DOCTOR'S CROSSING
CARPE DIEM PODCAST
BY HEATHER FORK, MD, MCC

TRANSCRIPT

EPISODE 201: A Rewarding Side Gig Where You Can Make 10K - 20K+ a Month

With guest Dr. Tom Davis

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TD: "I am not special. I'm just a regular old family physician. I realized, as far as telemedicine is concerned, once you strip away all of the uncompensated time and tasks that you can become so efficient that you can literally double your revenue. Hands down, it is the best work environment I have ever been in, ever."

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.

Hey there, and welcome back to the Doctor's Crossing Carpe Diem podcast. I'm your host, Heather Fork, and you're listening to episode number 201. Today, we have a special guest who is very passionate about a flexible and rewarding side gig that is often under the radar.

Joining us is Dr. Tom Davis, a family physician with 30 years of clinical experience. Dr. Davis has built a successful career not only in practice, but also as an independent contractor, conducting disability reviews for the Social Security Administration.
In a previous episode, we explored disability reviews in general, but today we're diving into the specific niche of working as a consultant for the Social Security Administration on disability determinations for claimants.

Dr. Davis will share the ins and outs of this role, qualifications, the inherent challenges, some steps to get started, and how he has been able to make over $50,000 in a month doing these determinations. He'll also provide a key contact for those of you who are interested in pursuing this opportunity. Without further ado, I'm thrilled to welcome Dr. Tom Davis to the podcast. Hey, Tom, welcome.

TD: Hi, Heather. Thank you very much. It's a privilege to be here.

HF: I'm so excited to have you, and you're an interesting guy to say the least, and you've done a number of different things in your career, and I'd love it if you could give the listeners a little bit of history about yourself.

TD: I'm a board-certified family physician. I did all of my training at the University of Missouri-Columbia, and I came out of residency in '94, and I joined a single specialty rural health practice, three-and-a-half docs, and about the same time, we signed the very first Medicare Advantage total risk contract ever offered anywhere in the United States. We were a sentinel market for that particular insurance company, and we had no idea what we were doing, but my partners were wonderful mentors and sharp as a tack, and we figured out how to make those contracts work. It helps that we all trained in similar locations, so we had a broad spectrum of services that we offered.

Fast forward about 18 years, we had built our own multi-specialty health system regional here in Eastern Missouri as Patients First Healthcare. We had 18 offices. We had

just about every service under the sun that made sense to internalize, including certainly the first micro-hospital licensed in Missouri and one of the first licensed in the United States.

And then one of the regional health systems made us an offer we couldn't refuse, so we went ahead and merged with them. Part of that was a personal service guarantee. I realized fairly quickly that I was not a good fit in the employed setting, so I decided to transition into doing independent medical care, but outside of the system where I can have more control over my treatment plan and my compensation.

And while I was exploring this, I ran into some venture capital folks in Washington State, and they started talking to me about how they're going to increase licensure for telemedicine. I got into that, became a great telemedicine provider, was very successful at that. COVID hit, I became one of the top hits on Google for consulting for telemedicine. And along the way, I just happened to pick up this gig with the Social Security Administration doing disability reviews, and I found that very, very rewarding, and that's what I'm here to share with you about today.

HF: Well, you're a man after my own heart because I found out very early on that I don't make a good employee. My last employed position was as a resident. Forging your own way, and you have been very successful in the telemedicine arena, and I loved how you've described in talks that I've listened to where you have an RV. I don't know, you still have it, but you would go around the country in your RV with your wife and seeing the sites, and you would be making more than you were making, I think, in private practice doing telemedicine. Is that correct?

TD: That's correct. The key here that I want folks to understand is that I am not special, okay? I'm just a regular old family physician who just started looking around, and I realized, as far as telemedicine is concerned, once you strip away all of the uncompensated time and tasks that your employers or even Medicare, if you're

self-employed, put on you, that you can become so efficient that you can literally double your revenue.

