Physicians are busy, constantly focused on treating their patients, staying up to date on the latest clinical guidelines and keeping their practices afloat. So, who is managing your money for you? Finding a financial adviser who knows what you are looking for, who can anticipate your needs and understands the unique challenges posed to physicians is a crucial aspect in making sure you and your family are financially protected and able to build the nest egg you need to live out your dreams.

Our focus in this issue of Medical Economics® is on physician personal finance, bolstered by a bevy of helpful financial content, including as follows:

- How to find the best adviser for you, including a review of the important qualifications and questions you should ask, to make sure you find a partner who puts you first.
- Our listing of financial advisers who serve physicians, including contact information and other helpful info.
- An analysis of how physicians, who often don’t qualify to use a Roth IRA, can still reap the tax benefits of a Roth account with some savvy financial planning.
- An interview with a financial expert on how physicians should handle debt in a smart and efficient way.

In addition to this excellent personal finance content, we’ve also got an in-depth feature on the problem with prior authorizations, and what needs to be done to end this headache for both physicians and patients.

I also want to mention that our upcoming June issue features the results of our 92nd annual Physician Report, including an in-depth look at physician salary, productivity and other interesting data. Stay tuned for that, both in print and on MedicalEconomics.com.

As always, thank you for reading Medical Economics®, and send any feedback on our content to our editorial team at medec@mjhlifesciences.com.

Mike Hennessy Sr.
Chairman and Founder
of MJH Life Sciences™

CHAIRMAN’S LETTER

Finding the best financial adviser for you

P
From the Editor-in-Chief

4 Let’s change health care for the better
And the pandemic is our opportunity.

Financial Advisors Guide

8 Find the best advisor for you
How to select someone that meets your needs and goals.

11 Financial advisor listings

14 Earn passive income
There’s an excellent way to generate income that many physicians ignore.

Money

16 Permission denied
The problem of prior authorizations.

21 Coding/documenting long COVID-19
How to code these symptoms

22 Physician’s Money Digest®
Physicians can reap the rewards of Roth IRA strategies.
Follow these easy steps.

24 Dealing with debt
Strategies to successfully manage your loan burden.

Practice Management

26 It’s time to revolutionize private practice
And here’s how to do it.

29 Prepare for a disaster
Make sure your practice is ready when the worst happens.
**Journal Table of Contents**

### Legal

34 **Cybersecurity insurance**
Is it worth it? What physicians need to know about these insurance policies.

### Tech

36 **Automated scheduling**
How you can turn cancellations into revenue.

39 **How tech can mitigate burnout**
It can help with practice efficiency too.

### Chronic Conditions

40 **Managing respiratory conditions**
Modern ways to reach patients with COPD and asthma.

44 **Coding scenario: COPD**
Can you code it right?

### Careers

45 **Master public speaking**
Give your audience something to remember.

---

**Medical Economics** (USPS 337-480) (Print ISSN: 0025-7206, Digital ISSN: 2150-7155) is published monthly (12 times a year) by MultiMedia Healthcare LLC, 2 Clarke Drive, Suite 100, Cranbury, NJ 08512. Subscription rates: one year $108, two years $204 in the United States & Possessions, $170 for one year in Canada and Mexico, all other countries $170 for one year. Singles copies (prepaid only): $18 in US, $22 in Canada & Mexico, and $24 in all other countries. Include $6.50 for U.S. shipping and handling. Periodical postage paid at Trenton, NJ 08650 and additional mailing offices. Postmaster: Send address changes to **Medical Economics**, PO Box 457, Cranbury, NJ 08512-0457. Canadian GST Number: R-124213133RT001. Printed in the USA. ©2021 MultiMedia Medical LLC. All rights reserved. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical including by photocopy, recording, or information storage and retrieval without permission in writing from the publisher. Authorization to photocopy items for internal/educational or personal use, or the internal/educational or personal use of specific clients is granted by MultiMedia Medical LLC for libraries and other users registered with the Copyright Clearance Center, 222 Rosewood Dr., Danvers, MA 01923, 978-750-8400 fax 978-646-8700 or visit http://www.copyright.com online. For uses beyond those listed above, please direct your written request to Permission Dept. email: etemple-morris@mmhgroup.com. SMARTER BUSINESS. BETTER PATIENT CARE. is used pending trademark approval.

**MJH Life Sciences™** provides certain customer contact data (such as customers’ names, addresses, phone numbers, and e-mail addresses) to third parties who wish to promote relevant products, services, and other opportunities that may be of interest to you. If you do not wish **MJH Life Sciences™** to make your contact information available to third parties for marketing purposes, simply call toll free 866-529-2922 between the hours of 7:30 a.m. and 5 p.m. CST and a customer service representative will assist you in removing your name from **MJH Life Sciences™** lists.

**Medical Economics** cannot be held responsible for the safekeeping or return of unsolicited articles, manuscripts, photographs, illustrations, or other materials.

Library Access: Libraries offer online access to current and back issues of **Medical Economics** through the EBSCO host databases.

To subscribe, call toll free 866-529-2922. Outside the U.S., call 218-740-6477.
COVID-19 COVERAGE CENTRAL

Medical Economics® editors are covering what you need to know during the ongoing COVID-19 pandemic. Our ongoing coverage of COVID-19 features:

- Breaking news on the latest developments.
- Tips for physicians to extend the life of N95 respirators.
- Mental health tips for doctors and other providers.
- How physicians can protect themselves from COVID-19.
- Strategies for using telehealth.

To read all of our ongoing coverage, go to MedicalEconomics.com

Perfect your telehealth program

Tabassum Salam, M.D., the ACP’s vice president of medical education, discusses what physicians need to know to get started with telehealth right away.

Watch this video and others at: bit.ly/MedEcVideo

Subscribe to our e-newsletter to get our latest articles.
Let’s use the pandemic to change health care for the better

The COVID-19 pandemic should have us reflecting on the state of our health care system and beginning a national dialogue on what type of system we want for this country and what investments we need to attain it.

Why were we so ill-prepared to mount a national response, why are our health care costs still so high, why do we still have such poor access to basic care for much of the population with racial and economic disparities still so pronounced? What should be our focus going forward? Here are a few thoughts and observations as we start examining some of the issues and begin that dialogue.

Clearly, health care delivery has undergone massive shifts over the last decade, but has it brought us closer to a better system of care for our country? Looking back to 2000, it is interesting to note that only a handful of the Fortune 50 companies were involved in health care. Now 20 of them have health care as a line of business, including six of the top 10. This massive shift of major corporate interest into health care clearly signals that there is big profit in health care. The question is whether that shift has resulted in better care at a lower price for the country as a whole or for the patients and businesses who pay the bills?

Many primary care physicians jumped all in on the promise of such reforms, investing countless hours redesigning their practices, attaining new certifications and making the prescribed changes, all while caring for their patients and communities. Where are we now with the promise of payment reforms and renewed investment in primary care? While there are clearly some success stories, it has been far less transformative. Has the movement just passed us by and given way to new interest and investment in retail services, internet-based services and venture-backed startups and primary care aggregators? What is our vision of a primary care system for the future?

As our nation fights its way out of this pandemic, we should examine how we can better prepare for future national health emergencies. Clearly a greater investment in public health and basic preparedness is needed. However, there are several aspects of our system that need to be separately examined. When the nation was facing massive COVID-19 spread and public fear, why were primary care providers seemingly sidelined without personal protective equipment and last in line to provide testing or vaccines? What effect has this had in exacerbating existing health care disparities and slowing our response? With so many states approaching vaccine distribution differently, what can we learn about successful models, such as in rural Alaska and West Virginia?

Common sense would tell us that mass vaccination events alone may not be the most effective way to reach the frail elderly, at-risk and rural populations. What approaches work best? Website appointments, travel and trust are all obstacles to the vulnerable. Maybe we should organize our primary care physicians as we do the National Guard, with periodic training and preparedness drills, along with adequate funding and coordination with local health departments. Then in a national

by L. Allen Dobson Jr., M.D., FAAFP
emergency, we could respond quickly, mobilize an already trained and available professional workforce and reach our citizens quickly and effectively.

My last thought is about rural health care and other at-risk communities. Having practiced in a small community for decades, it is clear to me that the minimum level of health care required in any community is access to a caring and comprehensive primary care physician/provider, a local pharmacy and emergency medical services. These health care professionals can provide the vast majority of a community’s health care needs.

Health care, along with good schools, grocery stores and other locally operated basic services, is what sustains the economy of many small towns. This is evident from the Alaska frontier to many of our inner-city communities. It is the norm for other industrialized countries.

Much has been written about the closing of our rural hospitals, but it may be worth examining more closely the effect of the loss of independent primary care physicians and pharmacies as well, not just as health care providers, but as small businesses that contribute to the community as leaders and employers.

What is the effect of the purchase or consolidation of health care resources? Does it sustain or grow the local economy by bringing more jobs and services, or does it just slow the decline as leaders and decision-making move to a distant corporate location, services are streamlined and consolidated elsewhere while participation in local community activities is lost? Are we seeing the “Walmart effect” on locally owned health care businesses?

Now that COVID-19 has shown the effectiveness of working from home, the need to no longer live close to work may represent a new dawn for small towns, if we can reexamine how to make them viable communities again with the health care, education and services people need and want.

L. Allen Dobson Jr., M.D., FAAFP, is a family physician and Editor-in-Chief of Medical Economics®.
View the video series!
https://www.medicaleconomics.com/medical-economics-pulse

Have a coding question you want us to cover? Email it to: Medec@mjlifesciences.com
How to find the best financial advisor for you

by Jordan Rosenfeld Contributing Author

Between juggling clinical care and handling the operations and billing sides of their practice, many physicians don’t have time to think about their financial needs and goals. Physicians can benefit from working with a financial advisor to help with everything from getting out of debt to retirement planning and more. It’s important to know where to start and how to find a qualified advisor. Experts recommend what to look for in an advisor and what to expect from the process:

“Financial planning for physicians is not a one-and-done thing, not a document with a bunch of recommendations that say, ‘Here you go, implement,’” says Chris Roe, CPA, PFS, founder and CEO of Rx Wealth Advisors in Pittsburgh. “It’s really understanding a client’s life, where they want to go, and then over time making a series of small adjustments, inputs, corrections and decisions in order to get to where the physician wants to go.”

Roe, whose company works with a significant number of physicians, has found that the education and confidence that allow physicians to be good at their jobs can sometimes lead to overconfidence in financial decisions.

“Doctors don’t wing it in providing medical care and advice,” Roe says. He advises them not to do so in their finances, either.

He recommends an approach he calls “the four Ps” for selecting an advisor: people, philosophy, process and price.

People
“The physician needs to understand the background, education and experience of the advisor. [They should ask:] Do they work with clients similar to myself? Do they have the wherewithal to provide me with the advice I need based on my specific situation?” Roe says.

He recommends choosing a professional with the certified financial analyst/professional designation (CFA or CFP) or certified professional accountant (CPA) designation. “These certifications mean that they really made a commitment to the profession and they’ve done the extra work and education. They don’t sell you solutions, they solve, advise and understand,” Roe says.

Roe compares physicians to actors in that their jobs include a high amount of education and training but take many years to get to a position of financial stability and even wealth. “Physicians can go from making a little in residency to making a lot on their first position as an attending. Advisors need to understand how to counsel them to get them over that so they don’t just start spending all their money.”

It’s also important for the advisor to understand physician career phases, says Tyler Reeves, CFP, founder of Plimsoll Financial Planning in Birmingham, Alabama. “There’s a difference between a physician in year two of attending just trying to get out of student loan debt versus a 60-year-old physician who has 30 years of experience and savings built up and [is] thinking about retirement. Those needs and situations change throughout the career trajectory of a physician.”

A good advisor will spend a significant amount of time with the client, no matter what stage of their career, says Aaron Sherman, CFP, president of Odyssey Group Wealth Advisors in Lancaster, Pennsylvania. “It’s important that the needs of a young physician don’t get swept aside, because that’s a precarious time in a physician’s financial life. They spend all this time, all this money for lots of schooling and
are carrying a large amount of debt. To make progress, you need to make sure you have somebody who can walk you through every step,” Sherman says.

A physician should expect to have a specific point person they can call and talk with, and not be handed around within a firm. “You want to have that foundational relationship that you can always fall back on,” Sherman says. Equally important is to understand your advisor’s succession plan for retirement and who will take over your account in their wake.

If trusted colleagues or family members don’t have referrals, Reeves recommends searching on professional organization websites such as National Association of Personal Financial Advisors, Alliance of Comprehensive Planners and Certified Financial Planner Board.

An advisor not only helps a physician grow their wealth, they help them protect it, says Aviva Pinto, CDFA, managing director of Wealthspire Advisors in New York City. “[Many] doctors accumulate a lot of assets, and you don’t want, when you pass away, the state and federal government getting a large chunk. You can set up charitable trusts and things such as that,” she says.

Pinto also believes solid financial advice should include the spouse and family. “I think having a financial advisor [who] will include the family in the discussions is a great thing, because if something happens you have people who know where things are and who to call,” she says.

**Philosophy**

Part of the process of finding the right advisor means exploring their and their firm’s philosophy on financial planning. Roe recommends selecting someone who has worked with physicians but also making sure that their process works for the physician individually. “If the advisors says they only meet with you once a year for an hour, that might not work for a particular physician,” Roe says.

He recommends physicians ask about the philosophy up front. “Ask them to tell you how they invest client money,” Roe says.

**Process**

If a physician thinks they’ve found a good fit, Roe says the advisor should walk the physician through a very specific process. “In other words, what is the introductory phase like, and what happens after onboarding, on an annual basis? What kinds of services are provided to the physician and does the advisor address one-off issues?” he says.

Roe’s firm follows a four-step process:

1. **Make an initial assessment** to get a baseline of financial health.
2. **Collect more information and learn about specific risks to the physician to protect against them.**
3. **Address long-term investment goals.**
4. **Look to enhancements to build more wealth and plan for retirement. Consider legacy planning, such as philanthropy and estate planning.**

“Throughout the process, the advisor should be making the intangible tangible to the physician, so the doctor gets a real clear vision of what they can expect, and more importantly, what they can’t expect,” Roe says.

If an advisor isn’t asking about the physician’s goals, it’s a good idea to find another advisor, Sherman says. “The entire financial process has to start with the client’s goals. [The advisor has]...”
to understand what the physician is trying to accomplish and what their priorities are before they can consider looking at the investment side of things,” he says. The time to start the process with an advisor is not toward the end of one’s career, Sherman says, but before significant assets have accumulated. “If you do it correctly, then those assets will accumulate more and you’ll be in a position when getting ready to retire that you’re not going to have to put much thought into it because you’ve been preparing all your life for it,” he says.

**Price/fees**
The best relationship and the smoothest process are not going to be useful, however, if the cost is too high.

“A good thing to ask is, ‘How do you get paid?’ And then, ‘How much would I pay, to the dollar amount, and how much would you expect my fee to change over time?’” Reeves says.

There are several ways that financial advisors get paid, according to Pinto.

**Commission-based**
Financial planners charge clients a fee whenever they buy or sell stocks (or other investments). Pinto warns, “They may be motivated by the purchase or sale of assets that may not be congruent with your goals. However, if you are looking for advice on a single transaction, this might be a good option.” For example, if you are interested in buying and holding a single mutual fund for the long term and don’t need ongoing advice, a commission-based advisor may be the cheapest option.

**Flat-fee**
Financial planners charge their clients for services on a per-use basis. They may charge a one-time fee to create a financial plan but also try to sell products for a commission or try to recruit you as a fee-based client. “If you are simply looking for a one-time plan to answer some of your questions about your financial future and do not require ongoing advice, a flat-fee advisor may be a good option,” Pinto says.

**Fee only**
These advisors charge clients through hourly rates or based on a percentage of the assets they manage. Although these advisors offer financial planning services, they are typically looking for long-term partnerships with their clients. “The advantage of fee-only financial advisors is that they do their best to coordinate your assets to create a comprehensive plan for you, which is reviewed regularly and revised as changes in your life come up,” Pinto says.

