

# Key Strategies for Economic Success

Business Survival Skills for  
Clinical Endocrinologists

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**“Those who do not  
remember the past are  
condemned to relive it “**

**George Santayana**



# **Sadly, Some Things Never Change**

***“One of the ways in which most, if not all, of our medical schools have failed to do their duty has been in graduating students into professional life without having given them the slightest idea of the economics of medicine.”***

***JAMA Feb 24, 1906 !***



# Obligations to Serve Versus Economic Reality

**Sure, everyone would like to make more money!**

However, physicians are in a unique ethical situation, since our desire to provide our professional services to any patient that needs them may have significant adverse financial consequences for our practice

The high value placed on medical care by our society stands in sharp contrast with our general inability as professionals to determine the value of our services

This conflict is causing progressively more physicians to make the socially undesirable, professionally painful, but financially necessary decision to limit or deny their services to indigent patients and to those insured by Medicaid, Medicare, and other “low payors”



# **Economic Success – A Moral Imperative ?**

**Our current healthcare system doesn't guarantee that endocrinologists will be compensated appropriately!**

**Therefore, we need to employ sound business principles in the operation of our practice in order to generate a personal income sufficient to allow us to comfortably accept into our practice any patient that is in need of our services**

**“It's easy to act professionally when you're not worrying about money ! “**



# Strategies for Economic Success

## Bigger is Better !

“Managed care” companies are progressively consolidating  
Learn from your opposition!

## Hire Professionals & Keep Them Happy !

Cheap inexperienced help with frequent turnover  
is a very bad investment!

## Capture Downstream Service Revenue !

You're responsible for ordering the tests and acting  
on the results, so why not profit from your work?

## Leverage Your Expertise with Physician Extenders !

Learn from your medical school classmates who chose  
anesthesiology, since many are already comfortably retired!

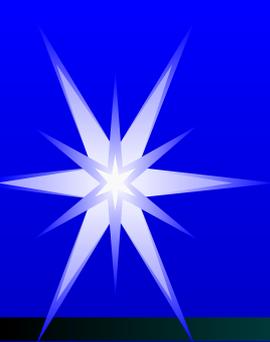


# Bigger is Better !

If you analyze the important recent trends in virtually any other area of business, one of the strikingly repetitive themes is that of CONSOLIDATION

Growing economic pressures have prompted many airlines, financial services firms, retailers, etc. to progressively amalgamate into a smaller number of larger corporate entities.

This combination of strengths and resources then allows them to operate more competitively and cost-effectively.



# Bigger is Better !

In order for endocrinologists to continue to uphold the hallowed ideals of our profession and to be able to afford to provide our services to any patient that needs our expertise, I believe that the same business principles must be applied to our own practices.

As the founding partner of a consultative endocrinology group that has now grown to nine endocrinologists and six physician extenders, I am convinced that the logistical, economic, and “quality of life” advantages of associating with other endocrine colleagues into a single, dominant corporate entity will greatly outweigh the disadvantages for most physicians.



# Bigger is Better !

## Shared Capital Expenses

The fixed costs of a DEXA or ultrasound machine, gamma counter, or laboratory analyzer can be paid off much more rapidly if many physicians share in these expenses.

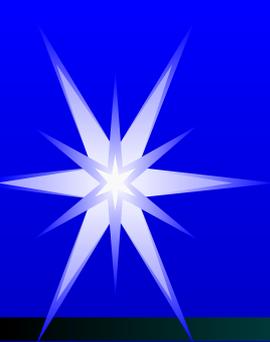
Once these costs are paid, these investments become revenue centers rather than cost centers.

Multiple economies of scale really mount up quickly!

## Shared Professional Staff

A 1-2 physician practice might find it difficult to afford the services of an MBA practice administrator, RN/RD/CDE, or a certified ultrasound technologist.

However, with many physicians contributing to these costs, both physicians and patients can greatly benefit from the services of these highly trained professionals on-site in your office.



# Bigger is Better !

## Decreased On-Call Responsibilities

Your family will particularly appreciate this!

## Convenient Collegial Interactions

It is quite gratifying to be able to easily discuss a complicated patient with your partner down the hall, who may have a particular interest in that area of endocrinology, rather than to try and chase down someone else for a second opinion by phone.

