Non-Clinical Career Opportunities for Physicians in Utilization Review and Health Insurance

Edited Transcript from SEAK's 2025 Virtual Non-Clinical Careers for Physicians Program

Moderator: Our next presentation is going to be on opportunities [for physicians] in **utilization review, which is a really important topic. It's probably the number one field that physicians transition into.** We're very pleased to have **Dr. Rebecca Lynn Moles** as our presenter. Dr. Moles is a child abuse pediatrician who transitioned from academic medicine to health insurance and utilization management as a medical director [for large insurance company]. She is a certified professional coach with a special interest in physician burnout in early and mid-career physicians. Dr. Moles is a SEAK alumna. She has had faculty appointments at UConn, Yale, and UMass. She earned her BA and MD at the University of Rochester, completed her internal medicine and pediatric residency at UMass In Worcester and her child abuse pediatrics fellowship at Brown, and she's a certified coach. Welcome back, Dr. Moles.

Dr. Rebecca Moles: Thank you so much. I'm going to tell you what I know about utilization management, and as Jim mentioned, I attended the in-person version of this conference when I showed up there eager to learn about different types of ways that doctors could spend their time, I knew exactly nothing about utilization management. So I put together this talk for someone who didn't know much about it. And I'm trying to answer for you the questions that I had and then pepper in information that I've gained along the way now that I work in that space as Jim also mentioned.

As Jim mentioned my entire clinical career I was doing child abuse pediatrics, so a super sub specialized niche of pediatrics.

In [year] I came to the SEAK Conference. I learned about utilization management as well as several other things. I never had any idea that I was going to actually do utilization management, but I handed in my resignation, walked away from my clinical career as a child abuse pediatrician and took a full-time job at an insurance company doing utilization management.

That's where I'm coming from. And here are the questions that I put together to answer for you today.

What even is utilization management? Right? This was my big question. We're going to go over that. What do doctors do who do this work? Where do they do it? Meaning physically? Where are they? And also for what organizations. For whom?

What do I even know to do need to know? To even do this job? How does it feel right? How does it feel to do this job? What's the day-to-day like?

How do I get experience in this type of field? How do I get noticed out of the different doctors who might want to do this work. And then, of course, how much could I get paid?

So let's jump in.

What even is utilization management?

I am not kidding when I used to hear those words, and just be like - I don't know what they're even talking about.

If you use that beautiful AI feature of the Google Search, it will tell you that utilization management is also called Utilization Review, but it is a process that assesses the necessity and efficiency of medical treatments, procedures, and facilities.

A cost containment strategy helps ensure that patients get the right care at the right time while avoiding unnecessary or inappropriate care.

What it means is you're reviewing things to see if they're medically needed.

So what is, what are the doctors do who are actually doing this utilization management work?

So, as you know, there's all kinds of things that are asked for - tests, procedures, medications, - asked for an insurance company to pay for hospitals, ask for payment for inpatient or observation level of care for people that are admitted to the hospital, and then patients ask to see providers that are inside or out of the network of their health plan, or to be seen in a hospital or to go to a lab that's maybe not part of their health plan. All of these things have to get reviewed for if they're medically necessary.

Many of those things do not ever need to come in front of a doctor. So every time you ordera CBC or an X-ray it's not a doctor at an insurance company who's looking to see if it's if that's needed. But many things do need to go in front of a doctor depending on what type of test it is.

So all of those different things that are asked for get reviewed for medical necessity and the way we do that is, reviewing the notes or information that's sent in with the ask. So, looking at the patient records other tests, etc.

Then you're making a decision about if we're approving that or not and using different criteria which I'll talk about to help decide if it's medically needed.

Then I'm also the person who then writes a letter to the patient to explain to them why something is being approved or denied. Generally, the patients don't get a letter from a doctor telling them why it's approved. They'll just get like it's an approved letter. But we write the

denial letters to help explain to the patient why it is that the insurance company is saying no to this request.

If any of you have ever looked at that for yourself, or as your own patient or the provider, looking at those - every different state, and different markets within each state have rules about how those letters have to be written. I happen to work in a market where the letters have to be written in [a certain] grade reading level language.

