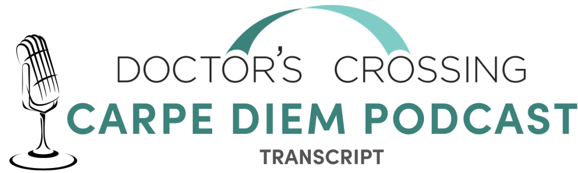

EPISODE 57 Working in health insurance - what's it like?

With guest Dr. Robert Kanterman

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RK: "People are under the impression that there are incentives to deny things. And I've seen that bantered about on social media and whatnot. And I will tell you that there is no such incentive whatsoever. There's no benchmark. There's no requirement to deny services."

HF: Welcome to The Doctor's Crossing Carpe Diem podcast. If you're questioning your career in medicine, you've come to the right place. I'm Heather Fork, a former dermatologist and founder of The Doctor's Crossing. As a master certified coach, I've helped hundreds of physicians find greater happiness in their career, whether in medicine, a nonclinical job, or something else. I started this podcast to help you discover the career path that's best for you and give you some resources and encouragement to make it happen. You don't need to get stuck at the white coat crossroads. So, pull up a chair, my friend, and let's carpe that diem.

Hello, hello and welcome back to the Doctor's Crossing Carpe Diem podcast. You are listening to episode number 57. A number of you have asked me to do an episode on what it's like to work at a health insurance company doing utilization management.

Utilization management or UM is one of the big buckets of nonclinical opportunities for physicians. There are a number of different types of organizations you can work for and various roles you can have when you work in utilization management.

A lot of my clients have transitioned into these types of jobs, and by and large have been very happy. I just got a message the other day from a former client who was a family practice physician. And she said she loves her job. She says it's a lot better than she found clinical practice to be after 10 years.

Today, we have a wonderful guest who you may remember from his popular podcast episode number 14 - Things to do before leaving medicine. His name is Dr. Robert Kanterrman. He is the board-certified interventional radiologist who was very creative in his exploration prior to leaving practice. Among other things, he investigated opening an ice cream parlor and having a travel business. As interesting as those ideas were, he ended up saying yes to working for a large health insurance company as a medical director.

Robert is going to give us the insider's perspective on what his day-to-day job is like as well as talk about what kind of physician might like this work, and some tips on how to explore this direction if you're interested.

Before we launch, I just wanted to let you know that there's a special holiday offer on my new LinkedIn for Physician's course. You can get 20% off using the coupon code 2021. This offer is good until the end of the year.

For more information about this course that teaches you how to use LinkedIn when you're making career changes, please go to doctorscrossing.com/linkedincourse. I'll also have this link with a code in the show notes.

Without further ado, I'm very excited and honored to welcome the one and only Dr. Robert Kanterrman to the podcast. Hey Robert.

RK: Hey Heather, thank you so much. I'm happy to be back. I'm very happy to talk about my new career in utilization review and answer any questions you or your clients might have.

HF: This is wonderful, and you are a big hit. You did a great job. I love your humor. And this is a big topic and people really want to know what exactly you do. And you don't know until you get behind those doors. So, we're going to open up the doors and take us into your world. Before we really launch in, could you give us a little bit of an understanding of what utilization management actually is?

RK: I think many doctors have the experience where they're on the phone or doing paperwork, trying to get an examination like an MRI or a medicine or a surgery approved from a third-party payer. And the process by which that happens using evidence-based guidelines and criteria is considered to be utilization management. And that's what I do.

HF: Right. And we need physicians to do this because you're the one who understands better the situations that you're evaluating. And as we know, there are different feelings about this, obviously. Health insurance.

RK: Right. I think a lot of doctors have a very negative opinion of utilization because they only really interact with it when there is a problem. But there's a lot going on behind the scenes that I think is actually very good. And maybe we'll get into some of that.

But the bottom line is that healthcare resources are limited and everybody can't do or have everything that they might want. So there have to be decisions that are made. And also, there is a fair amount of fraud, waste and abuse that goes on and nobody's watching the amount of resources expended to things that are wasteful or are frankly

fraudulent, will eventually take it away from things that truly are necessary and helpful to patients. I think it actually serves an important role.