“You want to have a clear sense of what the advisor’s duty is to the client,” Sherman says. “We operate as fiduciaries for our clients. We are legally obligated to put our clients’ best interests first. There are other ways of operating where there’s a lower standard of care where somebody could recommend one investment over another if they get paid more for what they’re recommending.”

Roe says that advisors selling financial products are not inherently bad or good, but “physicians have to ask themselves: ‘Are they selling me this product because it’s in my best interests or theirs?’” He says to be wary of “shiny objects,” such as when an advisor promises an easy or fast way to create wealth or save money.

“There’s never a one-size-fits-all answer for price. It really comes down to the physician, the philosophy, the firm and what they’re providing to the physician,” Roe says.

The experts agree that physicians need to do their research, ask strategic questions, and look for advisors who put the needs and goals of the client ahead of any fees or commissions. »
<table>
<thead>
<tr>
<th>Advisor name</th>
<th>Firm</th>
<th>City and contact Info</th>
<th>Company primary business</th>
<th>Years of experience</th>
<th>Minimum portfolio</th>
<th>Fee structure</th>
<th>Total assets managed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mickey Abeshaus, MD, CFP®</td>
<td>TCI WEALTH ADVISORS</td>
<td>Flagstaff • 928-226-0868 <a href="mailto:mickey.abeshaus@tciwealth.com">mickey.abeshaus@tciwealth.com</a> tciwealth.com</td>
<td>Financial Advisor</td>
<td>13</td>
<td>Flexible</td>
<td>Fee Only</td>
<td>$3.1B</td>
</tr>
<tr>
<td>Kyle Larson, CFP®</td>
<td>TCI WEALTH ADVISORS</td>
<td>Phoenix • 480-991-0401 <a href="mailto:kyle.larson@tciwealth.com">kyle.larson@tciwealth.com</a> tciwealth.com</td>
<td>Financial Advisor</td>
<td>7</td>
<td>Flexible</td>
<td>Fee Only</td>
<td>$3.1B</td>
</tr>
<tr>
<td>John Stephens, MD, CFA, CFP®, MBA</td>
<td>TCI WEALTH ADVISORS</td>
<td>Tucson • 520-733-1477 <a href="mailto:john.stephens@tciwealth.com">john.stephens@tciwealth.com</a> tciwealth.com</td>
<td>Financial Advisor</td>
<td>22</td>
<td>Flexible</td>
<td>Fee Only</td>
<td>$3.1B</td>
</tr>
</tbody>
</table>

**ARIZONA**

**CONNECTICUT**

<table>
<thead>
<tr>
<th>Advisor name</th>
<th>Firm</th>
<th>City and contact Info</th>
<th>Company primary business</th>
<th>Years of experience</th>
<th>Minimum portfolio</th>
<th>Fee structure</th>
<th>Total assets managed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leigh E. King, CFP®, CLU®, APMA®</td>
<td>King, Prell &amp; Associates, a private wealth advisory practice of Ameriprise Financial Services, LLC</td>
<td>Simsbury • 860-651-5969 <a href="mailto:Leigh.e.king@ampf.com">Leigh.e.king@ampf.com</a> KingPrell.com</td>
<td>Financial Advisor</td>
<td>30</td>
<td>No Minimum</td>
<td>Fee Based</td>
<td>$200M</td>
</tr>
<tr>
<td>David J. Lincoln, MSFS, ChFC, CLU, RICP, CFP®</td>
<td>Monoce Advisors</td>
<td>Fairfield • 203-319-3550 <a href="mailto:david.lincoln@ipl.com">david.lincoln@ipl.com</a> <a href="https://www.monceceadvisors.com/">https://www.monceceadvisors.com/</a></td>
<td>Financial Advisor</td>
<td>45</td>
<td>Flexible</td>
<td>Fee Based</td>
<td>$151M</td>
</tr>
</tbody>
</table>

**DELAWARE**

<table>
<thead>
<tr>
<th>Advisor name</th>
<th>Firm</th>
<th>City and contact Info</th>
<th>Company primary business</th>
<th>Years of experience</th>
<th>Minimum portfolio</th>
<th>Fee structure</th>
<th>Total assets managed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christopher Burgos, CFP®, ChFC®, CFS, AIF®</td>
<td>Diamond State Financial Group</td>
<td>Newark • 302-366-0366 <a href="mailto:christopher.burgos@ddefg.com">christopher.burgos@ddefg.com</a> <a href="http://www.ddefg.com">www.ddefg.com</a></td>
<td>Financial Advisor</td>
<td>21</td>
<td>$500k</td>
<td>Fee Based</td>
<td>$1B</td>
</tr>
</tbody>
</table>

**FLORIDA**

<table>
<thead>
<tr>
<th>Advisor name</th>
<th>Firm</th>
<th>City and contact Info</th>
<th>Company primary business</th>
<th>Years of experience</th>
<th>Minimum portfolio</th>
<th>Fee structure</th>
<th>Total assets managed</th>
</tr>
</thead>
<tbody>
<tr>
<td>W. Shane Hunt</td>
<td>Caduceus Consulting</td>
<td>Ponte Vedra Beach • 904-524-5907 <a href="mailto:shane@caduceusconsulting.com">shane@caduceusconsulting.com</a> <a href="http://www.caduceusconsulting.com">www.caduceusconsulting.com</a></td>
<td>Financial Advisor</td>
<td>26</td>
<td>$1M</td>
<td>Fee Based</td>
<td>N/A undisclosed</td>
</tr>
<tr>
<td>Elliot Sokalsky</td>
<td>Doctors Asset Group</td>
<td>Fort Myers • 610-217-5077 <a href="mailto:Esokalsky@dfg.com">Esokalsky@dfg.com</a> <a href="http://www.doctorsassetgroup.com">www.doctorsassetgroup.com</a></td>
<td>Financial Advisor</td>
<td>16</td>
<td>Flexible</td>
<td>Commission Based</td>
<td>N/A undisclosed</td>
</tr>
</tbody>
</table>

**GEORGIA**

<table>
<thead>
<tr>
<th>Advisor name</th>
<th>Firm</th>
<th>City and contact Info</th>
<th>Company primary business</th>
<th>Years of experience</th>
<th>Minimum portfolio</th>
<th>Fee structure</th>
<th>Total assets managed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julianne F. Andrews</td>
<td>Atlanta Financial Associates</td>
<td>Atlanta • 770-261-5385 <a href="mailto:jandrews@atlantafinancial.com">jandrews@atlantafinancial.com</a> <a href="http://www.atlantafinancial.com">www.atlantafinancial.com</a></td>
<td>Financial Advisor</td>
<td>32</td>
<td>$500k</td>
<td>Fee Based</td>
<td>$850M</td>
</tr>
</tbody>
</table>

**KENTUCKY**

<table>
<thead>
<tr>
<th>Advisor name</th>
<th>Firm</th>
<th>City and contact Info</th>
<th>Company primary business</th>
<th>Years of experience</th>
<th>Minimum portfolio</th>
<th>Fee structure</th>
<th>Total assets managed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jennifer Quire</td>
<td>Wrenne Financial Planning</td>
<td>Lexington • 859-538-6044 <a href="mailto:jen@wrennefinancial.com">jen@wrennefinancial.com</a> <a href="https://wrennefinancial.com/our-team/">https://wrennefinancial.com/our-team/</a></td>
<td>Financial Advisor</td>
<td>13</td>
<td>No Minimum</td>
<td>Fee Only</td>
<td>$40M</td>
</tr>
</tbody>
</table>

**LOUISIANA**

<table>
<thead>
<tr>
<th>Advisor name</th>
<th>Firm</th>
<th>City and contact Info</th>
<th>Company primary business</th>
<th>Years of experience</th>
<th>Minimum portfolio</th>
<th>Fee structure</th>
<th>Total assets managed</th>
</tr>
</thead>
<tbody>
<tr>
<td>T. Craig Lewis, III CPA, CFP®</td>
<td>Lewis Financial Group, L.C.</td>
<td>Shreveport • 318-797-0447 <a href="mailto:craiglewis@lewismfinancialgroup.com">craiglewis@lewismfinancialgroup.com</a> <a href="http://www.lewisfinancialgroup.com">www.lewisfinancialgroup.com</a></td>
<td>Financial Advisor</td>
<td>47</td>
<td>$250k</td>
<td>Fee Based</td>
<td>$50M</td>
</tr>
</tbody>
</table>

**MARYLAND**

<table>
<thead>
<tr>
<th>Advisor name</th>
<th>Firm</th>
<th>City and contact Info</th>
<th>Company primary business</th>
<th>Years of experience</th>
<th>Minimum portfolio</th>
<th>Fee structure</th>
<th>Total assets managed</th>
</tr>
</thead>
</table>
## Financial Advisor Guide for Physicians

<table>
<thead>
<tr>
<th>Advisor Name</th>
<th>Firm</th>
<th>City and Contact Info</th>
<th>Company Primary Business</th>
<th>Years of Experience</th>
<th>Minimum Portfolio</th>
<th>Fee Structure</th>
<th>Total Assets Managed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Michigan</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charles Zhang</td>
<td>ZHANG FINANCIAL</td>
<td>Portage • 349-395-5888 <a href="mailto:charles.zhang@zhangfinancial.com">charles.zhang@zhangfinancial.com</a></td>
<td>Financial Advisor</td>
<td>30</td>
<td>$1M</td>
<td>Fee Only</td>
<td>$4B</td>
</tr>
<tr>
<td>Ben Kirchner</td>
<td>MD Financial Advisors</td>
<td>Chanhassen • 888-256-6855 <a href="mailto:ben@mdfinancialadvisors.com">ben@mdfinancialadvisors.com</a></td>
<td>Financial Advisor</td>
<td>8</td>
<td>No Minimum</td>
<td>Fee Based</td>
<td>$115M</td>
</tr>
<tr>
<td>Josh Lantz</td>
<td>MD Financial Advisors</td>
<td>Chanhassen • 888-256-6855 <a href="mailto:josh@mdfinancialadvisors.com">josh@mdfinancialadvisors.com</a></td>
<td>Financial Advisor</td>
<td>11</td>
<td>No Minimum</td>
<td>Fee Based</td>
<td>$115M</td>
</tr>
<tr>
<td>Matt Morehead</td>
<td>CARLSON CAPITAL MANAGEMENT</td>
<td>Rochester • 507-206-2811 <a href="mailto:matt.morehead@carlsoncap.com">matt.morehead@carlsoncap.com</a></td>
<td>Financial Advisor</td>
<td>15</td>
<td>$1M</td>
<td>Fee Based</td>
<td>$2.3B (the firm)</td>
</tr>
<tr>
<td>Katherine Vessenes</td>
<td>MD Financial Advisors</td>
<td>Chanhassen • 888-256-6855 <a href="mailto:katherine@mdfinancialadvisors.com">katherine@mdfinancialadvisors.com</a></td>
<td>Financial Advisor</td>
<td>30</td>
<td>Flexible</td>
<td>Fee Based</td>
<td>$115M</td>
</tr>
<tr>
<td><strong>Minnesota</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ronald W. Rogé</td>
<td>30-Year R.K. Reger &amp; Company</td>
<td>Bohemia • 631-218-0077 <a href="mailto:info@rwroge.com">info@rwroge.com</a></td>
<td>Financial Advisor</td>
<td>35</td>
<td>$1M</td>
<td>Fee Only</td>
<td>$300M</td>
</tr>
<tr>
<td>Marian B White, CFP® AIF®</td>
<td>BIRCHFIELD PARTNERS</td>
<td>Tarrytown • 914-882-4974 <a href="mailto:mwhite@birchfieldllc.com">mwhite@birchfieldllc.com</a></td>
<td>Financial Advisor</td>
<td>30</td>
<td>Flexible</td>
<td>Fee Only</td>
<td>$46M</td>
</tr>
<tr>
<td>Damon G. Lichtenberger</td>
<td>NORTH STAR RESOURCE GROUP</td>
<td>Durham • 919-908-2457 <a href="mailto:damon@northstarfinancial.com">damon@northstarfinancial.com</a></td>
<td>Financial Advisor</td>
<td>18</td>
<td>Flexible</td>
<td>Fee Based</td>
<td>$100M</td>
</tr>
<tr>
<td><strong>Ohio</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kevin M. Doll, MS, CFP®</td>
<td>Hamilton Capital</td>
<td>Columbus • 614-545-4009 <a href="mailto:kmd@hamiltoncapital.com">kmd@hamiltoncapital.com</a></td>
<td>Financial Advisor</td>
<td>20</td>
<td>Flexible</td>
<td>Fee Only</td>
<td>$3B</td>
</tr>
<tr>
<td>Michael P. Faieta, CFP®</td>
<td>Hamilton Capital</td>
<td>Columbus • 614-545-4011 <a href="mailto:mpf@hamiltoncapital.com">mpf@hamiltoncapital.com</a></td>
<td>Financial Advisor</td>
<td>23</td>
<td>Flexible</td>
<td>Fee Only</td>
<td>$3B</td>
</tr>
<tr>
<td>Peter S. Geldis, MBA, CFP®</td>
<td>Hamilton Capital</td>
<td>Columbus • 614-545-4017 <a href="mailto:pg@hamiltoncapital.com">pg@hamiltoncapital.com</a></td>
<td>Financial Advisor</td>
<td>15</td>
<td>Flexible</td>
<td>Fee Only</td>
<td>$3B</td>
</tr>
<tr>
<td><strong>Pennsylvania</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donald L. DeMuth</td>
<td>Mighty Oak Strong</td>
<td>Mechanicsburg • 717-790-9001 <a href="mailto:ddemuth@investwithmsaic.com">ddemuth@investwithmsaic.com</a></td>
<td>Financial Advisor</td>
<td>19</td>
<td>$100K</td>
<td>Fee Only</td>
<td>$261M</td>
</tr>
<tr>
<td>Chad Chubb, CFP, CSLP</td>
<td>WEALTHKEELE LLC</td>
<td>Philadelphia • 267-590-9533 <a href="mailto:chadbubb@wealthkeel.com">chadbubb@wealthkeel.com</a></td>
<td>Financial Advisor</td>
<td>10</td>
<td>No Minimum</td>
<td>Fee Only</td>
<td>$30M</td>
</tr>
</tbody>
</table>
## Financial Advisor Guide for Physicians

### TCI Wealth Advisors

TCI Wealth Advisors is an independent, fee-only wealth advisory firm with an uncompromising commitment to helping clients balance wealth and well-being.

