Good and Bad Algorithms in the Practice of Medicine

https://mindmatters.ai/podcast/**ep187**/

Robert J. Marks:

Greetings. Welcome to Mind Matters News. I'm your capable host Robert J. Marks. Today, we're going to discuss how algorithms can either sharpen or derail services. Specifically, we're going to talk about the practice of medicine. Algorithms, if you're not familiar, are step by step procedures for accomplishing something.

Robert J. Marks:

When you bake a cake, for example, you have the input to the algorithm, which is all the ingredients. And then you have a step by step procedure. Put the cake mix in the batter, add some milk, some eggs, possibly beat it. Preheat the oven, cook for a certain amount of time, et cetera, et cetera. And you end up with a cake. So recipes are algorithms.

Robert J. Marks:

In fact, I'd like to think that algorithms are indeed recipes. I think it probably goes both ways. Google driving instructions are algorithms when I'm told to go to your place. And I'm supposed to go two miles on the freeway, turn left at the 7-11. Go a couple blocks, turn right on Oriole Street, and et cetera, et cetera. So those are step by step procedures to get me from point A to point B.

Robert J. Marks:

Now computers and AI are restricted to be algorithmic. In other words, computers can only do things which are algorithmic. Every computer follows a step by step procedure for doing something. If something is non algorithmic, it is not computable. And one of the things that we've shown at the Bradley Center is that creativity, nuance, and insight are human characteristics that are non algorithmic. You cannot write a computer program to do them, creativity, nuance, and insight.

Robert J. Marks:

And if you remove creativity, nuance, and insight and other criteria from making decisions, you are really stifling the degree to which you can interact. We're going to talk about how algorithms stifle and also enhance the practice of medicine. Our guest today is Dr. Richard Hurley. Dr. Hurley is a medical doctor who is board certified in anesthesiology and pain medicine. Dr. Hurley, welcome back.

Richard Hurley:

Thank you, Robert.

Robert J. Marks:

One of the things that we were talking about offline is algorithms and medical procedures. And the fact that a surgeon can come up with a new way of doing something and they can patent it. That's really

astonishing. So if a surgeon that you works with uses a procedure that's patented by somebody else, does he have to pay the person that originated and owns that patent for the right to use that procedure? Do you know?

Richard Hurley:

No, I don't. I'm not an expert in this. But of those physicians that I have known that have developed a technique or a device, they've usually partnered with companies that actually may produce or manufacture that. And the two of them together will get a patent either on that procedure or the type of procedure, or the device itself.

Robert J. Marks:

I have a personal story. I was trying to quit coffee, but every time I quit I started to get headaches. And then I got ahold to some bad calamari and that bad calamari put me in bed for about three days, just terrible. And just agonizing, agonizing pain and gastro discomfort. When I finally recovered, I thought I probably went through my headache withdrawal during my time when I was out with this food poisoning from the bad calamari.

Robert J. Marks:

And somebody told me about patent ability. And I thought I could have patented this for people that want to recover from addiction to coffee. But of course it would involve bad calamari. But I'm sure that there's ways that they can induce this sort of coma and distraction. I think they use this in drug recovery sometimes, don't they?

Richard Hurley:

Yeah, it's really interesting, for severe depression now. For different types of pain states. They're actually using the infusion of ketamine, which is its sister drug is LSD. And ketamine is a dissociative agent and actually seems to help depression. It's not such a strong deal in terms of abuse or addiction. But it has really been successful in the treatment of depression.

Robert J. Marks:

Okay. So do they knock you out for that or they put you to sleep for this?

Richard Hurley:

No. They don't have to give you an anesthetic dose. It's an infusion in which you are awake. You're not dissociated. In the infusion rights, you couldn't do anesthesia. You can actually use the drug for anesthesia. I used to use it all the time, but you got to use it at a higher dose. It's not necessary then to use high doses in order to get this response that you're looking for.

Robert J. Marks:

I see. Okay. Well, speaking of procedures, you've mentioned to me about the onslaught of technology in your field.

Richard Hurley:

Right.

