year-old woman, who  
3 is a smoker, who came in to see me for a 9:30  
4 appointment, so she saw me for her Medicare wellness  
5 exam.

6 She had her mammogram pre-booked already  
7 and had her mammogram done. She had her full labs done.  
8 She had her bone density done, and she had her CT  
9 screening low dose for lung cancer. All of that done,  
10 and she was back in my office at 11:30 to go over the  
11 results.

12 That's the level of care that we provide  
13 to patients, and that's why those patients, who are  
14 presently getting fractionated care at different health  
15 systems, are going to be full WESTMED patients and  
16 receive that comprehensive care under the WESTMED  
17 umbrella, and they will lose their 2,000 referrals.  
18 Thank you.

19 HEARING OFFICER HANSTED: Thank you.

20 MR. MONAHAN: And, just formally, would  
21 you adopt your pre-filed testimony?

22 DR. MOREL: And I adopt my pre-filed  
23 testimony.

24 MR. MONAHAN: And Dr. Jonathan Weiss, if

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1 you'd introduce yourself and adopt your testimony,  
2 please?

3 DR. WEISS: My name is Dr. John Weiss.  
4 I'm the Senior Radiologist at WESTMED Medical Group.  
5 I've been there for 15 years. Prior to that, I was at  
6 White Plains Hospital for 12 years. I would like to  
7 adopt the testimony I already submitted.

8 Our group does about 11,000 MRIs a year at  
9 this point. We operate four MRIs in New York State, none  
10 of which are 3 Tesla. A fifth is coming online shortly,  
11 and I'll leave it at that.

12 HEARING OFFICER HANSTED: Okay, thank you,  
13 Doctor. Does that conclude your presentation?

14 MR. MONAHAN: That concludes our  
15 presentation.

16 HEARING OFFICER HANSTED: Okay. Just stay  
17 there. Do you want to Cross?

18 MS. GROVES FUSCO: Sure. Good afternoon.  
19 Dr. Morel, I'll start with something you just said at the  
20 end of, right at the very end of your presentation.

21 So, you know, you talk about this desire  
22 to have patients receive comprehensive care under the  
23 WESTMED umbrella, correct?

24 DR. MOREL: Um-hum.

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1 MS. GROVES FUSCO: And that includes all  
2 services, such as MRI, you know, advanced imagine  
3 service, as well. So right now, today, in order for a  
4 Connecticut-based WESTMED patient to get comprehensive  
5 care, including MRI services, they're going to have to  
6 travel to New York for that MRI, correct, because you  
7 don't operate scanners here?

8 DR. MOREL: Correct.

9 MS. GROVES FUSCO: Okay and you also  
10 mentioned that you're very respectful of patients' time.  
11 Is asking patients, who right now often receive their MRI  
12 services in the same town where their physician's office  
13 is located and, you know, once Advanced Radiology moves  
14 their office, they'll be two doors down, does asking  
15 those patients, instead of going two doors down for their  
16 scan, to get in a car and go down 95 in traffic through  
17 Greenwich and what have you to get that scan, potentially  
18 hours round trip, is that respectful of patients' time?

19 DR. MOREL: It's respectful of patients'  
20 time, because, A, they'll have the opportunity to receive  
21 other aspects of their care, and it's also respectful of  
22 their time, because they'll have access to higher quality  
23 care.

24 MS. GROVES FUSCO: Okay, so, are you

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1 suggesting that the quality of MRI services that are  
2 provided by Advanced Radiology are not adequate?

3 DR. MOREL: No, I'm not.

4 MS. GROVES FUSCO: Okay, because you know  
5 that OAS refers them over 2,000 scans a year. They think  
6 they're good enough that they send 71 percent of their  
7 scans there, correct?

8 DR. MOREL: Yes.

9 MS. GROVES FUSCO: So these patients could  
10 get high-quality MRI services just a few doors away from  
11 their orthopedist's office.

12 DR. MOREL: But it's not just the MRI.  
13 So, for instance, we have -- I don't know if anyone is  
14 familiar with an IPU. So IPU is an Integrated Practice  
15 Unit, and we have one focused on spine care, and this is  
16 very similar to oncologic care, so what we do is we will  
17 have, in one room, you have spinal surgeons, pain  
18 medicine physicians, physical therapists, behavioral  
19 health, radiology, okay, physical therapy, all aspects of  
20 a team involved in that patient care.

21 Difficult patients will be presented. All  
22 members of that team will have their input, and a plan  
23 will be devised, based on all sides of that input, and,  
24 if scans are done outside, they don't have that quite

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1 same level of access.

2 MS. GROVES FUSCO: Will you acknowledge  
3 that there are certain patients that will not want to  
4 travel to New York for scans?

5 DR. MOREL: Oh, absolutely.

6 MS. GROVES FUSCO: Okay. You've been able  
7 to quantify what that percentage is? Because you state  
8 in your papers that pretty much all 2,000 patients are  
9 going to be leaving.

10 DR. MOREL: So, based on our experience,  
11 so we've grown, remember, from 16 to 430 providers, so  
12 we've seen this multiple, multiple times in the past over  
13 the last 20 years, and what happens is patients like to  
14 have all of their care under one system, they like their  
15 providers speaking to each other, and doctors like their  
16 job to be easier.

17 When you're trying to pull together all  
18 types of outside resources, it's very difficult to  
19 provide the same level of care to patients.

20 MS. GROVES FUSCO: You are aware that OAS  
21 recently relocated their office to be closer to sort of  
22 the New Canaan/Darien side of Stamford, because they get  
23 the majority of their referrals from New Canaan and  
24 Darien, which are further to the east, correct?

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1 DR. MOREL: Well I know they relocated. I  
2 do not know the reason they relocated.

3 MS. GROVES FUSCO: Okay. Assuming it's  
4 because they get a majority of their patients from that  
5 area, would you agree that traveling to New York from  
6 points east of Stamford is even more cumbersome than  
7 suggesting patients from Stamford or Greenwich go across  
8 the border, that you're increasing the travel time even  
9 more for these patients?

10 DR. MOREL: I'll agree it's increasing the  
11 travel time, but there are lots of people in this  
12 community, who work in Manhattan and travel to Manhattan  
13 for work every day.

14 MS. GROVES FUSCO: Understandable, but  
15 that's work.

16 DR. MOREL: And this is your health.

17 MS. GROVES FUSCO: That's not an MRI scan.

18 MR. MONAHAN: May I ask that counsel not  
19 be argumentative with the witness?

20 HEARING OFFICER HANSTED: Counsel, just  
21 ask the question.

22 MS. GROVES FUSCO: Okay. In your  
23 experience, you said, when I asked you if you could  
24 quantify how many scans we're talking about, you said, in

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1 your personal experience, most patients want to do it.  
2 Does your personal experience include asking patients to  
3 travel from lower Fairfield County, from the Stamford  
4 area and points east to New York for MRI scans?

5 DR. MOREL: So I'll give you another  
6 example.

7 MS. GROVES FUSCO: No. It's a yes or no  
8 question. Does it include that particular --

9 DR. MOREL: Repeat the question, please?

10 MS. GROVES FUSCO: Does your personal  
11 experience involve asking patients to travel from lower  
12 Fairfield County, Stamford and points east to New York?

13 DR. MOREL: We have only been in Stamford  
14 for the last seven weeks.

15 MS. GROVES FUSCO: So it's not part of  
16 your experience?

17 DR. MOREL: But I would say that it  
18 relates to our past experience over 20 years, and, as an  
19 example, I have a patient, who I saw in my Yonkers  
20 office, and needed a hand specialist and traveled up to  
21 OAS in Stamford to see a hand specialist.

22 MS. GROVES FUSCO: Are you aware, and you  
23 raised the possibility of applying for your own CON unit  
24 here in Connecticut, are you aware that you can't prove

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1 need for an MRI unit, based upon basically eviscerating  
2 the volume of an existing provider, taking what you would  
3 say would be 40 percent of another provider's volume to  
4 justify need for your unit?

5 MR. MONAHAN: I'm going to object to the  
6 question and the substance and form of the question,  
7 because we're not here on an MRI or an application in our  
8 proceeding, and --

9 MS. GROVES FUSCO: It's --

10 MR. MONAHAN: May I finish, please? And  
11 there is -- if the witness knows the answer, without  
12 having studied the legal components, that may be fine,  
13 but I believe it calls for a legal analysis, and I think  
14 it's inappropriate in this proceeding.

15 MS. GROVES FUSCO: With all due respect,  
16 the issue was raised by WESTMED in their petition. Will  
17 you let me now finish?

18 MR. MONAHAN: The issue --

19 HEARING OFFICER HANSTED: Let her finish.

20 MS. GROVES FUSCO: With all due respect,  
21 the issue was raised by WESTMED in their petition and in  
22 their filings. I can ask the question. If the witness  
23 cannot answer, it's fine for him to say he can't answer.

24 HEARING OFFICER HANSTED: It's fair game.

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1 You raised it in your petition.

2 MR. MONAHAN: Fair enough. Thank you.

3 HEARING OFFICER HANSTED: If he can't  
4 answer, he can't answer.

5 MR. MONAHAN: Thank you.

6 DR. MOREL: So we are considering applying  
7 for our own Certified of Need, but we haven't gone  
8 through all of the aspects of the legality and questions  
9 about that, no.

10 MS. GROVES FUSCO: One of the things, and  
11 I'm not sure if it was in pre-file or if it was in a  
12 rebuttal written by your counsel, was that, you know,  
13 you, as WESTMED now and OAS, have every right to refer  
14 patients wherever you want in Fairfield County, and I  
15 agree. Patients have a choice in where they go.

16 Do you have plans to refer patients away  
17 from ARC to other lower Fairfield County providers, and,  
18 if so, which providers?

19 DR. MOREL: We do not.

20 MS. GROVES FUSCO: You're aware that a  
21 majority of the providers in the Stamford area are  
22 hospital-based and potentially more costly providers of  
23 MRI services?

24 DR. MOREL: I am.

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1 MS. GROVES FUSCO: That Advanced Radiology  
2 is the only private physician practice, private radiology  
3 practice providing MRI?

4 HEARING OFFICER HANSTED: If you could  
5 just answer her verbally, just so it picks up on the  
6 record?

7 DR. MOREL: Oh, sorry.

8 HEARING OFFICER HANSTED: That's all  
9 right.

10 DR. MOREL: Repeat it again? Sorry.

11 MS. GROVES FUSCO: I'm sorry. That  
12 Advanced Radiology is the only private radiology practice  
13 in the Stamford area that offers MRI?

14 DR. MOREL: I am aware.

15 MS. GROVES FUSCO: How many of your -- I  
16 think you quoted 330,000 patients. How many of those  
17 patients are Connecticut residents?

18 DR. MOREL: I do not know the answer to  
19 that off the top of my head.

20 MS. GROVES FUSCO: And you quote a  
21 Medicaid percentage, which I assume is for your entire  
22 practice. Do you know what your Medicaid payer mix  
23 percentage is for Connecticut patients? I should say  
24 Connecticut Medicaid beneficiaries.

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1 DR. MOREL: I do not.

2 MS. GROVES FUSCO: The profits from the  
3 ancillary services that are provided under the WESTMED  
4 umbrella, including advanced imaging, those are  
5 distributed among WESTMED physicians, correct?

6 DR. MOREL: Partially, they're  
7 distributed, and, partially, they're used to fund other  
8 aspects of care, which are not able to fund on a fee-for-  
9 service basis, such as we have a large behavioral health  
10 program, which would operate at a financial loss.

11 We have a palliative medicine program. We  
12 have case managers in each office, so we use those  
13 profits to provide what we believe is valuable care to  
14 our patients.

15 MS. GROVES FUSCO: I'm talking about after  
16 you reinvest, the true profit, what's leftover. That's  
17 distributed among the WESTMED physicians, correct?

18 DR. MOREL: Yes, it is.

19 MS. GROVES FUSCO: Okay, so, WESTMED  
20 physicians do benefit financially from referrals of  
21 patients to WESTMED-owned advanced imaging units,  
22 correct?

23 DR. MOREL: WESTMED physicians benefit  
24 from the profit of WESTMED Medical Group.

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1 MS. GROVES FUSCO: Which includes revenue  
2 from practice-owned advanced imaging?

3 DR. MOREL: Which is partially funded from  
4 our imaging services.

5 MS. GROVES FUSCO: Okay. And I asked this  
6 question before, but I'll ask it to you. Have you had  
7 any discussions with ONS, Orthopaedic & Neurosurgery  
8 Specialists, about any arrangement that would bring their  
9 physicians or MRI units under the WESTMED umbrella or  
10 that would allow you to bring WESTMED MRI referrals to  
11 ONS?

12 MR. MONAHAN: I'm just going to object to  
13 that question. I'm going to allow the witness to answer,  
14 but for the record and to preserve the objection on the  
15 record, I believe it's inappropriate to delve into what  
16 may or may not be confidential communications, but I will  
17 allow, will ask the witness to answer, but I want to  
18 preserve that objection if we're going to start going  
19 down that road.

20 HEARING OFFICER HANSTED: Okay.

21 DR. MOREL: We have not.

22 MS. GROVES FUSCO: When you acquired  
23 Orthopaedic Associates of Stamford, did you make the  
24 requisite legal filings with the State of Connecticut,

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1 Attorney General's Office, regarding the practice  
2 transfer, to be qualified for those?

3 DR. MOREL: We did.

4 MS. GROVES FUSCO: Okay, so, those are  
5 available, if OHCA needs to review them?

6 DR. MOREL: Yes.

7 MS. GROVES FUSCO: Is there a reason why  
8 Advanced Radiology can't integrate with your EMR the way  
9 that they've integrated with other EMRs, as we've  
10 discussed in our presentation?

11 DR. MOREL: No. We would be happy to  
12 investigate that.

13 MS. GROVES FUSCO: And would you allow it?

14 DR. MOREL: Yes.

15 MS. GROVES FUSCO: Okay. There's one last  
16 question. Are all WESTMED MRI scans read by  
17 subspecialist radiologists? That's a question for you,  
18 Dr. Weiss. Sorry.

19 DR. WEISS: We're all Board Certified  
20 diagnostic radiologists.

21 MS. GROVES FUSCO: Okay, so, they're Board  
22 Certified, but are they fellowship trained in  
23 subspecialties, Board Certified in subspecialties, like  
24 neuroradiology?

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1 DR. WEISS: We have a fellowship trained  
2 bone radiologist. I don't know of any others.

3 MS. GROVES FUSCO: Okay, so, not every  
4 scan is read by a fellowship-trained subspecialist?

5 DR. WEISS: Correct.

6 MS. GROVES FUSCO: Okay. I have no -- I  
7 think I have none. No, I have no other questions.  
8 Sorry. All set.

9 HEARING OFFICER HANSTED: Do you have any  
10 Redirect?

11 MR. MONAHAN: I have no Redirect.

12 HEARING OFFICER HANSTED: Okay. If you  
13 could switch seats with Attorney Volpe and her client,  
14 I'd appreciate it.

15 MS. GROVES FUSCO: It will be short. I  
16 promise.

17 HEARING OFFICER HANSTED: I'm not rushing  
18 anyone.

19 MS. GROVES FUSCO: But I'm rushing myself.  
20 Hello, again. This will be much shorter. I do promise.

21 In your written testimony, you've claimed,  
22 and I think you stated it again in your remarks today,  
23 that there's no need for additional MRI within ARC's  
24 practice, correct? You stated that in your verbal

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1 remarks today and in your submission?

2 DR. CAMEL: Correct.

3 MS. GROVES FUSCO: Correct. Okay, but you  
4 also stated in your remarks earlier today, when you were  
5 talking about your own application, that, when an  
6 Applicant exceeds 85 percent of the 4,000 scan benchmark  
7 per year, there's need, and the need review should end at  
8 that point, and the application should be approved. Do  
9 you remember saying that?

10 DR. CAMEL: I do.

11 MS. GROVES FUSCO: Okay and you do know  
12 that 85 percent of 4,000 scans is 3,400 scans?

13 DR. CAMEL: I do.

14 MS. GROVES FUSCO: Okay. We're doing more  
15 math. And you know that Advanced Radiology performs  
16 6,617 scans?

17 DR. CAMEL: I do.

18 MS. GROVES FUSCO: Okay, so, that puts  
19 them at 165 percent capacity, based on that benchmark,  
20 correct?

21 DR. CAMEL: I do.

22 MS. GROVES FUSCO: And nearly twice the  
23 number of scans needed to justify an additional unit?

24 DR. CAMEL: I do, as long as we ignore the

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1 intent of --

2 MS. GROVES FUSCO: Okay. I'm talking  
3 about current volume.

4 DR. CAMEL: Current volume, you're  
5 correct.

6 MS. GROVES FUSCO: Okay, so, then you  
7 would agree that ARC meets that same criteria in the  
8 State Health Plan justifying need, based upon utilization  
9 of their existing unit, correct?

10 DR. CAMEL: Yes.

11 MS. GROVES FUSCO: And you know that what  
12 the State Health Plan says at page 61 is that, if you  
13 operate a unit in the primary service area and you're  
14 applying for another unit in the primary service area,  
15 that you have to show that that unit is at 85 percent.  
16 You don't have to look at the unit that's 40 miles away  
17 in Orange?

18 DR. CAMEL: Honestly, I don't know that,  
19 but I'll take your word for it.

20 MS. GROVES FUSCO: Yeah, I don't know if  
21 your attorney has the State Health Plan.

22 MS. VOLPE: We have it.

23 MS. GROVES FUSCO: Okay. Would you also  
24 agree, based upon Section Table 8 of the State Health

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1 Plan, but I think your attorney included it in your  
2 submissions, that Advanced Radiology's Stamford unit, at  
3 least as of 2013, was the busiest unit in the service  
4 area?

5 DR. CAMEL: I'm sorry. I don't have that  
6 data in front of me.

7 MS. GROVES FUSCO: Let me point you to --  
8 I think it was in your -- I think we have it in ours. If  
9 you look at -- do you have -- Michele, do you have Table  
10 8 of the State Health Plan?

