Is Private Equity Right for Your Practice?

Coding Advisor
How to Trigger Your Own Audit

PA Avenue Updates
2018 Regulatory Relief

Your Money
Maximize Your Financial Planning

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A n informed practitioner is not only clinically competent but also business-savvy. Despite intensive training as vitreoretinal fellows, our business management experience is typically limited by the time we enter retina practice. How can retina specialists best keep up with the philosophies of a successful business? To help you better understand the administrative principles involved in running a practice, Retina Today introduces the inaugural issue of Business Matters, a supplement that will provide valuable resources for retina specialists in all stages of their careers.

Each edition will consist of a quality lineup of columns, with topics across the scope of occupational development. These include PA Avenue Updates, which covers regulatory issues affecting retina specialists; Coding Advisor, to keep readers up to date on billing and reimbursement questions; Your Money, which offers professional insights into individual finances; and Perfecting Your Practice, in which contributors will highlight different management techniques for successful practice. Each issue will also include a feature article. On page 9 of this issue Reginald J. Sanders, MD, and Richard A. Garfinkel, MD, discuss the pros and cons of private equity. They advise careful due diligence for those considering entering into one of these arrangements.

From personal and professional financing to practice reimbursement and referrals, the articles on the following pages represent the latest takes on sound and sensible business practices. We hope you will find them useful. If you would like to see a particular topic covered in the future, please send your suggestion to RetinaEditors@bmctoday.com.

—George A. Williams, MD  
Section Editor

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Like many physicians in other fields, retina specialists are struggling with an increasing regulatory burden that can interfere with their patient care. This burden depletes the critical resources of physicians’ time and money with no apparent clinical benefit. The goal of programs such as the Quality Payment Program (QPP) of the Medicare Access and CHIP Reauthorization Act (MACRA) is to improve quality of care and lower costs.

**ADVOCACY EFFORTS**

Since the onset of the Affordable Care Act (ACA) in 2010 and MACRA in 2015, the American Academy of Ophthalmology (AAO) has looked for opportunities to diminish this regulatory burden and remove roadblocks to efficient, patient-centered care. In 2017, these efforts were rewarded with some, albeit insufficient, relief.

The AAO’s advocacy efforts resulted in substantial reductions to potential penalties in 2018 related to 2016 performance under the Physician Quality Reporting System (PQRS), electronic health record (EHR) meaningful use, and value-based modifier (VBM) programs.

For PQRS, the quality measure reporting requirement was decreased from nine required measures to six, and the need to report National Quality Strategy Domains was eliminated. The value of Qualified Clinical Data Registries (QCDRs), such as the AAO’s Intelligent Research In Sight (IRIS) Registry, was confirmed by the elimination of the requirement for IRIS participants to report high-priority measures.

Additionally, reporting requirements were decreased for meaningful use, and, importantly, the penalties of the VBM were eliminated for physicians who successfully reported the six required PQRS measures, and the penalties were cut in half for others.

For small practices (those consisting of nine physicians or less), the VBM penalty was cut to 1% and PQRS to 2%. For practices with more than nine physicians, the penalties were cut to 2% for both VBM and PQRS. Again, these changes were for 2018 payments based on 2016 performance. Such retroactive changes to a federal program are unusual.

**MEASURED BY MIPS**

In 2017, most physicians were measured under the Merit-based Incentive Payment System (MIPS) of the QPP. MIPS compares physicians across four categories with differential allocations that combine to create a single score between 1 and 100 that determines bonuses or penalties. The four categories are: quality (replacing PQRS), advancing care information (replacing meaningful use), clinical practice improvement, and cost.

The graphic on the next page shows the allocations for these four categories in 2017, 2018, and 2019. Performance in 2017 will be reflected in the 2019 payments. The Centers for Medicare and Medicaid Services (CMS) recognized the difficulty of transitioning to such a complex system, and 2017 penalties could be avoided simply by reporting one quality measure on one patient one time under what CMS termed “Pick Your Pace.”

The burden for reporting in 2018 has increased. While the allocations for advancing care information and clinical practice improvement will remain the same, cost will now account for 10% of performance and quality will drop to 50%. In 2019, the percentages could be adjusted further. Originally predicted to increase to 30%, the cost component for 2019 may remain at 10%. The future is uncertain, however, and the official allocations may vary.

The MACRA statute required that penalties and bonuses (5% in 2018) be applied to all Part B physician payments, including those for drugs. Like many other groups, including members of Congress, the AAO believed that the application of these penalties and bonuses was not the intent of Congress and was able to have them eliminated.