So that means very small words, short sentences, not very complex. Can't have many syllables, can't have a lot of complex sentences. So if you ever looked at one of those and thought, this is so silly the way they wrote that it's likely because of those types of rules.

So I'm working on distilling down a lot of information into some short sentences to help explain to the patient why their test isn't covered.

If something is denied, then it can go to the peer-to-peer process. So that would mean where the providing doctor who's ordering the test is talking directly to a doctor like me, working at the insurance company and talking about why it was denied, sharing more additional information that can help with the process. If something is still then denied, it can go to the appeals process. And that's when another doctor looks at the same case, it's like a second opinion, essentially, and more information can be provided.

So working in the field doing this type of utilization management work, you're doing all of these pieces. So I'm the person who's calling [the treating doctors] and doing peer to peers. I'm doing appeals.

What you *don't* do when you're the doctor who's doing this is see patients.

So many people do utilization, review or management work and also have a clinical role and see patients. And that is fine. That can happen as long as there's not a conflict of interest. And you're not seeing the patients that have your health plan.

But as the role of working for an insurance company or for other organizations that do utilization management, you're not seeing the patients. You're not their provider. So you're not ordering tests or medicines. So I had to leave behind that feeling of being the person in charge of their care or making the decisions about which tests.

So the way that the insurance companies phrase it is, they say we do not direct care.

So that means that if you send in a request for a certain test, let's say, for, like a facet injection of the back, you know, back joints for pain. But the notes that you send say that you really want an epidural steroid injection?

I have to deny that, because what you asked for is not what you said you wanted. I can't say, “oh, you know what- Dr. X really wanted this, so let's just change the code to match what they wanted.” Nope, because that would be directing care. We have to actually make sure that what is tested for and what is asked for is what's being asked for and make that aligned.

So this is a departure from the way that you're likely used to practicing medicine because you're not actually practicing medicine. You're not the doctor for the patient.

So *where* do people do this?

Where do doctors do [utilization review]? The majority of doctors who are working in this field are working for an insurance company. So there'll be these national large insurance companies, names like Aetna, United Health, Humana, all those types of places, and then they have lines of business or different health plans within that large company, so they could have a health plan that functions in Kentucky and something else in Nebraska and there'll be overlaps. But there are very different market specific things that are needed. So a doctor who works in one of those markets might not necessarily know all the nuances of the other market. If that makes sense, you can also work for commercial insurance. That would be like you have from your provider, or you purchased yourself or government sides would be Medicaid or Medicare. All different rules, different types of strategies that have to be applied. There can also [be] work for a place called an Independent Review Organization or an IRO. So these are 3rd party companies. So not hospital systems or healthcare systems and not insurance, but a separate organization whose whole role it is to provide medical necessity review on cases so they could be hired by hospitals. They could be hired by insurance companies, and they will often hire different subspecialists and generalists to do these types of reviews. So, as you can imagine, insurance companies cannot employ one of every single kind of doctor in the universe. But there can be times that they need a very specific type of specialist to review a case. So an IRO can be very helpful in that, because they can have doctors on a kind of a panel, they call it, where you might get called every once in a while to review a case in your super subspecialty niche.

Most insurance company jobs [for physicians in utilization review] in general are full time. Some are part time - there can be similar part-time things at an IRO. And like I said, there's a panel where you become one of multiple doctors who are employed on a contracted basis. So as a case-by-case kind of ad hoc more of a side gig, as people would call it, or a side job most of the time. **This is remote work. So there's not a brick and mortar building that you go to do this most of the time I happen to work at a company that requires me to go to an office once a week.**

It's a company mandate, but it's not necessarily that I need to be there to do the work I'm doing. So most of this is remote work from home, and we'll talk about the skills that you need for that work a little bit later.