**Find more financial content at:**
www.medicaleconomics.com/physicians-money-digest

---

### PENNSYLVANIA

<table>
<thead>
<tr>
<th>Advisor name</th>
<th>Firm</th>
<th>City and contact Info</th>
<th>Company primary business</th>
<th>Years of experience</th>
<th>Minimum portfolio</th>
<th>Fee structure</th>
<th>Total assets managed</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Sklencar</td>
<td>Physicians Private Client Group</td>
<td>Plymouth Meeting • 610-940-1733 <a href="mailto:info@PhysiciansWealthAdvisor.com">info@PhysiciansWealthAdvisor.com</a> <a href="http://www.PhysiciansWealthAdvisor.com">www.PhysiciansWealthAdvisor.com</a></td>
<td>Financial Planning, Retirement Plans &amp; Employee Benefits</td>
<td>30</td>
<td>Flexible</td>
<td>Fee Based</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### TENNESSEE

<table>
<thead>
<tr>
<th>Advisor name</th>
<th>Firm</th>
<th>City and contact Info</th>
<th>Company primary business</th>
<th>Years of experience</th>
<th>Minimum portfolio</th>
<th>Fee structure</th>
<th>Total assets managed</th>
</tr>
</thead>
<tbody>
<tr>
<td>William B. Howard, Jr., CFP®</td>
<td>William Howard &amp; Co.</td>
<td>Memphis • 901-761-5068 <a href="mailto:whoward@whcfa.com">whoward@whcfa.com</a> <a href="http://www.whcfa.com">www.whcfa.com</a></td>
<td>Financial Advisor</td>
<td>42</td>
<td>$500k</td>
<td>Fee Only</td>
<td>$240M</td>
</tr>
</tbody>
</table>

### TEXAS

<table>
<thead>
<tr>
<th>Advisor name</th>
<th>Firm</th>
<th>City and contact Info</th>
<th>Company primary business</th>
<th>Years of experience</th>
<th>Minimum portfolio</th>
<th>Fee structure</th>
<th>Total assets managed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katie Brewer, CFP®</td>
<td>Your Richest Life</td>
<td>Dallas area or Virtual across the US 469-708-7975 • <a href="mailto:info@YourRichestLifePlanning.com">info@YourRichestLifePlanning.com</a> <a href="https://YourRichestLifePlanning.com">https://YourRichestLifePlanning.com</a></td>
<td>Financial Advisor</td>
<td>15</td>
<td>Flexible</td>
<td>Fee Only</td>
<td>$10M</td>
</tr>
<tr>
<td>Bryce R. Danley, CFP®</td>
<td>Danley &amp; Associates, A private wealth advisory practice of Ameriprise Financial Services, LLC</td>
<td>Fort Worth • 817-210-0209 <a href="mailto:bryce.r.danley@ampf.com">bryce.r.danley@ampf.com</a> <a href="https://www.ameripriseadvisors.com/">https://www.ameripriseadvisors.com/</a> team/danley/associates/</td>
<td>Financial Advisor</td>
<td>24</td>
<td>No Minimum</td>
<td>Fee Based</td>
<td>$400M</td>
</tr>
<tr>
<td>Adam Todd, CFP</td>
<td>FMP Wealth Advisers</td>
<td>Austin • 512-329-5174 <a href="mailto:mail@FMPWA.com">mail@FMPWA.com</a> <a href="http://www.fmpwa.com">www.fmpwa.com</a></td>
<td>Financial Advisor</td>
<td>24</td>
<td>$1M</td>
<td>Fee Only</td>
<td>$809M</td>
</tr>
</tbody>
</table>

---

---

Let’s talk money

Curated content to achieve personal financial success

**Physician’s Money Digest**

Find more financial content at:
www.medicaleconomics.com/physicians-money-digest

---

Why a Family Chief Financial Officer may be just what the doctor ordered.

TCI Wealth Advisors is an independent, fee-only wealth advisory firm with an uncompromising commitment to helping clients balance wealth and well-being.

Tciwealth.com/financial-planning-for-doctors
John J. Stephens, MD MBA CFA CFP®
John.Stephens@tciiwealth.com
(877) 733-1859

---

Medical Economics.com

---

MAY 2021 | MEDICAL ECONOMICS
How can a successful physician create a work-life balance while dealing with countless demands from patients, employees and physician groups? How can physicians create financial independence, wealth and prosperity without working 15 hours a day, doing multiple jobs or offering additional products, services and treatments? Every investor has one goal: wealth creation. To achieve it, real estate is your best bet.

The overall process is quite simple. If you acquire a rental property by putting up a small amount of money as your down payment and the bank puts up the rest, then the rental income from the property should provide net cash flow that pays for all related expenses. You will own a valuable piece of real estate that will appreciate in value over time, and the senior debt will be reduced through your principal payments.

This concept is so straightforward that we can summarize it in a simple formula:

\[
\text{principal reduction} + \frac{\text{property value appreciation}}{\text{long-term wealth creation}}
\]

Here’s something else to keep in mind: Each year, rental rates tend to go up by approximately 2% to 3%, depending on inflation, supply and demand, etc. So, your property’s value is likely to increase each year because of the expanding net cash flow.

Now, the exciting thing is that by year five you will typically find that your equity has more than doubled (equity is the difference between the property’s value and the mortgage balance you owe the banks).

If you’re wondering why the value of your investment will increase that quickly, it is because as your property’s value rises, the balance on your mortgage is reduced by the rental income covering the interest and principal.

Another attractive benefit to real estate investing is that it can provide an ever-rising income without extra work from you. In other words, hire professionals to manage the property, collect rent, pay bills, etc. This form of income is attractive because it doesn’t keep you from practicing medicine. The money keeps rolling in.

Real estate is not subject to vagaries, emotions and political whims

There are many ways to build a passive income source. Some people invest in the stock market, Treasury bills or automated businesses. Others may lease or license intellectual property, and still others create online businesses. These are all great strategies.

However, as a medical practitioner who is probably very busy helping patients, it is vital that you choose investment options that don’t demand too much active participation. In my experience, there are very few available passive-income opportunities that allow your income to increase over time the way real estate does. Rents generally go up to keep pace with inflation, and in particularly bullish economic
times or because of other macroeconomic and supply-and-demand factors, rental income can even double in a short time.

I don’t invest in cars, antiques, art or collectibles. I do invest in stocks, commodities and bonds, but I feel as though I am always playing at a disadvantage. Larger investors with wealth managers and investment bankers have access to far more information and investment opportunities not available to regular investors. As an equity investor, you must be smart, well-diversified and strategic.

**The pros and cons of real estate investing**

As with most other investment opportunities, real estate investing is risky. The primary risk attached to real estate investing is that there are no guarantees.

General market risk are factors such as the rise and fall of the general economy, fluctuating interest rates, recessions in correlated markets, natural disasters and other factors that are out of your control. The only way to guard against total annihilation is to hedge your bets by diversifying your portfolio holdings. Do not put all your investment eggs into one real estate basket.

Asset level risk has more to do with the sensitivity of consumer demand associated with a certain property type. The demand for hospitality, retail and office space has been adversely affected due to COVID-19. However, properties that have stable demand all year have little risk. For instance, multifamily residential properties are usually in demand, even during bad economic times, making their risk significantly lower.

Liquidity risk is another form of risk peculiar to real estate. Finding buyers is not always easy, especially during market downturns, and most often it takes experienced brokers and real estate agents to find willing buyers during such times. So, any investment in real estate should have a longer-term investment horizon.

When you borrow money from a bank to finance the purchase of real estate, you are leveraging. A lot of leverage can magnify your returns, but it can also be risky. If you allow yourself to get into over your head with debt, you risk losing your initial investment and heading into an unending cycle of debt.

Remember, you do not have to keep working hard, paying huge taxes and letting what you have left in the bank doing nothing. That is a risky way of operating that could set you back financially in a few decades to come. It is a lot safer to park your money in real estate, where it will allow you to build wealth and retire comfortably.

If you diligently apply this knowledge, you could one day retire with a seven- or eight-figure net worth, or perhaps more. Who would not want a luxury like that?

**Masaki Oishi, M.D., Ph.D.** is a neurosurgeon who earned his medical degree from Cornell University Medical College in Ithaca, New York, and his doctoral degree in molecular and cellular neuroscience from The Rockefeller University in New York City. Oishi is the co-founder and chairman of MarketSpace Capital, to which he brings a wealth of experience in commercial real estate, having successfully invested and sold more than a quarter of a billion dollars in commercial properties over the past 30 years.

“As a medical practitioner who is probably very busy helping patients, it is vital that you choose investment options that don’t demand too much active participation.”
Permission denied

Why prior authorizations aren’t going away

by Todd Shryock  Managing Editor

Need a mortgage approved to buy a $400,000 house in less than an hour? Done. Want specialty pet food delivered to your door by tomorrow? No problem. Moving money between accounts at a bank? Instantaneous.

Need your patient to switch from Coumadin to Lovenox because they have surgery in three days? Sorry, there’s no way the prior authorization will be approved in time. Just have the patient reschedule and put their health at risk.

Physicians continue to wonder how we can live in a world where so many transactions are handled quickly with technology, yet decisions that affect patient health are slowed by faxes and bureaucracy, even when there is only one clear treatment option.

Why in 2021 is medicine moving at the speed of fax? Where is the progress?

In 2018, a consensus group made up of all the major medical associations and America’s Health Insurance Plans (AHIP), the industry trade group for payers, agreed on several principles on how prior authorizations should be handled and improved.

“We’ve been measuring progress against those principles, and it’s been slow at best,” says Anders Gilberg, senior vice president, government affairs, at Medical Group Management Association (MGMA). “2020 is a bit of an anomaly, but overall, there has not been significant movement toward simplifying things with the health plans as outlined in documents.”

Among the goals the group agreed to was establishing a national standard for how prior authorizations are handled and transmitted, a transparent list of services that require them, and a review of need when more than 90% of authorizations are approved.

CAQH, a nonprofit alliance focused on streamlining health care, tracks the progress of electronic prior authorizations. April Todd, a CAQH senior vice president, says that prior authorizations have the lowest electronic adoption rate of any transaction in the health care field, but there are some signs of improvement. In 2019, the most recent year studied, electronic prior authorizations increased from 13% to 21%. “We are seeing some improvement, but it is still the lowest in the industry,” Todd says.

Richard Bryce, D.O., a family medicine physician and chief medical officer for the CHASS Community Health and Social Services Center in Detroit, says he has seen some improvement in the prior authorization process in recent years, mainly in the use of computer-submitted data, but that there is still a long way to go.

“The potential for doing something online is definitely an improvement, but we’re just still running into the same problem: how do you determine what’s covered and what’s not?” Bryce says. “The problem with a lot of insurance companies is they change what’s on their formularies, and one day the insulin NovoLog is covered and then next day it changes to...
Humalog, and now the patient has to switch and it’s very confusing. And if you want to keep them on the same one, you have to put in the prior authorization, and the insurance company wants them to try the other one first.”

Bryce says the biggest drawback to not knowing immediately to what drugs are approved is when he has given a patient detailed instructions for a specific drug, but then the pharmacy tells the patient it’s not covered. This starts a long cycle of the patient having to call the office, a new prescription being written, new instructions given and the patient returning to the pharmacy.

“Now you’ve wasted a week or two figuring this process out when a patient needed the medication to take care of their ailment,” Bryce says. “The process should be easier.”

Why is prior authorization so difficult?
The reasons why prior authorizations are so frustrating to physicians are varied, but the lack of a unified technology standard is a major obstacle to fixing the problem.

“Health care vendors are the intermediaries that help exchange information between plans and providers, and they’ve been reluctant to put solutions in place because a federal standard for exchanging that information has not been set by CMS (Centers for Medicare & Medicaid Services) yet,” Todd says.

Companies are leery of investing a lot of money in a product that might be rendered worthless overnight if a federal standard emerges that is different than what they created.

At the end of 2020, CMS released a rule that attempted to standardize some aspects of the prior authorization process. But the rule was rushed, excluded large swaths of insured patients and was widely panned by physician groups, hospitals and insurers.

“What a missed opportunity this was,” Gilberg says. “If you are trying to move the dial on some degree of standardization, you can’t choose a handful of plans and not have them apply to bigger actors.” The Biden administration is reviewing the rule and the pandemic is likely to slow any progress, but Gilberg says he is hopeful for congressional support for future prior authorization standardization.

Without standardization, health care vendors are left either implementing their own standards, which won’t necessarily interface with other vendors or health systems, or waiting until a national standard is put in place.

Todd says that portals illustrate the problem. Portals are great for getting information into electronic form, but providers might have to log into 30 or 40 different ones to get information into electronic form, but providers might have to log into 30 or 40 different ones to exchange information.

“That’s an increased burden for providers,” Todd says. “Even when CMS comes out with a standard, there still needs to be encouragement for the entire industry to adopt

Better Ways to Play the Prior Authorization Game

by Linda Girgis, M.D. Contributing Author

There is nothing more frustrating to physicians than knowing a patient needs a certain diagnostic test or medication and having them not be able to get it because their health insurance company won’t cover it. All too often, many services require prior authorization (PA).

It wouldn’t be so bad if the insurance companies made the guidelines they use to make these determinations readily apparent to those practicing medicine. However, these guidelines are created by the insurance company (with a main goal being cost containment rather than evidence-based medicine), unavailable to treating clinicians, and often they use decades-old recommendations. We are often left to predict the insurance company’s decision.

Many of us feel that it is like playing an epic game where we try to give our best care to our patients, while the insurance companies deny as many

**Continues on Page 18**
MONEY / PRIOR AUTHORIZATIONS

it, and that often takes a number of years to do that.”

Ultimately though, it’s up to payers whether to adopt any standards or to accept electronic prior authorizations using either third-party software or their own platform.

AHIP put together its Fast PATH initiative, a demonstration project that illustrates the efficiencies and potential cost savings a totally electronic solution can offer payers.

“From the request time to the answer, it’s much, much, much faster,” says Kate Berry, AHIP’s senior vice president, clinical affairs and strategic partnerships. “That’s good news for the provider, the patient and the health plan ... Everybody is happy when a process using phone calls and faxes that can take days can now take seconds or a few hours to get an answer.”

But the project isn’t a required component for members; it’s just a way for AHIP to show how they could proceed in the future.

Berry says information about prior authorizations that physicians want is often already available through electronic health records (EHRs), especially on the prescribing side, yet not all physicians are using it.

“From the request time to the answer, it’s much, much, much faster,” says Kate Berry, AHIP’s senior vice president, clinical affairs and strategic partnerships. “That’s good news for the provider, the patient and the health plan ... Everybody is happy when a process using phone calls and faxes that can take days can now take seconds or a few hours to get an answer.”

But the project isn’t a required component for members; it’s just a way for AHIP to show how they could proceed in the future.

Berry says information about prior authorizations that physicians want is often already available through electronic health records (EHRs), especially on the prescribing side, yet not all physicians are using it.

“There should be support for providers to adopt that, because a lot of health plans have already invested in making their data on what services are subject to prior authorization tests as possible to increase their profits. The loser of this game is not the one who was able to get the least amount of services covered or earned the least money. Rather, it is the patient: delayed diagnoses/treatment, denied tests, forced to use less effective medications based on formularies developed by insurance companies using their own guidelines, and footing increased costs.

How can this prior-authorization game be played for better odds of winning?

**Whoever does the PA needs to have the progress notes in front of them.**

They will be asked clinical data and it should be at their fingertips.

**Know what needs to be documented in the chart.**

For example, I had a patient with knee pain who I suspected a torn ligament in the knee. When talking to the rep to get prior-authorization for an MRI, I told her the patient had a positive drawer sign. She never heard of this before and because I didn’t record the results of the Lachman test in the note, she could not approve the MRI. She didn’t know what this test was (I asked) either, but it was a checkmark on her decision tree. I record them all.

**If something is abnormal, stop and document.**

Jot a quick note to yourself or type in the abnormal exam into the computer. It only takes a moment and improves the likelihood that you will accurately capture the exam.

**Learn what is needed to get an approval.**

One example is that with certain insurance companies, every time I order an MRI of the lower back, they want the patient to have had a plain X-ray first. Why? There is no evidence that X-rays are a good test to diagnose back problems. If I am looking for a herniated disc, a plain X-ray will not show it but rather an MRI is needed. I know this but sometimes the only way to get the patient to get the test is to do it anyway.

**Don’t give up.**

If a test is denied, appeal it and keep appealing it. I find that this is not often successful but sometimes is. Plus, the insurance company should not be given an easy pass for refusing to cover something a patient needs.

**Get the patient involved.**

They should be contacting their insurance company as well. They will be talking to member services and sometimes they find a sympathetic ear who helps them get coverage or reveals the holy grail of coverage determination to them. They are often successful when we are not.

**Remember human resources.**

If a patient works at a company that has a HR department, have the patient get them involved. Insurance companies do not want to lose any covered lives so if they find a company is unhappy with the services provided, this can be a very effective weapon.

**Ask for the medical director of the insurance company.**

Most of them were practicing medicine at some point and understand our struggles on the frontlines. If we present our medical reasoning with them, they often are able to authorize a test. »
available electronically, along with what information needs to be provided to support it,” Berry says. “You can send them the information, but if they don’t receive and use it, then we’re not getting the full benefit from it.”

Gilberg points out that the lack of a standard puts all the burden on the doctor. “Health plans send them to a third party or use their own portals,” he says. “A physician might have contracts with 20 to 30 health plans, each with their own payment rules, their own rules on how to get services and how to get things approved. Each plan has their own way of doing things, and it’s extremely burdensome.”

He says ideally every physician would be able to transmit all clinical information using their EHR via one standard for all health plans. “I’m not saying there shouldn’t be any prior authorizations, but what I am saying is that the number can be reduced if we standardized the process and didn’t have 20 different systems.”