My wife and I bought our adventure van, and so we went all around the United States and Alaska, and I supported that doing telemedicine. I made the same amount of money as the average family physician in almost exactly half the time working, and this was before COVID. Since COVID, the market has changed dramatically, but it's even more straightforward to do something like that.

Once I discovered that, then I also discovered that you need a lot of different service lines, because when one telemedicine provider dries up, then you want to be able to have other options that you can work to maximize while you're trying to replace that particular provider. That's specifically in telemedicine, but it's also in your freelance and virtual remote world. You really want to have a number of different sources of revenue. And that's why when I was offered this opportunity, I took it.

I would love for you all to think that I was just brilliant, and I saw exactly the potential of it and just walked right into it. That's completely not true. It was total serendipity that I got into it and then realized what a phenomenal gig that it was.

HF: Okay, we're going for a phenomenal here, and I think, unfortunately, when people hear disability determinations, I don't know if their shoulders droop or they just think, like, “Gosh, this is boring”, or “There's going to be conflict”, or “This is nothing I'd ever be interested in”, but I'm glad you're talking about this because maybe you can shed some light on why this can be actually phenomenal. So I'd love to have you start us off with giving us whatever picture you want to paint of this kind of opportunity.

TD: What we're talking about here is doing reviews of the medical portion of disability applications for the Social Security Administration as an independent contractor. So that

is a 1099 position, meaning that you work however much that you want from wherever you want and for as long as you want, all within certain broad limits.

But you are a 1099 employee, meaning that you are an independent contractor. You are not an employee of the federal government. Social Security does not hire medical contractors directly. It hires them through a company who then hires you in turn. So you're not really working for SSA, you're working for your contractor. You're paid on a case rate, so you get paid for every claim that you review. And at the end of the month, Social Security counts up the claims, cuts a check to your contractor, they keep a piece of the action, and you get the rest.

And I tell you, Heather, if you only knew all the hoops that that contractor has to jump through in order to keep that contract current, you would count their commission as money very well spent.

Most people who do this, they do it on a catch-as-catch-can basis, in between patients or after for an hour at home. And those folks can usually generate about $300 an hour. I work in blocks of time so I can be more efficient and so I can earn $500 plus. And normally I will schedule myself to earn about $20,000 to $24,000 a month. June was an exceptional month. I decided to go all out to see what I could do. So I worked about 140 hours in June and I took home $70,000. And I sent Heather the evidence of that so that she can confirm the accuracy of that statement.

HF: Yes, I did see what you sent me and that verified that you did make $70,000 in that month. Tom, now, I just want to say here, you said you are not special, but I beg to differ. And this is not going to be a deal breaker for other people, but from what I've seen, Tom, you are incredibly efficient. And that was in the telemedicine work. It's in this work and you develop systems that really scale and allow you, I think, to probably work two to three to four times faster than the average physician. That being said, if you're making $500 an hour, that's like in the expert witness hourly range, sort of at the lower end. And

if a physician is making $300, even $200 an hour, that still can be very good. So they don't have to be like you, Tom, to still do well at this work.

TD: I encourage everyone who is considering this type of life to read Scott Adams' book, How to Fail. I think that's the paraphrase title. I can't remember specifically, but you'll find it if you just search for that on Amazon. And basically the bottom line on that book is that goals are for losers, systems are for winners. And so, once you understand what is required of a given job and you break it down to tasks, then you can create a system that's very adaptive. And boy, I tell you what, this job is 100% adapted to that approach.

HF: Okay, well, I love that title and we'll put the link for that book in the show notes for sure. I'd love it, Tom, if you could give us an idea of what type of disability determinations you're looking at. What are claimants coming with that they are seeking disability for?

TD: Well, with over 2 million applications a year, there's a pretty broad range. Most of it is musculoskeletal and limited functions from that and comorbidities associated with loss of function like obesity or diabetes. There are a significant number of mental health allegations that are involved. And again, I'm a somatic physician, so I don't deal with any of those types of allegations. Any type of mental health allegation goes to a clinical psychologist or a psychiatrist. So you don't have to deal with that at all.