One question I had is when I 1st learned about this, and in when I was considering taking this job is, what do I even know to do this job? And I have to tell you as a super sub specialized, pediatric child abuse doctor I was like, “do I even have enough experience with different types of medicine to do this job?” And the answer is, yes, I do. I'll tell you more about that. **But what you generally need to have is board certification, some places will say eligible, but the majority of them want you to be board certified in your field.**

If you are a subspecialist, you don't necessarily need the generalist. So if you are a gastroenterologist, you don't necessarily need internal medicine and gastroenterology, but board certified in something **you need to be licensed in at least one state**, and most of the time get **licensed in more than one state for the company, or wherever you're going to be doing the reviews.**

And then for **the majority of these positions, you need clinical practice experience beyond training**. So for those of you who are in medical school or residency now and [are] looking to transition to a non-clinical job immediately, this likely is not going to be for you. In a lot of ways that makes sense, because what these companies, the insurance companies or the IROs are trying to do is have doctors who have real life experience, taking care of patients helping to decide if tests and procedures that are asked for are medically necessary. So they want you to have more than just the book smarts, more than the training smarts. But some street credibility, if you will, for having done this type of work. As we talked about, you're using your own clinical judgment as well as many other resources.

There are 3rd party published criteria or guidelines that most insurance companies will subscribe to, and you have access to those. So that has a lot of different criteria for different types of tests and prerequisites of things that have to happen before you can get a certain test. Things like you have to have a certain amount of physical therapy before you can have surgery on your back like those types of things.

And so those are at your disposal as well as one thing I was very excited about to learn that I had no idea about at the insurance company I work at is that **there is a whole group of doctors and scientists who work for the insurance company, who come up with internal company guidelines to help determine if things are medically necessary and their whole job all the time is to review medical literature and constantly update the guidelines that they're using.**

So it's not these antiquated old dusty guidelines from a long time ago. They're constantly reviewing, constantly updating them. And when we look at them there's a whole bunch of footnotes. There's all of the different studies that they're looking at. So all of that is at your disposal as well. So that comes back to what I said about no matter what specialty you have, you can do this job because you have other things at your disposal. You also, of course, can use things like Up To Date, and the things you would regularly use in your clinical practice and Google searching and PubMed, and those things that you would use to find different studies and support to help understand what they're asking for and [if it is] medically needed?

All right? And now we're up to, how does it feel right? **How does it feel to do this job to work [in utilization review] in an insurance company.** So the 1st thing I got to address is, **does it feel like you went to the dark side?**

So I get this comment mostly from other physicians, like some from other colleagues who are still practicing clinical medicine. Oh, are you the person that I talk to when I do the peer-to-peer? I work the closest with other physicians and nurses in my health plan and we are constantly talking about what's best for the members, the patients. What is the right thing? How do we get the information we need to be able to get them the care that they need, so it does not feel like I'm going to work every day at like a dirty job.

I certainly, as I mentioned already, feel like **I'm using my medical knowledge in a different way.** I happen to have trained in internal medicine and pediatrics before fellowship, so I feel like I kind of dusted off my internal medicine knowledge that I had from Residency. **Just about every day I'm hearing about some new medication or some new treatment, or something that I have not thought about before or even known existed. And I find that interesting.**

I also find that I can advocate for patients. So I'm at the level of reviewing what's coming in. I can see the trends and help to flag that for the higher administration to say, here's what's going on with our members. Here's what they need.

I've now been working at this company for about [x] years, and I feel like I'm just stepping into this role because I, as I mentioned, I didn't know a lot about utilization management when I started. So the 1st couple of years, I was just basically figuring it out. And now I'm getting a bit more of understanding the workings of it to be able to make more meaningful change in the organization. So I certainly feel like I'm adding value to the company by making sure that the things that we are covering are the right things, helping with the patients, helping them to understand why we're covering things and not and getting them.

And one big reason that I end up having to deny things is because I don't get the information I need to approve it. And there's a lot of different reasons that that is but big the thing, and

I'm sure this will come not as a surprise to those of you who are working in clinical medicine is that the documentation is not great.

EMR is wonderful, but copy and paste is terrible, and so I can't always tell what's new information. What's old? What's the current information? And I need that information in order to justify saying yes or no to a specific ask.