HF: Yeah. It's going to be interesting to hear your perspective because you're seeing all the things that are approved and the things that are denied. I'd love it if we start with a typical day for you. What does that look like?

RK: Okay. Well, first I should say that I'm an appeals medical director. Everything that I see is something that's already been denied, either a prior authorization or something that comes in, we call post service, the service or the medication or whatever is being contested that has already been performed and a bill has been paid. The cases I see have already been denied.

I'm a radiologist, that's my specialty. And I do interventional radiology as well. I only really see cases that are related to radiology or interventional radiology. My typical day is actually a lot like the work of a radiologist. I sign onto my workstation. I have a work list. I opened a case. I look at it. And in this case, I'm not looking at images of a case. I'm looking at records of the case. Maybe it's doctor's notes, maybe it's previous imaging reports, maybe it's an appeal letter from a doctor or a member.

And based on that information in our guidelines, which I have open all the time, I make a determination whether the denial will be upheld or overturned. It's kind of double negative because when you overturn a denial, you're actually approving it. But that's sort of the jargon of our work. And I do that anywhere between 20 and maybe 40 times a day for various things like MRIs, for interventional radiology procedures.

And my colleagues do other services, whether an admission is inpatient or observation. A lot of it is pharmacy work, a lot of other surgical procedures, durable medical equipment. There's a whole lot of other things that I don't do.

And in an appeals level position, it is really specialty driven. A general person doesn't typically do things that are out of their practice range. And I think that's sort of part probably regulated or at least maybe the insurance company insists that it has to be that way on the appeals level. It's probably regulated to some degree that the appeals have to be done by a specialist that's familiar with that sort of work rather than prior authorization, a lot of general people can be doing a variety of things. I think it's frustrating for specialists at times when they're dealing.

HF: Could you give an example of why you might overturn a denial? For example, approve something that was denied?

RK: A lot of times the information that is required to meet the criteria for an exam or a procedure or medication doesn't come in with a request. And sometimes just getting a denial and seeing what's missing and turning it back, we'll get that whatever service is requested, overturned and approved. That's probably the most common reason.

HF: Yes. And when you're doing your work, are you often writing reports and including the rationale, maybe even citing articles and literature to substantiate what you determine?

RK: Yes. All the time. First of all, all of my work is reports. I think I started to tell you I feel like I'm doing radiology work. When I open a case, I look at it, I make my determination. Then I have to write a report. And part of the report is the rationale for my decision. We draw primarily on our guidelines, which are pretty complete in a lot of areas, but sometimes we have to go to places like up to date or to literature, sometimes appeals come with literature. “Hey, look at these papers. They show that, what so and so that you denied really is appropriate for this.” And usually, we'll listen to that.

And in addition, when we write a report that we make a negative determination or uphold the denial, I hit all these double negative things, but we also have to write a letter to members and it has grade level requirements. It depends on what state it's

from and whether it's commercial or Medicaid. You have to train yourself to write these letters. Sometimes it's eighth grade, sometimes it's as low as fourth grade and there's techniques to do all this.

But it gets very interesting. Sometimes the biggest part of a case, of a denial is trying to get the wording in under the grade level standard to explain a complicated medical decision in fourth grade verbiage.

HF: Now you said that you have this special role in doing the appeals, whereas a lot of physicians who might be working as a medical director for a health insurance company might be just looking at prior authorizations, medical necessities, standard of care. So, their work might be a bit different, and you've seen that in your other colleagues. What are some other things that you or these other physicians who have these roles might be doing during the day?

RK: I've spoken with a couple friends who do this and it's actually very similar. I have a friend who's a vascular surgeon who works at a radiology benefits management company. He does the same sort of things. In his role, he spends a lot of time on the phone during peer-to-peers. I don't do a whole lot of that in my role. I do a little bit of that. But he does a wide variety of cases.

And I have another friend who just started with another orthopedics benefits management company. He's a neurosurgeon. He does specifically prior authorizations for orthopedic work. And again, he spends a lot more time on the phone with peer-to-peers, but it's all fairly similar work.