In addition, each partner brings unique talents and insights into the group relationship, which can be applied for the benefit of the entire organization.



# Bigger is Better !

## Improved Contracting Ability

**This is the most compelling economic imperative favoring association into larger single-specialty entities.**

Since we are basically unable to negotiate higher allowances from Medicare (and usually from Medicaid as well), our only hope is to make our “profit” on services provided to individuals who are not insured by governmental entities.

Even a modest increase in revenue from services you’re already providing makes a huge difference in net revenue to the physician, since your costs are already paid.

As an example, if one is paying 65% of receipts as overhead, your net revenue is the remaining 35%. If you increase your total receipts by only 10% through improved contracting, your net income just increased by almost 30%!

**“Gentleman, either we all hang together, or most assuredly, we will all hang separately”! (Benjamin Franklin)**



# Hire Professionals & Keep Them Happy

Competent, experienced and loyal staff  
are a practice's most valuable assets

Treat them nicely and compensate them well, and  
they'll build your business for you ;

Disgruntled or incompetent staff will offend your  
patients and severely undermine your  
professional reputation

Outside consultants are rarely worth the  
investment!



# Hire Professionals & Keep Them Happy

**Avoid the Peter Principle trap!**

**as your practice grows, be wary of promoting your most senior employee to practice administrator**

**There's no substitute for an MBA with healthcare experience**

**if you're serious about operating a successful professional business!**



# Capture Downstream Service Revenue

You're ordering these services anyway,  
You're responsible for acting on the results,  
So why not directly supervise and profit from your work ?

Providing ancillary services on-site is  
much easier for your staff  
more efficient for your practice

Above all, providing ancillary services on-site is  
MUCH MORE CONVENIENT FOR YOUR  
PATIENTS!



# Evaluation & Management is Economically Marginal

Assume solo Endocrinologist doing E & M only:

## Yearly practice overhead

2.5 – 3.0 FTE employee costs (inc billing, collections, & accounting svcs)	\$100 - 110,000
~1000 sq ft space	\$19 - 25,000
Liability Insurance	\$10 - 20,000
Transcription (consults & correspondence only)	\$ 7 - 9,000
Postage, Computer & Phone Services	\$ 8 - 12,000
General Office Supplies	\$ 8 - 12,000
Amortized Capital Expenses (phone system, computers, FAX, copier, office and waiting room furniture, etc)	\$ 8 - 12,000

**TOTAL ~ \$150 - 200,000**



# An Endocrinologist's Time is Grossly Undervalued !

## Assumptions for 2010 Yearly Revenue Calculations:

**Solo Endocrinologist doing E & M only for 48 wks/yr**  
**7 hours of billed time daily (X 240 days/yr)**

(1 hour daily of empty slots, no-shows or last minute cancellations)

**Average allowance (all charges) 110% of Medicare**  
**and collection rate 95% of allowed charges**

### **Average daily service distribution:**

**3 Level 4-5 new pts (NOT consults) 1 hr each @ \$180 = \$540**

**5 Level 4 visits (2 hrs total) @ \$100 = \$500**

**8 Level 3 visits (2 hrs total) @ \$70 = \$560**

**Total = \$1600**

**Total Yearly E & M Revenue: 0.95 X 1600 X 240 = ~\$365,000**



# An Endocrinologist's Time is Grossly Undervalued !

Total Yearly E & M Revenue: ~\$ 365,000

Total Office Expense: ~\$ 150 - 200,000

Net Physician Income ~\$ 165 - 215,000\*\*

\*\*This figure is clearly optimistic, since it assumes:

- 1 - the ability to fill office schedule 7 hrs/day;
- 2 - a level of efficiency in charge generation and collection that may be difficult for many to achieve;
- 3 - no weekday time off;
- 4 - no income lost during office hours in provision of potentially less time-efficient hospital services, volunteer teaching of residents, etc.

