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- Moving Beyond Salary
- A Compensation Plan for Vision 2020
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# Impact

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See Page 52 for more details.

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It is truly amazing how quickly a year goes by! This has been a tremendously rewarding year, and it has been an honor to serve as your president.

The work that PPS has accomplished this year is the result first of having a great board of directors. We are fortunate that our board members have a sense of commitment to the section. They bring great vision and are always prepared to discuss the issues that allow us to continue to move the section forward in the best interest of the membership. The board cannot accomplish what we need to without the tremendous support that we get from our executive director, Laurie Kendall-Ellis, and the PPS staff. We couldn’t do it without them; they are incredibly organized and hold our feet to the fire!

The biggest issue facing private practitioners this year is health care reform. I am writing this as I fly home from a Government Affairs Committee meeting that focused on the issues of health care reform. This weekend the committee accomplished an incredible amount and was able to send very specific alerts to the APTA Board of Directors on what we see as acceptable and unacceptable components in any health care reform bill. As of publication, everyone should have received information about the APTA positions. The Government Affairs Committee and staff remain very aware of PPS issues and the impact that legislation could have on our patients and businesses. Two weeks prior to the committee meeting, the PPS board met and also held our strategic planning session. At strategic planning, twenty people committed to charting the direction of the section. Although we all didn’t always agree, the discussions were very productive, and the results will be presented at our general business meeting this month in Colorado Springs.

The big news to come out of the board meeting is that the PPS board decided to hire a lobbyist to help us through health care reform. This is being done in collaboration with Justin Moore, PT, DPT, vice president, Government Affairs & Payment Advocacy, APTA, and will allow us to have more of a voice on the important issues that have impact on private practitioners. Given the unknowns surrounding health care reform, the board felt that it is important to make the biggest commitment possible to advocating for our members and our patients. An overview of our lobbying focus will be presented at the annual conference, and we hope that scheduling allows our lobbyist to attend the meeting to meet and address the membership. We know the health care reform debate will become more intense after legislation is passed and negotiations on the regulations begin; our goal is to align PPS and APTA to be in the best position to have an impact on those regulations.

In closing, I would like to thank you for your continued membership in the section. I also want to thank all the members who have taken the time to contact me and the PPS office over the past year, as the best way for us to work for you is to hear from you. Finally, I would like to wish everyone very safe and happy holidays, and a very prosperous 2010. ■

Tom DiAngelis, PT
PPS President
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In this month’s Impact, you’ll notice a new feature called “Member Spotlight.” One of the best benefits of PPS membership is that it offers us the chance to learn from each other. In Impact, most of our authors are fellow practice owners. As a result, we get to read about the experiences, programs, and strategies of each other. But we don’t often get to read about each other.

Recently, I was doing an annual performance review for one of my key managers and it struck me that it has been more than twenty years since I’ve had a performance review. It got me to thinking. How am I doing at this job? Ultimately, the proof is in whether or not we are reaching our goals, whether they are reputation, financial, quality of life, or any other of the countless goals that drive us each day.

But it would be nice, even beneficial, to see how our peers are doing, what they thinking, how they manage their businesses, what their philosophies and concerns are, and even what they do for fun. While not a performance review per se, it seemed like a good idea to every now and then feel like we are not alone. Hence, “Member Spotlight” was born.

In “Member Spotlight,” you’ll see something new. It is meant to be a fun, light, and interesting look at the many unique owners who make up our section. There will also be much that we all can learn from as well.

If you are interested in being featured in “Member Spotlight,” please contact me at impact@ppsapta.org.

Bad News—Good News

With the close of this year, I’m sad to announce that Susan Isernhagan and Al Amato will be stepping down from the Impact editorial board. We will miss these two very much. Susan and Al were incredible assets to Impact. If you go back and take a look at the two issues they put together earlier this year, you will see what I mean.