It's primarily musculoskeletal. Those are the challenging ones. And then there is a small but real proportion of folks that have cancers or degenerative neurologic diseases. And it's important to understand, Heather, that once you're past 66.3, I think now, you're not eligible for social security disability anymore. You go on social security. So you don't deal with people that are above that age. There is a limit to how many neurodegenerative diseases that you deal with.

HF: Got it. Could you walk us through a sample case, Tom, like what you actually see and then the kind of questions that you are going to be answering?

TD: The disability evaluator is kind of the quarterback of the case. And their job is to get all the information together, to collate it, to organize it, to review the medical records. And summarize them for you and get everything teed up. And then they send it to you. Then you go ahead and review it.

And really there's just three questions that you have to apply to every case. It really is a very simple and straightforward algorithm. The first question is, "Is there enough information provided for you to assess the case?" And most of these folks live on the edge. And a lot of them either are non-compliant with providing records or they're non-compliant with the medical care. So the records aren't there. And you have to conclude in your best medical judgment, whether or not there's enough information to render an opinion. And if there is not, you just send that back to the disability evaluator. You get paid. It's a claim that you assess. Every claim has to be evaluated by a physician. So you're done.

Now, Heather, if there is enough information, then the next question is to apply the 100 or so specific definitions of disability as defined by the Social Security Administration. And they apply to a broad range of medical conditions from specific cancers to chronic diseases like CAD, COPD, rheumatologic diseases. These things have very objective definitions. Your COPD cases will have specific pulmonary function readings, for example. The CHF patients will have specific cath-related ejection fraction measurements. If these cases hit those numbers and you've memorized them very, very quickly, then you simply document when they hit those numbers and that they meet that specific definition. And then you send it back to the disability evaluator and you're done.

However, that's about 15 to 20% of the cases. About 15 or 20% won't have any and it won't have enough information. Another 15 or 20% will meet those definitions. So now you're left with 60% that you have to actually do a review and assess their function

based on Social Security's definition. It's based, it's just one form. You draw your conclusions and you send it back to the DE.

I average about 10 minutes per claim. The insufficient evidence claims obviously are really quick. The claims at the other end of the spectrum, they can take some time. In a complex case can take you 20 minutes and you really do feel it. But fortunately, everything is very specifically defined. And once you understand what the system wants, then you can create your own system, apply it to the process and really become very, very efficient. At first, I was only doing two or three an hour. Now I can go and do five, sometimes six an hour depending on the type of cases that I'm doing.

HF: Right, I think your efficiency can really scale as you do more of this work. And I'm sure some of the listeners are wondering, "Well, I have never assessed a patient's function." For example, they might not be used to physical function. Like can they lift this? Can they do this type of job? And they're not able to examine the patient. Is there training that you get or anything that helps you see if they meet this kind of criteria functionality?

TD: Yes, they do have training. It helps in certain things, but nothing beats having some sort of experience. I do want to emphasize though, you don't really need to have political exposure to these patients to draw these conclusions. I really don't have any idea what the function of these patients are. All I have is the third party data. And these folks are not my patients, they're claimants. I have no physician patient relationship with them. I've never examined them. All I can do is draw my conclusions based on the data provided. And based on that data, decipher whether or not the physician who performed the exams really did it thoroughly or really did it poorly. And you can tell that very quickly. And you don't need a lot of political experience to do that.

My clinical experience was doing workman's comp for my own little small town, but that was it. And it was very easy to pick this up. And so for folks that don't have a lot of

clinical experience, what's most important is to be able to do things systematically and understand that you're trying to draw information from a record and not from your own personal observations.

HF: And to be clear, when a physician is doing this work, they're not saying that this claimant should get disability or not. They're actually answering these three questions. And then the final determination is up to the Social Security Administration.

TD: Right, it is a process and everybody checks everybody else. I'm at the point now, I do quality checks. I get quality checks done on me. The disability evaluator gets checked. Everything gets checked and rechecked and rechecked. So when there's a determination, it is the process of a system. And the goal of the system is for it to be reliable, meaning the scientific definition of reliability, which is that you get the same result over and over and over again, no matter which different parts that you get.

