Money Matters: Generating Income

Most patients don't think of their physicians as businesspeople. But, like the owner of their favorite restaurant, clothing boutique, grocery store, and auto repair shop, the physician must learn to be a savvy businessperson if he or she wants to stay in business.

Fast Facts

- *Practices can improve cash flow by simply improving the efficiency with which they submit claims. According to a survey conducted last winter by America's Health Insurance Plans (AHIP), 29 percent of claims were received by the insurance companies more than 30 days after the date of service.* *Page 54*
- *Incorrect codes delay claims. Coding properly the first time will speed up reimbursement.* *Page 59*
- *A financial planner can help identify the most effective investment vehicles for your business, or the type of retirement plan that you should offer your employees.* *Page 63*

Since physicians deal with lives and health, as opposed to trendy clothes or fresh groceries, the priority of any practice must be quality care for patients. However, even in light of the higher mission of the profession, practices must maintain a healthy cash flow in order to provide care. Managed care, Medicaid, and Medicare are all sources of payment that require the physician to act judiciously in order to receive fees and receive them in a timely manner. It is imperative that physicians remind themselves of the financial side of a medical practice before going out on their own. The earnestness of medical students to care for the sick may get them through

Master the Fine Art of Sleep

Prescribe LUNESTA first-line—for a full 7 to 8 hours of sleep

LUNESTA has been studied in large, well-controlled clinical trials in **all** of the following patient types:

- Patients With Insomnia Comorbid With Major Depressive Disorder
- Patients With Insomnia Comorbid With Generalized Anxiety Disorder
- Patients With Insomnia Comorbid With Rheumatoid Arthritis
- Patients With Insomnia Comorbid With Menopause

The failure of insomnia to remit after 7 to 10 days of treatment should be medically evaluated.

Any night or every night

Leave the rest to...

Lunesta® (eszopiclone)c
1, 2 AND 3 MG TABLETS

LUNESTA is indicated for the treatment of insomnia. In controlled outpatient and sleep laboratory studies, LUNESTA administered at bedtime decreased sleep latency and improved sleep maintenance. LUNESTA is not indicated for the treatment of depression, generalized anxiety disorder, rheumatoid arthritis, or menopause.

Important Safety Information

LUNESTA, like other hypnotics, has CNS-depressant effects. Because of the rapid onset of action, LUNESTA should only be ingested immediately prior to going to bed or after the patient has gone to bed and has experienced difficulty falling asleep. Patients should not take LUNESTA unless they are prepared to get a full night's sleep. As with other hypnotics, patients receiving LUNESTA should be cautioned against engaging in hazardous occupations requiring complete mental alertness or motor coordination (eg, operating machinery or driving a motor vehicle) after ingesting the drug, including potential impairment of the performance of such activities that may occur the day following ingestion of LUNESTA. In clinical trials, the most common adverse events associated with LUNESTA were unpleasant taste, headache, somnolence, dizziness, dry mouth, infection, and pain.

LUNESTA has been classified as a Schedule IV controlled substance. Sedative hypnotics have produced withdrawal signs and symptoms following abrupt discontinuation. The risk of abuse and dependence increases with the dose and duration of treatment and concomitant use of other psychoactive drugs. The risk is also greater for patients who have a history of alcohol or drug abuse or history of psychiatric disorders. These patients should be under careful surveillance when receiving LUNESTA or any other hypnotic. Sedative/hypnotic drugs should be administered with caution to patients exhibiting signs and symptoms of depression. Suicidal tendencies may be present in such patients, and protective measures may be required. Intentional overdose is more common in this group of patients; therefore, the least amount of drug that is feasible should be prescribed for the patient at any one time.

LUNESTA, like other hypnotics, may produce additive CNS-depressant effects when coadministered with other psychotropic medications, anticonvulsants, antihistamines, ethanol, and other drugs that themselves produce CNS depression. LUNESTA should not be taken with alcohol. Dosage adjustment may be necessary when LUNESTA is administered with other CNS-depressant agents because of the potentially additive effects.

Impaired motor and/or cognitive performance after repeated exposure or unusual sensitivity to sedative/hypnotic drugs is a concern in the treatment of elderly and/or debilitated patients. See dosage and administration in complete prescribing information.

Please see brief summary of complete prescribing information.

6SRZO412

Lunesta®
(eszopiclone)C
1, 2 AND 3 MG TABLETS

BRIEF SUMMARY

INDICATIONS AND USAGE

LUNESTA is indicated for the treatment of insomnia. In controlled outpatient and sleep laboratory studies, LUNESTA administered at bedtime decreased sleep latency and improved sleep maintenance.

CONTRAINDICATIONS

None known.

WARNINGS

Because sleep disturbances may be the presenting manifestation of a physical and/or psychiatric disorder, symptomatic treatment of insomnia should be initiated only after a careful evaluation of the patient. The failure of insomnia to remit after 7 to 10 days of treatment may indicate the presence of a primary psychiatric and/or medical illness that should be evaluated. Worsening of insomnia or the emergence of new thinking or behavior abnormalities may be the consequence of an unrecognized psychiatric or physical disorder. Such findings have emerged during the course of treatment with sedative/hypnotic drugs, including LUNESTA. Because some of the important adverse effects of LUNESTA appear to be dose-related, it is important to use the lowest possible effective dose, especially in the elderly (see **DOSAGE AND ADMINISTRATION in the Full Prescribing Information**).

A variety of abnormal thinking and behavior changes have been reported to occur in association with the use of sedative/hypnotics. Some of these changes may be characterized by decreased inhibition (e.g., aggressiveness and extroversion that seem out of character), similar to effects produced by alcohol and other CNS depressants. Other reported behavioral changes have included bizarre behavior, agitation, hallucinations, and depersonalization. Amnesia and other neuropsychiatric symptoms may occur unpredictably. In primarily depressed patients, worsening of depression, including suicidal thinking, has been reported in association with the use of sedative/hypnotics.

It can rarely be determined with certainty whether a particular instance of the abnormal behaviors listed above are drug-induced, spontaneous in origin, or a result of an underlying psychiatric or physical disorder. Nonetheless, the emergence of any new behavioral sign or symptom of concern requires careful and immediate evaluation.

Following rapid dose decrease or abrupt discontinuation of the use of sedative/hypnotics, there have been reports of signs and symptoms similar to those associated with withdrawal from other CNS-depressant drugs (see **DRUG ABUSE AND DEPENDENCE**).

LUNESTA, like other hypnotics, has CNS-depressant effects. Because of the rapid onset of action, LUNESTA should only be ingested immediately prior to going to bed or after the patient has gone to bed and has experienced difficulty falling asleep. Patients receiving LUNESTA should be cautioned against engaging in hazardous occupations requiring complete mental alertness or motor coordination (e.g., operating machinery or driving a motor vehicle) after ingesting the drug, and be cautioned about potential impairment of the performance of such activities on the day following ingestion of LUNESTA. LUNESTA, like other hypnotics, may produce additive CNS-depressant effects when coadministered with other psychotropic medications, anticonvulsants, antihistamines, ethanol, and other drugs that themselves produce CNS depression. LUNESTA should not be taken with alcohol. Dose adjustment may be necessary when LUNESTA is administered with other CNS-depressant agents, because of the potentially additive effects.