Robert J. Marks:

Could you comment on that? One of the things you mentioned was a suture device for deep wounds.

Richard Hurley:

The spine surgery that I do is predominantly implanting spinal cord stimulators. And basically it's two very sophisticated wires that are put into the epidural space. It's tunneled up into the mid portion of the spine. And when you turn it on, patients feel tingles in their lower back and legs. And for some patients that is excellent pain relief. But you don't even have to feel the stimulation in order to get relief.

Richard Hurley:

The biggest problem we had with this is that active patients and even non-active patients, if they fell or whatever, the leads would move. They would either fall down or to the right or to the left. And so then you'd have to operate on them again and fix it. So I didn't have as much trouble as other people did. But I still had some, what we call migration of the lead. And so there was a group of, I don't even know who they were, that developed a product called Fixate.

Richard Hurley:

And basically, it's a device that allows you to suture a wire deep into a wound. And you don't even have to get your fingers down into it. It's just all designed with a way that it was done. And then when you pull up on it and tighten it up, it would cinch it down. And it's amazing. Once a lot of people started using this, the lead migration went way down and reoperations went way down. So it's just a simple device that's available to anybody that wants to use it.

Robert J. Marks:

That's interesting. So there are other technological advances. I understand that robotics is now being used for a lot of operations. And all of this is going to be algorithmic. You have to go in, and the physician either uses this as a tool. Or if it's unmanned it does it on its own.

Richard Hurley:

Exactly right. Yeah. Of course, I'm not as familiar as a lot of other people are, but we're using robotics in certain treatment of ... Some guys are using it for knee replacement, for any abdominal or pelvic surgery. And the list, it keeps increasing daily. But the advantage is, is that you don't have to have large wounds. You can do everything through a small incision. And so recovery time is better. And overall the results have been just as good if not better.

Robert J. Marks:

That's interesting. So what is the history of ... I guess technology has always been a part of medicine. But in terms of AI and some of this high technology, that's a recent development, isn't it?

Richard Hurley:

That's true.

Robert J. Marks:

Okay. Let's talk about algorithms in other places. So we have algorithms in the practice of medicine. And I think that's one of the reasons that we have nurse practitioners today. When I was a boy, we didn't

have nurse practitioners. You went to the doctor. But nurse practitioners kind of take care of, as I understand, the low level medical diagnosis that can be taken care of through algorithms. You come in, you got a fever, you got a temperature. And they probably say you got flu and you should take such and such medication. And this is pretty proforma.

Robert J. Marks:

And that's what the nurse practitioners are supposed to do. And then if they're outside of their silo of expertise, they put you and they refer you to a specialist who can take care of you. I use a nurse practitioner and I really appreciate that she knows her limit of expertise. I can go to her for normal things. But if it goes outside of her silo of expertise, she can refer me to other specialists. So nurse practitioners are followers of algorithms in terms of what they do.

Robert J. Marks:

One of the things that I wanted to talk about is the application of algorithms. Not necessarily in the practice of medicine, but in the constraints, which are put onto medicine by insurance companies and stuff. Could you talk to that?

Richard Hurley:

I can. So let me first, by the way, a nurse practitioner who refers a patient because they're not sure, I agree with you. I think you appreciate that about her.

Robert J. Marks:

Yes.

Richard Hurley:

You should also appreciate that about your own physician as well. I refer patients when I get out of my expertise. I don't treat somebody's diabetes. I don't treat their hypertension. I don't treat their stroke. I make sure that I get that patient into the right physician to take care of that.

Robert J. Marks:

Good.

Richard Hurley:

But if you look at algorithms, medical algorithms are, it's a visual roadmap to help guide you in your decision making. Okay? And that helps you plan for and evaluate your care. It's to help to remove the uncertainty. Okay? It makes the decision making much more accurate. And it's developed by physicians for either physicians or other healthcare providers. It's evidence based, and it's data driven. Now algorithms by health insurance companies, they use algorithms for prior authorizations to determine the medical necessity for hospital admissions, prescriptions, surgeries, and procedures.

