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# INNOVATION, INDUSTRY, AND ANCILLARIES: LESSONS FROM DR. JACK BERT (PART 2)

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**David Mandell:**
Let's get back to the ancillaries. So, you were saying in general, in general, you've got to have ancillaries to be financially efficient and to get lucrative. So, continue on that topic.

**Dr. Jack Bert:**
Yeah, sure. So, the most financially successful, and your point, to your point, orthopedists I know are the ones that delegate everything, whether that's having somebody doing your transcription in the office and then having a med tech, a couple of athletic trainers, a couple of physician assistants, and a phenomenal secretary. You can plow through 30, 40 patients in an afternoon, do your cases in the morning, and still have a good patient experience. Because once you see that patient, you've got to have a good team to drop them off to.

Now we had an ASC, in fact, we had two ASCs, and then we had overnight rooms eventually. We had physical therapy. We had a durable medical equipment portion of our practice. We had occupational therapy, we had MRI, and we had x-ray. So once that patient walks in the door or has had an occupational injury, we captivate that patient and we garner all the revenue by driving them through our revenue sources within the practice. A successful practice, 50 to 60% in private practice of the physician's income, will come from his ancillaries.

One quick point, I've got a son who is an employed physician in Arizona, and he is able, believe it or not, being employed, to do extremely well. He's got a very high workhour [inaudible 00:01:29] he's negotiated. I helped him a little bit.

**David Mandell:**
Yeah, we're going to talk about negotiate. That's next.

**Dr. Jack Bert:**
But I just wanted to make the point that he also was allowed to own part of an ASC, which is owned by the hospital system. So, he garners revenue from that plus what he does in his clinic and OR.

**David Mandell:**
Yeah, and obviously the specific ancillaries you're mentioning apply to orthopedics, but it really is, whether it's endoscopy centers or MRIs or physical therapy, there are other areas that the ophthalmologist hopefully is watching or listening and saying, "Yeah, I'm doing that too, but in this and this." Or your cardiologist or what have you, gastro, et cetera.

I spoke at a conference of vein clinic owners recently, and they're doing the work, but also having that being done at a center that they are part of the ownership for. So, for the docs watching and listening, they know what the areas are that are surrounding their clinical work. And I think the point that you're making is own those if you can.

**Dr. Jack Bert:**
Yeah, absolutely. Absolutely. And one other point I do want to make, which I'm going to upset some ASC companies by saying this, there are a couple of ASC companies in the United States now that are not wholly owned of your ASC. I'm sorry, I misspoke there. They do not own the majority share.

**David Mandell:**

Right. Because the typical deal is 51% for the company who's doing all the operation and 49 for the physician. I say typical, but whatever. That's the general sort of model where the physicians don't have control. They have only 49. But continue. Yeah.

**Dr. Jack Bert:**
Well, so they do what's called a cafeteria plan. They'll allow you to own, the majority stake is say even 75, 85%. Then they'll charge a management fee. They'll charge you upfront for the work they do, and then you will own the vast majority of it. I strongly urge all the private practicing docs or the fellows that are coming out to look at that model because it is just ludicrous to me how it gets set up and all they do is sit back and collect money, make hundreds of millions of dollars off the work that you are doing.

We did ours, a hundred percent of it. We hired a manager from the operating room to set it up for us. They did the research on all the laws in Minnesota. And so, we owned a hundred percent of our ASC. And I think that is absolutely paramount, not to let an ASC company come in and blind you with the fact that, say, "Oh, we'll do everything for you. Don't worry, we'll take care of everything." And then you end up getting 49% of it, they get 51%, and they don't do a darn thing after the first couple of years.

**David Mandell:**
Right. Yeah, no, that makes sense. I mean, we were talking about the importance of delegation, but there's also the, and this isn't, I don't think an argument of delegation. This is pointing out an argument for paying for reasonable service, which is, hey, there's some value to having a turnkey, but it's not 51%. If we're going, it could be 51% in year one, but year two it could be 41%. In year three, it could be 31%, and ongoing could be like 20%. So, you might be able to negotiate something like that, but it's not just that revenue, but it's also control. And if you give up control from the beginning, you're not getting that back.

So I think the point you're making is a very good one, which is get the best deal you can and don't just sign it away because it sounds like, oh, I don't want to deal with those business issues because later you're going to be like, God, what are they doing for their 51%? They're going to be, "It's a lot of money and I'm the one doing the surgery, and so is my buddy Jack, and we're only getting 49." Well, that was the deal you made.