The time spent trying to navigate health plans’ proprietary systems is time not spent with a patient, Bryce notes. “Do you want me to spend five minutes focusing on improving the patient’s health or spend it going to a website to figure out if Humalog is covered or not?” he says. “The formularies also change so often and that’s part of the frustration. Do I have to check this every single time or can I use my own experience?”

He adds that even having some way of expediting a case in a timely manner would benefit patients and physicians. “If the patient can’t get the drug, that actually can cause safety issues, and there’s no doubt the insurance company wants drugs to be safe and wants people to not have health problems because that decreases costs for them as well,” Bryce says. “But there is no way, at least that I’ve seen, that I can get a prior authorization expedited.”

Who ends up paying for improvements to the prior authorization process is an open question. If a standard is created that allows a doctor to do everything through the EHR, no one knows if it would be at an additional cost. EHR vendors tend to charge for every add-on, and the programming required for a prior authorization update is a significant investment in time and money. Even if physicians finally get a better process, experts say they may have to pay to use it, assuming their particular EHR adopts the standard.

**Who has an incentive to change the system?**

For sweeping change to happen, there needs to be an incentive for all involved. Gilberg says that private payers are reluctant because they have already invested in technology solutions of their own, so moving to a new system would be costly.

“Many plans are investing in electronic processes to make this whole process more efficient,” Berry says. “Just like we all use electronic tools every day in our routine activities, health plans are very committed to these types of technologies, and I think providers are, as well. It just takes time to fully adopt it and make it work really well.”

AHIP says that prior authorizations are necessary for patient safety and to confirm standards are being followed and the best care is being provided.

But Bryce says although part of that may be true, there is an incentive to use prior authorizations because then they won’t have to cover as many medications to save money. “I think the patients are the ones who get burdened the worst when you have to go through this process,” Bryce says. “But what’s the incentive for the plans to do it in a quicker way? I know a lot of doctors who don’t even do any prior authorizations at all because they don’t feel like it’s worth their time. And often, it can come back declined or denied.”

He hopes that the technology will create enough incentive for the health plans cost-wise that they will adopt it and reduce the burden on providers and patients.

“Money is the biggest issue or they wouldn’t be switching their formularies all the time,” Bryce says. “Why do I need to switch from Humalog to NovoLog, and one’s going to be covered and one we need a prior authorization? It can be very confusing for physicians, but if it’s confusing for us, think about how confusing it is for patients.”

If prior authorizations are about improving outcomes and saving money, then there’s a possibility that data-driven value-based care contracts could render them moot.

In value-based care, physicians are constantly measured on costs, utilization and outcomes. “Physicians are incentivized financially to not overutilize services, and if their cost profile goes up, they won’t get the incentive,” Gilberg says. “This makes prior authorizations completely redundant, and it could significantly reduce administrative costs.”

This would provide both physicians and health plans with incentives to reach the same goals, he says. At the very least, he says, health plans, which are very knowledgeable about every physician’s cost profile, should use that data to streamline the prior authorization process, regardless of the type of contract they are on.

“A doctor who has 100% of their requests approved on a regular basis shouldn’t have to go through it each time,” he says.

**Where will prior authorizations be in 5 years?**

The only thing that’s certain about the future of prior authorizations is that they aren’t going away.
“It’s really an important tool to promote patient safety, quality and more-affordable care,” AHIP’s Berry says. “But hopefully in the next five years, electronic prior authorizations will grow and make it less burdensome for everybody, and people can get safe, effective care that’s affordable without having to worry about so many phone calls and faxes.”

Todd expects the data from 2020 to probably not show much of an increase in electronic prior authorizations because of the pandemic, but she is hopeful it will really start to accelerate in the next couple of years.

“I am hoping we are at least double of where we are today in terms of adoption,” Todd says. “I’d like to say more than that and see the industry really accelerate things, but just knowing the history of how these things work, I don’t want to be too optimistic. But in five years, I’d like to see at least 50% of our prior authorizations moving electronically in close to real time.”

Gilberg says MGMA will continue to push for legislative changes to improve the situation and hopes technology will keep making it better. “With the technology available today, and hopefully we’ll have more alignment with consumers in terms of making it easier and simpler, my hope is that the next five years will be different than the previous five. We ask physicians every year what their major frustrations are, and prior authorizations keep rising to the top.”

As for Bryce, he’ll take whatever improvements to the process he can get to help his patients.

“Safety is an important thing, so having somebody reviewed through this process is good, but when it comes down to it, money is the biggest issue,” he says. “I get that’s part of how they survive, but I just hope that as we go forward we can make this process easier so that more people can get the right drugs and not have to deal with these challenges that probably shouldn’t occur, even though they still do.”
How to code lingering and late effects of COVID-19

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>POSSIBLE ICD-10-CM CODE(S) OR CODE B</th>
<th>CODE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortness of breath</td>
<td>R06.02, R06.00, R06.01</td>
<td>Shortness of breath, Dyspnea, unspecified, Orthopnea</td>
</tr>
<tr>
<td>Fatigue</td>
<td>R53.83</td>
<td>Other fatigue</td>
</tr>
<tr>
<td>Thrombosis</td>
<td>I74.0 (code block)</td>
<td>Arterial embolism and thrombosis</td>
</tr>
<tr>
<td>Dizziness</td>
<td>R42</td>
<td>Dizziness and giddiness</td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td>R41.840</td>
<td>Attention and concentration deficit</td>
</tr>
<tr>
<td>Memory loss</td>
<td>R41.3, R41.841</td>
<td>Other amnesia, Cognitive communication deficit</td>
</tr>
<tr>
<td>Hearing loss</td>
<td>H919.9 (code block)</td>
<td>Unspecified hearing loss</td>
</tr>
<tr>
<td>Visual problem</td>
<td>H53</td>
<td>Visual disturbances*</td>
</tr>
<tr>
<td>Stroke</td>
<td>K63.9</td>
<td>Cerebral infarction, unspecified</td>
</tr>
<tr>
<td>Depression</td>
<td>Code blocks</td>
<td>Major depressive disorder</td>
</tr>
<tr>
<td>F32.0 (single episode)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F33.0 (recurrent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD</td>
<td>F44.3.1 (code block)</td>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>Cough</td>
<td>R05</td>
<td>Cough</td>
</tr>
<tr>
<td>Arthralgia</td>
<td>M25.5 (code block)</td>
<td>Pain in joint</td>
</tr>
<tr>
<td>Chest pain</td>
<td>R07.1, R07.9, R07.89, R07.82, R07.2, I20.0 (code block)</td>
<td>Chest pain on breathing, Chest pain, unspecified, Other chest pain, Intercostal pain, Precordial pain, Angina pectoris</td>
</tr>
<tr>
<td>Myocardial inflammation</td>
<td>I51.4</td>
<td>Myocarditis, unspecified</td>
</tr>
<tr>
<td>Ventricular dysfunction</td>
<td>I51.9</td>
<td>Heart disease</td>
</tr>
<tr>
<td>Acute kidney injury</td>
<td>N17.9</td>
<td>Acute kidney failure, unspecified, acute kidney injury, nontraumatic</td>
</tr>
<tr>
<td>Rash</td>
<td>R21</td>
<td>Rash and other nonspecific skin eruption</td>
</tr>
<tr>
<td>Alopecia</td>
<td>L63.0 (code block)</td>
<td>Alopecia areata</td>
</tr>
<tr>
<td>Olfactory and gustatory dysfunction</td>
<td>R43.0 (code block)</td>
<td>Disturbances of smell and taste</td>
</tr>
</tbody>
</table>

Q: Is there a listing of the common late effects of COVID-19?

A: Late effects of COVID-19 comprise many conditions and symptoms. The Centers for Disease Control and Prevention (CDC) is learning about more every day. Many patients post-COVID-19 have one or more conditions and symptoms, including those listed to the left. These are general symptoms and therefore some unspecified codes are listed. If more information is known about a patient’s symptoms, more specific codes should be used.

What is not known, however, is what symptoms and complications may linger long after an initial COVID-19 infection. Early research by the CDC shows the disease attacks more than just the respiratory system, it also affects multiple organs with blood clots and inflammation.

The CDC also reports that, although older patients may have an increased risk for severe disease, young survivors, including those physically fit prior to having been infected with COVID-19, also have reported symptoms months after acute illness. The CDC is investigating how to differentiate symptoms of a prolonged course of COVID-19 illness from sequelae following resolution of the acute infection.

Some of these patients have been categorized as long haulers. Physicians may see these patients on a regular basis because the diagnoses can be frequent, long term and difficult to manage. Update these diagnoses at each visit to ensure correct coding.

 MORE ONLINE:
For the full list of codes go to the May 2021 issue on MedicalEconomics.com

Renee Dowling is a billing and coding consultant with VEI Consulting in Indianapolis, Indianapolis. Send your diagnosis coding questions to medec@mjhlisciences.com
Roth IRA strategies can save you money in retirement

by Syed Nishat, BFA Contributing Author

An internist client of mine in Pittsburgh retired recently. The theme that always comes up is how much he and his wife miss traveling. My client worked throughout his career to reduce his tax burden by contributing pre-tax funds into his retirement account.

As he nears 70, he’s concerned about the required minimum distribution (RMD), which will kick in soon. He has accumulated a large portion of his net worth in pre-tax 401(k) and individual retirement accounts (IRAs), and the reality of the hefty taxes that will be levied on his upcoming distributions is a major concern. The SECURE Act, which was passed at the end of 2019, didn’t help—it killed the stretch IRA strategy by making it mandatory that a non-spouse beneficiary exhaust an inherited IRA within 10 years after both spouses pass away.

This is a common situation for high earners such as physicians during retirement, as many in the medical field are in the highest tax bracket. In retirement, tax-free income is the ideal way to take distributions, and a Roth IRA remains one of the best ways to get that benefit.

However, high earners such as physicians may feel locked out of some tax-free withdrawal options as their high income disqualifies them from opening Roth IRA accounts.

They may be unaware of tools that could be at their disposal to get those same benefits, such as the backdoor Roth IRA and Roth IRA conversions.

So, what is a Roth IRA?
With a Roth IRA, the investor pays taxes on the money funding the account up front, unlike a traditional IRA, where the money is taxed when it is withdrawn. As long as funds are in the account, the assets grow tax-free, and future withdrawals are tax-free, as well. They tend not to be vehicles for high earners; if an investor makes too much money, they cannot use a Roth IRA.

The limit for single individuals in 2021 is $140,000, and for married couples the current limit is $208,000. Roth IRAs work well as a strategy when it seems that taxes will be higher in retirement than they are when funding the account. However, there are no age limits for contributions, and the account can be held indefinitely without the required distributions that are a feature of traditional IRAs.

Are there contribution limits in a Roth IRA?
Unlike those made to other types of accounts, contributions to a Roth IRA must be in cash rather than in assets. The annual limit amount is sometimes adjusted by the Internal Revenue Service; for 2020, the limit is $6,000 for the year. There is an exception for those over 50; those individuals can contribute up to $7,000 annually. There is no tax deduction available for Roth IRA contributions.

What are the benefits of a Roth IRA?
There are several benefits to Roth IRA accounts. Money contributed to the account can be withdrawn at any time. Investment returns taken as distributions may be taxed as income or changed an early distribution tax, so it makes sense to leave that money in the account longer. There is also no RMD requirement in Roth IRAs, as there is in a traditional IRA, and no tax on any distributions after age 59½, again unlike traditional IRA accounts, which makes them very attractive for tax-free growth and income.

If someone’s income is too high, are there other ways to contribute to a Roth IRA?
There are several ways high earners can contribute to a Roth IRA, including the 401(k) Roth IRA, a backdoor Roth IRA and a Roth IRA conversion.

What is a Roth 401(k)?
By adding a Roth IRA option to a 401(k), the hybrid product offers unique benefits. This plan allows both employers and employees to
Conversion, there is no tax on the backdoor Roth IRA. By doing a Roth IRA backdoor Roth IRA?

What are the benefits of a Roth IRA:

conversion and paying owed required from a rollover IRA.

What is a backdoor Roth IRA?

Although Roth IRAs are not usually available to high earners because of their level of income, there is a way to reap the benefits. A backdoor Roth IRA is not a type of Roth IRA but rather a strategy, and it is one of the most underused by physicians. It entails contributing money to a traditional IRA then doing a Roth IRA conversion and paying owed upfront taxes at that time. There is no income limit on a conversion of this type, so the funds are now properly established to gain the benefits of a Roth IRA.

For a larger funding amount, a married investor can make contributions for 2020 and 2021 together and then do the Roth IRA conversion, meaning $14,000 for the investor and then $14,000 for their spouse.

What are the benefits of a backdoor Roth IRA?

There are many advantages to saving with a Roth IRA. By doing a Roth IRA conversion, there is no tax on the principal. The money in the account grows tax-free and future withdrawals are tax-free, just as if the account had been a Roth IRA account all along. As traditional IRAs have no income or conversion limits, if an individual already has money sitting in an existing IRA, that also can be converted.

Here’s an example of growth in a Roth IRA: A married couple each contributes $7,000 to Roth IRAs to start, and then an additional combined $14,000 annually for the next 20 years. Considering a 7% rate of return, at the end of the 20-year period, they will have more than $668,000 from just those two Roth IRAs. When they take withdrawals, all of the income from those distributions will be tax-free.

What are the disadvantages of a backdoor Roth IRA?

One issue is the pro-rata rule if you have an existing IRA account open. In the case of converting an already existing traditional IRA account, the IRS considers the combined balance of all of the investor’s traditional IRA accounts when determining how much tax is owed on the converting funds. If, the investor has 70% pre-tax money and 30% after-tax money, that is the ratio that will determine what percentage of converted money will be taxable. No matter how much is converted or from which IRA account, 70% of the converted amount will be taxable. This pro-rata rule is applied using the investor’s total IRA balance at year end.

What is the solution for the disadvantages of the pro-rata rule?

One option could be to move traditional IRA funds to a 401(k) or other qualified employer plans, as 401(k) amounts do not count toward the balance used to determine the percentage of taxed money for the Roth IRA conversion. After this, a new traditional IRA can be opened, then that can be converted to a Roth IRA as planned. These are complicated strategies, however, and it’s best to speak to a financial adviser who will look at your full tax situation before including solutions such as these in a retirement plan.

What about a simple Roth IRA conversion?

There is no income restriction on Roth IRA conversion. If an individual already has money sitting in an existing IRA account, that can all be converted to a Roth IRA. However, taxes are a consideration when deciding if a Roth IRA conversion is a good fit for an investor. As the taxes will have to be paid up front when the traditional IRA is converted, it makes sense to analyze what the tax bill will look like at that time. Particularly for older clients, it is important to see if the amount of taxes paid will outweigh the benefits of the potential Roth IRA. An ideal situation for a conversion is when the market is down with an expected recovery.

Is a backdoor Roth IRA or ROTH conversion the best strategy for me?

Because careful planning is required to get a backdoor Roth IRA set up or to get a Roth conversion moving and to make sure it’s the best fit for your situation, it’s wise to consult with an experienced financial adviser who will take the time to do a thorough analysis of your personal situation and work with you to find the best strategies to secure your financial future.

Syed Nishat, BFA, is a partner at Wall Street Alliance Group.

Securities offered through Securities America, Inc., member FINRA/SIPC. Advisory services offered through Securities America Advisors, Inc. Wall Street Alliance Group and Securities America are separate companies. Securities America and its representatives do not provide tax or legal advice, therefore, it is important to coordinate with your tax or legal adviser regarding your specific situation.
MONEY / Q&A

Do a checkup on your debt

by Todd Shryock Managing Editor

Physicians often have to deal with medical school debt decades into their careers, and even those fortunate enough to be clear of school loans may find themselves with debts arising from lifestyle choices. If the number of loans or amount of debt has become unwieldy, debt consolidation may be an option.

Medical Economics® spoke with Chris Panebianco, chief marketing officer for Bankers Healthcare Group in Davie, Florida, about how debt consolidation works and debt-management strategies physicians should consider. This interview was edited for length and clarity.

