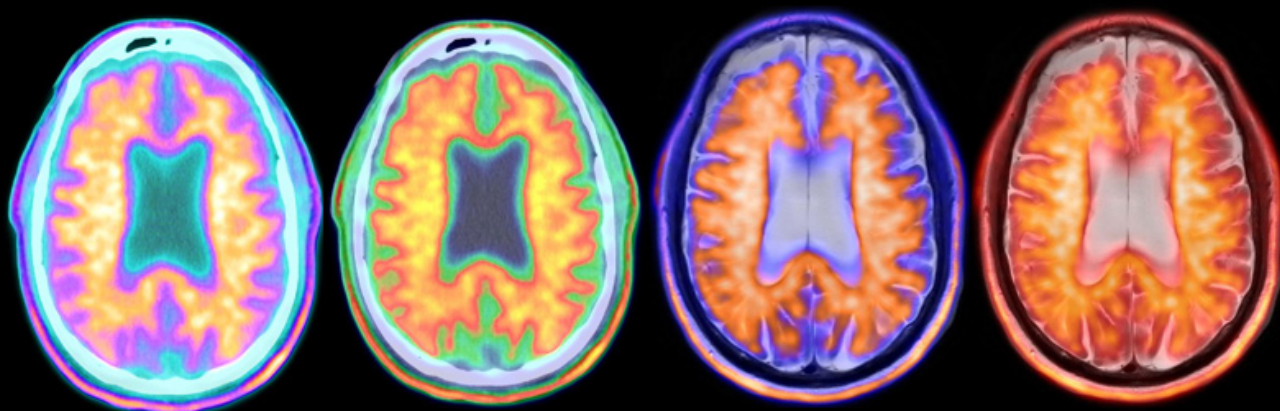


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Imaging Comes Home: Why More Neurology Practices Are Bringing MRI and PET Onsite



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Imaging Comes Home: Why More Neurology Practices Are Bringing MRI and PET Onsite

Executive Summary

Neurology care is entering a transformative era, driven by breakthrough anti-amyloid therapies for Alzheimer disease (AD), growing disease burden, and evolving economic incentives.

Advanced MRI and PET scans, now central to the diagnosis, treatment selection, and safety monitoring of AD, provide anatomical, functional, and quantitative information that clinicians can use alongside clinical evaluation, laboratory findings, and other assessments to support patient management decisions.

These shifts are occurring amid increasing pressure on neurology practices. An aging population living longer with chronic conditions means higher patient volumes, while the rise in biomarker-based disease definitions puts strain on already overburdened hospital-based radiology systems.

Meanwhile, payer policies continue to incentivize the migration of imaging from hospitals to lower-cost outpatient settings. In this environment, integrating onsite imaging allows neurology practices to expand capacity, shorten wait times, improve patient experience, standardize protocols, enable immediate results, and diversify revenue streams.

New technologies and evolving delivery models—including more accessible, easy-to-site MRI and PET/CT systems, AI workflows, flexible financing solutions, and alternate siting options such as mobile units, all supported by manufacturers like Siemens Healthineers, have lowered barriers to entry, making advanced imaging accessible to private practices of all sizes. Increasingly, these capabilities are being offered as fully integrated, turnkey solutions that combine equipment, implementation, staffing, and operational support, enabling practices of all sizes to deploy advanced imaging quickly and with reduced administrative burden.

Quick Facts

Neurology is rapidly evolving due to new Alzheimer therapies and rising demand from aging populations.

MRI and PET scans are essential, but reliance on overburdened hospital imaging causes treatment delays and inconsistency.

Onsite imaging is more accessible, improving efficiency, care, and revenue for outpatient practices.

Important Safety Information: MRI provides images to be interpreted by physicians; it is not indicated to determine disease stage or prognosis.

The Role of Imaging in Alzheimer Disease

The introduction of two first-in-class therapies for Alzheimer disease (AD), lecanemab (Leqembi) and donanemab (Kisunla), marks a historic turning point in clinical neuroscience. For the first time, clinicians can offer patients disease-modifying treatments rather than only palliative care for this devastating ailment. These therapies require extensive use of advanced diagnostic imaging tools to support clinician assessment of amyloid pathology, patient evaluation workflows, treatment planning considerations, safety surveillance, and longitudinal disease management.

