Introduction and clinic group overview

Today on the podcast, we have Dr. Mikael Daniels, who is easily one of the larger, well, owner of one the largest clinic groups we've had on this show.

13 clinics in management at Wheat Tree Feed Podiatry, and I had a great conversation with them. So I hope you enjoy this episode. Enjoy. You have 13 Clinics under management, easily biggest podcast guest we had had the show, what's the journey?

How did you end up managing this clinic group? This is probably like a long story, I'm ready for it. All right. Well, I always preference this by saying, be careful what you wish for, because you may get it.

And I'm absolutely the victim of that. So, 2002 I finished residency and I joined practice with a gentleman who'd been in practice for about 30 years by himself in basically a basement office.

By 2004 I was making more money than he was, so I took a pay cut to become a partner. In 2007, I bought him out and I started acquiring practices, and it's been a steady growth to get to the point where we are now, which includes the practice, as you just mentioned.

We have three outpatient ambulatory surgical facilities that are podiatry specific. They have a durable medical equipment supply portion. we have PCR microbiological lab.

With a billing and consulting arm as we do all of that in-house as well. And we do lots of other things that go along with the podiatry practice, such as radiology, for example.

Each one of our offices is equipped with radiological technology, so we can x-ray patients right there when we need them. And it's kind of been a long journey.

I always say that if there was an expensive mistake to be made, I've made it along the way. Here I sit today, almost 25 years later, saying, OK, yeah, that's a great question.

How did I do this? Well, yeah. Okay, let's start with the mistakes. Like any kind of mistakes that you think would be worth bringing up on the show? I think the one thing that seems to resonate with me as I look back on it is an expectation that people were willing to do what I am willing do on a daily basis.

I have been one of these people where my patients have always kind have come first. Um, I remember when my son was about three years old, he's 22 now.

Uh, when he was about three years old, we told him that if he, you know, went on the potty, I would take him to target and buy him a bike. And he went in the party and I got called to an emergency surgery and he just devastated that I couldn't take that day.

But then I of course took him the next day and now he's a mechanical engineer, so he did okay in life. I was willing to leave and go do that case and I knew that, you know, he would be asleep when I came home because that's kind of how it was.

Building the practice and early management lessons

And I've always kind Some of it is out of ego because I thought it would be great to build this large enterprise and then sell it to some private equity company for a lot of loud numbers to the left of the comma.

We'll get back to that. Expecting people to have the same level of dedication to either work and or to patients has

really been something that I have been wrestling with my entire career.

So then how do you hire staff? How do know that the staff you hired are gonna bring the same level that you're bringing to the practice, would you say?

Well, you simply don't. I mean, we break the practice up into segments and I only am responsible for hiring and firing physicians at this point. We have operations people and they handle the front desk people, the administrative people the middle management people department heads and those sort of things.

So I dont hire and fire them. Obviously I have the ability to if we want, but Ive only fired one person in my entire career. Well thats not true.

Two people in entire my career both times I was forced to have to do it. Can I have more context? One was a physician who said something that was so inappropriate to one of our nurses that I won't repeat it.

And we sent him home immediately and legal said, I had no choice. So if your lawyer says you have no What are you going to say? No, you're wrong. Defend me when I get sued.

That's one. And then the other one got up in a meeting that I wasn't in and told everybody that they had no respect for me and I didn't know what I was doing.

Of course they all came running to me. I'm like, well, can't have somebody handling your money who thinks you don't what you are doing? So we had to part ways with that person too, which was a shame because it was somebody who had been there for a couple of years.

This was early in my tenure of running the whole thing. It was fond of her and her family. It just didn't work out. So we had to do that. And then ironically, my brother, he's actually a restaurateur now.

He has seven or eight restaurants in Florida now, but at the time he was a general manager for an Applebee's franchisee. When I told him that story, He's like, why aren't you doing that?

Like, well, what do you mean? Why am I doing it? It's you don't even have people who do it for you. I'm like well yeah, I guess, But I kind of felt obligated because it was about me.

You hire people to do a job, let them do with job. Don't do their job for them. I said, Oh, okay. And this is the guy who hires and fires people all the time, because, you know, as he put it, waiters and waitresses can be Einstein one day and in the coma the next.