**BEYOND MEDICARE**

Regulatory issues are not confined to the Medicare program, however. Increasingly, retina specialists are burdened by commercial payers, including Medicare Advantage plans, using inconsistent preauthorization requirements, step therapy for drugs, limited networks, and arbitrary payment policies for office examinations and imaging.

Preauthorization consumes an increasing amount of staff resources. It often delays care, and, even after
preauthorization, denials are not uncommon. The AAO is advocating for a standardized process for preauthorization and assurance that preauthorization means payment.

Step therapy for retina specialists usually requires the use of bevacizumab (Avastin, Genentech) prior to the approval of more expensive drugs. Although bevacizumab is often an appropriate and effective therapy, patients are best served when they have access to all proven treatments.

Limited networks not only deny patients choices in their treatment, but they can also be confusing both to patients and to retina specialists who may be unaware of the restrictions.

Increasingly, retina practitioners are experiencing arbitrary restrictions on evaluation and management services for intravitreal injections through limitation or denial of use of modifier -25. The AAO has a long-standing, consistent position that modifier -25 is an appropriate and common standard of care, and we will be continuing the discussion of modifier -25 with CMS and commercial payers in 2018.

Last year, CMS announced a new initiative titled Patients over Paperwork. This is an encouraging development that suggests there are opportunities to address frustration with the current regulatory morass. The goals of this initiative are to streamline quality measures, reduce the regulatory burden, and promote patient-centered innovation.

A WORK IN PROGRESS

I believe that the current MIPS program is too complex and is destined to fail both patients and doctors. New approaches to improving quality and containing costs are required. One solution is to increase the role of QCDRs such as IRIS. These registries can address quality and costs in real time and can have a profound impact on clinical care.

AAO has advocated that successful participation in IRIS should fulfill all MIPS reporting requirements. As IRIS continues to grow, the value of registry reporting will become increasingly apparent.

Another critical component of patient-centered care is to have ophthalmologists develop more clinically relevant quality measures to improve outcomes. Recently, CMS announced the acceptance of five new retinal QCDR measures developed by ophthalmologists for use by both EHR and non-EHR IRIS participants. With these additions, retina specialists now have the most clinically relevant measures of any ophthalmic subspecialty.

Moving forward, our advocacy to-do list is long. It includes dropping Part B drug payments from MIPS penalties, returning to a zero-cost measure for 2018, improving preauthorization requirements, and enhancing integration of IRIS into QPP. Achieving any of these changes will help us to provide improved patient-centered care. Despite the continuing regulatory challenges, there is an opportunity to create significant improvement—particularly if CMS is serious about the Patients over Paperwork initiative.

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YEARLY MIPS ALLOCATIONS

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Quality</th>
<th>Advancing Care Information</th>
<th>Clinical Practice Improvement</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>60%</td>
<td>25%</td>
<td>15%</td>
<td>0%</td>
</tr>
<tr>
<td>2018</td>
<td>50%</td>
<td>25%</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>2019</td>
<td>50%</td>
<td>25%</td>
<td>15%</td>
<td>to be determined</td>
</tr>
</tbody>
</table>
Very payor conducts audits. Some are automated, meaning they are data-driven and involve no record review; others qualify as complex reviews and result in requests for documentation. The case scenarios presented below are true. We appreciate the practices that have shared their experiences so that others can be made aware of these common coding mistakes.

**AUTOMATED AUDITS**

**Example No. 1: Billing New vs. Established Patients**

**The Error:** When is a patient new? When he or she has never been seen by anyone in the practice, or when it has been 3 years plus 1 day since the patient was last seen by anyone in the practice.

Changing one’s taxonomy to a retina or uveitis subspecialty designation does not change the patient’s status. If you, a retina specialist, see a patient in practice A and then see that same patient in practice B within 3 years, the patient is considered established in the practice. If an anterior segment ophthalmologist refers a patient to you and you both practice under the same tax identification number, you must bill that patient as established—even though you personally have not had a previous face-to-face encounter with him or her.

**The Fix:** Staff must carefully screen patients perceived to be “new to the practice” in order to avoid this error.

**Example No. 2: Billing the Correct Units for a Drug**

**The Error:** Billing ranibizumab (Lucentis, Genentech) for treatment of age-related macular degeneration as 1 unit instead of 5 units (Table 1). Neither the person doing the billing nor the person posting payments caught the error, which references the quantity of units and results in payment of a fraction of the allowable.