Diagnosis and Biomarker Confirmation

Clinical evaluation of patients with suspected AD is increasingly supported by biomarker evidence, including amyloid PET imaging or cerebrospinal fluid analysis.¹ Amyloid deposition may begin years to decades before the onset of clinical symptoms,¹ although in clinical practice amyloid PET imaging may be used as part of the clinical workup in patients presenting with cognitive impairment.

Important Safety Information: Disease-modifying therapy (DMT) in Alzheimer disease is associated with risks. Refer to the prescribing information for the specific DMT for information regarding adverse reactions, contraindications, warnings, and precautions.

Imaging Findings and Disease Characterization

Clinicians are increasingly interested in identifying imaging and biomarker patterns associated with earlier disease presentation (low-tau burden), as clinical trials show that these individuals derive the greatest benefit from emerging therapies. Quantitative MRI may provide volumetric and structural information that can support clinician assessment of neurodegenerative patterns associated with earlier or



Imaging now plays a critical role across the entire Alzheimer's disease continuum. In the past year alone, RadNet performed approximately 7,000 amyloid PETs and 339,000 brain MRIs, underscoring the expanding role of advanced imaging in Alzheimer's care. This represents a cumulative 7,189% increase in amyloid PET volumes and a 25% increase in MRI brain volumes over the past two years.

—Suzie Bash, MD, Neuroradiologist at RadNet

later disease presentation. When a dementia other than AD is suspected, clinicians may order FDG PET to screen for an alternative diagnosis.

Treatment Monitoring and Safety

Once clinicians confirm a diagnosis of AD and that the patient meets MRI eligibility criteria, treatment may begin. Patients then undergo periodic MRI surveillance for amyloid-related imaging abnormalities (ARIA), a known safety risk associated with anti-amyloid therapy. If imaging findings consistent with ARIA are detected, clinicians may pursue more frequent MRI monitoring until ARIA-E (edema) has resolved and ARIA-H (hemorrhage) has stabilized.

The Changing Landscape of Neurology Care

Growing Treatment Burden

Anti-amyloid therapies arrive at a time when neurology already faces mounting patient volumes, driven largely by aging populations and longer life expectancies. A 2021 study found that since 1990, the global burden of neurological disease—measured in disability-adjusted life years (DALYs)—has increased by 18%.² More recent analysis suggests that neurological disorders now affect approximately 1 in 2 people in the United States.³ While mortality related to neurological disease has declined, this trend also means patients are living longer (about 10%) with chronic

conditions.³ Alzheimer disease, the most common neurodegenerative condition worldwide, currently affects an estimated 7 million people in the U.S.,³ a number projected to approach 13 million by 2050.¹

Market and Policy Drivers

Economic factors further reinforce neurology's growing reliance on imaging. In pursuit of cost savings, payers continue to push imaging services away from hospitals and into outpatient settings, a trend known as “outmigration” that shows no sign of slowing.⁴ The rise of high-deductible insurance plans and price transparency laws have driven many patients to seek more economical alternatives to high-cost hospital scans. Meanwhile, federal policymakers remain committed to advancing value-based care payment models. For example, Guiding an Improved Dementia Experience (GUIDE), a model program from CMS, extends Medicare coverage to support longitudinal, coordinated dementia care through interdisciplinary service “partners” such as community-based organizations and other non-acute care settings.⁵

Why Onsite Imaging Matters

Access and Patient Experience

Demand for neurological imaging is outstripping capacity, creating significant access challenges for patients.⁴ Long wait times for imaging

can exacerbate the burden of uncertainty and anxiety that patients with neurodegenerative disorders already experience in relation to their condition. By offering imaging technology in a single location, neurologists can expect to expand capacity, reduce patient wait times for scans, and spare patients the inconvenience of traveling to offsite radiology departments. Ideally, an integrated model reduces appointments, streamlines care, and eases patient and caregiver worry.

Clinical and Operational Efficiencies

Control over imaging referrals significantly influences diagnostic quality and downstream clinical decisions. Neurologists who directly generate imaging orders or oversee workflows add substantial value by ensuring clear communication of clinical context and protocol specifications. Referrals from non-dementia specialists (e.g., internal medicine or family practice physicians) can lead to protocol variability or ambiguity in imaging results. Direct neurologist-driven ordering maintains protocol consistency, which is especially critical in the era of anti-amyloid therapies. Uniform dementia imaging protocols across timepoints are essential—particularly for blood-sensitive sequences (e.g.,

Over 7 million Americans are living with Alzheimer disease.