Al’s June issue on outcomes, benchmarking, and customer satisfaction delivered top notch practical content from industry experts on how to implement what we all know we should be doing, but don’t always get around to. Then, in July, Susan hit a home run with her in-depth content on the diverse entrepreneurial opportunities in the industrial area. I don’t think any of us could have paid a consultant for what we learned in just these two issues.

Time and again, our section impresses me with the willingness of the members to reach out and help each other. It is something we can all be proud of. Susan and Al, we thank you for continuing that tradition with your service to Impact. Good luck in your future endeavors. If you see them at the Annual Conference this year, be sure to thank them. Remember, the editorial board position is 100 percent volunteer.

The good news is that we have two extraordinary new board members replacing them! Welcome to Deb Gulbrandson of Cary Physical Therapy & Sports Rehab in Illinois. Deb’s been in private practice for 19 years, so she brings a wealth of experience to the board. Also, welcome to Ed Ramsey of Ramsey Rehab in Massachusetts. Many of you will recognize Ed from his frequent posts on the PPS Message Board. If you’ve read his posts you know that he is willing to help and very knowledgeable. We’re fortunate to have these two fine additions to the editorial board.

The Annual Conference Issue

As we plot out our strategies to deal with our competitive, dynamic industry, there’s plenty of buzz about incentive compensation strategies and partnerships for physical therapists. If you have thought of these items recently, there is plenty for you in this issue. Thoughtful consideration and careful planning relative to your goals will ensure a viable model that enhances your practice. The articles in this issue will get you started and be good conversation to those networking at Annual Conference.

Finally, this issue should be out just in time for Annual Conference. I hope to get to meet as many of you there as possible. Please stop me and let me know what you think of Impact so we can improve it and give you what you are looking for in 2010 and beyond. (Be warned, I will try to recruit you to contribute to the magazine!) Also, for all authors from 2009, remember that you are invited to the Author’s Reception on Thursday, November 12, at 6:00 pm. Please do come by and be recognized for your contributions.

Best wishes for success to all who will be implementing enhanced compensation plans in the future. Enjoy the conference!
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Gus Gutierrez, PT, OCS, FAAOMPT
Partner/Clinic Director
BRPT-Lake Rehabilitation Centers
Baton Rouge, LA

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One of the more common questions private practice physical therapy owners face is how to compensate their team of professional staff. The next question for many is, Should I offer ownership to the physical therapist(s) I work with? Because these questions often seem to be asked in sequence, this issue of Impact explores both topics—compensation strategies and ownership models.

Recruitment and retention of team members are cited as leading drivers in most conversations centering around compensation. As practice owners, we strive to recruit and retain the “best and brightest” for our practice and the patients it serves. As such, these standout physical therapists are looking for the best compensation package available, and I would encourage us not to think of this compensation as just monetary. In my experience, many therapists are not looking only for dollars, but rather for opportunity. This opportunity may be in the form of ownership options, but it may also be clinical or business training and mentoring, or a specific practice environment.

In this issue, we have included articles on different living, breathing practice models. They include a few articles on ownership structure and an article on revenue-sharing compensation plans for staff physical therapists. In another article, a dual-credentialed physical therapist and attorney outlines key considerations in bringing on partners that every practice owner contemplating this option should read. Her points are revisited in varying degrees throughout the articles on ownership models.

The take-home message?

Aligned incentives generally work for both the practice owner and the staff (or emerging partner) physical therapist. They provide opportunity for individual growth as well as greater potential financial opportunity. Aligned incentives may lessen an owner’s risk when compared to that of a salaried employee. The opportunity for the individual to earn more dollars if he or she performs well and the practice is successful can attract great people. If the incentives are truly aligned (and well explained), it goes a long way toward addressing recruitment and retention issues.

Former chairman and CEO of General Electric Jack Welch makes a great point: “If you pick the right people and give them the opportunity to spread their wings and put compensation as a carrier behind it, you almost don’t have to manage them.”

