

Enhancing Your Practice's Revenue: Pearls and Pitfalls

A Primer for Orthopaedic Surgeons

AAOS

AMERICAN ACADEMY OF
ORTHOPAEDIC SURGEONS

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ORTHOPAEDIC SURGEONS



AAOS Practice Management Committee

Thomas Grogan, MD and Adam Soyer, DO
Co-editors



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Disclaimer

This *Primer* is intended to provide general, authoritative information, available at the time of publication, in regard to the subject matter covered. It is offered with the understanding that the publisher and the contributors are not rendering formal legal, accounting or information systems consulting advice. Nothing contained herein is intended to serve as a substitute for obtaining such advice. The American Association of Orthopaedic Surgeons and the American Academy of Orthopaedic Surgeons do not endorse, support or accept the applicability of this data to any reader's particular practice setting. Each practice has its own particular needs, patient populations, revenues, volume and mix of services, and professional goals and objectives.

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Preface

February, 2011

Dear Colleague:

The AAOS Practice Management Committee (PMC) was established in 2006. One of the PMC's key charges is to meet the educational needs of Academy members in practice management. To accomplish this objective, the PMC oversees the development of content for the Academy's on-line Practice Management Center (www.aaos.org/pracman). It is also involved in a variety of other activities, including courses, audio-programs, and webinars. Finally the PMC, together with other AAOS volunteer bodies, develops *Primers* for distribution to Fellows on an annual basis.

Primers are publications that cover the key elements of a subject in a focused way. Over the past four years, the PMC has been involved in the development of *Primers* on numerous key subjects, including Electronic Medical Records, Picture Archive and Communication Systems, Human Resources Management, and Hospital Employment. The subject of the 2011 *Primer* is "*Enhancing Your Practice's Revenue: Pearls and Pitfalls.*"

This topic is timely. In the past, development of a financially successful practice hinged primarily on a physician's clinical expertise – this alone served to attract patients and generate revenue. Nowadays the economic climate is very different. We must develop new ways to generate revenue while meeting the healthcare needs of our patients. Our long-term goal should be to generate revenue from multiple sources. By diversifying our practices we ensure practice viability even if one source of revenue does not meet projected financial expectations. If we fail to improve our revenue outlook, then many orthopaedic practices will fail. If that happens – at the exact same time as the baby-boomer generation reaches the age of needing a greater amount of musculoskeletal care – then our nation will experience a true healthcare crisis.

This *Primer* will assist orthopaedic surgeons in all practice settings to increase revenue flows and therefore remain profitable. Numerous strategies are discussed in the publication. Not all of the techniques are applicable to every surgeon, but all orthopedists should find several pearls to take home and help grow their practice revenues – even in this challenging environment. Note that most chapters emphasize the importance of conducting due diligence (including the development of *pro formas*) as a key tool to making an informed decision regarding any financial venture.

All twelve members of the 2010-2011 Practice Management Committee contributed to this initiative. Their names, as well as the names of other internal and external contributors, are listed on the previous page. In particular I would like to formally acknowledge the assistance and support provided by staff in the Academy's Department of Publications and the Practice Management group.



Thomas J. Grogan

Chair, AAOS Practice Management Committee

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INTRODUCTION

At the 2009 AAOS Annual Meeting Joseph Zuckerman, MD, in his presidential address, observed that, regardless of an orthopaedist's specialty or practice setting, "practice management is the tie that binds us together." That statement is no less true today than it was three years ago. Since then, reimbursements have continued to fall even as office overhead has increased. Just five expenses (salaries, benefits, occupancy, supplies and professional liability) constitute more than three quarters of the typical orthopaedist's operating costs, and operating costs now account for more than half of total medical revenue.

If the proposed 25% reduction in Medicare reimbursement for 2011 had actually taken place, orthopaedists' overhead ratio in 2011 would have been much, much higher. The result would have been catastrophic for many practices, particularly those with poor payer mixes. Despite this "near miss," orthopaedic practices are facing enormous challenges; these include the lack of comprehensive medical liability reform on a national basis, the enactment of the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act, and the passage (but now uncertain future) of the Patient Protection and Affordable Care Act (PPACA) of 2010.

It used to be relatively easy for orthopaedic surgeons to maintain their net incomes by seeing more patients and do-

ing more surgeries. Today, most orthopaedists are working as hard as they can, so this course of action is not viable. Other viable options include merging with other practices and employment by a hospital, HMO or insurance company; however, these may not be attractive to many physicians, particularly those who are happy with their current practice arrangements.

"In adversity lies opportunity," however, and orthopaedic surgeons are not without other options. The Practice Management Committee (PMC) collaborated and came up with twelve strategies for generating additional revenue that can be classified under the Five general headings shown in the sidebar. Each of the chapters in this *Primer* was written by a member of the PMC with expertise in that topic. An addendum of "Top Ten Tips" was written by the committee's staff liaison. The "voices" may vary because the intent was to allow individual authors to tell their own stories in their own way. Contact information is provided at the end of each chapter. Readers interested in obtaining more information, including sources and reference citations, should communicate with the authors. A bibliography is included in the on-line version of this publication. See www.aaos.org/pracman.

Personnel

Non-Physician Extenders
Non-Surgical Physicians

Services

PT/OT
Urgent Care Centers
Ambulatory Surgery Centers
Imaging Services

The Hospital

On-call Compensation
MD/Hospital Joint Ventures
Service Line Co-management

Other Income

Active: Medical-legal Practice
Passive: Real Estate

Marketing

Social Media Marketing

Section 1

Personnel

Chapter 1

Non-Physician Extenders

By: George V. Russell, M.D.

Non-physician extenders (NPEs) encompass a number of providers who assist physicians to care for patients. Also termed “mid-level providers,” non-physician extenders used in orthopaedic practices include physician assistants (PAs), nurse practitioners (NPs), and athletic trainers (APs). NPEs add to clinical practices in a number of ways: they increase physician productivity, patient satisfaction, quality of care, and physician revenue.

Physician Assistants (PAs)

There are more than 150 accredited educational programs for PAs in the US; the typical program is 24-32 months long. Most applicants to PA educational programs already have a college degree and some health-related work experience. Admission requirements vary from program to program. The prior experience of most PAs allows for easy integration into most primary care roles; transition to orthopaedics, however, may require additional training specific to musculoskeletal care. The number of physician assistants has tripled since the 1990's. There is now one PA for every 10-12 physicians.

PAs receive their national certification from the National Commission on Certification of Physician Assistants (NC-CPA). Only graduates of an accredited PA program are eligible to take the Physician Assistant National Certifying Examination (PANCE). Once a PA is certified, he/she must complete a continuous six-year continuing education cycle to keep the certificate current.

PAs typically function as primary care musculoskeletal providers in orthopaedic practices. They provide routine orthopaedic care, thereby allowing the surgeon to focus on more complicated problems and surgical management of musculoskeletal disease. The four ways PAs are integrated into an orthopaedic practice are: (1) operating room assistant only; (2) autonomous practice without a physician present; (3) autonomous practice with a physician in attendance; and (4) practicing “incident to” an attending physician.

The optimal method for PA integration must be developed by individual practices based on federal and state

laws, payer guidelines and the practices' unique needs. For example, in a lower extremity orthopaedic surgeons office, a PA might provide routine foot care such as cutting nails, shaving corns and calluses, and so forth. The bottom line is that PAs are highly educated, highly skilled individuals, and practices should think of ways to utilize them creatively.

Important note: a physician assistant (PA) is *not* the same as an orthopaedic physician assistant (OPA). Differences include the following:

- Educational standards
- Certifying requirements
- Accredited educational programs
- Scope of practice
- Certifying bodies
- Supervisory requirements
- Licensure
- Reimbursement

Additional information regarding PAs is available at www.aapa.org. Additional information regarding OPAs is available at www.asopa.org.

Nurse Practitioners (NPs)

Nurse practitioners have graduate, advanced education and clinical training beyond their registered nurse preparation. Most have master's degrees and many have doctorates. NPs diagnose and treat a wide range of health problems. They tend to focus on health promotion, disease prevention, health education and counseling.

The first NPs were educated at the University of Colorado in 1965. Programs soon spread across the U.S. As of 2010, there are about 140,000 practicing NPs. Close to 8,000 new NPs are prepared each year at over 325 colleges and universities.

NPs are licensed in all states and the District of Columbia. They practice under the rules and regulations of the state in which they are licensed. Most NPs are nationally certified in their specialty area. Additional information on nurse practitioners is available at www.aanp.org.

NP/PA Compensation and Collections

Estimates of NP and PA compensation differ depending on the source. The American Academy of Nurse Practitioners

(AANP) and American Academy of Physician Assistants (AAPA) websites both provide statistics in this regard; so does the Medical Group Management Association (MGMA). Generally speaking however, sources agree that salaries of NPs and PAs are not significantly different: the majority earn between \$85,000 and \$95,000 per year with variations relating to experience, practice location, specialty (orthopaedics often pays more), and so forth. Incentive and on-call pay may boost compensation by \$5,000 to \$10,000.

Collections for NPs, according to the Medical Group Management Association (MGMA) average approximately \$147,000 (median: \$105,000). Collections for primary care PAs average \$175,000 (median: \$150,000); collections for surgical PAs average \$123,000 (median: \$93,000). The reason for the difference between primary care PA collections and surgical PA collections is not immediately apparent especially since surgical PAs' mean charges were significantly greater than those of primary care PAs (\$648,000 vs. \$357,000).

Possibly primary care PAs function more autonomously or are able to collect more from third parties. Alternatively or in addition, surgical PAs may perform a great deal of work that (a) cannot be billed; (b) isn't billed even if it can be; and/or (c) cannot be easily collected.

Regardless, the advantages to orthopaedic surgeons of NPEs such as NPs and PAs are clear. Even if the practice breaks even in the sense that an NPE's salary plus benefits and overhead equals his or her collections, the existence of this person frees up the orthopaedists to perform more highly-compensated work.

Athletic Trainers (ATs/ATCs)

Athletic trainers (ATs) specialize in the prevention, diagnosis, assessment, treatment, and rehabilitation of muscle and bone injuries and illnesses. ATCs are ATs who have been certified by the Board of Certification (BOC); see www.bocatc.org.

ATs should not be confused with fitness trainers or personal trainers, who are not health-care workers, but rather people who train other people to become physically fit. ATs try to prevent injuries by educating people on how to reduce their risk for injuries and by advising them on the proper use of equipment, exercises to improve balance and strength, home exercises and therapy programs. They also help apply protective or injury-preventive devices such as tape, bandages, and braces.

Athletic trainers may work under the direction of licensed physicians and in collaboration with other health-care providers. The extent of the direction an AT receives ranges from discussing specific injuries and treatment options with a physician to performing evaluations and treatments as directed by a physician.

ATs held about 16,300 jobs in 2008 and are found in every part of the country. AT jobs are typically related to sports, although an increasing number also work in other settings. In 2008, 38% of athletic trainers worked in health care, including jobs in hospitals, offices of physicians, and offices of other health practitioners. Most athletic trainers work in full-time positions and typically receive a salary plus benefits. The salary of an athletic trainer depends on experience and job responsibilities, and varies by job setting. The median annual wage for athletic trainers was \$39,640 in May 2008. The middle 50 percent earned between \$32,070 and \$49,250. The lowest 10 percent earned less than \$23,450, while the top 10 percent earned more than \$60,960.

Employment of athletic trainers is projected to grow 37 percent from 2008 to 2018. This is much faster than the average for all occupations, because of their role in preventing injuries and reducing healthcare costs. Job growth will be concentrated in the healthcare industry, including hospitals and offices of health practitioners. The demand for health care, with an emphasis on preventive care, should grow as the population ages and as a way to reduce healthcare costs. Increased licensure requirements and regulation has led to a greater acceptance of athletic trainers as qualified healthcare providers. As a result, third-party reimbursement is expected to continue to grow for athletic training services.

Most third party payers only reimburse for "covered" (by the plan) and "medically necessary" services. ATCs currently receive reimbursement working in a variety of settings, including hospitals, physicians' offices, sports rehabilitation clinics and college and university settings. Some ATCs have received reimbursement on 60% to 85% of billings. Some have fared less favorably. Licensure is key to successful reimbursement from third party payers. Direct reimbursement for services notwithstanding, if a practice employs ATs or ATCs, this can be an excellent marketing tool. ATs and ATCs may be the first contact a patient or his/her family has with the doctor or practice.

Additional information on ATs and ATCs is available at www.nata.org.

Liability for non-physician Extenders

Lawsuits against physician extenders are uncommon; most cases name the supervising physician first. Settlements that do not involve the physician are rare. The average indemnity payment was \$174,871 which was higher than that for most physicians. Claims against NPEs can be grouped into the following areas: (1) inadequate supervision; (2) delayed referral to a supervising physician; and (3) failure of diagnosis. Across all specialties, diagnostic errors are the most prevalent medical liability claim against NPEs.

Difficult cases can lead to diagnostic errors by anyone; errors in judgment by PEs can be minimized by clarifying their scope of practice. Clear protocols should be written and should define (a) what conditions need to be evaluated by a physician, (b) how often a patient can be seen by the PE without a physician visit, and (c) guidelines for management of various conditions. An open line of communication must be maintained between the PE and the physician. If an error by the PE is noted, the physician must take steps to inform the patient and manage the condition appropriately.

Scribes/Medical Assistants

Finally, an alternative view of the role of scribes and medical assistants. These persons used to be considered a luxury or at best simply an expense in most medical offices. Now, with the advent of electronic medical records (EMR), they are increasingly being seen by orthopaedic surgeons as vital to improving patient flow and efficiency. For example, if a scribe earning \$15/hour enables the doctor to see two or three additional patients generating \$200-\$300 per patient, this more than pays for itself.

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Chapter 2

Non-Surgical Physicians

By James Keeney, MD

Background

To an increasing extent, medical practices have started to rely on passive sources of income to maintain net income and viability. See for example Chapter 11: Real Estate. While revenues obtained from these sources may be significant, regional and individual practice considerations may limit physicians' opportunities to participate fully in the activities. In the future, federal and state regulatory efforts could restrict access to some passive income sources and may, in fact, reward the development of completely new models for healthcare delivery. While passive revenues are important, practices must therefore still rely on providing direct patient care to maintain a healthy bottom line. The question is how to do this in the most efficient manner given that:

- Surgical procedures generally contribute more substantively to gross revenue than non-operative care.
- The best use of a surgeon's time (economically speaking at least) is therefore in the operating room.
- The average orthopaedist spends between 25% and 40% of his/her time in the OR but many spend more, particularly if he or she performs procedures in multiple locations.

- Not every patient seen in the office needs surgery; many can (and should) be treated non-operatively.
- Patients who do require surgery generally need to be seen several times in the office before and after the surgery takes place.
- The number of patients an average orthopaedist sees in the office per surgery performed varies significantly depending on subspecialty, practice setting, and utilization of clinical support staff.
- Overhead has been increasing steadily over the past five years; it is currently in the range of \$550,000 (between 45% and 55% of gross receipts per Medical Group Management Association (MGMA) and American Association of Orthopaedic Executives (AAOE)).
- There are numerous reasons – in addition to surgery – why a physician may not be in the office; e.g., rounds, CME, administration and vacation.
- Most office expenses, including staff salaries, occupancy, insurance, utilities, and marketing, are incurred whether there is a doctor physically present in the office or not.

Orthopaedists are placed in a "Catch-22" situation. Do they spend time in the office, utilizing it efficiently and generating surgical business, or do they actually perform surgeries? Complicating matters further is the fact that a great deal of practices' ancillary income, including revenues received from injections, x-ray, sales of supplies, and office procedures, is only generated when doctors are physically present, and ancillary income can have a profit margin of 50% to 70%. Hence, it is doubly important for an orthopaedic office to have professional (that is, physician) staff on site at all times.

A solution to this problem is for the office to recruit and employ additional doctors; that is, physicians who do not perform orthopaedic surgery. The key to success here is to develop a business plan for each practitioner the office wants to bring on board. The plan should consider the direct revenues the physician will generate (plus the indirect revenues the person will allow others to generate) and compare these against (a) the revenues that will no longer be generated by existing personnel and (b) the added costs the office will incur, including salary and benefits, professional liability insurance, etc.

Upsides

Staffing the office with physicians who do not perform orthopaedic surgery has numerous advantages.

- Patients can frequently be seen at very short notice. For many people, this is very appealing and enhances the office's reputation for quality and service.
- Non-operative physicians will often refer patients they see to orthopaedists for subsequent surgery.

- The physicians (particularly non-operative orthopaedists; see below) represent an excellent way to “test the waters” when consideration is being given to adding to orthopaedic surgeon complement.
- The physicians generate direct revenue for the practice. They also free up practice principals to perform surgery, which typically reimburses at a higher rate than work in the office.
- They allow for the generation of ancillary revenue, including (a) x-ray, (b) the sale of supplies, and possibly even (c) office procedures.
- They can potentially expand subspecialty practice with new products or services (such as pain management, and pre-surgical medical clearances) that may be in demand within the community.

Note: non-physician extenders such as Nurse Practitioners (NPs), Physician Assistants (PAs), Orthopaedic Physician Assistants (OPAs) and Athletic Trainers (ATs/ATCs) have been incorporated into orthopaedic practices for a number of years to enhance surgeons’ efficiency in the clinic and operating room. However, requirements for supervision may limit their use and reimbursement under new models of health care delivery. See Chapter 1: Non-physician Extenders.

Downsides

The recruitment of non-surgical physicians also has certain downsides.