ME: Who is a candidate for debt consolidation?

Panebianco: I think anyone is. If you’re a physician with multiple debts, if you want to simplify your monthly payments, or if you are just looking to improve your credit score — anyone in those categories is someone who should really consider debt consolidation.

ME: What is the benefit of consolidating debts? What makes the difference whether you have 10 small payments or one big one?

Panebianco: Typically, you don’t want to close them. But a lot of lenders, if you’re going for other types of loans or a mortgage, they’re looking at your debt-to-income ratio, the amount of debt you have compared with how much you make, but they also look at your credit utilization. And that’s what factors, in large part, into your FICO score. The more you can control that and open up other lines, the better your credit can be.

ME: What is the benefit of consolidating debts? What makes the difference whether you have 10 small payments or one big one?

Panebianco: The first thing I think of, with COVID-19 and all the stress of life, is managing those payments. With fewer payments, there are fewer balances and fewer due dates, with less of a chance to be late. It also helps improve your credit; paying off debt can decrease your credit utilization and actually opens you up to other opportunities. On the other side, it is a good exercise in better financial planning. You can adjust your way of life to that monthly payment and oftentimes save money. The increased cash flow will allow you to potentially have more money to work with each month.

ME: You mentioned improving your credit rating. How big of an impact is there on your rating if you close out some of those smaller accounts and consolidate them into one?

Panebianco: Typically, you don’t want to close them. But a lot of lenders, if you’re going for other types of loans or a mortgage, they’re looking at your debt-to-income ratio, the amount of debt you have compared with how much you make, but they also look at your credit utilization. And that’s what factors, in large part, into your FICO score. The more you can control that and open up other lines, the better your credit can be.

ME: If physicians want to consolidate their debts, what questions should they ask potential lenders?

Panebianco: First, what type of rate? Loans typically have a fixed or variable rate, so you want to see what that means for you and how it affects your payment. You want to see if they require personal collateral. One of the big disadvantages with many loans is that you’re signing off some of your personal assets. You also want to ask what is the repayment term? The longer the length of your loan, the higher the amount of interest [in the long run], but [with a longer loan comes a smaller monthly payment], which helps you. The other question is, will this application or loan appear on my credit report? That’s a very big question. Again, that’s what other lenders are looking for. It affects your FICO score.

ME: What is the application process??

Panebianco: It’s a very important step. Physicians are busy, you already have a lot to handle with COVID-19 with your practice and outside of the office. You want to make sure that it’s something that’s very easily obtained. And then you want to really look at what’s the process beyond that. How soon will it be processed? Typically, traditional lending tends to take longer, and there are [small business] loans, as well, which historically have taken longer. Some of the online lenders are much faster. But there are different requirements for each. You want to weigh each one of these. Then there is the approval. How quickly can I get my funds? That’s a big thing, especially if you’re trying to buy new equipment. If you’re trying to buy into a practice or anything to do with your business, speed is essential. And lastly, you want to
understand that the lender knows who you are. You want someone who’s going to take good care of you, who understands your business, who understands the challenges you face and how quickly you need capital.

**ME:** One of the things you mentioned was fixed rate versus variable rate. With interest rates so low, is that as big a decision as it used to be?

**Panebianco:** It really depends. It’s going to fluctuate based on the market conditions. With a fixed rate, you’re always going to know what the interest costs will be. It’s more predictable and you can manage that. The adjustable rates tend to move and that can have bigger consequences in your payment; the rate can adjust and you may not be prepared for that.

**ME:** Are there common mistakes doctors make with debt that ends up costing them money?

**Panebianco:** The average debt for an American is approximately $20,000 between credit cards and personal loans. When you factor in auto installment loans and mortgages, the average national debt for an American is more than $90,000. A lot of times when you dig into that debt, you see that individuals have maxed out all of their cards, they’re not paying attention to that available credit. They might have loans with multiple lenders, going from one lender to another with multiple loans for different uses. But they’re only able to make minimum payments. That’s one of the things that we see a lot of people do. They say, well, the payment that was listed on my statement was $50. But that’s the minimum payment due, and you’re not eating into the interest, you’re actually hurting yourself in the long term. Credit card companies have to put out statements that show you how long it’ll take to pay that off, and it’s a much, much longer term [if you only pay the minimum each month]. So, although it might be affordable, you can get yourself in trouble very quickly. We also commonly see that people have lost track of what expenses they have to pay on what date, and they may not have things set up for auto pay. That can get you in trouble.

**ME:** Is it ever too late in a career to tackle debt problems?

**Panebianco:** You’re never too old for that. I think finances are the same way. It only takes a few minutes to check on it each month. If you create a process, it’ll be easier going forward. It’s going to be painful, at first, but I think you’re never too old, you’re never too far into your career to go back and sit down and start at the basics. »

Check out **Medical Economics® Pulse:**

This interview was transcribed from a video interview that was recorded as part of Medical Economics® Pulse video program.

Check out more video interviews with experts at [bit.ly/MedEcVideo](http://bit.ly/MedEcVideo)
The past several issues of Medical Economics® have included many thoughtful articles about the impact of COVID-19 upon delivery of care, reimbursement and the opportunity for independent practices to work together. The post-COVID-19 moment for physicians has arrived and will remain with us for a while.

The disruption to health care was immediate and gigantic in the second quarter of 2020. The economic and medical aftereffects will likely shape the payment and delivery system for decades. The contracting implications for independent practice associations (IPAs), clinically integrated networks (CINs) and multispecialty group practices are many and just around the corner. And for the first time, much better technology is available to benefit these large and likely growing groups of doctors and their patients.

Tech-enabled health care is the collective term used for telecare, telehealth, telemedicine, digital health and e-health services. Technology, if done well, helps some patients manage their care and medications and alerts health care professionals in case of a material change in condition. But most of us don’t have many patients who fit this profile; real digital health uptake is probably a decade away.

However, doctors and their teams need tech-enablement now in order to improve the patient–doctor interaction and to assist physician workflow, which, for most, has been crippled by electronic health records (EHRs).

The rapid uptake of telemedicine and remote monitoring has begun to upend the traditional fee-for-service (FFS) business models. Also shifting are the contracting strategies that have allowed the duopoly of hospital systems and insurers to increasingly dominate the delivery of care for the past 50 years.

The cost-plus reimbursement model guaranteed that health care costs would inexorably rise, and they have, from $353 per capita in 1970 to $11,582 per capita in 2019. Some physicians, notably proceduralists, have benefited mightily. Most of the money, however, has flowed to hospital systems, insurers and consultants (more on this below).

But then the second quarter of 2020 happened. Telemedicine connectivity — voice, text, video — provided improved access for an enormous range of patients. We who deliver their care — usually quite happily — had a big “aha!” moment when we realized office overhead was suddenly greatly reduced. Likewise, patients appreciated the service. What’s not to love?

Paying for telemedicine
Prior to March 2020, hospital systems were receiving nearly $100 billion monthly in fee-for-service payments. When the pandemic struck, beds were not filled except by a relatively small number of chronically ill patients with acute compromise due to COVID-19, and payments from insurers fell by 75% to 90%. Nevertheless, insurers quietly held onto taxpayer, employer and individual premiums, even as only minimal payouts occurred. COVID-19 relief money poured in to fill the gap for hospitals.

But something big happened: reimbursement for telemedicine. This left many in the health care industry wondering what would happen if
Telemedicine had opened a very wide and new set of possibilities for medical groups to provide: (1) nearly all cognitive care remotely, (2) more timely and more frequent engagement for patients with chronic disease and (3) more primary care physician (PCP)/specialist collaboration on care plans to avoid duplicative in-person visits.

Let’s contemplate that for a moment. We have all been taught that “it’s all in the patient’s history.” Therefore, adding other tools can only mean that history taking will get better. We have learned in the past year that a majority of primary care decisions can be made during 10- to 15-minute calls or Zoom sessions. Our surgical colleagues are telling us that they have learned to use telemedicine tools for a significant percentage of office visits.

We have also learned how to deploy remote devices to monitor weight, blood pressure, heart rate and single-lead ECG. Because many patients carry a camera (on their smartphone) with them all the time, add the smart glucometer and a few other cool tools and then provide the same tool set for our nurse-practitioner and behavioral colleagues. You get the idea. Many of you have lived this in the past year.

We transformed the delivery of care, mostly for chronic care but also for acute self-limited care. We accomplished this mostly from our home offices. We never imagined saying, “Take a picture of your swollen finger” or “Reverse the camera on your phone, focus on your face, as you press in on your lower left belly and then let go really fast.”

FFS reimbursement models push approximately $900 billion annually to doctors, and doctors use approximately 75% of that for rent, personnel and other overhead costs. Those costs sometimes include purchase and maintenance of EHRs. For those in private practice, overhead includes a lot of money for consultants who help with coding and explanations of MIPS, APMs, PCMHs, PQRS, HEDIS, HCCs, etc.

**Generational opportunity**

But in this new era of remote delivery, independent physicians have a once-in-a-generation opportunity to come together. Physicians need to recognize that they drive, directly or indirectly, $4 trillion of spending. Private equity companies are now buying controlling interests in large medical groups.

What’s happening on the payer side? There is a newfound interest in providing capitated contracts to organized groups. There is a resulting immediate need for medical practices to find strength in numbers and form tight multispecialty CINs. Multispecialty groups organized as IPAs can take on risk contracts with monthly prepayment as much as 88% of the total premium.

Many of tech-oriented physicians have been forced to live with recurring technology failures over the past 20 years. The energy-sapping EHRs are the best example, but too many middleware systems — mostly decision support for care management — also cluttered the patient-doctor relationship.

Many physician-informaticists now realize that the foundational problem with medical information systems is that the core platform has always been wrong; it was designed around insurance claims and billing. As a consequence, attempts at clinically workflow have been layered into a beast of a machine. Technology innovation over the past 5 to 10 years has been limited to “tuck-in” solutions designed to fit into outdated, transaction-driven (billing and claims-centric) EHR systems.

An enormous number of physicians, who formerly thrived on the autonomy that private practice provided, became worn out by the top-down rules. Capital-constrained, the easiest route to relative freedom was to sell the practice, usually to the all-too-willing hospitals. That hasn’t worked out very well for either doctors or their patients. The enormous fee-for-service revenue decline in second quarter 2020 is now driving some physicians back to private practice, just as prepaid care is increasingly recognized as desirable, providing a focus on ambulatory management of chronic disease, as well as steady cash flow.

The awful U.S. health care experience of 2020 revealed the fundamental inadequacies of both FFS payment models and hospital-dominated systems of care. Hospital executives have long struggled with the concept of managing financial risk because they have never managed acute care services as cost centers in which an empty bed is a profitable bed.

Insurers likewise have had little incentive to reduce costs, especially as they are typically paid for administrative costs on a percentage of premium and/or volumetric basis. Under pressure from government payers and employers, insurers have typically sold value-based contracts with minimal associated risk as a small compromise to their cost-plus business models.

COVID-19 has provided the opportunity to think differently. Telemedicine engagement of patients, remote monitoring for chronic illness and, most importantly, the virtues of prepaid contracting have opened the floodgates for positive change for medical groups. Dramatically different business models are rolling out, offering partnerships with doctors...
in order to successfully manage fully delegated risk contracts.

Many of the new, growing firms, such as Bright HealthCare, Devoted Health, Aledade and Iora Health, tend to focus on Medicare Advantage Plans for IPAs. A Brooklyn, New York-based startup, Cityblock, recently raised $160 million and will focus on prepaid care for Medicaid. These are great places to start.

Meanwhile, the federal government is pushing direct contracting entities for individual primary care practices to assume risk contracts, and Medicaid accountable care organizations are proliferating. However, nearly all these new business arrangements continue to depend upon FFS payments. The concept of global capitation for IPAs for all lines of business should be on the negotiating table for all large medical groups.

Many new companies believe that independence, better patient care, lower financial risk and higher financial returns will be tied to the transition from FFS to fully prepaid models where doctors and doctor groups get paid in advance monthly, across all lines of insured business.

**The opportunity before us**

The pandemic and economic calamity have threatened assumptions about chronic disease prevention and stable cash flow. Simultaneously, 2020 provided the opportunity for fast rollout of innovative technologies that had previously barely threatened FFS business models. But then telemedicine, remote patient monitoring and even acute-care-at-home services were happily embraced by patients, doctors and care teams. These unprecedented events have accelerated an environment poised for massive structural change away from FFS and toward global-risk contracts.

Engineers are building software designed to solve for successful global risk contracting and modern clinical engagement and workflow. Initial products have been completed and a full suite of software will be available by the end of 2021. There is no need for a new EHR, but there is a great need for a thin layer of patient-driven workflow (non-claims-based care) that uses Fast Healthcare Interoperability Resources-based apps to pull requisite pieces of data — such as lab reports and prescription drug lists — from the physician’s existing EHR.

Some of us believe that doctors do not want to continue doing the data entry that has been forced upon them in order to fulfill coding and billing demands. The core innovation is to gradually replace the EHR with a “skinny” medical record system that captures the patient’s medical story and is easily accessed by doctors and their support teams. Many of us in the health information technology world expect that nearly full transformation of an IPA from fee-for-service volume to risk-based value will take five years.

With prepaid care, the imperatives for the contracted doctors are to prevent and preempt bad outcomes, coordinate care and eliminate low-value procedures and many unnecessary referrals and hospitalizations. With hospital beds in oversupply, IPAs assuming global risk will have enormous leverage to negotiate prices with hospitals.

Emerging technology platforms will allow physician groups to deliver care that is tech-enabled, consumer friendly, higher quality, less expensive and safer (mostly at-home).

Emerging software solutions must provide the following:

- Patient relationship management with simple front-end portals that embrace telemedicine; drive processes and communications between patients, doctors and teams; and automate most interactions between patients, doctors and payers.

- Easy-to-use workflow that eliminates data entry by doctors, aligns incentives among primary care and specialists to optimize health and removes systems friction that exists when patients are referred back and forth between PCPs and specialists.

- Analytics that inform doctors and their teams where clinical risk is emerging and increase focus on delivery of great outcomes for patients, employers, state governments and Centers for Medicare & Medicaid Services.

- Business software that provides multispecialty physician groups with the tools necessary to understand and manage the simultaneous assumption of clinical and financial risk.

Full risk + remote monitoring + telehealth + analytics, combined with 2020’s reveal of FFS shortcomings, has created a once-in-a-generation path for building and growing an alternative technology-enabled health care business model and delivery system. It’s time for a revolution in the delivery of medical care that can dramatically improve access and outcomes and reduce costs.

Physician groups can successfully deliver where hospital systems and insurers have failed. It is time for private practice to grow again.

John Christian Kryder, M.D., MBA, is a primary care physician and Boston-based health care information technology entrepreneur. He is the founder and CEO of New Era Medical Operations. Contact: info@docNEMO.com
Are you prepared for a disaster?

Make a plan to help keep your practice, patients and staff safe

by Keith Loria Contributing author

The past year has taught us that danger lurks in many places and the unthinkable is possible. Between the COVID-19 pandemic, California wildfires, and record number of hurricanes and tornadoes and other extreme weather that affected millions, disasters became something of the norm.

Being unprepared was a hard lesson for many physicians to learn. The pandemic proved that any practice — no matter where it is located — can be at risk.

John E. Bertini Jr., M.D., FACS, a urologist at Gulf Coast Urology in Houston, says to assume a physician practice will never endure a disaster is folly.

“Disasters happen everywhere, whether they are natural catastrophes, large-scale accidents, civil unrest or a pandemic,” he says. “Even a loss of power due to a blown transformer can derail practice operations for a period of time.”

That’s why thinking ahead about possible scenarios can help a physician and their practice better prepare instead of just reacting when the unexpected inevitably occurs.

“Working as a team to create a written disaster plan is key to this process, and it can serve two purposes,” Bertini says. “First, it can guide the practice through a disaster response, fostering order and a sense of calm. Second, it can enable readiness throughout the year because backup systems are current, contact information is up to date, and so on.”