**COMPLEX REVIEW AUDITS**

**Example No. 3: Mismanagement of Modifier -59**

**The Error:** Routinely unbundling CPT code 92250 Fundus photography, from code 92134 Retina OCT. In 2011, the National Correct Coding Initiative created this bundle. The bundle indicator is “1,” which means the two codes may be unbundled under certain circumstances.

**The Fix:** It is appropriate to unbundle code 92250 from code 92134 by appending modifier -59 Separate procedure to code 92250 when the payor has published in writing the appropriate conditions. To view the local coverage determinations by your area’s Medicare Administrative Contractor, visit aao.org/lcds.

**Example No. 4: Mismanagement of Modifier -25**

**The Error:** Appending modifier -25 to any level of evaluation and management (E/M) service or to an Eye visit code performed the same day as a minor procedure. In a

### Table 1. Correct Billing of Lucentis for Treatment of AMD

<table>
<thead>
<tr>
<th>HCPCS Office</th>
<th>HCPCS Facility</th>
<th>Description</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>J2778</td>
<td>J2778</td>
<td>Lucentis</td>
<td>3 units DME and DR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5 units wet AMD, RVO, myopic CNV</td>
</tr>
</tbody>
</table>

Abbreviations: AMD, age-related macular degeneration; CNV, choroidal neovascularization; DME, diabetic macular edema; DR, diabetic retinopathy; HCPCS, healthcare common procedure coding system; RVO, retinal vein occlusion Table adapted with permission from the American Academy of Ophthalmology.

**The Fix:** An audit is helpful in pointing out this costly error. Claims less than 12 months old can and must be corrected.
retina practice, modifier -25 can be applied to these CPT codes: 67028, 67101, 67105, 67221, 67227, and 67228 (Table 2).

**The Fix:** Understand the requirements of modifier -25

**Established patients:** When you review your documentation, remember this: Even if a procedure is medically necessary, if the established patient examination is performed solely to confirm the need for the minor procedure, then the examination is not billable separately from the minor procedure.\(^1\)

**Example No. 5: Mismanagement of Modifier -25**

The **Error:** Appending modifier -25 to all levels of E/M services and Eye visit code when any test is performed the same day. The modifier is not required for payment, and its overuse inappropriately inflates the frequency of modifier -25.

**The Fix:** Do not append modifier -25 when it is not necessary. This modifier is linked to minor surgical procedures or those with a global period of 0 or 10 days.

**Trying (and Failing) to Help**

Occasionally, in efforts to be helpful, staff members will make claim submission choices that are not in the best interests of the practice, such as those in the following examples.

### TABLE 2. CODES FOR WHICH MODIFIER -25 IS APPLICABLE

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Postoperative Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>67028</td>
<td>Intravitreal injection of a pharmacologic agent</td>
<td>0 days</td>
</tr>
<tr>
<td>67101</td>
<td>Repair of retinal detachment, including drainage of subretinal fluid, when performed; cryotherapy</td>
<td>10 days</td>
</tr>
<tr>
<td>67105</td>
<td>Repair of retinal detachment, including drainage of subretinal fluid when performed; photocoagulation</td>
<td>10 days</td>
</tr>
<tr>
<td>67221</td>
<td>Destruction of localized lesion of choroid; photodynamic therapy</td>
<td>0 days</td>
</tr>
<tr>
<td>67227</td>
<td>Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), cryotherapy</td>
<td>10 days</td>
</tr>
<tr>
<td>67228</td>
<td>Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation</td>
<td>10 days</td>
</tr>
</tbody>
</table>

Example No. 6: CPT Code 92250 vs. Code 92134

The physician orders CPT codes 92250 Fundus photography and 92134 Retina OCT with each injection. The coding staff, recognizing that the two codes are bundled, submits the higher paying test code (92250), which is subject to frequency edits. This results in a request for records for an extended period of time. CPT code 92134 is payable monthly for active disease.

Example No. 7: Changing CPT Code 92014 to Code 99214

The retina physician’s documentation supports an established patient visit (Eye visit code 92014) for a comprehensive examination. The coding staff inappropriately changes the code to the established patient E/M services, level four (99214). The high volume of code 99214 triggers an audit.