**Any decrease in revenue directly reduces your income,  
since expenses are fixed!**



# **Representative Economic Models of Downstream Revenue Potential**



# Disclaimer:

**The following economic modeling purports to vaguely represent data from a real world single-specialty group endocrinology practice.**

**Every practice situation is different !**



# Economics of Thyroid Ultrasound

## Approximate Acquisition Cost (one-time capital expense)

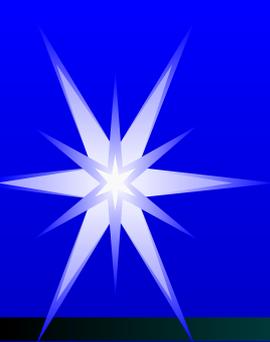
<b>Phillips HD11 (fixed location)</b>	<b>\$ 75,000</b>
<b>Sonosite M-Turbo (portable)</b>	<b>\$ 35,000</b>

## Ongoing Yearly Expenses

<b>Maintenance Contract</b>	<b>\$ 6,000</b>
<b>Space</b>	<b>\$ 2,000</b>
<b>Supplies (transducer covers, gel, printing)</b>	<b>\$ 3,000</b>

**TOTAL ~ \$ 11,000**

**+/- U/S Tech Salary & Benefits \$ 75,000**



# Economics of Thyroid Ultrasound

## Potential Additional Revenue

(assuming collection ~110% Medicare)

**Diagnostic Ultrasound (76536) \$ 110**

**U/S Guidance for FNA (76942) \$180**

**FNA Using U/S Guidance (10022) \$140**

**bill together**

**[FNA alone (10021) = \$135 ]**



# Economics of Thyroid Ultrasound

Assume each Dr bills weekly for 48 weeks:

5 diagnostic U/S \$550

2 FNA using U/S guidance \$640

\$ X 48 = ~ \$57,000/yr/Dr

However, if 4 physicians are using this machine,  
that's ~ \$230,000/year !

Now you can afford to hire the tech full-time,  
completely pay off the machine in 6 months,  
then each make an extra \$35,000/yr after that!



# Economics of DXA

Acquisition Cost ~ \$60,000  
(one-time capital expense)

Yearly Expenses

Maintenance Contract \$ 7,000

Space \$ 3,000

TOTAL ~ \$ 10,000

+/- 25% FTE DXA Tech S & B \$ 10,000



# Economics of DXA

## Potential Additional Revenue:

(assuming collections ~ 110% Medicare)

**5 DXA/wk/Dr X 48 weeks @ \$100: ~\$25,000<sup>+</sup>/yr**

**However, if 4 Drs using machine: ~ \$100,000<sup>+</sup>/yr !**

**Now you can afford to hire the tech full-time, have him/her handle your radioiodine needs also, completely pay off the machine in the first year, then each make an extra \$15,000/yr after that!**



# Economics of Retinal Scanning (Inoveon)

## Yearly Fixed Expenses

Lease for retinal camera	\$ 15 - 20,000
Space	\$ 2,000
Supplies	\$ 500
<b>TOTAL ~</b>	<b>\$ 20,000</b>

## Yearly Variable Expenses

\$50 per scan fee to ophthalmologist for report

~\$20 per scan for staffing S & B (for smaller practices)

**Alternatively, you can pay ~ \$80/scan and the company will provide everything, and you pocket the difference (if any)**



# Economics of Retinal Scanning (Inoveon)

## Potential Additional Revenue

(assuming collection 110% Medicare)

5 studies/wk/Dr X 48 weeks @ \$70: \$17,000

minus \$50/scan interpretation fee X 240: -\$12,000

minus \$20/scan staff costs X 240: -\$ 5,000

Profit per Dr per year: ~\$0000

minus fixed costs !! ~ \$20,000 = (???) net

Therefore , even with 4 physicians, one must average 4-5 scans/Dr/day and/or your collection rate for all services must average significantly more than 110% Medicare in order for this program to be financially feasible under the current fiscal model.

The costs of the Inoveon iSite program are structured to be profitable only for practices managing at least 3,000 diabetic patients yearly, and/or those with significantly higher contractual allowances.