Kelly Sanders, PT, DPT, OCS, ATC, is president of San Luis Sports Therapy & Orthopedic Therapy, San Luis Obispo, CA, and an Impact Editorial Board member. She can be reached at kelly@slsportstherapy.com or 805-788-0805.
Member Spotlight
Matthew J. Taylor, PT, PhD

Part 1: Personal Data
Practice, Location: Dynamic Systems Rehabilitation, PLLC, Scottsdale, AZ
Size of practice: Single location, five employees.
Years in practice: Twenty-eight.
Most influential book: Does my Kindle count? It is ergonomically great as opposed to hauling books across country. The “notes” function is a must-have for quotes and bibliographies! Otherwise, Peter Senge’s Presence.
Favorite vacation spot: Paris…no contest.
Favorite movie: Finding Neverland, starring Johnny Depp. It’s all about telling better stories than what is accepted as the norm… and having fun doing it.
How do you like to spend your free time? With my wife and children or in casual conversation with a few good friends.
Like most about your job: Making new friends every day with those I serve.
Like least about your job: Not enough time to do all the fun projects on the back burners.
Most important lesson you’ve learned: I’m not in charge, but I am expected do my best to make things better than I found them.

Part 2: Business Philosophy
Describe your essential business philosophy: Real simple…the Golden Rule and capitalism.
Describe your management style: Guide, mentor, and coach.
Best way you keep a competitive edge: The only person I compete with is myself, so coming back to my personal development practice every day keeps me focused on the edges that need attention. If I take care of that process, I am fine.
How do you measure your success? By the quality of relationships in my life.
Goal yet to be achieved: To meet the president by 2012.
Best decision: To convince my wife to marry me.
Worst decision: Buying a home in northwestern Indiana just as the steel industry there died.
Toughest decision: To go to cash practice plus Medicare.
How do you motivate your employees: I don’t. I create a stimulating environment that invites curiosity and growth.

Part 3: Your Practice
If you could start over, what would you do differently? Not worry what others thought and think for myself and the patient.
Describe your competitive advantage: Offer a high-value experience not available anywhere else in my area of 3.5 million people.
Describe your marketing strategy and highlight your most successful action: Ask for and receive referrals from clients so there are no sales or marketing expenses.
What unique programs do you offer that set you apart from the competition? An integrative, mindful approach to movement and pain management in both individual and group settings in a beautiful, relaxing environment.
What are the benefits of PPS membership to your practice? The camaraderie of peers that get up every morning trying to make things better.

Part 4: The Future
What worries you about the future of private practice? That we will restrict our thinking and potential as leaders in health care by clinging to constrained and tired concepts of human movement and potential. Fear freezes growth and development in individuals and institutions. If we hold onto the image of us as the “exercise” experts, market forces will move toward the most efficient provider—and it isn’t us. The avalanche of complex movement disorders headed our way demands we step up and address problems commensurate with our education.
What are you optimistic about? The potential and creative possibilities of human movement and awareness to bring change and healing to not only individuals, but institutions and communities.
What are your goals for the next year? To complete the curriculum for a certification process in the transformative aspects of physical therapy to directly address the above concerns and realize our fullest potential. I also have a number of book projects to complete.
Where do you see the best opportunities for your practice in the future? In leading the development of group programming to increase accessibility to rehabilitation services and offer affordable options to customers. I also see the development of my faculty to fuel both innovation and new business models that will keep private practice fresh and relevant.
What do private practitioners need to do to thrive in today’s health care environment? I believe if we each embark on a regular practice of movement-based self-development (i.e., not the same old, well-worn ACSM physical “workout”) to enhance our awareness, foster new insight and perspective, and set an example for our employees and patients, things will work out just fine. If we practice as we do because “we must” or “to get paid,” business dynamics will roll right past us and we will be a small fragment of what we can become.

Matthew can be reached at matt@myrehab.com.
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Executive Summary
This article provides an attorney’s perspective on the common question, “Should I offer my employees ownership in my practice?” The author reviews key considerations practice owners should ponder when contemplating bringing on additional owners.