Robert J. Marks:

So this really constrains your practice, doesn't it?

Richard Hurley:

Yeah, because their prior authorization purportedly is to reduce healthcare costs. But they claim to save money by denying health services that are considered to be experimental or unnecessary, even if that care or drug or procedure is FDA approved or approved by the Centers for Medicare and Medicaid Services.

Robert J. Marks:

Is that right? I was talking to a friend that is the ... His first name is John. I forget his last name. But he has a startup of a new service for like senior people that can monitor old people in their houses. And just make sure that they're okay, they're moving around. And then there's a lot of data mining, which comes from that, where how many times they go to the rest room, for example. How long they sleep. And you can monitor all of this from their technology.

Robert J. Marks:

But he was saying that his big hurdle was to get approval by Medicare and Medicaid. He said, "This is the main hurdle that needs jumping in approving new medicine and procedures." And also said, and I want to check your viewpoint on this, that the insurance companies would usually become a part of it and agree to cover this cost if Medicare and Medicaid did that. But you're saying ,that's not necessarily true, is that right?

Richard Hurley:

The Center for Medicare and Medicaid, they can approve payment for anything that they think is ... They're not going to approve something that's not FDA approved. Okay? In other words, if it's a drug. If it's a procedure, then there are all kinds of things that they have to do to get that done. But even then many procedures and devices have to be FDA approved. Okay? But insurance companies, private insurance companies, just because Medicare does it, they don't. They're not obligated to do that. Okay?

Richard Hurley:

So a lot of times they are actually behind the eight ball. They have other agendas. Or a perfect example is a new drug that comes out that may have a strong indication, FDA approved. But before I can write a prescription for that, I've got to use all the old drugs that were never approved for that particular diagnosis or problem. But we knew that if you used them off label, the patients got better. And then if they failed those, then you could order this new drug that might cost 100 times more than the old drugs. Okay?

Robert J. Marks:

I see. Okay. So the drug companies come in and they probably want to have everything approved by insurance. And then the insurance company come in and they make all the rules. To what degree do the drug companies stifle your practice of medicine?

Richard Hurley:

Well, to give you an idea, and it's just recently in the last three years, we've seen a number of pharmaceutical companies produce drugs that are called CGRP inhibitors, which are known to be fantastic drugs for migraine. And these drugs are given intramuscularly and they last about two months. It's been tremendous in terms of relief of patients who suffer for migraine. In order to get this approved, you've got to have 15 migraine attacks per month before they'll approve that drug.

Robert J. Marks:

Really?

Richard Hurley:

Now that number may have gone down. And I shouldn't probably say give you a exact number.

Robert J. Marks:

But there is a threshold that's . . .

Richard Hurley:

The threshold is so high and it's so hard and it takes a lot of time. And a lot of times the nurses or physicians have to go to their insurance companies to get this approved. And I have the same problem I have with the things that I do, but those issues are that way. And so it is tough. Now over time, those drugs will become cheaper and then insurance companies will use them and then they'll be fighting something else. You know?

Robert J. Marks:

I see. So it seems to me that in the practice of medicine ... We talked about algorithms and nuance and insight and things of that sort. It seems that with a physician, you have this nuance. You have this insight into patients. And that you should have this flexibility to prescribe what you think is appropriate. Yet, I kind of get the sense that insurance companies kind of stifle that creativity and your practice, if you will, in medicine. Do you agree?

Richard Hurley:

I do. I totally agree. So in other words, in pain medicine, I'm an interventional pain physician. So I do agree that we should approach the patient. Certainly, from a conservative standpoint, you shouldn't go into the most expensive treatment for modalities from day one. You got to get to know the patient.

Robert J. Marks:

Of course.

Richard Hurley:

They got to have some trusts in you and all that stuff. But if ultimately, if I have a patient with mechanical back pain, they're in their fifties to sixties, they've got enlarged facet joints, are the small joints in the lower back. And when they move a certain way it pitches them and it causes them severe pain. And they've been on a over the counter medications, such as Tylenol or ibuprofen or Naproxen. They've done some exercises at home. It didn't help. Maybe they've even had physical therapy or chiropractic manipulation, or maybe they've had acupuncture.