# Economics of Ankle-Brachial Index (ABI) Testing

## Expenses

**Initial equipment costs (often less than this) \$15,000**

### **Yearly costs:**

**Lease cost of space \$2,000**

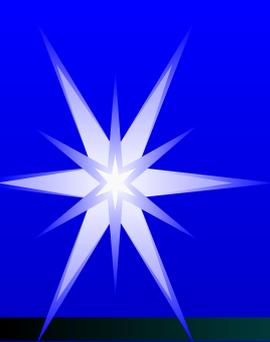
**10% of salary/benefit of staff \$3,000**

## Revenue Projections (assumes collections ~110% MC)

**Segmental (multiple level) ~ \$150 (TC)**

**2/wk per user X 48 wks = ~\$15,000/yr/user**

**With 4 users, machine is paid off in several months, and then each doc nets ~\$15,000 extra yearly**



# Economics of Radioiodine Services\*

**Initial Equipment Costs** **\$25000**

## **Yearly Costs**

<b>License</b>	<b>\$ 150</b>
<b>Maintenance Fees</b>	<b>\$ 75</b>
<b>Radiation Physicist Review</b>	<b>\$ 900</b>
<b>Radiation Badges</b>	<b>\$ 125/person</b>
<b>Lease cost of space</b>	<b>\$ 2000</b>
<b>10% of salary/benefit of staff support</b>	<b><u>\$ 3000</u></b>
<b>Total</b>	<b>\$ 6250</b>

**\* Scanning not included**



# Economics of Radioiodine Uptake & I131 RX\*

## Revenue Projections \*

(assumes practice collections ~110% MC allowances):

**RAI Uptake (78000)** **\$ 65**

**Prof Fee for I131 Rx HyperTx/Cancer (79005)** **\$ 150**

**Assume: 50 HyperTx pts/year X \$215** **~\$11,000**

**25 Cancer pts/yr X \$150** **~\$ 4,000**

**Total revenue ~ \$ 15,000/yr\***

\*Medicare only reimburses the invoice cost of the I131 dose (A9517), and ~ \$40.00 for RAI Dx Capsule (A9528), but the fee for these services may often be adjusted upwards when charged to private insurers and add to net revenue



# Economics of Radioiodine Uptake & I131 RX\*

## Summary:

Initial Equipment Cost	\$25,000
Annual Costs	\$ 6,250
Annual Revenue (per physician)	\$15,000+

Using the above volume assumptions, a solo physician, once licensed, can pay for the initial and ongoing costs in ~2 yrs and then make an extra \$10,000<sup>+</sup>/year after that

Marked improvement in convenience for your patient

Increased control of the process by the endocrinologist

The economics are much more favorable if volume is higher !  
(additional endocrinologists, thyroid-focused practice, etc)



# Economics of Endocrine Laboratory

**Main clinical advantage is ability to obtain same-visit test results – strong negotiating point!**

**Economic viability is critically dependent upon high volume (equipment and salary costs are fixed) and consequent ability to negotiate third-party payment, since many managed care plans typically require participating physicians to send out specimens to their contracted lab\***

**Can be VERY profitable and convenient for your patients IF above conditions met**

**\*Few physicians are still able to buy lab tests from commercial lab, be paid a higher fee by private insurer for tests, and pocket the difference**



# Leverage Your Expertise with Physician Extenders!

The productivity of most physicians is still determined by their personal piecework.

The owner of a business can only achieve maximum profitability through delegation.

We can TRAIN non-physician clinicians to do an excellent job of providing routine follow-up endocrine care under our direct supervision, thereby leveraging our expertise !



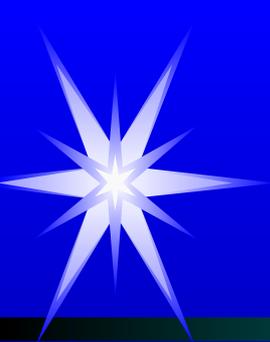
# **Physician Extenders: To Add or Not To Add ?**

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**1 – Critical requirements for success**

**2 – Practice objectives facilitated by  
addition of practice extenders**

**3 – Practical issues that must be  
addressed**



# Critical Requirements for Success

- 1- Current or anticipated demand for services is sufficient to keep another care provider fully busy**
- 2 – Sufficient space and infrastructure is available to comfortably accommodate the addition of provider and patients {office, exam rooms, reception area, support staff, record storage (if no EMR), etc}**
- 3 – Extenders are available, bright and highly motivated, capable and willing to be trained to become extensions of the physician's practice philosophy and to provide subspecialty-level quality of care to patients under the endocrinologist's supervision**
- 4 – Hospital patient coverage by extenders (if desired) is allowed by your institution**



