Using Midlevel Providers in Interventional Radiology

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ABSTRACT

Developing and implementing clinical services, including consultations, rounds, and clinic, is time-consuming, and for the interventional radiologist this means time away from the interventional laboratory. Using a team approach to providing clinical services is logical, and the midlevel provider is a perfect fit for an interventional radiology team. Midlevel providers can be grouped into two categories, advanced practice nurses (APNs) and physician's assistants (PAs). Under the umbrella of APN are several specialties including the nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse midwife, and certified nurse anesthetist. The midlevel providers that are particularly suited for interventional radiology are the NPs, CNSs, and PAs. This article discusses midlevel providers in-depth including skills, limitations, and expenses.

KEYWORDS: Midlevel providers, interventional radiology, nonphysician extenders, nurse practitioners, physician assistants

Objectives: Upon completion of this article, the reader should (1) understand the necessary components of a clinical practice and the value of employing physician extenders or midlevel providers and (2) know the difference between subcategories of midlevel providers, including their scope of practice, usual duties, governing bodies, and relative costs.

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The development of a clinical practice in interventional radiology is imperative for survival in today's competitive environment. Referrals to interventional radiology will be lost to other specialties as they obtain the skills and credentials to perform percutaneous image-guided procedures that have historically been within the domain of the interventional radiologist—that is, unless the interventional radiologist is ready to provide a full range of clinical services that the primary care physician expects when making a referral to a specialist. To maintain a healthy referral base the interventional radiologist must provide complete periprocedural and comprehensive care. Developing and implementing clinical services, including consultations, rounds, and clinic, is time-consuming, and for the interventional radiologist this means time away from the interventional laboratory. Using a team approach to providing clinical services is logical and the midlevel provider is a perfect fit for an interventional radiology team.

CHOOSING A MIDLEVEL PROVIDER

Midlevel providers can be grouped into two categories, advanced practice nurses (APNs) and physician's

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assistants (PA). Under the umbrella of APN are several specialties including the nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse midwife, and certified nurse anesthetist. The midlevel providers that are particularly suited for interventional radiology are the NPs, CNSs, and PAs.

An NP, according to the American College of Nurse Practitioners, is "a registered nurse with advanced academic and clinical experience, which enables him/her to diagnose and manage most common and many chronic illnesses, either independently or as part of a health care team." A CNS, according to the National Association of Clinical Nurse Specialists, is a graduate-prepared nurse considered an "expert clinician in a specialized area of nursing practice." APNs, generally, hold a masters degree in nursing, are credentialed (by exam) by the American Nurses Credentialing Center, and are licensed by the state as an APN. The APN works with a collaborating physician within the scope of a collaborative agreement. The collaborative agreement outlines the scope of practice, method of consultation and referral (to the physician), and delegation of prescriptive authority. The collaborative agreement does not mean the physician is in constant supervision of the APN. In fact, the APN can open his or her own practice as long as there is a collaborative agreement in place that defines some degree of intermittent medical direction (as defined by state law).

PAs, according to the American Academy of Physician Assistants (AAPA), are "health care professionals licensed to practice medicine with physician supervision." PA training programs are based on the medical model designed to complement physician training, are usually 2 years in length, and most require at least 2 years of college and some health care experience prior to admission. They are credentialed (by exam) by the National Commission on Certification of Physicians Assistants and are licensed by the state as a PA-C. The PA-physician relationship is one of more immediate physician supervision with the physician being available to the PA by some form of telecommunications at all times. In addition, a PA must be employed by a physician to practice and successfully bill Medicare for their services.

Similarities between APNs and PAs are many. Both can practice in almost all settings that physicians do since the passage of the Balanced Budget Act of 1997. In addition, both receive the same level of reimbursement from Medicare for their services. Prescriptive authority and scope of practice for the APN and PA are legislated by the individual states but prescriptive authority is generally granted equally to APNs and PAs. Scope of practice for both the APN and PA is limited to the scope of practice of the collaborating or supervising physician but generally encompasses first-assist, performing procedures independently and providing evaluation and management (E&M) services in both the inpatient and outpatient settings. Therefore, the question often arises, which is a better fit for interventional radiology, a PA or APN? The answer is easy: either. The most important considerations when hiring a midlevel provider for interventional radiology include good critical thinking skills, background and experience (intensive care experience is helpful), interest and willingness to learn, flexibility, confidence, and an affable personality.