By 2050, this number is projected to rise to nearly 13 million.

<https://www.alz.org/alzheimers-dementia/facts-figures#quickFacts>

GRE vs. SWI)—since even minor variations can affect professional assessments of safety and patient eligibility.

ARIA surveillance relies on direct comparison with prior exams, making imaging continuity vital. Integrated care models that combine



The rule of thumb used to be eight neurologists per scanner, but new economics and shared models have changed that.

—Joseph V. Fritz, PhD, Former CEO of DENT Neurological Institute, Founder of NeuroNet

clinical evaluation and imaging in one facility reduce care fragmentation and support consistent review of findings associated with ARIA.

Neurologist control over imaging pathways relies on collaboration with trusted neuroradiologists, enabling timely, accurate interpretations and prompt bidirectional communication to guide management. In anti-amyloid therapy—where ARIA may require suspending infusions—swift response to new findings reassures clinicians and patients. Timely results also mitigate malpractice risk amid radiology backlogs.⁶

Financial and Strategic Considerations

What to Analyze Before You Invest

Determining whether sufficient patient volume exists to support an investment in imaging technology depends largely on an office's geographic location and referral environment. The assessment process usually begins informally, perhaps by surveying patients about scan wait times or by speaking with colleagues at nearby health systems to gauge radiology backlogs and unmet demand.

When considering modalities such as PET, access to radiopharmaceuticals is a critical additional consideration. PET imaging depends on short-lived radiotracers (e.g., FDG), which require reliable, timely delivery from regional cyclotrons or radiopharmacies. Practices must evaluate proximity to suppliers, delivery schedules, regulatory handling requirements, and contingency plans for supply disruptions. Limited radiopharma-

ceutical availability or logistical constraints can significantly impact scheduling flexibility, throughput, and overall financial viability.

Ultimately, practices seriously considering onsite imaging must move beyond anecdotal evidence and develop a formal pro forma financial statement. This is typically paired with a feasibility analysis that integrates economic modeling, market research, and detailed local assessment. Key inputs include demand tied to relevant clinical drivers—such as multiple sclerosis (MS), headache and dementia—as well as population demographics, consumer utilization trends, market share and competitive dynamics, referral pathways, and reimbursement benchmarks.

The resulting analysis is not only critical for internal decision making, but also serves as a foundational document for securing the bank loans typically needed to finance imaging systems. As a result, practices almost always contract with healthcare management consultants to build out a pro forma. In addition to their invaluable market expertise, consultants play a pivotal role in negotiating payer contracts, an often highly localized process that depends on insider knowledge, direct engagement, and personal relationships.

Revenue and Ancillary Opportunities

Compared with other medical specialties, neurologists' salaries generally fall in the lower-middle range. This is largely because neurology emphasizes cognitive and

Onsite Imaging Feasibility Checklist

- ☐ High local neuroimaging volume
- ☐ Enough neurologists, subspecialists in the mix
- ☐ Enough space to house equipment
- ☐ Creditworthiness, including personal loan guarantees
- ☐ Sufficient workforce potential
- ☐ Knowledge of reimbursement benchmarks
- ☐ A trusted vendor partner
- ☐ A trusted group of neuroradiologists for imaging interpretation

consultative care, while higher-paid specialties, such as orthopedics, radiology, and cardiology, focus on procedural services that receive greater reimbursement. Further, neurologists generate limited ancillary revenue, because the diagnostic tests they typically order (e.g., EEGs, nerve conduction studies, LPs) are not highly compensated.

Consequently, some industry observers view onsite imaging as a strategy to offset overhead costs by establishing new ancillary revenue streams, while simultaneously enhancing the quality and efficiency of patient care.

Practice Size and Economics

The internal configuration of a practice's clinicians also comes into play. Historically, clinics were thought to need 8 to 10 neurologists to generate enough imaging volume to justify investing in diagnostic imaging equipment. A standard MRI unit, for instance, typically requires approximately 3,000 to 4,000 scans per year to turn a profit⁷ (although this figure varies widely depending on local reimbursement rates).

Based on national imaging volumes and workforce data, the average general neurologist orders about 500 scans annually.^{8,9}

However, that calculus is shifting. Subspecialists, especially those focusing on headache and MS, often order many more MRI scans per year. For example, a typical MS subspecialist might order as many as 1,200 scans a year.¹⁰ As a result, a practice staffed with one general neurologist and two or three high-volume subspecialists may generate sufficient MRI volume to justify the cost of in-office imaging equipment.