Richard Hurley:

They've had all kinds of conservative care. Ultimately, I may decide that what I want to do is a procedure called median branch blocks or facet nerve injections, where we actually anesthetize the joint to see if their function and pain improves. Now, once I request that I have to send all of my notes, all of my imaging, everything to the insurance company. And we might hear back from them in a week. So when a

patient comes in and they expect care at that particular time, I can't even offer it to them because it has to be approved.

Richard Hurley:

And they ask 15 different questions that my nurse will fill out electronically. Okay? But if she misses one, just one, or if she doesn't dot the I across T, then it gets denied. And the insurance companies have people who are not experts. They're not nurses. They're not even medical assistants. They are people who have been trained to read notes and then look for reasons to deny it.

Robert J. Marks:

Well, this is the whole point, right? They're following fixed rigid algorithms, which do not allow the flexibility that you need.

Richard Hurley:

Right. And these companies that do this have just blossomed with managed Medicare. Okay? So managed Medicare is essentially ... Everybody thinks managed Medicare is like standard Medicare, that's false. Standard Medicare, you have standard Medicare, but then you have to pay for your supplement.

Robert J. Marks:

Yes.

Richard Hurley:

Okay, which is 20% of the care. Well, sometimes that costs more than the standard Medicare. Well managed Medicare gets rid of all that. It's just one fee. And so if an insurance company like Blue Cross Blue Shield or Etna or whatever is going to be involved in that, they can make money if they deny services or postpone them.

Richard Hurley:

The algorithms that are set up are saying, "Well, the reason we have these algorithms are to get rid of unnecessary procedures." Okay? But it's really interesting, of the number of case procedures that I want to do and then I go to appeal, probably they don't reject more than maybe two or three, initially. But within a month, 100% of them are approved over time.

Robert J. Marks:

Really? Okay.

Richard Hurley:

Yes.

Robert J. Marks:

So they're reasonable, but you really have to go to battle with them.

Richard Hurley:

That's right.

Robert J. Marks:

How much time do you spend battling the insurance companies?

Richard Hurley:

So not all insurance companies require prior authorizations, but all managed Medicare does. And almost all primary insurance does, but standard Medicare does not. So if you have standard Medicare with a supplement, there's no pre-authorization. So what I say and what you agree to is the type of care you're going to get. But people who sign up for managed Medicare are not aware that they're going to be plagued with pre-authorizations for that year that they have that insurance.

Robert J. Marks:

The funny thing is I go in for procedures every once in a while and I'm given an estimate of what the insurance company will pay. And invariably, almost 100%, I get a bill for extra money. In other words, the medical doctor doesn't know how much the insurance company will pay. They guess, or maybe they have a standard reimbursement that they quote me, but it never seems to be enough.

Robert J. Marks:

On one occasion I did get a check back that I paid too much, but that was a rarity. And that seems to me to be frustrating and a very bad algorithm, if you can't decide a priori beforehand, what a procedure's going to cost.

Richard Hurley:

Absolutely, and you don't see that. In medicine, if there was no insurance and everybody paid cash, you'd have the prices written on the outside, on the billboard.

Robert J. Marks:

I've heard that and wondering, so the insurance companies are, the algorithms that they use, let me use the word brittle. You can't crack them. You can't go outside of them. And that certainly must be frustrating. On the other hand, we know that we need algorithms because there needs to be some sort of constraint in terms of containing cost. So Richard, how could it be fixed?

Richard Hurley:

So the thing that the state of Texas came up with in the last legislative session was the Golden Rule. I don't know if you've heard of it or not?

Robert J. Marks:

No.

Richard Hurley:

But essentially what they got passed was, if a physician had six months of care in which maybe they were a proceduralist or whatever it was, and all of virtually 90% of the requested authorizations were passed, then they would get a gold card, which will allow them to then-

Robert J. Marks:

Oh.