# Clearly Prioritize Your Objectives !

**This decision will govern the design of your logistical arrangements and training program!**

## **Potentially competing objectives include:**

- 1 – Changing physician case mix**
- 2 – Obtaining phone and/or hospital call coverage**
- 3 – Enhancement of physician net income**

**Actions that facilitate optimal achievement of one objective may force compromise on another, so physicians need to think through this before proceeding (and achieve consensus if in a group !)**



# Practice Objectives Facilitated by Physician Extenders

**Provision of**

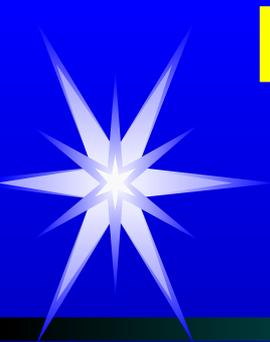
**more services to**

**more patients**

**more efficiently !**

**Decreased waiting time for new patient consultations  
pleases patients as well as your referring  
physicians**

**Prompt scheduling of visits for established patients  
reduces their apprehension and your no-show rate!**



# Practice Objectives Facilitated

## by Physician Extenders

### Change in Physician Case Mix

Allows transition of stable patients to extender for ongoing care rather than transferring care back to PCP, while keeping loyal patients (and their revenue stream) within the practice

Frees up time on endocrinologist's schedule to see more new consults with less delay

Extender's practice can be concentrated on specific areas (diabetes, lipids, HBP, thyroid, bone, etc), increasing their focused expertise and allowing physician to see more pts of personal interest



# Practice Objectives Facilitated by Physician Extenders

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## Phone & Hospital Call Coverage

so critical for quality of life in smaller practices

## Enhancement of Physician Income

should be realized by practices that meet  
critical conditions for success



# **Non-NP/PA Physician Extenders (RN, CDE, etc)**

**Can be trained to review records and generate background historical data for new consult or OV, which can then be reviewed and evaluation completed by endo**

**Can draft F/U communications to patients and referring clinicians and prepare visit documentation (facilitated by use of disease-specific templates) for review and signature by endocrinologist**

**Teach patient skills (use of BG meters, injection techniques for insulin/glucagon/exenatide/teriparatide/GH/testost, etc)**

**Physician must personally see each patient**

**but allows many more billable physician services to be completed in a specific time period**



# Practical Issues That Must Be Addressed

**State Regulatory Requirements (PA/NP)**

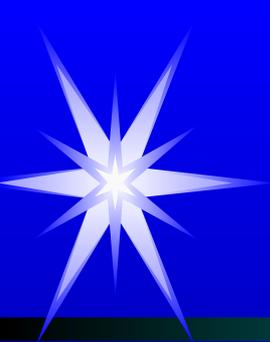
**Definition of Specific Supervisory Roles**

**“Incident To” Guidelines**

**Patients and referring clinicians must be familiarized and made comfortable with the incorporation of extender colleagues into your practice**

**Integration of Extender and Endo Schedules**

**Committing sufficient time for Personalized Training of your extenders is CRITICAL !!**



# Possible Concerns

## 1 – “My Referring Physicians won’t accept it”

Change is always stressful and resistance to it is natural. I can only respectfully observe that many excellent consultative endocrine practices across the country have been doing this for years, with only minimal and transient resistance from their referring physicians. In fact, many practices find that their referral sources become much HAPPIER overall, since their new patients can now be seen much more expeditiously !



# Possible Concerns

## 2 – “My Patients won’t accept it”

As much as we would like to think that we are the only individuals that can meet our patients needs, the reality is that this transition to care directed by an extender under our personal supervision is remarkably uneventful.