HF: I think that's a good distinction that you just made is that if a physician is working at a benefit management company, they're often doing more peer-to-peer calls. Can you describe what's the difference between a health insurance company and a benefit management company?

RK: I probably can't but I can try. I think that the benefits management companies tend to be fairly narrowly specialized and work at the behest of a larger entity, like a larger insurance company. I don't want to mention any names, but there is a radiology benefits management company, there's a psychiatric benefits management company with various orthopedics.

They're usually really on the front line of these. If an orthopedic surgeon wants to do a total knee on Mr. Smith, he has to go through an orthopedics benefits management company. And most of the time things get approved and we don't hear about it. And again, at my level at appeals, at the big insurance company, I see the cases that are tested for one reason.

HF: Yeah. I think you know exactly what the benefit is of these companies. Yeah, they're often an arm of a health insurance company to do the imaging studies or certain test procedures.

Now, what are some other things that you might be doing? For example, are you attending meetings? Are you helping with guidelines? Are you working on projects?

RK: Yes, actually I've had a fair amount of work in all of those things. We do have meetings. We have team meetings for our team. And just to be clear, I didn't say this earlier. I work from home. Most of the people in these jobs work from home. I guess there are some people who work from offices, but it's primarily a telecommuting job.

Meetings are pretty important because otherwise you have no interaction with your teammates. And surprisingly, I found that we're in a situation where we get to know our teammates, as well as one can know them working remotely. And I've already developed some telecommuting friendships, which is great. We have meetings a couple times a week.

There's also a variety of different projects centered generally on process improvement. I have a couple of particular projects I'm working on trying to get some guidelines changed, to be less restrictive for certain interventional radiology procedures that I think are kind of being considered to be unproven at this time, but are really sort of becoming part of the standard of care in many communities.

There are a lot of ways to make things better for your members, for your referring physicians and the medical community at large. And I think that's encouraged in my role.

HF: And if you think about the progression in one of these roles, where can you go? Say you start out as an entry level medical director. What are some opportunities for professional growth?

RK: That's funny when you mention that, medical director, because when we were talking about this before I took this job, I thought being a medical director was a big thing and it's just like attending basically. I'm like, "Oh yeah, it is. It totally is." That's like the entry level. It's like the junior attending is a medical director.

But there are senior medical directors. You can become a CMO or a vice CMO. There's plenty of room for growth in this role. I'm relatively young in this career. There are people on my team as old as about 80. That's a little bit unusual, but a lot of them are people like myself working on Career 2.0 and many are just happy to do cases and be part of the team. I have the sense that some people are looking for advancement and I think that's possible as well.

HF: Some of my clients are very interested in population health. They think of UM as something that they would like to do initially, but they don't want to necessarily keep doing the utilization management on a case-by-case basis. They're interested in how we can help the health of a population, a group of people. And they're very, very interested to see if this is something I could do in a health insurance company.

RK: I expect so. It's not something that I'm particularly interested in from my background. But I think that once you get into one of these big companies, there's a lot of docs doing a lot of different things and there's always jobs posted and people do move around a fair bit. I've seen that in friends who've worked in this business.

I think it might be an entry way to get into various different other roles. I'm just not quite attuned to it at the moment. But I ensure that that's the case because you have to start somewhere. The first job in insurance is the medical director, a low level person.

HF: What do you really like about your job?

RK: I actually like that I'm learning a lot every day. I'm still learning a lot about medicine. I think I relearned radiology from a completely different perspective in my first few months of this job. And I really was very excited about that. But every day I see cases that are interesting, that are challenging in the same way that doing radiology work was. And it's not at the pointed sphere of healthcare delivery like you are when you're a frontline clinician, but you are working in the background and you're making decisions that affect your members lives. And also, your colleagues that are in practice and the medical community at large.

I think the opportunity, as I mentioned earlier, to improve the processes, make it easier for things to get done, remove points of friction that are unnecessary. That's sort of what I'm excited about longer term, trying to make the process better and smoother..

HF: And what don't you like about your job?