Practices evaluating the financial feasibility of in-office MRI often begin with a simple contribution-margin framework. The average technical component (TC) revenue can be estimated from a weighted average of local payer fee schedules. Subtracting the variable cost of a scan (such as supplies or contrast) from the TC yields the per-scan contribution margin. Profitability ultimately depends on whether the contribution margin, multiplied by projected annual MRI volume, exceeds the fixed costs associated with equipment, facility space, and staffing.¹¹

Regulatory and Reimbursement Landscape

Stark Law and Compliance

Onsite imaging requires compliance with the Physician Self-Referral Law, commonly referred to as the Stark Law, as well as its In-Office Ancillary Services Exception (IOASE) rules. Practices must also implement appropriate training and receive accreditation from a recognized organization such as the American College of Radiology. In addition, many states require a Certificate of Need (CON) to establish imaging services, although CON requirements vary significantly by state.

Beginning with the introduction of Stark II in the mid-1990s,

DENT Neurologic Institute: A Physician-led Imaging Model

In an era of increasing hospital consolidation, the physician-run DENT Neurologic Institute in Buffalo, New York, stands out for preserving independence through control of neuroimaging and agile governance.

Founded more than 60 years ago, DENT has grown into one of the world's largest outpatient neuroimaging centers, with approximately 100 providers across 26 clinics.

Owned and operated exclusively by physicians, DENT's streamlined structure enables rapid adoption of new technologies, leadership in clinical trials, and swift responses to clinical and business needs.

Despite operating in a low-reimbursement region, the practice maintains profitability through high patient volumes across multiple subspecialties and an open-access model that allows new patients to be seen within 72 hours.

Its integrated infusion services program, supported by bulk purchasing through NeuroNet, further strengthens operational efficiency.

NeuroNet also connects DENT with a national network of practices, leveraging shared data from more than 4.5 million patients to support ongoing research initiatives.

neurological imaging and interpretation started moving away from neurology and toward radiology departments in hospitals. At the time, payers and policymakers were concerned that private practice self-referrals might lead to over-utilization and cost overruns. Since the Stark Law exempted hospitals from its self-referral prohibition, it seemed to make more sense that imaging should occur primarily in hospital settings.¹²

In recent years, however, this dynamic has changed. Declining reimbursement rates for diagnostic imaging have reduced hospitals' financial incentives to retain exclusive control over these services. In fact, many hospital systems now recognize the economic and clinical advantages of transitioning neurological imaging to outpatient settings.¹³ Consequently, procedural challenges facing practices seeking to establish outpatient imaging centers have become less arduous.

Compliance with Stark and state self-referral laws varies by jurisdiction and requires careful structuring with healthcare regulatory counsel.

However, thousands of physician groups across the United States successfully operate onsite imaging under the federal In-Office Ancillary Services exception.

The Stark Law's most important guidelines are straightforward and easy to understand. First, physician salaries and compensation can never be tied to scan volume. Any imaging-generated revenue must be distributed equally within the practice, with no hint of a per-scan payment structure. Second, patients must be informed, in writing, that they retain the option of receiving their scans at other, specifically named, imaging facilities nearby. If these provisions are followed meticulously, neurologists with competent legal representation should expect little trouble complying with the Stark Law.

Payer Policies

The Centers for Medicare and Medicaid Services (CMS) has encouraged the migration of diagnostic imaging procedures to lower-cost outpatient facilities, mainly through the implementation and expansion



It's not onsite [remote scan interpretation], but it feels onsite, because we and our reading radiologists have conferences every two weeks where we go over interesting images or interesting cases.

—Mani Nezhad, MD, Neurologist at Link Neurosciences Institute

Building Reading Care Teams: The Link Neuroscience Institute in California

An ideal onsite imaging model brings neurologists and neuroradiologists together in a collaborative, co-located environment, working as a unified team. Nevertheless, a shortage of in-house radiology expertise does not necessarily preclude onsite imaging. With strong communication and coordinated teamwork, neurology practices can successfully outsource remote scan reporting. The Link Neuroscience Institute in California, partners with RadNet for neuroradiology services. While this approach requires ongoing collaboration, such as frequent provider messaging and twice-monthly, practice-wide video conferences, it has proven effective in maintaining consistent workflows and delivering high-quality patient care.

of site-neutral payment policies. These policies reduce or eliminate reimbursement disparities that previously favored hospital outpatient departments over freestanding facilities, a trend that is expected to continue. In July 2025, the CMS solicited feedback on further expanding site-neutral policies to include additional services, such as diagnostic imaging services without contrast.