One of the most common questions I am asked as an attorney is how to bring an employee on as a shareholder or partner in a private practice. Occasionally the business owner is looking for an exit strategy for retirement, but the overwhelming majority of physical therapists who call me are desperate to hire someone and want to use the promise of ownership as a recruitment tool. This is not a good idea. Being in a business is like being in a marriage. When things go wrong, divorce can be both painful and expensive. Therefore, private practice owners should choose their partners wisely! Not every physical therapist wants the responsibility or risk of being an owner. It’s best if both the owner and the employee assess this before jumping in bed together. Here are a few pieces of advice.

1. DO NOT offer prospective or new employees an ownership interest until after you have worked with them past the “honeymoon” phase. Don’t even imply it! This can create a claim for breach of contract, or worse, cause bitter employees to open their own private practice across the street from you. If you are going to offer future ownership opportunities up front, make it contingent upon meeting clear performance expectations pursuant to an employment agreement. Consider offering “phantom” or “shadow” stock, requiring employees to gradually earn their shares on a vesting schedule, giving both you and the employees some time to make sure the relationship is going to work before they become full-fledged owners. Consult legal counsel before you begin negotiations, because verbal agreements are sometimes enforceable.

2. Evaluate the employee’s business owner acumen and work ethic. Don’t just offer ownership as a reward for clinical competency and/or longevity. Clinical competency should be a minimal expectation. Clinical excellence doesn’t necessarily need to be rewarded with ownership either. Ask yourself whether you could replace the employee with another equally qualified physical therapist. If the answer is yes, consider whether you can encourage outstanding performance with a bonus instead of ownership shares. Then ask yourself, “If this employee left and opened a clinic across the street, would he or she be a real threat to my business?” If the answer to that question is yes, offering shares may be an absolute necessity.

3. Require employees to buy their shares. Their willingness to contribute capital and take on risk is a good indicator of how serious they are about taking on the responsibilities of being a business owner. If the employee doesn’t have capital up front to invest, a payroll deduction could fund the share purchase, but make sure you consult an attorney about any possible tax or securities law issues.

4. Evaluate your options for maintaining management control and your ability to allocate profits and losses under your corporate structure and bylaws.
If you are structured as an S-corporation, you can maintain management control by offering nonvoting shares or controlling the new shareholder’s interest percentage. However, you cannot allocate profits and losses except through salaries and bonuses, and if a shareholder decides to leave the organization, you may find yourself buying back the shares you issued. A partnership, or limited liability corporation (LLC) that is taxed as a partnership, has more flexibility in allocating profits and losses among members. In addition, if the LLC is manager managed, you can bring the employee on as a member (similar to a limited partner in a partnership) with limited rights and responsibilities. An LLC that is taxed as an S-corporation does not have the same flexibility.

5. Consider the option of setting up a separate business entity for new business ventures or a new clinic in order to limit any risk to the established business, particularly if the two businesses could have different owners. The businesses can still share services and employees through contract agreements, but the established business would not be liable for the losses of the new venture.

Every practice, owner, and employee is different. There are many ways to motivate and reward hard-working employees. Whether you, as the business owner, decide to reward employees with equity ownership or some other form of compensation, protect the business that you’ve built by investing in good advice before you give away the store!

Gwen Simons, PT, JD, OCS, FAAOMPT, is a physical therapist and an attorney at Simons & Associates Law in Scarborough, ME. She can be reached at gwen@simonsassociateslaw.com.

Consider improving your continuing education benefit. Offer more funds and/or days off, for example. An investment in the skill of your staff helps improve the quality of your services and shows your staff that you are committed to their professional development. That’s a win-win.

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A Comprehensive Partnership Model

By Kevin Hulsey, PT, DPT

Executive Summary
This article illustrates one practice’s partnership model built on the concept of a career ladder. The concepts of return on investment (ROI), retirement, and exit strategy are highlighted as benefits of this model.

Partnerships have long been used to grow businesses, acquire capital, share risk, reward success and as exit strategies. Physical therapists should use partnerships to accomplish these same traditional business goals.