PREPARING TO HIRE A MIDLEVEL PROVIDER

Before hiring a midlevel provider, develop a detailed job description that reflects the needs of your practice. Will they be acting as first-assist for surgery, performing simple procedures independently, consultations, hospital rounds, or clinic duties? Is there call or weekend expectations? What are the work hours? Also, compile a list of clinical duties that will be preformed by the midlevel provider. This will come in handy when obtaining privileges from the hospital. Begin to think about the collaborative agreement and supervisory relationship. This should be developed together after the midlevel provider is hired and reviewed on a yearly basis for relevancy. In addition, you will need to develop a set of clinical practice guidelines or protocols that the midlevel provider should follow when managing patients.

Before beginning the hiring process, familiarize yourself with all rules and regulations governing midlevel providers. Three levels of compliance must be considered. The first is the national level and consists of the rules set forth by the Centers for Medicare and Medicaid Services (CMS; formerly known as Health Care Finance Administration), which can be found in the Medicare Carrier Manual. This document describes the minimum requirements needed to treat and bill for Medicare patients. In addition, it provides the Medicare reimbursement rates for services provided by physician extenders. Reimbursement rates for the physician extender are set at 85% of the physician fee schedule for E&M services, procedures, and for first assistant at surgery. To bill for Medicare services, the midlevel provider must obtain a Unique Physician Identification Number (UPIN) from CMS. Another consideration at the national level relates to prescriptive authority. The midlevel provider must register with the Drug Enforcement Agency (DEA) and secure a number for prescribing.

The second level of compliance is found at the state level. All states have a licensing agency for various professionals. Here, you will find the laws that govern how NPs, CNSs, and PAs practice medicine. Within these laws you will find a detailed accounting of issues concerning certification and educational requirements, licensing fees, scope of practice, as well as rules governing collaborative agreements (NPs and CNSs),

supervisory requirements (PAs), and prescriptive authority. If prescriptive authority is issued from the state, the midlevel provider will need a controlled substance license issued by the state before obtaining a DEA number from the federal government.

Third, the midlevel provider must practice in compliance with hospital bylaws and departmental rules and regulations. The hospital bylaws often deal with issues such as timeliness of maintaining medical records, staff meeting attendance, and cosigning notes and orders. Contact should be made with the credentialing office at the hospital(s) where the midlevel provider will be practicing prior to hiring to obtain a copy of the bylaws and information regarding the credentialing process. They generally require substantial documentation of education, previous work history, continuing education, state professional license information, controlled substance license, and DEA numbers. In addition, a list of requested clinical duties and procedures the provider will perform while in the hospital environment will be required before privileges will be granted. The midlevel provider will not be able to provide patient care until privileges are granted from the hospital.

SALARY AND BENEFITS

Salaries for PAs and APNs vary by region, responsibilities, hours worked, call and weekend responsibilities, and total benefit package offered. In general, annual salaries vary between $65k and $75k plus benefits. Information on average annual salaries is available from both the AAPA and the American College of Nurse Practitioners and can be found on their respective websites (www.aapa.org and www.nurse.org).

UTILIZING THE MIDLEVEL PROVIDER

As outlined above, the scope of practice of the midlevel provider mirrors that of the collaborating and supervising physician. Therefore, midlevel providers in an interventional radiology practice can perform procedures as well as clinical duties. Performing some procedures such as central line placements and random liver biopsies eases the workload of the interventional radiologist, and it may be cost-effective in the short term; however, clinical practice building is the issue today that will most ensure the long-term survival of a quality interventional radiology practice. Cultivating relationships with potential referral sources and providing the clinical services they expect will bring in the more complex vascular cases. The midlevel provider facilitates these relationships by maintaining communication and providing the clinical services in both the inpatient and outpatient settings.

When an inpatient consultation for interventional radiology services occurs, the midlevel provider is the first point of contact. The midlevel provider reviews the case to assure that the indication for the procedure is appropriate, performs the history and physical (H&P), develops an assessment and plan for the consultation, obtains the consent, and writes all preprocedure orders. If there are special circumstances to be addressed such as renal insufficiency, an elevated international normalized ratio, or thrombocytopenia, these issues are managed in accordance with our clinical practice guidelines and addressed in collaboration with an interventional radiology physician and the referring physician. Occasionally, additional or alternative testing is recommended such as an magnetic resonance angiography in place of traditional angiography. After discussing the case with the interventional radiologist, the midlevel provider can communicate the rationale for the recommendation to the referring physician and the patient/family. By identifying these situations before the patient arrives in the department, time and resources are saved.