- Tension can arise if the physician wants to become a practice principal. Issues such as income distribution, on-call, and governance are sufficiently complicated even in “homogenous” practices.
- Care must be taken to be certain that there is a real need in the community for the kind of physician who is recruited. Otherwise the practice will pay out a significant amount of money and generate little net income in return.
- Physicians in the practice will need to agree on the scope of practice for each non-surgical physician and utilize him or her accordingly.
- Unless employment agreements are constructed with an enforceable non-compete clause, employed doctors could leave at the end of their contract and take patients with them.
- The practice must exercise care in developing marketing and promotion material (and in educating office staff) so that patients can make informed decisions regarding whom they wish to see.

Types of Non-operative Physicians in Orthopaedic Practices

There are several options for the addition of non-surgical physicians into a practice.

Non-operative orthopaedic surgeons: Orthopaedic surgeons may choose to engage in non-operative practice for a variety of reasons. These include the decision to cut back as retirement age approaches; partial physical disability; personal/family commitments; or simply the decision to live life with less stress and pressure. There are several advantages of adding one or even more non-operative orthopaedic surgeons to a subspecialty surgical practice. Since they do not perform surgery, they have a greater immediate availability for new patient visits and consults. Because they have had previous experience in providing M/S surgical care, they are skilled in the assessment of patients who may need surgery and/or people who need to be seen on short notice for post-surgical concerns.

Further, referring PCPs can be assured that their patients will receive the same high quality of musculoskeletal care as they would receive from an operating orthopaedist. Finally, they provide timely initial fracture management for patients referred from an emergency department or urgent care clinic. Practices may choose to employ non-operative orthopaedists during traditional office hours, or use them “after hours; e.g., early mornings, evenings and/or weekends.

Physical medicine and rehabilitation physicians (Physiatrists): Physical medicine and rehabilitation physicians treat individuals suffering from both minor and serious physical injuries and conditions. The core of a physiatrist’s training focuses primarily on nerve, muscle and bone injuries as well as illnesses that can affect these areas. Many physiatrists treat a broad range of conditions but some choose to focus on specific areas such as sports medicine, the spine or the pelvis. They can read and interpret MRI scans as well as perform epidurals and nerve tests (EMG’s). Physiatrists can therefore generate several revenue streams for orthopaedic offices and at the same time, allow practice principals to focus on surgery. The practice also benefits from an “image” standpoint because patients view the office as place to go to receive care for a wide range of musculoskeletal conditions.

Rheumatologists: Rheumatologists treat more than 200 diseases and conditions, including rheumatoid arthritis, osteoarthritis, gout, lupus, back pain, osteoporosis and tendinitis. They also treat soft tissue problems related to musculoskeletal system sports-related soft tissue disorders. The specialty is interrelated with the physical medicine and rehabilitation of disabled patients (see above) and physiotherapy. As is the case with physiatrists, orthopaedic practices employing rheumatologists benefit because these doctors generate revenue directly and allow practice principals to focus on surgery. And again, the practice also

benefits from an “image” standpoint because patients view the office as place to go to receive care for a wide range of musculoskeletal conditions.

Other Non-surgical Physician Specialists: These include family practice sports medicine physicians, neurologists, endocrinologists and internists. These physicians serve as a referral source to orthopaedic practice principals and help to create an integrated care team for the treatment of patients with complex medical problems before and after surgery.

To Recruit or Not to Recruit?

Ultimately, the decision to recruit one or more non-operative physicians by a practice needs to be made based on a variety of factors including its mission, geographic location, current orthopaedic physician complement, payer mix, and the needs of the community. As stated in the Background section above, it is critically important for the office to develop a business plan for each practitioner. The plan should include qualitative issues such as whether the new doctor would enhance the practice’s image in the community and improve the quality of life for practice principals. It should also include a detailed *pro forma* of what the financial impact might be of bringing the new doctor on board. Elements of the *pro forma* include the following:

Income:

1. Direct patient care revenue generated by the new physician (but also see # 1 under “Deductions from Income” below)
2. Direct revenue generated by the new physician resulting from additional ancillary services not currently provided by the practice (either because no current practice principal is present to do so or because the services are outside the typical scope of routine orthopaedic practice; e.g., epidurals)
3. Additional revenue from surgery performed by practice principals due to referrals

Deductions from Income:

1. Revenue no longer generated in the office by existing practice principals (this is important and is often ignored in financial projections)
2. Non-operative physician salaries, benefits, professional liability insurance and other overhead such as occupancy
3. Possible decreases in referrals from other doctors (e.g., rheumatologists and physiatrists) whose business income has been adversely impacted

Salaries for non-surgical physicians with the exception of non-surgical orthopaedic surgeons are available on line from sources such as www.salary.com. The median salary, for example, for a physiatrist is in the range of \$200,000; for a rheumatologist, it is \$185,000. Note that different surveys use different methodologies and statistics are not always current. Also note that “Salary.com” and other websites do not distinguish operative and non-operative orthopaedic surgeons. The AAOS Research Department does collect this information via the Census (Orthopaedic Practice in the U.S.). It is available to AAOS members upon request: oracle@aaos.org.

Obviously, whatever salary is ultimately offered to an employed non-surgical physician will depend on factors such as experience, number of hours worked per week and number of weeks per year, number of patients seen, and anticipated reimbursement from payers and patients. If the practice offers excellent benefits (including contributions to pension and profit sharing), this should also be considered because what is important is the total package, not just the person’s paycheck.

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Section 2

Services

Chapter 3

Physical and Occupational Therapy

By Michael Q. Freehill, MD and William Evans, MBA

Physical Therapy (PT) and Occupational Therapy (OT) are crucial to successful outcomes for patients with musculoskeletal problems, and many excellent reasons exist to develop in-house PT/OT. However, the success of physician-owned physical therapy services (POPTS) is not a foregone conclusion. There is an array of operational, financial and political pitfalls.

Operational Considerations

The impact on existing facilities and staffing is one of the first issues to evaluate when considering adding PT and/or OT lines of service. If sufficient unused (or at least non-revenue generating) space currently exists, developing a new PT/OT clinic may be fairly simple. However, if additional space or significant renovation is needed, costs can quickly escalate. Federal regulations, such as Stark, generally encourage PT/OT to be housed in the same building as where the physician owners hold clinic, so space limitations can present significant obstacles unless new space is pursued.

Likewise, an evaluation of staffing and company culture is needed. For example, the increased throughput requirements for the front desk may dictate that additional staffing (or even an entire front desk remodel) is necessary to add PT/OT in existing clinic locations. Further, it is uncommon to simply employ one PT without some additional support, such as a PT Assistant, Aide, or perhaps a Certified Athletic Trainer (ATC). See Chapter 1: Non-physician Extenders. As a result, clinics should be prepared for additional staffing requirements. In the case of physical therapy, a 2:1 ratio of PTs to PT Assistants is not unreasonable, although every practice must determine its own needs based on volume of referrals

Operational questions to ask:

- Do we know of existing PTs and/or OTs whom we want to employ?
- What equipment will our PT/OT require to fit our practice?
- Do we have existing space or do we need to invest in new locations?

- How many patients per day do we expect PT/OT to add?
- Does our front desk have the capability of handling more patients?
- What other staff (e.g., billing and collections) will be needed to support the new lines of service?

Financial Considerations

Financial considerations are naturally intricately linked to the operational concerns. PT/OT can generate an excellent cash flow, although geographic location, payer mix, and practice type will all have a significant impact on profitability. For example, PT/OT in a practice with a large number of privately insured or Workers' Compensation patients is likely to be more profitable than it will be in practice with a very high percentage of Medicare patients.

Recently, Medicare, Workers' Compensation and private payor reimbursement cuts have focused on PT/OT services. Thus, it seems highly likely that future reimbursement changes will diminish the financial reward PT/OT services can create. However, the timing and severity of future cuts remains unclear and is likely dependent at least in part upon the geographic location of each practice.

Rumors of across-the-board prohibition of physician ownership of PT often surface, but it seems more likely that pushing reimbursement down to unsustainable levels is more likely than a complete prohibition, at least in most locales. [As of 2009, POPTS were banned in three states: South Carolina, Delaware and Missouri.] Finally, consulting an experienced healthcare attorney is crucial to determine if all Stark and anti-kickback regulations are being met, as the penalties associated with non-compliance can be significant. Persons violating either set of laws are subject to fines and penalties and exclusion from participation in government programs. Persons violating the anti-kickback laws risk being sent to prison.

Financial Questions to Ask:

- Does our payer mix favorably reward the inclusion of PT/OT?
- Will adding PT/OT eliminate other more potentially profitable lines of service, such as additional clinic rooms to be used by surgeons?
- Are there existing or future state or federal legislative efforts which might limit future PT/OT profitability?

- Have we met all current regulatory requirements to avoid Stark and anti-kickback issues?
- Can we afford the investment required to renovate space and purchase equipment?
- Do we have sufficient capital to fund the startup of a new provider?
- Do any of our insurance contracts prevent us from billing for therapy services?

Political Considerations

Perhaps the most important and often overlooked considerations pertain to political issues. The addition of PT/OT potentially jeopardizes existing relationships with existing PT/OT clinics, hospitals that offer PT/OT services, primary care physicians, and even the broader community. Serious discussion as to who may (or will) experience a negative financial impact if PT/OT is added must take place. Orthopaedic clinics would be naive to believe that there are no potential threats to relationships by developing POPTS, but each clinic's situation is unique and the risk/reward trade-off must be evaluated carefully.

Political Questions to Ask:

- Which of our existing relationships may be harmed with the addition of PT/OT?
- Do we potentially lose any of our referral sources?
- Are any of our hospital relationships at risk?
- Will our local community support us in adding these lines of service?

Benefits of Adding PT

While there are many potential pitfalls to adding PT/OT lines of service to an orthopaedic practice, there are also numerous benefits. Naturally, one of the primary benefits is financial. Profit in excess of \$100,000 per therapist per year is not unreasonable, and in many areas of the country the potential upside is even greater. Current MGMA data (2010 Report; 2009 Data) indicates mean collections are \$235,000 for PT and \$199,000 for OT, with an average profit nearly \$160,000. Although potential diminishing returns limit how many therapists a clinic may hire, these additional revenues cannot be ignored in an era of declining physician reimbursement. Next to ASCs, therapy is often the most profitable ancillary tool orthopaedic surgeons wield. See Chapter 5: Ambulatory Surgery Centers.

Moreover, in-house therapy yields greater control over the quality of therapy and improved continuity of care. With the physicians employing the therapists directly, there is a greatly likelihood of patients receiving the treatments the doctor expects. Being able to walk a patient down the

hall and introduce him or her directly to the therapist who will be providing treatment is a great way to extend the patient relationship the physician has already established. Furthermore, patients are increasingly demanding convenience, and a "one-stop-shop" model for all treatments is becoming the expected norm.

Therapists can also be used as an additional marketing tool through community outreach and education. Injury prevention training or rehabilitation education can generate goodwill among the community in general and the practice's existing patient pool in particular. Conducting ACL injury prevention sessions is just one example of how a therapist can also be used as an additional marketing agent for a practice.

Conclusion

While there are many potential operational, financial and political risks and pitfalls to consider pertaining to POPTS, an orthopaedic clinic would be remiss in not thoroughly evaluating such an important line of service. It seems highly likely that PT/OT will not be as profitable in future years as it is now if continued reimbursement cuts focus on rehabilitation services. However, the increased patient satisfaction and convenience may well outweigh any future declines in reimbursement. There are many valid reasons why an orthopaedic clinic may choose not to bring PT/OT in-house, but the potential benefits should not be underestimated. PT/OT services remain one of the most profitable ancillary tools available to orthopaedic surgeons, and the additional benefit and convenience for patients makes it a natural fit for many clinics.

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Chapter 4

Urgent Care Centers

By Thomas Grogan, MD

In today's challenging orthopaedic practice environment, increasing revenue and managing expenses are the keys to a successful practice. It is worth noting though, that "managing expenses" is not the same thing as "decreasing expenses;" *if an added expense generates revenue that more than offsets the expense, it serves to increase the practice's bottom line.* Many physicians fail to understand this reality (they want to operate "lean and mean") – sometimes to their ultimate financial detriment.

Since an orthopaedist's time is limited, revenue generation by developing ancillary income is becoming increasingly critical to maintaining the bottom line. The definition of ancillary income is "money earned by an

organization through an activity that lies outside its normal core activity and purpose.” Given that a significant portion of practice overhead relates to physical plant, equipment, insurance, and so forth, one way of increasing revenue lies in the development of an Orthopaedic Urgent Care Center (UCC).

Why Pursue this Course of Action?

The concept is relatively simple. Setting up a walk-in after hours or weekend clinic will not only maximize the use of existing office space, it will also allow the physician(s) to gain access to a population of new patients. In addition to expanding the practice’s patient catchment and revenue, these clinics provide a convenient alternative for patients accessing care. These days, patients’ time is limited, and they very much appreciate it when they have the option of visiting their physician when it is convenient for them. Further, it costs far less to receive emergency care (for example for a sports-related fracture incurred during after-school practice) in an orthopaedist’s office than in the ER.

The hours can be tailored to attract specific groups of patients that otherwise have trouble visiting the practice; for example, working parents, the elderly and children in school. The elderly in particular may appreciate the ability to visit the office on a Saturday, avoiding traffic delays that often take place on weekdays. And compared to the ER, patients can be seen much more quickly and efficiently.

A UCC has the potential to charge a premium for care that is delivered after hours especially if it is credentialed/designated. If it is just an extension of your own office, you may or may not be able to accomplish this in the short term. However, at the time you renew your payer contract(s), be sure to do your utmost to negotiate an additional bump in the after-hours “fee;” this will make a lot of sense to payers who want to avoid ER charges related to walk-in orthopaedic injuries. Since over 20% of ER cases are typically orthopaedic injuries that are able to be handled in the office, the potential savings to payers (not to mention the entire healthcare system) are huge.

This chapter is not intended to cover coding specifics. For this you need to seek expert counsel. Following however are a few general points to consider:

- The 99281-99285 range may or may not be recognized by payers; therefore, it is important to check with them to be sure your billing is consistent with their payment policies.
- Even if the payers will pay, reimbursement for this range of codes may be lower than for the 9920X and 9924X ranges based on RVU value.
- There used to be a 9905X code for after-hours care. However, Medicare no longer recognizes the code and it is not in the CPT book. Most payers will not reimburse but some reportedly will. (For more information, see

<http://www.aapc.com/memberarea/forums/showthread.php?t=46750>.)

- Exercise great care in balance billing the patient if a payer rejects a claim with a 9905X code. Is it being denied because it is seen as being “bundled?” Is it denied because it was deemed to be not-covered? When in doubt, consult a coding expert or a payer representative.

For more information, AAOS members should feel free to contact staff in the AAOS Medical Affairs Department. An alternative resource is to check with the Urgent Care Association of America or UCAOA (<http://www.ucaoa.org>).

As will be discussed below, one option is to set up your Urgent Care Center as a separate PC. In this situation, it may be possible to charge fee-for-service out-of-network. To reiterate, coding is key to operating a successful UCC; be sure you know how to code for appropriate reimbursement.

Organization Structure

Urgent care centers can be setup as an extension of your existing practice or a separate PC.

- *Extension of an existing practice:* A key advantage of setting up your UCC as an extension of your existing practice is a reduction in overhead *per hour*; this is because services are being rendered in the facility for a longer period of time. Note, however, that *total* overhead may increase because additional staff could be needed to run the center. It may be possible to lessen the impact of this, though, by staggering current employees’ work hours assuming their time is not currently fully utilized. Another advantage of setting up the UCC as an extension of the existing practice is the investment will be lower - - everything (or virtually everything) needed to run the center is already in place.
- *Setting up a separate PC:* This model would require more investment because (a) you would incur legal expenses of setting up a new venture and (b) you would likely locate the center elsewhere. However, as stated above, you would have the advantage of organizing the PC to be an out-of-network entity and setting up your own fee schedule. You could become a consultant to this center and receive a salary. You may also be able to develop a venture relationship with other local orthopaedic groups to solidify community acceptance and make it a mutually beneficial arrangement. Any joint venture arrangement with other physicians or healthcare institutions needs to be set up with care to ensure compliance with federal and state Stark and anti-kickback regulations.

Operations

Regardless of organization structure, to ensure that the UCC is successful it is critical to secure physician and staff buy-in. First, you must determine how many and which doctors will be providing care at the center. Staffing it at any given time with a hand surgeon or a joint specialist, for example, will not work if the majority of patients visiting the center present with trauma or sports injuries. Your employees (including administrative and clinical staff) need to be trained, organized and prepared to handle both additional volume and possibly an increased variety of orthopaedic cases. Plan in advance for the additional training that will be needed.

You will also need to decide which (if any) non-physician extenders or so-called mid-level professionals you wish to utilize; e.g., nurse practitioners, physician assistants, and athletic trainers. See Chapter 1: Non-physician Extenders. Some centers rely primarily on these individuals (regulations permitting) and medical doctors are contacted if the need arises. In other UCCs, a licensed physician is always present.

Contrary to a conventional orthopaedic office where the scope of elective patients is relatively controlled, the UCC physicians and personnel need to be able to provide care for a wide range of orthopaedic problems, from a shoulder dislocation to a pediatric supra condylar elbow fracture.

Note that other staffing options include a part-time non-operative orthopaedic surgeon, family practitioner, an internist with sports medicine experience (or even an orthopaedic resident looking to moonlight!). See Chapter 2: Non-surgical Physicians.

Projecting UCC Profitability

Conduct a survey to determine how many net new patients the center would likely generate. A simple phone survey asking local referring physicians or a mail-in survey to a cohort of practice patients should yield insight regarding how well the UCC will be received. Then, develop a *pro forma* (or three – see below) for your practice on a consolidated basis and compare it to your current situation.

