The Interventional Radiology Clinic: What You Need to Know

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ABSTRACT

It is increasingly recognized that clinical management in interventional radiology is necessary. To effectively participate in such management requires patient management infrastructure. The cornerstone of this effort is the clinical office.

KEYWORDS: Space, support staff, scheduling, documentation, promotion

Objectives: Upon completion of this article, the reader will be able to gain an understanding of the resources required for successful development of an outpatient interventional radiology office to support clinical activities of interventional radiology.

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For the past several years, it has been recognized that clinical management of patients undergoing interventional radiological procedures is an essential component of a successful, contemporary interventional radiology practice, with several well-respected interventional radiologists emphasizing the importance of direct patient management.¹⁻⁶ Yet, it has historically been difficult for the diagnostic and interventional radiologists within a given practice to agree on the priority that clinical management of patients should have within the services offered by that practice. However, the times are changing as evidenced by the white paper produced in 2003 by the American College of Radiology, which culminated a sentiment that has been growing in the interventional radiology community over three decades by formally recognizing the importance of assuming control of patient care responsibilities.⁷

As a consensus document, the diagnostic and interventional radiologists within the American College

of Radiology (ACR) listed several economic and competitive incentives for interventional radiologists to directly manage the patients they treat. It specifically states that managing patients in an outpatient setting will enable interventionalists to “maintain some control over the future care of these patients.”⁷ Although one can debate the use of the term “control” as it concerns patient care, it is clear that any physician or group that is perceived to have control over a patient is likely doing so because they have established the outpatient-based, physician-patient relationship that enables them to do so. Therefore, distinguishing one’s practice by establishing relationships in a clinic setting will help any physician have a greater role in the decision-making processes surrounding the care of one’s patients. More importantly, however, the white paper also makes it clear that understanding the needs of individual patients and acknowledging the importance of providing longitudinal care to patients undergoing interventional procedures are

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necessary to optimize patients' experiences with interventional radiologists and interventional radiological procedures.⁸

To effectively participate in clinical patient management, interventionalists require an infrastructure within their practice to support these services, and this infrastructure must encompass the resources required to manage patients in both the inpatient and outpatient setting.⁸ Certainly, an outpatient office will represent the cornerstone of this effort, as it does for medical practices in virtually every medical specialty. Physical space that is designated for one-to-one interaction between physician and patient has always been and remains a priority for these practices but has not, until recently, been felt to represent a necessary component of a successful interventional radiology practice. With publication of the ACR white paper, along with the growing sense among interventional radiologists that the procedures performed today demand more active involvement in direct patient care, the interventional radiology clinic is slowly becoming a fixture in most successful practices. This article will focus on the resources required to successfully develop an outpatient office supporting the activities of interventional radiology.

PHYSICAL SPACE

One of the first problems experienced by most interventionalists when attempting to develop an outpatient clinic is the fact the space within a hospital radiology department or outpatient imaging center was not designed for "nonimaging" outpatient consultations. Interventionalists interested in establishing an outpatient clinic need to recognize and then take steps to overcome this obstacle. The first step is the need to acknowledge the expectations that most patients have when going for an appointment at a physician's office. Based on past experiences with physicians, a patient expects a defined clinical space with a receptionist and a waiting area with old magazines, music, and/or a television. In fact, the reception area is often central to an outpatient office and a cordial and efficient reception area is typically the best way to provide a favorable first impression to patients.⁹ This office space must also contain private areas for both examination by and discussion with a physician, the number of which will depend on actual and anticipated patient volume. Finally, the reception area must contain space to review payment and billing information with a patient at the end of an office visit.