So. He was very, very used to evaluating, managing and dealing with people in kind of a large climate where at that point in my career, we were at two or three offices, maybe had 10 employees, so it wasn't a lot.

So we're still more like a family than a company at the point. I learned a lesson and to be honest with you, I haven't really fired anybody since. Yeah, of course.

I mean, a strong management team that you can delegate to, that's the core of any growing business. Okay, so you're acquiring all these clinics. What makes a clinic worthy of being acquired by you?

Like, what do you look for? What characteristics? So it's more on the line of how do you want to grow more than a particular clinic? So I decided a long time ago that I thought it was easier to buy an existing business than to start a De Novo one.

So that included levels of locations, because we don't really see them as clinics, even though most of the ones that we bought over the years have been single doctor, who are usually at the end of a career, either staying for a short period of time or even we've had ones retire as soon as three months after we acquired them.

You know, it's easier to buy them. The equipment is in place, the charts are in, place the staff is place. You don't have to go out and start from zero, which it can be time consuming building a patient population.

We are, I wouldn't say competitive market. There's still not enough podiatrists where we are and in the mid Atlantic region of the country, but there's enough that you can find one down the street somewhere.

So if you go somewhere into the Midwest, into a more rural area, or down south into more of a rural areas, you don't have a lot of choice in physicians.

And that's kind of the way it is all around. Northeastern and the Mid-Atlantic are very cramped areas. So there's about 400, 450 podiatrists in Maryland for about the six and a half million people who live here.

It's a decent mix. But again, starting and then attracting patients and building is, in my opinion, more expensive than just buying. Yeah. And I could see that.

So I'm looking at the list here of all the clinics you have, like, uh, and to be fair, I mean, Gettysburg is a long ways away from, from Baltimore. Um, not as far as you think.

How far is it? 60 miles, 60. Do you, do you commute around a lot or? Well, it's this morning I was in our Washington DC office. So I spend time in, in Washington, DC, office on Mondays and then in always meals the rest of the week.

And I spent time every morning in the hospital, Tuesday, Wednesday, Thursday. Not a lot. I mean, I don't go to a of a the offices, you know, at points in my career, You know I've gone to Towson, to Eldersburg, Dundalk.

so I have been to other offices seeing patients over the course of last 20 years or so, but now I'm down to just the two. And when you acquire a clinic, what's the playbook?

What are you doing? Like you said, staff's there, equipment's here, but there's gotta be something that's probably not there that now needs to be there.

What is that thing? Well, let's start with the fact that most practices either don't or more likely can't offer the services that we do. It is very expensive to run a PCR lab.

Acquisitions, ancillaries, and business strategy

And it's very to have a durable medical equipment side. I mean, I pay two people full-time salaries to chase paperwork for Medicare for diabetic shoes.

You know, that's how much paperwork there is related to this. So if you're a one or two doctor practice, you can't afford two people or just chasing paperwork all day.

It just doesn't make sense. But you know when you have 10 or 12 doctors, yes, she can all of a sudden because now you got all them prescribing diabetic shoes and you doing that, 50 or 100 pairs of shoes a year.

You're doing 1200 pairs a shoes here. So, you know, it pays to do that. So we look for where is the intrinsic value in the practice because we can grab a balance sheet in a P&L and we calculate whether or not this is profitable and how much we're going to have to pay somebody to work there and what the staff is and likely the stuff is to leave and the volume is.

And my whole rule of thumb is if I can break even without adding anything, then that's a clinic I want to acquire. because I know I can bring intrinsic value by bringing in the ancillaries that we do, which generate revenue for the practice.

I think a practice revenue, I mean, a little bit differently than a lot of people. And I don't think of it as do more stuff or

see more patients. People have done that throughout time.

Both business models are doomed to fail, especially in current environment. The way I've always looked at it is, what are they getting anyway? So if my patients are gonna get things, well, why am I not the one supplying them?

So we did that with our cultures. Why should I send my cultures to Quest or to LabCorp when I can do them myself and I will get paid for it? Where Labcorp and Quest has never sent me a patient, not once, ever, in 25 years, I've never got a patients that I prefer by Labcore.

You're thinking like a businessman, you're not thinking a doctor, which a lot of doctors don't do. As I said, they taught me that in business school. Oh, really?