11 MS. VOLPE: Yes.

12 MS. GROVES FUSCO: Or would it be easier  
13 to refer him to the chart you did with all the providers?

14 MS. VOLPE: Why don't you just ask your  
15 question? I have the --

16 MS. GROVES FUSCO: All I want to ask you  
17 is if you can confirm that it's the busiest unit of the  
18 13 units in the service area. I don't want you to have  
19 to go through the whole table.

20 MS. VOLPE: Currently?

21 MS. GROVES FUSCO: As of 2013.

22 MS. VOLPE: As of 2013.

23 MS. GROVES FUSCO: As of the data  
24 available in Table 8.

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1 MS. VOLPE: Yes, which was from 2012 data,  
2 but, yes.

3 MS. GROVES FUSCO: No. It was 2013 data  
4 reported in 2014.

5 MS. VOLPE: Reported in 2014. Yup, we  
6 have it.

7 HEARING OFFICER HANSTED: Can I just  
8 interrupt one moment? I want to give Attorney Monahan's  
9 clients the same courtesy I gave Attorney Cowherd's.  
10 Does anyone have any objection to his clients being  
11 dismissed? Do you have questions for them?

12 MS. GROVES FUSCO: No.

13 MS. VOLPE: Well, I mean, we don't have  
14 questions for them, but I think, if they don't mind  
15 staying.

16 MR. MONAHAN: We appreciate the courtesy.  
17 If people here and the panel don't mind, I think our  
18 clients are pleased to stay for the remainder.

19 HEARING OFFICER HANSTED: They're welcome  
20 to stay. I just wanted to give the same courtesy.

21 MR. MONAHAN: I appreciate that very much.

22 HEARING OFFICER HANSTED: Okay.

23 MR. MONAHAN: Thank you.

24 HEARING OFFICER HANSTED: All right. You

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1 may continue.

2 MS. VOLPE: We have Table 8.

3 MS. GROVES FUSCO: Yeah, no. My question  
4 was just whether, based upon the information in Table 8,  
5 is Advanced Radiology's unit the busiest unit in the  
6 service area for that year?

7 MS. VOLPE: As of the 2013 data?

8 MS. GROVES FUSCO: Yeah, as of the 2013  
9 data.

10 MS. VOLPE: Sure.

11 DR. CAMEL: Yes.

12 MS. GROVES FUSCO: Okay. As a physician,  
13 would you recommend that a patient with a back condition  
14 or some other sort of, you know, painful condition, or  
15 acute illness that made them uncomfortable sitting,  
16 driving a car two hours round trip to get an MRI scan?

17 MS. VOLPE: You know, I'm going to object  
18 to that, because she's asking him like a professional  
19 opinion. It's not really relevant to -- I mean she's  
20 asking him in his professional opinion as a doctor, and  
21 I'm going to object to that.

22 MS. GROVES FUSCO: He's raised the issue,  
23 that we should be sending -- they've raised the issue in  
24 their rebuttal, that we should be sending patients to

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1 underutilized units in our practice, that all of our  
2 units are interchangeable, and that we should be shifting  
3 around, and I'm asking if it's clinically appropriate,  
4 and his credentials state that he's a doctor, to send a  
5 patient from Stamford to Orange for a scan when they're  
6 in pain. That's all I'm asking, and I think it's  
7 perfectly appropriate.

8 HEARING OFFICER HANSTED: I think it is,  
9 too. Just don't go any further into the medical  
10 question.

11 MS. GROVES FUSCO: It's one question.

12 HEARING OFFICER HANSTED: That's fine.

13 DR. CAMEL: Is it never appropriate? I  
14 think it's sometimes inappropriate.

15 MS. GROVES FUSCO: Okay. Would you agree,  
16 sort of as a referrer of MRI services, that certain  
17 patients require scans on certain types of units, either  
18 based on the clinical information you require, or  
19 patient-specific issues, like claustrophobia or obesity?

20 DR. CAMEL: Yes.

21 MS. GROVES FUSCO: Okay and you did  
22 acknowledge earlier today that there are some patients,  
23 who do require or for whom 3T is preferable, correct, 3T  
24 MRI?

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1 DR. CAMEL: Yes.

2 MS. GROVES FUSCO: Okay, so, you know,  
3 given the fact that patients sometimes need to go to  
4 specific types of machines, and this may be for you, Dr.  
5 Sullivan, you can jump in, MRI machines aren't  
6 interchangeable, correct?

7 DR. CAMEL: Correct.

8 MS. GROVES FUSCO: Okay and just because  
9 it's a 1.5 Tesla unit doesn't mean it's interchangeable  
10 with another 1.5 Tesla unit, correct?

11 DR. CAMEL: Yes.

12 MS. GROVES FUSCO: They can have different  
13 applications, so the same thing. 3Ts aren't  
14 interchangeable with 1.5 or even among themselves. Some  
15 are closed. Some are open. Some have different  
16 applications. They're not interchangeable.

17 DR. CAMEL: That, I think, is a bigger  
18 question than you meant, because you asked a lot of  
19 questions.

20 MS. GROVES FUSCO: Sorry. I apologize.

21 DR. CAMEL: So I think that, as far as my  
22 knowledge is, all 3Ts are closed. There no such thing as  
23 an open 3T, so that specific question and answer is, no,  
24 they're all closed.

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1                   Two is, I don't know every model of 3T on  
2 the market, and I'm not an expert like the -- there are a  
3 lot more radiologists in this room, who can answer that  
4 question better. I'm a neurosurgeon, so I don't know  
5 what the answer -- I mean I don't know how to answer it.

6                   MS. GROVES FUSCO: I'll ask a different  
7 question. So one of the things that's been raised in  
8 your testimony is that Advanced Radiology operates a  
9 number of, you know, 1.5 and 3 Tesla units, you know,  
10 located from Stamford to Orange, and that we could easily  
11 do some shifting of our patients among the units to  
12 better spread our patient balance, so we don't have  
13 capacity issues.

14                   Is it fair to say you would need to know  
15 more about the capabilities of each unit to know if  
16 patients can be shifted and fix capacity issues?

17                   DR. CAMEL: Yes.

18                   MS. GROVES FUSCO: Thank you. You  
19 mentioned in your written testimony and again here today  
20 that the proposed Connecticut Orthopaedic Specialists'  
21 mobile MRI unit could meet ARC's patients' needs in  
22 Orange if the Orange scanner was relocated to Stamford.

23                   The proposed unit is not a 3 Tesla unit,  
24 correct?

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1 DR. CAMEL: I don't recall saying that. I  
2 did say that?

3 MS. GROVES FUSCO: You did.

4 MS. VOLPE: For the Connecticut  
5 Orthopaedic Specialists, they have a pending application  
6 before OHCA.

7 DR. CAMEL: Of a 1.5?

8 MS. GROVES FUSCO: Well that's what I'm  
9 asking.

10 MS. VOLPE: Of a mobile unit.

11 MS. GROVES FUSCO: It's a 1.5 mobile.  
12 That's not comparable to a 3 Tesla fixed, is it?

13 DR. CAMEL: It is not.

14 MS. GROVES FUSCO: Okay. Is your group in  
15 any discussions with Connecticut Orthopaedics regarding  
16 any sort of professional affiliation?

17 DR. CAMEL: None.

18 MS. GROVES FUSCO: Would you agree, based  
19 on your submissions and some of the information that was  
20 raised today, about Greenwich Hospital having a 3 Tesla,  
21 would you agree that a hospital-based, a true provider-  
22 based unit is more costly, in terms of reimbursement  
23 rates and facility fees than MRI units, like you operate  
24 and my client operates in private practice?

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1 DR. CAMEL: Yes.

2 MS. GROVES FUSCO: So it's not comparable?  
3 The 3T at Greenwich is not comparable to the proposed 3T  
4 from a cost perspective for patients?

5 DR. CAMEL: To be honest, I don't honestly  
6 know everybody's fee structure.

7 MS. GROVES FUSCO: But generally speaking?

8 DR. CAMEL: Generally speaking, that's  
9 correct.

10 MS. GROVES FUSCO: Okay. Just a few last  
11 questions. You state in your written testimony and again  
12 here that my client has a history of obstructing other  
13 people's CONs. When you -- you suggested that this first  
14 happened when they filed a waiver for an upgrade of their  
15 existing MRI unit in Stamford to a 3T, correct?

16 DR. CAMEL: You mean the one years ago?

17 MS. GROVES FUSCO: Yes.

18 DR. CAMEL: The nine years ago?

19 MS. GROVES FUSCO: Yes.

20 DR. CAMEL: Yes, I did say that.

21 MS. GROVES FUSCO: And do you claim that  
22 their failure to go forward with that waiver suggests  
23 that it was done just to obstruct your CON?

24 DR. CAMEL: No. I think they're two

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1 related incidents. One is that I don't know why they  
2 applied for it in 2008 or '09, and I don't know why they,  
3 once they got the waiver, they chose not to put it in. I  
4 have no information, so I don't know what their intent  
5 was.

6 MS. GROVES FUSCO: You say you don't know  
7 why they applied for it, but, in your petition, you  
8 suggest that they applied for it to block your CON.

9 DR. CAMEL: No.

10 MS. GROVES FUSCO: Do you believe that?

11 DR. CAMEL: I said they applied for this  
12 one only after our -- it's just coincidence, and you can  
13 draw whatever conclusion you wish to.

14 MS. GROVES FUSCO: So the references back  
15 to 2008 and the suggestion, I believe the word you used  
16 was that there's a pattern of obstruction, you don't  
17 believe they tried to obstruct you in 2008, do you?

18 DR. CAMEL: Did we have an application  
19 pending 2008? I don't know what their intent was.

20 MS. VOLPE: We went for our upgrade in  
21 2008.

22 MS. GROVES FUSCO: Did Advanced Radiology  
23 intervene in your 2008 proceeding?

24 MS. VOLPE: For the upgrade, no.

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1 DR. CAMEL: No.

2 MS. GROVES FUSCO: They didn't intervene  
3 and oppose? You got the CON, correct?

4 DR. CAMEL: Yes.

5 MS. GROVES FUSCO: Even though Stamford  
6 also got their waiver, so they didn't oppose you then, so  
7 that is not evidence of a pattern of obstruction of your  
8 CON. They did not get involved in your CON in 2008.

9 DR. CAMEL: Not to my knowledge, no.

10 MS. GROVES FUSCO: Okay and I think we  
11 talked about this this morning, but, after that CON, you  
12 actually -- someone from your office went to ARC's office  
13 to look at their unit before you purchased yours.

14 DR. CAMEL: You said that earlier, but I'm  
15 not aware of it.

16 MS. GROVES FUSCO: And just one last  
17 question. Sort of the most recent CON request for MRI  
18 services that was filed in the Stamford area was filed by  
19 the Hospital for Special Surgery, and ONS put a letter  
20 into the record objecting to that, correct?

21 DR. CAMEL: Yes.

22 MS. GROVES FUSCO: But didn't formally  
23 intervene in the proceeding for purposes of Cross-  
24 Examination and all this, correct?

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1 DR. CAMEL: Correct.

2 MS. GROVES FUSCO: And ARC didn't  
3 intervene in that proceeding, even though they were an  
4 existing provider in Stamford, correct?

5 DR. CAMEL: I wouldn't be aware of that.

6 MS. GROVES FUSCO: Okay. We didn't.  
7 That's it.

8 HEARING OFFICER HANSTED: Okay. Attorney  
9 Volpe, if you want to proceed with your Cross?

10 MS. VOLPE: Yes. I'm going to extend a  
11 professional courtesy to ARC and present questions and  
12 allow them to have whoever they feel appropriate address  
13 them, just in the interest of a fact finding proceeding.

14 MS. GROVES FUSCO: Can I ask for just a  
15 two-minute bathroom run before you start?

16 MS. VOLPE: Oh, sure. Go right ahead.

17 HEARING OFFICER HANSTED: Do you need a  
18 break? All right, we're off the record.

19 (Off the record)

20 MS. VOLPE: So my first question for ARC,  
21 the Applicants, is is ARC owned by only radiologists?

22 DR. KAYE: Yes.

23 HEARING OFFICER HANSTED: Please identify  
24 yourself.

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1 DR. KAYE: Alan Kaye. Yes.

2 MS. VOLPE: Okay. Does anyone, but a  
3 radiologist, have any interest in any affiliate of ARC?

4 DR. KAYE: Alan Kaye, no.

5 MS. VOLPE: Okay.

6 HEARING OFFICER HANSTED: Just initially.

7 DR. KAYE: Okay. It will be me, unless --

8 MS. VOLPE: Unless otherwise stated.

9 DR. KAYE: Even if I change my voice a  
10 little.

11 HEARING OFFICER HANSTED: Thank you.

12 MS. VOLPE: Alan and I like to talk to  
13 each other. Okay. When ARC filed its application, this  
14 current application, was it aware of OAS's merger with  
15 WESTMED?

16 DR. KAYE: I don't think so.

17 MS. VOLPE: Okay. Fair enough.

18 DR. KAYE: No. No. I just asked the  
19 person, who was the person, who told us about it.

20 MS. VOLPE: Okay, so, your projections  
21 included the WESTMED volume?

22 DR. KAYE: Yes.

23 MS. VOLPE: Were you -- are you aware of  
24 OSSM's doctors' affiliation now with the Yale health

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1 system, Northeast Medical Group?

2 DR. KAYE: Actually, not until I just  
3 heard it, but I believe some of my associates, yes.

4 MS. VOLPE: Okay. Are the volume referral  
5 projections of those orthopedists included in your  
6 numbers?

7 DR. KAYE: Yes.

8 MS. VOLPE: Okay. Do you consider 2,767  
9 MRI referrals and scans a significant number?

10 DR. KAYE: Significant number of patients,  
11 of course.

12 MS. VOLPE: Significant number of scans?

13 DR. KAYE: Yes.

14 MS. VOLPE: Okay. He answered the  
15 question. The question is whether he considered it  
16 significant.

17 DR. KAYE: I do consider that that is not  
18 to be the number of scans that patients, who referred for  
19 scans to us.

20 MS. VOLPE: That came from WESTMED's  
21 testimony.

22 DR. KAYE: And we rebutted it earlier.

23 MS. VOLPE: Do you consider an excess of  
24 2,000 scans a significant number of MRIs?

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1 DR. KAYE: Yes, but it does not affect our  
2 profitability.

3 MS. VOLPE: He answered the question. So  
4 how does ARC propose to replace that volume from WESTMED?

5 DR. KAYE: We don't believe that they will  
6 be able to send that many of their patients through the  
7 traffic on I-95 to New York State. The patients won't  
8 stand for it. They've gotten great service from us, so I  
9 do not believe that's going to happen. We do not believe  
10 that's going to happen.

11 MS. VOLPE: Okay, so, in your application,  
12 did you state that ARC will have incremental losses in  
13 the first few years?

14 DR. KAYE: Yes.

15 MS. VOLPE: And will those losses be  
16 greater if ARC does not have a significant amount of  
17 referrals from WESTMED?

18 DR. KAYE: I would think so, although we  
19 can't predict whether we're going to pick up additional  
20 scans, and I would say that we will still be profitable,  
21 and we're in this for the long haul, so we can absorb a  
22 year or two of losses.

23 DR. KAYE: So do you attest that the  
24 Stamford location will still be financially viable with

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1 two MRIs, noting testimony that's provided today with the  
2 loss of thousands of referrals?

3 DR. KAYE: I'm going to turn the  
4 financial-related questions over to our CEO, Clark Yoder.

5 MR. YODER: Hi. Clark Yoder for the  
6 record. Yes, we've ran pro formas subsequently looking  
7 at this potential loss of MRIs, and we are still  
8 profitable, and we're still financially feasible, even  
9 with that migration of some of those OAS patients, and  
10 even with the migration of all of them, we will still be  
11 financially feasible.

12 MS. VOLPE: Okay. My question is the  
13 financial feasibility of the Stamford location,  
14 specifically, not ARC's practice overall, so will the  
15 Stamford location be financially viable with two MRIs  
16 with the loss of potentially thousands of scans?

17 MR. YODER: ARC MRI partnership, we look  
18 at the whole profitability of the whole system and all of  
19 our MRIs together, not by location.

20 MS. GROVES FUSCO: And, just to clarify,  
21 they don't run their financials by office. They run  
22 their financials by service, so it's the entire ARC MRI  
23 service. That's how the profitability is determined.

24 MS. VOLPE: Will ARC -- are you placing

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1 this second MRI at 1315 Washington Boulevard?

2 MR. YODER: Yes. Yes, at our new office,  
3 which is located on East Main Street, which is two  
4 buildings down from the current OAS office in Stamford.

5 MS. VOLPE: So are you moving your  
6 existing 1.5 there?

7 MR. YODER: Potentially, yes.

8 MS. VOLPE: So are you vacating the  
9 Washington Boulevard location?

10 MR. YODER: I think it's to be determined  
11 at this time, but, possibly, yes.

12 MS. VOLPE: So the new location I think  
13 you said it's on East Main Street. That has the physical  
14 composition to site two MRIs at that location?

15 MR. YODER: Yes.

16 MS. VOLPE: Okay. In 2008, did ARC apply  
17 to OHCA for approval to upgrade its existing 1.5 to a 3T?

18 DR. KAYE: I'll take that. I'm not  
19 familiar with the exact date, but, yes, we did around  
20 that time frame. Alan Kaye.

21 MS. VOLPE: Okay. Did ARC implement the  
22 approved waiver?

23 DR. KAYE: Alan Kaye. No, we did not.

24 MS. VOLPE: Okay. Did ARC factor in

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1 Greenwich Hospital's 3T in Stamford when it was  
2 considering its projections for the proposed 3T now?

3 DR. KAYE: Yes.

4 MS. VOLPE: So when you filed your  
5 application in June, you were aware that Greenwich  
6 Hospital was locating a 3T in Stamford?

7 DR. KAYE: Yes.

8 MS. VOLPE: Okay.

9 DR. KAYE: Actually, I believe that unit  
10 already is in Stamford, so it's just moving from one  
11 Stamford location to another.