RK: Actually, there are enough cases that are clearly fraud, waste, and abuse type cases that I see. And it really is disappointing that we have colleagues that are engaged in this sort of thing or systems. And sometimes when I'm very cynical, I feel like I'm sort of a moderator of the tug of war between the insurance company and the big hospital. And

sometimes you have the feeling that the member, the patient, is sort of the person in the middle of all that. And it's kind of disheartening when you feel that way. But I think of the time I feel like I'm doing what I can to make things better for the members to the extent that I can from my position.

HF: What would you say to physicians who feel like you've gone to the dark side?

RK: Well, I'm going to answer a question that a lot of people have asked before answering that specific question. People are under the impression that there are incentives to deny things. I've seen that bantered about on social media and whatnot. And I will tell you that there is no such incentive whatsoever. There's no benchmark, there's no requirement to deny services.

In fact, the only time I've ever seen anybody get into trouble was when an appeal was upheld, not a serious problem. When an appeal is upheld or the denial is continued, but in terms of overturning denials, approving exams and procedures, there has been no feedback on that whatsoever. So, I'd like to dispel that myth and I've talked to other people in other roles at other places, it's the same. There's no incentive for denying care.

So, yeah, I can see where that would be. I understand that perspective. It doesn't feel like you're working on the dark side when you're doing this work. I think what you're trying to do is help allocate resources. The things that should be done, get done, and there are resources to do those things.

And hopefully diverting resources away from things that are unnecessary and especially the fraud waste and abuse category. I think you can find light in the darkness, if you will. On a daily basis, I don't feel like it's dark at all. I'm helping move things along in the way they should be moving.

HF: I can see you there in your office, your home office. And I'm wondering before you were in the hospital, you were doing these interventional radiology procedures. You were interacting with a lot of people. How does it feel to work in this one space all day long, all by yourself? Do you get bored?

RK: Actually, that's a good question. And I don't get bored. First of all, I have two colleagues that tried to interrupt our interview earlier. My dogs.

HF: Your two colleagues are your dogs.

RK: I call them my colleagues, my workmates. And my wife actually has been working downstairs. We meet at the lunchroom, which used to be called the kitchen, for lunch.

HF: The cafeteria.

RK: Yeah. And one of the things that's really nice actually, and it's the culture of my team is people take an hour off for lunch. I don't know too many doctors in practice that take an hour off for lunch.

HF: Nobody, nobody.

RK: Nobody. Right. So, I have a leisurely lunch. I'll usually listen to a podcast. And then I walk my dogs for half an hour every single day, no matter what. I guess if the weather is bad, I don't. But there's a lot of freedom and I don't feel like I'm that alone. Radiology has become somewhat isolating as well. Sitting by yourself, working at a workstation is very familiar to…

HF: True, the dark room.

RK: Yes.

HF: You were in the dark before.

RK: I was in the dark. There were times where I'd work all day in a closet, in a strip mall. And I felt a lot more isolated there than I do now with windows and my stuff around me. I could see where some people who are not used to this may not adjust to it. I think if you're super outgoing and gregarious and you're used to being around people a lot and doing things with your hands that don't involve typing, it might not be a good fit for you.

But if you're comfortable working at a computer sitting, or you could have a standing desk. I don't have a standing desk but a lot of people do. You can change positions. You can take breaks.

HF: You can eat ice cream.

RK: I could eat ice cream. And frankly, there's a lot of flexibility. I have a certain time where I'm supposed to be on duty. It's kind of like a shift. But if I need to go to a doctor, if I need to run to the grocery store or take the dogs to the vet or things like that, to pick up somebody at the airport. It's not like I'm chained to the desk. I take breaks and I don't feel that isolated or feel like I'm working in a boiler room or anything.

HF: Now let's shift gears a little bit and talk about if a physician is interested in doing this work, what's required? What are the minimum qualifications that you need to meet?

RK: Well, you have to have a medical license. It helps to have one in multiple states, but not required. You have to usually have three to five years of experience in your field. You mostly have to be board certified. Those are probably the requirements.

HF: That's right. And it's usually three to five years post residency or fellowship.

