

Managing the New Logistics of Retinal Therapy

In an ongoing series, a practitioner explains how his practice manages the increase in patient volume brought on by intravitreal injections.

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RETINA ASSOCIATES OF FLORIDA: PRACTICE PROFILE

Number of surgeons: 2*
 Number of FTE non-physician staff: 15
 Number of offices: 4
 Number of intravitreal injections in the past 12 months:
 ranibizumab: 2,897
 bevacizumab and triamcinolone: 485

** A third physician was added to the practice on January 1. Statistics and statements in this article reflect a two-physician practice.*

Q: Lucentis is a costly drug. How does your practice handle inventories to avoid loss?

A: Our practice is a little different, I think, from others that have been profiled in this series. When we decide to give ranibizumab (Lucentis, Genentech), we set the patient up for an injection visit. We occasionally give injections on the same day we make the decision, but generally we have the patient come back in a day or two.

During that 24- or 48-hour period, patients can take drops to reduce the risk of infection, and it gives us time to verify their insurance. If they do not have adequate insurance, or their insurance requires a large copay, we can inform the patient and ask how they want to handle it. We generally do not give the ranibizumab injection unless we have the copay in advance.

If patients do not have the money for a ranibizumab injection, they can choose bevacizumab (Avastin, Genentech). Generally, we encourage the patient to make that economic decision rather than us.

Genentech has great programs to help patients who do not have the money. If a patient cannot afford the copay or what insurance doesn't cover, we usually get some help through Genentech to pay for the ranibizumab. Alternatively, we offer them bevacizumab, or the patient can choose not to be treated.

Q: What if the HMO wants to supply the drug? Does that cause complications?

A: We do not have a lot of HMO business, by choice. Some companies want to supply the drug, and that's fine. But if they don't get the drug here in time, then the patient doesn't get the treatment. This has not been a problem. FedEx works.

Q: How do you handle insurance precertification?

A: Bringing the patients back for injections gives us 24 or 48 hours to verify their insurance. This is not done so much to ensure that we get paid, but rather to ensure that everybody knows what their responsibilities are. The patients know whether they are covered and what they are going to have to pay. They then have the ability to plan and make their own decisions, a situation we prefer over making decisions for them. '

Q: How do you handle collections?

A: Just like at Walgreens, if you don't pay the money, you don't get the drug. We are not a credit agency.

Q: Have you adjusted your physical plant to accommodate increased demand for injections?

A: We have not changed the buildings much. We had a parking problem at our main office, and we bought the building next door to get more parking. Once we became efficient at giving injections, patient flow has not been a problem.

Again, our approach is a little different from some other practices. We have set times when we give most of our injections, although there are exceptions when we go outside the usual times. Generally, on an injection visit the patient comes in, has an undilated vision check, and gets the injection, and we schedule another visit in 4 weeks. We are not monitoring them with optical coherence tomography at every visit; we are giving a series of injections.

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At every third injection visit—ie, every 3 months—we evaluate the patient with fluorescein angiography and OCT. That is planned and scheduled into the visit. The patients get the diagnostic procedures before they see the physician for evaluation, so it is fairly efficient.

Now, if they come in for a monthly injection and their vision is down on the undilated exam, we then dilate and reevaluate them. But if they are receiving regular monthly injections, the vision usually is not down. Evidence-based medicine suggests monthly treatment is the best treatment strategy. That is how I would want to be treated. That's how we treat (partner) Dr. Mark E. Hammer's mother.

Our main office can accommodate two physicians working at once. In that office, one physician will be giving injections while the other is seeing patients. In our satellite offices we do not always have room for that, so we schedule injections in the morning and see patients in the afternoon.

Q: Every physician has his or her own preferred way to give injections. How does your practice manage those different approaches?

A: With two physicians this is not much of an issue. Dr. Hammer and I have been in practice together for 20-plus years, and we have learned that it works best for the staff if we try to do things in a similar manner. We

tend to have joint agreement about the way to do things. That's not to say that we do not have our individual differences, but generally we do things the same way.

Our new physician, Dr. Ivan Suñer, is going to have to learn to do it our way (laughs). No, it's not that he will need to do it our way, but we will need to find a way that we all agree to do it.

Q: Do you have routine call-backs or follow-up visits after injections?

A: Neither. We tell patients to call us if they experience pain or visual loss. Pain or visual loss is not difficult to remember.

Q: Do you have a policy on when off-label injections are used?

A: We generally use ranibizumab for patients indicated for the drug: those with choroidal neovascularization secondary to age-related macular degeneration. We have been using bevacizumab in patients with AMD who choose to have that drug, and for indications that are off-label for ranibizumab, such as diabetic macular edema, central or branch retinal vein occlusion, plus disease, and other things.

There are a number of problems with using bevacizumab. Patients have to sign an advance beneficiary notice informing them that insurance may not pay for the drug. And indeed, sometimes the insurance plan will not pay, or they may pay initially and then reverse the decision and want the money back, in which case we have to go back to the patient to try to recover the money. So there are a number of potential problems with insurance.

Another potential problem with bevacizumab is the need to use a compounding pharmacy. We have a local compounding pharmacy that does a good job for us and gets the drug to us the next day. To date we have not had any inflammatory problems, but that may be a matter of time. I call this the "pharmacy risk" of using bevacizumab. There are extra steps, and we do not know the people doing the work personally or have direct control over them. We just don't know what is in that syringe from the pharmacist the same way we know what is in the vial from Genentech. My nightmare is giving 20 bevacizumab injections in a day, and the next day all of those patients have infections.

Genentech has a program that helps provide ranibizumab for off-label uses, and the company has been good about providing ranibizumab in most of those cases. So if possible we will use ranibizumab even for off-label indications.

Q: Are there special considerations in your practice due to your geographical area? For instance, are there differences in the way things are handled for "snowbirds"?

A: Tampa is pretty much a normal community in terms of demographics. It's got the port, businesses, banking, and so forth. So in our Tampa office, while there is some increase in business during the winter, maybe 10%, it is not as marked as in Lakeland, where a third of the business can be snowbirds.

There are sometimes treatment issues with the snowbird patients. We have seen some cases where we have been giving monthly injections, and when the patient goes north the doctor decides to follow them, and when they come back they have lost vision. We are not happy when we see that. On the other hand, if the physician up north has been following them with observation for 3 or 4 months and the patient is doing well, generally those patients do not want to start up the shots again, so we try to go along with what has been done up north.

As I noted previously, that is not the best care, in my

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opinion, but I may be wrong. When the CATT (Comparison of Age-related Macular Degeneration Treatment Trials) study results come out, we will all know the answers to these questions.

If a patient has been getting bevacizumab from the doctor up north and wants to continue with it, then that is what we give him. ■

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