Bear two things in mind as you do this. First, all patients seen in the UCC are not “gravy;” some are patients who would have been gone to your office and you cannot count them twice. Also, if you as an orthopaedic surgeon staff the UCC *during a time when you would have otherwise performed surgery and you do not make up this income at another time*, that too is foregone income.

1. Calculate the revenues from your practice and UCC combined, reflecting potentially higher levels of UCC reimbursement. Deduct money you will not receive from UCC patients who would otherwise have gone to the office (but don't forget to use office reimbursement rates). Also deduct income from surgeries you will not

be performing (if any) because you cannot be in the OR and see patients at the UCC at the same time.

2. Calculate the cost of your office and UCC combined. Consider:
 - Your occupancy costs will not increase if you open your UCC in your current office but will rise if you occupy another site. Utilities will increase in both scenarios.
 - If you open your center in a new location, you will need to purchase or lease furniture, fixtures and equipment. New equipment, including x-ray, will be expensive.
 - Check with your insurance broker as far as property, casualty and other insurance is concerned; costs will certainly increase with a new facility; they may not if you remain in one place.
 - Make an estimate of your total medical and surgical expenses; these will without doubt increase regardless of whether you use existing space or set up a new PC.
 - Think about other outlays you will need to make, including those for marketing, legal, accounting, information systems, and billing/collection, which are sure to increase.
 - Finally, calculate your total personnel costs, including (a) increased overtime for existing staff and (b) any new staff that you feel you need to hire. Remember to consider benefits.

Subtract projected expenses (2) from projected revenues (1) to determine net profit for the practice and the UCC combined. Compare this net profit to the projected profitability for your practice without the UCC *for the same period of time*. Your financial statements for the most recent year should serve as a basis for this. See # 1 in Ten Top Tips, in the Appendix.

Ideally, develop at least three *pro formas* for your combined operation: a best case, an expected case, and a worst case scenario. (Ask a business advisor for assistance with this if necessary.) If the worst case scenario still results in a profit that is acceptable to you, then developing a UCC is something you should definitely consider doing. The preceding may seem like a lot of work, but it is part of the due diligence that you need to undertake before you invest any money. Here are some statistics to consider as you consider developing a UCC:

- If the current overhead in your office is \$350,000 per year and the average doctor in your office sees 4,500 patients per year, then the break-even cost (excluding compensation to the physicians) to see a patient is almost \$78 per patient/year. You should calculate what the cost is for you in your particular office on at least an annual basis.

- If there are 2,080 working hours in a year (eight hours a day, five days a week, 52 weeks a year), and your overhead is \$350,000 per physician per year, then the cost of keeping your office open is \$168 per hour. Again, you should calculate what the cost is for you in your particular office on at least an annual basis.
- If the surgeons in your practice want to net \$500,000 per year (\$240 per hour assuming 2,080 hours), then the minimum revenue you must receive per hour must on average be \$240 plus \$168 or \$408. You can consult fee schedules for payers and workers' compensation to see if this is feasible. *Remember that ancillary income (X-ray, PT/OT, DME, casting, neutraceuticals, etc.) all add to the value of the patient encounter.*

Marketing

Appropriate marketing of the UCC has the potential of driving even more patients into the practice. The center needs to attract a population of patients that otherwise would have gone to the ER. Since the average ER cost (excluding physician fees) in 2008 was \$956 per patient visit, the use of an after-hours UCC is very much a cost cutting measure for the community. That said, your marketing should not suggest that the UCC is simply an alternative to the ER. Instead, it should emphasize that the UCC offers after-hours services that overcrowded and busy ERs – with the best will in the world – simply cannot provide. This approach will hopefully aid in community acceptance and minimize any hospital-clinic hostility. Marketing should be directed to patients, payers and referral sources alike. Gaining the support of referring doctors in particular is paramount to achieving success.

The Last Word from this Doctor

The development of an Orthopaedic UCC or after-hours clinic will allow orthopaedic practices to grow and generate additional revenue; it will also serve to position the practice for the evolving world of hospital/practice/payer consolidation that appears to be the future of health care. Specifically, the combination of *accessible, affordable, and high-quality* care offered by a well-run UCC will be key to making the center attractive to payers and hospitals alike, especially in the upcoming development of Accountable Care Organizations (See the ACO companion *Primer* developed by the Health Care Systems Committee). The keys to UCC success lie in effective planning, positioning, and above all staff and physician buy-in to the concept that “what is good for patients will be good for the practice.”

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Chapter 5 Ambulatory Surgery Centers

By Douglas Turgeon, MD

Managed care penetration is increasing. Medicare rates are drifting downward and these decreases are often mirrored by private payers. Total costs of doing business are not only rising but some that were previously paid by others are now being shifted to physicians. As orthopaedic surgeons, we are therefore forced to search for ways to maintain our practices' financial viability while at the same time meeting the healthcare needs of a growing and aging patient population.

Investment and participation in ambulatory surgery centers (ASCs) – either directly by a physician practice or group or indirectly via a joint venture with a hospital or a health care management company – has become a means to address orthopaedists' monetary concerns, and to directly and positively influence patient care delivery.

The enormous complexity of the ASC industry makes any overview a daunting task, and an exhaustive coverage of the topic is beyond the scope of this *Primer*. However, I hope this chapter will touch on many of the major issues that orthopaedists might consider in connection with ASCs, including:

- The importance of planning
- Go it alone vs. partner with a third party
- Physical facility location and design
- Staffing considerations
- Financial matters
- Compliance with regulations

Development of an ambulatory surgery center is not a strategy that will work for every orthopaedic surgeon. However, the number of ASCs nationwide has increased dramatically over the past decade. ASCs have been widely recognized for their efficiency and improved patient safety. They also add healthy competition to the healthcare marketplace even though they must adhere to the same protocols as hospitals. Physician owners of ASCs are universally proud of their ability to provide high-quality patient care in a cost-effective setting.

The Importance of Planning

The success of any business, and this includes an ASC, depends first and foremost on planning; that is, identifying the activities that need to be undertaken from start to finish. The plan should also identify who will be undertaking each activity and what the deadlines are for completion. The \$64,000 question though is who should

develop and oversee the plan? Oftentimes this falls to one or more of the physicians who are interested in developing the ASC. However, physicians in general, and orthopaedists in particular, are typically very busy people with little free time. Further, historically at least, physicians have not always been as astute in business as they are in providing patient care - - although this is changing as more and more physicians secure MBA and MHA degrees.

An alternative to the above approach is to empower a hospital executive (*if* the practice plans to enter into a joint venture – more on this in a moment) or employ an outside consultant. The advantage of using an outside consultant is that he or she will have expertise in project management and (hopefully) facilitate the completion of the ASC on time and within budget. The downside is that this will cost money, and hence increase the overall budget.

Regardless of who is in charge of the project, the first step in any plan to develop an ASC is for the physicians to come to an agreement regarding mission, goals and objectives. They need to decide (a) *why* they are developing the center, (b) *what* services the center will be providing, (c) to *whom*, (c) *when*, (d) *where* and (e) *how*. The first question (why) is particularly challenging. Presumably the purpose of the ASC is to make a profit, but in addition, the practice may wish to accomplish other things, including, for example, improve the quality of health care provided to patients and/or to maintain good relations with a nearby healthcare institution.

Further, even “making a profit” is an imprecise goal. Do the doctors have a minimum return on investment in mind or is it sufficient that the ASC have a positive cash flow after X years have passed? It is crucial that physicians come to closure regarding its mission or the center will almost certainly not be successful in the long term. For more information, See # 2 in Ten Top Tips, in the Appendix.

Another basic element of any plan is the creation of a *pro forma*, or a spreadsheet projecting revenues and expenses for the ASC over a period of at least eight years. This is something that a consultant is likely to have expertise in, even if individual physician investors do not. The *pro forma* needs to be reality-based and conservative because people do not want to put their money at risk. This is the case whether physicians invest out of their own savings/ investments or turn to a bank or other financial institution. *Pro formas* will be covered in greater detail in the Finance section, below.

Go It Alone vs. Partner with a Third Party

In developing an ASC, the advantages to physicians of “going it alone” are:

- The doctors may be more selective in including only the highest quality healthcare providers.

- They retain control of administrative and quality of care matters.
- Profits do not need to be shared with any other party.

The downsides are:

- Physicians must come up with the required money (out of savings or borrowed from third sources).
- They assume all the risk if the venture is a failure.
- They may not have the expertise to oversee the business.
- Nearby hospitals may feel that an income stream will be threatened and retaliate.

The advantages to physicians of partnering with a third party (e.g., the hospital or surgery center/real estate management company) are:

- The initial investment for physicians will be less than it otherwise would be.
- If the venture is a failure, physicians’ financial exposure is lower.
- The hospital may be in a position to provide management expertise in operations.

The downsides are:

- The physicians lose at least a certain amount of administrative and clinical control.
- Profits from the center are divided among a great number of parties.
- The hospital’s notion of high-quality management may not be the same as the doctors’.

There are, of course, options in between the two extremes described above. For example, if the center is initially entirely physician-owned, the doctors could sell a percentage of their ownership to an outside interest after the center becomes successful and realize a profit. The downside to that approach is that future profits will be reduced and operational control decreased.

Alternatively, if the ASC is organized as a JV, physicians could buy out the other stakeholders in the future. However, if the center is successful, this will cost money which must come from somewhere.

In the ultimate analysis, whether the physicians choose to “go it alone” or partner with a third party may be dictated by the size of the initial and subsequent capital investments. The larger the ASC, the greater the required up-front financial commitment. Further, most ASCs will likely will not be self-supporting for several years, during which time capital infusions will be required.

Physical Facility Location and Design

The real estate *dictum* “location, location, location” applies to planning for the ASC. It needs to be convenient for

patients, physicians and staff or “you can build it and they may *not* come.” Proximity to a hospital for emergency services for easy transport of seriously injured patients should be taken into account as well. As far as the center itself is concerned, there are many factors to be considered:

1. What services will be provided (e.g., one subspecialty such as spine or multiple disciplines)?
2. How many physicians will be performing surgery at the same time?
3. Will there be clinical support services on site, such as radiology or therapy?
4. What administrative services will be on site (e.g., scheduling, billing, etc.)?
5. Will the facility be owned or leased? Developed from scratch or placed in an existing facility?
6. What amenities are required (parking, restaurant proximity, etc.)?

All of these questions need to be addressed during the initial planning stages or the likelihood is that the physicians will end up with a facility that does not meet their (*or* their patients’) needs. If that happens, the facility may not be used optimally, and this in turn will have an adverse financial impact.

There are many architectural firms in the country that specialize in medical office design in general, and ambulatory surgery centers in particular. The Internet is a useful source of information regarding these firms. Another source of information is word of mouth. Regardless of which company is ultimately selected, it is important for physicians to have input into the final facility design since they will be the ones using it on a daily basis. Design factors include, but are not limited to, lobby design, patient flow, OR/PACU proximity, ancillary services, and so forth.

A quick observation relating to hours that the ASC is open. Although the center cannot generate income if it is not in use, occupancy costs remain roughly the same regardless of whether it is open from 9:00 AM to 5:00 PM weekdays or 7:00 AM to 9:00 PM weekdays and Saturdays. This is an argument in favor of longer hours (and that may be very attractive to patients depending on the nature of their surgery). Another argument for keeping the facility open for a longer period of time is that it may be possible to generate income from ancillary services even when no physician is present.

However, longer hours do increase personnel costs (see below); furthermore, when staff are asked to work long hours over an extended period of time, they can “burn out” and this can give rise to low morale and high turnover. There is a delicate balance and this must be reflected in the *pro forma*.

Staffing Considerations

The number of support personnel required for the ASC to function efficiently is directly related to the first four factors listed in the Physical Facility section (see above). The center will require staff in numerous areas, including: front office/reception, pre-op/PACU/OR, clinical support (patient technicians and orderlies), information technology, insurance and billing, human resources, and management.

Since staff salaries represent the highest expense in most ASCs, it is important to not over-staff the center because this will have an adverse impact on profitability. However, under-staffing the facility will also have negative consequences, including decreased patient flow, insurance billing back-ups, and potentially a decreased quality of care. The key to determining correct staffing levels is to hire a high-quality facility manager who can make informed decision regarding, for example, flexible and part-time staffing. High quality managers command correspondingly high salaries but they are worth the investment. See # 4 in Ten Top Tips, in the Appendix.

Regarding ASC staffing, a caution: if physicians own the ASC, then employees who work there will be accountable to them. If the center is structured as a joint venture with the hospital, it could be that JV staff could end up being leased hospital employees. Their loyalty or level of training may not be all that physician investors might desire.

Finances

There may be many reasons why physicians would invest in an ASC, but a primary one is income generation. As stated above, it is important that investors’ expectations in this arena are in sync. The first task that needs to be accomplished is to be sure that they are “speaking the same language” as far as profitability measurement is concerned; that is to say, what formula is to be used in defining profitability. For more information in this regard, see # 2 in the “Top Ten Tips” Appendix.

To make a profitability calculation using any formula, potential investors must first prepare (or cause to be prepared) a capital budget and a *pro forma*.

- The capital budget delineates the up-front funds that will be required in connection with the ASC. Funds will be required for a myriad of things, including consultants (if they are to be used, see above); permits; land acquisition (if a purchase); building construction (if new); building renovation (if existing space will be used); architect fees; equipment; furniture and fixtures; and so forth. The capital budget should be supported by quotes from the companies that will be providing the services so that the budget is based on reality.
- The *pro forma* is a spreadsheet that sets forth, in as much detail as possible, the anticipated revenues and

expenses for the ASC for a period of at least eight years. While it is true that the crystal ball becomes less clear the longer the timeframe, it is still important to project as far into the future as possible. This is because, as has been previously noted, an ASC will likely require several months, and perhaps even several years, to become self-supporting.

Development of a *pro forma* requires assumptions to be made on a variety of fronts, including:

- Number of physicians who will be performing procedures
- Number of procedures per physician
- Average reimbursement per procedure
- Ancillary income (e.g., x-ray, therapy, etc.)
- Operating expenses, including staff salaries and benefits, occupancy, insurance, supplies, etc.
- Any increase in professional liability insurance for participating physicians

Three *pro formas* should be developed: a best case, an expected case, and a worst case. The latter is very important so that investors understand clearly what they are risking in making their investment.

Following are ten observations regarding ASC profitability:

1. Payers typically reimburse ambulatory surgery centers at a lower rate than hospitals for the same services.
2. Efficient OR utilization can offset the lower reimbursement by increasing the possible number of cases performed daily.
3. Profitability is influenced not only by the number of cases, but also the types of procedures performed. Ancillary income contributes to revenues, but how much depends on many factors.
4. In general, orthopaedic cases are some of the more profitable for an ASC (compared, for example, with plastic surgery) from the standpoint of remuneration versus OR time.
5. Efficient work flow and turnover not only enhance profitability, but can also lead to greater patient satisfaction.
6. Since staff salaries and benefits are a major expense in any ASC, it is important to monitor them carefully (e.g., minimizing overtime, linking raises to performance that helps the bottom line, etc.).
7. Unless policies are established regarding implants and the use of equipment, there is likely to be a significant variance among physicians in the cost per case. Other things equal, lower is better!
8. Assuming there is a choice between leasing and buying, it is important to analyze which option is best. For more information, see # 5 in the Ten Top Tips Appendix.

9. Balance the advantages of accelerated payback of equipment, etc. (lower interest costs) with the reality that in the short term, money available for distribution will be lower.
10. It is advisable to be completely transparent with physicians about their utilization and expenses. They tend to pay attention to what they are doing when they face direct financial consequences.

Compliance with Regulations

The changing regulatory landscape poses a challenge to physicians investing in ambulatory surgery centers. They must deal with an alphabet soup of regulatory and professional organizations: Federal Ambulatory Surgery Association (FASA); The Joint Commission (formerly JCAHO – for accreditation); CMS (Centers for Medicare and Medicaid Services), etc. To receive Medicare payments, the center must become certified. In many states, it is not possible to break ground on an ASC without a Certificate of Need (CON), and even if a CON is not required, ASCs may need to apply for and obtain operating licenses. ASCs must also comply with relevant provisions of the 2010 Affordable Care Act.

Keeping abreast of frequent changes in rules for reimbursement, accepted procedures, etc., requires careful monitoring by the ASC Board representing physician owners and investors. The Board may delegate this task to lay (non-physician) management; however, investors should realize that it is not management of the facility that will incur fines and penalties if regulations are not adhered to but rather the owners themselves.

The AAOS web site is a valuable tool and resource for the above information. For more information, visit www.aaos.org/pracman; also see # 10 in the Ten Top Tips Appendix. It is also critical to engage the services of a competent attorney well-versed in healthcare legislation. He or she will provide advice not only during the start-up of an ASC facility but also on an ongoing basis once the center is in operation. The Board needs to be kept apprised of changes to federal, state and local regulations which may affect the ASC's viability. At present, the use of physician-owned facilities by the physician investors is not viewed as a conflict of interest under the Stark/Anti-kickback rules. This is, however, something that could change at any time.

Other Issues

Following is a list of other issues that come to mind that do not fall within one of the above categories:

- As part of the planning process, it is important to undertake a competitive analysis of other ASCs that exist in the community and who owns those ASCs. The *pro formas* that are developed need to take into consideration how much business the new ASC will generate that

existing ASCs will not longer have – this could generate significant ill-will with associated financial consequences.