If one has chosen a “partnership” as the model of choice for their business, structure and formality of that partnership is critical. It is the intent of this article to offer one model of how one may choose to structure a partnership.

Businesses are owned and partnerships are entered into for many reasons. Partnerships afford you the opportunity to share risk and liability. Partnerships allow for economy of scale, to do more with less. Partnerships can provide a wonderful opportunity to insure that you get everything you need out of your business.

A partnership should include elements of autonomy, flexibility, and personal and professional development, what I will call a “Career Ladder.” One should also receive a return on investment (ROI) for the literal cash investment risked. Consideration should also be given for blood, sweat, and tears you have poured into your business and your partnership. I will call that the “retirement benefit.” Finally, a partnership should offer an exit strategy. How do I get out of this thing...when I want to, on my terms?

Before I get much further, I must stress that the model that I am presenting has evolved over the past ten years with input from several business consultants, accounting groups, and many attorneys. I cannot offer legal or tax advice. You are advised to consult with legal and tax experts in your state to make sure that your organization is within the legal and regulatory limitations of your state.

Career Ladder. Physical therapists, particularly those in private practice, are competitive and driven to progress. There should be a clearly laid-out map for progression in your partnership. We progress qualified individuals from “Owner” to “Partner” to “Senior Partner.” Each progression involves pay raises, increased benefits, and elevated partnership responsibilities and titles. See Table 1.

Return on Investment. Each partner must have “skin in the game.” Without risk and cash investment, the blood, sweat, and tears of ownership cannot be fully realized, and therefore the partnership and the business will never be fully appreciated. When you invest cash, you expect a cash return on that investment. The ROI is consistent with the sharing ratio or shares that each partner owns. Our share value is based on a “Net Asset Valuation.” There are a myriad of methods to value your practice, and your accountant and tax preparer may have a preferred method. We fix our share value at $1.00 and return all profits above the $1.00 share value back to the “Owners” in the form of Dividends. The share value is based on tangible, real value of the company. When our partners leave the company, their initial investment ($1.00 per share) is returned to them over a five-year period.

Retirement Benefit. You should expect a reward for all of the late nights, early mornings, missed recitals, and missed ballgames. This is the “blue sky” of your business.
This is the intangible part of your business that is difficult to value, as no one will ever fully appreciate the sacrifices you have made to make your business a success. Your partners are the closest people you will ever meet that will have any idea of the intangible, blue-sky value of your contribution to the success of the business. We recognize and reward the intangible success of a partner with an “Unfunded Retirement Benefit” (URB). “Unfunded” because you do not set aside money in an account to make the payments; that would be considered a “funded” benefit.

Our URB is calculated in a matrix based on points. Points are accumulated in our matrix based on the following factors that we deemed important to our partnership:

- **Salary**—the more you make, the more valuable you are to your business.
- **Dividends**—The greater the risk, the greater the reward.
- **Bonus**—Our bonuses are paid on corporate or business contributions, and those should be recognized above and beyond treating patients.
- **Profitability**—Beyond profit sharing, one should be recognized and rewarded if clinics or divisions under one’s stewardship are profitable.
- **Growth**—growth is important to our partnership, and direct contributions to growth, clinics, or partners are rewarded.