Given the inherent limitations for this type of space within an existing radiology department, interventionalists are frequently forced to look outside of their physical department when establishing a clinic. Sharing space within a hospital-owned clinic or within another specialty clinic may be economical and initially helpful in that it may facilitate cross-consultation.^{4,7}

Because consideration must be given to making sure there is adequate parking surrounding the office building, that it is easy for patients to enter and exit the building, and that is easy for specific offices to be located, it may in fact be reasonable to consider a freestanding interventional clinic separate and distinct from a hospital.^{7,10} However, a clinic within or in very close proximity to the hospital, and in particular, to the interventional radiology suites, may facilitate the interventionalist being available for procedures if time permits during regularly scheduled clinic hours. In addition, including either view boxes or a computer viewing station within the office space may permit film interpretation and film review with patients during clinic time.

SUPPORT STAFF

It is no secret that physicians cannot accomplish everything that goes into a successful clinic without the help of competent support staff. It is the staff of any office that contributes to the overall tone of a medical practice and the satisfaction of patients seen in that office.¹¹ In fact, with the increasing workload facing many physicians today, patients have transitioned from relying exclusively on physician-patient relationships for their care. Instead, the role of support staff in the care of patients have led many physicians to make sure that their patients have "practice-patient relationships" as many people other than physicians now play a role in patient care.

Our experience has taught us that the assistance of providers other than physicians can contribute tremendously to the success of an outpatient interventional radiology practice. We agree with the ACR white paper when they recommend that consideration be given to adding a clinical nurse specialist, nurse practitioner (NP), or physician assistant (PA) to a practice staff to develop an outpatient interventional clinic.⁷ However, to add these providers to an interventional practice, it is important to become aware of the regulations surrounding their scope of practice. Each of these providers must practice with a collaborating or supervising physician, and while the physical presence of that physician is not always necessary, a means of consulting with the physician must be in place.¹² It is not always easy to know what these providers physically can and cannot do within the context of an interventional practice. Ultimately, the clinical privileges for these providers are determined by the supervising physician, the institution, state law, and Medicare regulations, all of which may, in fact, contain differences in what the different types of providers are able to do. The comfort and experience of the individual providers represents another factor to consider when determining the expectations for these providers.

In our experience, NPs and PAs are able to add their knowledge of direct patient management and

procedural assistance to become a critical asset to any successful interventional practice. Typically, these providers are able to perform a medical history and physical examination, review treatment options and develop a treatment plan, and write orders, prescriptions, and progress and discharge notes.⁴ In addition, each of these individuals is able to participate in the performance of interventional procedures, which represents another opportunity for them to become part of an interventional practice. Importantly, Medicare and many third-party payers reimburse for services provided by an NP or PA, which may represent an additional source of revenue for a practice.^{7,13}

When working with NPs and PAs, it is important for the supervising physicians within a practice to fully stand behind and support the services they provide.⁸ Remember, patients are forming relationships with you and your entire practice. In fact, as evidenced by our own practice, the NP or PA may potentially become the most important contact person for that patient, and this has been associated with a high degree of patient satisfaction.¹⁴ Therefore, it is incumbent upon the physician to be confident in their ability to carry out their clinical responsibilities and to respect their role as the patient advocate within the practice. This must be done so that patients have confidence in utilizing all of the personnel resources within a cohesive team of health care providers.

As we all know from our own individual experiences as patients in physician offices, it is just as important to acknowledge the importance of the receptionist in an outpatient office. It has been well established that every contact with staff in a medical office needs to be handled with concern, efficiency, and professionalism and the receptionist is typically the initial contact point for most patients.¹¹ Successful receptionists should not be seen as a barrier between the patient and physician, even if that person is acting with the best of intentions.¹¹ Physicians and other providers within an office need to work together with a receptionist to develop a strategy that will enable the office staff to handle family member questions, test result requests, and so on with compassion and respect. Involvement in an outpatient interventional practice also implies that time will be set aside on a daily basis for either the physician or another provider within that practice to return patient phone-calls in an effort to make sure that all questions are answered, further adding to the perceived credibility of the receptionist and other office staff who are the first line of communication between a patient and the office.⁸

