Orthopaedic
PRACTICE MANAGEMENT

In This Issue . . .

Vol. 2, No. 3 (pp 25-36) March 2009

Focus on boosting physical therapy services and reap the profits

Physical therapy (PT) can be a lucrative ancillary service for orthopaedic surgery practices, provided they avoid regulatory and competitive mine fields and establish proper guidelines and benchmarks to evaluate financial performance. Data collected by the American Association of Orthopaedic Executives (AAOE) for its annual *Orthopaedic Practice Benchmarking Survey* show that PT services collected $168,672 per physician FTE in 2007 compared to $105,407 per FTE physician in expenses. PT generated higher revenues among AAOE survey respondents than all types of ancillary services except surgery centers, and PT services were four times more common among survey respondents than surgery centers.

If anything, those findings provide conservative estimates of the potential added value of PT to orthopaedic practices, according to **Thomas G. Montebell**, MEd, director of

continued on page 28

Use benchmarking tools to become a better-performing practice

With the array of orthopaedic practice data growing at a dizzying pace, benchmarking is becoming more science than art. But practice managers still need to sift through the data at their disposal and use the information judiciously to improve their organization's performance, says **William R. Pupkis**, CMPE, CEO of Capital Region Orthopaedics in Albany, NY, and president of the New York State chapter of BONES.

Orthopaedic surgery practice benchmarks now are available from a variety of sources, including the Medical Group Management Association (MGMA), the American Medical Group Association (AMGA), and the American Association of Orthopaedic Executives (AAOE).

Benchmarks from annual surveys represent useful tools for orthopaedic practice administrators and surgeons. For example, MGMA's *Management Compensation Survey: 2008 Report Based on*

continued on page 31

PT services continued from p. 25

Physicians Rehabilitation Services (PRS) LLC, a PT consulting firm based in McLean, VA. A general orthopaedic surgeon should generate at least $300,000 to $400,000 annually in collected PT revenues just from his or her own patient population, based on an 8% referral rate.

And that referral rate can go much higher, Montebell insists -- in fact, closer to a 1:1 ratio of physician to PT visits because, on average, one physician visit generates 12 to13 PT visits. At a conservative reimbursement of $70 per visit, if each physician in a five-person orthopaedic surgery practice sent just one additional patient per week to PT, generating an extra 12 PT visits per physician per week, the practice could gain more than $200,000 a year from a single PT clinic, says **Anthony D. Kling**, chief financial officer at Potomac Valley Orthopaedic Associates (PVOA) in Olney, MD, and a consultant to PRS.

Unfortunately, "most practices don't know what metrics to evaluate," Montebell says. "If an orthopaedic practice runs a good physical therapy program, 100% of the patients are candidates for therapy. You won't capture all of them, but there's not a single patient who couldn't benefit from a good, active rehabilitation program."

Instead, many orthopaedic surgeons see less than optimal outcomes because they send patients home to exercise after a knee scope, shoulder surgery, or even tendonitis. "The probability of patients doing exercise programs properly on their own is about one in 10," Montebell maintains.

No cakewalk

Before you drop everything to establish or expand a PT clinic, consider that owning a PT service isn't exactly a cakewalk in the current regulatory environment. Many physician groups owned PT practices until Stark regulations forced them to divest of the clinics unless they could place the PT operation on the same floor and incorporate it into the flow of their practice.

Although later iterations of Stark have somewhat lessened this onerous requirement, physician-owned PT now faces attack from the American Physical Therapy Association (APTA) in Alexandria, VA, which is pushing therapists to operate independently from physicians, says **Dana Walker**, DscPT, general manager of PVOA. Thanks to pressure from APTA, Delaware, Missouri, and South Carolina have enacted laws preventing therapists from working for physician-owned clinics, and the American Academy of Orthopaedic Surgeons (AAOS) continues to beat back more state initiatives each year.