RK: Right, yes.

HF: And a lot of them do want those five years, but I have seen some companies saying three. Check out the job description. Those will be the minimum ones. And then there's other ones that they might prefer, like the UM experience. But as Robert shows, you didn't have to already be working in UM, other than being a physician.

RK: Well, if they all require UM experience to get the job, nobody will ever have the job. It's like a chicken and egg thing.

HF: Yeah, exactly.

RK: And they train you with what you need to know.

HF: Right. And some physicians do some chart review on the side, and we had this prior episode number 40 with Dr. Rinku Mehru who talked about how to do chart review. That is something where you can get some UM experience while you're still in practice. And even just see if this is something you're interested in. I'll link to that podcast in the show notes. Now let's talk a little bit about what kind of physician would make a good fit for this work and then who might not be.

RK: Well, I think you have to like working independently and being in a room by yourself, you have to have some degree of computer skills. I was a little intimidated when they told me I needed to use Excel. And I was thinking about all the Excel wizards out there because I was certainly not. I think anybody who's worked with an electronic medical record probably has the skillset to do this job. I think being able to type helps, but it’s not crucial. I actually use voice recognition for most of my work. And a lot of people use macro programs. So, you don't have to be a wizard at typing, but I think you have to be comfortable with the computer. And I think if you're not comfortable with the computer, it's probably not for you. You don't have to be a super user, just comfortable.

HF: Have you seen some situations where a medical director was hired and they haven't worked out? And do you know why it didn't work out?

RK: I've heard of one who was on the team before me, and it was largely because of computer skills. That person just could not cut it on the computer. The software is very easy to use. They train the heck out of you. It's not that difficult. You don't have to be a wizard, but I think you just have to be comfortable, adaptable with computers.

HF: And I think sometimes physicians realize that they miss patient care.

RK: Absolutely. Yeah.

HF: And they decide they want to go back.

RK: Yeah. I have not seen that yet. I imagine it does happen. As a physician, once you're out of practice for two years, I think it's harder to reenter into practice, but you probably know more about that than I do. And I think you even had a podcast on that.

HF: Yeah, we did a reentry. Yeah. After two years, it's really good or little before that mark, to figure out if you're really going back or not. Now one thing that doctors often worry about are doing the peer-to-peer calls. And you said you don't have to do too many of them, but a lot of physicians are doing quite a number in the benefit management company. What would you say about those?

RK: Well, I think that nobody loves them, but again, you get trained to do that. And when you're on one of those calls, even though the other doctor knows the patient better than you do, obviously, you probably know the standards and guidelines as well as or better. So, you're armed with the correct information.

And I've had some where actually they thanked me afterwards for explaining what the next step is. And if you know your stuff and what you're talking about, you're helping,

you're not a hindrance. Yeah, it's a hassle for the doctor who's on the phone with you instead in the clinic with their patients, but it can be educational for them and for you as well. I think they've been generally beneficial.

HF: And that's often what I hear is that there's a small percentage of those calls that can be nasty and it's understandable. The medicine is a pressure cooker and when someone's upset, they're upset. So, they have some percentage that can be difficult, but then by and large, like you said, they're okay.

RK: Most of them are okay. Occasionally they're really good. And I've had one or two that have really kind of gone south. But at the end of the day, everybody hangs up and moves on with their lives. It's not something to dwell on.

HF: Right. And would you like to touch upon the compensation? That's often something people really want to know about. As an interventional radiologist, you're running all up there pretty high.

RK: Well, as I told my friends early on, the new job is about 10% of the stress, 25% the mental energy, and about 50% the compensation of a private practice radiologist.

HF: Do the math, right?

RK: Yeah, right. I recently looked because we are adding to our team right now and the salary range for an appeals medical director that was published on the website was between $255,000 and $295,000. It probably depends on what special level of experience you have, and maybe where you're located. That's for an appeal medical director at a big health insurance company. Talking to friends, I think for the benefit management companies, the salaries are lower. And I don't really know beyond that. I just know from my own experience.