Richard Hurley:

For the next six months, they can go ahead and schedule the procedure without getting authorization. Now, that's just coming about now. In other words, it was supposed to have happened by, I think the beginning of the year. But interesting enough, insurance companies have trying to tackle on different rules. Okay? So it still hasn't been a decision. But that was something that the Texas legislature came up with was the Golden Rule.

Richard Hurley:

In other words, if they look at you over your past six months and everything you did, even though you might have done some appeals, if your appeals were approved, then we will grant you a six month reprieve from pre-authorizations. It's one thing or another. I disagree, but I understand why pre-authorization's there, because there are always dishonest providers who do things. They'll schedule procedures that are not indicated, or they'll do too many of them. Or they'll do it for the wrong reason. You know?

Robert J. Marks:

Wow. Now, when you or your assistants or your nurse talks to the insurance companies, I guess one of the things that must be frustrating to you, and you mentioned this, is that you as a physician are arguing with somebody who is trying to follow a strict algorithm, but which has no medical experience.

Richard Hurley:

Correct.

Robert J. Marks:

And they are still constrained of following their algorithm, yet you say that most of your controversies are concluded in a happy way. So how do they get around the algorithms? Are you given exemptions from the algorithm or what?

Richard Hurley:

Well, hopefully that's going to happen. In other words, maybe one day I'll have a gold card. I don't know.

Robert J. Marks:

Okay.

Richard Hurley:

I doubt that interventional pain physicians, because the problem with chronic pain is, is that everybody's going to be a patient at some time or another. You will be. I will be. You'll have some. Now how you cope with it is obviously different. Everybody copes with it differently. But authorizations for certain medications, like those CGRP inhibitors that I was telling you for migraine, well those drugs cost $600 a month. And you think about how many millions of patients who have that, and you just dump that on the system, insurances would really struggle with that. And I understand that as well.

Richard Hurley:

Maybe it's the cost of drugs. Maybe it's all that stuff. I don't think there's a real good answer. But to actually streamline this differently would be better. But the biggest problem I have is when I do a pre-authorization, it gets rejected. And then I go to appeal and I go back and review my notes. And then I talk to the doctor there. The reason I win is because they didn't read all the notes. They didn't look at the MRI report. You know what I mean?

Robert J. Marks:

Yes.

Richard Hurley:

They just missed it. And so I always ask them, "Why do you ask for us to send all the notes on the patient when you don't read them?" I mean, it doesn't make any sense.

Robert J. Marks:

Oh, my gosh. The gold card, the more I think about it, the better idea it is. I like the idea of vetting physicians to give them more flexibility in what they do. Another question I have, what is the difference between the different insurance companies? They all have this brittle sort of algorithmic criteria that they impose on the practice of medicine. Are there some which are better than other ones? You can mention names or not mention names. That's up to you.

Richard Hurley:

I'm not the expert in that, so I can't tell you. We have less problems with ... If people can afford standard Medicare with a supplement when they get Medicare age, I just encourage them to go that route. Because even though you're healthy, and even though you may not have used a lot of healthcare, you don't know what the future's going to bring. And even though you may be paying more, that's the way I would go. Managed healthcare changes. So what I mean by that is Blue Cross Blue Shield may have this criteria to do median branch blocks on a patient this year, but next year they're going to change it.

Robert J. Marks:

Really? So the rules keep changing?

Richard Hurley:

Oh, the rules change on the first of the year. They publish it. You might get to see it, you might not. And then all of a sudden you haven't met that criteria, so it gets denied.

Robert J. Marks:

How do you play the game without knowing the rules?

Richard Hurley:

Well yeah, it's really funny. You get denials, and then all of a sudden you find out what the new rule is, and then you start adjusting your notes so that that fits their criteria. Those are kinds of things that we as physicians get really frustrated with. And those rules seem to be quite arbitrary. And they're based on what they perceive as abuse-

Robert J. Marks:

Sure.

Richard Hurley:

... where okay, all of a sudden this procedure's going way up and is there any reason for it? Well, there may not be, and it may be abuse. But you're penalizing everybody else and all the other patients that are involved by changing the rules and not letting us know.