12 MS. VOLPE: I don't think so. I mean we  
13 can look at the statewide, Table 8.

14 DR. KAYE: There seems to be some  
15 confusion.

16 MS. VOLPE: We can look at Table 8 to  
17 clear up any confusion. Let's just, before we go any  
18 further, let's look at Table 8, which I pulled out  
19 earlier. It's our understanding from a 1.5 to a 3T,  
20 Greenwich Hospital.

21 HEARING OFFICER HANSTED: The Greenwich  
22 Hospital? And when did that occur?

23 MS. VOLPE: In Stamford. Like several  
24 weeks ago.

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1 HEARING OFFICER HANSTED: Okay.

2 MS. VOLPE: A couple of weeks ago.

3 DR. KAYE: Are we talking about the unit  
4 that's going in Long Ridge?

5 MS. VOLPE: Yes.

6 DR. KAYE: And are we talking about the  
7 one that they upgraded from 1.5 to 3T, the one that was  
8 in Stamford? So, in other words, they're moving their  
9 existing service from one location in Stamford to  
10 another, and they're putting --

11 MS. VOLPE: But it's a different Tesla  
12 strength, so were you aware that it was going to be a 3T  
13 when you filed for your 3T?

14 DR. KAYE: I suspected that it might be,  
15 but I don't think it made a difference to us, because we  
16 need to service our patients, provide them with the range  
17 of service from 1.5 to 3T.

18 MS. VOLPE: Okay. I know we want to be  
19 done at 3:00, so, in the interest of time, ONS is  
20 limiting its Cross-Examination of representatives from  
21 Advanced Radiology. ONS would very much like to conclude  
22 these proceedings today, this afternoon, without the need  
23 for any additional day of hearings, especially since ONS  
24 has an application before OHCA since January.

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1                   We're confident that OHCA will put forth  
2 questions to ARC, and the staff will be responsive to any  
3 unopened issues in the deficiencies in ARC's application.  
4 To the extent that ARC's legal counsel has any Redirect,  
5 we'd like an opportunity to address those.

6                   HEARING OFFICER HANSTED: Any Redirect?

7                   MS. GROVES FUSCO: I just have one  
8 question.

9                   HEARING OFFICER HANSTED: Okay.

10                  MS. GROVES FUSCO: Dr. Kaye, can you  
11 explain why you didn't implement the waiver to upgrade  
12 your Stamford unit to a 3T in 2008?

13                  DR. KAYE: Alan Kaye. At the time, that  
14 was in preparation for a possible move from our current  
15 location, 1315 Washington Boulevard, and we felt that it  
16 would be appropriate to upgrade at that point.

17                  We were unable to find a suitable  
18 location. As you may know, it's very difficult to find a  
19 place in Stamford that has sufficient parking and  
20 structure to accommodate an MRI, let alone a 3 Tesla,  
21 and, so, we could not find a suitable location, so we did  
22 not do the upgrade.

23                  MS. GROVES FUSCO: Thank you.

24                  HEARING OFFICER HANSTED: Follow-up?

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1 MS. VOLPE: Yeah, a follow-up to that.  
2 When you filed your waiver application in 2008 and they  
3 asked for the location for the waiver in 2008, what did  
4 you state it was going to be located?

5 DR. KAYE: I don't recall.

6 MS. VOLPE: Okay.

7 DR. KAYE: We did not have a location, so  
8 we may have had a placeholder. I don't recall.

9 MS. VOLPE: But you were already operating  
10 at 1315 Washington Boulevard in Stamford.

11 DR. KAYE: Correct.

12 MS. VOLPE: And the waiver, which I have  
13 in front of me, shows the approval of the upgraded  
14 replacement at 1315 Washington Boulevard.

15 DR. KAYE: Yes, but we were planning on  
16 moving once we got the waiver.

17 MS. VOLPE: But did you --

18 DR. KAYE: We were planning on moving  
19 anyway, we were unable to find one, and we were not able  
20 to find one that would be suitable for siting purposes  
21 for the upgrade, and we did not have a -- because we did  
22 not have a place, we used the 1315 as a placeholder.

23 MS. VOLPE: Okay, but when you filed with  
24 OHCA, you represented that you would be upgrading your

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1 existing equipment at that location, at 1315 Washington  
2 Boulevard?

3 DR. KAYE: Yes.

4 MS. VOLPE: Okay.

5 DR. KAYE: We did not have a full siting.

6 MS. VOLPE: Okay. We have no further  
7 questions.

8 HEARING OFFICER HANSTED: Okay, thank you.

9 MS. VOLPE: Thank you. That concludes our  
10 Intervenor --

11 HEARING OFFICER HANSTED: You're both  
12 finished. Okay. Do we have anything further from the  
13 Stamford Hospital or WESTMED, besides a closing  
14 statement?

15 MR. COWHERD: No.

16 HEARING OFFICER HANSTED: Please come up  
17 to the microphone.

18 MR. COWHERD: Stephen Cowherd on behalf of  
19 Stamford Hospital. Stamford Hospital didn't seek  
20 Intervenor status in the Advanced Radiology hearing.

21 HEARING OFFICER HANSTED: Okay, thank you.

22 MR. MONAHAN: This is Pat Monahan on  
23 behalf of Intervenor WESTMED, and we have nothing  
24 further, and we thank you for the opportunity.

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1 HEARING OFFICER HANSTED: Okay, thank you,  
2 both. All right, at this point, OHCA has some questions,  
3 so we'll begin with those. Who wants to start?

4 MR. LAZARUS: OHCA handed out a table and  
5 a map of the existing providers in the area, including  
6 the Applicants. It's labeled OHCA Exhibit 1, and OHCA is  
7 going to reference that in some of its questions. Does  
8 anybody want a couple of extra copies?

9 MS. VOLPE: I think we're good. Thank  
10 you, Mr. Lazarus.

11 MR. LAZARUS: Alla, do you want to start?

12 MS. ALLA VEYBERMAN: Alla Veyberman, OHCA  
13 staff, and I have a question for Dr. Mark Camel.

14 As we discussed today, there are several  
15 existing providers in the area. Can your patients be  
16 referred to other MRI providers, such as Hospital for  
17 Special Surgery, that is operating at approximately 50  
18 percent capacity?

19 DR. CAMEL: So there are a couple of  
20 issues to sending them. As you know, first, we're west  
21 of Exit 3 off 95, and it's about a mile and a half off  
22 Exit 3, which is the closest 95 exit, where, if you know  
23 the area a little bit, you get off 95 at Exit 3 and then  
24 wind your way through Downtown Greenwich and then down

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1 the Post Road until you get to our office, so that's  
2 where the starting point is from the ONS office.

3 The drive up 95, as we all know from  
4 living around here, and I don't presume to know where  
5 everybody lives, but the distance issue has become our  
6 biggest issue in growing our practice, and it's a great  
7 question.

8 So we recently opened up an office in  
9 Stamford, and that office is up on High Ridge Road, and  
10 one of the issues is getting patients back and forth  
11 during the day, because of what should take 20 or 30  
12 minutes can take an hour or more now, and, you know, it's  
13 a problem that doesn't have an obvious solution.

14 There is the convenience issue for  
15 patients, because that's really almost on the Darien  
16 border, Exit 9. The Darien border is just beyond it.

17 Secondly, the Hospital for Special Surgery  
18 doesn't have any relationship to Greenwich Hospital or to  
19 ONS and honestly is a competitor, both not on imaging  
20 alone, but of all the people we compete with, they are,  
21 because they're really the only subspecialty practice in  
22 the area, previously in New York, they have this office,  
23 so it would be, honestly, awkward to refer directly to  
24 our competitor.

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1                   The third issue is that, you know, the  
2 Hospital for Special Surgery is a hospital. I know that  
3 sounds ridiculous to say that, but what I tried to say  
4 more succinctly is that, as we've already determined in  
5 this room, the reimbursement for an MRI at any hospital,  
6 including Hospital for Special Surgery, as compared to  
7 ONS, is significantly higher, and much of Special Surgery  
8 is not in network, so it would be even higher than that,  
9 so it is not a referral base of choice for us.

10                   MS. VEYBERMAN: Okay. Also, today you  
11 mentioned that you're going to hire two more physicians  
12 for your office, and you said that one of them is coming  
13 from Philadelphia, and if you can please elaborate more  
14 about your new physicians?

15                   DR. CAMEL: Sure.

16                   MS. VEYBERMAN: Are they new to this area?  
17 Are they coming with their patient base? Just so we can  
18 get a better understanding.

19                   DR. CAMEL: That's a great question. So  
20 it's been our practice, we've made one exception, to only  
21 hire orthopedists and neurosurgeons, who have just  
22 completed their fellowship, so these are surgeons or  
23 physicians, who have not begun practice anywhere.

24                   For example, the hand surgeon, I think who

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1 you speak, is training at Jefferson in Philadelphia, and  
2 I'm forgetting the name of the group he's actually with.  
3 I apologize for that. But he is a -- he's training in  
4 hand surgery. He did his residency at Columbia, and then  
5 went to Philadelphia for this. They call it now an upper  
6 extremity fellowship, because it includes the elbow on  
7 down.

8 We have an offer out, and I think he's  
9 going to take it, to a physiatrist. A physiatrist is a  
10 specialist in physical medicine rehabilitation. He will  
11 be our fourth physiatrist, and he trained in New York at  
12 Rusk, which is the NYU-affiliated rehab program, then did  
13 his fellowship at Mount Sinai.

14 For family reasons, which, honestly, I'm  
15 still not clear on, he went to the Naples area in Florida  
16 last year following his fellowship, and even though his  
17 family and his wife's family was in Brooklyn, they went,  
18 and he soon decided he didn't want to stay, so he's  
19 joining us, so he's an exception, but he doesn't  
20 obviously have any practice here.

21 The other, if you go backwards in our  
22 history, and I'll go back as far as you want me to --

23 MS. VEYBERMAN: Just a few years.

24 DR. CAMEL: Yeah.

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1 MS. VEYBERMAN: So we can get a better  
2 understanding if your physicians coming includes their  
3 patient base or they come --

4 DR. CAMEL: Yeah, so, Dr. Wei, David Wei,  
5 also was a resident, orthopedic resident at Columbia, but  
6 did his hand fellowship in Boston at the Tufts program,  
7 and he joined us last September from Boston.

8 I'm going backwards, backwards in time, so  
9 I don't want to make a mistake. Dr. Mark Kowalsky joined  
10 us in March of 2015, and he's a very interesting guy.

11 He trained also at Columbia as his  
12 residency, but then subsequently did two fellowships, one  
13 of which was at Columbia, and the second one was actually  
14 in St. Louis at the combined Washington University/Barnes  
15 Hospital program.

16 He came back for family reasons and took a  
17 job at Lenox Hill Hospital. He's been our exception. I  
18 don't know, I didn't know him, but all of my orthopedic  
19 colleagues did, because they were senior residents or  
20 attendings when he was a junior resident.

21 He wasn't happy at Lenox Hill for pretty  
22 common reasons in my mind. His wife works as a pediatric  
23 emergency room nurse in Westchester County, and he wanted  
24 to make a move, so he came last March. Dr. --

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1 MS. VEYBERMAN: -- not from the area.

2 DR. CAMEL: No, no.

3 MS. VEYBERMAN: None are from the area?

4 DR. CAMEL: None are from the area. Dr.

5 Chris Sahler is a native of Rochester, New York. Now I'm  
6 going back to '14, the fall of '14. He's a physiatrist,  
7 went to college at the University of Vermont, did go to  
8 New York Medical College, but trained in New York City.

9 Okay. Michele was trying to get me to go  
10 shorter here, so I think I understand the point of your  
11 question, which I'm happy to do always.

12 Here's the thing. We don't, we haven't,  
13 and we have no plans to, and we have some business  
14 reasons, which don't matter here why we don't do that.  
15 We have a certain culture that we believe is unique and  
16 different, because we offer a team approach.

17 We're not individuals practicing together.  
18 In our group, everything goes in and comes out equally,  
19 and that's unique, even in not only in this area, but if  
20 you go across the country, you don't see that, and it  
21 allows us to do subspecialty care, which is the other  
22 reason I think we've grown so much and so fast.

23 We could have grown faster, but we were  
24 too reluctant to try.

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1 MS. VOLPE: So they're not taking doctors  
2 from the area and adding them, and, therefore, they don't  
3 have existing MRI volume that they're capturing from  
4 other providers, who would otherwise get that volume.

5 DR. CAMEL: No.

6 MS. VOLPE: This is all new volume to the  
7 marketplace.

8 DR. CAMEL: New growth. Sorry. You  
9 should have answered.

10 HEARING OFFICER HANSTED: Doctor, your  
11 voice changed.

12 MR. LAZARUS: Just to follow-up and just  
13 to get a little bit of clarification, you had mentioned  
14 those two doctors you are in the process of recruiting.  
15 How many additional are you recruiting, and what's the  
16 time frame for those?

17 DR. CAMEL: Well, so, the two I mentioned  
18 are hired or almost hired.

19 MR. LAZARUS: Okay.

20 DR. CAMEL: The next three, which are the  
21 neurosurgeon, the joint fellowship, and the physiatrist,  
22 are the next three.

23 MR. LAZARUS: Okay.

24 DR. CAMEL: So we've identified a joint

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1 replacement surgeon, who is doing his fellowship back to  
2 Philadelphia again, and he will be here -- well he  
3 finishes his fellowship on July 31st. They usually take  
4 a few weeks off to move. He's also -- so I expect him.  
5 Most of our guys start around Labor Day, typically.  
6 Sometimes, late August, but most choose to take the month  
7 off for moving and sort of decompressing from their  
8 fellowship.

9 The neurosurgeon we haven't identified  
10 yet. I've spoken to a highly-recommended woman at NYU,  
11 and we are in the process, but we're really just  
12 beginning that, and we currently are planning to  
13 interview current fellows in physiatry from I call it our  
14 usual suspects, which are Hospital for Special Surgery,  
15 Mount Sinai, and NYU, is where we typically get.

16 MR. LAZARUS: All right, thank you. OHCA  
17 handed out the OHCA Exhibit 1, and looking at the table  
18 with the existing providers in the area and the map, can  
19 you discuss the clear public need for acquiring this  
20 proposed MRI scanner for this population, and considering  
21 that there are approximately 10 other existing providers  
22 in the area, and does this proposal fill a gap?

23 DR. CAMEL: It does. It fills a gap in  
24 two ways, I think. I'll make this short. Most of these

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1 scanners are at expected capacity.

2 We, honestly, overrun our scanner, and one  
3 of the issues is, by going seven days a week and nights  
4 five days a week, we have issues of keeping  
5 technologists, because you have to get people to work on  
6 weekends, you have to have other people there.

7 We're going to continue that service,  
8 because it's convenient to our patient, to try and  
9 contract it. That's one thing.

10 The second thing is, and I apologize for  
11 not remembering names, but the doctor from WESTMED made a  
12 very good point, and, when he talks about integrated  
13 care, even at times when we send patients, we try and  
14 send patients elsewhere, who are from far away, because  
15 we're a subspecialty-based practice, because of the  
16 nature of the service we offer, they choose to come to  
17 see us, and they want care integrated, and this is really  
18 an important concept, which really isn't pertinent here  
19 so much, but it is by managing people's care, whether in  
20 our case we don't do laboratory testing, but we do do  
21 physical therapy, and we do imaging, both x-ray and MRI,  
22 and we see our patients and operate on them.

23 Patients want that communication, so, for  
24 example, our physical therapists communicate to us not by

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1 calling or sending e-mails, but through our medical  
2 record system. Their notes go into the same system, so  
3 every time they see a patient, we know it, and we know  
4 what they thought about that visit.

5 Similarly, Dr. Sullivan's reads come  
6 through our medical record system, and patients  
7 appreciate that integrated care. Secondly, we have no  
8 difficulty obviously accessing them, either from our  
9 office or from home.

10 MS. VOLPE: And just for point of  
11 clarification and direct to your question, the Applicant  
12 would direct OHCA to Dr. Camel's pre-filed testimony,  
13 specifically, Attachment B and Section 3, which is on  
14 page 28, and it shows -- it does the analysis under the  
15 Statewide Health Plan for the utilization of the existing  
16 providers, based off of that Table 8 data, which is  
17 published with OHCA, and looking at the volume numbers of  
18 all of the providers in the marketplace and the service  
19 area in the entire region and showing, taking that  
20 existing utilization on the 13 scanners in the service  
21 area and applying the Statewide Health Plan analysis to  
22 it I think is a very important analysis for OHCA's  
23 determination.

24 We did do that, and there's thousands of

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1 pages in the file, so I do want to direct you to  
2 Attachment B to Dr. Camel's pre-filed testimony, which is  
3 on page 28, and it shows the need analysis, as applied to  
4 the Statewide Health Plan, with the utilization of all of  
5 the scanners in the marketplace.

6 MS. KAILA RIGGOTT: Kaila Riggott, OHCA  
7 staff. Can I just follow-up on that and actually ask the  
8 question of both Applicants?

9 Our Statewide Facility's Plan also focuses  
10 on unmet need and gaps in services, and I think maybe  
11 what Steve might have been getting at are there patients  
12 that are not being served now in the area, given the  
13 number of providers that are in that region?

14 In our plan, you look at care on a  
15 regional basis.

16 MS. VOLPE: I think what Dr. Camel  
17 testified today certainly is there will be. I mean we  
18 can't wait until there's no capacity in the marketplace.  
19 That's why we have the Statewide Health Plan.

20 So with the growth of ONS's practice alone  
21 and the doctors it's adding and the patient population, I  
22 mean, if we wait until every single provider meets this  
23 capacity limit, then it will be too late, so, actually,  
24 we're being prudent and projecting that we have the

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1 volume now to meet it.

2 I mean that is why the Statewide Health  
3 Plan is in place. We're at 85 percent capacity. We  
4 should be allowed to get a scanner, based on the  
5 Statewide Health Plan Analysis.

6 And if you look at, like I said, if you  
7 look at our analysis, we took it even further, which the  
8 State doesn't want providers to do and didn't  
9 contemplate, and that is, if we wait until every single  
10 provider in this region is at excess capacity, it's too  
11 late.

12 I mean then we will have a significant  
13 backlog with the growth. And I think, if you look at the  
14 Connecticut population numbers, the only region in the  
15 State that has shown population growth is Fairfield  
16 County.