**Patients trust our extenders  
because they trust us !**



# Possible Concerns

## **3 – “I’m Training my own competition””**

While it is true that some states allow independent practice and billing by NP’s (but not PA’s), the reality is that such action would be very unlikely to materially impact an endocrinologist’s practice:

- 1 – they would have to set up, run, and pay for their practice with 85% of gross physician E & M payments**
- 2 – they are precluded from operating an on-site lab or doing most procedures to generate additional revenue**
- 3 – they would be unaffiliated with an endocrine specialist yet dependent on referrals (who would YOU want to see!)**
- 4 – Most endocrinologists are busier than they want to be, and would just hire another extender to take their place!**



# Summary: Benefits of Adding Extenders

**1 – Provision of**

**more services to**

**more patients**

**more efficiently**

**2 – Hospital and Call Coverage**

**3 – Change in Physician Case Mix**

**4 – Enhancement of Practice Revenue**

(see additional slides at end of syllabus)



# To Add or Not To Add?

## Remember:

It's nice to show a profit, but there are many other positive considerations associated with adding physician extenders to your practice that should be factored into your analysis !



# Key Strategies for Economic Success

Bigger is Better !

Hire Professionals & Keep Them Happy !

Capture Downstream Service Revenue !

Leverage Your Expertise!

# Key Strategies for Economic Success

Business Survival Skills for  
Clinical Endocrinologists

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# **Additional Detail Slides**



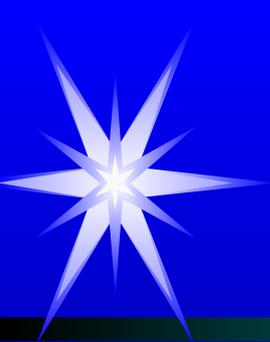
# Practical Issues That Must Be Addressed

## State Regulatory Requirements (PA/NP)

**Highly variable, and your responsibility !!**

Continuous physical presence of supervising physician is rarely required, but virtually all states require immediate physician availability by some means (phone, radio, etc) and formal designation of alternate supervisory physician if primary MD/DO unavailable.

**For specific info, check with your state medical licensing board, the annual summary of legislative issues affecting APRN's published in The Nurse Practitioner journal, and the American Society of Endocrine Physician Assistants**



# Practical Issues That Must Be Addressed

## State Regulatory Requirements (PA/NP)

Prescribing authority – Virtually all states allow non-scheduled drugs; many allow schedule III-V, and some allow schedule II

Some states require Specific Formularies to be agreed upon between Physician and extender

Physician chart review generally required, but many states do not specify details of volume or frequency. Some do require chart review within specific time interval from service date



# Practical Issues That Must Be Addressed

## State Regulatory Requirements (PA/NP)

- ✓ Periodic meeting and performance review is usually required, particularly if PA/NP off-site
- ✓ Geographic restriction as to distance allowed off-site frequently exists
- ✓ Periodic personal evaluation by physician of patients primarily managed by NP/PA is rarely required
- ✓ Scope of Practice is typically limited to that of the supervising physician



# Practical Issues That Must Be Addressed

## Definition of Specific Supervisory Roles

There should be a clear delineation of supervisory responsibility within any group practice, so the extender can clearly identify to whom patient management questions should be addressed

## Questions are ENCOURAGED!

Extenders MUST feel totally comfortable to ask for advice at any time, without fear of ridicule or embarrassment.

## Remember:

It's YOUR Reputation at Risk  
if they mess up!



# Practical Issues That Must Be Addressed

## “Incident To” Guidelines

( Medicare carrier regulation 2050.1)

- The initial and subsequent services furnished as part of the course of treatment need to reflect the physicians' active participation in the management course of treatment.
- Direct supervision requirements must be met if NP/PA services are billing under the physician's provider identification number.
- Direct supervision guidelines require that the physician must be within the office suite when the service is performed , and immediately available to render assistance if necessary.



# Practical Issues That Must Be Addressed

Patients and referring clinicians must be familiarized and made comfortable with the incorporation of extender colleagues into your practice.

List extender names and degrees proudly on your office marquee, stationary, etc

For New patients - introduce this paradigm immediately in your general practice welcome brochure

For Established patients being transferred – introduce your extenders personally and explain their essential role in your practice



# TRAINING IS CRITICAL !

Patients and referring clinicians rightly expect that the care patients receive through your office will be sub-specialty level quality, regardless of who is primarily seeing the patient.

## NP/PA's are not endocrinologists !

They are trained as generalists, so you have to rigorously supplement their general clinical background before they can be expected to function competently at a specialist level with minimal supervision.

YOUR reputation is on the line here!