So, as an example, I was just reviewing the other day a review for an ask for a wound Vac. So a special treatment for serious wounds that are not healing with underlying conditions, like diabetes, etc. So I was reviewing the notes from a person who was in the hospital for several days for this complicated wound and I, as part of that review, have to look to see how deep is the wound, how big is the wound, what has been tried, and every single note said left leg wound. That's it. And I kept looking and nobody described it. Nobody talked about it, nobody measured it, and I was like, there's just not enough information.

A left leg wound could be a paper cut right like. I can't tell what it is so I have made sure that when I am talking to doctors and the providers during the peer to peers, that I'm explaining to them what I needed and if it's the certain situations I'll say here we didn't get. Here's the information we didn't get. If you could include these things in your notes. If you have a template in epic, or whatever. EMR, if you could add these things that would help us to know what we need to have what we need when you send it in.

There's also issues that sometimes the doctor's notes are good, but whoever sends in the request to the medical company to the insurance company doesn't send the right note or doesn't send the right information. So sometimes there's an internal kind of snafu, and how those things work. So I try to point that out as well, the goal being that we don't want to spend our time in committee, in paperwork and keep doctors from providing care and patients from getting it. So that's all. The ways I feel like I add benefit. **I also do not feel like I am pressured to deny care in order for a profit for the company.** And **when I was looking at my job I said to the person who was interviewing me, is there a certain percentage of things I have to deny, and they no joke, laughed out loud, and they were like, no, no, and that's that like dark side mentality that I was going into thinking. As a matter of fact, for my company, I have to sign a thing every year that says that I'm not being pressured to deny medical things for a profit, and I feel no problem signing it because it's true.**

Back to how it feels. I will also say that my busiest day still feels slower and by slower I mean just more manageable, less harried, you know, just kind of less obnoxious than when I was doing clinical work in a hospital. That does not mean I'm not busy, and we'll talk about that, but it just feels at a pace that's much more reasonable even on my busiest day, and some of that is that nothing is life or death right? I'm not getting paid to intubate somebody. So it's

even if there's a decision that has to be made, or something that quickly needs to be turned around, or there's something that's expedited, and it has to happen right away. It's still not like the patient's going to die if I don't get there or I'm making some life or death decision about them. **It's also there's not overnight call. I don't have a pager,** so it's much easier to have clear boundaries about when I'm working, and when I'm not working, even though I'm at home, we'll talk about that.

And then at the end of the day, I turn off my computer. And I don't really think about my job again. Certainly not the way I used to, and it's so much healthier for me.

There are definitely physicians who work in the utilization management sphere and have a career in it. Right? They're advancing up the company. They're doing things. We'll talk about promotion opportunities in a little while.

So how do I get experience in this without walking away and taking a job like I did. So, we talked about these independent review organizations, and there is a National Association of Independent Review Organizations.

We'll look at that website. And that is a group that these IROs have to apply and get approval to be full members. So there are other independent review organizations that are not part of that. These are the kind of the vetted companies a good place to start. (**Editor's note, please also see the list of 100+ companies that may hire physicians for utilization review contract work here].**

Also, there are opportunities to do it on the doctor side of the house, not the insurance company side. So a lot of larger hospital systems are going to have a physician advisor, or some type of role. So that's a PA, but not a physician assistant, not a clinical role, but **physician advisor who work for hospitals [and]are doing things like reviewing denials and saying, are they medically necessary or not, and they are often the ones who do the peer-to-peers on behalf of all the hospitalists or all the inpatient docs.**

So some of them do it full time and remotely. There are some companies that do it full time, and then the hospital system orders. There might be ways that you can be on the quality committee and some ways to get some type of utilization management experience other than taking a full time job.

And then the other experiences you learn on the job. As I mentioned. **I just happened to know nothing about it when I started, and they taught me everything that I needed to know.**

[Let's look at] **a quick snapshot from my Linkedin search that I did. You can see here the top here medical director utilization management in the United States. So that's what I searched for and got all these results.** And I clicked on this one for Humana. And you'll see here the

range of salary that they have now, I would say, that's a little bit higher than I have seen, but we'll talk about that, but if you can click on there, and you can actually keep clicking, and it'll come up with the required qualifications. So it has this, you know, use your skills to make an impact. And here's the things we already talked about. **An MD degree, plus years of clinical patient care experience post residency, board certification, unrestricted license.** You know. You're not in trouble with the law, you know, with the government and the standard, you know, you can communicate, and you can figure problems out right? That's the must have. Then they have these preferred qualifications for this specific job Medicare experience or Medicare advantage similar to other things you've heard.