APPOINTMENT SCHEDULING

An efficient outpatient clinic requires appointment scheduling that works from both the patient and physician perspectives. The goal of any practice is to see as many

patients as possible within a specific amount of time. However, increased volume should never come at the expense of quality patient interactions and reasonable waiting times. In the past, patients often perceived a long waiting time as a sign of a good and successful physician.¹⁵ Today, however, patients are less tolerant of long waits.¹⁶ It is virtually impossible to eliminate patient waiting in an outpatient clinic setting, primarily because the exact amount of time each patient will require during the course of their individual visit is never known with certainty. However, sensitivity to the issue of patient waiting time can ultimately benefit a practice as patients experiencing reasonable wait times that are handled well have a positive perception of and often return to that practice.¹⁶

Given the potential benefits of efficient scheduling, Blender and Maxey described several strategies for reducing patient waiting time.¹⁶ It is intuitive to pay attention to scheduling procedures, with particular attention paid to overbooking and leaving time to catch up in between patient visits. The amount of time allotted to a patient must depend on whether the patient is new to the office or is an established patient being seen in follow-up; remember to leave more time for new patients. One must also be aware of potential obstacles that might stop a physician from moving smoothly from patient to patient. These obstacles may include unavailable imaging films and reports or laboratory results that need to be reviewed with a patient, lost or inaccessible medical records that provide the physician with information that needs to be discussed with a patient, and an inadequate number of examination rooms.¹⁶ Taking the time before the day starts to gather medical records, old imaging studies, laboratory results, and so on will increase the efficiency of an outpatient office and lead directly to improved patient satisfaction.

Reducing late arrivals and missed appointments with reminder phone calls, postcards, or e-mail messages can also improve office efficiency. Despite the best effort of any office staff, patients will inevitably be late for their appointments, potentially throwing an entire day into disarray. Fontanesi and colleagues demonstrated that patient arrival time may not be random.¹⁷ Instead, they observed that patients tend to arrive in "clumps," possibly due to factors such as traffic patterns and parking availability, both of which are clearly outside any physician's control. Therefore, when establishing appointment times in an outpatient office, consideration must be given to the lives of prospective patients and the external factors that are going on concurrently with appointment times (e.g., rush hour, lunch hour, end of school day, etc.).

Finally, demonstrating a commitment to reduced patient waiting can go a long way to improving patient satisfaction with the operation of an outpatient office. Communication is potentially the easiest and also the

most effective way to accomplish that goal, which again highlights the importance of a receptionist within an outpatient practice. Patients want to know when they will be seen by their physician so it is often helpful to encourage office staff to keep patients informed about wait times. If a day is not progressing well, consideration should be given to calling patients at home or at work to delay or reschedule appointments. Finally, physicians should always apologize directly to patients for any wait times that they experienced. These strategies can all contribute to office efficiency, reduced patient waiting time, and improved patient satisfaction.¹⁶

MEDICAL RECORD DOCUMENTATION

A patient's medical record has a potential role in everything from procedure planning, physician-to-physician communication, secondary consultations, billing and reimbursement, quality assurance, and potentially defense of a medical malpractice claim.¹⁸ As is the case with documentation surrounding the reports from diagnostic radiology studies, documentation in the medical records developed during patient visits must support the reason for the office visit, support the reimbursement desired for the service provided, and contain the information necessary to assist an interventional team and potentially consulting physicians in making treatment decisions for that particular patient. Notes should only contain objective documentation that supports a diagnosis and treatment plan.¹⁸ Subjective documentation should not be included in the medical record as it is not supported by facts and can be open to interpretation.¹⁸ Laboratory results that are ordered and/or reviewed while providing care for a patient must be signed and dated by the physician with all abnormal laboratory results addressed.¹⁸ Any action taken in response to an abnormal laboratory or radiological study must be documented in the medical record. Finally, patient education regarding planned interventional procedures needs to be documented with clear references made to discussions including the risks and benefits of procedures and the expected recovery as well as limitations or restrictions following procedures.¹⁸