PRECAUTIONS

General

Timing Of Drug Administration: LUNESTA should be taken immediately before bedtime. Taking a sedative/hypnotic while still up and about may result in short-term memory impairment, hallucinations, impaired coordination, dizziness, and lightheadedness.

Use In The Elderly And/Or Debilitated Patients: Impaired motor and/or cognitive performance after repeated exposure or unusual sensitivity to sedative/hypnotic drugs is a concern in the treatment of elderly and/or debilitated patients. The recommended starting dose of LUNESTA for these patients is 1 mg (see **DOSAGE AND ADMINISTRATION in the Full Prescribing Information**).

Use In Patients With Concomitant Illness: Clinical experience with eszopiclone in patients with concomitant illness is limited. Eszopiclone should be used with caution in patients with diseases or conditions that could affect metabolism or hemodynamic responses.

A study in healthy volunteers did not reveal respiratory-depressant effects at doses 2.5-fold higher (7 mg) than the recommended dose of eszopiclone. Caution is advised, however, if LUNESTA is prescribed to patients with compromised respiratory function.

The dose of LUNESTA should be reduced to 1 mg in patients with severe hepatic impairment, because systemic exposure is doubled in such subjects. No dose adjustment appears necessary for subjects with mild or moderate hepatic impairment. No dose adjustment appears necessary in subjects with any degree of renal impairment, since less than 10% of eszopiclone is excreted unchanged in the urine.

The dose of LUNESTA should be reduced in patients who are administered potent inhibitors of CYP3A4, such as ketoconazole, while taking LUNESTA. Downward dose adjustment is also recommended when LUNESTA is administered with agents having known CNS-depressant effects.

Use In Patients With Depression: Sedative/hypnotic drugs should be administered with caution to patients exhibiting signs and symptoms of depression. Suicidal tendencies may be present in such patients, and protective measures may be required. Intentional overdose is more common in this group of patients; therefore, the least amount of drug that is feasible should be prescribed for the patient at any one time.

Information For Patients: Patient information is printed in the complete prescribing information.

Laboratory Tests: There are no specific laboratory tests recommended.

Drug Interactions

CNS-Active Drugs

Ethanol: An additive effect on psychomotor performance was seen with coadministration of eszopiclone and ethanol 0.70 g/kg for up to 4 hours after ethanol administration.

Paroxetine: Coadministration of single doses of eszopiclone 3 mg and paroxetine 20 mg daily for 7 days produced no pharmacokinetic or pharmacodynamic interaction.

Lorazepam: Coadministration of single doses of eszopiclone 3 mg and lorazepam 2 mg did not have clinically relevant effects on the pharmacodynamics or pharmacokinetics of either drug.

Olanzapine: Coadministration of eszopiclone 3 mg and olanzapine 10 mg produced a decrease in DSST scores. The interaction was pharmacodynamic; there was no alteration in the pharmacokinetics of either drug.

Drugs That Inhibit CYP3A4 (Ketoconazole): CYP3A4 is a major metabolic pathway for elimination of eszopiclone. The AUC of eszopiclone was increased 2.2-fold by coadministration of ketoconazole, a potent inhibitor of CYP3A4, 400 mg daily for 5 days. C_{max} and $t_{1/2}$ were increased 1.4-fold and 1.3-fold, respectively. Other strong inhibitors of CYP3A4 (e.g., itraconazole, clarithromycin, nefazodone, troleandomycin, ritonavir, nelfinavir) would be expected to behave similarly.

Drugs That Induce CYP3A4 (Rifampicin): Racemic zopiclone exposure was decreased 80% by concomitant use of rifampicin, a potent inducer of CYP3A4. A similar effect would be expected with eszopiclone.

Drugs Highly Bound To Plasma Protein: Eszopiclone is not highly bound to plasma proteins (52-59% bound); therefore, the disposition of eszopiclone is not expected to be sensitive to alterations in protein binding. Administration of eszopiclone 3 mg to a patient taking another drug that is highly protein-bound would not be expected to cause an alteration in the free concentration of either drug.

Drugs With A Narrow Therapeutic Index

Digoxin: A single dose of eszopiclone 3 mg did not affect the pharmacokinetics of digoxin measured at steady state following dosing of 0.5 mg twice daily for one day and 0.25 mg daily for the next 6 days.

Warfarin: Eszopiclone 3 mg administered daily for 5 days did not affect the pharmacokinetics of (R)- or (S)-warfarin, nor were there any changes in the pharmacodynamic profile (prothrombin time) following a single 25-mg oral dose of warfarin.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis: In a carcinogenicity study in Sprague-Dawley rats in which eszopiclone was given by oral gavage, no increases in tumors were seen; plasma levels (AUC) of eszopiclone at the highest dose used in this study (16 mg/kg/day) are estimated to be 80 (females) and 20 (males) times those in humans receiving the maximum recommended human dose (MRHD). However, in a carcinogenicity study in Sprague-Dawley rats in which racemic zopiclone was given in the diet, and in which plasma levels of eszopiclone were reached that were greater than those reached in the above study of eszopiclone, an increase in mammary gland adenocarcinomas in females and an increase in thyroid gland follicular cell adenomas and carcinomas in males were seen at the highest dose of 100 mg/kg/day. Plasma levels of eszopiclone at this dose are estimated to be 150 (females) and 70 (males) times those in humans receiving the MRHD. The mechanism for the increase in mammary adenocarcinomas is unknown. The increase in thyroid tumors is thought to be due to increased levels of TSH secondary to increased metabolism of circulating thyroid hormones, a mechanism that is not considered to be relevant to humans.

In a carcinogenicity study in B6C3F1 mice in which racemic zopiclone was given in the diet, an increase in pulmonary carcinomas and carcinomas plus adenomas in females and an increase in skin fibromas and sarcomas in males were seen at the highest dose of 100 mg/kg/day. Plasma levels of eszopiclone at this dose are estimated to be 8 (females) and 20 (males) times those in humans receiving the MRHD. The skin tumors were due to skin lesions induced by aggressive behavior, a mechanism that is not relevant to humans. A carcinogenicity study was also performed in which CD-1 mice were given eszopiclone at doses up to 100 mg/kg/day by oral gavage; although this study did not reach a maximum tolerated dose, and was thus inadequate for overall assessment of carcinogenic potential, no increases in either pulmonary or skin tumors were seen at doses producing plasma levels of eszopiclone estimated to be 90 times those in humans receiving the MRHD—i.e., 12 times the exposure in the racemate study.

Eszopiclone did not increase tumors in a p53 transgenic mouse bioassay at oral doses up to 300 mg/kg/day.