"The APTA is strongly against physician-owned clinics," Walker says. "They want their own physical therapist-owned clinics so that physical therapists can make some money from the physicians. It's a business decision." Thus, orthopaedic practices may find themselves in the peculiar position of struggling to recruit seasoned therapists rather than picking the cream of the crop of prospective employees.

Hands-on approach needed

Many orthopaedic practices must also overcome practical obstacles before they establish or expand a PT service. They must change their internal culture and style, beginning with physician buy-in. Many orthopaedic surgeons are content to let therapists "run with" the program, Kling says, and that's the wrong approach for a complex ancillary service that requires expensive equipment and highly skilled technicians.

"When you expand physical therapy like a business, instead of a Mom and Pop shop, you need to stay on top of every aspect of the operation and you need to hire a good manager to coordinate it," Kling tells *OPM*.

For example, orthopaedic practices shouldn't restrict their PT services to weekday hours because patients with full-time jobs and students need early morning and evening appointment times, Kling says. If physicians take a hands-off approach, therapists may gravitate to a conventional workday instead of scheduling patients more flexibly.

"Scheduling is all about patient convenience," he says.

In addition, orthopaedic surgeons often ignore the financial nuts and bolts associated with PT. The docs may know that PT generates $500,000 in annual revenues, but they don't know any details about expenses or profit margins. "Get your doctors on board with the program," Kling says. "Set up budgets and have the financial manager or practice administrator work collaboratively with the therapists to run the financial side of the business."

Establish financial awareness

Kling developed a simple monthly report (see **Figure 1** on p. 29) that he provides to each physician at PVOA so they understand the financial value of

continued on page 29

PT services continued from p. 28

PT to the practice. "Obviously, they see the clinical impact of the care when patients come back to see them," he explains. "With this tool, they can also see that PT is a great profit center for the practice."

An orthopaedic practice with multiple PT sites also needs to standardize operating procedures across all locations. Except in rare instances when PT operations are segregated by service, "you shouldn't have four clinics running four different programs," Kling insists. Instead, coordinate patient services, employee schedules, physician referrals, and third-party billing across all sites, and roll up the numbers from each clinic in your monthly statements to physicians.

PVOA has a therapy committee with a rotating chairman, "but all of our doctors understand the importance of therapy services to the practice," Kling says. "It's helpful to have a physician champion when you're just starting the therapy practice, but once it gets going, all of the doctors should recognize its value."

A PT practice shouldn't dictate the physicians' style, however. Therapists have a wide range of skills, tools, and professional philosophies, and the orthopaedic practice should seek to match the therapists' personal qualities and goals with those of the physicians.

"It's important to establish guidelines from the get-go," Walker says. "From those guidelines, you develop a similar style of patient care, which leads to continuity of care and the achievement of quality outcomes."

Expect a quick return on investment

Established orthopaedic practices often struggle to initiate internal change and may benefit from using an outside consultant or networking with peers. Kling first met Montebell because he was running a spine clinic, which PVOA's therapists didn't offer. Once PVOA began referring spine patients to Montebell, Kling was so impressed with the operation that he asked Montebell to help improve PVOA's PT services.

"The practice took a risk by asking for outside help," Montebell recalls. "No one likes to admit that their operation can be improved."

The same advice that Montebell gave PVOA applies to other orthopaedic practices. First, examine your own strengths and weaknesses, since there's no cookie-cutter approach to PT. Practices that don't offer PT should conduct a feasibility study to determine whether such services could improve patient care and generate additional ancillary revenue. Look at the number of physician visits to the practice as a whole and by subspecialty, and the number and types of procedures performed on a monthly and annual basis, Montebell says. Next, run a zip code analysis to determine the likelihood that patients will use your PT program, based on local competition.

continued on page 30

Figure 1

	Current paid			Year-to-date		
	Actual month	**Prior year month**	**Budget**	**Actual month**	**Prior year month**	**Budget**
New patients (NP)						
Follow-up patients (FU)						
Total NP and FU						
Billings						
Collections						
Expenses:						
Rent/buildout/equipment						
Labor						
Supplies						
Administrative						
Repairs and maintenance						
Total expenses						
Net operating income						
Profit margin						
Average bill per patient						
Average collection per patient						

Source: Anthony D. Kling, Physicians Rehabilitation Services LLC. Reprinted with permission.