Medical record documentation does not end with face-to-face patient encounters in the clinic. The medical record for any patient must make reference to all contact between the patient and the physician or office staff. This includes missed appointments, telephone conversations, and e-mail correspondence.¹⁸ Although attention to this type of detail will aid in all aspects of the clinic, including quality assurance, education and research, and reimbursement audits, it will be most important for providing seamless patient care.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the 2002 modification of the final standards for privacy of individually identi-

able health information have had a tremendous impact on medical records kept within an outpatient medical practice. In general terms, HIPAA was designed to protect patients from the use and disclosure of individually identifiable health information by health care providers and its specific requirements are actually fairly intuitive. Most of the misunderstandings surrounding HIPAA concern the transfer of protected health information and when patient consent is or is not required. HIPAA states clearly that providers can use and disclose protected health information for the purposes of treatment, payment, and health care operations without the patient's permission.^{19,20} Treatment in this case means the provision, coordination, or management of health care, including consultations and referrals between health care providers.^{19,20} Payment in this setting means efforts to obtain reimbursement, determine eligibility, billing, claims management, and utilization review.^{19,20} Health care operations include quality assessment and improvement activities, case management and care coordination, and reviewing the competence or qualifications of health care professionals among other things.^{19,20} In general, these are the situations that interventionalists will be facing when obtaining and storing information within a clinic setting. Scenarios that require specific consent include disclosure to public health, military, and law enforcement authorities and disclosure for research purposes among a long list of other scenarios.

In an effort to be certain that patients are made aware of these regulations, HIPAA also requires that physicians provide patients with a written notice describing the privacy policies of their particular practice. This notice should be given to patients at the time of an initial clinical encounter and a written acknowledgment from the patient that they have received this information is expected to become part of the patient's medical record.^{19,21} It is important that this notice include a description of the types and uses and disclosures of information that are permitted, including those that are permitted without the individual's written authorization.^{19,21} By signing this notice, patients are acknowledging an office's privacy practices and are in fact consenting to the release of information for treatment, payment, and health care operations. Although it is the responsibility of every practitioner to know how these regulations impact their clinical practice, it is just as important when establishing a clinic to develop a system for storing and sharing medical records with patients themselves and other health care providers that are compliant with these regulations.

Medical record storage and retention is another issue that needs to be considered when establishing an outpatient clinic. The American Medical Association addresses this issue within Section E-7.05 of their Code of Ethics.²² This section specially states that physicians

have an obligation to retain patient records that may reasonably be of value to a patient. The amount of time that is necessary to retain medical records will depend on several factors, including state regulations, Medicare and other third-party payer requirements, as well as the statute of limitations for bringing medical malpractice claims against a healthcare provider. The records of any patient covered by Medicare or Medicaid must be kept for at least 5 years.²² The statute of limitation for malpractice claims will vary from state to state but two general points need to be remembered: physicians should measure time from the last professional contact with the patient and the statute of limitations for minors may not apply until the patient reaches adulthood. With all of these issues in mind, medical considerations should always be the primary basis for determining how long to retain medical records. The AMA suggests a physician should always consider whether another physician would want the information if he or she were seeing the patient for the first time before destroying medical information.²² Patients should always be given the opportunity to claim records or have them sent to another physician before records are destroyed. When medical records are destroyed, care should be taken to be certain that patient confidentiality is not compromised.

CODING AND BILLING

Another important component of an interventional radiology outpatient clinic is the coding and billing for services rendered within that clinic. Most interventionalists will at some point be asked to financially justify the costs associated with establishing and maintaining an outpatient clinic. Most if not all of the services rendered within an outpatient clinic will be considered evaluation and management (E&M) services, which are coded with Current Procedural Terminology codes that are separate and distinct from the codes typically used to describe interventional radiology procedures. E&M codes describe clinical services according to a variety of features, including physician status (treating physician versus consultant), patient status (inpatient versus outpatient), encounter time, and service complexity.²³ It is beyond the scope of this review to describe the methodology and nuances of coding for services rendered within an interventional radiology clinic. That said, it is mandatory for interventionalists establishing a clinic to consult with coding and billing experts as to how to incorporate the use of E&M codes into an interventional practice.