- The time horizon for developing an ASC ranges from a few months to more than 18. During this period, the facility will generate no revenue, but costs will be incurred. Physicians need to take this into account before they make the decision to invest. One or more additional capital calls may be required.
- Many ASCs market themselves very actively (especially if they are owned in full or in part by hospitals or hospital chains). However, there is no data indicating that patients choose an ASC facility because it has been actively marketed; most simply follow their surgeon to the recommended facility.
- While there is no requirement at this juncture to disclose, it may be advisable for a physician practice to clearly indicate on its website – and in any patient literature – that it owns “ABC Ambulatory Surgery Center.” That way, patients can make an informed decision regarding whether or not “ABC” is where they wish to receive care.
- Although physicians frequently wish to develop ASCs independent of hospital involvement, the reality is that partnering with a hospital in an ASC joint venture sometimes is better for both parties. Trends toward improved reimbursement for hospitals coupled with declining payments for physicians have forced some doctors involved with ASCs to accept the clout that hospitals have with payers, which results in greater negotiating potential and better contracts.

The Last Word

Excerpt from AAOS Position Statement 1161: “ASCs provide a benefit to both patients and orthopaedic surgeons because many musculoskeletal surgical procedures can be provided in an efficient, cost-effective manner. ASCs can improve the quality of care received by the patient and delivered by the physician.”

Further, from the standpoint of this author, physician ownership/investment in ASCs may restore a sense of control in quality healthcare delivery to involved surgeons, allowing them to take back some control of their practice and provision of health care. It also serves as a viable source of revenue generation.

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Chapter 6 Imaging Services

By Dale Reigle, MS

Background

Imaging has become an integral part of many orthopaedic offices. In-house imaging provides an ancillary revenue stream, improves practice efficiency, and may play a role in overall patient satisfaction. The types of imaging services offered vary depending on a variety of factors which include but are not limited to practice size, geographical location, political considerations, and orthopaedic specialties represented in the office.

Revenues from imaging services can add significantly to your bottom line. A reasonably busy MRI for example may generate more revenue and profit for the practice than an orthopaedic surgeon, while X-ray often generates an additional \$50,000 - \$100,000 or more of operating profit per orthopaedic surgeon. Other imaging equipment, by contrast, such as bone densitometry (Dual Energy X-ray Absorptiometry – DEXA for short), has proven to be less profitable or unprofitable for many practices.

Practice control over imaging services, including quality management and scheduling, are non-financial factors that often help drive the decision to acquire new imaging equipment. It would be difficult to run a highly efficient orthopaedic office without X-ray in-house. Ultimately the most expensive resource in a medical practice is the physician. Maximizing physician efficiency should always be a high priority and imaging is an important element. Prompt, easy access to advanced imaging services such as Magnetic Resonance Imaging (MRI) can help improve patient satisfaction. If competing MRI providers have a waiting list that delays care by even a few days, this can be a strong negotiating point in contracting, especially for Workers' Compensation carriers that are very sensitive to lost time at work.

Several expenses are associated with imaging services and must be evaluated when making the decision to add or upgrade services offered in your office. Imaging equipment often requires a significant up-front capital outlay that can range from tens of thousands of dollars to well over a million. Therefore it is important that a practice exercise due diligence in performing a cost/return and cost/benefit analysis of the service line. Capital decisions of this magnitude generally require evaluation of purchase/lease options as well as tax and cash flow implications in both the short and long term. Note, however, that in many cases equipment can be acquired in the second hand market.

In addition to the cost of the equipment, most practices opt for after-warranty service and maintenance contracts to ensure access to quick support and upgrades. The costs of such contracts are often 8% - 12% of the original purchase

price of the equipment. These expenses are sometimes overlooked because they are not incurred until the warranty period ends. In some cases you can negotiate a discount if you include extended support at the time of purchase. If you opt to go this route, make sure that the contract states that you can cancel the service and maintenance contract if the equipment is removed from service.

Although there may be some variation from state to state, offering imaging services generally requires employment of certified staff (American Registry of Radiologic Technologists – ARRT). ARRT-certified employees are among the most expensive hourly staff employed by an orthopaedic practice.

Numerous websites including www.payscale.com and www.mysalary.com estimate the average salary for a basic X-ray tech to be between \$20 - \$25 per hour – plus benefits which (depending on the practice) can run up to 30% of the person's salary. Technologists with advanced training or additional supervisory duties can be significantly higher (salaries vary significantly by locale, so these numbers should be used only as a general guideline).

Site preparation expenses and space requirements must also be factored into the costs of imaging services. The extent and cost of site preparation can vary significantly from service line to service line. In many cases professional engineering, architectural, and physicist services must be contracted to design, oversee, and certify the room(s) involved.

When evaluating the cost of space, it is important not to just look at square-foot occupancy expenses, but also at the opportunity costs involved in foregoing alternative services that might be offered in the same space. This is especially important when the ability to expand your office site is limited.

As more imaging services become fully digital, the cost of supplies related to imaging services has decreased dramatically. However, in offices still using wet film technology for X-ray, the costs of film and processing chemicals are significant.

Depending on your state, a Certificate of Need (CON) may be required before you can offer certain imaging services in your office. The following website can be useful in determining whether or not a CON is required for the type of imaging you are considering:

<http://www.ncsl.org/IssuesResearch/Health/CON-CertificateofNeedStateLaws/tabid/14373/Default.aspx#Regulated>.

Currently 20 states and the District of Columbia require a CON for MRI. The level of difficulty in obtaining a CON varies by state. In some states the consultant, attorney, and application fees can reach \$150,000 or more. The time from initiation of the CON process to opening an advanced imaging service could take up to two years.

In the past few years Medicare, Medicaid and commer-

cial insurance carriers have recognized that imaging is one of the fastest growing categories of cost. Cost containment measures have been put in place to help slow this growth. Physicians should anticipate that this trend is likely to continue or even accelerate. A few years ago Medicare capped imaging reimbursement to the lesser of the Medicare Physician Fee Schedule (MPFS or PFS) or the Outpatient Prospective Payment Schedule (OPPS) rate.

In recent years Medicare instituted reductions in reimbursement for contiguous body part imaging. In 2011 MRI reimbursement is scheduled to decline as a result of practice expense adjustments based on the hours a typical MRI is assumed to be in operation.

A few commercial carriers are requiring that practices acquire certification if advanced imaging is offered in the office. The costs associated with obtaining and maintaining certification generally run in the tens of thousands of dollars. In some markets, the commercial carriers direct subscribers to “preferred” imaging centers and will not pay for (or they impose a higher deductible on) imaging performed in the physicians’ office. Knowledge of payer rules is important in assessing the potential profitability of imaging services.

X-ray

There are large capital costs associated with X-ray. An X-ray room (including X-ray unit, table, wall buckies, and miscellaneous positioning devices can easily run \$50,000 to \$300,000 depending on the type of equipment you are purchasing. The lower-cost systems are usually lower generator systems. Such systems are not well suited to future upgrades to CR (generally CR requires at least a 65Kw generator) and require higher X-ray dosing with dense anatomy (large patient). 65Kw systems will generally start at about \$85,000. The space itself must meet stringent safety standards. Walls must be lead lined and in many cases special support structures for overhead gantries are necessary.

Despite the cost, X-ray services have been considered necessary in most private practice orthopaedic offices for a long time. The real question regarding X-ray is if/when to upgrade to digital format imaging. Digital imaging offers several benefits, with quick access being one of the biggest. The physician in the office can often view the X-ray before the patient even gets back to the exam room. Digital imaging also provides physicians with the ability to view X-rays from home or a remote location without carrying film. This can be very helpful to an on-call doctor or a surgeon who wants to review images the night before surgery.

Digital imaging does not require film and chemicals, so there will be some savings on these variable costs. There are two types of digital imaging equipment. “Computed radiography” (CR) units require use of plates/cassettes that

have to be replaced periodically. The cost of plates can be from \$1,000 to \$3,000 depending on the size of the plate. Direct radiography (DR) units do not have any of these costs. However, the up-front costs of DR units are, at present at least, considerably greater than for CR units.

A key component of digital X-ray is the Picture Archive and Communication System (PACS) which stores and transfers images for reading. PAC systems often cost more than the X-ray machine and generally require ongoing service and support contracts. In addition to the basic unit, you also need diagnostic reading stations in enough locations to insure physician efficiency. (Stations must comply with the HIPAA Privacy regulations.) Choosing the right PACS is a highly important decision that should be made after considerable research, site visits, and negotiations.

Detailed discussion of the pros and cons of CR versus DR X-ray systems, as well as various PACS products, is beyond the scope of this *Primer*. The Practice Management Committee, however, has developed a *Primer* focused specifically on PAC Systems. Electronic copies of the *Primer* are available on the AAOS on-line Practice Management Center (www.aaos.org/pracman). For more information about the Practice Management Center, see # 10 in the Ten Top Tips Appendix.

X-ray Image Intensifier (C-arm)

While physiatrists were fairly uncommon in orthopaedic offices just a decade ago, a large number of groups have added this specialty. See Chapter 2: Non-surgical Physicians. Orthopaedic spine surgeons and interventional physiatrists often provide in-office, pain management spine injections. Needle guidance for these injections is generally considered the standard of care. Through 2009 practices were generally able to bill a separate technical component fee for the use of a C-arm for needle guidance. In 2010 Medicare began bundling payment for the C-arm with some of the injection codes. In 2011 Medicare intends to bundle technical component payments for the majority of spine injections.

Despite the decreased revenue from payment bundling, total reimbursement for interventional spine pain management remains a highly profitable service for most practices. The payback on the cost of the C-Arm (\$80,000 - \$120,000) is less than a year for a fairly busy spine pain practice. However, practices should be aware that the high cost of injections is on the CMS radar, and these codes may face increased scrutiny for reductions in coming years.

[Additional perspective by Thomas Grogan, MD, PMC Committee Chair: One encouraging area of imaging is the development of the “mini” C-arm (such as the Fluoroscanner) unit for use in the office. The mini C-arm is capable of taking both static images as well as fluoroscopic views. Hand and pediatric orthopedic surgeons have found use of

the machine both cost efficient and patient-friendly. Since no technician is needed to run the machine, the cost of an image is almost zero. The initial investment can be a factor (new machines cost around \$60,000); however the machines last a long time and can generate significant positive cash flow. If the cost of the machine is amortized over 5 years, the cost including a maintenance contract is around \$1,500 per month. If there are 22 business days a month and the doctor generates on average \$70 per study, the break-even number of studies is about one per day. After that, the machine generates positive cash flow with every patient. One interesting feature of the fluoroscopy component of the system is that Medicare pays an added amount for fluoroscopy (code 76000) of \$89 per study. Thus, the fluoroscopy feature of the mini C-arm is not only a useful clinical tool (to demonstrate stability of fractures or further define ligament instability), it also generates a not insubstantial amount of revenue (the added \$89 per study). For many offices, the decision to acquire and use the machine will therefore be an easy one.]

MRI

MRIs are scanning machines that use strong magnets rather than X-rays. An MRI is probably the most expensive capital purchase that a practice will make other than real estate. A new 1.5 tesla whole body scanner can run from \$600,000 to \$1,500,000 depending on bore size and other features. A new extremity scanner can be \$200,000 – \$650,000 depending on tesla strength and features. Second hand equipment may cost significantly less. Facility upgrades for MRI include radio frequency (RF) shielding, enhanced fire suppression systems, specific power requirements, and an emergency cooling system. MRI techs generally command a higher salary than X-ray techs.

Because of the high fixed cost of any MRI, it is vitally important that volume and reimbursement estimates are as accurate as possible to determine whether or not the machine will be profitable in your situation. Insurance carriers vary significantly in terms of their reimbursement rules, taking into consideration factors such as tesla strength of the magnet to whether or not the machine has been certified by the appropriate entity.

Generally speaking though, if your historic MRI referrals have been mostly for extremity studies, the cost/return ratio may be better on an extremity machine. However, if your practice includes a lot of spine and hip studies (at least ½ of the total scan volume), a full body scanner is probably necessary and will also be more profitable than an extremity scanner.

Many practices choose to utilize the services of a consultant to help take the risk out of the MRI purchase decision. The consultant can assist in performing a breakeven analysis and help determine the best type of machine for

your needs. Most will participate in writing a Request for Proposal (RFP), reviewing specifications provided by vendors, and negotiating with vendors.

If you cannot afford to purchase an MRI, you may wish to consider a lease arrangement. However, regulations on leasing arrangements have been tightened in recent years and this trend is likely to continue in the future. Consultation with a healthcare attorney is recommended. For more information about leasing vs. purchase, see # 5 in the Ten Top Tips Appendix.

DEXA

Bone densitometry testing for patients at risk for osteoporosis is recommended by the AAOS. Generally orthopaedic offices that have DEXA machines do so for patient care reasons and not because DEXA is highly profitable. Medicare and most commercial payers drastically cut reimbursement for DEXA as a result of the Deficit Reduction Act of 2006. Current reimbursement in most locations is less than half of what it was in that year. That said, it is often possible to find used DEXA equipment at a relatively low price.

Many orthopaedic offices have little interest in managing the patients who are diagnosed with osteoporosis and therefore consider DEXA more appropriate for a family practice setting. Some, however, view DEXA scanning as a service that rounds out their array of musculoskeletal services. See Chapter 12: Social Media Marketing.

Ultrasound

Ultrasound in an orthopaedic office is a fairly recent phenomenon and was driven at least partially by Platelet

Rich Plasma (PRP) therapy. Ultrasound for guided needle placement is often reimbursable. As the emphasis for providing quality care increases, procedures under ultrasound may become a standard of care, especially when they are performed by mid-level providers in connection with injections.

Ultrasound also has diagnostic capabilities and can be useful for physicians who do not have space for MRI and do not want to have patients wait for imaging. Finally, with the increase in high deductible insurance plans, there is an increasing number of patients who are unwilling to have an MRI for financial reasons.

Ultrasound machine prices vary widely depending on features and accessories. New ultrasound equipment that is appropriate for orthopaedic offices will generally cost between \$30,000 to \$50,000. As with MRI, accurate estimates of volume and reimbursement are critical to profitability.

Final Thoughts

For orthopaedists, the history and physical has long been key to the successful diagnosis of patients with musculoskeletal patients. Traditional film X-rays provided them an additional diagnostic tool. Imaging technology continues to evolve, allowing orthopaedists to diagnose diseases, disorders and conditions more quickly and with even greater accuracy. The result is a win-win situation for patients and doctors alike.

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Section 3

The Hospital

Chapter 7

On-Call Compensation

By Aleksandar Curcin, M.D., M.B.A.

Why Has On-call Compensation Become an Issue?

From the perspective of physicians trained in the “old guard” (and I am a proud card-carrying member of that group), taking call was simply a rite of passage. We all had that responsibility ingrained in us from the beginning of our third year in medical school, when we started our clinical rotations. Quite frankly in that context taking call, initially at least, was sort of fun and exciting. For the most part we were young and energetic and accustomed to long hours and sleep deprivation. We never knew what next fascinating case or medical problem we would encounter. At times being on-call was downright entertaining as evidenced by the post-call stories of some of the more “colorful” patients that may have paraded through the Emergency Department (ED). In summary, being on-call in the context of medical school and residency was akin to being part of a fraternity or sorority.

Once we completed our graduate medical training (GMT), call took on an entirely different meaning for many of us. In addition to “helping out” our partners, taking call meant a more rapid exposure to the community and expansion of our referral base. Basically, taking call meant patients came to us that we didn’t necessarily have to recruit. In many practices the more a physician took call, the more quickly his or her practice and income grew. Several parameters have changed, however, that have brought about substantial resistance and outright dislike for what the “old guard” considered part of “being a doctor.” The changes that occurred can be classified into three categories: financial, regulatory, and social.

Financial: In 1992, the government implemented the Resource Based Relative Value Scale (RBRVS) system, which drastically changed the way physicians were reimbursed. The downward spiral in physician payments seems to intensify with each passing year. It is easy to understand from a purely dollars and cents basis the reluctance of current-day physicians to take call under these circumstances. What our predecessors collected for getting out of bed at 2:00 am and going to the ED to set a fracture is a far cry from what

today’s physician receives on a current dollar value basis. Furthermore, it is an unfortunate reality now that many of our society’s uninsured patients utilize the Emergency Department as their resource for primary care. Once that patient is seen by the orthopaedic surgeon in the emergency room, despite their ability or inability to pay for their medical care, their follow-up care and associated cost (at least to an extent) becomes our responsibility as well.

Regulatory: In 2003, the Accreditation Council of Graduate Medical Education (ACGME) made significant changes in the medical postgraduate training policies, including the 80 duty hours per week regulation. This rule, while well intended, set into motion a cascade of behavior changes. One of those included the ability for young doctors to say, “No.” In the “old guard” regime, refusing to take call or stay late to see one more case was essentially taboo and bordered on career suicide. With the new regulations, however, a new breed of doctor began to emerge, a doctor who suddenly answered to a new authority which empowered him/her to say, “No” to a variety of things, including automatically accepting the responsibility of taking call. [Note: in fact, another significant regulatory change had already taken place in 1986 with the enactment of the Emergency Medical Treatment and Active Labor Act (EMTALA). A detailed discussion of this statute and its updates and revisions is beyond the scope of this chapter; however, it is relevant to note that this law places a substantial burden of responsibility on any physician participating in a hospital on-call schedule. See www.aaos.org.]

Social: From a social perspective, taking call brings with it the unpredictability of managing personal and family schedules. The fabric and composition of the medical workforce has changed substantially over the past twenty-five years. Along with that change has come a greater expectation for a physician’s private time to be protected. For the “old guard,” missing a soccer game or dance performance was a badge of toughness; for today’s breed of doctor, doing that on a routine basis is simply unacceptable. As a result, taking part in the on-call schedule becomes even more onerous. Lastly, and this too is a social phenomenon, society in general (and patients in particular) have become increasingly litigious. This also impacts physicians’ willingness to take call. Our generally litigious society – combined with the reality that hospitals often have limited resources and some physicians have a limited sense of personal

responsibility – sets up a perfect scenario for a professional liability lawsuit.