17 So when you combine the population growth,  
18 when you combine the internal orthopedic and neurosurgery  
19 patient population growth and you extrapolate that out  
20 and apply it to the marketplace, you know, we could have  
21 a problem with capacity issues very soon in this region  
22 with these 13 providers. I don't know if that's  
23 responsive to your question.

24 HEARING OFFICER HANSTED: Do you want to

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1 add anything?

2 DR. KAYE: Yes. Definitely would like to  
3 add something. Alan Kaye. First, we have a unique  
4 position in the marketplace. If you look at every one of  
5 these, most of them are provider-based, that is hospital-  
6 based, which means that they charge, as Dr. Camel had  
7 pointed out, significantly higher fees, and they get  
8 that, and if you have a high deductible plan, as most do  
9 today, then you are going to come up with out-of-pocket,  
10 which could, within one or two MRI scans at most of these  
11 provider-based institutions, could end up taking up your  
12 entire deductible, so we are unique in that.

13 We are unique in -- almost unique in that  
14 sense, but we are unique, in that we're also an  
15 independent provider, and Dr. Camel had mentioned earlier  
16 about not wanting to send to competitors.

17 Well I think that we are probably the only  
18 one that's not a competitor with any of these, and,  
19 probably, if you're going to approve one and your  
20 Statewide Health Plan says let's see if we need it, it  
21 ought to be ours, because we have, first of all, we have  
22 the highest number of any of the providers here per MRI  
23 unit, we are accessible to all --

24 MS. VOLPE: I would just object to that.

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1 DR. KAYE: Excuse me. Oh, I'm sorry.

2 That's an objection. Can I finish?

3 MS. VOLPE: I mean he's asking to only  
4 approve one.

5 DR. KAYE: No, I'm not.

6 MS. VOLPE: If you're only going to  
7 approve one. Again, there's an issue, as to their  
8 volume, but we're not rehashing that. I think we're  
9 trying to be responsive to your question in the  
10 marketplace, and let's look at all the providers in the  
11 region. There's 13 of them.

12 This is what you all know. We don't need  
13 to tell you.

14 DR. KAYE: Who is testifying?

15 HEARING OFFICER HANSTED: I understand  
16 your objection. Dr. Kaye, hold on. Do you have a  
17 response?

18 COURT REPORTER: Microphone, please?

19 HEARING OFFICER HANSTED: What I want you  
20 to do, Dr. Kaye, is just answer the direct question. I  
21 don't want you to start getting into what should be  
22 approved and what shouldn't be approved.

23 DR. KAYE: The question was capacity.

24 HEARING OFFICER HANSTED: The question is

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1 the populations that aren't being served, okay? So let's  
2 keep it to that, not how many machines. It's our job to  
3 decide how many machines get approved or if any.

4 MS. GROVES FUSCO: And there's just one  
5 thing I'll add that I know Michele has put in her CON  
6 application, as well, is that I think it was intentional  
7 that the State Health Plan was drafted in such a way that  
8 it gives sort of two avenues to proving need when you're  
9 talking about an MRI unit.

10 I mean if you are a new provider to the  
11 primary service area, you've got to go out, and you've  
12 got to do that application of the population and the  
13 demographics and the existing units and, you know, can  
14 they fill what you're saying you're coming into the  
15 market to fill?

16 This was a negotiated process, involving  
17 your agency and many providers and health care entities  
18 in this state, and they carved out almost an exception  
19 for people, who have an existing unit in a primary  
20 service area, and the health plan clearly states that  
21 that's what you look at.

22 You look at that provider's utilization  
23 within the primary service area to see if it triggers the  
24 85 percent threshold. We all understand that that's a

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1 myopic view, and, even if that's what the State Health  
2 Plan says, we all want to prove that there's need beyond  
3 that and there are other, you know, quality measures and  
4 things like that.

5 But even if you looked at the whole  
6 population, as if we were coming into this market anew,  
7 if you look at it based on the number of units and the  
8 scans those units are doing in applying 85, or if you  
9 look at the population statistics, which I believe  
10 Michele did, they're showing you 94 percent utilization  
11 in the market, so, even though there are some units that  
12 have low volume, those are far outbalanced by the number  
13 of units that are overcapacity at this point in time, so  
14 I think that's part of the basis for the need, as well.

15 MS. VOLPE: And I'm sure you're aware of  
16 this, but the one unit that has lower volume than the  
17 others, Hospital of Special Surgery, is the newest one in  
18 the market, and, also, by its own admission, does not  
19 anticipate doing more than 2,500 scans on its scanner,  
20 even though OHCA applies a 4,000 number.

21 And if you look at all of their scanners  
22 in their New York market, that's all they do. That's all  
23 they will do on their scans, and they represented in  
24 their filing they will only do 2,500 scans, so they're at

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1 nearly 2,000 now, so it is important to highlight that,  
2 so there isn't a lot of room in this market for the  
3 population to access this service.

4 DR. KAYE: May I now finish?

5 MS. VOLPE: And we all have our views on  
6 how they should access it, but irrespective of how we  
7 differ on how they should access it, the point is is  
8 there access available?

9 And I think, if you don't approve, we're  
10 going to have an access issue. I mean the numbers don't  
11 lie, and these are numbers from, again, from 2014, and  
12 the population has grown.

13 DR. KAYE: May I finish?

14 HEARING OFFICER HANSTED: Go ahead.

15 DR. KAYE: I'll try to be very brief here.  
16 A final point. All scanners and all referral entities  
17 are not equal. You can't necessarily -- so there's all  
18 sorts of demand.

19 As Michele just pointed out, Hospital of  
20 Special Surgery only plans on doing 2,500 at the maximum,  
21 so you cannot necessarily compare their numbers with  
22 ours.

23 Likewise, an independent imaging practice  
24 is not equivalent to an internal in-office imaging

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1 practice or to a provider base, because of economic or  
2 referral considerations, so the answer is, I'll borrow  
3 from the ONS, there is a crisis.

4 Sixty-seven hundred scans per year is a  
5 crisis, based on technologists, based on access, hours of  
6 availability, based on everything, and that is a crisis,  
7 and every other one on here, except ONS, is a provider  
8 base, which has an economic one, as well, and our  
9 economic one is, also, we take all payers, so I think you  
10 can't just apply there's X number of scanners, divided by  
11 13.

12 And, lastly, 3 Tesla does imaging faster,  
13 so it can absorb a higher --

14 HEARING OFFICER HANSTED: Okay, thank you.

15 MR. LAZARUS: I only have a couple more  
16 questions for ARC. In your testimony, you had talked  
17 about, well, actually, even in your application I think,  
18 your offices in Fairfield, Stratford and Trumbull  
19 facilities. Patients over there they're saying they may  
20 not have timely access to imaging services. Are they  
21 being referred out, or --

22 DR. KAYE: Referred out, meaning to other  
23 practices?

24 MR. LAZARUS: To other practices, or to

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1 other locations within your practice.

2 DR. KAYE: Our centralized scheduling does  
3 try and move patients around to available slots, yes.  
4 There are limitations, however.

5 MR. LAZARUS: Yeah, because those are 3  
6 Tesla machine.

7 DR. KAYE: Well there's 3 Tesla. There's  
8 differences among the 1.5 Teslas. There are different  
9 software packages on the 3 Tesla. For instance, prostate  
10 imaging isn't available everywhere, etcetera, so there's  
11 one example, but there's also geographic and patient  
12 preference.

13 I think we mentioned earlier, but, if we  
14 didn't, to send a patient from Stamford to Orange is  
15 virtually saying find it somewhere else.

16 MR. YODER: I'm sorry. Just to add one  
17 more to that --

18 HEARING OFFICER HANSTED: Just identify  
19 yourself.

20 MR. YODER: Oh. Clark Yoder.

21 HEARING OFFICER HANSTED: Thank you.

22 MR. YODER: Advanced Radiology. We also  
23 do flex hours and address capacity issues that way, by  
24 adding schedules, as needed, into the evenings and to

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1 weekends to accommodate this volume and this movement of  
2 shifts of these patients.

3 MR. LAZARUS: All right, thank you. For  
4 the proposed scanner, what's the time frame to get it up  
5 and running, including construction, for a 3T?

6 MR. YODER: I would say our projections  
7 would be early second quarter by the time to do that  
8 level of construction and purchasing.

9 MR. LAZARUS: And would that affect the  
10 other machine currently running?

11 MR. YODER: No.

12 MR. LAZARUS: No. Okay. And you can  
13 accommodate in the same location?

14 MR. YODER: Yes.

15 MR. LAZARUS: Okay. Dr. Kaye, you had  
16 talked about some subspecialties at your practice. Could  
17 you elaborate a little bit more on that?

18 DR. KAYE: Yes.

19 MR. LAZARUS: And how that can be offering  
20 an advantage.

21 DR. KAYE: There are different  
22 certifications for radiologists, so, for example, there's  
23 the Board certification, which historically has taken  
24 place after the residency program. That gives you Board

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1 certification, but most radiologists and all the  
2 radiologists we take are subspecialty trained, which  
3 means they have at least one additional year of training  
4 in a subspecialty area.

5 I'm glad you asked this question, because  
6 I wasn't sure if it was getting across right. A brain  
7 scan is read by a neuroradiologist, which is why I asked  
8 the WESTMED people if they do that.

9 A brain scan in our practice -- every MRI  
10 scan is read by a subspecialty radiologist, so brain and  
11 spine are read by the neuroradiologists. Joints,  
12 tendons, bones are read by the musculoskeletal  
13 radiologist. Pancreas, liver, pelvis, gynecological  
14 organs are read by body imaging radiologists, all of whom  
15 have subspecialty training in that.

16 Currently, there are additional Boards  
17 required for neuroradiology, so you have to actually pass  
18 a test. That will probably be the case in the future for  
19 other subspecialties, but everybody, as I said, just to  
20 reiterate, every scan, every patient that's scanned has  
21 their images interpreted by a subspecialty fellowship-  
22 trained radiologist in that discipline.

23 We may be the only practice in the area,  
24 in south Connecticut that does that.

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1 MS. VOLPE: Just for point of  
2 clarification, Greenwich Radiology, who we use, also has  
3 nine fellowship-trained radiologists, who also have  
4 subspecialty, as well, and those are the individuals  
5 reading the ONS scans, so I think that it is important,  
6 and I don't know that that fact has come out today, for  
7 both of the Applicants, but we wanted, you know, for the  
8 record to note that, as well.

9 MR. LAZARUS: Thank you.

10 DR. KAROL: Can I say something?

11 MR. LAZARUS: Sure. Can you identify  
12 yourself?

13 DR. KAROL: Hi. My name is Ian Karol, Dr.  
14 Karol from Advanced Radiology.

15 I did the scheduling for Advanced  
16 Radiology for 15 years, and, just to let you know, just  
17 so you have perspective, we have 32 radiologists. Of our  
18 32 radiologists, there are only five, who read  
19 musculoskeletal MRIs.

20 If you have an MRI of your knee in our  
21 practice, only one of those five people read it ever, so  
22 it's a highly subspecialized read. Where most people in  
23 the country just have people that say they're fellowship  
24 trained, they cross-cover, and they do other specialties,

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1 we don't. I only read MSK MRIs. We have five of us of  
2 the 32.

3 Of the 32 radiologists, we only have six  
4 that read the neuroradiology exams, and only two or three  
5 read the pediatric neuroradiology exam, so when you come  
6 to our practice and you have a brain MRI, it's not just  
7 any radiologist. It's only six of 32, who are  
8 specifically specialized to read that exam, so we're  
9 really super specialized, which most practices are not.

10 DR. KAYE: I just need to reiterate or  
11 clarify, because there's a difference between we have all  
12 subspecialty-trained radiologists, which I said we do,  
13 but there's a difference between saying everybody has a  
14 subspecialty and that every single scan is read by a  
15 subspecialist in that particular discipline.

16 So we don't have a fellowship-trained body  
17 imager reading pediatric neurological MRIs. Do you  
18 understand what I'm saying?

19 MR. LAZARUS: Yes. Yes, we do.

20 DR. KAYE: It's very different from saying  
21 everybody is subspecialty trained.

22 MR. LAZARUS: Got it. Thank you. I think  
23 the last question I have is that, and this might be a  
24 late file, can you provide us the most recent fiscal

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1 year's volume by types of scans?

2 DR. KAYE: The most recent fiscal year?

3 MR. LAZARUS: Yeah, the most recent fiscal  
4 year.

5 DR. KAYE: What do you mean by types of  
6 scans?

7 COURT REPORTER: Mike, please?

8 MS. GROVES FUSCO: Sorry. So just like we  
9 submitted in the scan already, but per 2016 year-to-date?

10 MR. LAZARUS: Yes, exactly. Yes.

11 MS. GROVES FUSCO: Okay.

12 HEARING OFFICER HANSTED: That will be  
13 ordered as Late File No. 1, and how long do you need to  
14 get that in?

15 MS. GROVES FUSCO: We could get it in by  
16 the end of the week.

17 HEARING OFFICER HANSTED: Okay, end of the  
18 week, then.

19 MR. LAZARUS: I think that would probably  
20 be fiscal year 2015.

21 MS. VEYBERMAN: So we have a full 12-month  
22 --

23 MS. GROVES FUSCO: I think you have the  
24 full 12-month, but, if you don't, I'll give you that, as

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1 well.

2 MR. LAZARUS: Okay.

3 MS. VEYBERMAN: Can you give us both 2015  
4 and 2016 up-to-date?

5 MS. GROVES FUSCO: Yes, I can. I'll  
6 verify that what we provided for '15 -- what we provided  
7 for '15 should have been complete, because we submitted  
8 this in '16, right?

9 MR. LAZARUS: We can double check that.

10 MS. GROVES FUSCO: We'll double check, but  
11 I'll get you it anyway. I can send it again. Thank you.

12 HEARING OFFICER HANSTED: Okay. OHCA is  
13 concluded with its questions. I'll allow the  
14 individuals, I'm sorry, the Applicants and the  
15 Intervenors very brief closing statements, and we'll  
16 start with Docket No. 16-32063, so, ONS, if you want to  
17 give a brief closing statement?

18 MS. VOLPE: We do have closing remarks. I  
19 don't know if the Intervenors do, but we certainly have  
20 closing remarks.

21 HEARING OFFICER HANSTED: Okay.

22 MS. VOLPE: Would you like us to proceed?

23 HEARING OFFICER HANSTED: Yes.

24 MS. VOLPE: Okay, so, what OHCA is charged

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1 with is reviewing the application for Orthopaedic &  
2 Neurosurgery that's before you, in accordance with the  
3 criteria for a clear public need and whether it's  
4 financially-feasible and in accordance with Connecticut  
5 General Statutes, 19a-639.

6 If you go through those 12 factors, which  
7 we have done at length during this proceeding in our  
8 application, we clearly satisfy the need for an  
9 additional MRI in our practice.

10 Also, if you apply the criteria and  
11 standards for the need methodology, as laid out in the  
12 Statewide Health Plan, we need every aspect of that, even  
13 though, as ARC counsel and I have pointed out today,  
14 based on the Statewide Health Plan, we merely have to  
15 show that we're at over 85 percent capacity in our  
16 existing machines, which we are well over that.

17 And when you factor in the capacity limits  
18 and restrictions on the other MRI providers in the  
19 region, we well exceed the need analysis under any  
20 formula that OHCA wants to apply.

21 If you look at the 12 criteria, we've met  
22 it, based on our own internal volume and projections,  
23 which we've shared with you, based on our existing  
24 capacity, based on the capacity of all the providers in

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1 the marketplace.

2 ONS has demonstrated that we will have a  
3 positive impact on the diversity of health care providers  
4 in the region. Everybody has noted they're primarily  
5 institutional providers, with the exception of us and  
6 ARC, and we are both unique in that respect, so we will  
7 add a positive impact in the diversity of health care  
8 providers.

9 We have demonstrated that there will be no  
10 impact on existing providers in the marketplace. It has  
11 been clear in our testimony, in our pre-filed data that  
12 ONS will always -- ONS patients will always need more  
13 MRIs than we're going to provide in our office, whether  
14 because it's imaging capability, the type of patient,  
15 location, where they live. We're always going to have  
16 more MRIs being performed in the marketplace than we  
17 could handle within our office for all the reasons we've  
18 stated, so there will be no impact on existing providers.

19 I think it's important for OHCA that, you  
20 know, we've demonstrated that the proposed MRI that ONS  
21 is looking will strengthen the health care system, and it  
22 is cost-effective.

23 We have to keep in mind in Connecticut  
24 that there's tremendous consolidation in the marketplace

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1 right now of all health care providers. You have to  
2 appreciate, if you look at the numbers of what's happened  
3 in Connecticut with physician practices being acquired by  
4 health systems that are institutional based, we went from  
5 90 percent of the practices of doctors being independent  
6 community-based doctors.

7                   You look at that number, and it's  
8 completely reversed. We have very few independent  
9 physician-owned community-based doctors in the  
10 marketplace, and imaging is just an extension of our  
11 practice, and it's an important one. It's an ancillary  
12 function.

13                   It does allow us to absorb costs and  
14 financial harm in other areas. That's how we're able to  
15 give away lots of free Medicaid services, hundreds of  
16 thousands of dollars in that, so we, based on us being  
17 wholly physician-owned and community-based, we do  
18 strengthen the health care system.

19                   You can't want, the State cannot want all  
20 of the doctors to be owned by health systems. That would  
21 be a bad move.

22                   A lot of people would have you say that  
23 we're not servicing the Medicaid population, because  
24 they're not getting a Caid(phonetic) scan in our office.

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1 The clear public need on the factors say you have to  
2 demonstrate good cause if you're not providing, like in  
3 this instance, an MRI to the Caid population.

4 We want to point out that the Caid  
5 population is being serviced in lower Fairfield County.  
6 It is being -- there's no Caid patient, who is going  
7 without an MRI that needs one.

8 We have a system in place in the Greenwich  
9 market, where there are highly-cooperative health care  
10 providers servicing that population and servicing it  
11 well.

12 We don't need to tell the State about how  
13 the Caid population accesses care, where they go for  
14 their care, how they evidence at the ER first, or at  
15 hospital clinics.