### Table 1

<table>
<thead>
<tr>
<th>PARTNERSHIP LADDER</th>
<th>URB (UNFUNDED RETIREMENT BENEFIT)</th>
<th>CLASS A SHARES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pathway to Partnership/Corporate Ladder</strong></td>
<td><strong>What do I get when I am finished?</strong></td>
<td><strong>1. Must be purchased with cash</strong></td>
</tr>
<tr>
<td><strong>1. Access</strong></td>
<td>1. Not a guaranteed benefit</td>
<td>2. Purchases may occur only at the annual shareholder meeting</td>
</tr>
<tr>
<td>a. Invitation only—Unanimous vote of board of directors</td>
<td>2. Based on many factors</td>
<td>3. Valued at $1.00</td>
</tr>
<tr>
<td>b. Must be employed one year</td>
<td>3. Matrix will decide “points”</td>
<td>4. True ownership</td>
</tr>
<tr>
<td>c. Must be risk tolerant</td>
<td>a. Salary</td>
<td>5. ROI = dividends</td>
</tr>
<tr>
<td><strong>2. Owner</strong></td>
<td>b. Dividends</td>
<td>6. Dividends paid quarterly and annually</td>
</tr>
<tr>
<td>a. Has been officially invited to participate</td>
<td>c. Bonus</td>
<td>7. Buy-out</td>
</tr>
<tr>
<td>b. May purchase/own Class A shares</td>
<td>d. Profitability</td>
<td>a. 5 yr/60 months</td>
</tr>
<tr>
<td>• Title(s) = PT, owner, rehab director, executive titles, etc.</td>
<td><strong>5. Points will equate to dollars</strong></td>
<td>9. Voting privileges – 1 share = 1 vote unless otherwise noted</td>
</tr>
<tr>
<td><strong>3. Partner</strong></td>
<td><strong>6. Vesting Schedule</strong></td>
<td><strong>10-year pay-out, after Class A shares have been paid out</strong></td>
</tr>
<tr>
<td>a. Purchased/owns a minimum of 10,000 Class A shares</td>
<td>a. 0–3 yr = 0 benefit</td>
<td><strong>7. Penalties possible for early dissociation that leaves debt</strong></td>
</tr>
<tr>
<td>b. Benefits</td>
<td>b. 4 yr = 10%</td>
<td><strong>1. Must be purchased with cash</strong></td>
</tr>
<tr>
<td>• Health Savings Account with $100/mo health care benefit</td>
<td>c. 5 yr = 20%</td>
<td>2. Purchases may occur only at the annual shareholder meeting</td>
</tr>
<tr>
<td>• Cell phone</td>
<td>d. 6 yr = 30%</td>
<td>3. Valued at $1.00</td>
</tr>
<tr>
<td>• Con-Ed = $750 per year</td>
<td>e. 7 yr = 40%</td>
<td>4. True ownership</td>
</tr>
<tr>
<td>• 4 weeks of paid time off</td>
<td>f. 8 yr = 50%</td>
<td>5. ROI = dividends</td>
</tr>
<tr>
<td>• Tax prep</td>
<td>g. 9 yr = 60%</td>
<td>6. Dividends paid quarterly and annually</td>
</tr>
<tr>
<td>• Eligible to participate in real estate ventures</td>
<td>h. 10 yr = 70%</td>
<td>7. Buy-out</td>
</tr>
<tr>
<td><strong>Path</strong></td>
<td>i. 11 yr = 80%</td>
<td>a. 5 yr/60 months</td>
</tr>
<tr>
<td>• Profit driven over a 52-week period</td>
<td>j. 12 yr = 90%</td>
<td>8. Penalties for early dissociation</td>
</tr>
<tr>
<td>• Cash invested</td>
<td>k. 13 yr = 100%</td>
