

Managing the New Logistics of AMD Therapy

In a new series, retinal practice administrators explain how they have integrated the increased patient volume from intravitreal injections into their practices.



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Q: LUCENTIS IS A COSTLY DRUG. WITH MULTIPLE LOCATIONS, HOW DOES YOUR PRACTICE HANDLE INVENTORIES TO AVOID LOSS?

A: We have one person responsible for keeping track of the use of injectables each day at each practice location. At the end of the day, the clinical person compares notes with the front desk to make sure the records and charges accurately reflect what quantities of what drugs were used that day.

Entries are also made in a spreadsheet program that is shared by all the offices. This helps us to keep track of inventories. The record for each visit contains the name of the patient, the physician providing the service, the date of service, and the agent that was injected. We use the same spreadsheet to track insurance payments from the primary and secondary insurance, and any third party if applicable.

Q: HOW DO YOU HANDLE INSURANCE PRECERTIFICATION?

A: When a patient is new to the practice and needs an injection for the first time, our physicians like to do the injection on the same day. Once the physician has seen the patient and determined that an injection is necessary, the patient goes back to the front desk. We then call the insurance company and certify that there is coverage, specifically coverage for Part B injectables. Some companies have special considerations for Part B injectables, such as higher deductibles or only providing a percentage of coverage. Once benefits have been verified, the patient is merged back

Illinois Retina Associates: Practice Profile

Number of surgeons: 11

Number of FTE non-physician staff: 85

Number of offices: 10

Number of intravitreal injections in the past 12 months: anti-VEGF: 6,570
other: 508

into the physician's patient flow to receive the injection.

For established patients coming back for an injection, we call their insurance in advance.

We have just purchased software capable of certifying that patients have coverage with their primary insurance. A few days in advance of the patient's visit, the software automatically sends an electronic message to the insurance company, and we receive an electronic response as to the nature of coverage. The software works for primary insurance only, not the secondary, but this new automation will help streamline the process.

Q: HOW DO YOU HANDLE COLLECTIONS?

A: The insurance market in Chicago has been very traditional. Most of our patients are covered by Medicare, with secondary coverage through BlueCross BlueShield or another good carrier, and as a result we have not had problems with collections. With the advent of Medicare Advantage plans, however, we are seeing patients who are not covered for the 20% deductible on the drug, and this can create a hardship for the patient. Although this has not been a major issue for us in the past, it may become one as we go forward.

Fortunately, the drug companies have charitable foundations (eg, Genentech's Access to Care Foundation) that can assist patients, if they meet the criteria both medically and financially, with their lack of coverage or copay.

Q: HAVE YOU ADJUSTED YOUR PHYSICAL PLANT TO ACCOMMODATE AN INCREASED DEMAND FOR INJECTIONS?

A: Not really. We have not made any physical changes or added space. But we have increased the use of some rooms that were previously underutilized.

We have procedure cards for each physician so the clinical staff knows how to set up the injection for the doctor.

Q: EVERY PHYSICIAN HAS HIS OWN PREFERRED WAY TO GIVE INJECTIONS. WITH 11 PHYSICIANS, HOW DOES YOUR PRACTICE MANAGE THOSE DIFFERENT APPROACHES?

A: The way injections are given is purely up to the physician; there is no practice-wide policy, although the physicians often compare notes on how each other are performing injections or other procedures. Most of our physicians prefer to perform injections throughout the course of the day, not grouped together. Every physician has slight variations in how he preps the patient, how he gives the injection and the follow-up instructions, and we accommodate all of the variations.

Because we have two or three physicians rotating through an office, we have procedure cards for each physician so the clinical staff knows how to set up the injection for the doctor.

Q: DO YOU HAVE ROUTINE CALL-BACKS OR FOLLOW-UP VISITS AFTER INJECTIONS?

A: After a patient's first injection, we bring them back 1 week later. We want to look at them and remind them what they should be looking for—redness, irritation, and pain. The fact that we bring them back helps to reinforce the message. After that, once they are in the routine, they do not come back until their next scheduled injection, unless they have a problem.

We call every patient who has any procedure—whether injection, laser, cryotherapy—2 or 3 days postprocedure to see how they are doing. For injection patients we run down a list of questions looking for signs of problems.

Q: DO YOU HAVE A POLICY ON WHEN OFF-LABEL INJECTIONS ARE USED?

A: If a physician wants to use a drug off-label because he thinks it is medically necessary, that is his decision. If a physician is using a lot of a certain drug off-label and the practice is not being reimbursed, we will discuss that with him. Everyone is concerned about the practice's financial welfare, so of course no physician is going to do something that will hurt the practice in that way, but there is no specific policy.

Q: BEVACIZUMAB (AVASTIN, GENENTECH) IS SPLIT INTO MULTIPLE DOSES FOR INTRAVITREAL INJECTION. HOW IS THAT HANDLED?

A: We obtain bevacizumab through a compounding pharmacy, which supplies it to us in a syringe with a needle affixed. We do not want to aliquot the drug ourselves because of the risk of infection. The more the drug is handled, and the less experience the person has in handling it, the higher the risk.

We selected the compounding pharmacy we use based upon their experience and their procedures for aliquoting. The pharmacy we selected has experienced staff that uses special precautions in handling the drug. We believe that this reduces the risk.

Q: INTRAVITREAL INJECTIONS ARE GIVEN AT ALL YOUR LOCATIONS. WHAT ARE THE CHALLENGES POSED BY HAVING THESE DRUGS AT MULTIPLE SITES?

A: The companies ship directly to our offices, so acquisition is not a problem. Large inventory can be a problem, however, so I want all offices to minimize what is kept on hand. Large inventories tie up cash, and also we want to avoid losses due to power outage or refrigerator failure. The inventory of drug at each office is therefore kept to a pretty tight supply.

Yet we never want an office to be without the drug. Each office is responsible for the amount they order, but we monitor their orders and question large amounts. A problem with multiple locations is the number of invoices we have to process to maintain the small inventories, but this is worthwhile to avoid the pitfalls mentioned. Other than that, as long as there is a responsible person comparing notes on drug usage with the front desk at the end of each day, we have not had problems with multiple locations. ■

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