Mutagenesis: Eszopiclone was positive in the mouse lymphoma chromosomal aberration assay and produced an equivocal response in the Chinese hamster ovary cell chromosomal aberration assay. It was not mutagenic or clastogenic in the bacterial Ames gene mutation assay, in an unscheduled DNA synthesis assay, or in an *in vivo* mouse bone marrow micronucleus assay.

(S)-N-desmethyl zopiclone, a metabolite of eszopiclone, was positive in the Chinese hamster ovary cell and human lymphocyte chromosomal aberration assays. It was negative in the bacterial Ames mutation assay, in an *in vitro* ^{32}P-postlabeling DNA adduct assay, and in an *in vivo* mouse bone marrow chromosomal aberration and micronucleus assay.

Impairment Of Fertility: Eszopiclone was given by oral gavage to male rats at doses up to 45 mg/kg/day from 4 weeks premating through mating and to female rats at doses up to 180 mg/kg/day from 2 weeks premating through day 7 of pregnancy. An additional study was performed in which only females were treated, up to 180 mg/kg/day. Eszopiclone decreased fertility, probably because of effects in both males and females, with no females becoming pregnant when both males and females were treated with the highest dose; the no-effect dose in both sexes was 5 mg/kg (16 times the MRHD on a mg/m^2 basis). Other effects included increased preimplantation loss (no-effect dose 25 mg/kg), abnormal estrus cycles (no-effect dose 25 mg/kg), and decreases in sperm number and motility and increases in morphologically abnormal sperm (no-effect dose 5 mg/kg).

Pregnancy

Pregnancy Category C: Eszopiclone administered by oral gavage to pregnant rats and rabbits during the period of organogenesis showed no evidence of teratogenicity up to the highest doses tested (250 and 16 mg/kg/day in rats and rabbits, respectively; these doses are 800 and 100 times, respectively, the maximum recommended human dose [MRHD] on a mg/m^2 basis). In the rat, slight reductions in fetal weight and evidence of developmental delay were seen at maternally toxic doses of 125 and 150 mg/kg/day, but not at 62.5 mg/kg/day (200 times the MRHD on a mg/m^2 basis).

Eszopiclone was also administered by oral gavage to pregnant rats throughout the pregnancy and lactation periods at doses of up to 180 mg/kg/day. Increased postimplantation loss, decreased postnatal pup weights and survival, and increased pup startle response were seen at all doses; the lowest dose tested, 60 mg/kg/day, is 200 times the MRHD on a mg/m^2 basis. These doses did not produce significant maternal toxicity. Eszopiclone had no effects on other behavioral measures or reproductive function in the offspring.

There are no adequate and well-controlled studies of eszopiclone in pregnant women. Eszopiclone should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Labor And Delivery: LUNESTA has no established use in labor and delivery.

Nursing Mothers: It is not known whether LUNESTA is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when LUNESTA is administered to a nursing woman.

Pediatric Use: Safety and effectiveness of eszopiclone in children below the age of 18 have not been established.

Geriatric Use: A total of 287 subjects in double-blind, parallel-group, placebo-controlled clinical trials who received eszopiclone were 65 to 86 years of age. The overall pattern of adverse events for elderly subjects (median age = 71 years) in 2-week studies with nighttime dosing of 2 mg eszopiclone was not different from that seen in younger adults. LUNESTA 2 mg exhibited significant reduction in sleep latency and improvement in sleep maintenance in the elderly population.

ADVERSE REACTIONS

The premarketing development program for LUNESTA included eszopiclone exposures in patients and/or normal subjects from two different groups of studies: approximately 400 normal subjects in clinical pharmacology/pharmacokinetic studies, and approximately 1550 patients in placebo-controlled clinical effectiveness studies, corresponding to approximately 263 patient-exposure years. The conditions and duration of treatment with LUNESTA varied greatly and included (in overlapping categories) open-label and double-blind phases of studies, inpatients and outpatients, and short-term and longer-term exposure. Adverse reactions were assessed by collecting adverse events, results of physical examinations, vital signs, weights, laboratory analyses, and ECGs.

Adverse events during exposure were obtained primarily by general inquiry and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a smaller number of standardized event categories. In the tabulations that follow, COSTART terminology has been used to classify reported adverse events.

The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while the patient was receiving therapy following baseline evaluation.

Adverse Findings Observed in Placebo-Controlled Trials

Adverse Events Resulting in Discontinuation of Treatment: In placebo-controlled, parallel-group clinical trials in the elderly, 3.8% of 208 patients who received placebo, 2.3% of 215 patients who received 2 mg LUNESTA, and 1.4% of 72 patients who received 1 mg LUNESTA discontinued treatment due to an adverse event. In the 6-week parallel-group study in adults, no patients in the 3 mg arm discontinued because of an adverse event. In the long-term 6-month study in adult insomnia patients, 7.2% of 195 patients who received placebo and 12.8% of 593 patients who received 3 mg LUNESTA discontinued due to an adverse event. No event that resulted in discontinuation occurred at a rate of greater than 2%.

Adverse Events Observed at an Incidence of ≥2% in Controlled Trials. The following lists the incidence (% placebo, 2 mg, 3 mg, respectively) of treatment-emergent adverse events from a Phase 3 placebo-controlled study of LUNESTA at doses of 2 or 3 mg in non-elderly adults. Treatment duration in this trial was 44 days. Data are limited to adverse events that occurred in 2% or more of patients treated with LUNESTA 2 mg (n=104) or 3 mg (n=105) in which the incidence in patients treated with LUNESTA was greater than the incidence in placebo-treated patients (n=99).[1]

Body as a whole: headache (13%, 21%, 17%), viral infection (1%, 3%, 3%). Digestive system: dry mouth (3%, 5%, 7%), dyspepsia (4%, 4%, 5%), nausea (4%, 5%, 4%), vomiting (1%, 3%, 0%). Nervous system: anxiety (0%, 3%, 1%), confusion (0%, 0%, 3%), depression (0%, 4%, 1%), dizziness (4%, 5%, 7%), hallucinations (0%, 1%, 3%), libido decreased (0%, 0%, 3%), nervousness (3%, 5%, 0%), somnolence (3%, 10%, 8%). Respiratory system: infection (3%, 5%, 10%). Skin and appendages: rash (1%, 3%, 4%). Special senses: unpleasant taste (3%, 17%, 34%). Urogenital system: dysmenorrhea* (0%, 3%, 0%), gynecomastia** (0%, 3%, 0%).

*Gender-specific adverse event in females

**Gender-specific adverse event in males

[1]Events for which the LUNESTA incidence was equal to or less than placebo are not listed, but included the following: abnormal dreams, accidental injury, back pain, diarrhea, flu syndrome, myalgia, pain, pharyngitis, and rhinitis.

Adverse events that suggest a dose-response relationship in adults include viral infection, dry mouth, dizziness, hallucinations, infection, rash, and unpleasant taste, with this relationship clearest for unpleasant taste.