<td>9. Voting privileges – 1 share = 1 vote unless otherwise noted</td>
</tr>
<tr>
<td><strong>4. Senior Partner</strong></td>
<td><strong>7. Penalties possible for early dissociation that leaves debt</strong></td>
<td><strong>10-year pay-out, after Class A shares have been paid out</strong></td>
</tr>
<tr>
<td>a. Purchased/owns a minimum of 50,000 Class A shares</td>
<td><strong>8. Penalties for early dissociation</strong></td>
<td><strong>7. Penalties possible for early dissociation that leaves debt</strong></td>
</tr>
<tr>
<td>b. Benefits</td>
<td><strong>9. Voting privileges – 1 share = 1 vote unless otherwise noted</strong></td>
<td><strong>10-year pay-out, after Class A shares have been paid out</strong></td>
</tr>
<tr>
<td>• HSA with $250/mo health care benefit</td>
<td><strong>10. Penalties for early dissociation</strong></td>
<td><strong>7. Penalties possible for early dissociation that leaves debt</strong></td>
</tr>
<tr>
<td>• Cell phone + spouse cell phone</td>
<td><strong>11. Voting privileges – 1 share = 1 vote unless otherwise noted</strong></td>
<td><strong>10-year pay-out, after Class A shares have been paid out</strong></td>
</tr>
<tr>
<td>• Con-Ed = $1,000/yr</td>
<td><strong>12. Penalties for early dissociation</strong></td>
<td><strong>7. Penalties possible for early dissociation that leaves debt</strong></td>
</tr>
<tr>
<td>• 6 weeks of paid time off</td>
<td><strong>13. Voting privileges – 1 share = 1 vote unless otherwise noted</strong></td>
<td><strong>10-year pay-out, after Class A shares have been paid out</strong></td>
</tr>
<tr>
<td>• Tax prep</td>
<td><strong>14. Penalties for early dissociation</strong></td>
<td><strong>7. Penalties possible for early dissociation that leaves debt</strong></td>
</tr>
<tr>
<td>• Eligible to participate in real estate ventures</td>
<td><strong>15. Voting privileges – 1 share = 1 vote unless otherwise noted</strong></td>
<td><strong>10-year pay-out, after Class A shares have been paid out</strong></td>
</tr>
<tr>
<td>• Eligible for URB!</td>
<td><strong>16. Penalties for early dissociation</strong></td>
<td><strong>7. Penalties possible for early dissociation that leaves debt</strong></td>
</tr>
<tr>
<td><strong>Path</strong></td>
<td><strong>17. Voting privileges – 1 share = 1 vote unless otherwise noted</strong></td>
<td><strong>7. Penalties possible for early dissociation that leaves debt</strong></td>
</tr>
<tr>
<td>• Profit driven over a 52-week period</td>
<td><strong>18. Penalties for early dissociation</strong></td>
<td><strong>7. Penalties possible for early dissociation that leaves debt</strong></td>
</tr>
<tr>
<td>• Cash invested</td>
<td><strong>19. Penalties for early dissociation</strong></td>
<td><strong>7. Penalties possible for early dissociation that leaves debt</strong></td>
</tr>
</tbody>
</table>

