Tracking Changes in the Practice of Interventional Radiology

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ABSTRACT

The Society of Interventional Radiology survey in 2000 to 2001 reported what appeared to be favorable results. However, closer scrutiny provides more information. The Society of Interventional Radiology's strategic plan calls for 80% of interventional radiologists to be clinical practitioners by the year 2006. Recent American College of Radiology practice guidelines support this goal. Interventionalists need to decide whether they are going to provide clinical care and those who chose to take on the clinical practice model will most likely be successful.

KEYWORDS: Evaluation and management, strategic plans, patient care

Objectives: Upon completion of this article, the reader will gain appreciation of limited clinical activity interventional radiologists have performed or report performing in the past versus current trends.

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The Society of Interventional Radiology (SIR) conducted a socioeconomic survey in 2000 to 2001 that reported that 65% of respondents performed preprocedure visits. Ninety-two percent performed rounds on patients after the procedure, and 53% provided postprocedure outpatient visits. The vast majority (84%) had admitting privileges. Seventy-five percent of respondents used admitting privileges, and 70% accepted direct referrals for patients (Fig. 1).

On the surface, these numbers appear favorable, although one might question why only 75% are admitting patients and why only 65% are performing preprocedure visits. However, closer scrutiny of these numbers provides quite a bit more information about interven-

tional radiology at that time. Only 53% of respondents said they provided any postprocedure outpatient visits. It is certainly not consistent with accountability to the patient's outcome to never see the patient again after the procedure. This number clearly represented a shortcoming of the specialty at that time.

Additionally, Dr. Rich Duszak and Mike Mabry of SIR reviewed billing practices by interventional radiologists and found that in 2000, only 9662 evaluation and management (E&M) codes were billed by interventional radiologists, compared with 2.5 million codes overall.¹ This number is woefully small. By conservative estimates, less than 20% of major therapeutic interventions done by interventional radiologists had any

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Figure 1 2001 Society for Interventional Radiology socioeconomic survey regarding clinical interventional radiology.

E&M codes associated with that service, including patient consultation, patient referral, patient hospital follow-up, and outpatient established patient follow-up. Many interventionalists will look at this data and say that they performed the service, even though they didn't bill for it. That is unacceptable! If the service was done but not billed, it is questionable as to whether this service was of a quality that would be traditionally acceptable for a patient care specialty. However, these data are old and were collected at the beginning of what we recognize as a steep rise in performance of clinical services by interventional radiologists. Data obtained more currently may tell quite a different story.

The SIR's strategic plan calls for 80% of interventional radiologists to be clinical practitioners by the year 2006.² The recent American College of Radiology practice guideline on interventional clinical practice supports this goal. It is becoming increasingly stressed in organized radiology that this is the right way to practice. Although community standards may indicate that it is not yet malpractice to not perform clinical services in patients who are undergoing therapeutic interventions, that specter is raised and could come to the fore in the near term. Therefore, interventionalists need to decide whether (1) they are going to be hospital-based practitioners who perform procedures that are "ordered" or (2) they are going to provide therapeutic interventions for patients for whom they are ultimately responsible and for whom they will provide clinical care over time. If interventionalists do not or

cannot adopt a clinical practice model around elective or scheduled interventions, the standard of care may be suboptimal. In this situation the performance of elective therapeutic interventions like stent, angioplasty, or embolization procedures would most appropriately be discouraged. If they continue to do so, it is unlikely that they will succeed in the long term, unless they are in a community without any competition. Those who choose to take on the clinical practice model and devote resources to it will likely be successful, despite the competition. They will be able to promote themselves as experts in peripheral arterial disease, cancer, and/or uterine fibroid treatment and have good success in their local markets. Their procedure schedules will be populated with interesting and well-reimbursed services. Those who do not provide patient care will provide the services that are available by default, including percutaneously inserted central catheter lines, other central access, dialysis, tube maintenance, and so on.

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