The following lists the incidence (% placebo, 2 mg, 3 mg, respectively) of treatment-emergent adverse events from combined Phase 3 placebo-controlled studies of LUNESTA at doses of 1 or 2 mg in elderly adults (ages 65-86). Treatment duration in these trials was 14 days. Data are limited to events that occurred in 2% or more of patients treated with LUNESTA 1 mg (n=72) or 2 mg (n=215) in which the incidence in patients treated with LUNESTA was greater than the incidence in placebo-treated patients.[1]

Body as a whole: accidental injury (1%, 0%, 3%), headache (14%, 15%, 13%), pain (2%, 4%, 5%). Digestive system: diarrhea (2%, 4%, 2%), dry mouth (2%, 3%, 7%), dyspepsia (2%, 6%, 2%). Nervous system: abnormal dreams (0%, 3%, 1%), dizziness (2%, 1%, 6%), nervousness (1%, 0%, 2%), neuralgia (0%, 3%, 0%). Skin and appendages: pruritus: (1%, 4%, 1%). Special senses: unpleasant taste (0%, 8%, 12%). Urogenital system: urinary tract infection (0%, 3%, 0%).

[1]Events for which the LUNESTA incidence was equal to or less than placebo are not listed, but included the following: abdominal pain, asthenia, nausea, rash, and somnolence.

Adverse events that suggest a dose-response relationship in elderly adults include pain, dry mouth, and unpleasant taste, with this relationship again clearest for unpleasant taste. These figures cannot be used to predict the incidence of adverse events in the course of usual medical practice because patient characteristics and other factors may differ from those that prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators.

The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contributions of drug and non-drug factors to the adverse event incidence rate in the population studied.

Other Events Observed During The Premarketing Evaluation Of LUNESTA. Following is a list of modified COSTART terms that reflect treatment-emergent adverse events as defined in the introduction to the **ADVERSE REACTIONS** section and reported by approximately 1550 subjects treated with LUNESTA at doses in the range of 1 to 3.5 mg/day during Phase 2 and 3 clinical trials throughout the United States and Canada. All reported events are included except those already listed here or listed elsewhere in labeling, minor events common in the general population, and events unlikely to be drug-related. Although the events reported occurred during treatment with LUNESTA, they were not necessarily caused by it.

Events are listed in order of decreasing frequency according to the following definitions: **frequent** adverse events are those that occurred on one or more occasions in at least 1/100 patients; **infrequent** adverse events are those that occurred in fewer than 1/100 patients but in at least 1/1,000 patients; **rare** adverse events are those that occurred in fewer than 1/1,000 patients. Gender-specific events are categorized based on their incidence for the appropriate gender.

Frequent: chest pain, migraine, peripheral edema.

Infrequent: acne, agitation, allergic reaction, alopecia, amenorrhea, anemia, anorexia, apathy, arthritis, asthma, ataxia, breast engorgement, breast enlargement, breast neoplasm, breast pain, bronchitis, bursitis, cellulitis, cholelithiasis, conjunctivitis, contact dermatitis, cystitis, dry eyes, dry skin, dyspnea, dysuria, eczema, ear pain, emotional lability, epistaxis, face edema, female lactation, fever, halitosis, heat stroke, hematuria, hernia, hiccup, hostility, hypercholesteremia, hypertension, hypertonia, hypesthesia, incoordination, increased appetite, insomnia, joint disorder (mainly swelling, stiffness, and pain), kidney calculus, kidney pain, laryngitis, leg cramps, lymphadenopathy, malaise, mastitis, melena, memory impairment, menorrhagia, metrorrhagia, mouth ulceration, myasthenia, neck rigidity, neurosis, nystagmus, otitis externa, otitis media, paresthesia, photosensitivity, reflexes decreased, skin discoloration, sweating, thinking abnormal (mainly difficulty concentrating), thirst, tinnitus, twitching, ulcerative stomatitis, urinary frequency, urinary incontinence, urticaria, uterine hemorrhage, vaginal hemorrhage, vaginitis, vertigo, vestibular disorder, weight gain, weight loss.

Rare: abnormal gait, arthrosis, colitis, dehydration, dysphagia, erythema multiforme, euphoria, furunculosis, gastritis, gout, hepatitis, hepatomegaly, herpes zoster, hirsutism, hyperacusis, hyperesthesia, hyperlipemia, hypokalemia, hypokinesia, iritis, liver damage, maculopapular rash, mydriasis, myopathy, neuritis, neuropathy, oliguria, photophobia, ptosis, pyelonephritis, rectal hemorrhage, stomach ulcer, stomatitis, stupor, thrombophlebitis, tongue edema, tremor, urethritis, vesiculobullous rash.

DRUG ABUSE AND DEPENDENCE

Controlled Substance Class: LUNESTA is a Schedule IV controlled substance under the Controlled Substances Act. Other substances under the same classification are benzodiazepines and the nonbenzodiazepine hypnotics zaleplon and zolpidem. While eszopiclone is a hypnotic agent with a chemical structure unrelated to benzodiazepines, it shares some of the pharmacologic properties of the benzodiazepines.

Abuse, Dependence, and Tolerance

Abuse and Dependence: In a study of abuse liability conducted in individuals with known histories of benzodiazepine abuse, eszopiclone at doses of 6 and 12 mg produced euphoric effects similar to those of diazepam 20 mg. In this study, at doses 2-fold or greater than the maximum recommended doses, a dose-related increase in reports of amnesia and hallucinations was observed for both LUNESTA and diazepam.

The clinical trial experience with LUNESTA revealed no evidence of a serious withdrawal syndrome. Nevertheless, the following adverse events included in DSM-IV criteria for uncomplicated sedative/hypnotic withdrawal were reported during clinical trials following placebo substitution occurring within 48 hours following the last LUNESTA treatment: anxiety, abnormal dreams, nausea, and upset stomach. These reported adverse events occurred at an incidence of 2% or less. Use of benzodiazepines and similar agents may lead to physical and psychological dependence. The risk of abuse and dependence increases with the dose and duration of treatment and concomitant use of other psychoactive drugs. The risk is also greater for patients who have a history of alcohol or drug abuse or history of psychiatric disorders. These patients should be under careful surveillance when receiving LUNESTA or any other hypnotic.

Tolerance: Some loss of efficacy to the hypnotic effect of benzodiazepines and benzodiazepine-like agents may develop after repeated use of these drugs for a few weeks.

No development of tolerance to any parameter of sleep measurement was observed over six months. Tolerance to the efficacy of LUNESTA 3 mg was assessed by 4-week objective and 6-week subjective measurements of time to sleep onset and sleep maintenance for LUNESTA in a placebo-controlled 44-day study, and by subjective assessments of time to sleep onset and WASO in a placebo-controlled study for 6 months.