Did you go to this school? I do. I have an MBA. Oh really. That's right. Yes, you have a MBA, okay. Yeah. Well, that's a fun story I tell people. Right around, it was about 2010, we hit a million dollars in revenue for the first time.

And I thought I was like the bomb. Look at me, I'm generating a billion dollars a year. Woo. And then I was like, well, wait a minute. I don't really know what I'm doing here.

Maybe I should find out. So I went and I got a business degree, which taught me that I had absolutely no idea what was doing. And sometimes I am just not sure I do.

But what it did is it taught the vocabulary. It's funny because medicine is a vocabulary, business is vocabulary if you don t have the vocabularies, you can't speak to it.

And it's all about, you know, You can teach anybody how to treat things. You know nowadays there's a lot of medicine by flow chart that goes on and you can.

Teach most people how. To do it. The problem is in the reason medical school is four years is there is a. Lot of basic science that. Goes beyond that that allows you to reason through it and.

And you can just memorize the algorithm and do it. That's one thing. But if you have the reason for it, that's when you start to be able to treat the things that are falling out of the algorithms.

And things fall out the of algorithm every day. Not everybody who walks in with plantar fasciitis has pinpoint tenderness on the bottom of their heel when they go to bed in the morning.

Most do, but not everybody. Understanding the mechanics of tissue that is there and what happens allows you to be able to work through a list of differential diagnoses to come up with a correct one, where if you have a flow sheet, it doesn't hurt in the morning.

Yes, no, yes. Does it get better with walking? Yes. No. And you get to the diagnosis at the end of the flowsheet. So then what was it like going to get your MBA then?

Um, I actually really had a lot of fun with it. Uh, people laugh at me. Um. My, my, mentioned my brother who's a restaurant tour, who, you know, spent one semester in cooking school and couldn't hack it and never went back and he couldn' go, he could stand teaching, couldn"t stand classes.

So he was done. You know? I did it when I was, did at night and on weekends when was practicing full time. But I get a program. Which was, which was all writing based.

And I have a liberal arts education for my undergrad and the one thing they teach you in a Liberal Arts school is how to write. So for me, it was it, was kind of fun.

I just, you know, I could do my research and I can sit down and i can write my topics and, You know I did very well kind I would see, it was always funny because you could always find stuff online that people had done to kind of

see what they were doing and what grades they got for things.

And I find this section and I'd find a four page paper on this and then I looked down and mine was 19. because I like to be thorough. So I was just kind of right and right.

And it was very much research-based. Everything I did was research based. Yeah, so that was fun. Listen, Google made a world of difference. When I wasn't in school, we didn't.

Google was brand new in 96 when I graduated from college. I went through college and grad school and everything else without Google. Probably 20 years ago now, when either I needed information, I just started Googling it.

So when I was a student, I had these large crates of file hangers with folders. And I would, every time I got an article from anywhere, from a journal club, or from paper, drug wrap, anything, file these away.

These were four large, very heavy boxes. They sat in my basement for years, and about 10 years ago, realized I looked at them in 10 and threw them all away, but I spent so much time organizing them.

Yeah, organizing and alphabetizing these things. And now they're all gone. But when I realized I was Googling it and getting the articles online and not using it, I'm like, Yeah.

Um, and then, uh, like this, this sounds like a crazy, you must have a decent work ethic. If you're able to go to the NBA on the weekend and run the practice, do you have any secrets for work?

Ethic or anything like coffee? What's like, what's, What do do to fuel this? I don't really sleep. So that's part of the problem. A couple episodes ago.

Did you? Well, one of my fraternity brothers from college is a, is, uh, Paul Krenner Teradai, who now practices sleep medicine. So, I mentioned it to him once and he says he doesn't sleep either.

He said that some people actually don't need to sleep. You said, that there are, there's a very small demographic that actually just does not really need a lot of sleep, but the average person does.

I mean, you might just not genetically need. Hey, well, then I'm kind of tired all the time. So I don't think that's quite right. But I mean, listen, 30 years ago, I read the art of the deal and the president said he sleeps maybe four hours a night.

I write the book. Yeah, I love that book. I loved the first couple of minutes of Art of the Deal, because you're in the head of an 80s businessman, and it's such a lost time.