Obtaining preauthorization from a patient's health insurance company is often a complex process that is required for appropriate payment of both E&M and procedural services to occur. Traditionally, radiology practices have relied on the offices of physicians referring patients to their practice to provide these services. However, this clearly provides radiology practices with

a competitive disadvantage when it comes to interventional procedures because the specialties changing their practices to provide competitive services have the mechanisms in place within their own offices to effectively communicate with and obtain preapprovals from health insurance companies. In our opinion, the interventional radiologists that establish outpatient offices so they can take on more responsibility surrounding the care of their patients must also by default take on the responsibility of communicating with health insurance companies and helping their patients to manage these often complex issues. It has been shown that providers who effectively manage the preauthorization process have the opportunity to transform an administrative burden into a competitive advantage.²⁴ From an economic perspective, nobody except the interventionalist and his or her staff are able to effectively communicate with an insurance company regarding the procedure to be performed, the indications for the procedure, and the nature of the pre- and postprocedure care that is required in association with the procedure.⁸ Without this input from the interventionalist, it is less likely that procedures will be approved and bills will be paid. In addition, relying on the office staff of a referring physician simply isn't reasonable when there is little to be gained by the referring physician's office to provide these services.

PRACTICE PROMOTION

Once the outpatient office and clinical team has been assembled, promotion of these services throughout the physician and lay populations can take place. An integral part of developing this type of clinical practice is to let both the physicians and patients who may be utilizing these services in the future to understand this type of interventional practice. Therefore, targeted promotional activities designed to raise awareness of interventional radiology services by physicians and/or patients will be the next step in growing an outpatient service. The decision as to whether to focus promotional efforts on patients or physicians will be individual decisions made by the physician and administrative staff of the practice, and in fact, it will likely be different depending on geography and local medical politics. Although some interventionalists may be most comfortable marketing their services to physicians, others, especially those in cities with a high concentration of interventional radiologists, may determine that direct patient marketing may serve their needs the best.⁸ Brochures highlighting one procedure or a related group of procedures are an effective and comparatively inexpensive method for internal and external marketing of a practice.²⁵ Remember to take advantage of everything at your disposal when promoting your practice. One potential advantage of interventional radiology is its association with larger radiology practices that often have busy in-hospital or

community-based imaging centers. These waiting rooms can be used to display promotional materials that will be seen by many of the patients there for imaging services. Once brochures have been created, a variety of strategies including participation in grand rounds, teaching, and other conferences, developing patient-centered reports to be covered by local television news stations or local newspapers, participation in local and regional health fairs, and even direct patient advertising can be used to grow outpatient services successfully.^{26,27} The one thing that each of these methods has in common is the commitment required by the physicians, clinic staff, and practice administration to make them work. If the commitment and motivation to succeed is present, the investment of money and time into these marketing strategies will secure a place for an interventionalist in the care of specifically targeted patient populations.

CONCLUSION

There is little doubt that longitudinal care of patients undergoing endovascular and other minimally invasive procedures will be required for an interventional practice to consider themselves successful in the future. It is just as clear that significant time, staff, and resources are required to establish a clinic designed to foster effective and compassionate physician-patient relationships. In doing so, radiology departments and practices will be sending a message out to the medical community at large that interventional radiology is committed to providing the care that meets and quite possibly exceeds the standards that are in place within other procedural specialties. Ultimately, this will help gain the confidence of both patients and referring physicians and secure a place for interventional radiologists as leaders in minimally invasive, percutaneous therapy.

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