OVERDOSAGE

There is limited premarketing clinical experience with the effects of an overdosage of LUNESTA. In clinical trials with eszopiclone, one case of overdose with up to 36 mg of eszopiclone was reported in which the subject fully recovered. Individuals have fully recovered from racemic zopiclone overdoses up to 340 mg (56 times the maximum recommended dose of eszopiclone).

Signs And Symptoms: Signs and symptoms of overdose effects of CNS depressants can be expected to present as exaggerations of the pharmacological effects noted in preclinical testing. Impairment of consciousness ranging from somnolence to coma has been described. Rare individual instances of fatal outcomes following overdose with racemic zopiclone have been reported in European postmarketing reports, most often associated with overdose with other CNS-depressant agents.

Recommended Treatment: General symptomatic and supportive measures should be used along with immediate gastric lavage where appropriate. Intravenous fluids should be administered as needed. Flumazenil may be useful. As in all cases of drug overdose, respiration, pulse, blood pressure, and other appropriate signs should be monitored and general supportive measures employed. Hypotension and CNS depression should be monitored and treated by appropriate medical intervention. The value of dialysis in the treatment of overdosage has not been determined.

Poison Control Center: As with the management of all overdosage, the possibility of multiple drug ingestion should be considered. The physician may wish to consider contacting a poison control center for up-to-date information on the management of hypnotic drug product overdosage.

Rx only.

SEPRACOR 12/06

their years of study to become physicians; but if they do not acquire the skills necessary to stay afloat financially, they hang their shingle over quicksand.

A practice can be successful for doctor and patient only if the doctor's office is run like a business, and all businesses have at least one common element: they need a positive cash flow. Philip Campbell, C.P.A., former columnist for *Inc.* magazine and author of *Never Run Out of Cash: The 10 Cash Flow Rules You Can't Afford to Ignore* (Grow and Succeed Publishing, 2005), suggests that medical practices take control of their cash flow.

A practice can be successful for doctor and patient only if the doctor's office is run like a business, and all businesses have at least one common element: they need a positive cash flow… Without cash flow, your business can't survive, so it's critical to monitor and expedite what is coming in, and to keep tight controls on what goes out of your business.

Running out of cash is the definition of failure in business, says Mr. Campbell. Without cash flow, your business can't survive, so it's critical to monitor and expedite what is coming in, and to keep tight controls on what goes out of your business. It may sound basic; but too often, he says, businesses don't even know their current cash balance.

"Even the most intelligent and experienced persons will fail if they are making business decisions using inaccurate or incomplete cash balances," he says.

However, that's not to say that your bank balance should determine your spending. Mr. Campbell says that the amount of cash you have does not necessarily equal the amount of cash you have to spend. Think more conservatively, he advises, and consider what you expect your balance to be six months from now. In order to do that, look at your cash flow history. Does your practice have busy periods and slow periods? Are your patient visits and collections rising? By making these projections and planning accordingly, you can avoid unpleasant surprises in your cash flow.

Establishing Good Business Practices

The measures you take to make your practice profitable—no matter what type practice you run—are similar to a point.

The differences often occur in how you collect fees. Understanding how to collect fees efficiently is one of the factors that will allow your practice to run smoothly and grow. However, these good business practices are not often taught in medical school.

According to Judy Capko, founder of Capko & Company, a medical practice management and marketing research firm in Thousand Oaks, Calif., and author of *Secrets of the Best-Run Practices* (Greenbranch Publishing, 2005), "Many physicians are focused so much on their clinical expertise and 'passing their boards' that they pay too little attention to the business side until they are in the trenches of private practice."

Ms. Capko realizes residency programs are now doing a much better job at emphasizing the business side than in the past. However, she feels, "It stills seems obscure to physicians until they are in the real world of practicing medicine, where the revenue and expenses dictate their future stability."

Physicians who feel ill equipped to deal with the financial elements of their practices do have options, says Ms. Capko. An accountant experienced in dealing with medical practices may offer insight and advice. In addition, hospitals, medical associations, or specialty societies may offer classes in business management, accounting, and related topics. If the physician feels that the needs of the practice fall beyond the scope of those remedies, he or she might consider hiring a medical-practice management consultant who can evaluate the challenges of the business and may be able to offer solutions.

Having clear-cut financial responsibilities within the practice is essential to keep the process running smoothly. At the front line is the billing specialist or billing firm, depending on the system you have created within your practice. According to the size of the practice, you may also have an office manager, financial department head, or partner physician to whom the billing specialist or firm reports.

"Every staff member is important, and everyone can impact the practice's financial and service performance. That being said, it takes strong leadership. The role of the [office] manager is paramount in ensuring everyone is on board and does his or her best to serve the practice and the patients," says Ms. Capko.

Where the Money Comes From

For most practices, cash flow primarily comes from payers such as Medicare, Medicaid, and private insurance companies, with a smaller percentage coming from patient co-pays and other miscellaneous revenue. How fast this cash flows into the practice is largely a function of how efficiently the practice files claims to these payers. Establishing a method that grants quick reimbursement from insurance companies will help ensure the healthiest bottom line possible.

Today most insurance claims are filed electronically, which has helped speed up reimbursements. According to a survey conducted last winter by America's Health Insurance Plans (AHIP), 75 percent of claims were filed electronically in 2005, up from 44 percent in 2002, and triple the rate of a decade ago. However, the practice must ensure claims are sent out with proper information and coding, as well as in a timely manner, to avoid delayed payments and denied claims.

The survey, which was based on data from nearly 25 million claims, also found that 98 percent of those claims were processed by the payer within 30 days of receipt.

That relatively quick turnaround is good news for physicians' cash flow, but the survey did reveal an area of concern: There was a significant gap between the time a patient sees a physician and the time the physician files the claim. Almost a third—29 percent—of claims were received from physicians more than 30 days after the date of patient service, and 15 percent were received from physicians more than 60 days after the service was provided. That means that practices can improve cash flow by simply improving the efficiency with which they submit claims. Ms. Capko agrees that physicians need to submit insurance claims more quickly in order to cut the time to reimbursement by the insurance company. However, that's not the only collection area that needs improvement in many practices, she says.

"Start with getting accurate and complete upfront demographic/insurance information when a patient registers and annually thereafter. Next, put your staff to the task: They need to collect the patient's portion (co-payment) and any patient responsibility balance on accounts when the patient comes in for care," she says.

Why? Ms. Capko points out that by requiring co-pays before services are rendered, the practice immediately benefits from the increased collection effort. It is easier to get money from patients in person than to get them to mail a check later, she says.

Filing claims that are correct the first time—coded accurately and all information complete—will decrease the time to reimbursement. According to the 2006 AHIP survey, the 98 percent of electronic claims that were processed within 30 days were "clean" claims, that is, ones that required no additional information. The definition of "processing time" is how many days transpire from the time a claim is received until it is paid, denied, or classified as pending. A pended claim needs additional or corrected information, which may include a missing code or an incorrect birth date. On average, the survey says that pended claims take nine more days to process while the needed information is being sought.