Just calls, calls. Got to get on TV. Yeah. But that's a good point. He says The Mentions doesn't sleep very much either in that. Right. So the other thing is I'm exceedingly loyal and very stubborn, so I don't give up.

ever. And that's not necessarily a good trait. You know, sometimes you need to leave well enough alone and sometimes, you know where you cut your losses and I find that that is one of the problems that I have is I continually work the product or problem until I get to a solution.

I wish I could cut and run a little bit easier sometimes. But that just not my nature. What was COVID like for you at the clinic group? So COVID was pretty, it was a pretty harrowing and pretty miserable experience.

And funny, I was on a cruise for Christmas. When I went to ask the cruise director thing, and I asked him the exact same question, what did you do during COVID when the fleet wasn't sailing?

So it kind of came out of nowhere. At the time, I was helping to mentor my son's high school robotics team. And the previous year, we had won a banner at the world championships.

So real successful. This is the next season. My older son is a junior now. We start on that in January, and the first competition was in March. You know, you spend all this time hours and hours building this robot, then we get to the competition and we have a pretty good showing at first and then everything stopped.

stay home for two weeks and everything just closed and that was the end of robotics season. So I still went to work. There was a debate as to what was an essential business.

I live in Maryland. Maryland shut down. They closed everything. My wife taught at home, she's an elementary school teacher, taught from at-home for almost a year.

Uh, after that, so, uh, but I went to work and initially I was in the hospital and people were getting tons and tons of pressure sores.

MBA, work ethic, and COVID impact

So I really busy. I had dedicated COVID floors with precautionary things and isolation protocols and everything else. And I would go to the office and there would be tumbleweed blowing down the hallway because nobody would come and I have like four patients would And it was like that probably until about May or June.

And then it started to empty out a little bit again. Then in December, we got vaxxed. We were the first ones to get vaxed and things started really to open up from then and then we went through.

Ironically, I got COVID in 2022 when I was in Norway. So I spent two years on COVID floors, treating COVID patients, Didn't get COVID, I go to Norway, and I get Norwegian COVID.

That's bizarre. I guess maybe it was a different strain. Maybe you were immune to it in Norwegian, right? I honestly didn't even know I had it. My wife tested when we got home, she was positive.

It was Monday, so I went back to work and she sends me a picture of a positive test with a text that says, come home. So I had no symptoms, and she was asymptomatic too, but we had just gotten back from Norway and that's what we did.

So thank goodness I was symptomatic the whole time. It took me five days to test negative again. I called my primary, I'm like, what do I do? He's like asymptotic.

Not at all. He put a mask on and go back to work. So I did. And it was fun. So COVID was real. I mean, again, from a business standpoint, it Was devastating.

We stayed open, we didn't furlough anybody. we Didn't close any offices, We didn t change our business model very much. e survived on PPP money like everybody else.

Thank goodness for the government in that sense. Yeah. But, you know, we saw, I saw some, a couple of cases of COVID toes, which was a condition. I've never heard of that before.

Yeah, people who got gangrenous toes from COVID. Remember. Can you elaborate on that? Yeah so, at the beginning of Covid, one of the reasons everybody was dying at such a large clip is they were dying of blood clots and we had no idea.

because COVID caused some weird sort of coagulopathy or clotting all over the place. So once they started anticoagulating people in the hospital, the death rates started to come down.

Well, one of the coaguilopathies that people would get is they would COVID toes, and their toes would be embolic, they'd become gangrenous, people'd lose toes.

handful, maybe three or four cases, not a tremendous number of them, but we have them. So that was a really big

issue and nobody knew. And then the steroids, when steroids started becoming part of the regimen, because you don't usually give steroids to sick people, they started giving people steroids and that made a big difference too.

But they shut down the ORs at the hospital. So for any, elective surgery was off and any non-elective surgeries needed permission from the chief to be able to take the case, which wasn't a problem for me.

You know, you've got to infect the diabetic foot that has to go to the O. R. and no one's going to say no. But, that was it for surgery probably for four or five months.

I didn't do any electives cases for 4 or 5 months, it was all just emergent stuff. you know, some of the other surgeons were dying, the ones who didn't do that sort of stuff.