Robert J. Marks:

There are a number of different companies that give healthcare, health insurance, if you will. Is there a monopoly happening unsaid where the rules for all of these insurance companies are roughly the same? The reason I ask this is it seems that if there were true competition in the spirit of free enterprise, in the spirit of capitalism between the different healthcare insurance providers, that there would be a competition to give the best service. Which would be a motivation to sharpen their algorithms to make them more user friendly to the physician.

Richard Hurley:

When you're buying health insurance, I feel sorry for the lay person who doesn't know a lot about medicine and how healthcare is done. Because you basically you would think, "Well, I'm probably not going to buy the cheapest, but I'm certainly not going to buy the most expensive. And so I'm going to try to hit one in the middle of the road."

Richard Hurley:

If you ask the lay person in the United States, what a pre-authorization is for healthcare, many patients might know, but most people don't. And they don't ask that when they go to get their plan. But in answer to your question, an all the managed care providers use other companies to develop these algorithms to decide whether a procedure is medically necessary or if it's experimental. Okay?

Robert J. Marks:

Really? So they farm it out then.

Richard Hurley:

Right. And one of the largest companies is a company called eviCore. They manage 100 million Medicare Advantage patients. 100 million.

Robert J. Marks:

How do you spell that name, eviCore?

Richard Hurley:

eviCore E-V-I-C-O-R-E. Okay?

Robert J. Marks:

eviCore. Okay, thank you.

Richard Hurley:

Yeah. So I usually have to talk to eviCore. By the way, I have the right under the state of Texas, I have the right to talk to a peer of my own. So in other words, if I call and my nurse sets up an appeal, she'll say, "Now, Dr. Hurley does want a pain physician, board certified, who he'll talk to." And by law, they have to get that. I don't know if they have to be board certified, but you have to have a ... In other words, I don't have to argue in front of an oncologist or a primary care. Somebody who's-

Robert J. Marks:

It's peer review, if you will?

Richard Hurley:

Right. It's a peer review. You have to have peer review in order to do that, and that can't change. If that ever changes, it's time for me to retire.

Robert J. Marks:

Okay. You mentioned previously, and I thought this was interesting, if we didn't have insurance, the price of every procedure of every medicine would be printed on the bottle.

Richard Hurley:

Absolutely.

Robert J. Marks:

And do you think that the use of insurance would increase this price? So there's kind of an implicit price on everything, according to what insurance provider you have. Do you think that this price is going to be higher or lower if we didn't have insurance?

Richard Hurley:

Anytime the federal government gets into anything, the price goes up. You know that as well as I do.

Robert J. Marks:

Yes. Okay.

Richard Hurley:

Okay. So they get into whatever it is they do, the price goes through the roof. And that's because you're very inefficient if you run anything from Washington DC, as opposed to doing something local. The state can do things cheaper than the federal government can do. And the local governments can do things cheaper than that. A private institution, like Baylor or whatever. In other words, there are ways to do things. But if the federal government gets involved, whether it is in medicine, whether it's in construction, whether it's in military, whatever it is, the price goes through the roof.

Richard Hurley:

A perfect example that I had was I had some properties down in Belton during Katrina. And for people who were looking for places to live, they came up and we had a place for them. Well, I put up this family

for that and I'd been renting. My place had been renting for $800 a month before they came. And then we moved them in and the government paid me $1250.

Robert J. Marks:

Really? Oh, my goodness, [inaudible 00:29:28]-

Richard Hurley:

I mean, I didn't ask him. They said, "That's what we paid for a three bedroom, one bath house." Said, "Well, okay. All right." Well, I didn't argue. I just took it, you know?

Robert J. Marks:

Yeah. It strikes me that in order to improve insurance, I do like the idea of free enterprise. I'm a big believer in it. I do believe that the FDA has to stay in the mix. I mean, what was that drug that caused birth defects a number of decades ago that-

Richard Hurley:

Oh, you're talking, well, it was a German drug for sleep. It was called Thalidomide.