16 Sometimes, you know, I mean that is a  
17 pattern of utilization by that population that shouldn't  
18 be disrupted if the population is getting served, and  
19 they are.

20 I mean even by everyone's own admission,  
21 their Caid numbers are low. 3.9 is low. Hospital for  
22 Special Surgery, under all the OHCA conditions, requiring  
23 them to reach out to the Caid population, market the Caid  
24 population, if you look at the number they're serving in

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1 Caid, it's very low, and it's not because these patients  
2 aren't being met. It's because there isn't an additional  
3 need for the Caid population in that marketplace.

4 The other thing is Hospital for Special  
5 Surgery was required to service the Caid population. You  
6 have to keep in mind that that is a tax-exempt hospital  
7 facility. These hospitals get lots of funding to service  
8 an indigent population to have access of care from the  
9 State. They get lots of funding.

10 They get funding from being their  
11 charitable mission. We're a private practice. We are  
12 not tax-exempt. We are not-for-profit, so we can't --  
13 those aren't the type of conditions you can impose on us,  
14 however, we're servicing this population, you know, by  
15 hundreds of thousands of dollars that we're not making.

16 Could we scan Caid patients? Sure. If  
17 you look at the amount of money that is made in scanning  
18 from Caid, if you look at the volume of 3.9 and do the  
19 math on how much it is, you know, it's not a significant  
20 amount of anyone's cost structure, so we just want to  
21 point that out.

22 So ONS has demonstrated that the proposed  
23 MRI will improve accessibility. We've talked about that  
24 with the Caid population. It allows us to continue to

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1 give away that free care.

2                   We've shown that the proposed MRI that  
3 we'd like to have improves quality. We are not in the  
4 business of getting people in and out quickly in a scan,  
5 short slots, get the scan, get them off the table, get  
6 the next one on.

7                   The doctors in our practice use these  
8 images to determine whether they're going to operate, and  
9 they use them during surgery, so they are not going to  
10 want to have a scan done that's missing sequences if  
11 you're operating on the spine.

12                   There's a lot more at stake than a fee for  
13 an MRI when you are a neurosurgeon and you're operating  
14 on someone's back, so everyone needs to put that in  
15 perspective, so these quality images are very important  
16 to us.

17                   And you know what they say; when you want  
18 something done right, you've got to do it yourself, so  
19 ONS has demonstrated that our CON is financially-  
20 feasible. That is a very important element in looking at  
21 clear public need. It's stated time and time again in  
22 the regulations and the statute.

23                   So, in conclusion, we've met all of the  
24 criteria outlined in the statute. We've shown how our

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1 proposed MRI is consistent with the Statewide Health Plan  
2 and actually goes beyond what's even qualified in the  
3 Statewide Health Plan for showing need, and we  
4 respectfully request that you approve a 1.5 Tesla MRI for  
5 ONS. Thank you.

6 HEARING OFFICER HANSTED: Thank you.

7 MS. GROVES FUSCO: First, I want to thank  
8 you guys for, on behalf of my client, for the time and  
9 effort involved in reviewing the voluminous submissions  
10 in this matter and then putting up with all of us today.

11 I know it's been a long day, and you've  
12 heard a lot of information, but we know that you give  
13 careful consideration to everything that's said in these  
14 proceedings, whether it comes in written testimony,  
15 whether it's mentioned at a public hearing, and we  
16 appreciate how difficult it can be to filter that  
17 information when you're faced with so many differing  
18 viewpoints and interests and agendas, such as you have in  
19 a joint contested hearing, where both parties are  
20 opposing each other and there are other Intervenors.

21 And, so, I think the focus of my closing,  
22 and I'm going to do a joint closing sort of for both  
23 proceedings, is to just try to bring us back to, much  
24 like Michele did to the issues that are at hand here,

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1 which is whether Advanced Radiology and ONS have met the  
2 statutory requirements for the issuance of a CON, and I  
3 can say, unequivocally, that Advanced Radiology has met  
4 those requirements.

5           ARC has, without question, established a  
6 clear public need for the acquisition of a second unit  
7 for its Stamford office.

8           They have not just met, but far exceeded  
9 the State Health Plan utilization requirements. The  
10 guidelines in this regard are very clear, and I just  
11 talked about them a few minutes ago; an Applicant, who  
12 already provides MRI services and is looking to acquire  
13 an additional unit in the same service area, must show  
14 that its existing unit is operating at 85 percent  
15 capacity, based upon a benchmark of 4,000 scans a year.

16           So that means a provider must be  
17 performing at least 3,400 scans each year, and, in 2015,  
18 Advanced Radiology performed 6,617 scans in its Stamford  
19 office. This is nearly twice the amount of scans  
20 necessary to justify a second scanner, and,  
21 interestingly, it's more than the 24/7 hospital unit  
22 Stamford provides.

23           They're working unrealistically long hours  
24 to be able to meet the demands of their patients, and

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1 they need a second unit for quality of care purposes.  
2 The unit is operating at 165 percent capacity. It's  
3 going to soon reach the limits of the patients it can  
4 serve, okay, so, it doesn't have -- that scanner doesn't  
5 have to complete a single other scan, in order to justify  
6 need for a second scanner. The need is clear, and the  
7 need is immediate.

8 My client's proposal will also enhance the  
9 quality of MRI services in the Stamford area by the  
10 addition of 3 Tesla MRI in a practice that's on the  
11 cutting edge of health information technology advances.

12 You heard Dr. Muro testify quite a bit  
13 today about what a 3 Tesla can do and the type of  
14 advanced health information technology the networks and  
15 such that ARC can provide that are different than what  
16 some other providers in the area are offering.

17 Despite the assertions to the contrary by  
18 one of the Intervenors in our proceeding, 3 Tesla  
19 represents the highest quality imaging and is preferred  
20 for vascular brain and prostate exams, just to name a  
21 few, and ONS's own physician has acknowledged the  
22 benefits of 3T, and their contract radiologist expert I  
23 believe said it's robust in the imaging of choice, so  
24 acquiring a 3 Tesla for our office is certainly going to

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1 be a benefit to our patients.

2 Our would-be competitors suggest that we  
3 might save some money by purchasing a perfectly  
4 acceptable 1.5 Tesla unit to serve our patients'  
5 outpatient imaging needs, and while the ARC doctors could  
6 have easily chosen to make such an application, instead  
7 they're here before OHCA, opting to bring the best MRI  
8 technology to Stamford for the benefit of their patients,  
9 even if it means less money in their pockets at the end  
10 of the day.

11 These same would-be competitors have  
12 challenged the financial feasibility of the proposal. As  
13 it stands, even with the short-term incremental losses,  
14 Advanced Radiology MRI and, I think, as we explained,  
15 like their MRI services are all done under one entity, so  
16 you're looking at all six units, even with the short-term  
17 incremental losses, the net income of that entity is \$1.5  
18 million in the first year of operation.

19 If you factor in what you believe will be  
20 the actual cost of the unit, once we negotiate it down to  
21 \$1.9 million, that net income goes up to \$1.6 million in  
22 the first year of operation.

23 The practice has run every conceivable  
24 scenario since we've read these submissions that was

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1 raised in opposition to our CON. We looked at the loss  
2 of 100 percent of the OAS scans, which obviously would be  
3 a tremendous financial hit and one that we would not want  
4 to see, but even with the loss of those scans, they still  
5 show close to \$1 million in profit.

6 We've looked at an increase in Medicaid  
7 percentages. If we were to increase our Medicaid  
8 percentage by two percent, it would only drop our net  
9 income by \$52,000 that first year, and we also looked at  
10 growing things at a slower rate.

11 If we wanted to grow it by two percent or  
12 three percent versus the five percent that was called  
13 aggressive and it still remains financially feasible,  
14 there's no scenario we've come across, whereby this  
15 doesn't work for us as a practice, so it's really a  
16 question of these physicians have the money, they want to  
17 make the investment for the benefit of their patients,  
18 and they should be allowed to do that.

19 Their proposal also represents the most  
20 cost-effective way of introducing this much-needed  
21 capacity in the Stamford area. As many people have  
22 talked about today, private physician practices are  
23 typically reimbursed at a much lower rate than hospitals.  
24 They don't charge facility fees. Advanced Radiology is

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1 also the only private physician practice in the area that  
2 offers MRI and does not self-referral, the idea being  
3 that self-referral relatively inflates volumes, which  
4 makes it a less economical alternative.

5 And, last, but certainly not least,  
6 Advanced Radiology's proposal represents the addition of  
7 MRI capacity that's accessible to all referring  
8 specialties and all patients in our service area.

9 The practice participates with Medicaid  
10 and is proud of its long history of providing services to  
11 some of the State's most vulnerable patients.

12 With healthcare reform, there's been, as  
13 you know, like an expansion in Medicaid enrollment, and  
14 providers, like Advanced Radiology, stand ready to  
15 provide MRI and other services to these patients,  
16 regardless of their ability to pay.

17 Medicaid enrollment is expected to  
18 increase by 14 percent in the Stamford area over the next  
19 five years, and, as such, we believe OHCA should only  
20 approve CON applications by providers, who proactively  
21 participate with Medicaid and provide a meaningful level  
22 of services to this population, however, providers, who  
23 service Medicaid patients, like ARC does, end up being  
24 disadvantaged by those, who avoid it.

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1 All of the above supports Advanced  
2 Radiology's request to acquire a second MRI unit for its  
3 Stamford's office.

4 And now compare this with a case put forth  
5 by ONS for the addition of a second scanner for use at  
6 its Greenwich office. Although ONS puts forth a case for  
7 need, based upon the volume of its existing unit, the  
8 self-referral nature of the unit and the financial  
9 incentives that ONS providers have to refer patients to  
10 it calls into question the validity of that volume.

11 From a perspective of quality, ONS is not  
12 offering to invest in the 3 Tesla technology that even  
13 one of their radiologists says would be beneficial to  
14 many of their neurological -- many of their patients,  
15 including their neurological patients, nor does the  
16 practice offer the imaging capabilities pioneered by  
17 Advanced Radiology.

18 Their pro forma shows it's financially-  
19 feasible, but when you're 100 percent in control of the  
20 volume of referrals to your scanner, it's easy to  
21 engineer a profit, and, despite the claims to the  
22 contrary, the fact that ONS self-refers for MRI scans  
23 does drive up the cost of care.

24 As Dr. Kaye told you, and I'll say it

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1 again, study-after-study shows it, and ONS's rebuttal to  
2 this claim is just that some studies are older, but what  
3 I'm referencing are current reports, like the GAO study  
4 that Dr. Camel acknowledged was a current study that  
5 showed that the same concerns raised in the 1990s are  
6 still important today, and that's why there's now a push  
7 on the federal level to close the loophole that allows  
8 advanced imaging to be captured under the in-office  
9 ancillary services exception.

10 But perhaps for us, and we've said much  
11 about this, the most troubling aspect of ONS's proposal  
12 is its failure to provide even a minimal amount of access  
13 to MRI services for Medicaid patients.

14 As Dr. Camel acknowledged today, since ONS  
15 acquired its first MRI unit in 2008, nearly a decade ago,  
16 it has not provided a single MRI recipient, a single MRI  
17 scan to a Medicaid recipient either through the program  
18 or for free.

19 ONS does not participate with Medicaid.  
20 Although they provided nominal care to Medicaid patients  
21 in their office and they cover some clinic hours at  
22 Greenwich Hospital that they may or may not be  
23 compensated for and they wrote off care for 23 Medicaid  
24 patients out of, you know, 51,000 in their practice, the

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1 reality is they're proposing to acquire an MRI unit, on  
2 which no Medicaid volume is projected and for which no  
3 Medicaid referrals will be made.

4 So regardless of the many ways in which  
5 ONS has tried to spin it, their failure to participate in  
6 the Medicaid program is a de facto denial of access for  
7 these patients, and the State Health Plan makes it clear,  
8 that a provider seeking CON approval to acquire an MRI  
9 cannot deny access to patients, including Medicaid  
10 beneficiaries, based on payer source.

11 And if the manner in which they've  
12 described providing access to MRI services for Medicaid  
13 patients meets the requirements of the State Health Plan  
14 or the CON statutes that were intended to increase access  
15 for these patient populations, then I would say those  
16 statutes are meaningless, of very little meaning.

17 We'd also be remiss not to point out that  
18 ONS does have the ability to relocate any approved MRI  
19 unit anywhere in the State of Connecticut without CON  
20 approval. They can also enter into an affiliation with  
21 another orthopedic group or an integrated delivery  
22 network, that, if structured in a certain way, could be  
23 done without further CON review.

24 This means that any MRI unit OHCA approves

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1 for use by ONS and its patients can end up somewhere,  
2 other than Greenwich, serving patients, other than ONS's.

3 Approving ONS's CON would be a step  
4 backwards in the effort to provide equitable access for  
5 all residents in the State.

6 For all the reasons I've summarized, our  
7 position is that ONS's request for permission to acquire  
8 a second unit should be denied, and for the many reasons  
9 meticulously documented in our CON submissions regarding  
10 need, quality, access and cost-effectiveness, my client's  
11 request for permission to acquire a 3 Tesla unit for its  
12 Stamford office should be approved.

13 HEARING OFFICER HANSTED: Okay, thank you.

14 MS. GROVES FUSCO: Thank you.

15 HEARING OFFICER HANSTED: Attorney

16 Cowherd?

17 MR. COWHERD: Yes, thank you.

18 HEARING OFFICER HANSTED: It's already  
19 after 3:00, so please be very brief.

20 MR. COWHERD: For the record, Stephen  
21 Cowherd, Jeffers Cowherd, P.C., on behalf of Stamford  
22 Hospital.

23 So I know the hour is late, and I want to  
24 thank you and OHCA staff for the opportunity to provide

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1 closing remarks. I'm feeling a little fish out of water  
2 today. I'm the only attorney representing a hospital,  
3 the only guy wearing -- not wearing a dark suit. I'll do  
4 it.

5 So let me articulate for you Stamford  
6 Hospital's positions. I think it's clear. Stamford  
7 Hospital is not taking a position in the ONS application  
8 with regard to its approval or disapproval if that unit  
9 is sited in Greenwich.

10 What it is asking is that OHCA exercise  
11 its regulatory authority to impose conditions if the unit  
12 is approved, the second unit is approved, that neither  
13 the new unit, nor the existing unit, be moved into its  
14 primary service area of Stamford, Darien or Rowayton  
15 without a CON process that would allow Stamford an  
16 opportunity to oppose that relocation.

17 So we're not asking Dr. Camel to predict  
18 the future forever, but if there is a need and there is a  
19 need to move the unit on ONS's viewpoint into that  
20 primary service area of Stamford Hospital, Stamford  
21 Hospital would like the opportunity to oppose, if it  
22 chooses to do so.

23 There is no vehicle right now under  
24 Connecticut law that would allow it to do so. That's the

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1 position that Stamford Hospital is taking.

2                   There's been a lot of talk about fairness  
3 and meeting the statutory criteria under 19a-639 today,  
4 and I'd like to speak briefly to that on how it supports  
5 the relief Stamford Hospital is seeking here on imposing  
6 conditions, if there is approval.

7                   What's in the record is that ONS provides  
8 no Medicaid scans to Medicaid patients. It is not  
9 projecting, providing any scans to Medicaid patients, and  
10 with respect to the completely uninsured, it treated 46  
11 patients of over 51,500 patients in 2015, who did not  
12 have insurance.

13                   They are also, with respect to Medicaid,  
14 23 patients in 2015 were treated, and they are asserting  
15 to OHCA that they wrote off \$87,000 in care to treat that  
16 patient population.

17                   Look at just the profit that they are  
18 making on their MRI service alone. It runs between \$2.6  
19 and roughly \$3 million in the last two fiscal years.  
20 Divide that by 23 physicians. \$87,000 is not even one  
21 physician share of the profit of the MR, if, in fact,  
22 they divide it equally or how they divide it. That's an  
23 issue, and that is not a meaningful service to the  
24 Medicaid population.

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1                   Also, OHCA should not be distracted by  
2                   1,453 patients that have Medicaid as a secondary payer.  
3                   Those are most probably Medicare dual eligibles. Twenty-  
4                   four percent of ONS's volume is coming from Medicare, and  
5                   ask the hospitals about the cost differential and the  
6                   reimbursement differential even on the private side  
7                   between Medicaid and Medicare.

8                   The entire Greenwich Hospital argument  
9                   that -- and ONS should be rightfully commended for doing  
10                  its part with Greenwich Hospital, but here's the point.  
11                  That's a straw man argument.

12                  Greenwich Hospital is a tax-exempt, non-  
13                  profit. It must provide community benefit, and, in order  
14                  to do that, it has to use doctors to provide those  
15                  community benefits.

16                  Many times, I don't know Greenwich  
17                  Hospital's bylaws, but I represent hospitals, and I know  
18                  most hospital bylaws, coverage in the ED is required.  
19                  Call coverage is required. That's part of your  
20                  requirement to refer patients and admit patients into  
21                  that hospital.

22                  I don't know about clinics, but I  
23                  represent hospitals that require, also, care of their  
24                  clinics.

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1                   So the issue here is, from a fairness  
2 perspective, is it fair that a provider that is providing  
3 no meaningful service to the Medicaid and the uninsured  
4 populations be able to move its unit into a market, where  
5 there are five other existing providers, all of which are  
6 providing service to that population? Is that fair?

7                   Turning now to the statutory criteria that  
8 have been talked about so much, again, the relationship  
9 of this proposal to the Statewide Health Care Facility  
10 Services Plan, I was struck by both pages 17 and 18 of  
11 ONS's application on that point.

12                   One says that it is consistent with the  
13 Statewide Health Plan, because it promotes and supports  
14 the long-term viability of the State's health care  
15 delivery system, then, on the next page, they explain  
16 why.

17                   The long-term viability of ONS will be  
18 increased, as it will be better equipped to adapt to the  
19 demands and needs of its patients to continue to receive  
20 the benefit of enhanced continuity of care, etcetera.