# Option 1: Extender does Primary Eval. Of New DM Pts

**First Week: No charge generation !**

Give background review articles/guidelines

Shadow endocrinologist/NP/PA while seeing pts

Conduct individual educational sessions with endo

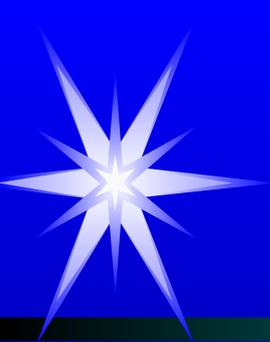
**Spend several days with RN/RD CDE's learning :**

CHO counting/ratio development techniques

Principles and practice of MDI and intensive Rx

Insulin pump features and programming details

Features of various meters & injection devices



# Practical Issues That Must Be Addressed

## Extender and Physician Schedules Must be Integrated For New Patients or Initial Patient Transfer Visits

**This is critical to maintain maximum efficiency and patient satisfaction:**

**Both parties must be cognizant of time, so they don't throw the other way behind;**

**Both schedule templates must be integrated, so that the endocrinologist's schedule is blocked when the extender should be ready to present the case;**

**Consider booking new/Tx patients early am/pm to minimize potential for schedule**



# Option 1: Extender does Primary Eval. Of New DM Pts

## 2<sup>nd</sup> Week:

Schedule one new patient am & pm

Block 2 hours on extender schedule

60 min - History & Physical

30 min – review with endo and see pt

(have to coordinate time block on ENDO schedule also!)

30 min – discussion with pt & dictation

Remaining two hours am & pm spent  
shadowing other NP/PA's (or endo or CDE,  
as they feel most needed)



# Option 1: Extender does Primary Eval. Of New DM Pts

3<sup>rd</sup> – 6<sup>th</sup> week (for DM-focused pts) :

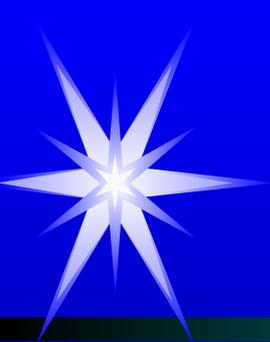
schedule 3 new patients daily as before, with remaining time allotted for 30 - 45 minute follow-up visits (**don't overwhelm them!**).

6<sup>th</sup> - 12<sup>th</sup> week:

schedule 2 – 3 new patients daily, with remaining time allotted for 30 minute follow-up visits

12<sup>th</sup> week on: 2 new patients/day, rest 30" OV

**Be Penny-Foolish, Pound-Wise !**



## **Option 2: Extender sees only Established Patients Tx from Endo**

**Since established patients should generally not need to be seen back quickly, first several months will be spent seeing patients new to the extender, whose schedule will need to be coordinated well in advance with Endo's schedule to ensure appropriate patient selection and allow adequate time for supervision of transfer. Over time, their return pts will predominate, requiring progressively less of Endo's time during working hours.**



## Option 2: Extender sees only Established Patients Tx from Endo

Depending on complexity of case, extender's level of experience, and legibility/organization of chart, allow 30-45 minutes for extender's initial patient evaluation & relationship building and 15 minutes for discussion of findings and recommendations with Endo in the presence of the patient (to reassure them re- extender's command of their situation).

Can bill 99215, using time as basis of charge.

F/U visits will be with extender only.



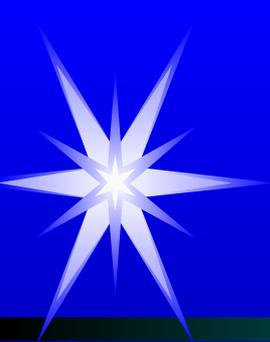
# Disclaimer:

**“Garbage in, garbage out”**

The following economic modeling purports to vaguely represent data from a real world single specialty group endocrinology practice.

The validity of any modeling is critically dependent on the validity of the underlying assumptions.