Filing claims that are correct the first time—coded accurately and all information complete—will decrease the time to reimbursement. According to the 2006 AHIP survey, the 98 percent of claims that were processed within 30 days were "clean" claims, that is, ones that required no additional information.

Even though the study showed physician offices have a lag time in submitting claims, it further showed that with electronic filing the lag time decreased. The 2006 survey showed that since physicians began submitting claims electronically, more physicians are sending in claims within a week of the service date. In 2006, 30 percent of all claims were submitted within 7 days, compared with 19 percent in 2002. However, a large number of claims continue to be received after long lag times. In 2006, 29 percent of claims were received more than a month after the date of patient service. Electronic claims are also processed faster than paper claims. AHIP says that 69 percent of clean electronic claims are processed within 7 days, while only 29 percent of clean paper claims are processed that fast.

Fully automated offices can decrease the amount of times that a claim is pended. Kathryn I. Moghadas, R.N., C.C.H.C., C.H.B.C., C.L.R.M., founder of Associated Healthcare Advisors in Fern Park, Fla., and author of *Medical Practice Policies and Procedures* (American Medical Association, 2005), says that

touch-screen or data-screen entry by the patient can increase the accuracy of patient records and, ultimately, the processing of claims. Ms. Moghadas says that a patient is much more likely to notice an inaccuracy in his or her own information. In addition, systems with the ability to scan insurance cards eliminate the possibility of human error in data entry, she says.

Oncologists face unique challenges in processing claims and are particularly sensitive to the demands of insurance companies and other payers.

"I've done this for 16 years," says Judy Stone, administrator of Carolinas Hematology-Oncology Associates in Charlotte, N.C. "Since I began, I noticed more and more work is pushed back to the practice office for less and less financial gain. This has been particularly true over the past five to six years."

Ms. Stone has seen reimbursements decline while paperwork and documentation demands on the practice increase. This requires more billing and collection resources, which cost money and reduce the ability to provide funds to run the practice. She points to the 2004 Medicare Modernization Act, which instituted a reimbursement system based on average sales price, or ASP, as one of the culprits.

"They gave us a 32-percent increase on our administration

Kicked-back Claims

Claims are pended or kicked back to the medical office for a variety of reasons. According to AHIP survey findings, here are some reasons, in order of frequency, that a claim may be pended:

Duplicate claims submitted	35%
Lack of necessary Information	12%
No coverage based on date of service	8%
Non-covered/non-network benefit or service	7%
Coordination of benefits (COB)	5%
Coverage determination	4%
Utilization review	3%
Authorization	3%
Pre-existing condition review	1%
Invalid codes submitted	1%
Other	21%

codes for 2004; for 2005 they reduced that to a 3 percent amount, and for 2006 it was gone altogether," says Ms. Stone, who adds that the ASP approach lowered private practice's reimbursement rate for drugs. "Medicare gave us the cushion the first year, then took it away over the next two years and continued to play games with the codes," she says.

Ms. Stone says that from 2004 through 2006, oncology practices had three different coding systems. In some cases, she says, Medicare changed codes in the middle of the year, creating confusion in the billing departments. In another case, Medicare actually changed the definition (and the reimbursement) for a "push" and an "infusion" (two ways of administering chemotherapy).

These changes make it critical for oncology departments to regularly update their coding systems in order to avoid delays in claims processing.

Adding Revenue by Adding Services

One of the ways that practices are beefing up their revenue potential is to introduce new services, often those that are not covered by traditional insurance, says Scott Lorenz, president of Westwind Communications, a medical marketing communications firm based in Plymouth, Mich.

Mr. Lorenz says that some of his clients are moving into elective surgeries and wellness programs, for which some patients are willing to pay out of pocket. He has seen an increase in practices offering laser vision surgery, weight loss surgery, laser hair removal, weight loss management programs, and holistic health programs among his clients—all of which patients generally pay for themselves rather than depending on insurance coverage.

Mr. Lorenz advises physicians who are interested in expanding into these lucrative areas to look at the most profitable aspects of their practices in order to decide what practice areas might be ripe for expansion through elective services. Clearly, their area of specialization may make some choices obvious; it makes sense that ophthalmologists would expand into laser vision correction, for example.

"There is no question we have had to become very inventive about how we manage our practices, and you also have to be very careful because our number-one goal is to give quality

patient care," says Ms. Stone.

Still other physicians are opting out of insurance altogether. Janine Suvak, M.D., a general practitioner in southern California, has repositioned her practice as an age-management medical practice.

Dr. Suvak previously had a more traditional medical practice. However, she found that getting reimbursed for care was a constant source of strain on her ability to practice medicine. "Not to mention the frustration for myself and my patients, who were limited by their insurer from getting timely or appropriate care," she says.

Dr. Suvak's new boutique practice operates on cash-only terms. "My patients undergo an initial comprehensive workup for which they pay up front. Once we go over their results, if they require any treatment, then they pay for my professional fees in six-month increments plus the cost of their treatment," says Dr. Suvak.

The boutique practice employs an office manager as well as a nutritionist, and a phlebotomist. Dr. Suvak shares exam room space with a plastic surgeon, so that area is already staffed with front-office support. The physicians meet weekly to address their patient flow as well as their businesses. Since many of her affluent patients travel frequently, she needs to be very responsive in her communication and flexible in scheduling. Dr. Suvak does external marketing of her practice but says that approximately 25 percent of her practice is referrals from friends, family, and other patients.

Dr. Suvak previously had a more traditional medical practice, which included front-office and back-office staff as well as ancillary personnel such as a therapist and a physical therapy aide. She says that that practice had a typical mix of income from co-pays, self-pays, insurance, worker's compensation, and similar sources. However, she found that getting reimbursed for the care that the practice provided was a constant source of strain on her ability to practice medicine.

"Not to mention the frustration for myself and my patients, who were limited by their insurer from getting timely or appropriate care," she says. "Currently, I can provide great care and simply not have to deal with the hassle of the reimbursement system."

Billing Services

Billing services are a viable option for the physician, but they are not without their issues.

"The first is that all billing services are not created equal. If there is competition among billing services, this tends to make the service work harder for business," says Peter Lyle, director of Medical Management Services, Inc., a practice management firm in Atlanta, Ga. Outsourcing your claims management and billing still means keeping a watchful eye on how well the billing service is doing its job.

"You should make sure your claims are filed accurately and in a timely manner, and you will still need to assess how well your reimbursements are standing up to your expenses and how to troubleshoot the weak areas. Claims that are pended need to be resubmitted in a timely manner, and denied claims need to be investigated," says Mr. Lyle.

Other professionals, such as Ryan Losi, C.P.A., of Piascik Associates in Glen Allen, Va., believe that medical billing outsourcing can be an important strategy to allow practices to focus on their core business: providing care to patients.