And I will interject here, because you're part of the system, and I have a very sensitive nose for liability because that's always part of the compensation equation. That's fine, give me a lot of money, but how much potential liability do I have, right? I'm not an attorney. I'm just talking about from a personal standpoint. I can't sniff a hint of professional liability due in this case.

As long as you use ordinary care, like anybody would, I don't see how there's any, certainly a malpractice action will fail because there's no physician-patient relationship. It should fail, I should say. But as long as you use reasonable care, I don't see anybody coming after you as an independent contractor.

The decision is the product of a system. And when you add in the lack of liability, compared to how much revenue you can generate with clinical medicine, and the risk that your employer will throw you under the bus if there's a real problem, there's just no math there. You got to do things like this when they present themselves.

HF: Do you get any type of liability coverage for this? I guess if you're an independent contractor, then you'd have to have it on your own. For example, errors and omissions, coverage or anything, would that be helpful for a physician to get?

TD: Well, again, that would be something that you have to talk to an attorney about. All I can tell you is from my personal standpoint, I don't smell any liability from this at all, as long as you're using reasonable care. You're not doing them when you're drunk or on meth or something like that, and you're following the rules. So that would be a question that you should ask your attorney.

HF: I guess potentially you could have a claimant who didn't like the decision, and then I don't know if they can see that your name is on the determination, and then they try to come after you. Like, I don't know if that's happened.

TD: Well, anybody can be sued for any reason at any time. When I have talked to my colleagues who do this work, including the ones that are in a supervisory role, I have been told that that is never an issue, ever. But that's my personal experience. I'm not an attorney, so you go ahead and consult an attorney.

HF: All right. Well, I want to talk a bit more in a minute about qualifications and also what it's like to get started in this job, because I know it's a bit of a Mount Everest climb. But before that, I want to take a short break, and we'll be right back with Dr. Tom Davis.

All right, my dear listeners, I have had some questions, people asking me, "Well, how can I support the podcast?" because they, and I really appreciate these kind words, feel that the podcast has been very helpful for them in different ways. And the podcast will always be free for you, always. But I do appreciate anything you do that helps us spread the word and also helps support the Doctors Crossing.

Some of the things that you can do if you're interested in supporting us is, one, you can subscribe to our weekly newsletter so you hear about the podcast. And to do that, you can reach out to us at team@doctorscrossing.com, or simply, if you download one of our free resources on the website under the freebie tab, please help yourself and you will be automatically added to our weekly email list.
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All right, we are back here with our guest, Dr. Tom Davis. Tom, let's first talk about qualifications because people often wonder, "Well, do I need to be board certified? Do I need to have a license in the state where I'm doing the reviews? And do I need to have a certain number of years after residency to be eligible, et cetera?" Can you help us out here?

TD: The explicit requirements as far as I can tell is that you have to have an unrestricted license in any state or territory in the United States as an MD or DO. That is as much as I can tell you. Anything more than that falls under the category of Social Security's desires as opposed to the explicit requirements. And that I can only speak to from an indirect process. I do know that there is no requirement for a residency. I also know that there's no absolute requirement for clinical experience.

But I have helped a number of folks with their applications and some folks that I thought were eminently prepared to perform the job, they didn't get hired. And other folks that had no experience and they got hired on their first try. So it's a bit mystifying, but I can

tell you that as long as you have an unrestricted license in a state or territory in the United States, then you should reach out and at least investigate this.

HF: And are you only able to do reviews from claimants in the state that you're licensed in or can you do work in other states without one license?

TD: Any state, as long as you have a state license. It's kind of like the VA. The VA only requires one state license. So it's the same process.

HF: But Tom, you are a family practice physician and you are doing this work and killing it. Can you speak to other specialties that are able to do this kind of work? Because we often are familiar with a disability, they want PMNR or ortho or psychiatry, neurology. Is this more of a wide open field for physicians?