You need to probably have all of this top part. **You don't necessarily have to have all their preferred qualifications before you can apply.** But this is just to show you kind of what it'll show online and different than if you are depending on where you are in your career. When you used to have to like, send in a paper application. These things are available and you can do them automatically online, which means that **they get tons and tons of these types of applicants. So we're going to talk about that, because then how do I get noticed right? How are you noticed out of this sea of other applicants that you could see for this for this type of job.** So some of it is, gonna be your specific skill set.

Certainly the IROs are often looking for specific skill sets. Certain insurance companies are sometimes looking for very specific types like you can be looking for an OB/GYN or radiology, or something like that. So sometimes it'll be your qualifications that set you apart.

The other thing that helps you get noticed is persistence. So you are likely going to have to send lots and lots and lots of applications to different places in order to get noticed. This is different than probably your experience with getting a clinical job.

The way that I got into this is that my medical school roommate was working in this at this insurance company and reached out to me and said, we're looking for pediatricians. Are you interested in looking [at] it? You cannot overemphasize knowing someone. So you really need to network.

One way is through the in-person version of the SEAK Conference has a ton of networking opportunities, and certainly other conferences you go to.

But don't discount interactions you're having in your daily life. So it could be people in your specialty. It could be people in your hospital. **It could be the person you're doing the peer-to-peer with**. **So we have somebody on my team right now at the insurance company who was working as a physician advisor, and we used to talk to him on the phone, doing peer-to-peers. And now he comes and works with came and worked with us. He left the hospital system and came to us.**

If there's people that you talk to doing your peer to peers, don't feel embarrassed about asking them like, “Hey, how did you get this job? What do you like about it?” Just ask them because they're not the Disney villains in the dark keep. They're just people at the other end of the phone, who used to be like you and seeing patients. And now they're doing this other job. So ask them also, **think about things like your medical school class, your residency class you know, doctors, you know, from other areas as well as regular people. Right? So people in your life, in your town, in your network of you know your people that are at your church, or belong to some group that you do, or coach your kids because they likely, if somebody works for an insurance company.**

And now, how much could I get paid? Like so many things? It depends right? And it's gonna depend a lot on the company, the type of work, and where you live. Because again, these national companies do a lot of research about where you live and the cost of living because a lot of their employees are remote. So they're used to doing that.

I would guess it's more like the low to mid 200s. For starting. Now for some of you, that can be a step down from what you're used to getting. I can tell you, for me, even as a rare board-certified child abuse pediatrician who was relatively well paid in my field, **I ended up with a larger base salary, taking this job than I had working for my children's Hospital.**

You also have to remember that you're working generally [40 hours a] week for real, not [40 hours a week] on paper but [40 hours a week] for real right like. There's very little nighttime or weekend work. There's some different things we have to do on the weekends at times, but generally nothing at all like when I was doing clinical work.

There's also merit increases. There's true cost of living raises for a lot of the companies, you know, meaning not half a percent. There's corporate bonuses that I found to be so much more robust than anything I got in clinical medicine. The corporate bonuses now are more like [a significant] % of your salary. So a huge amount compared to what I was used to getting in academics. **And things as well like stock options which I was like, what is a stock option?** That's a different talk. But they, you know, they have other things that they reward you with as well as there's so many less other costs which are minor, but really add up so costs like **I don't have to commute**, so I'm not paying, **I don't buy nearly as much gas**, wear and tear on my car. **I don't have to pay parking fees**, which I've had to at certain hospitals. **I don’t have to have real clothes right?** My clothing budget. Not that I was ever like Super well dressed, but **like I wear yoga pants and sneakers**. So if you are somebody who has a big clothing budget or dry cleaning, or those types of things, all of that is going by the wayside.

