The Basics of Interventional Radiology Management in a Large Radiology Group: A Bird's-Eye View

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ABSTRACT

Through nearly 6 decades of growth we have enjoyed and suffered under many different types of management structures. From these experiences we have become believers in a central committee structure that advances our agenda with hospital administrators and third-party payers. The best way to illustrate what we think is a winning solution is by describing our present management system. Herein we describe what we do and what works for our large radiology group as well as our interventional practice. Although this structure works well for our large medical group, it will likely work equally well for a smaller medical group.

KEYWORDS: Management, interventional radiology, committee structure, corporate governance

Objectives: Upon completion of this article, the reader should understand the complexities and advantages of several types of management models used in a mid- to large-sized radiology practice.

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Our practice, Central Illinois Radiological Associates, Ltd. (CIRA), has undergone several transformations. CIRA was once a moderate-sized practice in a single hospital with 10 radiology shareholders and is now a corporation covering most of central Illinois, six hospitals, and 14 medical offices. Through nearly 6 decades of growth we have enjoyed and suffered under many different types of management structures. From these experiences we have become believers in a central committee structure that advances our agenda with hospital administrators and third-party payors. The best way to illustrate what we think is a winning solution is by describing our present management system. Below

we describe what we do and what works for our large radiology group as well as our interventional practice. Although this structure works well for our large medical group, it will likely work equally well for a smaller medical group. Smaller radiology groups can streamline CIRA's algorithm and tailor the structure to their own practice.

A TIME FOR CHANGE

The need for change in governance became apparent when in October 2000 Peoria Radiology Associates and Methodist Radiology Group merged to form

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Central Illinois Radiology Associates, Ltd. From that merger we increased staff and corporate complexity significantly. From the first day of merger, CIRA was tasked with managing a large radiology group employing more than 40 physicians. The relationships that CIRA has with its patients, hospital administrators, nonradiology physicians, and third-party payors are an integral part of its practice. In addition, the relationships between and among the shareholders of CIRA is likewise important. The interaction between CIRA and those groups mentioned above promotes the success of the group and cannot be overemphasized. When the stratagems of the group have been followed, we have enjoyed exceptional contract negotiations, patient referrals, political stability, and wealth building. Likewise, when the stratagems have been bypassed or ignored, albeit with good intentions, we have come very close to financial and political loss.

A large group allows for the physicians to practice subspecialized care. Our interventional radiology practice has grown each year by number of physicians and number of procedures, and at present CIRA employs seven fellowship-trained full-time interventional radiologists and two neuro-interventional radiologists.

CORPORATE GOVERNANCE

As with most large medical group practices, corporate governance and the relationships among the shareholders and the individual sections determine the success of the group and likewise the success of the sections. Limiting the number of shareholders who provide governance to the practice management is a must! If a large group delays decision making until all of its shareholders can consider any issue, the management will be significantly limited. An executive committee (EC) provides the means by which the shareholders can interact with its management team in addition to hospital administrators, payors, and other entities from whom it receives services.

For many years our group functioned without an EC, allowing each shareholder to have input on every decision that the corporation considered. On paper this appeared reasonable and democratic, but when 10, 20, or more physicians attempted to discuss and resolve management and contractual issues, the corporate meetings became protracted, argumentative, and nonproductive. We found the benefit of having group shareholder input to be outweighed by the inability to respond to day-to-day business decisions in a timely fashion. The formation of an EC did two things: the EC facilitated the decision-making process and allowed the implementation of the decisions quickly.

THE EXECUTIVE COMMITTEE

The adoption of an EC within any large group requires the consideration of three important issues:

1. Number of physicians to be included on the committee;
2. Term for each shareholder;
3. Corporate authority granted to the EC.

CIRA adopted an EC with 10 members. Each committee member is assigned between three and four non-committee member shareholders to keep apprised of the EC's discussions and decisions. The formation of an EC allows for its members to meet on a regular basis with limited notice for special meetings. The more members on the committee, the more difficult it becomes in obtaining a quorum. Ultimately, the comfort level of the shareholders not on the EC will determine the total number of committee members.

The membership terms should be rotated and staggered; this will infuse new blood into the EC on a periodic basis, promulgating new ideas and different decision-making processes within the committee. Generally speaking, the corporate bylaws should discuss the formation of the EC, its membership and the authority granted to the committee to make decisions without the approval of all of the shareholders. An EC should have authority to enter into short-term contracts with vendors, spend a specified sum of corporate funds, and provide guidance on personnel issues.

With an EC, the relationship between management and the shareholders improves the corporate decision-making process. This will allow for strategic planning for long-term business decisions.

In addition to interaction with the EC, management should be involved on a day-to-day basis with the president of the group. Without this access, management decisions become delayed. The relationship between this trio (management, the corporate president, and the EC) will facilitate the decision-making process so that management can implement those decisions.