TD: The folks who are generalists, the general internists, the family physicians, they'll have the best opportunity to do this work. SSA will hire orthopedists, neurologists, and they will use them for specialized cases. My experience is that those folks are just used for complex cases that SSA is not satisfied with the generalist's evaluation and they seem to be pretty unusual.

The one exception to that is ophthalmology. The ophthalmology requirements are very, very specific. And as we both know, ophthalmologists are kind of like those ancient Egyptian scribes, they speak in their own language. Sometimes it's difficult to match the records to the results. So ophthalmologists have a unique opportunity in the system and they're always looking for those. But the orthopedists and the neurologists, they can still fall back on their generalism and do the work as well.

The bottom line here is if you're a generalist, you have the best opportunity here. If you're a specialist, your opportunity here is as a generalist, not as something for specific

to your specialty, unless you're an eye doctor. If you're an ophthalmologist, then this is unique and you should reach out right away.

HF: I know that some of the physicians who do the employed position, there is one who's physical medicine and rehab, another one who is a general surgeon. I did have an ophthalmology client a long time ago who was doing this for her state. So it seems a little bit varied, but I think it sounds like from your experience, people with a broad base of medical knowledge are able to do more of the cases.

TD: Well, that's the benefit of being a family physician because we can do it all, right? So I take pediatric cases, internal medicine cases, ortho cases, all of them. I can do all of them. The people who are general internists, they can't do the cases for less than 18 year olds. Really it is based on the scope of your specialty. And then within that scope, then you simply get good at the different issues that come in front of you.

HF: Now, I don't know if you can speak to this, but for example, for someone who was an orthopedic surgeon or maybe even a dermatologist, could they have an independent contractor position and maybe they're just not getting as much cases, but they still have the opportunity to do this kind of work?

TD: Well, certainly. Dermatologists, orthopedists, we all started as either general internists or general surgeons. We have a broad enough base to do what is necessary. I can only speak from direct experience. The folks that I work with that are on there as specialists, as dermatologists, orthopedists, they do generalist charts themselves. They're really just limited with their interest and drive and desire to engage.

I guess the difference, Heather, is that the compensation rate compared to someone who's doing procedures is not as attractive to someone like you and I who are paid on cognitive work. And that may be what the differential is. But if you're not competing against doing a series of total knees every day, then really it's a very competitive

compensation system. And it's really only limited by your desire to engage because as we've been discussing, the demand is absolutely there. I logged on this morning and there were dozens and dozens and dozens of cases that are just badly in need of evaluation. And every one of those is a person that's waiting for their benefits. And if that can't get you out of bed in the morning to go, then the compensation will.

HF: Well, thank you, Tom, for that. And I guess if anybody's really wondering about their specialty, they could reach out to Medstaff and inquire.

TD: That's correct. I will tell you that Medstaff is just like every other company today. They are dealing with large demands and workforce challenges. So be persistent. If they don't get back to you in a week or so, don't be afraid to reach out to them again and use my name. That might cut through some of the red tape and get you directly the person that you need to speak to.

HF: That's perfect. Tell them Dr. Tom Davis sent you.
TD: That's right.

HF: And how about the process of applying and getting on board?

TD: I came across this opportunity as the result of a process that I started about seven years earlier. And it's probably the single most valuable thing that we can talk about today. When I had a recruiter reach out to me, I tried to, in a systematic way, respond by saying, “Hey, this opportunity is not for me. I will spread it around my network. However, if you get a remote opportunity, I may be interested. Contact me.” And I always will put their first name on it and put thanks at the end of it with my name.

And so, I have dozens and dozens and dozens of recruiters who I'm at least on a pseudo first name basis. I don't mean they come and go, but they also now have me at the top list because they think I've done them a favor by putting it on my network. I don't know

if I've ever helped them get somebody, but that's how they get paid. So they appreciate that. That's a value to them. When remote opportunities come up, they send them to me. And once COVID hit, I had more opportunities than I could possibly fulfill in a dozen lifetimes.