One bit of due diligence that Mr. Lyle suggests that can improve your receipts is to ask about the company's record on delayed or pending claims, including the average time between claim submission and reimbursement. Your billing service should be able to tell you its ratio of clean claims to pending claims, says Mr. Lyle.

The billing service should also regularly update its Common Procedural Terminology (CPT) and International Classification of Diseases-9th Revision (ICD-9) codes to process claims. CPT codes relay the medical service delivered and ICD-codes indicate the diagnosis.

Incorrect codes delay claims, and many CPT codes must have an additional two-digit modifier to make the procedure more identifiable. This is another situation in which the claim can be delayed, says Mr. Lyle. So the job of billing is one of accuracy to ensure quick reimbursements.

The billing service should be experienced in working with a variety of insurance companies, and it should know the information and format required by insurance carriers that are

accepted by your practice. Mr. Lyle says that making the insurance company's job as easy as possible means a greater likelihood that claims will be paid when presented. If the company routinely requires extra documentation, be sure that the billing company and your staff know that and submit it initially.

Mr. Lyle advises that, no matter whether your billing is in house or outsourced, you should make sure you meet frequently with your office manager to get timely reports on where you stand with billing and reimbursements. This will give you an accurate picture of income flow as well as help ensure that your practice is following regulations and requirements.

Monitoring and Negotiating Fee Schedules

In her days of working with insurance companies, Dr. Suvak developed an integral knowledge of how the process works. She believes physicians should be proactive in knowing in detail the percentage reimbursement they are entitled to and work to do that well and better.

"All insurers have fee schedules," she says. "Don't trust that they actually are paying correctly, but actively double-check. I believe in incentives; setting standards in these areas helps with measuring employee performance," says Dr. Suvak.

She says that financial reports are as important to the health of the practice as labs are to the health of a patient. Ignore them at your peril.

"I had an acquaintance who didn't realize for years that his [billing specialist] didn't know how to dispute claim denials, so she just filed them; but she had been there so long that he was accustomed to the low reimbursement rate he was getting."

Medical practice administrator Edward Gulko says that dealing with insurance carriers and monitoring fee schedules is one of the primary challenges to profitability and efficiency at Englewood Orthopedic Associates, a seven-doctor practice in Englewood, N.J. His key for coping is to have dedicated staff.

"I have two people who spend their time getting pre-authorizations and certifications for procedures. It adds nothing to the bottom line or to the care of the patient, but it allows us to keep our practice running smoothly," he says. "We have to have these authorizations in order to provide services to our patients. But

98 percent of these services are approved. It would be a lot more effective if insurance companies would give the authority to order them without going to machinations and subject them to retrospective review. Then, if the doctors start playing games, take that power away from them."

Consultant Kathryn I. Moghadas says that doctors can also negotiate their fee schedules. Large group practices are most effective at this, she says, but independent physicians and small groups can also be effective at getting concessions by appealing the fee schedule, especially if they form or join independent physician associations that can use their collective power to bargain with insurance companies. Ms. Moghadas says that smaller practitioners can often get better terms on "carve-outs"—ancillary services, such as laboratory fees. However, larger practices and groups can be successful in getting reimbursement increases by as much as five percent. It may not seem like much, but when applied across all of the practice's billing, she says it can add up.

"Every little bit helps. Any win is a win, no matter how much the win is, in the war on reimbursement," she says.

Some other strategies Ms. Capko advises for increasing cash flow include the following:

- **Setting goals for per-day charges.** Give your staff incentives to meet the "patients seen" goal.
- **Work only with insurers that have good reputations** for paying promptly and reimbursing at a good rate.
- **Make sure your fee schedule is readjusted** as time goes on. You should set your fees according to the Resource-based Relative Value Scale (RBRVS). RBRVS is a system that sets values for procedures physicians perform on patients. This value takes into consideration physical location in the country. The value is multiplied by a conversion factor that changes annually. Each year you should re-evaluate your fee schedule. An accountant or consultant can help you re-assess where you are and where you want to be by the next year.

Future Planning

Cash flow is just the beginning. Once you bring in the income, it's important to find ways to invest and grow your money. Charles Massimo, CEO of CJM Fiscal Management, based in

Garden City, N.Y., says that mistakes made by physicians in the planning phase can severely limit their ability to retire and live the type of lifestyle they'd like.

He has seen some common mistakes and offers advice on how to avoid them:

■ **Going it alone.** Complex finances and high-income individuals usually call for professional assistance to guard against missteps. Physicians, especially those with small to midsize practices, may resist professional assistance with their pension and other retirement plans, says Mr. Massimo. "Most physicians believe that their education in the medical profession easily crosses over to being able to effectively manage their portfolios," he explains. However, managing money takes time. "Most physicians might make great money managers if they had the time. The demands on a medical practice to be profitable today are enormous; taking time to manage their money in addition to managing their practice is committing financial suicide," he says.

■ **Not getting it in writing.** According to Mr. Massimo, a well-written Investment Policy Statement (IPS) is one of the most powerful tools to increase the probability of your investment success: "An IPS defines an investor's objectives and constraints, including risk tolerance, return objectives, time horizon, liquidity needs, amount of funds available for investment, and investment methodology."

■ **Investing with emotion rather than intellect.** Mr. Massimo cautions that brokerage firms aren't in the business of educating the public. "Brokerage firms are interested primarily in pushing customers' emotional hot buttons, generating commissions, and making money for their shareholders, as any good business should," he explains. "As the market peaks and contracts, investors shift from greed to denial to anxiety to out-and-out fear," says Mr. Massimo. Working out of fear or greed will grant an unstable investment record. You can avoid this with a well-written IPS, he adds.

■ **Not covering their assets.** Asset protection means employing legally acceptable concepts and strategies to ensure that a person's wealth is not just unjustly taken from him or her. Mr. Massimo says that some of these strategies include using state law exemptions or restructuring the medical practice so that it exists

under various ownership entities. Your financial advisor can advise you about the use of asset-protection trusts, which essentially remove your assets from your ownership, protecting them from liability while allowing them to remain under your control.

■ **Not diversifying.** Mr. Massimo estimates that the success of the vast majority of investment portfolios depends on how well they are diversified among the different asset classes, such as domestic and international stocks, bonds, and other vehicles, rather than on individual stock selection or market timing.

■ **Underestimating retirement needs.** According to a 2006 study of 941 physicians conducted by Alan Prince, Gary Rathbun, and Arthur Bavelas for their book *Wealth Preservation for Physicians: Advanced Planning for Affluent Doctors* (Wealth Management Press, 2006), 95.1 percent of physicians are concerned about losing their ability to maintain their current lifestyle throughout retirement. Mr. Massimo sees this as a common problem among physicians who have no real concept of how much they will need during their retirement years.

The key in finding a financial advisor is trust, says Mr. Reed: "It is not just a matter of knowing who is competent; it is equally if not more important to find someone who can be trusted." This may be a "daunting task," says Mr. Reed, but it's worth taking some time for it.