Which leads me to my next topic, which is negotiation. You don't get the deal you deserve; you get the deal you negotiate. That's sort of the golden rule of business. So, you've helped tens, if not hundreds, of younger doctors with their contracts, looking at them, giving them some advice, telling them to talk to this attorney, et cetera, helping them negotiate. You mentioned your son. We can dive into that a little bit if you want. So, what's your approach? What's some nuggets, some best practices that you would give advice to physicians on employment agreements?

**Dr. Jack Bert:**
Yeah, no, it's a great question. One of the things that I have to say is that you've got to be really careful of administrators because first of all, there's so much data out there. In fact, I was just reading something yesterday about administrators compared to physicians' salaries over the last 10 years was over 50 times greater than physicians in terms of increase in salaries compared to physicians.

And what happens is, I was negotiating a contract, I'll never forget this. I flew down to Texas a couple years ago for a nine-man group to help them with negotiation and a contract. And this guy sits across from me and he says, "We're going to use the MGMA guidelines. You're going to get 50% of what the normal amount is. In other words, we use that 50% mark, so it's 500 grand and that's what you're going to get."

So, I looked at him and I said, "Okay, if they're in the 50th percentile, does that mean they're the best of the worst or are they the worst of the best? Is that what you think of these guys?" In other words, aren't they the top 10% of docs

in this area? "Well, no, I mean, this is the way it is. This is the way we do it." I said, "But why do you do it this way?" And then he kind of looked down and he got real angry with me because obviously I was hitting home on his pitch.

And the bottom line is that a lot of them try to use a work-hour view of 55 to 60. And what I've done with some of the healthcare attorneys is I've asked them to look at, and the groups, look at what the docs are getting in the area, for the private practice docs. So, let's say they're getting 70 to 72 per work-hour view. One thing that Dave Glazer, who is the attorney, the healthcare attorney for the Mayo Clinic, is a very close friend of mine and we've lectured for 20 years. And what he's made the argument and actually broken some of these contracts up pretty beautifully is saying, wait a minute, if these guys are getting $72 per RVU and they're in your practice area, there's no reason in heck that you can't make the same negotiation.

And they'll say, "No, no, no, we've got to stay in those MGMA guidelines." That is absolute nonsense. They'll try to say that that's the law. It's not the law. David has argued it in court actually, and it falls apart immediately because the prevailing area that you're working in has a 72 or even $75 per RVU work-hour view, and all of a sudden, their salaries bump up by three to 400 grand. That's a critical thing I want to make mention of when you ask me that question.

**David Mandell:**
Yeah. So, I think what you're saying is that they use these national databases, which are probably to some degree skewed for the employer. Again, that's just my opinion. I mean-

**Dr. Jack Bert:**
No, you're right.

**David Mandell:**
Because they're paying for it, right? They're the ones, your group, my group, et cetera, physicians, we don't get together and sponsor it. The employers do because it's in there. And they're a business. So, they're always going to come

in with a lower number. I think it's funny because as a layperson slash patient, what do I see all over the billboards of South Florida is the top orthopedics here at whatever, Holy Cross Medical. But you would say, "Well, you're putting it on the billboard that we have the top orthopedics, but yet you're giving us, what did you say, the worst of the best or the best of the worst."

So, it's not matching because they're trying to get patients, they're trying to drive people. But I think what you're saying is that the market forces, if you can find groups similarly situated in your marketplace that have a high or an ideal reimbursement or RVU schedule, that's your match. That's what you're going for. That's what you want to find. Because then it's your baseline essentially. Hey, you're paying them this, they're in the local marketplace. We should be able to get that as well, rather than a national sort of generic number. Has that been your experience? That's worked out better.

**Dr. Jack Bert:**
And David, one very important point that, again, I looked at a contract recently, and I see this in every darn contract, they'll try to write in that if you develop something, they own it. If you go-

**David Mandell:**
Intellectual property or something like that.

**Dr. Jack Bert:**
They own it. And you've got to be careful about getting all of that out of your contract. But because who knows, in 10 years you may develop something that is just brilliant and bring it up and administration says, "Well, we own that. You can't have any of that income," which is absolutely ludicrous in my opinion.