How is the problem being resolved around the country?

The “old guard” mentality stipulated that taking call was a responsibility, a foregone conclusion. However, as we have established, there are many factors that lead current-day physicians to reject that premise. Hospitals, on the other hand face a dilemma: they must ensure, as a result of a variety of factors, that they have an appropriate complement of physicians/specialists available on-call. As a result, many have found it necessary to “compel” physicians to participate in the call schedule.

Frequently, hospital by-laws require a physician on the medical staff to participate in his or her department’s call schedule. That “stick” approach, however, seems to be diminishing. According to a recent California Orthopaedic Association (COA) study, in 2010, just 56% of surgeons surveyed were required to take ED call as opposed to 75% responding to a 2004 survey. Interestingly, 44% of respondents in that survey reported that by-laws existed in their institutions exempting physicians from taking call after the physician reaches a defined age threshold.

Hospitals seem to have accepted the reality that they need to implement a “carrot” approach to guaranteeing that the ED will have sufficient on-call coverage. In a 2007 report, the Medical Group Management Association (MGMA) found that nationally 26.7% of practices were receiving compensation from their hospital to cover call. In the 2010 COA study, 72% of physicians were receiving compensation for taking call (up from 26% in 2000).

The methodology by which compensation is implemented varies considerably. The most frequently reported options include a flat payment for taking a defined segment of call, regardless of whether or not a physician must come in to provide care. Some institutions have a stratified system that additionally compensates for each instance that a physician actually does come in to see a patient in the ED. Higher payments for taking weekend and holiday call are also common.

Many hospitals have resisted the “blank check” approach of paying for physicians to simply take call. In many ways this is understandable. Frequently the CEO/CFO dislikes the concept of paying a doctor and potentially getting nothing in return in terms of procedures or hospital admissions. Secondly, the fear of an “entitlement mentality” developing on doctors’ part worries many hospital administrators; they worry that once a precedent is established, it will be very difficult to reverse. In response to these concerns, some institutions have adopted a system whereby physicians are paid for the cases that they take care of while on call. Typically, this applies to uncompensated/uninsured

patients. In the COA survey, 33% of respondents reported that their hospital guarantees payment for uninsured patients.

The MGMA publishes a report entitled “*Medical Directorship and On-Call Compensation Survey*” on an annual basis. The 2010 Report (based on 2009 data) is currently available for purchase. The report provides a wealth of information, including detailed descriptions of the types and rates of compensation arrangements based on specialty and geographic region. [Note: AAOS cannot advise members regarding precise compensation amounts of any kind, including compensation for on-call.]

Case Study: A Three-pronged Solution

The orthopaedists at “Silver Star Community Hospital” (renamed to protect the innocent) had been trying unsuccessfully to convince the hospital that compensation for on-call coverage was appropriate and necessary. Needless to say, the relationship between the doctors and the hospital became increasingly strained. For a long time the hospital was able to exercise the power of the by-laws and require that an orthopaedic surgeon be available on-call, satisfying trauma center requirements.

However, as the newly appointed CEO studied the situation, and took into consideration national trends on this topic, he quickly realized that a new approach was necessary. Various options, described above in the “How is the problem being resolved” section, were considered. For the most part, the surgeons were keenly interested in a daily stipend for taking call; however that option was the least appealing to the hospital administration. A key component in the ultimate solution was the willingness of physician leadership and the hospital CEO to remain open to discussion of alternative arrangements. The resolution that became a “win-win” for both sides included the following:

1. The hospital established a system to be the insurer of last resort for uninsured patients. The current year CMS conversion factor was the accepted standard. This ensured that physicians who took care of uninsured patients while on mandatory call rotation, weren’t effectively also paying for the privilege of being on-call out of their own pockets.
2. The hospital hired a Physician Assistant (PA) dedicated to the Orthopaedics Department. The PA’s primary responsibility was to assist with the care of uninsured patients including staffing a hospital-based fracture clinic for ER follow-ups. This immediately relieved the burden on the PAs who worked for the individual surgeons and who were previously providing such services for free (i.e., at the expense of their employing physicians).
3. Last, the hospital agreed to a daily stipend for call

coverage on specified holidays. While this did not meet physicians' desire for a daily stipend, it at least provided some recognition for covering call above and beyond the routine basis.

Summary

In conclusion, payment for call coverage is the new reality and has become the norm across the nation. There are several important resources that have been identified above, which can help you benchmark what your practice can expect in terms of payment amounts and methodology. It is critically important to keep an open mind and an open dialogue as these negotiations evolve between the hospital and the physicians. Sometimes a multi-pronged approach may be the best possible outcome for all parties.

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Chapter 8 Physician-Hospital Joint Ventures

By Frederick N. Meyer, MD

Overview

Joint ventures (JVs) between physicians and hospitals can take many forms, including not just ASCs (See Chapter 5: Ambulatory Surgery Centers), but also independent diagnostic testing facilities (IDTFs), specialty centers (e.g., hand, shoulder, etc.), a satellite UCC, and so forth. Physicians and hospitals may also invest jointly in equipment leasing and real estate ventures, although those are not the focus of this chapter. The typical "clinical" joint venture consists of an outpatient facility that offers the technical component of health care services. These businesses typically offer services that generate a technical and/or facility fee that is billed to payers. Physicians are credentialed to perform services at the facility - - - but credentialing is not necessarily limited to investors.

JVs can present physicians with an opportunity to supplement practice income and offset the negative financial impact of decreasing reimbursement and increasing overhead. One of the biggest stumbling blocks to physician-hospital joint ventures (and this is the case regardless of what the business is) is the traditional lack of trust that may exist between the parties. This must be overcome or the venture will not be successful. Further, there needs to be a sharing of risk and reward that, even if this is not precisely "even," is at least "acceptable" to the various stakeholders.

Another stumbling block is the regulatory environment. Clinical JVs were once very common. Then, the Stark laws were passed and enforcement of federal anti-kickback rules became more rigorous; consequently, many clinical joint

ventures were sold off to third parties or discontinued. Recently, rules defining joint venture safe harbors and clarification of the Office of Inspector General's (OIG) position on joint ventures have resulted in a renewed interest in this business model. These safe harbors notwithstanding, Congress and the Centers for Medicare and Medicaid Services (CMS) have recently begun a major effort to restrict physician-hospital joint ventures. Their basis for doing so is that JVs have been identified as potential areas of fraud and abuse. Therefore all joint ventures need to be implemented with sound legal advice. Bear in mind that in addition to the federal Stark and anti-kickback laws, many states have enacted their own statutes. See below.

The "bottom line:" when designed and structured properly, physician-hospital JVs can improve patient care and physicians' net incomes. However, ventures that are designed and structured improperly can lead to poor financial results, hard feelings between participants and disrepute in the community.

Advantages of Physician Hospital Joint Ventures

• Advantages for the Hospital

Hospitals are often concerned that they will lose their ancillary revenues to competitive physician ventures. It may be better for hospitals to joint venture with physicians and keep part of these revenues than do nothing and lose all of them. By partnering with physicians, hospitals may be able to share a substantial portion of the cost of capital expenditures with investing physicians. In addition, hospitals may be able to set conditions on the partnership such as resolving concerns about "cherry-picking," a practice whereby some physicians refer better paying, high margin patients to their own facility while sending lower paying, lower margin patients to the hospital.

Partnering with physicians can create new and improved relationships which can contribute to (a) inpatient and outpatient market expansion, enhanced working relationships between the hospital and physicians; (b) increased awareness of physicians about cost management and efficiency; (c) increased physician loyalty; (d) a strong governance/organization structure; and (e) a coordinated approach to serving the needs of the community. All this can be a valuable tool for the hospital to recruit new physicians to the community.

Note: focusing specifically on ASCs for a moment, the federal government has been regularly increasing reimbursement to Ambulatory Surgery Centers while decreasing reimbursement to hospital-based units. Third party payers are demanding greater efficiency and are showing a greater willingness to contract with freestanding ASCs for fees below those of the hospital. In addition, other competitors including hospital and health care conglomerates are buying ASC companies and developing ASCs to grow their

share of the market. Thus, hospitals should realize that partnering with physicians gives them a competitive advantage with third party payers and stops the proliferation of freestanding, physician, and or conglomerate-owned ASCs.

• **Advantages for Physicians**

Partnering with hospitals also has many advantages for physicians. Partnering allows access to payer contracting support while ensuring their hospitals' viability. (Few practicing orthopaedic surgeons, after all, can maintain a financially viable practice without a hospital for inpatient surgery.) In addition, partnerships limit market threats while allowing access to capital. By partnering with the hospital, physicians share risk but are able to leverage hospital assets with vendors, banks, etc. Finally, joint ventures enhance working relationships with the hospital while serving the surgical needs of the community.

By helping orthopaedic surgeons increase their income, hospitals improve a practice's ability to recruit and retain physicians. Further, third party payers often desire to enter into global contracts with hospitals for delivery of care. As a result, a partnership with the hospital can result in the physician having increased access to managed care contracts, as well as the ability to develop a relationship with a strategic partner to (a) capture greater market share and (b) deliver lower cost, high quality care.

The Planning Process

As is often the case with business arrangements, commitment and common sense are paramount. Partners need to commit to develop and review their organizations' policies on joint ventures. Physicians and the hospital need to identify a joint work group to consider the issues involved. This group needs to develop standard policies for the formation of the joint venture. It is imperative that this group consider both the hospital's and the physicians' circumstances and needs as well as their past experience. Negative past experiences need to be discussed and worked through.

Formation of a new entity often requires approval from the hospital board. With physicians as co-investors in a JV, the hospital will have more at risk than just its capital investment. If the venture fails, it may jeopardize the good will of the medical staff. A board-adopted policy along with a set of principles to guide hospital participation can help maximize the benefits of joint ventures while minimizing the risk. Finally, it is critical that partners obtain appropriate legal and business advice to ensure that policies developed meet complex federal and state legal and business requirements.

When physicians and hospitals develop a joint venture, they need to work together to address a number of critical issues.

- The parties need to agree on precisely what the business activity will be (as well as what it will be limited to). The hospital in particular needs to decide if it is willing to put services that are currently wholly-owned (e.g., an existing ASC) into the joint venture and if so, under what circumstances?
- Joint ventures are typically implemented to generate positive cash flow, so the next questions that need to be resolved are (a) Is the business model fundamentally sound; (b) Are the forecasted financials realistic (see the Feasibility Analysis section below); and (c) What do the various stakeholders expect in return for their investment? *Never forget: no investment vehicle (that is, way of investing money) will make a bad business venture into a good one.*
- Ownership and control need to be agreed upon at the outset, before any agreement is executed. Will the hospital accept less than 51% ownership and if so under what circumstances? Both the hospital and the physicians need to be aware that if not carefully structured, revenue generated by the joint venture can put the hospital's tax-exempt status at risk. Partners also need to decide if control will reflect the ownership percentages. Risk of loss of tax-exempt status to the hospital can be minimized if it retains control of the venture by having a majority representation on the board of the venture. The downside of that *modus operandi*, of course, is that physicians' may not have as much influence in decision-making as they would like.
- It is important to determine in advance who will be allowed to participate in the venture. Will all physicians on the medical staff be allowed to invest? How about new physicians who join the staff after the JV is formed? How about non-physicians, e.g., for-profit firms such as management companies (regulations permitting)? The hospital might want to limit types of investors to minimize the risk of violating anti-kickback laws, securities laws or Stark laws. [ASC note: primary care or other physicians who would not use the facility themselves – but who would be incentivized to refer patients to physicians who do – should not be offered investment interests in the venture as this could compromise the ASC's anti-kickback safe harbor; see below.]
- Participants in a joint venture must decide in advance what reserved powers and guarantees will be given. For example, a Catholic hospital could be required to ensure compliance with religious and ethical directives for Catholic Health Care Services. The hospital or the physicians could be prohibited from entering into competing ventures. Physicians may want to retain control over clinical standards.

- Partners must recognize that the venture may be subject to public scrutiny. Therefore they need to ask themselves if it would be embarrassing if the press, the government, or non-investing physicians were to learn of the details of the joint venture. Would moving forward put the organization in legal jeopardy? In other words, would the joint venture pass a “straight face” test?
- If the venture were to fail, it may have to be “unwound.” Defining the exit terms in advance makes it easier for investors down the road. It is important to realize that in many instances the hospital will be unwilling or unable to bail out physician investors.
- Participants must agree to how they are going to assign a value to the assets. This is particularly critical if the venture does need to “unwind” (see above). It is best if participants deal with each other on an “arm’s-length” basis using an objective third-party valuation of assets. While this arrangement may add some additional expense, it protects all parties under both the Medicare laws and the Internal Revenue (IRS) Code.
- A project implementation timeline must be established. See # 9 in the Top Ten Tops Appendix.

Organizational Structure

Joint ventures are often structured as limited liability companies (LLC). This has several advantages. First, the physician investor avoids double taxation; and second, it limits personal liability. Some physicians may choose to invest personally while others may invest through an entity specifically created for the purpose of investing in the joint venture. As has been stated above, however, before any final decision is made, it is wise to seek advice from competent legal and accounting counsel who are (a) familiar with federal and state laws governing JVs and (b) the specific JV being considered.

Feasibility Analysis

Before proceeding with any JV – from an ASC to a shopping center – potential partners should perform a feasibility analysis. *Pro formas* should be developed that relate specifically to the nature of the venture. In the case of an ASC, for example, it is important to determine what the volume will be as well as whether public and private payers will reimburse for care provided to patients who receive care at the ASC. (In the case of a shopping center, it is crucial to consider occupancy rate as well as per square foot rent; etc.; these will vary depending on the local economy and what other similar space is available nearby.) In addition to revenues, the *pro formas* should identify all appropriate expenses which will (again) vary depending on the venture. Expenses include but are not limited to staff salaries and benefits, occupancy, insurance of all kinds,

medical/surgical supplies, billing and collection costs, marketing, janitorial and maintenance, etc. In addition to the revenue and expense budget, there should also be a capital budget and an statement of sources and uses of funds.

Reimbursement Issues

The Medicare reimbursement consequences of any proposed venture where patient care is rendered should be carefully analyzed. If the venture is an Ambulatory Surgery Center, it should be certified by CMS and is required to comply with 42 C.F.R. Part 416 (Medicare regulations applicable to ASCs).

Again, see Chapter 5, which focuses very specifically on Ambulatory Surgery Centers.

A Summary of Stark Laws: You Need to Know This

The Stark laws prohibit a physician from making Medicare and Medicaid referrals for “designated health services” (DHS) if the physician or an immediate family member has a financial relationship with the entity providing the service. These services include clinical laboratory services, radiology services, radiation therapy services and supplies, durable medical equipment, prosthetics, orthotics, home health services, outpatient prescription drugs and inpatient and outpatient hospital services. There are numerous “exceptions” to the Stark laws. One relates to physicians making DHS referrals within a group practice (this would *not* typically be the case with a physician-hospital JV). Another exception is if 75% or greater of the entity’s services are supplied in a rural area. (In 2009, however, the Senate Finance Committee proposed eliminating this exception.) A third exception is for services furnished in an ASC as long as payment for those services is included in the payment rate. A similar regulation applies to clinical laboratory services.

The Stark laws are *civil* statutes; that is to say, persons who are determined to have violated the laws are not subject to imprisonment. However, they are subject to denial of payments, mandated refunding of payments made in error, monetary penalties ranging from \$15,000 to \$100,000, and exclusion from participation in Federal programs.

Readers are strongly encouraged to seek competent legal counsel to understand the complex issues associated with the Stark laws as they relate to physician hospital joint ventures.

Summary of Anti-kickback Statute and Safe Harbors: You Need to Know This Too

The anti-kickback statute prohibits “the knowing and willful solicitation, receipt, offer, or payment of any remuneration directly or indirectly, in cash or in kind, to any person in return for referring or inducing to refer, an

individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment will be made in whole or in part under government programs including, Medicare, Medicaid, TriCare and CHAMPUS.” Distributions made in connection with any physician hospital joint venture *must not* be disguised remunerations for referrals.

Anti-kickback is a *criminal* statute. A violation of the law is a felony offense that carries criminal fines of up to \$25,000 per violation, imprisonment for up to five years and exclusion from government health care programs. The statute currently has 23 “safe harbors.” (Note: these are not the same thing as the Stark “exceptions.”) Safe harbors protect people who have entered into specified arrangements covered by the statute from criminal and civil prosecution. To be fully protected by a safe harbor, an arrangement must fit squarely into the safe harbor. Failure to comply with a safe harbor provision, however, does not mean that an arrangement is illegal.

Note relating to physician hospital ASC joint ventures: the Office of the Inspector General (“OIG”) of Health and Human Services (HHS) released Advisory Opinion 98-12 on September 23, 1998. In that opinion the OIG indicated that it would not take action against an ASC facility even if the requisite intent was to induce referrals. The OIG concluded ASCs are less expensive than hospital inpatient surgery facilities and offer a setting that is preferred by many patients.

The OIG proposed a safe harbor to protect surgeons who, as an extension of their personal office practice, routinely perform procedures in ASCs in which they have an investment interest. Legitimate reasons for surgeons to perform services in an ASC in which they have an investment interest include personal and patient convenience, professional autonomy, accountability, and quality control. However, Advisory Opinion 98-12 is conditioned on each of the participating physicians generating at least one-third of their total medical practice income from performing ASC procedures. Physician investors need to provide patients with a written disclosure of their ownership in the ASC.

