By Cynthia Matossian, MD, FACS

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On hiring a subspecialist

Alternate title: I loathe surprises.

Regular visitors to this space know that I strive to plan and prepare carefully. Poor planning can result in surprises, which in my mind, should only come in piñatas and holiday packages.

Depending on what the unforeseen issue is – a better term than surprise – the practice could lose money, patients might go elsewhere, and staff could leave as well.

So when we set out to hire our first retina specialist – I am a refractive cataract specialist — I did my due diligence.

Or so I thought. Three little words delayed the successful office integration of our new staff members: Avastin, Lucentis and Eylea.

MAKING BUSINESS DECISIONS

When a practice begins referring lots of patients to other subspecialists because the practice lacks that skillset, the partners need to make a business decision: Should you continue to refer these patients out, or should you hire that subspecialty and bring it in-house?

We confronted this question a few years ago. We were sending too many of our patients to retina specialists, so we made some basic calculations to determine whether adding staff and retina equipment made economic sense.

While assessing the pros and cons of a new hire is not an exact formula, we found the following factors to be important in hiring a retina specialist:

- Determine the number of patients a retina specialist can see per day.
- Look at the number of patients referred out to retina from your practice.
- Review the diagnostic testing and treatments these patients are getting, many of who return on a regular basis. Tests, like fluorescein angiography, procedures like lasers and surgery generate additional revenue.

FIGURING OUT INTEGRATION

We decided to hire two part-time retina specialists; between the two, they could take care of the majority of our patients' retina needs, we determined. We figured out schedules – the right days, times – because, after all, there are only so many exam lanes.

We looked at what equipment they needed, such as ultra-widefield retinal imaging with fluorescein angiography capability and optical coherence tomography (OCT). Then staff had to be trained on the equipment. They didn't know how to start IVs. So I invited several RNs from our ASC to train our ophthalmic technicians on how to start IVs. Some of our staff didn't want to work with blood. Those interested in working with our new retina specialists attended a series of in-services learning about IVs and taking fluorescein pictures with the Optos system.

NO COMFORT

And then that unforeseen issue struck. For as much training as our staff goes through to learn about billing, precertification for anti-VEGF injections has a learning curve unto itself. Because of hurdles in the precertification process, several of our claims were initially rejected and we had to draw on our own cash reserves and credit line to pay for the injectables until the billing situation was worked out.

Genentech representatives said we weren't the first practice to be faced with this situation, but that was no comfort. For a practice that works hard to see what problem is around the corner and then beyond that, we didn't see this coming. Our only comfort in climbing this steep learning curve: we had systems in place to deal with this unforeseen issue. OM