21                   My point is ONS is not the health care  
22 delivery system. The delivery system and the safety net  
23 for that system resides with the hospitals and other  
24 providers. It's not ONS alone, who is that delivery

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1 system, and that this certainly will help their financial  
2 viability should not be an issue that OHCA focuses under  
3 that part of the Statewide Health Care Facility Plan.

4 And then the third bullet on page 17, this  
5 will promote equitable access to health care services,  
6 e.g., reducing financial barriers, increasing  
7 availability of physicians and facilitate access to  
8 preventative and medically-necessary health care. For  
9 whom? Not Medicaid patients. Not the underserved on the  
10 record before you.

11 Whether there's a clear public need for  
12 the proposed service, one letter of support in this  
13 application. Greenwich Hospital is not supporting this  
14 application. There's one from Greenwich Radiology.

15 I also think that it is a, again, a false  
16 or misleading to rely on HSS in serving the Medicaid  
17 population here, and, to draw from that, HSS's reports to  
18 OHCA, that there's not a need for the underserved to have  
19 MRI, I don't see why Medicaid recipients, other poor  
20 people, wouldn't need MRIs just as much as others, so  
21 it's already been brought out in testimony here today.  
22 Let's ask the federally-qualified health centers. Let's  
23 ask the community health centers in lower Fairfield  
24 County whether there's a need. I think there is, and

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1       Stamford Hospital certainly thinks there is.

2                       Whether the Applicant has satisfactorily  
3       demonstrated how the proposal will impact the financial  
4       strength of the health care system in the State, again,  
5       we've spoken to that.

6                       I'm not going to belabor areas 19a-639a-5  
7       and 6, which specifically go to OHCA's charge to be  
8       looking at the interests of Medicaid patients in  
9       deliberating on CONs, but I do want to go to Sub 10, and  
10      that is whether the Applicant, who has failed to provide  
11      a reduced access to services by Medicaid recipients or  
12      indigent persons, has demonstrated good cause for doing  
13      so.

14                      Okay. You just heard ONS say they have  
15      demonstrated good cause. The issue of covering a clinic,  
16      a free clinic of Greenwich Hospital for basically nine  
17      hours a month among a 23-physician practice to me is not  
18      meaningful service to this population, but they do, and  
19      they also cover the ED. Excuse me?

20                      MS. VOLPE: Yes. You know, I --

21                      MR. COWHERD: Excuse me. I didn't --

22                      HEARING OFFICER HANSTED: Excuse me.

23      Attorney Volpe --

24                      MS. VOLPE: Our closing remarks are

ORTHOPAEDIC/NEUROSURGERY SPECIALISTS & ADVANCED RADIOLOGY  
AUGUST 30, 2016

1 supposed to be brief, and he --

2 HEARING OFFICER HANSTED: Attorney Volpe,  
3 you're just making this longer. Attorney Cowherd, I was  
4 just about to say I'd ask you to wrap this up. We still  
5 have to hear from Attorney Monahan.

6 MR. COWHERD: I'm wrapping up. I think  
7 I'm done, right where we need.

8 HEARING OFFICER HANSTED: Okay.

9 MR. COWHERD: My point on this is,  
10 actually, ONS has shown that no good cause exists. If  
11 they participated in Medicaid, which is a conscious  
12 choice to participate, those patients that they see in  
13 the ED, that they see in the free care clinic would be  
14 able to follow their doctor into their private practice.

15 So saying that it's referral patterns that  
16 are causing these patients to go into the free clinic and  
17 the ED is misleading. The referral pattern is they're  
18 not on, ONS is not on any of the lists as a Medicaid  
19 provider.

20 When a Medicaid patient calls, what I  
21 assume is said is, sorry, we don't participate in the  
22 Medicaid program, so that condition and that criteria  
23 clearly is lacking here.

24 For all those reasons, there is going to

ORTHOPAEDIC/NEUROSURGERY SPECIALISTS & ADVANCED RADIOLOGY  
AUGUST 30, 2016

1 be an impact on existing providers if, in fact, this  
2 application is granted and there is unfettered ability  
3 for ONS to move either of its MRIs into the primary  
4 service area of Stamford Hospital, and it is that relief  
5 that we are asking be conditioned, if, in fact, OHCA  
6 approves this application. Thank you.

7 HEARING OFFICER HANSTED: Thank you.

8 Attorney Monahan? Sorry to cut you short, but you have  
9 two minutes.

10 MR. MONAHAN: Very briefly.

11 HEARING OFFICER HANSTED: Thank you.

12 MR. MONAHAN: I'm going to take a minute  
13 and a half.

14 HEARING OFFICER HANSTED: Excellent. I'm  
15 going to hold you to it.

16 MR. MONAHAN: Thank you very much. Two  
17 points. I'd just like to focus on what I think is a bit  
18 of what I would call self-denial or denial, in general,  
19 of what we're hearing from ARC about what has been  
20 described to you about the polyclinic model, what has  
21 been disparagingly referred to as a self-referral model,  
22 and the good value-based practices that have been  
23 provided by WESTMED and others like it.

24 The fact that there is going to be a

ORTHOPAEDIC/NEUROSURGERY SPECIALISTS & ADVANCED RADIOLOGY  
AUGUST 30, 2016

1 historical traditionally-based depletion in scans from  
2 ARC I do not think is properly recognized with that kind  
3 of rhetoric, and I think, when you do parse the record,  
4 you will actually find their own admissions of their  
5 financial -- why it is not financially-feasible for them  
6 to accomplish that, to make up for that loss.

7           Second, I think the whole idea of trying  
8 to create a vision of a wall between New York and  
9 Connecticut when it comes to travel time is a red  
10 herring.

11           The travel time that has been focused on  
12 the most here has been from Stamford to Fairfield,  
13 Stamford to Bridgeport, and the idea that one would  
14 consider going for quality health care from Stamford to  
15 Purchase, New York or anywhere else close to the border  
16 is a somehow different rationale is a red herring. Let's  
17 not be duped by the border issue.

18           Thank you very much, and thanks for the  
19 opportunity for us to intervene.

20           HEARING OFFICER HANSTED: Thank you.

21           And just one last time, is there anyone  
22 here from the public that would like to give comment on  
23 these matters?

24           Okay, hearing and seeing none, this

ORTHOPAEDIC/NEUROSURGERY SPECIALISTS & ADVANCED RADIOLOGY  
AUGUST 30, 2016

1 hearing is adjourned. Thank you, all.

2 (Whereupon, the hearing adjourned at 3:22

3 p.m.)

ORTHOPAEDIC/NEUROSURGERY SPECIALISTS & ADVANCED RADIOLOGY  
AUGUST 30, 2016

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## Greer, Leslie

---

**From:** Fernandes, David  
**Sent:** Tuesday, September 20, 2016 2:13 PM  
**To:** Karen Wackerman (kwackerman@Jeffers-Law.com); Michele Volpe (mmv@bvmlaw.com); Kathleen Gedney (kgg@bvmlaw.com); Patrick J. Monahan II (pmonahan@pppclaw.com); Jennifer Groves Fusco (jfusco@uks.com)  
**Cc:** Riggott, Kaila; Veyberman, Alla; Lazarus, Steven; Greer, Leslie; User, OHCA  
**Subject:** 16-32063 and 16-32093 Close of Combined Hearing  
**Attachments:** 16-32093 Close of Public Hearing.pdf; 16-32063 Close of Public Hearing.pdf

Good Afternoon,

Attached please find official notice of the closure of the public hearing held on August 30, 2016.

If you have any questions, please do not hesitate to contact me.

Have a great day.

### David Fernandes

Planning Analyst (CCT)

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue, Hartford, Connecticut 06134

P: (860) 418-7032 | F: (860) 418-7053 | E: [David.Fernandes@ct.gov](mailto:David.Fernandes@ct.gov)



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.  
Commissioner

Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

### Office of Health Care Access

September 20, 2016

VIA EMAIL ONLY

Jennifer G. Fusco, Esq.  
Updike, Kelly & Spellacy, P.C.,  
265 Church Street  
New Haven, CT 06510

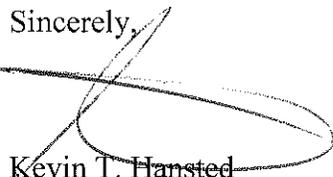
RE: Certificate of Need Application; Docket Number: 16-32093-CON  
Acquisition of a 3.0 Tesla MRI Unit by Advanced Radiology MRI Centers  
Closure of Public Hearing

Dear Attorney Fusco:

Please be advised, by way of this letter, the public hearing held on August 30, 2016, in the above referenced matter is hereby closed as of September 20, 2016. OHCA will receive no additional public comments or filings.

If you have any questions regarding this matter, please feel free to contact David Fernandes at (860) 418-7032 or Steven Lazarus at (860) 418-7012.

Sincerely,



Kevin T. Hansted  
Hearing Officer

KTH: swl, df, av



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Hartford, Connecticut 06134-0308  
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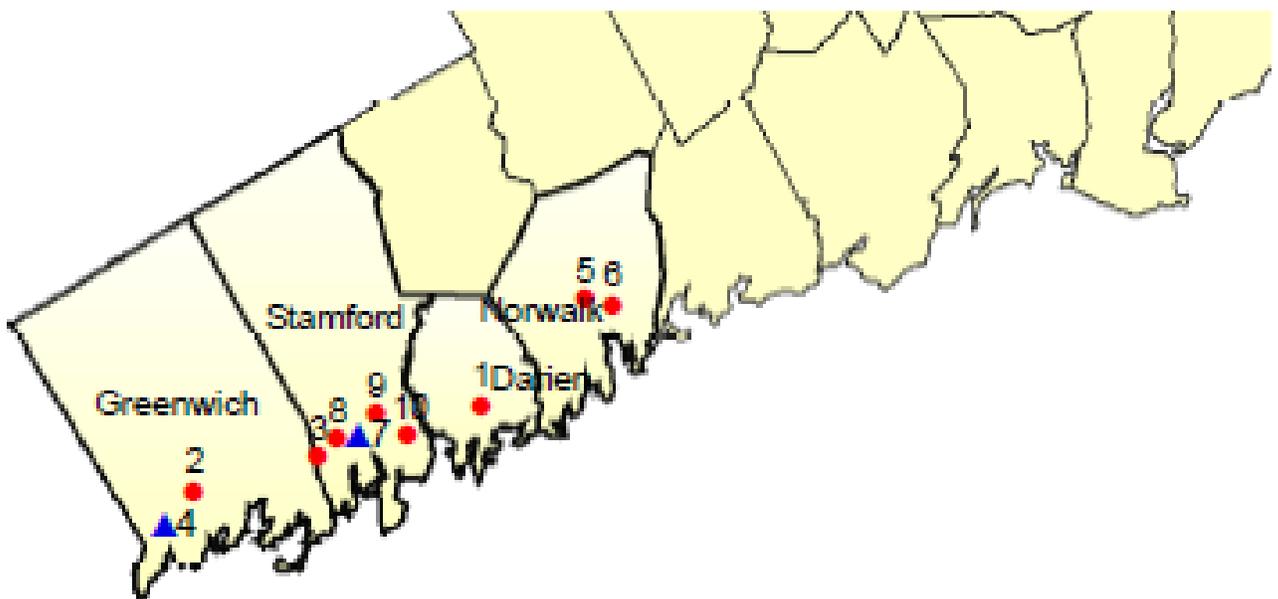
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## OHCA Exhibit

| ID | MRI FACILITY                                    | MRI TYPE                   | TOTAL SCANS FY 14 | Distance from Stamford Advance Radiology Center | Distance from Greenwich ONS Practice |
|----|---|----------------------------|-------------------|---|--------------------------------------|
| 1  | Darien Imaging Center                           | 1.5 tesla                  | 1,827             | 5.0 miles                                       | 10.8 miles                           |
| 2  | Greenwich Hospital                              | 1.5 tesla<br>3.0 tesla     | 4,693<br>3,128    | 7.5 miles                                       | 1.6 miles                            |
| 3  | Greenwich Hospital Diagnostic Center            | 1.5 tesla                  | 1,991             | 1.9 miles                                       | 5.9 miles                            |
| 4  | <b>Orthopedic Neurosurgical Specialist</b>      | <b>1.5 tesla</b>           | <b>4,800</b>      | <b>7.7 miles</b>                                | -----                                |
| 5  | Norwalk Hospital                                | 1.5 tesla                  | 3,174             | 9.2 miles                                       | 15.1 miles                           |
| 6  | Norwalk Hospital Radiology & Mammography Center | 1.5 tesla(2)<br>& .7 tesla | 9,797             | 9.7 miles                                       | 15.6 miles                           |
| 7  | <b>Stamford Advance Radiology Center</b>        | <b>1.5 tesla</b>           | <b>6,705</b>      | -----   | <b>7.7 miles</b>                     |
| 8  | Stamford Hospital                               | 1.5 tesla                  | 6,427             | 0.8 miles                                       | 6.8 miles                            |
| 9  | Tully Health Center                             | 1.5 tesla                  | 4,360             | 0.9 miles                                       | 8.3 miles                            |
| 10 | Hospital for Special Surgery *                  | 1.5 tesla                  | 1,981             | 2.2 miles                                       | 8.8 miles                            |

Source: Statewide Healthcare Facilities and Services Inventory-2014

\*Hospital for Special Surgery figure includes scans from February 2015 through January 2016



**Greer, Leslie**

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**Subject:** FW: CON-32093 Questions  
**Attachments:** DOCS-#1391852-v1-ARC\_STAMFORD\_MRI\_CQ\_RESPONSES\_(2).docx

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**From:** Jennifer Groves Fusco [<mailto:jfusco@uks.com>]  
**Sent:** Wednesday, October 19, 2016 9:42 AM  
**To:** Fernandes, David  
**Cc:** Riggott, Kaila  
**Subject:** RE: CON-32093 Questions

Good morning, David & Kaila,

Attached are response to your follow-up requests. Please let me know if you need anything further.

Thanks,  
Jen

---

**From:** Fernandes, David [<mailto:David.Fernandes@ct.gov>]  
**Sent:** Monday, October 17, 2016 10:26 AM  
**To:** Jennifer Groves Fusco  
**Cc:** Riggott, Kaila  
**Subject:** CON-32093 Questions

Good Morning Ms. Fusco,  
OCHA is currently in the process of drafting a decision for CON 16-32093 and in doing so, would like clarification/updates on a few things.

1. Please update the below table to include FY2019.

| Payer                       | Projected by Fiscal Year |   |
|-----------------------------|--------------------------|---|
|                             | 2019                     |   |
|                             | Discharges               | % |
| Medicare                    |                          |   |
| Medicaid                    |                          |   |
| CHAMPUS & TriCare           |                          |   |
| <b>Total Government</b>     |                          |   |
| Commercial Insurers         |                          |   |
| Uninsured/Self Pay          |                          |   |
| Workers Compensation        |                          |   |
| <b>Total Non-Government</b> |                          |   |
| <b>Total Payer Mix</b>      |                          |   |

2. Please complete the below table to reflect ARC's overall financial health.

|  | FY 2017 | FY 2018 | FY 2019 |
|--|---------|---------|---------|
|  |         |         |         |

|                                  |  |  |  |
|----------------------------------|--|--|--|
| Revenue from Operations          |  |  |  |
| Total Operating Expenses         |  |  |  |
| <b>Gain/Loss from Operations</b> |  |  |  |

- Can you explain why the loan in the amount of \$2,910,000 is different from the total capital expenditure of \$2,916,000 as found on page 39 of the application? How will the difference of \$6,000 be financed?

If you could provide this information at your earliest convenience, that would be appreciated.

Thank you,

**David Fernandes**

Planning Analyst (CCT)

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue, Hartford, Connecticut 06134

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**LEGAL NOTICE:** Unless expressly stated otherwise, this message is confidential and may be privileged. It is intended for the addressee(s) only. If you are not an addressee, any disclosure, copying or use of the information in this e-mail is unauthorized and may be unlawful. If you are not an addressee, please inform the sender immediately and permanently delete and/or destroy the original and any copies or printouts of this message. Thank you. Updike, Kelly & Spellacy, P.C.

**ADVANCED RADIOLOGY MRI CENTERS, LIMITED PARTNERSHIP  
 RESPONSES TO OHCA QUESTIONS  
 DOCKET NO. 16-32093  
 OCTOBER 19, 2016**

1. Please update the below table to include FY2019.

| Payer                       | Projected by Fiscal Year |               |
|-----------------------------|--------------------------|---------------|
|                             | 2019                     |               |
|                             | Discharges               | %             |
| Medicare                    | 1,398                    | 17.39%        |
| Medicaid                    | 313                      | 3.89%         |
| CHAMPUS & TriCare           | 0                        | 0%            |
| <b>Total Government</b>     | <b>1,711</b>             | <b>21.28%</b> |
| Commercial Insurers         | 5,733                    | 71.30%        |
| Uninsured/Self Pay          | 303                      | 3.77%         |
| Workers Compensation        | 294                      | 3.65%         |
| <b>Total Non-Government</b> | <b>6,330</b>             | <b>78.72%</b> |
| <b>Total Payer Mix</b>      | <b>8,041</b>             | <b>100%</b>   |

2. Please complete the below table to reflect ARC's overall financial health.

|                                  | FY 2017          | FY 2018          | FY 2019          |
|----------------------------------|------------------|------------------|------------------|
| Revenue from Operations          | 19,910,286       | 20,507,595       | 21,122,822       |
| Total Operating Expenses         | 12,401,206       | 12,959,260       | 13,542,427       |
| <b>Gain/Loss from Operations</b> | <b>7,509,080</b> | <b>7,548,334</b> | <b>7,580,395</b> |

3. Can you explain why the loan in the amount of \$2,910,000 is different from the total capital expenditure of \$2,916,000 as found on page 39 of the application? How will the difference of \$6,000 be financed?

RESPONSE:

The estimated total capital expenditure for the Stamford MRI proposal is \$2,916,224 (CON Application, p. 39). In providing its approval of financing for the project, Bank of America used whole numbers to approximate the amount at \$2,910,000 (CON Application, p. 137). ARC is certain that, to the extent necessary, Bank of America will increase the amount of financing to reflect the additional \$6,224. However, as noted at the public hearing on this matter, ARC anticipates that the cost of the 3.0 Tesla scanner will be less than projected and the total capital expenditure will be within the confirmed amount of financing.