As the COVID-19 pandemic began to unfold and executive orders mandating the immediate closure of practice sites were announced, many primary care physicians turned to their professional societies and physician organizations for assistance in developing not only a natural-disaster plan but also a business continuity/recovery plan.

Ewa Matuszewski, CEO of Michigan-based physician organization MedNetOne, says most primary care physicians and their practice teams did not have a basic emergency preparedness plan in place, nor were they aware of the four phases of an effective plan: mitigation, preparedness, response and recovery.

“Many quickly found themselves creating simple response and recovery plans for both the health care and business areas of their practices,” she says. “Today, primary care physicians have developed and tested their personal disaster preparedness, having learned that the first and most effective intervention to reduce the impact of disasters is to have a plan.”

Creating a plan

Depending on the type of practice, a physician may have to figure out how to ensure uninterrupted care. For example, if their practice provides dialysis or chemotherapy, they will want a plan that addresses how to continue treatments during the crisis.

Bertini says creating a disaster plan
“The bright spot about a disaster is that, if you manage it right, it can bring people together. ... You begin to see people in a different light. It becomes a great team-building exercise that often strengthens everyone’s ability to work with each other.”

—John E. Bertini Jr., M.D., FACS, Gulf Coast Urology, Houston

involve sitting down with staff and going through the systems and processes that support clinical care and business operations and figuring out how those would be affected by a loss of essential services such as heat, power or internet.

“It entails talking through different scenarios and deciding if and how you will keep the doors open and the lights on,” he says. “We find it valuable to include all members of the office staff in developing the plan because each person can offer things that others may have forgotten or overlooked. We also review our plan periodically to make sure it’s up-to-date and reflects the type of disasters our practice could experience.

Although every practice’s plan will be different, there are some common areas to address.

First, the plan should cover backup systems. Questions to ponder include: “How frequently should we check battery backups for phones and computers?” “How will we provide backup for electronic medical records if the power and/or internet are down?” “What about generators? Do we need them?” And if so, “Where will we get them?”

Operational considerations may relate to the answering service, vendors, payroll systems and supplies. If a practice has refrigerators with drugs in them, can the refrigerators be switched to backup power? Are there critical drugs that will spoil? These all need to be accounted for in the plan.

Supplies are another area to review. If deliveries are delayed and you haven’t thought through how to maintain adequate supplies to hold you over, you may be facing challenges that could have been prevented, Bertini says.

“How you handle this situation may depend on where you’re located and what types of disasters you typically face,” he says. “If your area has a ‘disaster season,’ such as forest fires, mudslides, tornadoes, hurricanes and so on, you’ll want to establish a different preparedness level during that season in terms of supplies and alertness.”

Hamid Abbasi, M.D., chief medical officer for Inspired Spine in Burnsville, Minnesota, recommends always knowing what supplies are on hand and how to secure supplementary supplies in case something happens to halt the supply chain.

“As part of your practice planning, help each of your staff to develop and implement business resilience plans for their families and households,” she says. “Your staff will be of limited help during a disaster recovery if they are distracted with worry about their families and homes.”

Communication concerns

Patient communication is a further consideration. When a disaster occurs, patients may be unsure whether an office remains open. Bertini experienced this with the recent winter storm in Houston.
“As things got better, people wanted to know when we were going to reopen,” he says. “Anticipating those calls — and putting staff in place to answer them — is critical to keep patients abreast of what’s happening. Using your website in these scenarios is helpful because you can update it in real time. Having those capabilities is something to think about before disaster strikes.”

The plan should also describe scenarios where a practice can reach out to patients ahead of a disaster to let them know what to expect. Bertini uses an app that is Health Insurance Portability and Accountability Act-protected to interact with patients via text, video and phone messaging.

“If we know a disaster is coming, such as a hurricane, we can look ahead at our list of patients and start calling them,” he says. “Depending on the patient’s illness severity and need for care, we prioritize those communications differently.”

**Money matters**

Physicians should have business interruption insurance, which will replace revenues lost when disaster closes their medical practice, Bertini says. Although this coverage has been the subject of controversy in the context of the pandemic, it is still important to replace revenues lost to more traditional disasters, such as fires or floods.

“From a payer perspective, you should anticipate that your billing and collection cycle may be interrupted,” Bertini says. “Payers may not grant billing and collections grace periods depending on the disaster’s size, scope and location.”

Matuszewski says practices need to review their most recent fiscal years, establish an annual budget and make it a goal to save a minimum of 4 to 7 months’ operating expenses in case there is a loss of service.

**After the event**

Once a disaster happens, physicians should touch base with their office staff. Cell phones are great for this unless the cell phone network is down. Consequently, it’s a good idea to have more than one way to reach people.

“You have to be flexible to accommodate people’s circumstances,” Bertini says. “When you talk about disaster preparedness, there is an emotional aspect to it. As a physician and an owner of a practice, you should acknowledge the importance of your employees’ mental and physical health.”

If the people and the facility are available, you should start your response and begin meeting patient needs.

Once the disaster is over, it’s important to debrief when things are fresh in your mind. Was there something you overlooked when planning ahead? What could be done differently? Based on those conversations, you can update your plan.

“The bright spot about a disaster is that, if you manage it right, it can bring people together,” Bertini says. “As you work side by side, you begin to see people in a different light. Doctors might be pushing stretchers because you’re short of people in transportation. Or you’ll discover that your receptionist has an amazing ability to prioritize and complete phone calls quickly. It becomes a great team-building exercise that often strengthens everyone’s ability to work with each other.”

---

Access Managed Services

Call or text today to learn more
(844) 527-7669
or visit us online
www.accessrpm.com

REMOTE PATIENT MONITORING

STAY CONNECTED WITH YOUR PATIENTS REMOTELY

Improve Patient Outcomes
Earn New Revenue for Your Practice
Zero Upfront Costs to Get Started
Wireless Devices for Patients
(No Smartphone or Internet Required)
As we enter the next stage of the pandemic, ISMIE continues to support and encourage healthcare professionals in their fight against COVID-19. With vaccinations more readily available, our Risk Management team has released COVID-19 vaccines: Guidance for healthcare professionals to aid medical practices steering through these extraordinary times. Read more at visit ismie.com/vaccines.
As we enter the next stage of the pandemic, ISMIE continues to support and encourage healthcare professionals in their fight against COVID-19. With vaccinations more readily available, our Risk Management team has released **COVID-19 vaccines: Guidance for healthcare professionals** to aid medical practices steering through these extraordinary times.

Read more at visit [ismie.com/vaccines](http://ismie.com/vaccines).
LEGAL

What physicians need to know about cyber liability insurance

by James F. Sweeney Contributing Author

As the threat of being hacked increases, more health care providers are purchasing cyber liability insurance to protect against data breaches or online attacks. However, many still are unfamiliar with what cyber insurance policies cover, how they work, and how much they cost.

What cyber insurance does

Cyber insurance covers losses and damages resulting from patient data being stolen, exposed, held for ransom, or improperly shared. It covers deliberate actions, such as hacking or ransomware, as well as accidents, such as the loss of a laptop containing unencrypted patient information or a coding error that accidentally exposes patient data.

A comprehensive policy covers paper records, as well as so much information is still stored in physical files.

Cyber insurance helps providers deal with the consequences of a data breach, which can range from relatively minor to catastrophic, and it covers almost any loss or expense that can be attributed to the breach. Examples include:

- Paying regulatory fines and penalties.
- Compensating for loss of income from downtime or patients who leave the practice.
- Hiring information technology (IT) experts to find and fix the breach.
- Hiring a call center to handle inquiries from patients.
- Hiring a public relations firm to deal with unwelcome publicity.
- Hiring attorneys to represent the practice in any lawsuits filed by patients (as well as any damages awarded).
- Paying a ransom to free hijacked data.

Coverage typically applies only to the data and not the computer hardware a practice uses, such as laptops, smartphones, tablets or servers, which often are covered under a general business insurance policy.

A complete policy includes first-party and third-party coverage, says Marcin Weryk, head of business development for Coalition, a cyber insurance firm.

First-party coverage pays for damages suffered by the policyholder, such as lost revenue, business interruption, IT forensics and data restoration. Third-party coverage compensates for damages caused to others by the data breach, such as the legal costs incurred from lawsuits filed by affected patients.

Practices that haven’t bought cyber insurance often have some coverage through their malpractice or general business policies, but it’s usually limited to approximately $30,000 in damages and contains exemptions, says Brandon Clarke, co-founder of Affenix, a brokerage specializing in cyber liability insurance.

Before deciding whether to purchase additional cyber insurance, physicians should know what coverage they already have, Clarke says.

How much does it cost?

The cost of a cyber insurance policy varies, depending on the carrier, the size of the practice, and the extent and amount of the coverage, experts say. The larger the practice, the greater the risk and the more a policy will cost.

The good news is that cyber insurance is less expensive than malpractice and liability insurance. A typical five-physician primary care practice should
have at least a $1 million umbrella cyber policy, Clarke says. That coverage would cost anywhere from $1,200 to $5,000 a year, he estimates.

Christine Marciano, CIPP-US, a certified information privacy professional and president of Cyber Data Risk Managers, a cyber insurance broker, recommends $1 million to $5 million in coverage for that same practice and says it would cost $1,500 to $8,000 a year. Coverage can be purchased from general insurers or companies that specialize in cyber insurance.

Some insurers will assess a practice’s cyber security practices before deciding whether to write a policy. They may recommend ways to decrease risk, such as encoding laptops and improving passwords.

**A team response**

When shopping for cyber insurance, practices should investigate exactly what help they will receive in case of a breach. Unlike a fire, managing a data breach often requires the help of a team of experts, not just a check to cover damages. Depending on the nature and size of the breach, that team may include lawyers, forensic accountants, IT experts, publicists and call center operators.

Besides the coverage itself, another benefit of cyber insurance is being able to turn over management of the crisis to a carrier with experience in data breaches. Most practices do not have the time or resources to handle it themselves, Clarke says. Once an insurer is notified by a policyholder of a breach, it assesses the situation and decides which corrective actions need to be taken to prevent further damage and deal with the aftermath. The insurer hires vendors and contractors to provide the necessary services.

For example, a lawyer would handle Health Insurance Portability and Accountability Act notification, IT specialists would locate and fix the breach and a PR firm would write the notification to patients whose data have been affected. The decision whether to pay ransomware is up to the practice, but the insurer typically recommends a course of action and handles any payment, if one is made.

**EHRs and partners**

Patient data are exchanged between practices, insurers, hospitals and labs every day. The more places data are stored, the more vulnerable they are to attack and accidental disclosure. Even a practice that is not targeted directly can be liable for data lost by a partner or vendor.

Many data breaches involve electronic health record (EHR) systems. Although the electronic records providers usually work with IT experts to find and fix the breach, it does not mean the vendors are legally or financially responsible, experts say. “Many practices expect their EHR system to handle breaches or pay for damages, and that’s not always the case,” Clarke says.

Practices should investigate what sort of cyber protection and coverage their partners and vendors have, with an eye toward working together to keep data safe, says Lee Kim, J.D., CIPP-US, director of privacy and security at HIMSS.

“It’s really a shared responsibility between you and your vendors,” she says, “and you each have a responsibility to keep it secure.”

**Small does not equal safe**

Health care data breaches are rampant. In a 2017 survey by the American Medical Association and Accenture, 83% of physicians reported experiencing some sort of cyberattack, although not all resulted in breaches. Cybercriminals target health care organizations because their data contain patient names, birthdates, addresses, Social Security numbers, credit card numbers, and health insurance information.

Whether the hackers use the information themselves or sell it to others on the black market, it’s used to steal identities and commit fraud. That’s why health care data is more valuable even than credit card records.

Physicians in small primary care practices who think they would not be a worthwhile target for hackers should look at the Department of Health and Human Services’ list of reported breaches of health care information.

There, among the giant health insurers, government agencies and large hospital systems, are medical practices that found out the hard way that they, too, can be targeted: an 11-doctor cardiology practice in Knoxville, Tennessee; a solo primary care physician in Weston, Florida; a solo internist in Scottsdale, Arizona, and many more.

In fact, a practice might be targeted specifically because it is small, Marciano says.

“I think it’s the smaller offices that are much more vulnerable,” she says. “They’re focused on treating patients, not on (encrypting) their laptops, and making sure they have the latest security measures.”

Kim says attacks on small practices were uncommon five years ago, but no longer.

In fact, some hackers will test and refine their methods on small practices before going on to attack larger targets, such as health care systems. Kim says she sees more of a new kind of attack, which isn’t after a practice’s data or patient information, but its computing power to earn digital currency.

Attackers have hijacked practice servers to mine for cryptocurrencies, such as Bitcoin. Users might be unaware that the reason their computers are operating so slowly is that they’re running the complex calculations to reap the currency.

“Even though you’re a small practice, the motivation to attack is still there. People who say they haven’t been targeted simply haven’t been targeted yet,” Kim says. “
Automated scheduling turns cancellations into revenue

You can revolutionize your practice and save money by using technology

by Drew Franklin, MBA, FACMPE; Jade L. Bedell, Dr.PH., MHA; and Adam E. Block, Ph.D. Contributing Authors

The internet has changed the way all industries do business. By giving consumers direct and instant online reviews of various products and services, suppliers can improve overall customer satisfaction.

However, health care has lagged behind other industries in its focus on customer satisfaction.

Electronic health records (EHRs) have expanded dramatically in the last decade, starting in hospitals, and have penetrated to smaller provider practices. Most EHRs focus on billing, clinical care and legal documentation, not on enhancing the patient’s experience.

Whereas a surgeon may be assisted by a robot and an MRI may be read with the assistance of artificial intelligence (AI), making an appointment for services often is still done by telephone or even a fax machine. This is an opportunity for EHRs to offer a package that would result in the improvement of both patient satisfaction and operational efficiency, in addition to practice revenue and clinical care.

Improving the patient experience in an era of medical consumerism is increasingly important.

Current practice

In most practices, a patient calls the office to make an appointment and speaks to a staff member who offers a few available times after reviewing the schedule.

There are three key issues with the current practice:

1. **It is less efficient for patients.** Health care is notorious known for having the longest hold times compared with other industries. After calling the office and possibly being put on hold, the patient is given a small selection of appointments because the scheduler can only see a portion of the available times. They may have to select from 2 to 3 times that they may not want or may not be efficient for the physician.

2. **It is time-consuming for staff.**

An automated schedule system would be much less expensive and more productive. In addition, people are more likely than systems to make errors. If the process could be automated, staff’s time on the phone would be reduced by permitting patients to select times directly. These processes have been accelerated in the COVID-19 era with enhanced digital adoption and potential for further refinement through machine learning and artificial intelligence.

“You can book almost any other type of appointment in other industries by seeing what’s available in a self-scheduling type of platform,” says Gavin Setzen, M.D., of Albany ENT & Allergy Services in New York. “(AI) would also make the process of finding available appointments significantly faster for schedulers.”
3 Same-day cancellations are inefficiently backfilled.

This leads to reduced practice revenue by not optimizing physician schedules. For a physician, in an eight-hour shift with 20-minute reserved appointments, three unfilled cancellations cause a productivity decline of 12.5%. In a day when only 80% of visits are filled, this is a 16% decline. If this happens every day, a practice earning a potential revenue of $1 million earns $160,000 less but does not have any fewer costs.

Current cancellation process

Most practices still employ a system to confirm appointments, usually within a 24-hour window. This helps prevent no-shows but does not address the need to backfill canceled appointments.

“One in four patients forgets to show up for medical appointments. No-shows and cancellations are an inevitable part of health care scheduling. However, most practices do not realize that this presents a great opportunity for optimization and revenue recovery,” says Adnan Iqbal, CEO of Luma Health, a company founded with the patient-doctor experience in mind. “Long wait times to see a specialist invariably make patients more likely to cancel or no-show, leading patients to shop for earlier availability elsewhere or indefinitely postpone care. As a result, you lose out on revenue, and your patients’ experience and health could be compromised.”