So it was rough. Yeah, I wouldn't want to go back there. I remember my father, who is in very poor health and has been for many years, even back then, got COVID early.

He was in a facility in Florida, a nursing facility of Florida. And there were mandates here in Maryland where if you left Maryland and you came back, they could take your license, that you were not allowed to travel out of the state.

So here I am sitting there thinking, oh my goodness, my dad is gonna die of COVID and I'm also not able to go. I'll not gonna be able go to the funeral.

My dad didn't pass, thank goodness. But it was a really weird time. And I was on the phone with my brother who lives down there and he's telling me what's going on.

It was wild time, it really was. Lots of people died. I saw lots of people die who shouldn't have. I see lots who should have died make it. Just really not a happy time.

Glad I don't need to wear a mask anymore, although they're telling us we should be wearing masks because of all the respiratory stuff that's going around right now.

There's big signs over the hospital, wear a mask. During COVID, telemedicine became a big thing and there's a lot of talks about is tele medicine still relevant?

Should it be covered by insurance? What's your thoughts on tele-medicsine? As a pathologist, probably don't do it too much. No, we did a little bit during COVID.

Mostly wound checks for me, which was funny because I'd have Mr. and Mrs. Smith, and Mr Smith would be trying to hold his phone where I could see it. And I'll be like, do you have a ruler?

And they'd go get a roller. I'm like do have one that has centimeters on it? You know, just trying to manage those sort of things. I think it was valuable for people who really couldn't get out.

Um, I found that my telemedics and visits often devolved into just regular conversations with my patients. Just like being on a podcast, you know? Just chatting for a while, because again, they weren't getting out either.

So everybody was kind of desperate for human connection. That was kinda nice. People did weird things. I still have buddies like primary carers and some medical specialties who still do telehealth.

It's more convenient for patients when they don't have to actually physically touch their patients. But actually it's a very tactile profession. We have put our hands on things, you know.

You can't give an injection through telemedicine. So the core stuff that I do really was hands-on and needed to be done so. But we did do a little bit and I did actually speak to the state society about it.

I was asked to do that to kind of go through my experience with it and how it worked and it works fine. And I didn't

particularly care for it, I missed the interaction with people, but we we didn do it And do you think that there's a huge component to it?

The one thing we had during COVID which has gone away was was licensures were allowed across state lines. So I didn't have to be licensed in Maine, for example, to see one of my patients telemedicine who was up in maine.

Now you do. You need to license in the jurisdiction where the patient's residing at that time. So it's a little bit of a kind of conundrum because why is the only answer you can come up with?

I mean, if you're in New York or you are in main and I'm sitting right here, what difference does it make that I am not in Mane but I m in new York, I don't know.

I mean, these are kind of exposed a little bit, but they got rid of it briefly in a moment of crisis. So, yeah, so lots of things happened and some things stuck around and something's went away.

And, you know, I think we all learn to deal with things in little of a different light based on just sheer necessity. But I hope that's the only one I have to be part of during my lifetime.

One thing I thought was super interesting when I looked into your unit group, We Treat Feed, you're a sponsor of the Baltimore Orioles. We have been, yes.

Which has been fun. What's up with that? What is the history of that. I mean, again, listen, for the right amount of money, you too can be a sponsor of the Baltimore Orioles.

You know, we signed on. They did two things with the Oriole. We had digital rights and a digital page takeover. So, twice a year, there was the We Treat Feet was all over the Oriel's website.

And we did WeTreatFeet Upgrade Your Seat. So they take two people from the nosebleeds and move them down on the first baseline and put them on a big Jumbotron and have them wave and say thank you and those sort of things.

So it was just some cross-promotional things, they had a corporate partners box, so I got to go to a bunch of Orioles games sitting in the box. You're just supporting the local team, right?

Pretty much. It's like fun, it's fun. That's awesome. And it was fun. I really liked the Orioles people, the business people.

Telemedicine, sponsorships, and private equity

It was really funny because they really are segmented and fragmented. The businesspeople have no idea what the baseball people are doing. As soon as baseball, people have idea of what they're doing, yeah.

That is such a great accomplishment to be able to sponsor your local team. When you know you've made it a little bit, definitely. Yeah, I'll know when I made, it when i retire and don't have to work anymore.