## Greer, Leslie

---

**From:** Greer, Leslie  
**Sent:** Wednesday, December 07, 2016 12:03 PM  
**To:** Jennifer Groves Fusco (jfusco@uks.com)  
**Cc:** Fernandes, David; Riggott, Kaila; Hansted, Kevin; Lazarus, Steven; Martone, Kim; Olejarz, Barbara  
**Subject:** Advanced Radiology MRI Centers DN: 16-32093-CON  
**Attachments:** 32093\_201612071114.pdf

| Tracking: | Recipient                                 | Delivery                      | Read                     |
|-----------|---|-------------------------------|--------------------------|
|           | Jennifer Groves Fusco<br>(jfusco@uks.com) |                               |                          |
|           | Fernandes, David                          | Delivered: 12/7/2016 12:03 PM | Read: 12/7/2016 12:08 PM |
|           | Riggott, Kaila                            | Delivered: 12/7/2016 12:03 PM |                          |
|           | Hansted, Kevin                            | Delivered: 12/7/2016 12:03 PM |                          |
|           | Lazarus, Steven                           | Delivered: 12/7/2016 12:03 PM | Read: 12/7/2016 1:06 PM  |
|           | Martone, Kim                              | Delivered: 12/7/2016 12:03 PM |                          |
|           | Olejarz, Barbara                          | Delivered: 12/7/2016 12:03 PM |                          |

Attorney Fusco,  
Attached is the Agreed Settlement for Advanced Radiology MRI Centers Certificate of Need application.

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
Website: [www.ct.gov/ohca](http://www.ct.gov/ohca)



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.  
Commissioner



Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

### Department of Public Health Office of Health Care Access Certificate of Need Application

#### Agreed Settlement

**Applicant:** Advanced Radiology MRI Centers  
1259 East Main Street  
Stamford, CT 06902

**Docket Number:** 16-32093-CON

**Project Title:** Acquisition of a Magnetic Resonance Imaging Scanner

**Project Description:** Advanced Radiology MRI Centers (“ARC” or “Applicant”) is proposing to acquire and operate a new 3.0 Tesla (“T”) magnetic resonance imaging (“MRI”) scanner to be located at 1259 East Main Street, Stamford, Connecticut at an associated capital cost of \$2,916,224.

**Procedural History:** The Applicant published notice of its intent to file a Certificate of Need (“CON”) application in *The Advocate* (Stamford) on March 14, 15 and 16, 2016. On June 14, 2016, the Office of Health Care Access (“OHCA”) received the CON application from the Applicant for the above-referenced project and deemed the application complete on July 20, 2016. On August 5, 2016, the Applicant was notified of the date, time and place of the public hearing. On August 8, 2016, a notice to the public announcing the hearing was published in *The Advocate*. Commissioner Pino designated Attorney Kevin T. Hansted as the hearing officer in this matter. Thereafter, pursuant to Connecticut General Statutes (“Conn. Gen. Stat.”) § 19a-639a (f)(2), a public hearing regarding the CON application was held on August 30, 2016.

On August 25, 2016, Orthopaedic & Neurosurgery Specialist, P.C. (ONS) filed a petition requesting intervenor status. ONS was granted intervenor status with full rights in this matter on August 29, 2016.



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By petition dated August 25, 2016, Westchester Medical Group, P.C. requested intervenor status with full rights of cross-examination regarding the Applicant's CON application. The Hearing Officer designated Westchester Medical Group, P.C. as an Intervenor with limited rights of cross-examination on August 29, 2016.

The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. § 19a-639a (f)(2) and the Hearing Officer heard testimony from witnesses for the Applicant and the Intervenors.

The public hearing record was closed on September 20, 2016. In rendering the decision, Deputy Commissioner Addo considered the entire record in this matter.

## Findings of Fact and Conclusions of Law

1. Advanced Radiology MRI Centers (“ARC” or “Applicant”) is a private radiology practice with offices in Stamford, Fairfield, Stratford, Trumbull, Shelton and Orange. Ex. A, p. 12.
2. ARC provides a full range of diagnostic imaging and interventional radiology services, including magnetic resonance imaging (“MRI”), computed tomography (“CT”), ultrasound, mammography and general x-ray. Ex. A, p. 12.
3. ARC’s Stamford facility is located at 1315 Washington Boulevard and has operated for over 15 years providing body, breast, musculoskeletal, neurological and vascular MRI scans. Ex. A, pp. 12-13. ARC will be relocating its Stamford office to 1259 East Main Street in 2017. Ex. A, p. 235.
4. In 2005, ARC received OHCA approval to replace its Stamford low-field open MRI unit with a 1.5 Tesla (“T”) Siemens Espree (Docket Number 04-30277-CON). Ex. A, p. 12, 21.
5. The existing scanner has exceeded 100% capacity since fiscal year (“FY”) 2011. The table below shows ARC’s existing MRI’s annual utilization<sup>1</sup>:

**TABLE 1**  
**STAMFORD ARC’S UTILIZATION PERCENTAGE BY YEAR**

|                        | Fiscal Year |      |      |      |       |
|------------------------|-------------|------|------|------|-------|
|                        | 2011        | 2012 | 2013 | 2014 | 2015* |
| <b>SHP Utilization</b> | 132%        | 156% | 168% | 175% | 165%  |

\*The decrease in utilization from 2014 to 2015 was due to upgrading ARC’s Trumbull MRI unit, allowing new scan types to be conducted at ARC’s Trumbull site, thereby shifting some of the Stamford volume to Trumbull.

Ex. A, pp. 13, 52.

6. ARC has extended hours of operations to 92 hours per week. Since FY 2011, ARC’s Stamford location has operated from 7 a.m. to 10 p.m. on weekdays and 7 a.m. to 3:30 p.m. on weekends. Ex. A, pp. 14, 17.
7. Finding MRI technologists willing to work late night and weekend shifts has been difficult for ARC. Additionally, public transportation is not available to some patients during ARC’s extended hours. Ex. A, pp. 14, 27.
8. Complicated scans, such as contrast cases and arthrograms, are only performed during normal business hours, as they often require a physician to be present. Additionally, some MRI scans require the coordination of multiple clinical resources and personnel and therefore are more easily accomplished during normal business hours. Ex. A, p. 14; Ex. D, p. 146.

---

<sup>1</sup> The 2012 Statewide Health Care Facilities and Services Plan established capacity guidelines indicating the possible need for an additional MRI scanner if 85% capacity is exceeded; however these guidelines have not been formally adopted into regulation.

9. Consequently, ARC has been diverting patients from its Stamford location to its closest facilities in Fairfield, Stratford and Trumbull, which were at 167%, 136% and 128% capacity, respectively, in FY 2015. Ex. A, pp. 14, 23.
10. ARC is proposing to obtain a second MRI scanner for the Stamford office, a G.E. Signa Pioneer 3.0T, which will offer high-quality advanced imaging techniques. Procedures such as diffusion tensor imaging<sup>2</sup>, functional imaging<sup>3</sup> and brain perfusion<sup>4</sup> are not feasible or practical with the 1.5T MRI. Ex. A, pp. 15; 43-45; Testimony of Dr. Muro, Ex. V, p. 124.
11. A 3.0T MRI will allow for much higher quality vascular imaging of the head, neck, body and extremities and may eliminate the need for vascular imaging that requires radiation or may be more invasive. Furthermore, a 3.0T MRI is preferred for brain scans, Lyme and Parkinson's disease scans and certain prostate, spine and magnetic resonance angiography scans. Ex. A, pp. 15, 24. Testimony of Dr. Muro, Ex. V, pp. 124-125.
12. The Applicant's Stamford location will accommodate local patients in need of the enhancements provided by the proposed 3.0T MRI that would have previously been referred to ARC's Orange or Fairfield location. Ex. A, p. 15.
13. The Applicant's primary service includes Stamford, Norwalk, Darien, New Canaan and Greenwich. Ex. A, pp. 13, 38.
14. In FY 2015, ARC performed 84.86% of its total number of scans on persons residing within its primary service area towns:

**TABLE 2**  
**ARC'S UTILIZATION BY PATIENT TOWN OF RESIDENCE**

| TOWN         | UTILIZATION<br>in FY 2015 | PERCENT OF<br>TOTAL |
|--------------|---------------------------|---------------------|
| Stamford     | 3,648                     | 55.13%              |
| Greenwich    | 661                       | 9.99%               |
| Norwalk      | 652                       | 9.85%               |
| Darien       | 379                       | 5.73%               |
| New Canaan   | 275                       | 4.16%               |
| <b>Total</b> | <b>5,615</b>              | <b>84.86%</b>       |

Ex. A, p. 42.

<sup>2</sup> Diffusion tensor imaging is a method that provides a description of the diffusion of water through tissue, and can be used to highlight structural changes in tissue tracts. Johns Hopkins Medicine, *Diffusion Tensor Imaging (DTI)*, available at <http://www.hopkinsmedicine.org/psychiatry/research/neuroimaging/> (Accessed on 10/14/16).

<sup>3</sup> Functional imaging is a technique for measuring brain activity. This is accomplished by detecting the changes in blood oxygenation and flow that occur in response to neural activity. PsychCentral, *What is Functional Magnetic Resonance Imaging (fMRI)*, available at <https://psychcentral.com/lib/what-is-functional-magnetic-resonance-imaging-fmri/> (Accessed on 10/14/16).

<sup>4</sup> Brain perfusion is a type of brain scan that indicates the blood supply in certain areas of the brain. This type of scan provides information on how the brain is functioning. Johns Hopkins Medicine, *Brain Perfusion Scan*, available at [http://www.hopkinsmedicine.org/healthlibrary/test\\_procedures/neurological/brain\\_perfusion\\_scan](http://www.hopkinsmedicine.org/healthlibrary/test_procedures/neurological/brain_perfusion_scan) (Accessed on 10/14/16).

15. ARC utilizes an image sharing network which minimizes scheduling effort, data entry redundancies and errors while allowing physicians and providers real time viewing of patient imaging records and reports via an Internet-enabled clinical viewer, physician web portal or mobile application. Ex. D, p. 147.
16. The image sharing network lessens duplicative procedures by permitting physicians and providers new to the patient to search for recent MRI results and scans, minimizing the need to rescan patients, and lessening patient cost, exposure, and delay in diagnosis and treatment. Ex. D, p. 148.
17. The Applicant’s electronic medical record (“EMR”) system is integrated with Yale’s Epic system and with several other EMRs throughout the Applicant’s service area. The integration allows the ordering and uploading of patient results directly into the Epic system. Testimony of Dr. Yoder, Ex. V, pp. 129-130.
18. The table below shows ARC’s Stamford historical utilization by MRI scan type for the existing scanner:

**TABLE 3  
STAMFORD ARC’S HISTORICAL UTILIZATION BY FISCAL YEAR**

|                         | Fiscal Year* |              |              |              |
|-------------------------|--------------|--------------|--------------|--------------|
|                         | 2013         | 2014         | 2015         | CFY 2016**   |
| <b>Number of Scans:</b> |              |              |              |              |
| Body                    | 340          | 328          | 323          | 404          |
| Breast                  | 205          | 223          | 168          | 179          |
| Musculoskeletal         | 3,220        | 3,284        | 3,059        | 2,894        |
| Neurological            | 2,794        | 3,042        | 2,954        | 3,047        |
| Vascular                | 146          | 125          | 113          | 110          |
| <b>Grand Total</b>      | <b>6,705</b> | <b>7,002</b> | <b>6,617</b> | <b>6,634</b> |

\* Applicant’s fiscal year is January 1 to December 31.

\*\* Annualized totals based on scans completed from January 1 to August 29.

Ex. U, p. 249.

19. The following table shows the projected number of scans at ARCs Stamford location.

**TABLE 4  
STAMFORD ARC’S PROJECTED UTILIZATION**

|                                    | FISCAL YEAR* |              |              |
|------------------------------------|--------------|--------------|--------------|
|                                    | 2017         | 2018         | 2019         |
| <b>Number of Scans by Scanner:</b> |              |              |              |
| 1.5T Unit                          | 3,647        | 3,829        | 4,021        |
| Proposed 3.0T Unit                 | 3,647        | 3,829        | 4,020        |
| <b>Total</b>                       | <b>7,294</b> | <b>7,658</b> | <b>8,041</b> |

\* Applicant’s fiscal year is January 1 to December 31.

\*\* ARC projects 5% annual growth based on the aging population. This compares to previous growth of 25% from FY 2011 through FY 2015.

Ex. A, pp. 31-32, 50.

20. Of the existing providers in the service area, all but one utilize either a .7T or a 1.5T strength MRI scanner. The one provider that offers MRI services with a 3.0T does so in a hospital setting.

**TABLE 5  
EXISTING PROVIDERS**

| MRI FACILITY                                    | TESLA STRENGTH  | TOTAL SCANS | Distance from ARC |
|---|-----------------|-------------|-------------------|
| Darien Imaging Center                           | 1.5             | 1,827       | 5.0 miles         |
| Greenwich Hospital                              | 1.5             | 4,693       | 7.5 miles         |
|   | 3.0             | 3,128       |                   |
| Greenwich Hospital Diagnostic Center            | 1.5             | 1,991       | 1.9 miles         |
| Orthopedic Neurosurgical Specialist             | 1.5             | 4,800       | 7.7 miles         |
| Norwalk Hospital                                | 1.5             | 3,174       | 9.2 miles         |
| Norwalk Hospital Radiology & Mammography Center | 1.5 (2)<br>& .7 | 9,797       | 9.7 miles         |
| ARC   | 1.5             | 6,702       | -----             |
| Stamford Hospital                               | 1.5             | 6,427       | 0.8 miles         |
| Tully Health Center                             | 1.5             | 4,360       | 0.9 miles         |
| Hospital for Special Surgery *                  | 1.5             | 1,981       | 2.2 miles         |

\*Hospital for Special Surgery figure includes scans from February 2015 through January 2016 Source: *Statewide Healthcare Facilities and Services Inventory-2014*, Exhibit AA  
[http://www.huskyhealthct.org/provider\\_lookup.html](http://www.huskyhealthct.org/provider_lookup.html)

21. The proposed MRI will be staffed by the same technologist and scans will be interpreted by the same subspecialist radiologists that staff the existing MRI unit. Ex. A, p. 24; Testimony of Dr. Kaye, Ex. V, p. 206.
22. The Applicant is the sole private radiology practice that provides MRI services in the service area and does so with no facility or add-on fees. Of the 13 MRI scanners in the area, 11 are hospital-affiliated, which typically charge a facility fee. Ex. A, pp. 17, 26, 35-36.
23. The fees typically charged by private physician practices and the reimbursement rates for MRI services are typically lower than those found in a hospital setting. Ex. A, pp. 17, 26, 28; Testimony of Dr. Yoder, Ex. V, pp. 119-120.

24. The Applicant does not anticipate any changes in payer mix for the next three fiscal years.

**TABLE 6**  
**ARC'S CURRENT & PROJECTED PAYER MIX**

| Payer                       | FY 2016      |               | Projected by Fiscal Year |               |              |               |              |               |
|-----------------------------|--------------|---------------|--------------------------|---------------|--------------|---------------|--------------|---------------|
|                             |              |               | 2017                     |               | 2018         |               | 2019         |               |
|                             | Discharges   | %             | Discharges               | %             | Discharges   | %             | Discharges   | %             |
| Medicare                    | 1,208        | 17.39%        | 1,268                    | 17.39%        | 1,332        | 17.39%        | 1,398        | 17.39%        |
| Medicaid                    | 270          | 3.89%         | 284                      | 3.89%         | 298          | 3.89%         | 313          | 3.89%         |
| CHAMPUS & TriCare           | 0            | 0%            | 0                        | 0%            | 0            | 0%            | 0            | 0%            |
| <b>Total Government</b>     | <b>1,478</b> | <b>21.28%</b> | <b>1,552</b>             | <b>21.28%</b> | <b>1,630</b> | <b>21.28%</b> | <b>1,711</b> | <b>21.28%</b> |
| Commercial Insurers         | 4,952        | 71.28%        | 5,200                    | 71.29%        | 5,460        | 71.30%        | 5,733        | 71.30%        |
| Uninsured/Self Pay          | 262          | 3.77%         | 275                      | 3.77%         | 289          | 3.77%         | 303          | 3.77%         |
| Workers Compensation        | 255          | 3.67%         | 267                      | 3.66%         | 279          | 3.65%         | 294          | 3.65%         |
| <b>Total Non-Government</b> | <b>5,469</b> | <b>78.72%</b> | <b>5,742</b>             | <b>78.72%</b> | <b>6,028</b> | <b>78.72%</b> | <b>6,330</b> | <b>78.72%</b> |
| <b>Total Payer Mix</b>      | <b>6,947</b> | <b>100%</b>   | <b>7,294</b>             | <b>100%</b>   | <b>7,658</b> | <b>100%</b>   | <b>8,041</b> | <b>100%</b>   |

\*10.26% of MRI volume practice wide is comprised of Medicaid, uninured, and self-pay.

Ex. A, pp. 16-17, 32, 41; Ex. Y, p. 250.

25. The Applicant is the sole private physician practice that serves the Medicaid population in the region. ARC has history of and a commitment to serving Medicaid recipients as well as the indigent population. The proposal will not impact access to care for the Medicaid and indigent population. Ex. A, pp. 16-17, 28, 32.

26. ARC is the only private physician practice in lower Fairfield County that offers MRI services to patients referred by third parties. The referrals, an estimated 500 in FY2015, are from different sources and include primary care physicians, orthopedist, neurologists, gastroenterologists, pulmonologists, ophthalmologist, gynecologists, urologists, podiatrists, chiropractors and endocrinologists. Ex. A, pp. 13, 16.

27. The Applicant will finance the proposed scanner, along with the construction costs, with a loan from Bank of America. Ex. I, p. 137.