A new scheduling model

An automated scheduling system would require patients to answer a few simple questions to determine location, reason for visit, insurance and physician preference. It would then provide a list of available appointment times to patients without requiring a scheduler. This can be done via a smartphone. It would also allow for cancellations to be reflected in the schedule in real time and provide notifications to patients that would like to be seen sooner than their existing appointment. Automating the process of notifying patients that a new appointment is available and allowing them to book it directly without any scheduling staff involvement caters to the patient’s desire to self-serve and drives practice efficiency without investing in human resources, which is often the most expensive line item for practices.

Some practices have adopted more automated solutions. Zocdoc, for example, allows patients to book appointments online with participating physicians, although some physicians are wary of being charged a marketing fee for new bookings.

Finally, some operationally sophisticated practices have considered using patient behavior and characteristics to predict no-shows and cancellations before they occur and schedule appointments based on these predictions the way same way airlines oversell flights. Based on these prospective predictions, practices can adjust workflow for high-risk no-show patients by double-booking or doing more aggressive pre-appointment outreach.

The technology exists, so why are we making our call centers use judgment that could be automated? Why are we not looking at how cancellations could be turned into revenue opportunities? In our experience, practices have been focused on other priorities: optimizing the billing and revenue cycle and improving the physician’s experience to cut down on burnout. If EHRs can store a patient’s entire medical history and images, as well as identify which providers are in-network and warn about adverse drug interactions, they can be programmed to refresh a new calendar for office staff every time a patient cancellation occurs. It is time to address scheduling.

Drew Franklin, MBA, FACMPE, is a physician practice manager with more than 16 years of experience. An adjunct professor at New York Medical College in Valhalla, he has a passion for data and analytics that drive health care decision-making. He is a fellow of the American College of Medical Practice Executives.

Jade L. Bedell, DrPH, MHA, earned her doctorate in public health with a focus in health management and policy from New York Medical College in Valhalla. She is a public health professional with research and consulting experience in health economics, health policy and social determinants of health.

Adam E. Block, Ph.D., is an assistant professor of public health at New York Medical College in Valhalla. He is a health economist with deep experience in the hospital, health plan and government sectors. He does expert witness and consulting work through Charm Economics, LLC.
Introducing MedEx

exclusive content from Medical Economics®

Bringing you an extension of our great editorial content you won’t find anywhere else. MedEx offers omni-channel practice management solutions posted weekly. Featuring extended interviews with experts, exclusive conference coverage, first take on survey data and more!

Only accessible online, MedEx exclusive content will be where you are.

Check us out!

medicaleconomics.com/topics/exclusive-content
The ongoing COVID-19 global health emergency has pushed physicians to a breaking point. But physician burnout has more to it than just the huge workload that COVID-19 has brought with it and the difficult decisions that need to be made. It’s also routine stressors like the IT used to do administrative work. Technology can be a powerful tool for alleviating stress.

**Streamline documentation**

According to a recent research study conducted by ScienceDaily, one of the biggest sources of stress for doctors is the inclusion of maintaining electronic health records (EHR) to their already exhaustive list of duties to be performed on a regular basis.

More time spent doing clerical documentation work implies less time spent with patients and/or less personal time spent out of the workplace. This obviously isn’t ideal, but it also puts a strain on disillusioned physicians who spent years studying with the hope of getting to work closely with patients and honing their craft.

So then, where exactly does the solution lie? Effective data management is the key to rid physicians of this problem. Some of the ways this can be done include as follows:

- Automating processes within the EHR itself that don’t require a physician’s immediate attention,
- Leveraging data management software to keep information consistent, concise and easily accessible,
- Leveraging cloud hosting to store patient data in order to boost its interoperability across the organization,
- Natural language processing (NLP) is one effective technology solution physicians can leverage for processing unstructured text-notes,
- Clinical Decision Support Systems (CDSS) can help make sense of healthcare data with the latest evidence, as well as suggest treatments tailored to each patient and furnish personalized care plans,
- Machine learning (ML), a subset of AI, can be applied to complex data in order to predict patterns that the human eye could have missed, and health outcomes in general.
- Health data is growing highly complex and multi-dimensional with every passing day. Data management is now more a necessity for any medical organization trying to mitigate burnout among physicians and other support staff than it ever has been.

**Adopt telemedicine**

The unnerving number of tasks that demand too much of a doctor’s time and attention on a daily basis can drive them up the wall—more so if their schedules aren’t designed as they should be, and there is a shortage of resources.

A report conducted by HIMSS Analytics found that continuous interruptions from phone calls, pagers, alerts from apps, and texts create stress that, in succession, fuels burnout in doctors and nurses.

This suggests that one of the factors that can help prevent burnout considerably is having an integrated, well-designed solution in place.

Telemedicine can prove to be one effective solution on this front. By integrating telemedicine within one’s practice, or even adding telemedicine to a hospital system, physicians can easily streamline processes, offload some aspects of their work, and generally make their lives easier.

This is clearly evident from the fact that telemedicine adoption has skyrocketed in recent years. Close to 60% of human healthcare providers now regard telemedicine as a favorable solution, and a lot of patients feel the level of care furnished through this solution is as effective, or even better than in-person doctor visits (per the 2020 Doximity telemedicine report).

There are a number of reasons telemedicine can help mitigate physician burnout and stress:

- By providing remote consultations, doctors can focus more on patient care, deploy any interventions as needed and strengthen treatment adherence,
- Physicians feel less rushed or pressured for time when they use telemedicine since they aren’t backed up or trying to get to the next appointment as soon as possible. This makes them feel more in control of the situation and keeps them from suffering at the hands of burnout,
- Telemedicine allows physicians to complete administrative work while at home versus them having to stay late at the office, which can positively impact their emotional and mental health.

Ashley Mitek is a contributing author. Send your technology questions to medec@mjlifesciences.com.
Because COVID-19 is a respiratory virus, individuals with chronic obstructive pulmonary disease (COPD) or asthma fall into higher-risk categories for getting the disease. Approximately 10% of American patients 40 or older have COPD. It is associated with high morbidity or mortality, and it is one of the leading causes of death in the United States.

COPD exacerbations lead to higher medical costs and increased emergency department (ED) visits and hospitalizations. “It is important to diagnose COPD early so we can appropriately treat our patients to help keep them healthy and prolong survival,” said Karen Wetherell, M.D., medical director of Village Medical in Glendale, Arizona. “Underlying lung disease is a risk factor for having serious complications from respiratory infections [such as COVID-19] and influenza, so we need to be actively engaged with our patients.”

Asthma is another significant inflammatory disorder that needs to be actively managed by primary care providers. According to the Centers for Disease Control and Prevention, 1 in 13 Americans — more than 25 million — have this challenging respiratory condition. If a patient hides symptoms or lifestyle choices from their physician, the conditions could go undetected and lead to more serious issues later in life.

COPD and asthma both can be mild and in the background at times for many people. But when patients have an exacerbation, it often is severe or even life-threatening. That’s why it’s important for physicians to talk to patients ahead of time about how to prevent flare-ups.

Pandemic puts COPD and asthma in spotlight
A look at how physicians can help patients manage their respiratory health

by Keith Loria
Starting the conversation
David Beatty, a general practitioner with more than 30 years’ experience in Essex, England, says both asthma and COPD are underdiagnosed. Once a patient receives a diagnosis, there should be a discussion with their physician about the condition and how best to treat it, he says.

“COPD is far easier to manage at the mild or moderate stages,” he says. “Once severe COPD is established, the response to treatment is not so good.”

Whether it’s COPD, asthma or another respiratory health condition, Wetherell notes that establishing a good rapport with patients and getting to know them helps physicians get the conversation started.

“Having a long-term relationship with our patients and monitoring our patients on a regular basis has proven to keep them healthier and reduce visits to the [ED] and hospitalizations,” she says. “As a matter of fact, visits with the primary care provider on a more frequent basis — for example, every 90 days — has proven to reduce exacerbations, ED visits and hospitalizations by as much as 30% to 40%.”

One of the ways to discover respiratory problems is for physicians to ask patients about exposures that increase their risk for lung disease, such as smoking.

“This helps us evaluate our patients and intervene early,” Wetherell says. “Ask detailed questions. For example, ‘How often are you coughing during the day?’ and ‘How much mucus do you have?’ and ‘Are you short of breath when you climb stairs?’ This helps us determine how lung disease might be impacting their quality of life, including their ability to work, sleep and perform activities of daily living.”

Stephen Buksh, M.D., an internist with Northeast Tarrant Internal Medicine Associates in Euless, Texas, notes many of the triggers of worsening respiratory health are related to behavior and lifestyle management that can be managed by a patient with proper education. Such triggers include smoking, exposure to allergens, air quality, protection of airways occupationally and during hobbies involving fumes or bad air quality, as well as exposure to viral or bacterial pathogens from other contagious persons.

“It takes time to talk and educate patients to best manage COPD and asthma,” he says. “It’s also important to show the value of rescue versus maintenance inhalers, and their proper use along with when to seek help during exacerbations — earlier is always better.”

Ben Tanner, a physician assistant at Envision Physician Services in Las Vegas, says that emphasizing how powerful prevention can be is critical for patients in these cases.

“It can be very empowering to patients when you let them know there are steps they can take to help avoid exacerbations,” he says. “Most of them already know how bad a flare-up can be, so if they realize they can potentially prevent it if they take the right measures, they’ll probably be pretty motivated to do that.”

He also finds it helps to educate the patient about other

Free Spirometer!
($995.00 value)

Available to the first 100 customers only
Call Now!

In celebration of our 100th Anniversary, we’re offering a brand-new Satellite/Base Station spirometer for FREE as our way of saying “thank you” to the providers who have helped Jones Medical become the most trusted spirometry company in the USA.

Here is how to get your spirometer:
To receive your FREE Satellite/Base Station spirometer, be one of the first 100 customers to call and purchase one box of 500 mouthpieces ($695) to get you started. It’s that simple.

Features:
• Includes 3-year parts & labor warranty!
• Easiest-to-use spirometer available
• Full function, fast, and fully reimbursable
• Hand-held cordless Satellite weighs only 1 pound, maximizing mobility and eliminating tubes and cables
• Lowest cost disposable sensor design eliminates sterilization and calibration hassles
• EMR-ready/paper-free capability
• Maintenance-free
• Best customer support in the industry
• Designed, manufactured & supported in the USA by Jones Medical, the most established name in spirometry

Call Now!
800-323-7336

www.jonesmedical.com • info@jonesmedical.com
healthy lifestyle measures that may reduce their chances of getting a flare-up. For example, reducing intake of refined sugar and other refined carbohydrates lowers inflammation in the body, which can reduce the likelihood of getting a flare-up.

Tanner notes one of the main things patients should know to prevent worsening or exacerbations is to avoid smoking. It also helps to avoid secondhand smoke and any other irritants, such as exhaust or other noxious fumes.

“Eating an anti-inflammatory type of diet — which includes avoiding excess sugar and consuming plenty of vegetables and fruits — also helps; asthma flares or COPD flares are essentially an increase in inflammation,” he says.

Preventive treatment includes steroid inhalers, which keep inflammation in the lungs at bay.

A team approach to care
During follow-up or preventive visits, a physician should always ask the patient about any problems with breathing, Buksh says. This is especially important for patients with established diagnoses that affect breathing such as asthma, COPD, heart failure, interstitial lung disease, obesity and anemia.

“The physician should spend time explaining that lungs are directly affected by poor air quality so that patients can alter their habits or take measures to protect their lungs,” he says. “Develop a team approach to chronic lung disease care. Include a pharmacist and nurse or respiratory therapy driven care management program.”

He explains that pharmacists assist with patient adherence by monitoring refill frequencies and education regarding use of maintenance medications, whereas care management nursing and respiratory therapists can ensure patients have appropriate appliances such as nebulizers or CPAP machines or oxygen, either portable or in-home units.

Tech talk
The past year has brought much more attention to respiratory health amid the COVID-19 pandemic, since respiratory failure is the prime concern and cause of death with severe COVID-19 infection.

Because of that, Buksh says, more people have purchased pulse oximeters and are more aware of their oxygenation. Devices such as smart watches have added features to monitor oxygenation as well, which has led to many patients paying closer attention to respiratory symptoms and respiratory health.

Thankfully, COPD and asthma care have improved significantly with advances in the technology of inhaled medications. However, Buksh notes that affording them has become a significant challenge.

“As a physician, I must be more aware of formulary structure and changes along with the difficulties of patients not being able to afford inhalers that were once the key to the stabilization of their chronic lung disease,” he says. “I am hopeful that pharmaceutical companies and insurers of all types will work together to make sure patients have access to affordable inhaled medications, recognizing that exacerbations and hospitalizations are much more expensive to the system than maintaining control of these chronic lung diseases [such as] asthma and COPD.”

—Karen Wetherell, M.D.,
medical director, Village Medical,
Glendale, Arizona

“It is important to diagnose COPD early so we can appropriately treat our patients to help keep them healthy and prolong survival.”

Register for our e-newsletter to receive similar content.
Coding case studies

Chronic Obstructive Pulmonary Disease (COPD)

by Renee Dowling, CPC Contributing author

In the medical billing and coding field, getting paid requires accurate documentation and selecting the correct codes. In our Coding Case Studies, we explore the correct coding for a specific condition based on a hypothetical clinical scenario. This scenario involves a patient presenting with symptoms of chronic obstructive pulmonary disease (COPD). See if you can choose the correct codes.

Clinical Scenario

History of Present Illness

Cough

Episode onset: over the last week. The problem has been gradually worsening. The cough is nonproductive. Associated symptoms include rhinorrhea, sore throat, shortness of breath and wheezing. Pertinent negatives include no chest pain, chills, fever, headaches or myalgias. Symptoms are aggravated by lying down. Patient has tried a beta-agonist inhaler for the symptoms. The treatment provided no relief. There is no history of pneumonia.

Patient denies any history of lung problems. Had this same issue in September and was treated with Medrol Dosepak (methylprednisolone) and azithromycin.

In October, patient presented with same issue and was prescribed Medrol Dosepak and Augmentin (amoxicillin/clavulanate). Wife states patient has had moderate relief with past treatment but breathing problem has not completely gone away.

Review of Systems

Constitutional: Positive for fatigue. Negative for chills and fever

HENT: Positive for congestion, rhinorrhea and sore throat. Negative for sinus pressure, sinus pain and trouble swallowing

Respiratory: Positive for cough, chest tightness, shortness of breath and wheezing

Cardiovascular: Negative for chest pain and leg swelling

Gastrointestinal: Negative for nausea and vomiting

Musculoskeletal: Negative for arthralgias and myalgias

Neurological: Negative for dizziness, light-headedness and headaches

Psychiatric/Behavioral: Negative for confusion

$49 BILLION


THAT’S AN INCREASE OF 52% IN THE LAST DECADE.

Source: CDC
**Physical Exam**

Constitutional: Patient is oriented to person, place and time.
Head: Normocephalic and atraumatic
Cardiovascular: Normal rate
Pulmonary/Chest: Accessory muscle usage present. He has wheezes in the right upper field and left upper field. He has rhonchi in the right middle field, right lower field, left middle field and left lower field.
Neurological: He is alert and oriented to person, place and time.
Skin: Warm and dry
Psychiatric: He has a normal mood and affect. His behavior is normal.

**Assessment and Plan**

COPD with acute exacerbation
- DuoNeb (ipratropium-albuterol) 0.5 mg-3 mg (2.5 mg base) / 3 mL nebulizer solution; 3 mL doxycycline hyclate 100-mg tablet; Deltasone (prednisone) 20-mg tablet
- Patient given nebulizer treatment doxycycline hyclate in clinic. Lungs improved but still have expiratory rhonchi and wheezes. Patient reports breathing easier but still somewhat tight

**Documentation Coding Requirements**

With
- acute lower respiratory infection
- acute exacerbation

Unspecified

**Coding notes**

- Code also type of asthma, if applicable (J45.-)
  Use additional code to identify:
  - exposure to environmental tobacco smoke (Z77.22)
  - history of tobacco dependence (Z87.891)
  - occupational exposure to environmental tobacco smoke (Z57.31)
  - tobacco dependence (F17.-)
  - tobacco use (Z72.0)

- Code also to identify infection

---

**Renee Dowling** is a billing and coding consultant with VEI Consulting in Indianapolis, Indianapolis.
Send your diagnosis coding questions to medec@mjlifesciences.com
Public speaking tips for physicians: Give your audience something to remember

by Heidi Moawad, M.D.