Yeah. Okay. So here's something I always ask doctors about. There's always this big thing about private equity buying clinics. You've got a couple clinics under management.

What is your thoughts on the private equitization of clinics? It's a more complicated question than that because I think with the core of that question what you really need to be looking at is, is there a place in the modern world for for profit medicine.

So I work in for-profit medicine, I am not a not-for- profit company. A lot of the medical systems that are not for profit only have the not-for-profit arm, and they have a for- profit arm.

Usually that's the one that employs the physicians. And you look at the big companies, United Healthcare or Cigna or Etna, or Blue Cross, they pay their executives millions of dollars.

So is that something that is ethical? Should your healthcare be based on the value of a dollar? I mean, again, you're talking about a much larger socioeconomic construct than I think is intended here.

The truth of the matter is, is I it depends on who is in the management group of equity group and what their actual intentions are. Because I've dealt with private equity a lot, both as buy side and sell side consultants.

And I can tell you that every single one I have ever spoken to has been waiting to buy, build and sale to the next guy. And eventually, someone gets stuck without a seat when the music stops.

And there always just seems to be this opinion that there's somebody else, somebody, else somebody. So, you know, when he economy went bad during COVID, all the activity basically stopped.

I was working with groups and they just went on hold for eight months or 10 months. Then they started back and now there's a lot of interest again and there are people forming around.

There is an economy of scale argument to be made for all of this. I make that in my own business. Why do you have so much? Well, because again, I can afford two people full time to do the work for 10 or 12 doctors.

Whereas if I'm by myself, there is no way I could afford one person to that work. So there there that sort of argument is to made. I have not found that things are a lot better.

I do know some people who are in equity-owned groups who were very happy with it. They do take away the administrative burden and make practitioners' lives easier for someone like me who's spending full-time practicing and full time running a business.

But by the same token is you always have to be super careful because Everybody wants to play doctor and, you know, Dr. Google's right there. And, it is tempting to start saying, well, why aren't you doing this?

And the answer is, is because it's not medically necessary. So you run into some problems. So I do think it is. And there's a conflict that can happen there.

You do have less than ethical people on both sides, not just the equity guys, physicians who just try to find stuff to do for the purposes of billing.

As I said, again, we don't do that. What we try do is find what they're getting anyway and provide it. It's a different way of looking at providing services to patients.

If they're not going to get it, we're going not to give it to them. But if they were going get anyway. You know, might as well be us who provides the service and that way we can control, you know the dispensing, the quality, we have better control over what the patient does from a utilization standpoint or compliance standpoint.

It just makes a lot of sense when you think of it that. But right now equity is still going and you deals are getting done. And I think, bar a larger economic conversation, I you're gonna see a huge amount of private equity activity in 26. Yes, yes.

And that's kind of a major theme on this podcast, especially because we're like an AI company. Doctors are so nervous to get AI involved in the practice, at least doctors without MBAs, but not me, private equity.

They, you know, they're ready. efficiencies. So we started using about, it's probably been about 18 months now, ambient AI technology for patient visits.

I utilize it basically for everything. Some of my doctors don't use it at all. there was a lot of material in my notes that

I just thought of as passive conversations that were medical advice that should have been in, my note's all along that increased the level of complexity of the things that i'm doing and it took AI to show me that to really understand the value of what I was bringing people because you know we would have diabetic foot care visits and we talk about diabetes and the need for better A1C control and diet and exercise, and that would be nowhere in my note previously where now it's forefront in mind.

And I am providing those services to patients, but I never really thought of it that way before. So AI has helped me kind of consolidate what I've been doing all along into words that therefore improve my documentation and in theory, then improve the patient care we're providing.

I'm a big proponent of that. You know, same thing with billing and posting. I sneak peek writing an article for a publication where I'm arguing that the doctor-patient relationship is now dead, and it's now the Dr.

EHR patient relationship. Yes. That has now replaced it. And the saving grace in that relationship can possibly be AI because EHR has taken the largest chunk of attention in the room.

It's no longer the doctor, it's not longer a patient. The EH is where everyone's attention is focused. So I've been toying around with that for a couple of weeks now as I'm trying to kind of polish that up and get it ready to submit.