The corporate relationship extends into each subspecialty section. For example, in the interventional section we have section chiefs who interact directly with our corporate management team and EC. This relationship facilitates the continued growth of the interventional practice and is considered bilateral. In that, we mean that CIRA has realized the importance in allowing the interventionalists (both non-neuro and neuro) to participate in clinical trials of devices and interventions from different manufacturers even though this may initially cost the group money. In the long run, this has proven a smart business decision, making CIRA interventional radiology the regional experts in endovascular medicine, bolstering our referral base. CIRA has a research and education foundation

permitting relationships with individual manufacturers. A secondary benefit of this relationship involves assisting device manufacturers with evidence concerning the efficacy of their devices, placing us on their radar screen, so to speak. This helps us get the “latest and the greatest” from industry in the form of cutting edge clinical trials. This type of trial is one that brings desirable technology (such as carotid stenting and endoluminal grafts) to CIRA 2 or 3 years in advance of our local competitors, again advancing our stature in the community.

DISTINGUISHERS OF A SUCCESSFUL INTERVENTIONAL RADIOLOGY PRACTICE

Three distinguishers have allowed us to advance our clinical practice: first, developing a growing clinical research arm in the form of The Peoria Radiology Associates Research and Education Foundation. This provides us with the investigative backbone for our interventional practice, the benefits we listed earlier. Second, establishing an outpatient office practice allowed us to garner patient referrals and follow patients after procedure, in a surgical office-based practice model. Third, we hired several physician extenders (six advanced practice nurses over a 10-year time period) who provide a significant service in evaluating the patient (both before and after the procedure). These services are billed under evaluation and management Current Procedural Terminology codes. And, while the reimbursements for their services do not represent a profit, their services allow us to develop a clinical presence, free up time for teaching residents and fellows, and conduct research and author articles. Perhaps most importantly, physician extenders improve our daily procedural throughput significantly.

RELATIONSHIPS WITH HOSPITAL ADMINISTRATORS

CIRA has relationships with six separate hospitals, three within the city limits and three in surrounding counties. Communication between the hospital administrators occurs on three different levels: physicians, CIRA management, and representatives of CIRA's billing companies.

Certainly, the most important communication is the day-to-day communication that individual radiologists have with hospital administrators, staff, and attending physicians directly related to patient care. Individual conversations and discussions are appropriate and should be geared toward the medical management of patients.

When discussions turn toward corporate contracts, business decisions, or group policy, radiology groups need to designate certain physicians that will communicate directly with hospital administrators on the various issues that arise. Identification of a finite

number of shareholders who may communicate with hospital administrators provides for constant and consistent communication. In our smaller institutions, where a limited number of physicians provide radiology services, those physicians communicate with hospital administrators directly under the auspices of the EC and CIRA management.

The second most important means by which a radiology group communicates with the hospital is through its management team in the contractual relationship between the hospital and the group. It is prudent to assign one individual from the management team to speak on behalf of the corporation in negotiating the service agreements. This cannot be overstated. We have chosen our chief operating officer and legal counsel to perform this task. If several individuals are assigned that task, miscommunication will occur, contract negotiations will become frustrated, and in the end the relationship is strained.

If the radiology group has an outside billing company, this company provides the third level of communication between the radiology group and the hospital. The representative of the billing company who is assigned to communicate with the hospital should have health care experience, an understanding of the technical requirements for the transmission of data sets, and good communication skills.

Placing the appropriate individuals at these three levels of communication will facilitate the relationship between the hospital and the radiology group.

The interventional radiology section has been able to reach out to the needs of other hospitals and another group of radiologists who elected to discontinue the support of an interventional practice. An agreement to provide interventional services in another institution in which another radiology group provides diagnostic services should be mutually beneficial. CIRA's involvement in this type of relationship has allowed for continued growth of the section and further expanded the referral base.

FEE FOR SERVICE

Contracting with payors and or manufacturers of stents, devices, or therapies has become a delicate and intricate process. Many years ago, one- or two-page contracts were acceptable. In today's environment, the payor contracts have lengthened in content, become a haven for disputes, and depersonalized the relationship between the payors and medical groups.

CIRA currently has a contract with an employer that has no more than 225 words contained within the agreement. Relationships between payors and the group have remained positive. The parties have had no disputes in many years. On the other side of the spectrum, managed care companies have proposed contracts with

30 and 40 pages of language. Counsel must review these contracts and give advice on each of the contract terms. A medical group that executes an agreement without legal review is similar to a patient receiving an interventional radiology procedure without informed consent or the proper workup. The language within a contract can result in additional discounts that were not contemplated. Although the famous remark by the plotter of treachery in Shakespeare's King Henry VI stated, "The first thing we must do is kill all the lawyers," lawyers can provide guidance to management of large medical group practices with interventional radiologists and should not be disposed of until after contract negotiations!

There are many subjects within a payor contract that need to be negotiated. Important issues include

the rates and timeliness of reimbursement and timing of payment, and, in addition, dispute resolution must be resolved in an appropriate fashion. Mediation and arbitration is not recommended! Payors only respond to litigation or threats thereof, and therefore the option for civil litigation should remain in any contract.

CONCLUSION

CIRA's interventional radiologists have built a strong clinical practice through their relationships with hospital administrators, manufacturers, referring physicians, and, most importantly, patients. Attention to detail by the individuals involves a team approach to be successful.