But this one crossed my desk and I was very encouraged. And I went ahead and reached out and performed the application process. So if you all want to know where these fantastic opportunities come from, it comes from simply using reciprocity and engaging with those annoying recruiters to let them know what you're specifically interested in, because it's in their interest to engage with them. That's a power tactic right there that I strongly recommend anybody who's thinking about moving outside the system take advantage of.

HF: And you have a specific recruiter that we're going to put in the show notes.

TD: Well, this is actually not a recruiter. This is an organization that actually has contracts with Social Security to provide medical contractors to Social Security to perform this service, because that's one of the keys. We all know that there's varying qualities of these contractors. And these folks here at MedStaff, they have always paid. Whenever they've said they needed, they're going to pay, they have paid. And they've also provided me with just elite level of support to a shocking degree. So these would be the people that I would go through. And I want to emphasize that I have no financial interest. I don't get a fee to recruit or anything for them. And this is all in service to you.

HF: Well, that's great for you to share that. And we'll put it in the show notes, the contact or is it MedStaff?

TD: MedStaff.

HF: Perfect. And how about the onboarding process? Because I know when you, we talked earlier, the time from when you first were trying to secure this position to when you actually started doing work and then the training involved, it was very extensive. And I think it's good to let people know what they could be looking at.

TD: I tried to apply once, got turned down, got a second request from the folks at MedStaff. That was in September. The application is 90 pages, at least when I did it. Almost all those pages are asking the same question in different ways, which is about your unrestricted license. And then there's one question that is the key, which is "How many hours a week do you think you can commit to this job?" And from my experience in helping other folks trying to navigate this, that seems to be the key question. You should put down honestly how many hours a week you can commit. And again, it's not eight to five hours. You can work whenever you want, but the more hours you can commit, the more attractive a candidate that you are.

It took about nine months for that to be processed, for me to get a favorable determination, and for me to be placed in a training class because they train in bunches. The training at first was two weeks, nine to five. You get paid for it. It's about $80 an hour, I think, for 80 hours. But you have to be attentive all the time. They really check you to make sure that you're paying attention. So it's nothing that you can do in between patients. If I was working full time, I'd have to take a vacay to do that. That would be a significant investment. That's 80 hours. And then once you're done with that, you're assigned a high-quality disability examiner to mentor you through a hundred very simple and straightforward claims. They tell you that that should take three to four months, maybe as long as six.

I tell you, Heather, by the time I got to that point, I was like, there's no way I'm messing around for four months with this. I did mine all in a month. That apparently was unheard of and caused some shockwaves, but that did really well. And then they start you out on really simple cases, and then they add the complex cases as you earn their trust.

I will say that the one thing that is missing that they should have was to have an MC like me now mentor a new MC for, say, 10 cases or so. That would have really accelerated my learning curve because I made some pretty spectacular mistakes early on that I wouldn't have made otherwise. But that's not happening.
It takes about six months after your externship with the DE to really start firing on all cylinders, and it'll be about a year before they train you on all the different types of claims that you need. There's plenty of work to start with just with the basic ones, but once you get to the quality reviews and all the other ones, then you'll never be lonely.

HF: Okay, I think it's great you brought this point out because this isn't something you decide to do on a Monday and by Friday you're doing this kind of thing, or even a couple weeks. There's a significant investment in time here. Now, I just want to state for clarification that there are employed positions doing Social Security determinations, but you're actually working for the Disability Determination Service Department in a specific state. And so it's paid by the hour, and it's somewhere around $100 an hour. It could be a bit less. It could be a bit more. The actual compensation is going to be different.
I would love at some point to do an episode on this topic. If there's anyone out there listening who has worked as an employee for the Disability Determination Services of their state or is currently doing this, please feel free to reach out to me so we can compare and contrast these two types of positions.

Okay, Tom, we're getting close to wrapping up here, but I mentioned in the intro that we would talk a little bit about some of the challenges. Now, there's definitely a challenge in getting started, but any specific challenges you want to mention when you're doing this work?