Documentation requirements are not equal between the two examinations. The chart note is not set up to capture all the documentation needed for the level four E/M service: Review 10 body systems and past family and social history. Had the physician reviewed monthly productivity reports, this error could have been caught and corrected. A protocol should be established so that no one alters any component of the chart note, CPT code, or ICD-10 code without physician approval.

To add insult to injury, the typical Medicare Part B allowable for code 99214 is $110, compared with $130 for code 92134.

Example No. 8: Splitting One Vial of Single-use Drug for a Bilateral Injection

Triamcinolone acetonide injectable suspension 40 mg/mL (Triesence, Alcon) is supplied in a vial labeled for single use. Its labeling states that it is “reimbursed per vial, not per dose (mg),” and that “In order to receive appropriate reimbursement, providers must bill 40 units.”\(^2\) Clearly, with 40 units, there is enough drug for both eyes when a bilateral injection is given. Nonetheless, the single dose payment rule is one vial per eye. Incorrect billing will trigger a request for records.

In 2017, CMS mandated the use of modifier -JW for Medicare Part B claims to demonstrate that units were wasted. Here is how this should be coded, duplicated for each eye:

- Triesence 40 units
- J3300 4 units
- J3300-JW 36 units wasted.

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Many private retina practices have recently shown interest in entering into negotiations with private equity firms as a means of growing and capitalizing on their established business models. There is often confusion regarding the role of private equity firms versus that of venture capital firms, and it is not uncommon to see the terms used interchangeably. To clarify, private equity applies to investments in mature and often successful businesses, including medical practices. Venture capital is more often involved in investing in cutting-edge technologies.

For retina specialists, the prospect of selling one’s practice, or a significant share of one’s practice, to a private equity firm comes with a long list of pros and cons. This article aims to provide an accurate assessment of the role of private equity in the medical community by analyzing the benefits and the risks.

**The Good and the Bad**

The relationship between a private equity firm and a medical practice is sometimes called a partnership, but it is really a transaction. The owners of a practice are selling their company, or a significant share of it, and private equity firms look at these transactions no differently than they would any other. In selling your practice, you become an employee rather than the employer, and you subsequently lose a lot of the freedom and job security that comes with ownership.

Why are some retina practices now seeking such arrangements? It is expensive to expand a practice. It requires increased overhead, additional staff, and the ability to keep up with the speed of progress. It may also entail new practice management strategies or the purchase of a new electronic health record system. These adjustments are also costly.

When practices sell to private equity firms, there are sometimes multiple payouts associated with the original sale and any successive resales. A private equity firm offers a practice a buyout in exchange for a percentage of the business. As the firm builds and repackages the practice, there are opportunities for resale to other investors. By maintaining a stake in the practice, the physician shares in any of its long-term successes or failures. It is important to note that subsequent payments from these additional sales cannot be counted on during the initial consideration, as the market may change. As such, there may be a substantial difference between entering into a private equity partnership at age 40 versus doing so at age 60.

**Then and Now**

Private equity is not a new concept in the US health care industry. The strategy first rose to prominence in

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**AT A GLANCE**

- Private equity applies to investments in mature and often successful businesses, including medical practices.
- Private equity firms look for private practices with potential value (ie, those they can shape without the need for much management).
- Practices looking for a potential investment from a private equity firm should consult with an investment banker and legal counsel.
the 1980s and 1990s due to a general feeling of uncertainty about the future, similar to what many physicians are experiencing today. At the time, doctors were concerned about managed care, increasing government regulation, decreasing reimbursement, and whether their practices could remain financially viable.

Private equity firms began buying up practices and consolidating them for resale. Unlike today, however, there was not enough money in the health care industry to support this kind of business management, and the firms lacked the necessary understanding of the industry to guide practices appropriately.

Today’s private equity firms have a better idea of what to look for in a medical facility based on a purportedly better understanding of both the industry and the long-term market. The uncertain future of health care policy, once again, has left private practices open to buyouts.

For private equity firms currently looking to acquire private practices, the name of the game is potential value. These firms are looking for a base upon which they can build: a practice they can shape into a platform without the need for a lot of management or oversight. This hands-off approach represents the ideal situation, but, as was demonstrated in the 1990s, not every practice fits this model.

Practices interested in a private equity buyout should consult with an investment banker to find out whether their organization is appealing and, if not, what steps could be taken to make it attractive to investors. Because a private equity buyout is a business contract, legal counsel is also essential to the selling party. These consultations offer valuable perspective on the operational efficiency and profitability of the practice overall.