In 1999 the OIG finalized the ASC safe harbor that protects physician-hospital ASC joint ventures. Because this safe harbor is tailored to ASCs, many joint ventures offering non-surgical services are ineligible for protection under this safe harbor.

Readers are strongly encouraged to seek competent legal counsel to understand the complex issues associated with the anti-kickback statute and the associated safe harbors as they relate to physician hospital joint ventures.

State Regulations

In addition to the federal regulations, readers should bear

in mind that individual states may have laws that need to be taken into consideration. These include “Certificate of Need” requirements, state licensing standards, state self-referral, kickback, or fee-splitting prohibitions, and state securities laws.

Other Considerations relating to Distribution of Joint Venture Revenues

CMS issued a ruling that took effect on October 1, 2009 eliminating the “per procedure” (per click) and percentage-based reimbursement on equipment and rental space. Also, in January 2009 a revision to the anti-markup rule took effect which prohibits physicians from marking up charges for the technical or professional components of Part B diagnostic tests purchased from a third party unless the test are performed in the same building as the billing physician.

In July 2008, CMS issued a proposed exception to the Stark Law that would cover incentive payment programs also known as “pay-for-performance” and shared savings programs. Shared savings programs are commonly referred to as “gainsharing” arrangements. In “gainsharing” arrangements, the hospital contracts with a group of physicians to set targets for cost savings on the use of supplies and implants. The hospital then pays the physicians a portion of savings achieved. In a “pay-for-performance” arrangement the hospital pays physicians cash incentives for achieving objective, clearly defined, quality measures.

Regulations are always changing, however, so as stated above it is critical for physicians who are in a JV with a hospital (or who are contemplating entering into one) to retain legal counsel and conduct conferences with that individual on a regular basis. Alternative sources of information include AAOS Now and the Government Relations segment of the AAOS website (www.aaos.org.)

Take-away Messages

- Physician-hospital joint ventures are a way for orthopaedic surgeons to maintain their income while at the same time providing high-quality, lower-cost patient care.
- Generally speaking it is easier for physicians in larger groups to enter into JV arrangements with their hospitals.
- However, with careful planning it may be possible for solo practitioners and physicians in smaller group practices to do this as well.
- All physicians, whether they practice in one setting or many, must have a shared vision of what they collectively want to achieve, and this vision must be in sync with that of the hospital.
- Development of a successful joint venture requires

careful planning, creation of a realistic business plan and implementation of a good governance structure.

- JV arrangements need to be developed with great care to ensure compliance with government regulations.
- As far as compliance is concerned, the greater number of stakeholders, the more important it is to “dot all the I’s and cross all the T’s (and the more difficult this can become).
- The blueprint for the initiative must include a mechanism for addressing disagreements, since these are sure to arise over time.
- All JVs must include a mechanism for “unwinding” because times change and circumstances change (including federal and state regulations); nothing lasts forever.

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Chapter 9

Service Line Co-Management

By Craig Mahoney, MD

What Exactly Is Service Line Management?

In today’s healthcare environment, hospitals are realizing that they cannot be all things to all people. Given limited resources, it is not possible for them to provide a full range of high-quality medical services to everyone in the community in a cost-effective manner. They are increasingly focusing their human and capital resources on what are now referred to as “service lines.” A service line is a group of services that relates to the treatment of a set of diseases, disorders and/or conditions. Resources can be focused and coordinated around specific groups of patients.

Service line management (SLM) covers all the activities that go into overseeing a given service line. This includes (a) what clinical functions should be included, (b) requirements for physician and allied health staff, (c) requirements for equipment and space, and (d) back-office support activities; e.g., billing and collections.

The introduction of SLM to the healthcare field began in the early 1980s; the impetus was implementation of the prospective payment system (PPS). PPS resulted in a sea-change in terms of the way hospitals were paid. Patients admitted into the institutions had to be classified into “diagnosis related groups” or DRGs. DRG payments received from government agencies covered all the services to patients during their stay. Thus, management of costs became extremely important because reimbursement, except under unusual circumstances, was fixed.

By grouping related services together into service lines, hospitals were able to calculate total revenues and total

costs associated with the lines. This allowed them to decide which lines they wanted to focus on, at least from a financial standpoint. The approach is not dissimilar to Ford Motor Company looking at the profitability of one car model, for example, relative to another one, and making decisions regarding the models’ futures.

	A: High Profitability	B: Low Profitability
1. High Volume	A1	B1
2. Low Volume	A2	B2

Service lines can be classified as high volume-high profitability; high volume-low profitability; low volume-high profitability; and low volume-low profitability.

Each hospital needs to determine where the services it offers fall in the above grid. Orthopaedics and cardiology almost always fall into quadrant A1. Medical services typically fall into quadrant B2.

It makes economic sense to actively manage service lines in quadrant A1 because this will maximize cash flow for the institution as a whole. That in turns means that the additional cash can be allocated to other arenas. The old adage that “a hospital full of patients is always a profitable one” is not true if many of the patients suffer from conditions the institution cannot treat in a high-quality, cost-effective manner.

Note: focusing on service lines such as orthopaedics does not mean that other service lines should be ignored. For example, if a service is high volume-low profitability (B1), managers should be looking at ways to increase profitability, either by improving revenues or eliminating (unnecessary) costs. By the same token, if a service line is low volume-high profitability (A2), managers should be looking at ways to increase volume. If the hospital wishes to continue to offer low volume-low profitability services (B2), it is critical to move as many other service lines as possible into the A1 quadrant, and actively manage them. The more money a healthcare institution generates from high volume-high profitability services, the more it will be able to continue to serve the community in other arenas.

Advantages of Service Line Management

There are numerous advantages to service line management including:

- Coordination of care among related clinical areas translates to improved overall quality of care.
- Revenues and costs can be aligned to determine service line profitability.
- Traditionally independent “silos” (e.g., nursing, imaging, PT/OT) start working together.

- The hospital develops strategies for “targeted growth” as opposed to just “expense management.”
- Marketing can focus on specific service lines, rather than just, “We’re the best.”

The \$64,000 Question: What Role Can Orthopaedists Play in Co-managing Service Lines?

In the past, hospital executives were traditionally charged with overseeing the myriad services delivered in healthcare institutions. They came to the table equipped with a great deal of knowledge derived from their education, including finance, accounting, personnel management and so forth. Many however did not have clinical backgrounds that would enable them to understand the complexities of patient care. (Nursing was often an exception to this but, again, “nursing services” was typically a silo, independent of other silos.)

Hospitals are increasingly recognizing the value of asking physicians to help co-manage service lines because they do understand the complexities of patient care and have recently made great strides to improve their business acumen. The physicians receive payment in return for this assistance - - just like any other hospital executive. Conceptually, the arrangement is similar to using consultants or outside managers in private business. In that situation, the personnel are on specific projects. The consultants have a defined set of goals and are engaged for a predefined amount of time. They are paid based on time spent and/or goals achieved.

In the case of orthopaedics, the service line could (a) cover all musculoskeletal care provided in the institution or (b) focus on specific orthopaedic subspecialties such as adult hip and knee, spine, and/or trauma, where many of the operations associated with the care of patients are coordinated. *Doctors can be compensated in a variety of ways, including an hourly, case-based, or annual wage. They may also receive bonuses based on clinical outcomes, patient satisfaction, improved operating room efficiencies and/or overhead management, as stipulated by contracts.*

Why Is It Vitaly Important for Hospitals to Use Doctors in Service Line Management?

Hospitals have been asked by the Centers for Medicare and Medicaid Services (CMS) to launch focused initiatives to improve quality of care. In the future, it is likely that payment will be increasingly based on successful outcomes, and not on a specific diagnosis, regardless of what resources are allocated to treat that diagnosis. Physicians represent a logical partner to help the hospital improve quality of care delivered in the institution and thus maximize reimbursement that the institution receives. They can also help with cost management. Doctors can assume a variety of roles in service line management,

ranging from overseeing patient flow to establishing “med/surg” purchasing guidelines to setting up audit programs monitoring outcomes.

How Do Hospitals and Physicians Go about Defining “Orthopaedic Service Lines?”

Service lines can be defined in a number of different ways. One alternative relates to anatomic site or body system. This is easy in principle but can be confusing in practice since multiple medical specialties can work within the context of any given site or system. It can also complicate compensation arrangements if only one medical practice is engaged to manage a service line.

The use of diagnosis related groups (DRGs) refines the body system approach because they classify hospital cases into one of approximately 500 groups. This allows the hospital and the medical group to (a) come to closure regarding exactly what the service line will consist of from a clinical standpoint; (b) agree on what they jointly want to accomplish; and (c) decide how physicians should be recognized for their contributions. Physicians and the hospital also need to identify how results will be tracked.

The bottom line is that whatever the two parties ultimately decide constitutes the service line, is the service line. The line can involve some of the members of a medical section within a subspecialty in a given hospital system, or all of them. It can incorporate all associated ancillary services, or just some of them. And the line may or may not be linked, from a marketing perspective, with related lines.

Specific Benefits of Service Line Co-management

The “quality of care benefits” of including orthopaedic surgeons in service line management have already been mentioned above. Orthopaedists are in a good position to help out in this arena because they are very focused on the quality of the work they themselves perform both in the office and the hospital. Since outcomes in inpatient orthopaedic care also depend on actions of hospital staff, functionality of equipment, and so forth, they tend to pay a great deal of attention to “institutional issues” that may arise. After all, if there is a poor outcome, regardless of who may be at fault, a lawsuit is likely to name both the physician and the hospital.

Another benefit relates to expense management. In their own practice settings, orthopaedic surgeons are very aware of recent cost increases, including salaries, benefits, occupancy, and “med/surg” supplies. Many may be already working with their institutions on ways to trim unnecessary expenses in those institutions in such a way that quality is not compromised. As business owners (versus employees) they truly understand that a dollar saved translates directly to the bottom line.

When physicians are compensated by the institution for identifying ways of managing costs, they will seek to do so in any way possible without compromising care. This is a far cry from the traditional “pat on the back” way that doctors have been recognized by hospitals for their suggestions.

Requirements for Success: Leadership, Clear goals and Accountability

One requirement for successful service line co-management is identifying leaders on both the hospital and physician side. Both parties need to see value in the arrangement and the leaders will need to champion the cause moving forward. While there are many benefits, co-managing a service line will require an extra effort on both sides, especially during startup. Leaders need to sell the relationship as it gets off the ground and thereafter.

The leaders will also need to jointly decide what the goals of the arrangement are. Implementing strategies to achieve the goals is the job of the managers who are “in the trenches. Benchmarks must be established as a way to measure progress. The benchmarks that are developed need to be (a) tangible and (b) easy to measure. They should focus on outcomes and operational efficiency.

Holding both sides of the agreement accountable is critical both from a financial and a legal standpoint. The availability of data to track work effort and outcomes related to the service line allows physician managers to more readily identify operational problem areas (e.g., forgone revenue and unnecessarily high expenses). It also serves as a means of ensuring that hospitals are reimbursing the doctors correctly for time spent and goals achieved. Setting up periodic meetings between the two parties aids in monitoring progress and can also motivate both sides to unify their work efforts.

Note: tax-exempt hospitals must avoid entering into financial relationships with physicians that result in private inurement; that is to say, an impermissible private benefit. Any contract that is negotiated between the parties needs to be reviewed before it is executed. The agreement must be strictly adhered to. Records must be maintained regarding all aspects of the arrangement including time spent by physicians, goals, and compensation paid out, including base and incentive pay relating to the goals.

Measuring Results Requires Enhanced Reporting Capabilities

As stated above, there will be extra work involved in establishing a service line co-management arrangement. Some of what the physicians will be responsible for will fit into their existing work load. However, keeping track of the service line through (a) periodic meetings and (b) data acquisition and interpretation is a requirement. Both sides need to take ownership in the endeavor.

The information obtained must be made available not only by the parties involved, but legal and accounting counsel as well. The enhanced reporting is critical to the success of the undertaking.

A service line co-management agreement will be beneficial to both the hospital and the involved physician group. The hospital can potentially see improved efficiencies, decreased costs and enhanced outcomes when an interested physician group is involved. Physicians can also see benefits through a closer relationship with the hospital and the financial remuneration for work they may already be participating in. Given the current healthcare climate, one that demands improved outcomes and efficiencies, service line co-management is a great way to benefit both the hospital and the physician.

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Section 4

Other Income

Chapter 10

The Medical - Legal Practice

By G. Klaud Miller, MD

Introduction

The word “forensic” is defined as “characteristic of, or suitable for a court of law or public debate.” Because of the frequent involvement of orthopaedics in injuries, almost every orthopaedic surgeon has been involved in the medical-legal arena at one time or another. Forensic medicine is a broad term that includes such areas as personal injury, impairment (disability) evaluations, medical malpractice, expert witness, second opinions, fee disputes and independent medical examinations (IMEs). The AAOS feels that this is so important that it has dedicated a portion of the website to the expert witness program and has made an advisory statement outlining ethical principles of orthopaedic medical testimony (see www3.aaos.org/member/expwit/expertwitness.cfm).

The “Bad and the Ugly” Part of “the Good, the Bad and the Ugly”

Many surgeons by choice avoid contact with the legal profession or case managers at all costs, realizing it is a world with which they are not familiar. It is an area where lawyers have written the rules and doctors must comply. Lawyers or case managers in turn have rules and deadlines imposed upon them by the courts and administrative judges. For example, if you are asked to serve as an expert witness and cannot provide reports within established deadlines and according to established rules, you will not see any repeat requests.

Reports must be impeccably unbiased & scientific. Opinions must be based only on literature (“evidence”), not personal views. It is not sufficient to justify opinions based upon “That’s the way I’ve always done it.” Every report you write must be written as if you will be defending your opinions in court against an attorney, because this may well happen. If opinions contained in a report cannot be substantiated by scientific literature you will be (figuratively speaking of course) eviscerated.

Attorneys are trained to take what opposing witnesses say and turn the English language 180°. Your qualifications and opinions will be routinely attacked. (“How long ago did you train?” “When was the last time you performed

the procedure under discussion (i.e., CPT code 12345)?” “How many of these procedures have you done?” “Are you familiar with textbook ABC or a paper written by Dr. Jones?” And finally, a nearly universal question, “How much money are you being paid for your testimony?”) The opposing attorney may be condescending, argumentative or hostile, and will almost certainly actively try to make you feel confused, frustrated and angry. Through it all, you must remain calm and answer questions objectively. Medical-legal testimony has been described as a “full contact sport.” It is important for you to leave your ego at the door. An “I know because I’m the Doctor!” may play in Peoria, but not in front of a jury.

If It’s So Bad, Why Should I Want to Get Involved with This?

In today’s challenging economic environment, forensic medicine can be a significant financial addition. To a large extent, it is independent of the government, insurance companies, and medical politics. In fact, in my opinion, the biggest single factor in favor of such work is that you can largely “control your own destiny.”

The work is totally independent of insurance company fee schedules or IPAs or HMOs. Moreover, I also personally enjoy the intellectual challenge of, “There but for the grace of God go I,” or “What is the literature concerning procedure or disease X?” Even if you feel that you are already completely familiar with the literature on a given topic, it is amazing how much you can learn from searching the literature to make sure that you really are up-to-date. Think of every case as if you are preparing it for a grand rounds presentation in front of your professors. As stated above, you must be able to substantiate your opinions with *published* literature. I guarantee that you will learn something.

In addition, there is the intangible benefit of “experience” in the legal system. The reality is that every orthopaedic surgeon will be sued, perhaps several times, in the course of an orthopaedic career. You will likely be called to testify in your own defense. That is *not* the time to encounter the legal system for the first time! In reviewing records, you will also see how other orthopaedic surgeons document. Over the years, I have incorporated multiple forms and procedures that I have encountered during my reviews. Finally, while there are deadlines, for the most part, you can do this work at night or on weekends. You don’t have to adhere to an office schedule or deal with appointment cancellations.

Qualifications

As a minimum, you must be Board-eligible or Board-certified in orthopaedic surgery in order to testify in orthopaedic cases. However, just because you are Board-certified does not mean that you are qualified to testify in every case. If you do not perform spine surgery on a regular basis, you cannot testify on spine surgery or any other area which is not a part of your training and/or regular practice. Beyond your years of practice, a fellowship or an academic appointment, publications and presentations improve your value in the medical-legal process.

The American Board of Independent Medical Examiners (www.abime.org) was established with the intent of raising the level of knowledge and standards and providing a national mechanism of certification of physicians who have undergone additional training in impairment and disability evaluation *and* who have pledged to provide independent and unbiased evaluations. A candidate must (a) be in practice in the area of orthopaedic surgery, neurology, physiatry, neurosurgery, occupational medicine, or a “related field”; (b) take prescribed CME regarding impairment evaluations and the American Medical Association’s *Guide to the Evaluation of Functional Impairment*, and (c) take a Board examination. If the candidate passes, he or she becomes a Certified Independent Medical Examiner (CIME). ABIME runs multiple courses throughout the year regarding issues involved in case management, workers compensation, injury and impairment evaluations, the use of the Dictionary of Occupational Titles, national clinical algorithms for the treatment of various injuries, and of course, the *Guide* I made reference to above.

How Do I Get Started in Forensic Medicine?