TD: The biggest challenge is the system itself. I'm going to start this by saying that I will bow to no one in my disgust in dealing with bureaucracies, not just government bureaucracies, but bureaucracies of any sort. I just cannot deal with them, and I will tell

you that this is hands down the best job I have ever had in my life, including the one that I created for myself in my own practice. The people are mission-driven. They're competent. They're kind. They are extremely helpful. Everybody has their eye on the ball.

I know what I'm saying. It's the Social Security Administration. How can that possibly be true? I must be a shill of some sort. I tell you, Heather, hands down, it is the best work environment I have ever been in, ever. And if this job ever ended, it's the only job I will be truly, truly sad that it has ended.

All of that said, the system itself, the technology, is extremely cumbersome. Up to about four months ago, my success rate in sitting down to work and actually work was only about 75%. As you imagine, you have to penetrate a lot of security in order to get on the sites that you need to work. There's a lot of technology involved. The government provides all of it. They send it to you in the mail, but about 25% of the time, you will sit down to work and there will be either a technical problem or a budgetary problem.

Last summer, I sat down to work and something had flipped on a security switch on my account. I don't even know if it was my fault. It was six weeks before I could work. On January 1st, I sat down to work and I couldn't work for 17 days for some technical and there's budgetary problems. That's the biggest barrier. It's been a little better lately. Aside from that, I love the people that I work with. I don't really have to deal with them all that often, but when I do, boy, oh boy, it is a wonderful environment. If healthcare was like this, there wouldn't be a burnout crisis.

HF: That's a lovely endorsement. I know you have no vested interest in saying that. It's very genuine. We do need something to make up for the difficulties, for sure. I just want to stress, too, that you have made a very good income doing this. I did mention in the intro that you've made over $50,000. We have validation that you made $70,000. For an average, a physician might expect maybe $10,000, $20,000 if they're working at an

average speed and not putting in a ton of hours. Would you say that's a reasonable estimate?

TD: Once you're firing on all cylinders, again, we're talking 18 months from the time you apply, any physician should reasonably be able to generate $10,000 a month.

HF: Okay. Well, that's really helpful. All right, Tom, any last words that you want to share? Do you want to remind the listeners of that resource where they can listen to your talk?

TD: Well, I will share two things. One, as I said at the beginning, every claim has to be evaluated by a medical contractor. So, if you don't evaluate these claims, these people don't get disability. And if you're in clinical medicine, you understand what the impact is to that personally. So, this is needed and it is a service, and it is a service that only you as a licensed physician can provide.

So, you're not just some sort of pension pusher. Each one of these claims is a life, and they are reaching out because they need the security, and they feel disabled, and so it's up to you to determine, what their limitations are, so the system can see if they qualify. So, it is a mission-oriented task.

That said, if you do decide to contact the good folks at MedStaff, and if you do get hired, and go through the training, and do everything that you want to do, then what I want you to do is reach out to me on the system. I'm easy to find, once you're there. Reach out to me and say, “Hey, I heard about you on Heather's podcast”. And just because of that, just because you're one of Heather's audience, then I will give you one hour of my time free and provide you the mentorship that I should have had when I started, and that'll help accelerate your learning curve. And it's all because you found me through Heather. So, let's consider it good luck, take control of your own future, and every time you fail, you're a step closer to success.

HF: I just love that. You are a mission-driven man, and thank you so much. And that's such a generous offer. Folks, please remember that, and Tom will help you, and you make it through the gauntlet, and he'll be there for you. That's a great light at the end of this tunnel. Thank you again so much, Tom, for coming on the podcast. I really appreciate you.

TD: You're welcome. It's been a privilege.

HF: Thank you. All right, my dear listeners, thank you so much for being here. I really appreciate you. I couldn't do this without you. I wouldn't want to. Please feel free to share this podcast far and wide, even with your mother. That's the only person you can think of. I know if no one else listened to the podcast every week, my mother will be sure to. Did you hear that, mom? All right. Anyway, don't forget to carpe that diem, and I'll see you in the next episode. Bye for now.

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Podcast details

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