**DO YOUR HOMEWORK**

There are benefits and drawbacks to any business agreement. Before selling some or all of a practice to a private equity firm, the practice partners should investigate the firm to which they are thinking of selling. Does it have experience in the medical field? In the ophthalmic realm? Have its previous projects been successful? If possible, the partners should also consult with other practitioners who have gone down the private equity route. To better understand the risks, we urge private practice retina specialists to do their due diligence before entering into one of these arrangements.

### PROS AND CONS

Private equity firms are looking to buy a practice, expand and repackage it, and then sell it again for a profit. This can be either mutually beneficial or potentially harmful to the practice. Below are some pros and cons to consider.

**CON:** A private equity buyout means that the practice owner loses control.

**PRO:** The sale takes the burdens of growth out of the hands of the providers.

**CON:** For young physicians, the up-front monetary value of a buyout may be nice in the short term, but the seller can also lose money in the long run if the investor’s exit strategy is unfavorable to the seller.

**PRO:** For physicians in the late stages of their careers, a sale may provide a large monetary payout before retirement.

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Building a professional referral network is a skill that is crucial to just about every career path in medicine, but rarely is any time dedicated to it in our formal training. Retina specialists, however, often enter the field with an informal background in networking courtesy of research projects, residencies, fellowships, and society meetings. As such, many develop an essential referral base fairly early. But it is easy to forget that professional connections must be reinforced throughout one’s career. How do we maintain this network as the practices around us grow and evolve?

Having grown up where I currently practice, in Boulder, Colorado, I was able to forge many relationships based on my connections to the local community from childhood and young adulthood. It is not uncommon in my practice to see a patient who knows me or my family personally, and the same can be said for many of the referring physicians in the area. My experience as a hometown girl returning to her community, however, is not the standard for most retina specialists.

As for the many potential sources for possible referrals, I try to give every community practice equal time and treatment. Face-to-face meetings are invaluable, both as you form professional relationships and as you maintain them throughout your career. I make it a point to have lunch or dinner with each referring physician. Between these engagements, I reach out in other ways, such as an office visit or even a phone call.

Personal vs. Professional?

Connecting on a professional level is similar to doing so on a personal level. You discover shared interests, hobbies, hometowns, etc., and these details add a layer of authenticity to the relationship. Be personable, be open to meeting new people, and be open to sharing your personality. A personal connection shows respect for your colleagues and demonstrates the treatment their patients will receive in your care.

But what about relationships that go the extra step from being friendly to actually being friends? Navigating social affiliations with referring physicians outside of work can be tricky, but as long as a high level of care is maintained by both parties these relationships can foster personal and professional growth.

Networking Standards

As a retina practice grows, practitioners need to expand their pools of referring physicians. Hospital-sponsored meet-and-greets are an excellent way to grow your referral base among primary care providers and ophthalmologists. Speaking engagements provide opportunities to display your knowledge, skill set, and personality. Take full advantage.

It can be challenging to maintain a referral relationship with practices that seem to have a revolving staff of physicians. Although the networking process can go smoothly when a referring practice brings on a new hire, it can be difficult to maintain if these physicians cycle through the practice too often or too quickly. In these situations, I work to maintain a strong relationship with the senior partner or partners, and I do my best to carry this rapport down through the ranks.

Quality and Respect

Your success in generating referrals and expanding your professional network ultimately comes down to the quality of your treatment in terms of clinical outcomes and patient satisfaction. Whether you are part of a small practice or a large institution, your reputation is everything. It will help you to establish long-term relationships with referral sources in your area, and it will benefit you in the eyes of referred patients. Make yourself available to your referring physicians, keep them updated, and always be respectful to both your colleagues and your patients.
TIPS TO MAXIMIZE YOUR FINANCIAL PLANNING

Flexibility is a fundamental factor for success in any retina specialist’s financial plan.

BY DAVID B. MANDELL, JD, MBA, AND ROBERT PEELMAN, CFP

When it comes to long-term financial and retirement planning, many individuals, families, and even some practices rely on static, set-it-and-forget-it plans. This article examines flexibility as a key component of achieving long-term financial success and building an individual retirement plan. The financial elements below should each incorporate a level of flexibility.

INCOME AND CASH FLOW

Few physicians can accurately predict their future incomes, so flexibility must be part of retirement planning. Living below one’s means and prioritizing saving (each month, quarter, and year) can position the physician to weather any temporary or long-term financial droughts.