I mean, Scott definitely helped with I mean, it depends on what you mean scribes. So they're human scribs. And human Scribes, I think are a huge waste of time because you've ever seen notes by human scribes.

All they really doing is pushing the buttons that doctors would push by themselves. For lack of a better term, the monkeys monkey. They're not adding any value, they're just allowing the clinician to do less, which allows them to more other stuff.

Whether or not that's value or I think that is a different conversation, but the truth of the matter is it didn't improve documentation.

AI, documentation, and healthcare economics

AI improves documentation, so the question now becomes is, okay, if AI improved documentation and AI there improves efficiency and billing, Who should supply the AI to the practice?

Should the physician be paying for the, or should the insurance company be giving the eye out to patients? So the company is getting proper documentation and coding support to their level.

Well, they don't want that. Do they? I mean, again, do they imagine you're united and you build your super AI, like your denials AI. And all these doctors, they go, ah, I don't need AI.

Next thing you know, you get your denial rate up. I mean, that's the ultimate goal, right? Well, it depends. The other thing with this way, this is the one thing that people neglect.

If they have to reprocess claims, It costs them money. Reprocessing is not something they do. We've always talked about them denying claims for the purposes of the float to hold onto the money to collect more interest to boost their bottom line.

But every time they process a claim, And if we have to send it three, four, or five times, sure, we're losing money too, but so are they. It's an inefficient system.

So if there was a system that could be sitting there that would randomize the data in a way that the insurance company couldn't understand which patient it was, yet alone ensure documentation, completeness, fairness, and coding compliance, that might save them money, too.

So it's one of those things where if you look at it, depending on the study, somewhere between 8 to 17 cents of

every dollar Medicare spends is what goes to physicians.

The rest of it 80 plus cents goes everything else. So, it is really not physicians that are the problem here. The physicians are actually the ones who just, you know, eat the chunk of it.

You know last year we had a 2.8% Medicare fee reduction. This year, we got a two point 5% increase except it wasn't 2,5% across the board, it was 2 of the three items that compile an RVU unit.

So it's really about 2 point 1% when you break it down. And inflation was 3% this year. I mean, they're arguing that's a good thing. So, you know, look at how we're falling behind.

RVUs originally came about, I think, in the 80s. They're about 33, 34 bucks for an RVU now. But if they were indexed for inflation, there'd be 70 bucks.

That's how far doctors have fallen behind in reimbursement since the eighties. And my question to you is, well, where's the money going? The money's there.

It's still coming in. These companies make record profits. They're taking in record premiums. Premiums go up every year. I'm sure your health insurance premium went up this year, so everybody's premium goes up.

Where's the money gone? The answer. Administrative overhead, there's way too much of it. I don't know if there is enough to make a difference, but there are way to much.

The amount the executives are being paid is grossly ridiculous. Can't imagine what the CEO of a hospital or UnitedHealthcare needs tens of millions of dollars in salary.

And I understand the argument it's not the money, it is what it says. But still, those are dollars that are not being spent on patient care. And if you watch NBC Nightly News every week or whatever, they have this cost of denial series they've been running now for months where they find somebody with a unique condition that insurance denied and miraculously gets improved when NBC gets involved.

This week, it was about a prosthetic foot. It was a college young woman in Texas who I missed the part of how she lost her foot, but the prosthetic foot was 7,500 bucks and insurance didn't want to pay for it.

And it wasn't, you know, at the end of the day, I paid very close attention. Everybody in my family was hysterical because I like walked away from him but he stood in front of television and watched the story.

But it was one that was cosmetically appearing foot. It wasn t just, a peg. If you've ever seen a bologna prosth etic, they're just a little, Foot shaped piece of plastic or carbon fiber or something.

No, it was a very, very eloquent like the toenails were painted. It was it, was her tone flesh tone. I understand the argument. I mean, you're talking about a 22 year old, young lady who doesn't have a foot and wants something to walk around on.

But is that the best use or should we be spending that money giving Crotruda to cancer patients to save their lives? There's life preserving and life affirming, which is more important.

And where do you draw the line? I'm not an ethicist, so I can't answer that question, but I could sure ask it. Yeah, but thank you so much, Dr. Daniels.

It was one of my favorite episodes, definitely. Oh, it's been a pleasure. Thank you for having me.