It is actually more difficult to *avoid* medical-legal cases than to *participate*. By the very nature of orthopaedics, almost every orthopaedic surgeon will be involved in a second opinion, a personal injury, or with case managers for a variety of reasons. Even if you studiously attempt to avoid workers’ compensation cases, if you take emergency room call, you will become involved eventually. The easiest way is to treat case workers with respect and realize that they too, are just doing their job as a representative for the one who is paying the bills. Ask them what they need. Provide timely, detailed and accurate (evidence-based) reports. Make them aware that you are available for their clients. Eventually, some of these cases will be adjudicated and you will be involved with attorneys.

Provide the same high-quality services to the attorneys and make them aware that you are available for additional cases. Word of mouth is your best advertisement. However, there are numerous companies that provide attorneys with names of physicians who are willing to provide legal evaluations. Some services are free, some charge a fee. These include:

- The SEAK directory (www.seak.com)
- Corvel (www.corvel.com) Coventry (www.coventryhealthcare.com)
- Medical Communications Network (www.mcn.com)
- Evalumed (www.evalumed.com)
- Medical Evaluation Specialists (www.mesgroup.com)
- Concentra (www.concentra.com)
- Gallagher-Bassett (www.gallagherbassett.com).

Most of these companies are actively looking for interested physicians. There always seems to be a greater demand than willing physicians.

Finances: The “Good” Part of “the Good, the Bad and the Ugly”

Every attorney will ask the loaded question, “Doctor, how much are you being paid for your testimony?” The appropriate answer is, “I am being paid for my time away from my practice of orthopaedic surgery.” This is a simple statement of fact and avoids the pejorative impression that you are a “hired gun” who is willing to say anything for money. You are spending your time and sharing your hard-earned expertise; you deserve to be paid for this.

Certainly, the attorneys are not providing their services for free. *They* expect to be paid for their time and expertise and so should you. Obviously, there are physicians who do make their entire living testifying. However, for most reputable attorneys, you are not valuable unless you are a full-time practicing physician. In fact, this is a statutory requirement in many states.

While you can set your rates at whatever you feel your time is worth, you should remain within your community’s standards. A fair and defensible rate is based upon your yearly gross income divided by +/- 2000 hours (i.e., 40 hours times 50 weeks). The following is an example to clarify the preceding sentence, not a recommendation.

- If your gross yearly receipts are \$1,000,000, then your fee would be \$500/hour. Yes, you may appear to bill more than that for a single surgical procedure. However, that procedure involves preoperative time in the office, indirect operating room time (i.e., waiting time between cases), postoperative or office follow-up, and whatever paperwork that is associated with the surgical procedure that is included in the global payment.
- While an IME requires you to physically examine the patient in the office, all of the paperwork can be done on your schedule and still billed at an hourly rate. Because you are using office staff and resources and this does have medical legal risk, it is only fair that this activity contribute its share to your malpractice and other expenses. As an example, you might receive a total of \$1,500 for a total hip arthroplasty from Medicare.

- You could easily spend 3 hours in *toto* earning that surgical fee. A record review, examination, and report at \$500 per hour would probably generate exactly the same fee, most of which you could complete at home on an evening or weekend.

Summary

There is no need to perceive forensic medicine as “taking away from the regular practice of orthopaedic surgery.” In my opinion, it does not detract - - it actually complements and supplements my own clinical practice.

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Chapter 11 Real Estate

By Adam Soyer, DO

Introduction

Physicians typically rely on the practice of medicine to generate revenue. The fee-for-service model is the primary source of income for most of us and funds most investments. This type of income is finite and ends once we cease practicing medicine. Ideally, we would like to work less and make more, while having investments that generate revenue with little direct involvement.

Types of Income

There are several types of income. **Active** or “**linear**” income (in which time is traded for money) is income generated by direct involvement. Once the service is completed, the income ends. A subset of active income is **recurring** income. Recurring income is a regular, consistent source of income, such as a weekly nursing home consultation. Recurring income is stable but is limited in earning capacity since it is based on volume.

Passive income is income that does not require your direct involvement. There are two types of passive income: **residual** and **leveraged**. Residual income is income that occurs over time from work done once. In medicine, this could be from the sale of a book or royalties on surgical implants you may have designed. Leveraged income is income that leverages the work of other people to create income for you. For a physician, this could be ownership of ancillary services run by other professionals such as physical therapy.

Being familiar with the different types of income will give you a better idea of ways to generate additional revenue. Having multiple streams of income is the key to earning more and working less.

Utilizing your real estate investment via rent is a good way to start recognizing an additional source of income. Rental income is considered passive residual income. There

are several ways to make your real estate work for you, including space sharing, subleasing and real estate development.

Anti-Kickback Safe Harbor

When considering any financial venture that involves other physicians, it is imperative that the arrangement complies with the federal **Anti-kickback law**. The initial law adopted in 1972 is broad; it states basically that anyone who knowingly or willfully receives or pays anything of value to influence the referral of federal health care program business, including Medicare and Medicaid, can be held accountable for a felony. In 1987 the law was amended to include specific “**safe harbors**” for various payment and business practices that, while potentially prohibited by the law, would not be prosecuted. In 1991 and 1992, 13 regulatory safe harbors were established. In 1999, the number was expanded to 23 safe harbors.

Space Rental Safe Harbor

Space rental has a safe harbor. In section 1128B of the Federal Anti-kickback Act, “remuneration” does not include any payment made by a lessee to a lessor for the use of the premises as long as all of the following standards are met:

1. The lease agreement to set out in writing and signed by the parties.
2. The lease covers all of the premises leased between the parties for the term of the lease and specifies the premises covered by the lease.
3. If the lease is intended to provide the lessee with access to the premises for periodic intervals of time (rather than on a full-time basis) for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length and the exact rent for such intervals.
4. The term of the lease is not for less than one year;
5. The aggregate rental charge is (a) set in advance, (b) consistent with fair market value in arms-length transactions and is not determined a manner that takes into account the volume or the value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.

Any lease arrangement, whether it be space-sharing or a sublease, should be scrutinized. A well-written lease, which clearly identifies the space and its proposed use as well as a fair market value offering, is essential to compliance with the anti-kickback law. Referrals that are generated as a result of the lease arrangement should be well-documented and clinically appropriate. Consultation with a health professions attorney is recommended before any real estate venture is considered.

Space-sharing Arrangements

Whether you own or lease your real estate, having a good location is paramount to the success of a practice. Quality office space is desirable by all medical practices. Your space will therefore have value to another physician or medical group looking to expand to a satellite office.

Sharing your space with another physician or group of physicians has numerous advantages. First, the additional source of income will offset your own overhead. You will be able to justify additional staffing that previously may have been under-utilized. Second, sharing with a subspecialist within your field will be a good marketing tool for your own practice. In essence, you will be expanding your services with no investment. Third, sharing with a synergistic specialty, such as rheumatology or pain management will enable you to broaden the types of referrals you accept.

The terms of your space-sharing agreement will have to be approved by the lessor. In a small group, sharing space will improve utilization of idle office space and staff. Space-sharing arrangements may be made on a *per diem* basis, weekly, bimonthly, or monthly depending on need and availability.

Considerations in space sharing arrangements include:

1. Number of rooms to be shared (Calculate on square foot basis.)
2. Dedicated staff (Consider salaries on hourly basis and how appointments and calls for the new practice will be handled by the existing staff.)
3. Availability/utilization of ancillary services; e.g., x-ray
4. Utilities and Internet access
5. Use of computer hardware
6. Insurance (Will the liability carrier require addition of the new physician's practice on the certificate and will there be additional cost?)

Bear in mind: in a space sharing scenario you are providing 'turn-key' office space with staff. All of these amenities should be considered when you determine fair market value (FMV) for the arrangement.

There is no universal formula to determine FMV.

Evaluating the space using the criteria given and using local comparables or 'comps' will give you the best valuation of your space. 'Comps' are available from real estate professionals but also by doing your own research. Again, consult with a health professions attorney before you move forward with any space-sharing arrangement to determine how the arrangement should be documented.

Subleases

Subleases (subordinate leases) are similar to space-sharing arrangements. In a large office setting, additional space

may be available for subleases. Identifying vacant space in your building and leasing the space for subleasing is also an option. You may be in a unique bargaining position to negotiate a reduction in rent as an existing tenant and then sublease the space to one or multiple tenants for a profit.

If you lease space for the purpose of subletting, you will assume the responsibility as landlord. Although generating additional revenue through rent is the goal, there is significant responsibility assumed by you as the landlord. Be aware that your tenant has no responsibility to your landlord under these circumstances as a sub-lessor. The sublease should be very specific regarding the tenant's responsibilities and charges. If the tenant defaults on a payment or damages the space, you are ultimately responsible to the landlord.

Considerations in subletting space include:

1. The amount of rentable square footage
2. Will the space be 'turnkey,' (completely furnished), partially furnished, or unfurnished?
3. Will the space be partially staffed or unstaffed?
4. If you're leasing space with the intention of subletting to another tenant will there be any build-out costs for the space?
5. How will the utilities, phone system and Internet access be apportioned?
6. Liability insurance for the space as far as the lease holder is concerned

It is important in any subletting arrangement that accurate documentation of the condition of the space and an inventory of all tangible items be made and acknowledged by the tenant. Security deposits of 2-4 months are considered customary in commercial real estate. Credit checks and references are also standard.

Finding the right tenant is not easy. A good, stable tenant is worth a reduction in rent. The landlord/tenant relationship needs to be cultivated and constantly reassessed. A good landlord will be proactive and anticipate problems before they become unmanageable.

Real Estate Development

Medical office space in the right location can be very valuable. If you are considering moving your own group practice, developing medical space may be a good option for you. The advantages are ownership, space built to your specifications, and the ability to bring multiple practices together in one location. As an owner, you have rent as an additional source of income. For your own space, you would be able to develop a floor plan based upon your specific workflow as opposed to retrofitting one in

a leased space, thereby maximizing your own practice efficiency. Additionally, you may be able to attract high-profile tenants that will make your space the 'medical care destination point' in your community and thus increase your own practice's visibility.

Real estate development is a complex business that may range from the renovation of existing buildings with the intention of re-lease to the purchase of land upon which new buildings are built and leased. In any real estate project, the initial obstacles to success are usually financial. A large amount of capital is required to fund these ventures. As a result, multiple investors are usually necessary to make the deals successful. In order to solicit investors successfully, a sound business plan must be created.

Before you consider a real estate development project, you must conduct meaningful due-diligence. Commercial real estate transactions are not the same as residential. The due-diligence inspection is the responsibility of the commercial investor. Caveat emptor; that is to say, let the buyer beware. Due diligence checklists can be found online or from a real estate attorney. The following checklist is necessarily incomplete but will give you a good idea of the issues that must be resolved.

1. What property does the purchaser believe it is acquiring?
2. What is the purchaser's planned use of the property?
3. Does the physical condition of the property permit use as planned?
4. Are there any zoning considerations?
5. How much is the purchaser expecting to pay?
6. Is there any condition that is likely to increase the effective total cost of acquiring the property; e.g., removal of underground storage tanks, etc.?
7. Is the real estate tax in line with the value?
8. Are there any encroachments on the property; e.g., from contiguous parcels?
9. Are there any encumbrances on the property that will not be cleared at closing; e.g. easements?
10. If leases exist, what are the terms of the leases in case of property sale? How are security deposits handled?

This checklist will give you a good idea of items/questions that should be satisfied in advance of proceeding with your project. Deciding on whether to renovate an existing space (with or without tenants) versus construction of a new building is dependent on a number of factors including space availability and cost. There are advantages to renovation of existing space. The cost of the renovation can be controlled and therefore lessen the long-term real estate tax liability based on assessed value.

There may also be tax incentives for renovation of existing structures in city and state development zones. Since real estate taxes are usually determined based on total project value, the development of a new construction project will most likely increase the long-term tax liability as the project will be assessed at full value. Consultation with a tax attorney and accountant is highly recommended.

Once a due diligence investigation has been performed, a complete analysis of the project including an overview of the development process, land acquisition and sight improvements should be performed. This should be followed by:

1. A market and feasibility analysis with specific emphasis on office market demand (What are the other commercial spaces available locally?)
2. Development of project financing (This would include mortgage financing, and equity development.)
3. Building design and construction
4. Marketing and leasing of the space
5. Property operations and management

Real Estate development requires a systematic approach and an experienced team of professionals to succeed financially. These projects should be reserved for the seasoned real estate investor with sufficient knowledge of the local commercial market and sufficient financial support to see the project to completion.

Summary

Passive income can be generated in many ways. Having more than one source of revenue will give you more versatility to expand your practice and protect your future practice solvency. Utilizing your real estate is a straightforward method of generating income. By space-sharing or subleasing you can reduce your own office overhead while taking advantage of idle space and under-utilized staff. You may even find that you are able to practice rent-free. I strongly recommend starting small and learning about commercial investing before you consider larger ventures. Large scale real estate investing can be profitable but also costly if the market is not thoroughly researched and the correct development team is not assembled.

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Section 5

Marketing

Chapter 12

Marketing in the Social Media Age

By D. Kay Kirkpatrick, M.D and Richard J. Lenz

A physician cannot practice good medicine for long if he or she does not run a successful business. And, according to business guru Peter Drucker, "... Because the purpose of business is to create a customer, the business enterprise has two — and only two — basic functions: marketing and innovation. Marketing and innovation produce results; all the rest are costs."

Here, Drucker's definition of marketing was broad: basically, anything a business does to earn a customer (or, in the case of a physician practice, a patient). Without marketing, no one knows what you have to offer. Without innovation, your product and services lose ground to your competition. Marketing is an ongoing function or process, not an event, and it plays a crucial role in the three pillars of any strong business, especially in health care: customer relations, operations, and innovations.

Health care is big business, with one in 11 U.S. workers earning a living in this \$2.5 trillion segment of the U.S. economy, which makes up 17.3 percent of U.S. GDP. According to the Bureau of Labor Statistics, 7.2 million health care providers and technicians — of whom 690,000 are physicians — earn \$502 billion in wages.

Over the past several decades, the practice of medicine — an essential and growing part of the U.S. economy — has experienced as much change as any other industry in America. And the *business* of practicing medicine is the most complex, demanding, and regulated industry in the U.S., as any exhausted physician will testify.

Doctors are forced to spend more and more time on business aspects of their practice, and less and less time on their original calling. Practices have not only had to keep pace with the art and science of healing, but also deal with changing technologies and government regulations, litigious patients and expensive staffing issues, while simultaneously navigating nonsensical and complex billing rules from private and government payers. To survive and thrive in this ever-changing arena, physicians now find themselves invested in real estate developments, expensive technologies, and complex corporate structures.

Into this mix comes a fresh consideration of the benefits of marketing. Physicians have been among the last to

adopt well-tested marketing approaches to their business. A discussion of marketing at a partnership meeting has the tone of a religious argument between believers and non-believers. Traditionally, marketing has been misunderstood as "unethical," viewed as an unnecessary "luxury we can't afford," or delegated to administrative staff. It was the last thing considered, if it was considered at all.

Practice Marketing, Then and Now

Typically, physician marketing in the broad sense consisted of peer-to-peer relationships generated by contact in the hospital, on boards, or at conferences. Sometimes, gift baskets or lunches were sent during the holidays or if someone new entered the community. "Getting aggressive" with their marketing, a practice would produce brochures with their new and very complex logo plastered on the front, and launch a career in publishing with a monthly practice newsletter. The first issue would come out late because no one had time to write the articles, and eventually the project would be dropped.

Paid advertising occurred when looking to hire or to show support for the local school. Occasionally, after someone's arm was twisted, a charitable event might be supported at the hospital or in the community. This meant the practice logo was on a program or t-shirt with everyone else's, and perhaps available and willing personnel would staff a table with brochures and newsletters. Physicians would attend the event only if it felt absolutely necessary for business reasons, given their hectic schedules and pressing family obligations. Does all this perhaps sound familiar?

Today, health care is a competitive, fast-changing business with many factors at play, so you cannot afford to let time and natural events build your reputation and success. You need to market to keep up with the competition. While old-school, peer-to-peer marketing is still the most powerful approach and should certainly not be abandoned, it is also the slowest and most time-consuming in our already over-tasked work day.

More and more, health care is consumer-driven and less referral-driven, and patients desire and have been forced to have more control over health care decisions, as you surely notice when they come to your office with printouts and questions gleaned from the Internet.

Today, reputations are built using modern strategies, tactics, and tools such as market research and brand assessment, branding, web sites, social media and interactive

campaigns, paid media campaigns, promotions, media, and PR efforts. Those who use the “evidence-based” strategies, tactics, and tools of modern marketing are stabilizing and protecting their businesses and probably growing market share. *And good news for practices that do market: many of your competitors are poor or non-existent marketers, so you have a huge advantage to position your practice at a lower cost.*

Marketing Benefits

Marketing builds your reputation. Marketing increases patient numbers. Marketing attracts the right kind of patients. Marketing helps with managed care relations. Marketing attracts better physicians, medical providers, and staff. Marketing helps employee morale. Marketing gets you in the news – and can keep you out of the news. Marketing is not an unseemly, untruthful activity; it is an attempt to communicate honestly and effectively your quality and the benefits your practice offers.

Over time, marketing has the effect of branding your practice’s identity into the mind of the consumer (referrers included) so that they prefer and trust your services over your competitor’s *before they even know they need it*. This is especially important in health care, where you need to be establishing a trustworthy brand image into the minds of consumers before they have a health crisis. Just as the pharmaceutical industry has marketed prescription drugs directly to consumers with great success, you can market directly to consumers even though you may be a referral-driven practice.