Another tactic is the implementation of a savings vehicle that allows uneven funding or investing from year to year. In the area of qualified retirement plans, one example would be a defined contribution plan that allows flexibility in individual contributions each year. This is in contrast to a defined benefit plan, which requires a certain level of funding and can entail underfunding penalties.

More relevant still is the nonqualified plan, which allows much higher contributions than a defined plan when an individual’s income is high but can be skipped entirely during years in which income wanes.

TAX RATES

Significant changes to the 2017 and 2018 tax code underscore the need for flexibility in retirement planning. Taxes will continue to change, and tax rates may look different in 10, 20, or 30 years. A “tax diversification” approach helps alleviate potential future issues. Many financial planners advocate diversification of asset classes in investments, but it is equally crucial to diversify the tax rate exposure to one’s wealth.

When we look at investment plans from the perspective of tax diversification, we see that most investors have inadequate investments in asset classes or structures that will be immune to future increases in income or capital gains taxes. Assets such as cash-value life insurance, tax-free municipal bonds, Roth IRAs, and other vehicles should be part of any wealth-building plan. The bottom line is that individuals need enough flexibility to be prepared for possible tax rate changes during their investment timelines.

THE MARKETPLACE

In this context, “marketplace” means more than the small sample of the stock market in the United States that is represented by the Dow Jones Industrial Average or even the S&P 500 index. There is volatility in all securities, commodities, real estate, and other asset marketplaces domestically and internationally. Values often go up, but they also come back down.

Savvy investors understand that portfolio diversification is key to reducing risks. Rather than staying within a specific area, such as securities or real estate, diversification must cross investment classes, especially in a volatile market. A balance of asset classes—international and domestic, traded and untraded, correlated to

AT A GLANCE

- Living below one’s means and prioritizing saving can position physicians to weather any income or cash-flow issues.

- Cash-value life insurance, tax-free municipal bonds, Roth IRAs, and other assets should be included in any wealth-building plan.

- It is imperative that conservative wealth plans take potential health changes into consideration.

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markets and noncorrelated—constitutes a flexible long-term approach.

Another asset class that allows flexibility is permanent life insurance—specifically, a policy with tax-deferred growth and asset protection. In universal life policies, funding can be flexible from year to year, unlike whole life policies, for which funding must occur each year.

**LIABILITY**

Any planning designed to shield wealth from a legal claimant, creditor, or even a soon-to-be-former spouse is typically not effective if it is implemented only when the threat becomes reasonably foreseeable. That is to say, asset protection planning must be put into place before there is a problem.

The challenge is that the physician wants to maintain ownership of, control of, and access to his or her assets at times when there is no looming liability threat. Fortunately, with comprehensive asset protection planning, these goals can typically be accomplished utilizing exempt assets, legal tools, insurances, and proper ownership forms. Individuals can generally build flexibility into financial plans using tools that protect wealth if and when there are liability threats but still allow ownership, control, and access to that wealth when the coast is clear.

**HEALTH**

Health is the single most important element in planning. At one extreme, being in good health is a blessing that allows individuals to be more productive, to create more wealth, and to enjoy it. At the other extreme, poor health can keep individuals from earning a living and even lead to premature death, which can have a devastating economic impact on the surviving family. Because of this, it is imperative that conservative wealth plans take potential changes in health into consideration.

Disability and life insurance are essential. Securing insurance protects the physician’s ability to earn, providing a regular income stream in the event of disability and offering financial protection to heirs in the event of death. The likelihood of a significant long-term disability is higher than the likelihood of premature death.

According to a US Social Security Administration fact sheet, little more than 25% of today’s 20-year-olds will become disabled before they retire. Nonetheless, many high earners are underinsured for disability. In the same sheet, the US Social Security Administration also noted that about 100 million American workers are without private disability income insurance, presenting a financial risk.

Life insurance coverage is needed not only if one has concerns about meeting individual financial goals, but also if these concerns apply to the financial welfare of one’s family. There is a variety of life insurance products, from term to cash value and from whole life to private placement.

Whatever product is chosen, planning is needed to assure adequate coverage given one’s income, debt, assets, family situation, tax rate, state of residency, and goals. These are typically analyzed on a case-by-case basis depending on one’s situation.

**START PLANNING, STAT!**

The sooner a physician starts financial planning, the better off he or she will be for the future. The elements of individual plans will differ, and circumstances such as age, income, and goals will dictate what must be emphasized. It’s important to get started and build some flexibility into the plan to remain as prepared as possible for changes down the road.

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