One thing that I have found that is very different, though, is that they don't have a robust CME budget. So continuing medical education budget which I've just found, I just have to pay for it myself.

I also wanted to add to you just some lessons that I have learned doing this for a couple of years. I've obviously peppered in a lot of that during this talk but I have learned that **there is a ton of corporate lingo.** So if you can remember your 1st couple days on your OB/GYN rotation in medical school, where you realize that everything has a letter acronym. That sounds almost the same. And you have to figure out what it means, yeah, there's a lot of that in the corporate world. And I'm still figuring that out.

I also had to learn how to start a new job completely remotely and how to meet a team and work with people every single day, who I have never met who I have never walked by, who I will never run into. It's very different skill set and I struggle every day to try to figure out how to connect with people and make it fun. You might be surprised doing that in child abuse medicine, a lot of how we survived was by making things fun. So I'm always trying to ask the people I'm working with something silly or share something about what's going on in my environment, because it actually just makes it more real. So that's a skill set.

I've had to learn that working from home is a skill. You need to be focused if you are somebody who has trouble completing your charts or trouble kind of working independently.

I had to set up an office. So I'm in an office in my house because I knew that I was gonna need to have a space. It's like it's like dating myself now, but like Mr. Rogers comes home and he takes off his work clothes, and he puts on like his home clothes and his home sneakers.

A colleague of mine has a table set up literally. She can touch it from her bed and has all of her computer stuff. Sit there and that, and she just gets out of bed and sits there.

I don't have that kind of focus like it's amazing to me that she can sit like right there next to her bed and do her work like that all day. But it's everybody's to each their own right? **So you have to have a space that helps you stay focused.**

And it's also important to know that working from home is still working. So I've had a lot of people who ask me who say, Oh, you know. I want to retire, and I only want to work a little. So I thought I would get a full time remote job. Okay, so full time. Right. **It is full time I am working all day.**

Yes, **I have more flexibility than when I was doing clinical medicine in terms of I can pause, work and like, go pick up my kid from school type of thing differently than when you have patients waiting, and you can't just walk out and do that, but I still have enough work to fill**

an entire day, and I'm expected to be working, and some companies even track things like how many keystrokes are you doing. So make sure that you're not just walking away from your computer and not doing work. You're also, you know, they watch how many cases you're doing, etc. So it's still working. So this is important for you to know as well as setting boundaries for others.

So a big person I have to set boundaries for is my mom, who lives like a mile from me [and] can't understand that she can't just knock on my door and stop over to tell me all of the things that happened to her today, because I'm actually working. It's a work day. So **you have to have boundaries for people around you and for yourself to make sure that you stay focused.**

I also found that there's not necessarily the same clarity or opportunities for promotion as I felt like there were in academic medicine. So in academics there's the assistant professor, associate Professor, Full Professor Ladder, right, and you know, kind of what you need to do. And you're constantly working on those academic pursuits to help you gain that. And then there might be things like you're the, you know, the medical director, and then the division chief and the chair, and that type of progression. It's a bit different in the corporate world, and there are people who come in, and the entry level for this is called in many companies a medical director. **So you already come in as this title as a medical director [but it] does not mean I'm directing a team. That's just the title.**

There are people who've worked at these companies for years or more, and are a medical director, the same as they were the moment they walked in.

And they're doing similar jobs like they clearly are gaining skills, and they might have little projects. But they're not necessarily moving up in the company, and as you move up in the company, you tend to get more and more corporate. So if that may or may not be your interest, so you're not necessarily getting more and more specialized medical projects. You might be getting more about, how is the health plan working on the global level, you know. Like, so it depends on what kind of opportunities you're looking for.

It's also a lot of difference between government. **So Medicaid and Medicare versus commercial in terms of what's covered what's not covered**. So there's a lot of different things to learn there.

And I learned that this was a really competitive market. Again, I told you this opportunity kind of fell in my lap at the right place the right time. But it is hard for people who are trying to break into it. And again **network, network.**

So overall for me I have found that **utilization management does not have the highs that I had in clinical work.** It does not have that. I'm [not] looking in the face of the child or the parent whose life I have changed with the care that I have given. I don't get that sense.