This retirement issue is compounded by the fact that many physicians do not make significant money until later in their careers, which leaves a smaller window in which to accumulate wealth for retirement, Mr. Massimo says.

"With student loans and other expenses, coupled with their relatively low income in the first few years in practice, it takes many physicians an average of eight years after they've gone into practice before they can save any substantial money for retirement," he says.

Finding a Financial Planner

While a good accountant can help you review how to save on taxes and how to find places where your business is leaking money, he or she may not be the best person to advise you on the most effective investment vehicles for your business, or the type

of retirement plan that you should offer your employees. Finding a financial planner who fits your practice needs may take time.

Generally, practice specialty does not alter the financial planning issues doctors encounter; an obstetrician and a urologist have the same concerns, says Gregory L. Reed, C.F.P., C.F.S., C.L.U., M.B.A, director of planning at Smith, Frank & Partners, LLC, a financial-planning firm based in Dallas, Tex. However, cautions Mr. Reed, "one issue that can play a very large role—depending on the litigation risk a doctor faces—is how 'asset protection' planning will be handled. Just as malpractice insurance premiums vary greatly depending on the type of practice a doctor has, the approach to protecting what the doctor has worked so hard to earn can vary greatly as well."

In a recent survey conducted by Paladin Registry, 85.2 percent of investors said they did not know how to determine the quality of financial advisors. Just over 93 percent said they were confused by the "alphabet soup after many of the advisors' names."

The key in finding a financial advisor is trust, says Mr. Reed: "It is not just a matter of knowing who is competent; it is equally if not more important to find someone who can be trusted." This may be a "daunting task," says Mr. Reed, but it's worth taking some time for it.

In a recent survey conducted by Paladin Registry, an independent source for finding high-quality financial professionals and firms, 85.2 percent of investors said they did not know how to determine the quality of advisors. Just over 93 percent said they were confused by the "alphabet soup after many of the advisors' names," says Jack Waymire, author and founder of Paladin Registry, LLC.

Searching for financial planners for your business is a bit different from searching for other professionals, says Mr. Waymire. Usually it's good advice to seek referrals from others, including professional associates. In this case, however, that may not be the best course of action.

"We warn investors that referrals from [professionals other than doctors] and friends may be biased. For example, CPAs and financial advisors exchange referrals. Friends may be referring friends of theirs, like a fraternity brother. Associations will list

any of their members regardless of quality. It usually takes only money to join associations. This is not a value-added service when 85.2 percent of investors don't know how to determine advisor quality," he says.

Instead, look for financial professionals with the following qualifications, he says:

■ **Registrations:** It's usually best to deal with a registered investment advisor (RIA) or another investment management company that is registered with the Securities and Exchange Commission (SEC), says Mr. Waymire. Investment advisor representatives (IARs) are individuals registered with RIAs, the larger of which are overseen by the SEC and the smaller by the state in which they are based.

RIAs and IARs are the companies and individuals, respectively, who are permitted to provide financial advice for a fee, as opposed to stockbrokers, insurance brokers, or other sales representatives who are paid through commission on the financial products that they sell. Such representatives cannot provide advice for fees, so they may call their sales pitches "investment recommendations." However, this can cause confusion: A significant percentage of investors may take these recommendations as advice.

Both RIAs and IARs, under the law, have fiduciary responsibility, which means that they are responsible for putting the investor's best interest first. However, says Mr. Waymire, there are a number of firms and individuals who may try to skirt that responsibility in their agreements, burying a disclaimer of fiduciary responsibility in a lengthy agreement with the hope that the investor will not read the agreement carefully. Such a disclaimer is a red flag, says Mr. Waymire, since it is an attempt to refuse to be held to the higher ethical standard required of entities with fiduciary responsibility.

■ **Compensation structure:** There are three methods of compensation for financial advisors: fee-only, commission, and fee-based. **Fee-only** means the advisor can only be compensated with one of three types of fees: asset-based (a percent of total assets), fixed (a predetermined fee), or hourly. An advisor working on **commission** takes a percentage of the amount invested or traded. A **fee-based** structure means that the advisor can be com-

pensated by a combination of fees and commissions.

Mr. Waymire says that investors should pay financial advisors fee-only, the same way they pay other professionals, such as CPAs and attorneys. Imagine the potential conflicts if a doctor were paid a commission to "recommend" a particular drug and some drug companies were willing to pay higher commissions than others.

"One of the questions that you want to ask that advisor is this: 'How are you compensated?' The only correct answer is 'For fees for advice that I provide,'" says Mr. Waymire.

■ **Certifications:** One way to determine advisor quality is to ask them about their certifications. The ones valued by Paladin are these: Chartered Financial Analyst (C.F.A.), Certified Investment Management Analyst (C.I.M.A.), Certified Financial Planner (C.F.P.), and Certified Public Accountant (C.P.A.).

Mr. Waymire warns investors of the existence of the equivalents of diploma mills, which generate financial "certifications" for money. He also warns that certifications from the insurance

Who's Paying?

Most investors pay an annual asset-based fee—say, one percent of $500,000, or $5,000—for investment services. Sometimes there is a set fee of a few thousand dollars for a financial plan. This type of compensation rewards the advisor for helping investors achieve their financial goals. It's interesting to note that a 5-percent commission is the equivalent of paying five years of asset-based fees in advance to representatives at the time of the sale. Therefore, commission representatives have no economic incentive to help investors achieve their financial goals, says Jack Waymire, author and founder of Paladin Registry, LLC.

Sales representatives frequently tell investors their services are free because they are paid by investment and insurance product companies. But this is not true. While investors may not pay the sales representatives directly, the cost of commissions comes out of the fees that financial product companies charge to investors. Mr. Waymire says once investors understand this, they usually become more comfortable paying fees. Since there are fewer conflicts of interest, they should know what they are getting in return for paying a fee.

industry have biases towards insurance products—for example, chartered life underwriter (C.L.U.) and Chartered Financial Consultant (Ch.F.C.).

■ **Compliance Record:** You should check with the governing body of the RIA (remember that IARs are registered with an RIA and that information should be readily available to you) to ensure a clean compliance record for the advisor you're considering, says Mr. Waymire. Be very wary of those individuals or firms that have problematic histories with their governing agencies.

■ **Regular Reports:** "Most of the planners will say that everyone is different and that they can't share client information, so they don't really have track records," says Mr. Waymire. He agrees that is correct. However, the planner should be willing to provide you with regular reports on how *your* investments are performing against the market as a whole.

"You want to see where your investments are compared to the S&P 500," he says. "And you want them to show you that not only do they beat the market, but they beat the market plus the fees they charge you and then some. Otherwise, you could set up an account, invest in an index fund on your own, and probably achieve the same results."

Tracking and maximizing your income are as essential for medical practices as they are for any business. With good advisors, good financial planning, and solid systems in place to process, submit, and monitor claims as quickly as possible, you can ensure the financial health of your practice and provide the resources you need to grow your practice.