HF: Yeah. And the experience I've had is that if we look at the range of UM, it tends to be at the low end, around $175,000 - $180,000. At the high end $300,000-ish for the entry level. And with an average of $200,000 to $250,000. What you're reporting is true, that we're in that ballpark. And then when people get into these positions with bonus seeing and with stock options and with going up in seniority, that number can increase.

RK: Absolutely. There are raises and bonuses. And there are a lot of highly paid physicians at these health insurance companies and they start utilization review. I don't know if the sky's the limit, but the ceiling is very high for this kind of work.

HF: And how about call? Do you do call? Do you do some weekend coverage?

RK: Actually, nobody told me about that until I started. But yes, we have a Saturday responsibility. It has to do with regulatory deadlines and some work just happens to have to get done by Saturday. I think for me, it's about twice a year and it's like between 10:00 AM and 3:00 PM. And I think I have to be available by phone and that's how it works. I'm sure every job is a little bit different. They call it a call, but compared to any call that most of us have done, basically we have to be available by phone, which everybody is nowadays anyways. So, it's not that big of a deal.

HF: And you're not going to have to deal with life threatening emergencies.

RK: No, no. When I think of a call, I think of getting up in the middle of night and somebody's bleeding or something like that. It's nothing like that at all.

HF: Right. Everything's relative. This has been wonderful. I really appreciate you coming on and sharing all this good insider information. Is there anything else you'd like to emphasize or share that we haven't really covered?

RK: If somebody is interested in a job like this, probably the best way to get a job like this is the way I got this job. I had a friend who was recruiting for his team. They were looking for radiologists and that's how I got my job. And so, if you think you might want to do this and you know somebody who's in the field, let them know that you're interested or try to network and get to meet people that are in the field. Because when jobs are made available, the people that are already there know about them and people that they can recommend often get first dibs. Sometimes the job languishes for a while, sometimes it is in a very high demand. So, it would be good to get to know some people in the field if you think you might want to do this in the future.

HF: Yeah. That's a great tip. And we had talked before about how you can do some chart review if it's something you want to do while you're in practice, you can earn some money, you can see if you like this kind of work. And then if you do apply, then the company knows that you've tried this work and you like it. So, you're less risky.

I love your suggestion about networking because that's probably the best way to first have an insider understanding of the work, have somebody potentially promote or follow your application. And the companies are much more willing to hire somebody who knows someone who's already working for them, because it just shows to work out really well.

RK: Absolutely. I actually applied for several of these jobs and never heard back from any of them. I'm sure that I was qualified and could be working at one of the other competing companies. But unless you know somebody, sometimes your application doesn't get a look. And I think networking is often the answer to many of these nonclinical careers.

HF: Oh, it's so true. And if I can just put a little plugin for my LinkedIn course. One of the things that was really important to me to illustrate and teach in this course is how do you actually network on LinkedIn that gets results. And so, I show you how to write your messages, how to find people, how to do something called the alumni hack, where you

can find alumni who are working in these companies and they're much more likely to respond to you and help you.

I really even show the example of searching for medical director positions in these companies. I show you how to find them, how to apply to them because I really wanted to make it doable for you. Because I know this can be overwhelming and just feel like you're out there flopping in the breeze. So, this course walks you through step by step, how to potentially get a job like this.

RK: Well, I will offer your listeners or clients if they want to connect with me on LinkedIn, feel free.

HF: Oh, great. Great.

RK: Yeah. I don't know if I can help them, but my name is out there.

HF: That's so lovely. Well, I will put your LinkedIn profile in the show notes. Thank you, Robert. You're so gracious and I'm really glad this has worked out for you. And now you get to travel when you want, where you want and enjoy ice cream and you don't have to do that as a job.

RK: I think I'm going to go buy ice cream right now.

HF: All right. Well guys, this has been a lot of fun. Thank you so much for listening. And of course, don't forget to carpe that diem and I'll see you in the next episode. Bye for now.

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the free resources tab. You can also go to doctorscrossing.com/free-resources. And if you want to find more podcast episodes, you can also find them on the website under the podcast tab. And I hope to see you back in the next episode. Bye for now.

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Podcast details

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