Marketing Basics to Save You Money and Time

Marketing’s goal is to get consumers to change their behavior. How? *Repeatedly communicate your brand message with the target audience in a variety of ways over a period of time*. Why market repeatedly? Consumers must hear something over and over to change their behavior: seven touches is a rule of thumb. Why market with variety? No single communication vehicle reaches everyone, or enough of everyone you want to influence. Why market over a period of time? Consumer behavior is highly variable and you are communicating with a “passing parade.” If you do not follow these rules, you may be wasting your money. Industry wide, more money has been spent with ineffective, reactive marketing one-offs than on ongoing marketing programs.

What Should I Invest In Marketing?

Some excellent marketing, in the broad sense, has little cost, as it should flow through the three pillars of your business (customer relations, operations, innovation). Does your phone system work properly? Is your front desk staff always attentive, friendly, and helpful? How long are patients made to wait? Are your doctors respectful to

patients, and to staff? Do doctors communicate well with referrers? Your practice should be reviewed and assessed for every way it touches all its customers, and a plan implemented to improve all aspects.

Other marketing efforts require directed planning and resources. First, decide on a set of goals. Resources should be allocated accordingly: do you want to build a rowboat to cross a creek, or an aircraft carrier for plane landings?

Five to ten percent of net revenue is the usual range investment in many industries. Most physician practices by contrast wade into marketing with much less than one percent funding, and then complain about the results. Partners may view it as a necessary evil or overhead coming out of their pockets, instead of an opportunity. Despite a low investment, some benefits can be seen because of the empty playing field. Yours might be the only voice out there.

The bottom line: spending money on marketing should be considered an “investment” because, like any investment, it takes time to pay off. Marketing done well pays for itself out of the growth you generate.

How to Get Started

Not unlike differential diagnosis, you winnow down your marketing by a process of decisions.

- Set your **goals**: *Grow a service line? Target a certain payer mix? Expand geographically?*
- After you decide on a **budget**, formulate your **strategy**: *Target high-income zip codes with our messaging?*
- Make a decision regarding the right **tactics/tools**: *Is direct mail the best way to reach these zip codes?*
- **Execute** effectively: *Does our mailer have proper design and messaging to attract the health care deciders?*
- Finally, **measure** the results and make adjustments.

Goals and budget are set by the practice, but it may be helpful to go to a marketing specialist to assess strategy, tactics/tools, and execution. The right outside agency may save you money from fruitless, time-consuming endeavors, help you squeeze the most out of your dollar, and have the professional chops and experience to deliver effective quality marketing and results.

Marketing Tools and Uses

Marketing today is a very large (\$500 billion) and mature industry with great specialization in many aspects. Each specialty has its adherents pushing a wide variety of methods and tools. Advertising is ubiquitous, from your grocery receipts to the phone in your pocket. Even the ruins of Pompeii contain commercial and political messages! All these choices add to the confusion. Don’t let this distract and prevent you from moving forward.

Wise practices first perform **market research and brand assessment**, instead of jumping to conclusions about their identity. A brand is a person's perception of a product, service, experience, or organization. You may be surprised at the gulf between how you interpret your brand versus how others do, and this difference may be a driving factor in your marketing pursuits, leading to better return on investment.

After gaining insight, the next most absolutely essential piece of directed marketing is creating, supporting, and leveraging your **web site**. It is the No. 1 way consumers first get to know you and judge you. Used correctly, your web site performs business and marketing functions. It presents your brand identity, communicates your services, acts as a customer service tool, speeds up operations, recruits talent, and can be used to attract business.

Neglected, it will work against you. For better or worse, people judge others by their looks, and if you look sloppy, disorganized, and incomplete through your materials, you will be judged as sub par. The practice should always follow ironclad brand identity rules where all the visual elements of the practice — collateral, web site, advertising, signage, — are cohesive and distinctive to your look. Your web site is your “home base” that you use to judge interest in your practice, to convert visitors into new patients, and to serve as a type of “sales close” when they come to your web site stimulated by other marketing programs, such as interactive campaigns, promotions, and paid media.

Most will find your web site not by knowing your dot com address, but rather by searching for you through Google or other search engines. You want to be found, so your web site should be built, supported, and managed (a specialty called “search engine optimization”) to attract quality traffic, called “**organic search**.”

Another way to attract eyeballs on the web is “**paid search**” or **online advertising**. Here you purchase space on Google or other web sites with banner ads. You may pay for every time someone clicks on your ad or whenever it appears on their web site. Your web site is like one media channel on a TV that has multiple millions of channels that are controlled by multiple millions of people with different goals and behaviors. This has led to the rise of a wide variety of uses, such as blogging, wikis, mashups, content aggregation, widgets, discussion boards, events, video, and hundreds of other concepts that pull people together for common goals and interests.

Here we will look at the most useful elements of the web that have significance for your practice: **ratings and review sites, social media, and micro-blogging**.

Ratings and review sites have received a lot of attention from physicians, who have disturbingly found themselves publicly rated like a new restaurant or movie, on sites like HealthGrades, Kudzu, Yelp, Rate MD, and at least 30 oth-

ers at last count. A patient who has a poor experience with a practice is now only a few keystrokes away from negatively affecting your reputation. This review may come up first on the list the next time someone searches your name, perhaps even before your web site. What can you do?

- First, don't panic. Physician rating sites have yet to achieve the popularity of other review sites.
- Second, it is worthwhile to see what is “out there” on these sites about your practice. There may be some legitimate complaints that you need to address. Also, you will be prepared to respond to any other patient's concerns when you meet them about finding negative remarks about the practice.
- Third, consider encouraging positive postings from satisfied patients, which will have the effect of outweighing and pushing down negative reviews. Occasionally, if you can show a comment to be unfair or planted, a review site will take it down.

There are hundreds of **social media** sites, each with their own niche and audience. For most people, “social media” equals Facebook, a web site where you create a profile and share your thoughts and activities with all your friends who are also on Facebook. Sounds simple, but it has grown to more than 400 million active users, 50 percent who update their status every day. More than 100 million check in with Facebook on their mobile phones. In this virtual universe, people are sharing their opinions of your practice ... even as they wait in your exam room.

In the Facebook universe, one can set up a fan page of a company. Here, you are running a web site that has news and useful information about your practice. Anyone who “likes” your practice can indicate so on their Facebook page. Thereafter, they will receive updates from your Facebook profile. In other words, they ask to receive news from you, which they then automatically receive when you post new information.

Micro-blogging is a popular and surprisingly powerful communication tool of the Internet that pushes out a small message with a link to a web site for more information about the subject. As with Facebook, the people who receive this information have asked to get it. Twitter is the most popular of the micro-blogging sites, but there are more than 100 others.

Twitter can be used effectively to get the word out to a loyal and interested fan base. The key here, as with most online media, is not to be sending ads but instead sharing useful information that evolves into a conversation and the development of a positive brand relationship between you and those who use and support your services.

Note: unlike most paid media, the distribution costs associated with pushing your brand throughout the Internet

are low; however, management and content creation can be significant. While social media is the bright and shiny object many are discussing, paid media is still a strong choice. It has lost influence and changed in many ways, but it still may be the best option to get your message out in a cost effective way.

When looking at TV, radio, print, and outdoor advertising, consider the target audience that is reached, and at what cost per thousand. Each media type has different strengths and weaknesses and cost structures. Consider consulting an expert before making the plunge here.

It is well-established that news articles are more persuasive than paid advertising in establishing a reputation. An integrated marketing approach that incorporates **promotions, media, and PR** efforts into your marketing mix is a smart investment. Over time, you will be seen as the expert in your field, which will reap rewards. Appearing in the news probably means your name will also appear on a web site, which will be picked up by search engines. People considering your services will trust you more if they search your name and find you in the news.

There are a lot of approaches to getting press, but here are some tried-and-true methods. Whenever there is basic business news about your practice — such as personnel changes, new locations, or new technology — write and distribute a press release. Include in the press release a quote from a physician that comments on the news with positioning language. For example, *“We are thrilled Dr. Smith is joining us, because it means our practice now has have the highest number of Board-certified, fellowship-trained hand surgeons in New England.”*

Finish every release with boilerplate information about the practice, including what services you offer and what you are known for and how to find you. Many smaller newspapers and trade magazines will run the entire release without any editing, giving you what amounts to free advertising. The more you are in the news, the more you will be in the news because you start developing a reputation as an authority and the media learn you can be trusted to help them do their job.

Print feature stories in major media are much harder to land, but are worth their weight in gold and can more quickly establish your reputation than any other type of marketing. Effective branding over time will start to bring journalists to you as they also live in your community and are influenced by your marketing efforts. Feature stories can be pitched with some success if you have a relationship with print editors and TV producers. PR agencies usually have these relationships in place and can speed the process. You cannot badger these contacts into stories and you can't get a story every week. You must look at it from their point of view and serve them a story that fits their narrow interests and tastes. Remember, as the old saying goes, if a dog

bites a man, it isn't news, but if a man bites a dog, it is.

When journalists do come, be prepared to jump at a moment's notice and make their job as easy as possible. If you do this, you will be building a relationship and they will return again and again. This is especially important with TV, which usually shoots and airs a spot on the same day. If you tell them no, they will stop calling.

Being an advertiser helps you get into the news in two ways. Some publications, whether publicly stated or not, will run your news stories or write features about you if you are an advertiser. The other way it helps is that media become aware of your existence from your advertising and will think to call you. For example, even news writers who say they are not influenced by advertising may call a practice that advertises that they are the No. 1 orthopaedic practice in town when they are writing a story about sports medicine or total joint replacement.

Another way to get news coverage is by supporting or launching a charitable event or organization. Not only does it help the community, but it also should have the effect of promoting your practice's compassion for the afflicted. Publicity can go year round if done correctly. Finally, investigate what interview shows are found on TV and radio in your community. Consider being a guest during the period on the calendar that relates to your profession. For example, an oncologist should make himself or herself available to discuss new breakthroughs in treatments during Breast Cancer Month.

Measuring Marketing Success: Return on Investment

The bottom line is you want to protect and grow market share. Your marketing should, over time, generate business beyond the cost of your investment. But it does take time for your marketing to work its magic: remember the rule of repetition. So don't pull the plug too soon and waste your investment. Basic ways to measure the action your marketing is generating are the following: Is web visitation up? How about appointment requests? Patient visits and new patient numbers? Are you in the news more? Measure and compare to previous periods. Account for economic forces that may skew your numbers up or down. **The take away message: adjust your program and keep going. Marketing is a process, not an event!**

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Appendix: Ten Top Tips

By Steven E. Fisher, MBA

The preceding chapters outline twelve different strategies for generating additional income. This appendix contains general information relating to the strategies. Some of the tips will help you make good decisions regarding which of them might make sense for you to pursue. Others provide guidance that will ensure that the ventures you ultimately do pursue are financially and operationally successful.

1. Financial Statements and Budgets

Many authors made reference to financial statements and/or budgets. It is of crucial importance for the owner(s) of any business to understand how their business is performing from a financial standpoint. This involves, at a minimum, learning about the three major financial statements: the Profit and Loss (P&L), the Balance Sheet, and the Statement of Sources and Uses of Cash. In addition, owners need to understand what is involved in developing capital and operating budgets every year and comparing actual results against budgets. This is a tool that allows business owners and administrators to identify problems before they become serious. Examples of financial statements are available on the AAOS on-line Practice Management Center. For more information, see (www.aaos.org/pracman). See also # 10 below.

2. Formulas for Calculating Investment Return

There are many formulas for calculating returns but following are three in common use:

- *Net Present Value (NPV)* is the difference between the amount of the up-front investment required to start a business venture and the discounted value of the future cash flows. The NPV will vary depending on the discount percentage used, and different practices will use different percentages.
- *Return on Investment (ROI)* measures the efficiency of an investment. It is a ratio whose numerator is "Gain from Investment minus Cost of Investment" and whose denominator is "Cost of Investment." It does not take into account the time value of money.
- *Payback* is the length of time that it takes for a project to recoup its initial cost out of the cash receipts that it generates. The premise of the payback method is that the more quickly the cost of an investment can be recovered, the more desirable is the investment. Like ROI, it does not take into account any discount rate.

Many financial analysts argue that NPV is the most

sophisticated measure of the three described above. However, investors' access to capital is limited; therefore it is likely that they will be obligated to choose between alternative investments vehicles even if all of them have positive discounted cash flows. Investors in any business need to discuss alternative formulas for calculating investment return and come to closure regarding which formula they will utilize.

3. Governance vs. Management

Governance and management are not identical and confusing the two will can result in operational problems. Governance is something that the owners of a business venture must do. Among other things it involves (a) making strategic decisions regarding the mission and goals of the enterprise; (b) executing agreements that allow the business to commence operation and remain in business; and (c) formulating short and long term plans. Management by contrast involves oversight of day-to-day operations. Day-to-day operations include finance and accounting, human resources management, oversight of clinical operations, regulatory compliance, information technology, and marketing. In some cases, one of the doctors may function as the senior manager; in most cases, however, it is wise to recruit and employ someone who has business-related education and experience. See #4 below.

4. Critical Need to Employ High-quality Management

Historically, it was often true in solo offices that the spouse of the orthopaedist functioned as the office manager. These days, however, it takes a great deal of knowledge and skill to run even a small practice. To the extent that physicians decide to embark on any of the activities described in the *Primer*, they should seriously consider recruiting and employing a professional manager, someone who has knowledge and skills in areas such as (a) negotiating with payors; (b) hiring, training, evaluating and terminating staff; and (c) developing policies and procedures to ensure practice compliance with government regulations such as Stark, Anti-kickback and HIPAA.

5. Lease vs. Buy Analyses

If an orthopaedic practice plans to pursue many of the income generation strategies outlined in the *Primer*, it will be necessary to acquire equipment. The question arises as to whether leasing or buying is the better option. The decision is not always an easy one to make because the two acquisition options both have advantages and disadvantages. For example, leasing generally requires minimal down payment (or none); it may protect the practice against obsolescence; and payment may be spread over a longer period of time. Purchasing may provide tax advantages, and the monthly costs may be lower but it

may restrict the practice's financial operations. Making the correct lease vs. buy decision may be key to a business venture's long-term success. Once a decision has been made in this regard, investors need to review the terms of the lease or purchase in detail to be sure they understand the financial and operational consequences. See # 8 below.

6. Human Resources Management

Human resources (HR) is something that operates "behind the scenes" and physicians may not think much about. Establishing a full-fledged HR function at the outset, however, is critical to the success of any new or existing business. This includes (a) employment (recruitment, selection and retention); (b) compensation and payroll, (c) benefits (medical, dental, life and disability insurance, pension, vacation); (d) training and development; (e) performance management; (f) policies and procedures (including clinical policies and procedures); (g) an employee manual; and (h) legal compliance and federal reporting.

7. Don't Rob Peter to Pay . . . Peter

Reference to this was made by several chapter authors but it bears repeating. When a group of potential investors assesses the profitability of a business venture, they must consider what the impact of that venture may be on existing operations. For example, if a practice wants to open another office, it will be necessary to develop a *pro forma* that sets forth anticipated revenue and costs. It is likely however, that some patients that otherwise would have gone to the first office will no longer do so, so this must be taken into account. By the same token, it may also be the case that economies of scale may limit certain expense increases.

8. Seek Counsel from Appropriate Outside Advisors at the Appropriate Time

Not infrequently, potential investors in a business are loath to seek counsel from outside experts because this can increase the initial cost of the investment. They may simply do some reading on a subject such as Stark, HIPAA or Anti-kickback or ask for information from a source who will give them feedback at no charge. This is *never* a good idea. Anyone who desires to grow his or her current business, or create a new one, *must* consult appropriate advisors – recognizing that not all advisors can provide all kinds of advice. For example, an accountant may be able to assist with calculating profits and losses of an existing business but may not wish to involve him or herself in projecting a future investment return (see # 2 above). An attorney may know all about the law but may or may not feel equipped to weigh in on whether the business model makes sense. Investors must decide which advisors they need as part of their initial plan. See # 9 below.

9. Planning the Plan

One or two *Primer* authors made reference to the value of the concept of project planning. Planning is perhaps the key element in the success of any enterprise (all "to do's" identified, responsibilities assigned, and deadlines established). The more detailed the plan, the greater the likelihood of success. Planning, however, is a tedious, detail-oriented process that many people want to dispense with or think about only in broad terms. Orthopaedists tend to be "take charge doers" but many have limited patience with the seemingly-never-ending meetings, email exchanges, negotiations and compromises that are required to develop any comprehensive plan. They must learn a new set of skills if they are to contribute meaningfully to the plan's development. [Note: one element of every successful plan involves planning for the unexpected. While it is never possible to account for everything, it's useful to think at least about the "known unknowns" even if it is not possible to take into account the "unknown unknowns."]

10. AAOS Practice Management Resources

Finally, Academy members who are considering embarking on any new business venture are well-advised to look to the AAOS to determine if information is available regarding that venture. The AAOS Practice Management Group, in conjunction with the Practice Management Committee has a wide array of resources to help Fellows improve their practices' efficiency and effectiveness. For example:

- The on-line Practice Management Center (www.aaos.org/pracman) contains hundreds of articles, white papers and spreadsheets on a wide array subjects including options for practice growth.
- Every year, AAOS sponsors two educational courses: a one day course at the Annual Meeting and a 2.5 day course in the fall.

In addition to the on-line Practice Management Center and courses, Practice Management Group staff offer advice and counsel over the phone and via the Internet. This advice and counsel is provided free of charge as a membership benefit. AAOS is one of the few national medical specialty societies that employ former orthopaedic practice managers and practice management consultants in its practice management area. These individuals have not only "talked the talk;" they have "walked the walk," and members should avail themselves of their expertise.

Contact: Steven Fisher, MBA: sfisher@aaos.org

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The AAOS logo features the letters 'AAOS' in a bold, serif font. The 'O' is stylized with a circular graphic element inside it.

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