I actually looked at a contract six months ago that was 40 pages, single-spaced pages of a contract. Mine was two pages double-spaced when I first started. And it said, "You'll not solicit an inheritance from a patient during clinic hours." Literally. I mean, these guys want to bump up their fees so much and

put in more work hours. They'll think of anything they can think of to put in a contract.

So, it's really critical to make sure that when you get that contract, you have somebody smart look at it, whether it's your group or a healthcare attorney. Somebody's got to peruse that thing. And I'm not an attorney, but when I look at them, this stuff is out there like a red flag. It's just simple to see. But if you're a resident or a fellow, you don't have a clue because you've never looked at a contract before.

**David Mandell:**
And frankly, it's something we don't do at OJM. Now, we have some great healthcare attorneys we've had on the podcast who we refer to. We don't get a dime for that, nor should we. We just make the referral who we think is good.

But it's also that company I referenced, I did with two orthopedic surgeons, Dr. Bhatia, Dr. Preventer, and we developed an AI tool that at least will give someone, they can upload their contract, and it'll spit out everything that it says and some suggested negotiation points. It's not meant to supplant a healthcare attorney, but when we started to look at it, Jack, one of the things that I was really shocked at is how many, especially young docs, don't do anything. They just sign it.

**Dr. Jack Bert:**
Yeah.

**David Mandell:**
They don't even really, they don't hire a healthcare attorney. I understand, it's hard to get them during hours. They're running around, they're done in July, they've got to start the job in three weeks. They get the contract; they have two weeks to decide. And can they even afford a healthcare attorney? So, it's just like, well, it's a lot more than I'm getting paid as a fellow, I'll just sign it.

**Dr. Jack Bert:**
Exactly. That's the whole point.

**David Mandell:**
And so, we've developed this tool so at least they can go on an AI tool for hundreds of dollars, literally almost nothing. And at least it spits out to them what the contract says in plain English and some negotiation points and language around it. So maybe they can get a little bit here or a little bit there.

Once you're out in practice or you're negotiating as a group, you've got to be spending the money because your return on investment in getting some things out of that contract, getting better numbers, might be the best investment you make in your entire life versus just-
**Dr. Jack Bert:**
I agree a hundred percent.

**David Mandell:**
... whatever they just give you on the first offer.

**Dr. Jack Bert:**
And the other thing, David, I think I should make a point of very quickly, is that there's something called easy and easy out. We did that in our group. Several groups around the country do that. And what that means is they might say, "Well, listen, it's going to cost you $2 million to buy into all these ancillaries," which is probably accurate, by the way. And so, what we did is we said, "Okay, you're going to get paid 300 grand your first year and any revenue you bring in from the ancillary referrals, we're going to keep track of that. And so, once you hit that number, whatever it is, a million, a million five, two million, then you become a partner and then you start getting the ancillary revenue, and when you leave, you don't get anything."

So at the end of the day, you build up that amount, instead of having to take a loan out, pay six to nine percent for it, and it works out really, really well and

doesn't make it a struggle for the new kid who's coming in, who's going to get paid 300 grand, right?

**David Mandell:**
Yeah.

**Dr. Jack Bert:**
[inaudible 00:14:45] a house to get.

**David Mandell:**
Right, right, right. Yeah. That's a topic for another podcast because I'm interested in that because it is a struggle in all sorts of firms, even in firms like ours. How can folks buy into a practice or a business? And that may be something else we want to talk about.

A couple other topics I want to hit. So, you're in the retirement red zone. It's there. We're using a football term. So, what has been your approach, and I know you and I have talked about this a little bit. As that approached, one, from a financial point of view. Let's start there first because you've done some things and you've made some priorities. We'll talk about the soft side in a second.

But from a financial planning point of view, as you've looked out, rewinding back a bit and saying, hey, at some point I'm not going to be practicing, I'm going to need my assets to sustain me, what are the things that you found that were really helpful to you? You mentioned defined benefit plan already, but what are other things that you have done that you think has been helpful to you?

**Dr. Jack Bert:**
Yeah, I tell the young kids, save. Take 25% of your salary. I don't care if you want the expensive car, I don't care if you want the expensive house, put it somewhere with somebody smart so that you can get a six to eight percent return. Rule of 72s, right? So, nine years at six percent is a significant amount.

Bottom line is that you've got to have that attitude, so you're not like a pro athlete that burns through that money right away. And physicians do it all the damn time. I talk to these guys when they're 65 and they say, "Yeah, well, I've got $2 million in savings." I say, "Okay, do the math on that."