Great speakers make an impact. But an audience may daydream or surf the Internet on their phones when a so-so speaker is talking. As a physician, it is likely that you will give lectures and presentations at many stages in your career. Your own special brand can shine through, and your approach should differ for each type of presentation.

Pay attention to audience needs and wants
Many speakers, especially those seeking a professional goal (for example, tenure or a job offer), view a presentation as an interview and an opportunity to showcase their qualifications. Although a brief speaker introduction is part of most presentations, it is important to remember that the best way to make a good impression is to structure the talk to serve the audience.

Attendees will value your presentation if they leave with something they didn't have before. It might be information, facts, instructions, confidence in themselves or inspiration — the key is for the audience to leave thinking about what they gained from your speech rather than thinking about praising or criticizing you.

Clarify confusing concepts
When you are speaking about a complicated subject, think about what you knew before you were the expert. Consider the knowledge level of your audience and how to clarify counterintuitive points, exceptions to the rule and common mistakes. Examining the confusing material in detail can illuminate overwhelming aspects of the subject.

This empowers your audience by letting them know that it is possible to untangle the knotty aspects of the topic. When you show your audience that you understand how nuances of your topic of expertise can get a bit tricky, you provide both information and confidence to your listeners.

Use slides
It's popular for speaking coaches to say that slides should have as few words as possible for maximum impact. Although visuals often send a
more powerful message than words, this strategy is not helpful when your listeners are going to study the material for an examination.

In those situations, it can be valuable to include key words and phrases so attendees can focus on comprehending and taking minimal notes rather than rushing to write down every detail.

**Be kind**
We live in a highly sophisticated time with knowledge, especially medical knowledge, advancing at a rapid pace and medical misinformation flourishing.

As a speaker, you may need to address medical misinformation, but it is important to stay away from judging any group of people. Medical science is difficult to comprehend and widely accepted understanding of risk factors and best practices can become outdated. Don’t ridicule individuals who don’t understand the subject just to get a chuckle from the audience.

**Be grateful for the audience**
If you are speaking at a conference, you may wish for a full house. However, there can be a variety of reasons that attendance at your talk may be smaller than you wished. Perhaps another presentation scheduled in the same time slot includes vital continuing education content or presents the only update on a crucial subject.

Even if your audience is small, you should appreciate each person who thought your talk might be valuable. Don’t look at your talk as a springboard to something better — be present in the moment during your presentation. When you speak to an audience, keep in mind that each person who is listening to you deserves your best and that what you have to say can help them with what they are seeking—whether it’s passing an exam, improving patient care, deciding about their career goals or managing their own physical or mental health."

Heidi Moawad, M.D., is a contributing author.
MEDICAL EQUIPMENT

### accucold Performance Series

Refrigeration designed and purpose-built for pharmacy, medication, and vaccination applications to support meeting CDC/VFC vaccine storage guidelines

### PHARMA-VAC

**Solid & Glass Door Refrigerators**
From 1 to 15 Cu.ft.

- 1/3°C deviation derived from the maximum deviation of an NTC sensor in a 5 oz. vial located nearest the chamfer geometric center during a 24 hour test period

#### Advanced Temperature Control & Durable Performance
- Intelligent microprocessor digital temperature controller
- Adjustable operating control range from -12 to 4°F
- Digital display of the min/max temperature in Celsius or Fahrenheit
- Optimized forced air cooling for excellent stability & uniformity with rapid recovery
- Factory installed lock conveniently located towards the top of each unit
- Open door and high/low temperature alarms

#### For product application suggestions or recommendations please feel free to contact

- Joanna Shippoli
- plowe058@gmail.com
- (440) 895-2615

### Supplies

**ARG1PV** 1 cu.ft. 21.5" 17.5" 20" **Glass**
**ARG4PV** 4 cu.ft. 23.5" 18.5" 22" **White**
**ARG5PV** 5 cu.ft. 32.5" 25.5" 25" **Glass**
**ARS3PV** 3 cu.ft. 33.75" 18.5" 19.5" **White**
**ARS4PV** 4 cu.ft. 50" 23.38" 24.5" **White**
**ARS5PV** 5 cu.ft. 50" 23.38" 25" **White**
**ARS6PV** 6 cu.ft. 32.5" 25.5" 25" **Glass**
**ARS7PV** 7 cu.ft. 23.5" 24.5" 25" **Glass**
**ARS8PV** 8 cu.ft. 50" 23.38" 24.5" **White**

### Choosing the Right Sized Unit

Below are a few handy steps for determining the ideal refrigerator size for your clinic:

1. Estimate the maximum number of doses of publicly-provided vaccine and a publicly-purchased vaccine that will be in your vaccine center during a 24 hour test period.

**Refrigerator:**
- Total doses
- Publicly-provided doses
- Privately-purchased doses

2. Calculate the volume of the vaccine storage refrigerator using the formula:

   \[
   \text{Volume (cu. ft.)} = \frac{\text{Max. Doses}}{\text{Total doses per cu. ft.}}
   \]

   - Max. Doses: 2,000 doses or more
   - Total doses: 1,000-1,999 doses
   - Total doses: 500-999 doses
   - Total doses: 100-499 doses

3. Match your maximum年度 with the appropriate annual doses for your vaccine storage refrigerator:

   - Max. Doses: 2,000 doses or more
   - Total doses: 1,000-1,999 doses
   - Total doses: 500-999 doses
   - Total doses: 100-499 doses

### Pharma-Vac Refrigerators

#### Accucold Capacity Height Width Depth Door PT#PRICE

<table>
<thead>
<tr>
<th>Model</th>
<th>Capacity</th>
<th>Height</th>
<th>Width</th>
<th>Depth</th>
<th>Door</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARG1PV</td>
<td>1 cu.ft.</td>
<td>21.5&quot;</td>
<td>17.5&quot;</td>
<td>28&quot;</td>
<td>Glass</td>
<td>820.00</td>
</tr>
<tr>
<td>ARG4PV</td>
<td>4 cu.ft.</td>
<td>23.5&quot;</td>
<td>18.5&quot;</td>
<td>25&quot;</td>
<td>White</td>
<td>897.00</td>
</tr>
<tr>
<td>ARG5PV</td>
<td>5 cu.ft.</td>
<td>32.5&quot;</td>
<td>25.5&quot;</td>
<td>25&quot;</td>
<td>Glass</td>
<td>997.00</td>
</tr>
<tr>
<td>ARS3PV</td>
<td>3 cu.ft.</td>
<td>33.75&quot;</td>
<td>18.5&quot;</td>
<td>19.5&quot;</td>
<td>White</td>
<td>906.00</td>
</tr>
<tr>
<td>ARS4PV</td>
<td>4 cu.ft.</td>
<td>50&quot;</td>
<td>23.38&quot;</td>
<td>24.5&quot;</td>
<td>White</td>
<td>1,218.00</td>
</tr>
<tr>
<td>ARS5PV</td>
<td>5 cu.ft.</td>
<td>50&quot;</td>
<td>23.38&quot;</td>
<td>25&quot;</td>
<td>Glass</td>
<td>1,287.00</td>
</tr>
<tr>
<td>ARS6PV</td>
<td>6 cu.ft.</td>
<td>32.5&quot;</td>
<td>25.5&quot;</td>
<td>25&quot;</td>
<td>Glass</td>
<td>1,500.00</td>
</tr>
<tr>
<td>ARS7PV</td>
<td>7 cu.ft.</td>
<td>23.5&quot;</td>
<td>24.5&quot;</td>
<td>25&quot;</td>
<td>Glass</td>
<td>1,690.00</td>
</tr>
<tr>
<td>ARS8PV</td>
<td>8 cu.ft.</td>
<td>50&quot;</td>
<td>23.38&quot;</td>
<td>24.5&quot;</td>
<td>White</td>
<td>1,794.00</td>
</tr>
</tbody>
</table>

### Pharma-Lab Refrigerators

#### Accucold Capacity Height Width Depth Door PT#PRICE

<table>
<thead>
<tr>
<th>Model</th>
<th>Capacity</th>
<th>Height</th>
<th>Width</th>
<th>Depth</th>
<th>Door</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARS1PV</td>
<td>1 cu.ft.</td>
<td>21.5&quot;</td>
<td>17.5&quot;</td>
<td>20&quot;</td>
<td>Glass</td>
<td>3,331.00</td>
</tr>
<tr>
<td>ARS2PV</td>
<td>2 cu.ft.</td>
<td>23.5&quot;</td>
<td>18.5&quot;</td>
<td>22&quot;</td>
<td>Glass</td>
<td>3,613.00</td>
</tr>
<tr>
<td>ARS3PV</td>
<td>3 cu.ft.</td>
<td>32.5&quot;</td>
<td>22.5&quot;</td>
<td>22&quot;</td>
<td>Glass</td>
<td>3,989.00</td>
</tr>
<tr>
<td>ARS4PV</td>
<td>4 cu.ft.</td>
<td>50&quot;</td>
<td>23.38&quot;</td>
<td>24.5&quot;</td>
<td>White</td>
<td>4,323.00</td>
</tr>
<tr>
<td>ARS5PV</td>
<td>5 cu.ft.</td>
<td>50&quot;</td>
<td>23.38&quot;</td>
<td>25&quot;</td>
<td>Glass</td>
<td>4,805.00</td>
</tr>
<tr>
<td>ARS6PV</td>
<td>6 cu.ft.</td>
<td>32.5&quot;</td>
<td>25.5&quot;</td>
<td>25&quot;</td>
<td>Glass</td>
<td>5,303.00</td>
</tr>
</tbody>
</table>

### Pharma-Lab Freezers

#### Accucold Capacity Height Width Depth Door PT#PRICE

<table>
<thead>
<tr>
<th>Model</th>
<th>Capacity</th>
<th>Height</th>
<th>Width</th>
<th>Depth</th>
<th>Door</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARG1PV</td>
<td>1 cu.ft.</td>
<td>21.5&quot;</td>
<td>17.5&quot;</td>
<td>20&quot;</td>
<td>Glass</td>
<td>2,311.00</td>
</tr>
<tr>
<td>ARG2PV</td>
<td>2 cu.ft.</td>
<td>23.5&quot;</td>
<td>18.5&quot;</td>
<td>22&quot;</td>
<td>Glass</td>
<td>2,633.00</td>
</tr>
<tr>
<td>ARG3PV</td>
<td>3 cu.ft.</td>
<td>32.5&quot;</td>
<td>22.5&quot;</td>
<td>22&quot;</td>
<td>Glass</td>
<td>3,503.00</td>
</tr>
<tr>
<td>ARG4PV</td>
<td>4 cu.ft.</td>
<td>50&quot;</td>
<td>23.38&quot;</td>
<td>24.5&quot;</td>
<td>White</td>
<td>4,037.00</td>
</tr>
</tbody>
</table>

### For product application suggestions or recommendations please feel free to contact our product specialists to discuss your options at:

877-646-3300

www.medicaldevicedepot.com

### Medical Device Depot

Welcome to the Medical Device Depot, a one-stop-shop for all product information and options.

![Medical Device Depot Logo](https://example.com/logo)

Reach your target audience. Our audience.

Contact me today to place your ad.

Joanna Shippoli
(440) 891-2615
shippoli@mhj lifescience.com

Medical Economics

MAY 2021 | MEDICAL ECONOMICS

“Advertising in Medical Economics® has accelerated the growth of our business by putting me in contact with healthcare professionals around the country. It has allowed me to help both my colleagues and my patients.”

— Mark J. Nelson, MD
FACC, MHR

Soft Pediatric Practice for Sale

Suburban city in Michigan, close to a major university and excellent school district. Surrounded by golf courses, downhill skiing and lakes.

Excellent place to raise a family. Busy practice with major hospitals nearby.

Gross revenue in excess of $800K – Terms Negotiable –

Call (810) 355-6134 or email plowe058@gmail.com

with any inquiries

## MEDICAL EQUIPMENT

### Medical Equipment DEALS!

**www.medicaldevice depot.com**

**Tools for Increased Reimbursement & Office Efficiency at Discount Prices**

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ilisent Cardiacare 2000</td>
<td>$1,355.00</td>
</tr>
<tr>
<td>Seidler AT-2 Plus</td>
<td>$2,826.00*</td>
</tr>
<tr>
<td><em>add Sporometry: $499.00</em></td>
<td></td>
</tr>
<tr>
<td>Burdick DL 290</td>
<td>$3,998.64</td>
</tr>
<tr>
<td>Welch Allyn CP150 w/w (仪具):</td>
<td>$3,405.00</td>
</tr>
</tbody>
</table>

**EMR-Compatible PC-Based Diagnostics**

<table>
<thead>
<tr>
<th>Device</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardio-Testing EKG</td>
<td>$1,895.00</td>
</tr>
<tr>
<td>Cardo Monitor</td>
<td>$2,895.00</td>
</tr>
<tr>
<td>Cardio-Stress</td>
<td>$2,895.00</td>
</tr>
</tbody>
</table>

**Screener Audiometer**

Only $878.00

**EMR-Compatible Spirometry**

<table>
<thead>
<tr>
<th>System</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>simpleABI™ ABI Systems &amp; Segmental Studies</td>
<td>Includes FREE Laptop</td>
</tr>
</tbody>
</table>

**CLIA WAIVED COVID-19 TEST**

**CardiStart SARS-CoV-2 Rapid Antigen Test (20 Tests)**

As an extended point-of-care (POC) designated test with a 10 min processing time, CardiStart COVID-19 Antigen Test allows effective testing of COVID-19 infection on a large scale. Results within 10 minutes, identify acute infection with 83.4% sensitivity and 100% specificity. FDA & EUA approved!

**Boost Your Revenue!**

**Medical Device Depot**

**Contact me today to place your ad.**

**Joanna Shippoli**

(440) 895-2615

jshippoli@mjhlifesciences.com

---

### MARKETPLACE / PRODUCTS & SERVICES

**Joanna Shippoli Advertising**

(440) 895-2615

jshippoli@mjhlifesciences.com

"Advertising in Medical Economics® has accelerated the growth of our business by putting me in contact with healthcare professionals around the country. It has allowed me to help both my colleagues and my patients."

— Mark J. Nelson, MD FACC, MPH
MEDICAL EQUIPMENT

3 WAYS TO START IMMEDIATELY INCREASING REVENUE

1 **Neuro-Cognitive Testing**
- Medicare mandates yearly cognitive assessment
- Takes 10-15 minutes to prep patient, 20 minutes to test
- Analyzes: brain health (EEG), brain processing speed (Evoke Potentials), heart health (EKG), mental health (neuropsychology)
- Reimburse using 6 CPT codes, National Average = $750 - $1000 per test
- Each test is processed into a fully-finished, clinically actionable report
- Easy to understand biomarkers facilitate more informed medical interventions, such as biofeedback

2 **ANS Testing**
(can be combined with SudoMotor into 1 full system)
- Takes less than 10 minutes to perform, software provides verbal cues
- Tests for autonomic balance, vascular health, physical/mental stress, peripheral nerve health and other critical hidden risk factors
- Reimburses $170/test using 3 CPT codes
- Provides a 1 page summary up to a full 24 page comprehensive report

3 **SudoMotor Testing**
(can be combined with ANS into 1 full system)
- Takes 3 minutes to analyze a patients’ hands and feet
- Provides a 1 page summary report
- Assesses peripheral nerve health (c-fiber function) and asymmetry between each hand and foot
- Reimburses $130/test (national average)

**CALL TOLL FREE 877-646-3300**

Reach your target audience. *Our audience.*
Contact me today to place your ad.
Joanna Shippoli
(440) 891-2615
jshippoli@mjlifesciences.com

Build your team.
Place a recruitment ad.

Joanna Shippoli
(440) 891-2615
jshippoli@mjlifesciences.com
Listen now!
New episode released every month.

www.medicaleconomics.com/podcasts