Robert J. Marks:

Yeah, Thalidomide and it caused all of these birth defects. And to our credit, the FDA didn't approve it. So all of those birth defects occurred in other countries that had the slippery slope that allowed it to be approved prematurely. So I like the idea of the FDA in terms of clearing stuff. But it seems to me that we really don't have free enterprise among the insurance companies from the small amount I know.

Robert J. Marks:

And I do like the idea that the state has some control over it. Your gold ticket, for example, was at the state level. I'm wondering if some of these different insurances were localized more and separated, like the divestiture of the Bell Systems Labs, where they broke up the company, that maybe we would get a better deal?

Richard Hurley:

Oh, yeah. Well, the drugs that we use in the United States cost X dollars. The same drug in Canada cost 75% less because they have one payer and that's the Canadian healthcare system. They buy all the drugs and they dispense them out, you know?

Robert J. Marks:

Okay, so that's a vote for socialism.

Richard Hurley:

It is. It is, and I'm not saying [inaudible 00:31:07]. But what I'm saying is, is that was there any reason why two years ago the price of insulin doubled and tripled and quadrupled? I mean, I don't know. I don't know that information. But then if the federal government goes in and says, "Okay, you can sell insulin, but you can only sell it for $35 a vile" how many people are going to play with that? I don't know. I don't have the answers in terms of the cost and how to control it. All I know is everybody wants American healthcare and they come here in drove to get it.

Robert J. Marks:

It's still the best. Yes.

Richard Hurley:

It's still the best. And I think it always will be as long as we do it. And it's not truly private. Okay? There's a mixture of the federal government, state, government, private enterprise and all that other stuff. And so I like the drugs that I take. And I like the facts that my pharmacist's provide them. But how to handle the costs are not there.

Richard Hurley:

But algorithms that are involved in healthcare to help patients get better, whether in surgery or on the floor, are designed by physicians to help other physicians or providers to do things. And the algorithms for insurance companies are done differently.

Robert J. Marks:

Yeah. So that's another interesting question. This eviCore, do you know what degree that they employ physicians to set up these policies?

Richard Hurley:

I have no idea, but they must have hundreds, if not thousands of physicians that work either part-time. But please don't give me that job. I don't want to have to answer the phone and listen to guys about appeals. I couldn't do that job.

Robert J. Marks:

Yeah. The interesting thing is probably all those medical doctors make these recommendations and it's eventually decided by a bunch of guys with MBAs.

Richard Hurley:

It may be true.

Robert J. Marks:

Yeah, that would be my hunch. Okay. Any final words, Richard?

Richard Hurley:

No, I'm glad we had a chance to at least talk about this. I doubt that the public is aware of the algorithms that are involved in pre-authorization of patients for procedures or medications. Frequently they blame the physician. Okay. Why are you not getting this done? Why am I having to wait? They don't realize that the hangup is not at the office where you see your physician. But it's in computers and insurance companies that actually want a say in whether you can have that care or not.

Richard Hurley:

And if that was something that everybody knew, then my suggestion for people who are buying health insurance is how much pre-authorization is this product going to have? And I might run away from it. You know?

Robert J. Marks:

I see. Okay. How would you find that out though?

Richard Hurley:

You can always ask.

Robert J. Marks:

Always ask.

Richard Hurley:

Always ask. Always ask that, is the procedure ... Do I have to have pre-authorization to be admitted to the hospital? Do I have to have pre pre-authorization for this type of surgery? All of those things. Okay? You have to do all that. Yeah.

Robert J. Marks:

Oh, wow. Very interesting. Richard, this has been a fascinating conversation, fascinating chat. Thank you. Thank you very much.

Richard Hurley:

You're welcome.

Robert J. Marks:

Our guest today has been Dr. Richard Hurley. Dr. Hurley is a medical doctor who is board certified in anesthesiology and pain medicine. So until next time be of good cheer.

Announcer:

This has been Mind Matters News with your host, Robert J. Marks. Explore more @mindmatters.ai. That's mindmatters.ai. Mind Matters News is directed and edited by Austin Egbert. The opinions expressed on this program are solely those of the speakers.