28. The proposal's total capital expenditure is shown below:

**TABLE 7**  
**ARC'S TOTAL PROPOSED CAPITAL EXPENDITURE**

| Item                                      | Cost               |
|---|--------------------|
| Equipment (Medical, Non-Medical, Imaging) | \$2,506,224        |
| Construction/Renovation                   | \$410,000          |
| <b>Total Capital Expenditure</b>          | <b>\$2,916,224</b> |

\*Final capital expenditure costs are anticipated to be less than projected but will be within the confirmed amount of financing.

Ex. A, p. 39; Ex. Y, p. 251.

29. The Applicant projects initial incremental operating expense losses in Stamford due to MRI volume growth not generating sufficient revenue to cover the cost of a second unit. However, ARC as a whole will remain profitable.

**TABLE 8**  
**ARC'S STAMFORD LOCATION PROJECTED INCREMENTAL REVENUES AND EXPENSES**

|                                  | FY 2017            | FY 2018            | FY 2019            |
|----------------------------------|--------------------|--------------------|--------------------|
| Revenue from Operations          | \$212,504          | \$431,221          | \$665,464          |
| Total Operating Expenses         | \$836,758          | \$915,310          | \$1,007,818        |
| <b>Gain/Loss from Operations</b> | <b>(\$624,254)</b> | <b>(\$484,089)</b> | <b>(\$324,354)</b> |

\*The loss in operations is attributed to depreciation from the proposed scanner, and increased costs from salaries and fringe benefits.

**TABLE 9**  
**ARC'S OVERALL PROJECTED INCREMENTAL REVENUES AND EXPENSES**

|                                  | FY 2017            | FY 2018            | FY 2019            |
|----------------------------------|--------------------|--------------------|--------------------|
| Revenue from Operations          | \$19,910,286       | \$20,507,595       | \$21,122,822       |
| Total Operating Expenses         | \$12,401,206       | \$12,959,260       | \$13,542,427       |
| <b>Gain/Loss from Operations</b> | <b>\$7,509,080</b> | <b>\$7,548,334</b> | <b>\$7,580,395</b> |

Ex. A, pp. 29, 31, 39; Ex. Y, p. 250.

30. Based on the fixed costs necessary to operate the proposed scanner (annual lease, employee salaries and wages, fringe benefits, the occupancy fee, other equipment, license and permit fees, and other miscellaneous expenses) and the pro rata share of all adjustable costs (professional fees, supplies and drugs, billing fees, and transcription fees), the minimum number of MRI scans required to show an incremental gain is 1,925. It is anticipated the incremental gain would be achieved by FY 2021. Ex. A, p. 31; Ex. D, p. 147.
31. ARC's proposed scanner will be accredited by the American College of Radiology ("ACR"). Ex. A, p. 19.
32. The proposed scanner's construction and installation will have no effect on the current MRI scanner. Operation of the proposed 3.0T MRI would begin early in the second quarter of 2017. Testimony of Mr. Yoder, Ex. V, p. 205.
33. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations not yet adopted by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1))
34. This CON application is consistent with the Statewide Health Care Facilities and Service Plan. (Conn. Gen. Stat. § 19a-639(a)(2))
35. The Applicant has established that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3))
36. The Applicant has demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))

37. The Applicant has satisfactorily demonstrated that the proposal will improve the accessibility and quality and maintain cost effectiveness of health care delivery in the region. (Conn. Gen. Stat. § 19a-639(a)(5))
38. The Applicant has shown that there would be no adverse change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6))
39. The Applicant has satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7))
40. The Applicant's historical provision of services in the area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))
41. The Applicant has satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))
42. The Applicant has demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10))
43. The Applicant has demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the region. (Conn. Gen. Stat. § 19a-639(a)(11))
44. The Applicant has satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or access to care. (Conn. Gen. Stat. § 19a-639(a)(12))

## DISCUSSION

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in § 19a-639(a) of the Statutes. The Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board*, 309 Conn. 727 (2013).

Advanced Radiology MRI Centers (“ARC” or “Applicant”) is a private radiology practice with office locations in Stamford, Fairfield, Stratford, Trumbull, Shelton and Orange. *FF1*. ARC provides a full range of diagnostic imaging and interventional radiology services, including Magnetic Resonance Imaging (“MRI”), Computed Tomography (“CT”), ultrasound, mammography and general x-ray. *FF2*. ARC’s Stamford facility has served the community for over 15 years providing body, breast, musculoskeletal, neurological and vascular MRI scans. *FF3*. The Stamford location primarily serves the towns of Stamford, Norwalk, Darien, New Canaan and Greenwich. *FF13*.

In 2005, ARC received approval from OHCA (Docket Number 04-30277-CON) to replace its low-field open MRI unit. *FF4*. The current 1.5 Tesla (“T”) scanner has seen capacity in excess of 100% for the past four years and is projected to increase by 5% each year through 2019. *FF5*, *FF19*.

Since 2011, ARC has attempted to accommodate the increased volume by extending its hours of operations to include nights and weekends. Hours of operation now total 92 hours per week. *FF6*. Extended hours have proven troublesome as ARC has experienced difficulty recruiting MRI technologists willing to work extended hours. *FF7*. Additionally, complicated MRI scans such as contrast cases and arthrograms can only be performed during normal business hours due to the need for a physician to be present during the scan. Some MRI scans also require coordination of multiple clinical resources and personnel which can more easily be accomplished during normal business hours. *FF8*. In response to the limited appointment availability, ARC has diverted patients from its Stamford location to its closest facilities in Fairfield, Stratford and Trumbull. The diversion has impacted capacity at each of those facilities, whose capacity exceeds 100%. *FF9*.

In an effort to meet demand, the Applicant is proposing the acquisition of a 3.0T MRI which will allow for much higher quality vascular imaging of the head, neck, body and extremities and may eliminate the need for vascular imaging that requires radiation or may be more invasive. *FF11*. The proposed MRI scanner will offer high-quality advanced imaging techniques such as diffusion tensor imaging, functional imaging and brain perfusion which are not feasible or practical with a 1.5T MRI unit. *FF10*. Furthermore, a 3.0T MRI is preferred for brain scans, Lyme and Parkinson’s disease scans and certain prostate, spine and magnetic resonance angiography scans. *FF11*. It will also permit ARC to perform such examinations currently not available in a non-hospital affiliated setting due to the limited availability of a 3.0T MRI in the Stamford area. *FF20*.

There are 13 MRI scanners in lower Fairfield County with 11 located in hospital-affiliated settings. *FF22*. The remaining two MRI scanners are owned by two private physician practices --

the Applicant and a self-referring private practice. *FF20*. Out of the two, the Applicant is the only physician practice that accepts third party referrals allowing patients not under the care of a physician who owns an MRI a choice. *FF26*. Fees typically charged by private physician practices and the reimbursement rates for MRI services are typically lower than hospital-affiliated scanners. *FF23*. The proposed MRI would continue to positively impact patient choice by offering increased access and at a lower cost and with no facility fee when compared to hospital-affiliated MRIs. *FF22*.

The Applicant is the only private physician practice that accepts Medicaid recipients. This ensures access to services and patient choice for Medicaid recipients that would otherwise have no choice but to go to a hospital-affiliated MRI for a 3.0T scanner. *FF25*. The Applicant has and continues to serve Medicaid recipients, the uninsured and self-pay resulting in 7.66% of all patient volume in the Stamford location and 10.26% practice wide. *FF24*. The Applicant has demonstrated the commitment to preserving access to medical care for Medicaid and indigent patients.

The Applicant does not project any changes in payer mix in the next three years and thus, the proposal will not impact the indigent population and Medicaid patients' access to care. *FF24*.

The proposed MRI scanner would allow more patients to benefit from ARC's image sharing network, which provides physicians and providers real time viewing of patient imaging records via internet access. *FF15*. The technology increases health care system efficiency by reducing duplicative procedures as physicians and providers new to the patient are afforded the ability to search for MRI results and scans, minimizing the need to rescan the patient. *FF16*. Further efficiencies are achieved through the imaging network's ability to minimize scheduling effort, data entry redundancies and errors. *FF15*.

Although ARC projects incremental losses in operating expenses due to MRI volume growth not generating sufficient revenue to cover the second unit, overall the Applicant, as a whole, will remain profitable. *FF29*. The Applicant estimates it would need an additional 1,925 scans to show an incremental gain, which is anticipated to be achieved by FY 2021. *FF30*. The total cost of the proposal will be financed through Bank of America. *FF27*.

The acquisition of a 3.0T MRI scanner by the Applicant will improve access as it will make available advanced imaging techniques that are not otherwise offered in the service area in a non-hospital affiliated setting. In addition, the scans conducted on the 3.0T MRI will be of higher quality, reduce the need for scans that require radiation or are more invasive and will be offered without associated facility fees. Thus, OHCA finds the Applicant has demonstrated clear public need for the proposal. Additionally, the aforementioned benefits are consistent with the Statewide Health Care and Facilities Plan.

In order to ensure that access to care will improve for the population currently being served, including that of the Medicaid population, and to ensure the proposal is consistent with the Statewide Health Care Facilities and Services Plan, OHCA requires that the Applicant agree to take certain actions as stated in the order attached hereto.

## Order

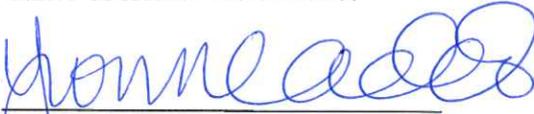
**NOW, THEREFORE**, the Department of Public Health, Office of Health Care Access (“OHCA”) and Advanced Radiology MRI Centers (“Applicant”), through their authorized representatives, hereby stipulate and agree to the following terms of settlement with respect to the Applicant’s request to acquire and operate a new 3.0 Tesla magnetic resonance imaging (“MRI”) scanner to be located at 1259 East Main Street, Stamford, Connecticut:

1. The Applicant shall not relocate the proposed MRI outside of Stamford, Connecticut as long as the MRI is in operation.
2. OHCA and the Applicant agree that this settlement represents a final agreement between OHCA and the Applicant with respect to OHCA Docket No. 16-32093-CON. The execution of this settlement resolves all objections, claims and disputes, which may or could have been raised by the Applicant with regard to OHCA Docket Number 16-32093-CON.
3. OHCA may enforce this settlement under the provisions of Conn. Gen. Stat. §§ 19a-642; 19a-653 and all other remedies available at law, with all fees and costs of such enforcement to be governed by State Law.
4. This settlement shall be binding upon the Applicant and its successors and assigns.

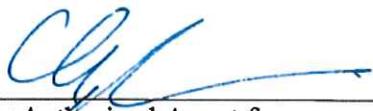
All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the  
Department of Public Health  
Office of Health Care Access

12/6/2016  
Date

  
Yvonne T. Addo, MBA  
Deputy Commissioner

12/5/2016  
Date

  
Duly Authorized Agent for  
Advanced Radiology MRI Centers

Signed by CLARK YODER,  
(Print name)

CEO  
(Title)

## Greer, Leslie

---

**From:** Jennifer Groves Fusco <jfusco@uks.com>  
**Sent:** Wednesday, December 07, 2016 12:04 PM  
**To:** Greer, Leslie  
**Cc:** Fernandes, David; Riggott, Kaila; Hansted, Kevin; Lazarus, Steven; Martone, Kim; Olejarz, Barbara  
**Subject:** RE: Advanced Radiology MRI Centers DN: 16-32093-CON

Thank you!

---

**From:** Greer, Leslie [<mailto:Leslie.Greer@ct.gov>]  
**Sent:** Wednesday, December 07, 2016 12:03 PM  
**To:** Jennifer Groves Fusco  
**Cc:** Fernandes, David; Riggott, Kaila; Hansted, Kevin; Lazarus, Steven; Martone, Kim; Olejarz, Barbara  
**Subject:** Advanced Radiology MRI Centers DN: 16-32093-CON

Attorney Fusco,  
Attached is the Agreed Settlement for Advanced Radiology MRI Centers Certificate of Need application.

Leslie M. Greer  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134  
Phone: (860) 418-7013 Fax: (860) 418-7053  
*Website:* [www.ct.gov/ohca](http://www.ct.gov/ohca)



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## User, OHCA

---

**From:** Jennifer Groves Fusco <jfusco@uks.com>  
**Sent:** Wednesday, August 09, 2017 4:04 PM  
**To:** User, OHCA  
**Cc:** Yoder, Clark (clark.yoder@adrad.com)  
**Subject:** Advanced Radiology Stamford MRI -- Docket No. 16-32093-CON  
**Attachments:** DOCS-#1630726-v1-ARC\_STAMFORD\_MRI\_NOTICE\_LETTER.doc

Please see attached notice regarding acquisition and installation of the MRI unit approved in Docket No. 16-32093-CON.

Thanks,  
Jen

Jennifer Groves Fusco, Esq.  
Principal  
Updike, Kelly & Spellacy, P.C.  
One Century Tower  
265 Church Street  
New Haven, CT 06510  
Office (203) 786.8316  
Cell (203) 927.8122  
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Jennifer G. Fusco  
(t) 203.786.8316  
(f) 203.772.2037  
jfusco@uks.com

August 9, 2017

VIA ELECTRONIC MAIL

Kimberly R. Martone, Director of Operations  
Office of Health Care Access  
410 Capital Avenue, MS #13HCA  
P. O. Box 340308  
Hartford, CT 06106

Re: Advanced Radiology Consultants, LLC  
Acquisition of a Magnetic Resonance Imaging Scanner  
Docket No. 16-32093-CON

Dear Kim:

Please be advised that Advanced Radiology MRI Centers, L.P. (“ARC”) has acquired and installed the MRI unit authorized in Docket No. 16-32093-CON. The scanner, a GE Pioneer 3 Tesla unit, was installed at ARC’s new Stamford office located at 1259 East Main Street. The MRI became operational on July 24, 2017.

Please feel free to contact me with any questions.

Very truly yours,

A handwritten signature in blue ink, appearing to read 'Jennifer Groves Fusco', written in a cursive style.

Jennifer Groves Fusco

JGF/dla

cc: Clark G. Yoder

**Updike, Kelly & Spellacy, P.C.**

One Century Tower ■ 265 Church Street ■ New Haven, CT 06510 (t) 203.786.8300 (f) 203.772.2037 [www.uks.com](http://www.uks.com)

## User, OHCA

---

**From:** Roberts, Karen  
**Sent:** Thursday, August 10, 2017 3:15 PM  
**To:** Jennifer Groves Fusco (jfusco@uks.com)  
**Cc:** User, OHCA  
**Subject:** FW: Advanced Radiology Stamford MRI -- Docket No. 16-32093-CON  
**Attachments:** DOCS-#1630726-v1-ARC\_STAMFORD\_MRI\_NOTICE\_LETTER.doc

Thank you for the notification Jen. This document will be placed within the record for Docket Number 16-32093-CON. Karen

Sincerely,

*Karen Roberts*

Principal Health Care Analyst  
Office of Health Care Access  
Connecticut Department of Public Health  
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308  
P: (860) 418-7041 / F: (860) 418-7053 / E: [karen.roberts@ct.gov](mailto:karen.roberts@ct.gov)



---

**From:** Jennifer Groves Fusco [mailto:jfusco@uks.com]  
**Sent:** Wednesday, August 9, 2017 4:04 PM  
**To:** User, OHCA <OHCA@ct.gov>  
**Cc:** Yoder, Clark (clark.yoder@adrad.com) <clark.yoder@adrad.com>  
**Subject:** Advanced Radiology Stamford MRI -- Docket No. 16-32093-CON

Please see attached notice regarding acquisition and installation of the MRI unit approved in Docket No. 16-32093-CON.

Thanks,  
Jen

**Jennifer Groves Fusco, Esq.**  
**Principal**  
**Updike, Kelly & Spellacy, P.C.**  
**One Century Tower**  
**265 Church Street**  
**New Haven, CT 06510**  
**Office (203) 786.8316**  
**Cell (203) 927.8122**  
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[www.uks.com](http://www.uks.com)



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Jennifer G. Fusco  
(t) 203.786.8316  
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jfusco@uks.com

August 9, 2017

VIA ELECTRONIC MAIL

Kimberly R. Martone, Director of Operations  
Office of Health Care Access  
410 Capital Avenue, MS #13HCA  
P. O. Box 340308  
Hartford, CT 06106

Re: Advanced Radiology Consultants, LLC  
Acquisition of a Magnetic Resonance Imaging Scanner  
Docket No. 16-32093-CON

Dear Kim:

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Please feel free to contact me with any questions.

Very truly yours,

A handwritten signature in blue ink, appearing to read 'Jennifer Groves Fusco', is written over a light blue horizontal line.

Jennifer Groves Fusco

JGF/dla

cc: Clark G. Yoder

## User, OHCA

---

**From:** Jennifer Groves Fusco <jfusco@uks.com>  
**Sent:** Friday, August 11, 2017 9:54 AM  
**To:** Roberts, Karen  
**Cc:** User, OHCA  
**Subject:** RE: Advanced Radiology Stamford MRI -- Docket No. 16-32093-CON

Thanks, Karen.

---

**From:** Roberts, Karen [mailto:Karen.Roberts@ct.gov]  
**Sent:** Thursday, August 10, 2017 3:15 PM  
**To:** Jennifer Groves Fusco  
**Cc:** User, OHCA  
**Subject:** FW: Advanced Radiology Stamford MRI -- Docket No. 16-32093-CON

Thank you for the notification Jen. This document will be placed within the record for Docket Number 16-32093-CON. Karen

Sincerely,

*Karen Roberts*

Principal Health Care Analyst

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308

P: (860) 418-7041 / F: (860) 418-7053 / E: [karen.roberts@ct.gov](mailto:karen.roberts@ct.gov)



---

**From:** Jennifer Groves Fusco [mailto:jfusco@uks.com]  
**Sent:** Wednesday, August 9, 2017 4:04 PM  
**To:** User, OHCA <OHCA@ct.gov>  
**Cc:** Yoder, Clark (clark.yoder@adrad.com) <clark.yoder@adrad.com>  
**Subject:** Advanced Radiology Stamford MRI -- Docket No. 16-32093-CON

Please see attached notice regarding acquisition and installation of the MRI unit approved in Docket No. 16-32093-CON.

Thanks,  
Jen

Jennifer Groves Fusco, Esq.  
Principal  
Updike, Kelly & Spellacy, P.C.

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