I also have found that it doesn't have the lows of the clinical work. It doesn't have that pace. That feeling like you can never do enough that threatening feeling like, if you do something wrong, someone's going to die right, or you're going to get sued. So it doesn't have those types of lows**. So I used to describe my day to day work in clinical medicine was like highs and lows and highs and lows. And now, I'm kind of like you know, kind of in the middle.**

And that's okay. Because with any job there are stimulating parts.

And there are really tedious aspects. The bread and butter of what you're doing for this type of work is sitting in front of a computer. I actually have screens right, sitting in front of my screens looking at cases and reviewing records, and making these decisions over and over all day without that interpersonal contact, like I was used to from clinical, so that part can get tedious.

However, it does have flexibility like, I said. **When I need to take time off. I don't have to reschedule a hundred patients.**

The pace generally is very sustainable, and the compensation is very reasonable for the work that I'm doing and as I mentioned, I don't feel like I'm like working on the dark side. So that's all great.

With that I thank you for your attention, and I hope that you came away from this with a better understanding of what utilization management is, and what opportunities there could be for you. So thanks so much.

Moderator: Thank you so much, Dr. Moles. No one would know that you're fighting off a cold. Fantastic as always. A few questions. I have been furiously taking notes here.

Q: When you are doing your oral communicating as a home-based person in your particular company, is the is it default, zoom or something else? Teams that that's video, or is it just voice only?

A: Great. So we happen to use Teams at my company. But I would say **[a lot] of the time the cameras are off** which was a huge change to me from clinical work and working at the hospital, where even remote meetings, the cameras are on. You have to get in the right mindset of working from home because you can legitimately be in your pajamas, you know. So you have to, actually, you know, make sure that you have your brain on, and be awake and ready to go.

Q: And now, obviously, you're trained in and certified in peds and internal medicine and which covers a lot of things. But you're not a surgeon. You're not a proceduralist. **How often do you have to make calls outside of your specialty, approving a surgical procedure?** Things like that.

A: That's a great question. So I would say a couple of things. So there's a lot of different things that I get asked to review. If there is something that I am not comfortable with, **there are other doctors on my team that are my 1st resource, that I can go to. We have, like a palliative care doctor, and an endocrinologist, an ophthalmologist, you know, like those types of things.** So I can ask those very subspecialty specific questions. We also have resources to have other subspecialists look at things outside of my immediate team. So I always feel like I have resources that I can call on, and also in my particular company, very specific things, so like spine surgery, other types of neurosurgery, or like chemotherapy. Those types of things are often done by more subspecialty physicians in the company, and then they come to me to kind of add whatever is needed to fit the rules of my specific state.

Q: Is it fair to say that's it's fun and interesting to learn these areas of medicine like OB/GYN that you haven't seen since your internship, and things like that?

A: Yes, like, I said, **I learned something new every day**, and I feel like it helps. I actually feel in some ways more relevant than I did doing child abuse work, you know, because that was so sub specialized that there was a lot of regular medicine stuff that I didn't even know was happening. So now I know.

Q: Thank you. And how many, just a ballpark I know it's going to vary, but how many cases do you think you're dealing with a day that different patients I know they're not your patient, but their patients like, what? What's the what's the volume in any hour? Day, ballpark?

A: So it's it varies day to day. And I will also give the caveat that there are cases that are really quick, right, and there are cases that take much longer similar to, I would imagine, in clinical practice where you have, I mean pediatrics, right like the ear infection visit versus the like rheumatologic disorder, not otherwise specified, visit those types of things, but I would say it varies between probably and different patient cases that I would be interacting with in different ways. Not all of them am I writing a letter for? But I also talked to nurses about patients in the hospital, etc. So the pace is faster than I was used to in child abuse.

Q: Is the system that they have at your employer sophisticated so they don't give you complicated ones, and no simple ones, **does it work itself out so you are not getting overwhelmed?**

A: Right, it kind of works itself out. And I also happen to work with a really great team, and we recognize that some days are really busy for me and light for somebody else. You know other doctors, and we are constantly kind of covering for each other, or we can always say, like, Hey, S.O.S like, I've got a lot of cases. Can somebody help, you know, and then they jump in and help. So it has been manageable, for sure.