When you get your RMD, your required minimum distribution, which is what, up to 73 now, you take it out and you're taking four percent of two million. What's that? 80 grand a year and then you've got taxes on it. Can you live on that? Well, of course I can't.

So, you start doing the numbers and people ask me, "How much do you need to retire on?" I look at them straight and I say, "$10 million." And they go, "Are you kidding me?" But now, if you have a defined benefit plan that you've started early in your savings, you could get pretty darn close to that. And so, it's really critical to do that.

Now, number two is you've got to have something to retire to. Now, I still work, believe it or not, a day and a half every two weeks, I do plaintiff independent medical Exams. I make a lot of money doing that instead of defense exams. That's a whole different discussion.

**David Mandell:**
Yeah, that's another time. We've had some orthopedics. We started the season, for those of you listening, watching who didn't watch or listen, I just want to make this point, to the beginning of season five with an orthopedic surgeon on who got injured at the age of 57 snowboarding with his son and realized right then, "I'm not going to be able to perform surgery for a while." And it turns out he was right, he could no longer perform surgery, but he's been able to through disability insurance, which was a really good thing that he did as financial planning.

**Dr. Jack Bert:**
Pre-tax.

**David Mandell:**
It pays out pre-tax, exactly right. And doing independent medical evaluations and some other things, he's been able to actually thrive even though he can't perform surgery anymore. And you're using that same revenue source and side hustle, as they say today, to sustain income and be active in that sort of retirement process. So that's great. Now, choosing plaintiff side versus defense side, that's another conversation for another podcast. We've got another episode already, I think.

**Dr. Jack Bert:**
30 seconds. So, I owned an IME company for 20 years and sold it about five years ago. It was all defense. And for those of you who are interested, look at the plaintiff side. We can have a conversation about that, David, some other time. Hugely different, hugely more lucrative, and the patients, those people love you when you support them in court. So, I'll just leave it at that.

**David Mandell:**
Okay. Okay. Yeah. So, you've been doing that and what other things you've retired to. Do you want to talk about the new business? You want to get into the new venture in terms of matching up providers? Or is there something else you wanted to talk about?

**Dr. Jack Bert:**
Well, just one quick comment.

**David Mandell:**
Yeah, fine.

**Dr. Jack Bert:**
Something to retire to. One of the big mistakes guys make, and I play golf with some very unhappy retired physicians.

**David Mandell:**
Yeah, okay.

**Dr. Jack Bert:**
Get done with golf. They look at you, go, "Well, what else am I going to do today?" And for me, I'm busy doing other stuff, so golf two to three times a week is just a kick for me. But the bottom line is that I believe strongly you have to have something to retire to.

So, seven years ago I ran into a guy from Optin, and we call that the Evil Empire United Healthcare in Minneapolis, and we had lunch together, and he was so disgusted by what Optin was doing that he and I decided to form a company, and we call it MD Direct. And what we do, we go right from employers to providers because I've always hated insurance companies, and I don't think there's anybody listening to this podcast that doesn't think the way I do.

**David Mandell:**
Some people who are driving are probably beeping their horn.

**Dr. Jack Bert:**
Oh God, yeah. So the deny, delay is out there and it's getting worse and worse. And so we said, what if we went to self-insured employers, took care of their musculoskeletal care, and then found orthopedic surgeons that wanted to do the work, but we're going to communicate with the patient. It's not a second opinion company. We do something we call diagnosis, discuss, and disposition.

So we talk to the patient. I have 12 retired orthopedic surgeons with 30 to 35 years of experience, from foot and ankle up to spine, that do this work, and they really have a lot of fun with it because we can pay them well for a 15 to 20 minute conversation with a patient. We give them direction as to their care. We do not treat them. We have doctors around the country that see these folks after we've made a diagnosis and disposition them.

So to give you an example, we started seven years ago with a small school district that had 1500 employees. The first year, we saved them 45% of their musculoskeletal [inaudible 00:20:55]. How the hell did we do that? Well, for one thing, everybody with 10 to 20% collapse of their joint space does not need a total knee. They can get some injectables. They don't need 50 rounds of physical therapy for a rotator cuff tear. They need it fixed. They don't need a $5,000 MRI. They can get a $750 MRI from a group of scanners around the country that have over 300 scanners. Simon Medical, they do a fabulous job. They're read overnight by Cleveland Clinic docs or Northwestern University radiologists, and they're 750 bucks.

