Managing the New Logistics of Retinal Therapy

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

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Mid Atlantic Retina: Practice Profile

Number of surgeons: 10

Number of FTE non-physician staff: 90

Number of offices: 7

Number of intravitreal injections: ranibizumab: 600/month
bevacizumab: 600/month

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

A: We leave it to each office manager to determine the appropriate stock to keep so that it is available for patients. Each office orders its own drugs: for bevacizumab (Avastin, Genentech) from a compounding pharmacy, for ranibizumab (Lucentis, Genentech) from the distributor. We have it shipped directly to the offices from the source, not sent to a central location and then re-shipped.

In probably less than 1% of our volume of cases, a payer wants to supply the ranibizumab for its patients. If a patient requires monthly injection, and his or her payer requires direct shipment under its pharmacy plan, we prefer to have the drug available prior to the patient's visit. The problem arises when that patient does not need an injection and we have the drug on hand. Many of those patients have a substantial copay, and because of the regulations regarding pharmaceuticals, many pharmacies will not allow a return shipment so we end up wasting that. We discourage that type of arrangement for that reason.

Q: HOW DO YOU HANDLE INSURANCE PRECERTIFICATION?

A: We have a strict policy regarding insurance precertification. Every patient who checks out of our office with a diagnosis of wet age-related macular degeneration (AMD) is automatically offered Genentech's Benefits Investigation Program to check their eligibility for coverage. Many of those patients turn out not to need an injection, but we we still prefer to gather the information. This gives the most flexibility to the physician and the patient so that a return visit does not have to be scheduled.

Also, for every patient requiring ranibizumab injection, the paperwork is resubmitted every single visit, for two reasons: first, we want to verify that they are still eligible for benefits; second, we want to confirm their coverage and deductible.

We have a dedicated billing person whose only responsibility is to coordinate the precertification of these injections. It is that person's responsibility to collect the information returned by the Benefits Investigation Program and notate on the patient's encounter form for that day what the out-of-pocket cost is, whether or not ranibizumab is covered, and what percentage is covered. Therefore, before any patient receives an injection, the benefits have been verified and that information has been transferred to the encounter form. With that done, the physician can make sure the patient understands his or her financial responsibility.

The only time we do not have the coverage information in advance is for an initial encounter with a patient. If we are not able to immediately verify coverage, we offer them the option of signing a Patient Financial Responsibility form and paying out of pocket for

ranibizumab until we can verify benefits, returning in several days to allow time for benefits and coverage verification, or having an off-label injection of bevacizumab for that first visit. When they return for their second visit we have the information regarding their eligibility for ranibizumab.

Q: HOW DO YOU HANDLE COLLECTIONS?

A: We limit collections because we do not allow ourselves to be put in that position. We know a returning patients' coverage when they arrive for their visits prior to the injection. If there is an out-of-pocket expense, this has been verified and explained to the patient, so payment is expected and required at the time of the injection.

We prefer not to send patients to collections. Having our billing staff work on collections is not in anyone's interest. If there are any payment issues, certainly they have to be clarified by the time the patient returns for the next visit, and before we continue with treatment.

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

A: Yes. Our use of optical coherence tomography (OCT) has skyrocketed. OCT is the main diagnostic modality we use for determining the need for injections. So we now have an OCT room at every location, a separate space from our angiography and photography room. The flow is significantly slowed when you try to mix the two functions in one room.

Second, we have a designated injection room, used solely for the purpose of intravitreal injections. There are two physicians in each office at any one time, and two of our recently remodeled offices have two dedicated injection rooms, one for each physician. One shared injection room for two physicians works, but it can create a bit of a bottleneck.

Q: EVERY PHYSICIAN HAS HIS OR HER OWN PREFERRED WAY TO GIVE INJECTIONS. WITH 10 PHYSICIANS IN SEVEN OFFICES, HOW DOES YOUR PRACTICE MANAGE THOSE DIFFERENT APPROACHES?

A: In general, we all use the same components of the injection. Anesthesia, sterilization of the fornix and the ocular surface, and the injection component, followed by an antibiotic drop. Some use a speculum, some do not; some use a cotton swab, some do not; some use a caliper and some do not. Basically, the staff has adapted to this. I assume they have a preference card, as you would have for the operating room, listing the procedures each physician likes, the equipment they use.

We have designated staff for each office. They do not travel with the physicians; the physicians rotate through the offices. Because they work with different physicians each day, that increases their flexibility.

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

A: In the past, we brought each patient back at 1 week post-injection. Currently, I bring the patient back at 1 week after the first injection, and for subsequent injections we call them at 1 week. That's true for either bevacizumab or ranibizumab.

I ask the patient to remember what this first injection was like, assuming there were no complications; now they know what to expect for the next visit. We also give each patient a detailed post-injection instruction sheet, along with a sample bottle of antibiotic drops. The instructions are reviewed before they leave, so if there is a problem they will know the appropriate time to call.

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

A: In general, if a patient has insurance coverage and a diagnosis of wet AMD because ranibizumab is the drug that is approved by the Food and Drug Administration for that indication, I will recommend that drug. Patients who receive bevacizumab are either those whose diagnosis does not support reimbursement for ranibizumab, or for whom the out-of-pocket expense is beyond their ability to pay. Of course, that is a decision the patient makes based on the information given to them.

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

A: Because of our high volume of injections, our turnover of the drugs is so rapid that this is not much of an issue. A smaller practice might have more of a problem.

There are potential issues with storage at multiple sites. This is a refrigerated medication, so if the refrigeration breaks or there is a power outage over a weekend we could have a substantial loss. Genentech has assured us that if that occurs and product is destroyed, there is an exchange program so that we can be reimbursed.

We have one account number for the entire practice, but each individual site is given permission to order to meet its demand. We try not to split orders between offices. We send an entire lot to one office if possible.

Q: YOU HAVE BOTH SUBURBAN AND URBAN LOCATIONS. ARE THERE DIFFERENCES IN THE WAY THINGS ARE HANDLED AT THESE SITES?

A: In our case, there is no difference. Our goal is to provide the injection service at the same encounter as the office visit. I have heard that other practices have office visits and then other days designated for injections . When we schedule patients, we have specific injection slots, so we try to schedule patients who may need an injection in those spots. We do not want 10 people who need an injection coming in at the same time.

Our goal is to take care of the patient completely at the time of the visit and not have return visits for injections. That simply makes the office busier.

Q: HOW HAS YOUR THINKING EVOLVED ON THE USE OF BEVACIZUMAB VERSUS RANIBIZUMAB?

A: In our practice we have had a major shift in the way we view ranibizumab. My opinion now is that if it is managed correctly, ranibizumab can be profitable for the practice. When ranibizumab was first available, we were not as diligent in precertification of patients' insurance coverage. Financially, we were not doing well.

Now we have a dedicated billing staff member whose primary responsibility is ranibizumab reimbursement. She knows the policies of the major payers in our area. We also pay careful attention to detail in using Genentech's benefits investigation program, complementing that with our own follow-up when necessary. We also use the available charitable programs to help patients with large copays when they do not have secondary coverage.

With all of this effort, we have found that ranibizumab can be financially advantageous to our practice. We have shifted toward more use of ranibizumab over the past year by a significant amount. We were previously using mostly bevacizumab, but now we have moved to more of an equal amount of each drug. That may sound like a lot of bevacizumab, but remember that includes injections for diabetic macular edema, retinal vein occlusions, and other off-label indications for which ranibizumab would not be reimbursed. So within the population of patients with choroidal neovascularization from AMD, most patients are now receiving ranibizumab. That has been a major shift for our practice. ■

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