Outpatient imaging can also benefit from bundling opportunities. Under the Medicare Physician Fee Schedule (MPFS) and similar commercial structures, onsite imaging allows neurologists to bill for both the professional component (PC, interpretation) and technical component (TC, equipment/use), often as a global code. This “bundling” of PC and TC into one claim represents a key opportunity, as it captures higher total reimbursement compared to hospital settings, where the TC is billed separately by the facility.

As with other medical procedures, prior authorizations (PAs) continue to proliferate for imaging approvals.

While increased PAs add to administrative burden, they constitute an advantage in at least one sense: Payers' authorizations strengthen a practice's defense against any potential Stark Law legal challenges.

Radiology Access management (RAM) Considerations

Beyond these federal and state frameworks, practices must also address Radiology Access Management (RAM) licensing requirements. RAM programs—implemented by many commercial payers—govern prior authorization, site-of-service restrictions, and utilization management for advanced imaging such as MRI, CT, and PET. These programs often require practices to use designated clinical decision support tools, adhere to evidence-based appropriateness criteria, and obtain payer approval before performing certain studies. Compliance with RAM protocols can influence workflow, scheduling, and revenue cycle operations, and may favor lower-cost outpatient or office-based imaging settings over hospital-based care.

Operational Readiness and Implementation

Staffing Solutions

Amid persistent workforce shortages, recruiting and retaining qualified technologists remains one of the most significant operational hurdles for practices considering onsite imaging. Clinics have adopted a range of strategies to mitigate staffing constraints and maintain service continuity, including:

- Early engagement with radiologic technology students, often prior to graduation—a tactic that has proven especially effective for freestanding clinics, which typically face fewer onboarding and credentialing barriers than hospital-based systems
- Hybrid staffing and shared-services models, frequently in partnership with third-party providers, to provide coverage flexibility and reduce dependence on full-time hires
- Expanded use of teleradiology and remote work arrangements, enabling practices to access a broader talent pool while maintaining clinical throughput
- Vendor partnerships that include training and temporary staffing programs, such as [Siemens Healthineers' FlexForce® Tech](#), which allow practices to address short-term staffing gaps while creating pathways to transition contract technologists into permanent roles
- Adoption of AI-enabled workflow automation, which reduces manual tasks, improves efficiency, and helps offset staffing limitations without compromising quality of care

Partnership Models

When neurologists rely entirely on external imaging providers, they

often relinquish control over key aspects of imaging management, including protocol standardization, scheduling prioritization, and timely access to imaging data critical for clinical decision-making. In competitive markets, external imaging providers may also capture downstream referrals for related services such as infusion therapies or clinical trials.

As a result, even smaller or growing practices should recognize that there are strategies available to retain more control over imaging services. Several partnership and access models can help practices expand imaging capabilities without assuming the full financial burden of equipment ownership:

- **Co-located imaging:** Joint ventures, management agreements, or collaborative arrangements with imaging centers, radiology groups, or technology contractors can provide access to imaging while mitigating the financial risks associated with sole ownership.
- **Leasing:** Leasing offers a flexible alternative to purchasing expensive imaging equipment, with structured payments spread over time and options often tailored to medical practices. “Block” leasing—where two or more practices share access to equipment—combines the benefits of structured payments with co-located imaging. However, this approach may involve additional regulatory considerations and potential payer restrictions related to shared ownership arrangements.
- **Mobile solutions:** Mobile imaging units provide a lower-commitment option that avoids the high cost, space requirements, and infrastructure demands of fixed installations. Typically housed in trailers or coaches, these scanners visit clinics on designated days, allowing

practices to offer onsite imaging access to patients.

- **Turnkey solutions:** Full-service, turnkey models offered through third-party partners enable practices to deploy imaging capabilities without managing day-to-day operations. These arrangements typically bundle equipment, site planning, staffing, workflow management, maintenance, and revenue cycle support into a single integrated solution. Turnkey models are particularly well suited for practices seeking rapid implementation, minimal operational burden, and a predictable cost structure, especially when internal administrative or technical resources are limited.
- **Industry support:** Imaging manufacturers such as Siemens Healthineers can assist practices during the planning process with demographic analysis, referral pathway evaluation, bank financing guidance, reimbursement benchmarking, pro forma development, and other early-stage planning tasks.