Q: In your experience is moonlighting allowed? So, for example, I'm an ER doctor, I want to do urgent care or ER on a weekend - stuff like that? What's your experience with moonlighting?

A: Sure. Yes, so they have to make sure that there's not a conflict of interest. So if you are working for an insurance company, I think that they have rules about what percentage of patients you would see would be also have your insurance, you know, because you can imagine it's a conflict of interest if I'm seeing you as a patient and then I'm asking the company I work for to approve the procedure that I'm asking for. So there's some rules about that. **As long as you're fulfilling those rules, there's not any problem with you seeing patients. As a matter of fact, they kind of like it because it keeps you clinically relevant.**

Q: Do you need a license in every State where the patient is located? If you're doing this work and how many licenses do you have now?

A: **Yes, so I primarily work for the State of Florida. So I have a Florida license.** But I live in Connecticut, you know. I currently have a Connecticut license, because this is where I live. I don't need that necessarily for my job, but I have a Florida license, which is what I'm using day in and day out. **My company also has us get licenses for the other States in our region. That's so that we could, if needed, cross cover certain plans They'll pay for all of the licensing fees.**

Q: Do they pay for the boards as well?

A: All of the licensing fees, Yeah.

Q: **So peer to peers, what percentage to them would you say, get worked out?** They just need to document something better as opposed to denied at the end day.

A: That's a good question. I've never actually thought about the percentage of it. **One thing that I have been surprised about for peer-to-peers is that the majority of them are pleasant. And some of it is, I think my demeanor because I come at it to say, here's what I know. What didn't I know? Like, what did I miss? Help me know what's missing? And then sometimes, you know, it is a denial. It needs to stay a denial for reasons. And I'm explaining to the doctor why. And then they're like, Oh, you know, that makes sense.**

And actually a lot of the things that I do now are with those physician advisors that I talked about, which are doctors working for the hospitals, and in some ways those are the easiest ones, because they understand the way that the insurance companies thinks and they're looking at the same guidelines. And sometimes we get on the phone. And they say, this is totally an observation patient. I don't know why we're even on the phone. They take seconds. They're like this person was a clear cut asthmatic, came in overnight. Got better. Went home, I don't, you know, like this should not be inpatient level of care, and then we're like, bye. See

you later, you know, like, **so they're not nearly as like gut wrenching, argumentative, the way that I think some people have experienced them.**

Q: And I and you mentioned that that you, **when you write the denial letters to the patient, they have to be done at like a 4th grade level. They have to be understandable, which is fair enough. Can you use AI to try to tweak your language to make it more understandable?**

A: Yes, so we do have some AI capabilities that they're exploring within our company. There's certainly rules about using any AI technology and putting protected health information in. **But I will say that writing it in the 4th grade level, I think, is very specific to the Florida market. Other places, I think, are higher, and you know 4th grade is a lot more difficult. You know a lot easier to write to than a 7th grade level, and I would say, as a pediatrician.**

Q: **Can you tell us a little bit more about your coaching practice, and who you help, and how you help them?**

A: Sure. **And actually, that reminds me, one thing I didn't say is that having this role compared to having my clinical job is, I do feel like when I turn off my computer at the end of the day, I actually have physical time and emotional and social bandwidth to like have a hobby.** This was like a big deal, because I suddenlyhave free time at night when I'm not completely exhausted. So that ties into what you're asking me, because I am, as you mentioned, a certified coach. I came into that after I came to SEAK the 1st time. So I enjoy meeting with physicians who are doing some type of transitions so they can be thinking about what's the next step they've now they've gotten their feet wet in their academic world or their attending hood, so to speak. And now they're trying to design their career. I'm not trying to get people to leave clinical medicine. **I want to help physicians build the careers that they love, that fill, you know, fill their need and fill their dreams and help them to know what that is.** So I work with physicians, one on one, and I also have done workshops and other things within hospital systems to help with that.

Moderator: Thank you very much, Dr. Moles.