PT services continued from p. 29

"People will fly across the country to see a doctor, but when you ask them to go to therapy two or three times a week, the rule of thumb is that they won't drive more than 15 minutes or 15 miles," Montebell says. "When gas was at $4 a gallon, we weren't even sure they would drive that far."

Based on these metrics, plus insurance data, you can estimate your "capture rate" -- the number of prospective patients and the percentage of those patients who would actually use your clinic. In general, using an "active" (exercise-based) model of care, a 2,500-sq. ft. PT clinic can support 1,250 patient visits per month, according to Montebell. Getting a realistic estimate of volume is key. "I've seen practices with four orthopods that still couldn't support a physical therapy practice," Montebell says.

Start-up costs for PT can vary widely, based on local construction costs and the amount and types of PT equipment the practice selects. An active orthopaedic surgery practice with five to six surgeons and little local competition might support a 5,000-sq. ft. clinic, which could require an up-front investment of $600,000 -- half to build out the space and half to furnish it with top-of-the-line equipment, Montebell suggests. PT practices that don't use spine equipment won't spend as much money, "but if you have an orthopaedic spine specialist and you don't have a spine rehab program, you're probably losing $500,000 a year in revenue," he maintains.

No matter what the initial outlay, the return on investment is rapid. "In all of our clinics, we were turning a profit within six months," Kling says. "You might take five years to pay off the loan, but once the doctors are sending the patients and you have the staff to treat the patients, the revenues grow quickly."

Differentiate your clinic from competitors

Practices also should establish a standard for the number of PT patients per hour -- PVOA therapists see three per hour -- and for the supervision of those patients.

"All of our patients receive one-on-one care, either with a physical therapist or with a physical therapy tech," Walker says. "In many physical therapy clinics, patients are put into a room and told to complete X, Y, and Z exercises, then left on their own. In our clinics, patients always have supervision. Everyone does better when they have someone looking over their shoulder than when they're on their own."

Running an operation from 6 AM to 8 PM requires creative scheduling -- often using two shifts of therapists per day or alternating long and short days. "When you have therapists who are willing to work until 8 PM at night, you want to keep them around," Kling says. In fact, he suggests adopting a profit-sharing program that aligns the incentives of the practice and the therapists.

PT clinics also must establish billing and treatment guidelines for all insurers, including worker's comp and auto insurance companies. "Therapists need to know what they should be doing and how to bill for those services," Walker says. PVOA has one receptionist for every three clinicians, which allows the PT clinics to manage scheduling, check-in and check-out, and insurance authorizations efficiently.

Despite APTA's advocacy for independence from physicians, patients typically have a higher comfort zone with a PT service that's either operated by or affiliated with their orthopaedic surgeon. "Patients will at least give their physician's clinic an opportunity to provide physical therapy services as long as the hours are convenient, the care is good, and it makes sense for them economically," Montebell says.

Still, it's important to differentiate yourself from the competition. PVOA uses state-of-the-art equipment, which patients notice and appreciate, Walker says. In fact, the practice markets its PT services to patients even before they see their physician. Each PT clinic shares a window with the waiting room of the adjoining orthopaedic surgery practice, so patients can observe therapy while they wait to see their physicians. The experience even prompts some patients to ask their physicians about PT.

Along with this visibility to patients, "it's important to market to your own docs -- to keep them up to speed and educated on the programs you're running in therapy," Walker says. "Let them know what techniques you're using and what success you've had so you're constantly building a strong relationship with your referring physicians."

Contact Kling at 301-774-0501 ext. 1140 or akling@pvoac.com; Montebell at 240-418-5915 or tgmmssh@aol.com; and Walker at 301-774-0501 ext. 1144 or dwalker@pvoac.com. ◆