Emerging Technologies in Neuroimaging

Streamlined Imaging

Access to neuroimaging remains limited in remote, rural, and underserved regions. In response, manufacturers have introduced a new generation of scanning systems designed to be more affordable and compact, with reduced siting requirements and lower operating costs. Many of these systems also incorporate cloud-based quantification tools intended to enhance workflow consistency and image analysis, as well as deep-learning AI designed to shorten scan times, all of which may improve efficiency and the overall patient experience.

Practice Readiness Checklist for Onsite Neuroimaging

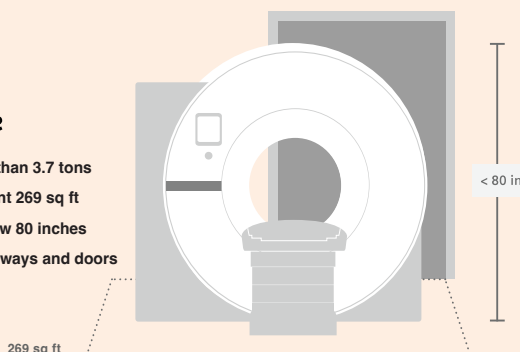
- ☐ **Patient-Centric Care Model**
Build an imaging model aligned with neurologic workflows and patient care pathways.
- ☐ **Regulatory Readiness**
Ensure compliance with the Stark Law and related regulations with guidance from a qualified healthcare attorney.
- ☐ **Flexible Adoption Pathways**
Lower barriers to entry through partnership models and scalable, low-field imaging technologies.
- ☐ **Data-Driven Feasibility Assessment**
Evaluate onsite imaging viability using local demand, reimbursement benchmarks, and financial modeling—not rules of thumb.
- ☐ **Strategic Industry Partnerships**
Partner with manufacturers for support in planning, financing, training, and implementation.
- ☐ **Integrated Care Team Collaboration**
Foster close collaboration between neurologists and neuroradiologists to ensure protocol consistency and timely interpretation.

The MAGNETOM Flow MRI system from Siemens Healthineers illustrate this shift. Its dry-cool technology allows for elimination of a quench pipe, resulting in simplified infrastructure and siting requirements, and it can be safely installed in a standard examination room with a smaller footprint than most MRI systems. The system requires minimal liquid helium, significantly reducing operational costs, and is designed to be simple enough for a trained medical assistant to operate, helping to lower staffing expenses.

As disease-modifying therapies expand, demand for amyloid and tau PET imaging is expected to rise significantly, particularly in centers that manage large volumes of patients with memory disorders. Growing demand for early AD screening has also increased interest in hybrid imaging systems. PET/CT provides a less invasive

Simplified MRI infrastructure

- Total scanner weight less than 3.7 tons
- Minimum siting requirement 269 sq ft
- Transportation height below 80 inches
– fits through existing hallways and doors



With its compact footprint, the Siemens MAGNETOM Flow MRI can accommodate reduced siting requirements and operational costs.

alternative to cerebrospinal fluid assessment for evaluating amyloid pathology. Emerging hybrid PET/MRI systems enable clinicians to combine amyloid PET biomarker assessment with baseline MRI[†] screening for structural abnormalities, infarcts, or preexisting hemorrhages, as well as the capability for quantitative volumetric analysis—effectively consolidating two clinical visits into a single examination.

Conclusion

The arrival of disease-modifying therapies for AD, rising patient volumes, and imaging outmigration are reshaping how neurologic care is delivered.

Onsite imaging allows neurology practices to expand capacity, reduce wait times, and improve the patient experience. It may support greater protocol consistency for longitudinal imaging workflows, including imaging associated with ARIA surveillance, while restoring clinician control over increasingly complex patient management pathways.

Flexible partnership models, including co-located arrangements, leasing structures, mobile solutions, and turnkey offerings, are lowering barriers to entry and allowing practices of varying sizes to adopt imaging capabilities in ways that align with their clinical, operational, and financial goals. Practices that strategically integrate imaging through ownership or partnership will be positioned to deliver high-quality, patient-centered care while maintaining autonomy in an increasingly complex and competitive health-care environment.

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