Referrals from outlying facilities or a physician's office are easily managed with the midlevel provider on the team. The admission H&P is performed and dictated upon arrival, and all admission orders are written including referrals to other services. Interventional radiologists generally understand their limitations regarding medical management of patients, and we often utilize the services of the medical teaching service or hospitalist to assist us in the care of patients with complex medical comorbidities. The midlevel providers perform daily rounds and maintain communication with the medical staff regarding patient progress. Furthermore, the midlevel provider will orchestrate the discharge of the interventional radiology patient when appropriate, making additional referrals to home care if necessary and communicating with the referring physician regarding outcomes and follow-up.

Outpatient services are performed in the Interventional Vascular Clinic. The clinic was opened in 1997 and has seen consistent growth every year. All patients referred from a primary care physician for peripheral arterial disease are seen in the clinic first. In addition, all carotid stenting, venous ablation, uterine artery embolization, cryoablation, vertebroplasty, kyphoplasty, and abdominal aortic aneurysm (AAA) patients are seen in the clinic before proceeding with any intervention. In addition, all vascular patients are followed in the clinic for at least 2 years postprocedure. All new patients are assessed by the midlevel provider first and then seen by the interventional radiologist. The plan is developed in conjunction with the interventional radiologist and explained in depth to the patient and family while in the office. A letter is dictated by the midlevel provider to the referring physician that includes the findings, assessment, and plan and is cosigned by the interventional radiologist. All follow-up visits are seen by the midlevel provider;

Table 1 2005 Clinic Visits

	Cancer	Fibroids	Aneurysm	Carotid Disease	Veins	Vertebroplasty	PAD	Misc
New patient visits (99243 and 99244)	24	14	71	54	41	28	222	20
Follow-up visits (99213 and 99214)	63	45	150	137	63	53	679	35
Total	87	59	221	191	104	81	901	55

PAD, peripheral arterial disease; Misc, miscellaneous.

usually the interventional radiologist will make a progress note, dictated by the midlevel provider and again cosigned by the interventional radiologist, and the note will be carbon copied to the referring physician. Table 1 shows a breakdown of our clinic visits for the year 2005.

In our practice, almost all E&M services are billed under the midlevel UPIN. In 2002, total annual income by E&M charges billed under the four midlevel UPINs was approximately $350,000, which covered the benefit and salary package for all four midlevel providers. In general, the E&M codes most frequently used in an interventional radiology clinical practice are those of low to mid complexity whether in the inpatient or outpatient setting. Although the reimbursement for these types of codes is modest and the numbers of clinical encounters performed by an active interventional radiology service are many, clinical work is clearly reimbursable regardless of the specialty that is providing the service.

One of the most important duties of the midlevel provider is obtaining informed consent. Having a midlevel provider who has a thorough understanding of the procedure and who can take the time to explain the procedure from start to finish along with the attendant risks, benefits, and alternatives is invaluable to patient satisfaction. Furthermore, most are uncertain of what interventional radiology is or what medical services we provide, and the informed consent process provides a great opportunity for the midlevel provider to educate the patient on what an interventional radiology service can do for the patient.

Our practice includes a very active research program with patient enrollment in 5 to 10 studies at any given time. The midlevel provider plays a key role in identifying potential candidates who fit the inclusion criteria. Although the research coordinator is actually responsible for consenting and enrolling the patient, the midlevel provider must have a good understanding of the inclusion and exclusion criteria and be vigilant for potential candidates.

We employ five APNs in our practice, one CNS, two family NPs, and two acute care nurse practitioners. We cover two hospitals, a large teaching facility with ~600-bed capacity and a small community hospital with a 250-bed capacity. The APN workload is divided into five jobs and we rotate through those jobs on a weekly basis. This promotes fairness and helps prevent burnout. One APN covers the small community hospital until 12:00 P.M. and then returns to cover the clinic in the afternoon. Four APNs cover the large teaching hospital daily. One is assigned to the holding area to perform workup on all outpatients presenting for procedures. Another will see all of the inpatient consults for the week. The third performs hospital rounds, and the fourth is assigned to the clinic. In addition, each APN has special projects to manage. Some of the special projects include facilitating Legs for Life, managing an AAA database, and managing patients undergoing aortic stent grafts and venous procedures. In addition, one of our APNs serves as marketing specialist.

CONCLUSION

Midlevel providers are an invaluable part of the interventional radiology team. We maintain communication with and facilitate education of the patient and their family as well as the medical and nursing staff. We are often the first and last person the patient will see during a hospital admission and often first responders to the patient in a crisis. We are the face of interventional radiology, providing the extra pair of skilled eyes, ears, and hands that allows the interventional radiologist the opportunity to remain productive throughout the day and at the same time develop a clinical practice that maintains that competitive edge.

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