**Every practice situation is different !**



# Addition of Extenders: Economic Analysis

## Representative Extender Direct Costs (year)

<b>Salary</b>	<b>\$75,000</b>
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<b>Productivity Bonus</b>	<b>\$15,000</b>
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<b>Other Direct Costs/Benefits</b>	<b>\$15,000</b>
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(health/life/disability insurance,  
retirement plan contribution,  
medical liability insurance,  
CME, medical licenses, etc)





# Addition of Extenders: Economic Analysis

If Extender is seeing new consults,  
don't forget to include in your calculations:

**Value of Physician  
Supervision Time**



# Addition of Extenders: Economic Analysis

## Value of Physician Supervision Time\* :

\*work-day time only during initial year

(required to staff new/transfer patients –  
this should decrease significantly over time)

assumes average of 5 hrs/wk X 48 wks  
(4 weeks vacation & CME)

= 240 hr/yr X \$275/hr in lost MD receipts

**\$ 65,000**



# Representative Extender- Associated Costs (year)

## Total Extender-Associated Costs/Yr :

**\$ 185,000: Direct & Associated**

**\$ 65,000: Physician Supervision**

**\$ 250,000 Total**

**(+ \$35,000 for Lab costs if applicable)**



# Economic Analysis

## NP/PA - Associated Revenue Projections

### Numerous variables to consider:

Is your demand for clinical services sufficiently great to keep them busy?

Have you crafted a productivity bonus structure that will motivate them to ensure that their schedule is full?

Can you provide the necessary space and support to allow them to achieve maximum productivity?

Do your contractual allowances, case mix and collection percentage allow you to cover their costs and make a profit?

If Not, STOP IMMEDIATELY !!!



# Option 1: New Pts + OV's Extender Revenue (year)\*

## NP/PA Is Seeing New DM Patients and OV's

New Office Patients (2010 MC Allowance ~ \$180) ~\$ 88,000

assume ave. 2/day = 440 level 5 @ ~\$200 each

Level 4 (30'') OV (2010 MC Allowance ~ \$92) ~\$144,000

assume ave 6/day = 1440 @ ~\$100 each

+/- In-House Labs (inc. lab-only visits) ~\$115,000

(chemistries, A1c, lipids, TFT's, ClCr, Uma, etc)

( 1800 encounters @ \$65 each)

TOTAL: \$230 - 345,000

\*Assumptions: 48 wks X 4.5 days/wk = 220 full working days/yr, 7 hrs billable/day  
average allowances at 110% of Medicare  
net collection rate is at least 95% of allowed charges  
billing is done for on-site supervision using physician billing number at 100%  
allowance (revenue drops ~15% off the top if charges are billed using  
NP/PA provider number, while expenses are unchanged!)







# Option 2: Tx Pts & OV's only Extender Revenue (yr)\*

## NO NEW PATIENTS – OV's & Transfer Pts only

Level 5 OV Tx Pts (1 hr) (2010 MC allowance ~ \$123) ~\$60,000  
assume ave. 2/day = 440 level 5 @ \$135 each

Level 4 (30'') OV (2010 MC allowance ~ \$92) ~\$220,000  
assume ave. 10/day = ~2200 @ \$ 100 each

In-House Labs (inc. lab-only visits) ~\$170,000  
(chemistries, A1c, lipids, TFT's, ClCr, Uma, etc)  
( 2650 encounters @ \$65 each)

**Total: \$280 (450,000)**

**\*Assumptions:** 220 full working days/yr, 7 billable hrs/day  
average allowances at 110% of Medicare

net collection rate is at least 95% of allowed charges

billing is done for on-site supervision using physician billing number at 100%  
allowance (revenue drops ~15% off the top if charges are billed using  
NP/PA provider number, while expenses are unchanged!)



# Option 2 Economic Analysis at 110% Medicare

**NO NEW PATIENTS – OV's & Tx Pts only**

<b>Total NP/PA Revenue (+ Lab)</b>	<b>\$280 (450,000)</b>
<b>Total NP/PA - Assoc Costs(+ Lab)</b>	<b>\$250 (285,000)</b>
<b>Yearly (Loss)/Profit per NP/PA</b>	<b>\$ 30 (no lab)*</b>
	<b>\$165 (with lab) *</b>

## Where do I Sign Up !

\*Direct physician income may be somewhat lower, assuming you do fewer MD OV's and more new pt consults, which typically generate less charges/hr. In addition, some time will need to be spent reviewing charts and discussing cases with extender, which will likely decrease charge generation as well.