So I can make that diagnosis. I can tell the patient if it's wrong, and we can disposition them. If they need a rotator cuff care, they get it right away. If they don't need a total knee right away, we send them to somebody who's going to try an injectable first. So that's how we're working. We're up to about a million and a half patients in 10 states that we're working with, with self-insured employers, and we're really upsetting the insurance companies, which I absolutely love.

**David Mandell:**
Yeah. Well, hey, if you're an orthopedic listening or watching this, we'll put a link in the show notes, but maybe there's a way they can get involved or expand what you're doing.

**Dr. Jack Bert:**
Absolutely.

**David Mandell:**
If you're a doc in another specialty, maybe this is an idea to bring into other areas of medicine. If it works in one, it works for others, right?

**Dr. Jack Bert:**
Yeah. We're working with several OBs. We've got three ENTs now. We're trying to expand it. And I've got to tell you, it's shocking how much money you can

save if you just kind of cool it on the therapy and they're not going to chiropractic care for six weeks, five modalities per visit, at a cost of $400 per visit. It's just phenomenal how much waste is out there.

**David Mandell:**
Yeah. Well, just in basic business terms, there's a middle person, this insurance company that has lots of overhead, and so there's taking out a middle entity and there's also just waste, as you're saying. So it's just not done efficiently. Even if there was a middle person and they did it efficiently, you'd still save some. But if it's a middle entity and they're not efficient, well, then you've got a lot of opportunity to cost-effectively get the better results even for less dollars, which is obviously-

**Dr. Jack Bert:**
Exactly right. Yep.

**David Mandell:**
Excellent. Last thing I want to talk about. So my partners, Andy, who's been on the podcast, Andy Taylor, Carole Foos has been on multiple times. She's our tax expert, so we always need her on when there's a tax change of course. They've both been out in Hawaii at the meeting that you help run each January. My partner, Adam, as we're talking here in the fall, he'll be out there this coming January, which is January 2026. So tell us about that meeting for the orthopedists who are here or watching, listening. Tell us a little bit about that meeting you've been involved in.

**Dr. Jack Bert:**
Sure. So Orthopedics Today Hawaii is based upon the Orthopedic State Journal, which you're part of, the monthly publication. I run the practice management session for that. So I used to run the knee session. I gave that up a couple of years ago when I stopped operating. And I've always run the practice management session, actually since 2000, believe it or not, since 2007.

And so what we do is we take Thursday and we address practice management subjects that are critical for a private practice or employed orthopedic surgeon. In fact, we bent it more towards employed last year because we had a higher percentage, believe it or not, of employed orthopedic surgeons present. And so we run through practice management topics that we think are relevant. We have an open session, an open mic session. We have an open session where afterwards you could spend time with a healthcare attorney, with any of us that are on the panel. We get people from your group, which are fabulous, that talk about tax planning, that talk about retirement, talk about how to manage your money.

And it's such a huge problem, especially for the younger kids. But what's really surprising, I get so many of these guys in their sixties coming up to me after, saying, "What are you doing now? I'm not really sure I want to quit, but my group wants me to stop operating and what should I do? I don't think I can sit around and read all day or fish all day and play golf."

And so we try to address those concerns for everybody, and we've been pretty successful. Usually it's about 700 orthopedists. We think we're going to hit 800 this year, believe it or not. And usually by Thursday, despite the fact that the weather is perfect, we usually get about four to 500 to come to our practice management session. So we've been really pleased with it.

**David Mandell:**
Yeah, it's a great meeting, obviously a beautiful place to do it, and we're excited about continuing to do it and proud that we have in the past. So we appreciate the invite, Jack.

I really appreciate you being on. We covered a lot of good stuff and we uncovered a couple of things that we'll have you on another time, probably season seven, to get into. So thanks for being a part of it.

**Dr. Jack Bert:**
My pleasure. I really enjoyed it. Thank you very much.

**David Mandell:**
And for everybody watching and listening, of course we'll have another episode in another two weeks. And if you like what you've heard, subscribe on any of the major podcast platforms. Give us a five-star review, if you're so inclined. Tell your colleagues and friends about us. We're growing. We're up to well over 50,000 downloads. We might even be at 60,000 by the time this comes out. So, lots of people are finding some value. So, look for us in another two weeks. Thank you.