PTNERSHIP MODEL, continued on page 16
Once you have your matrix, and point values, you then need to assign a dollar value to the points. We use the total equity number from our balance sheet to assign a dollar value to the points. We also implemented a vesting schedule for the URB. Our vesting schedule offers no URB for the first three years of partnership and escalates 10 percent per year thereafter. The URB is paid out over a ten-year period, and begins after the initial investment has been returned over the first five years of retirement. So, the first five years of retirement returns the initial investment and the next ten years reward via the URB for a total of fifteen years of payments.

Why points? Points are not taxed. Gifted shares are a taxable event at the time of the gift, not necessarily at the time the shares are monetized. See Table 2 for an example of these concepts.

**Exit Strategy.** This model has a mechanism for repayment of your cash investment, a mechanism for rewarding you for your blood, sweat, and tears (URB), that includes incentive for growth of new partners that are being groomed to take your place. Plus, terms of your buy-out have been predetermined.

Partnerships can be a wonderful tool to offer you what you want out of your business, a career ladder, ROI, URB, and built-in exit strategy! If you are getting any less than this from you business, you may consider some other models for business that will help you get what you want from ownership.

---

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### Table 2

**PARTNERSHIP PROGRAM—EXAMPLES**

<table>
<thead>
<tr>
<th></th>
<th>Salary 1 Point / $1,000</th>
<th>Dividends 1 Point / $1,000</th>
<th>Bonus 1% of Salary 1 point / $1,000</th>
<th>Profit Sharing 1 Point / $1,000</th>
<th>Growth Points</th>
<th>TOTAL Points</th>
<th>URB Pool $276 / pt.</th>
<th>Vesting</th>
<th>Class A Shares $1.00 ea</th>
<th>Total Retirement Class A + URB Pay / mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 yr Owner</td>
<td>65</td>
<td>0.5</td>
<td>0.65</td>
<td>0.3</td>
<td>66.5</td>
<td>$16,946</td>
<td>0%</td>
<td>$0</td>
<td>$10,000</td>
<td>$10,000 0.5%</td>
</tr>
<tr>
<td>5 yr Partner</td>
<td>330</td>
<td>2.5</td>
<td>3.25</td>
<td>2.5</td>
<td>100</td>
<td>438</td>
<td>$120,957</td>
<td>20%</td>
<td>10,000</td>
<td>$10,000 0.5% $167 / $201</td>
</tr>
<tr>
<td>10 yr Senior Partner</td>
<td>715</td>
<td>27.5</td>
<td>10</td>
<td>9</td>
<td>200</td>
<td>961</td>
<td>$265,374</td>
<td>70%</td>
<td>50,000</td>
<td>$235,761 $833 / $1,548</td>
</tr>
<tr>
<td>14 yr</td>
<td>955 ($75k/yr)</td>
<td>37</td>
<td>16</td>
<td>14</td>
<td>300</td>
<td>1,322</td>
<td>$364,872</td>
<td>100%</td>
<td>50,000</td>
<td>$220,000 $833 / $3,040</td>
</tr>
<tr>
<td>20 yr</td>
<td>1,405 ($90k/yr)</td>
<td>58</td>
<td>33</td>
<td>43</td>
<td>500</td>
<td>2,039</td>
<td>$562,764</td>
<td>100%</td>
<td>100,000</td>
<td>$662,764 $1,667 / $4,690</td>
</tr>
</tbody>
</table>

**EXPLANATION of your Unfunded Retirement Benefit (URB)**

1. First column is “The Owner.” I have attempted to demonstrate a possibility over the span of a career at RehabAuthority (RA).
2. Second column shows how you will accrue points based on salary. The salary points begin to accrue when you are officially invited to participate in the Partnership Program. Points increase as salary increases.
   a. Owner/Partner/Senior Partner (O/P/SP) will receive one URB point for every $1,000.00 of salary received each year.
3. Next column is “Dividends.” Return on investment (ROI) is an important part of our Partnership Program. Risks, cash investment, and “skin in the game” are important measurements of ownership. A partner’s willingness to assume risk is certainly a factor in the calculation of your retirement benefit.
   a. O/P/SP will receive one URB point for every $1,000.00 of dividends received.
4. Next, we wanted a system that would reward the partners for business contributions to RA, outside of treating patients and building a practice. Paying a bonus based on a performance review is a direct reflection of the contributions of the O/P/SP!
   a. O/P/SP will receive one URB point for every $1,000.00 of bonus received.
   b. Executive positions require work outside of the day-to-day grind of seeing patients.
   c. We want to reward and recognize our O/P/SP for exceptional work.
   d. To be eligible, one must have “Exceeded Expectations” on their job performance review.
   e. Realizing that many owners fill many titles, this bonus is based on the title that is the highest on the organizational chart. Ideally, this is the title that would contribute the most to the infrastructure of our organization.

Continued on page 17
f. The O/P/SP will complete the review as an exercise of self-reflection. Then, the O/P/SP will contact the person directly above them on the organization chart for completion of the review. It then becomes the responsibility of the person completing the review to schedule the in-person review, before November 30 of the year in question.

g. If you have “Exceeded Expectations” on the performance review in question, you will receive a 1 percent cash bonus in December.

h. If the O/P/SP does not complete their portion and notify their senior on the organization chart, the O/P/SP becomes ineligible for a bonus for the year in question.

i. If the O/P/SP completes their portion of the review and notifies their senior for completion, but the senior fails to finish the review before November 30 of the year in question, it will be assumed that the O/P/SP in fact scored “Exceeded Expectations” and will receive the cash bonus and the URB points.

5. Next is profit sharing. Profit sharing is a direct reflection of the success of RA. Profit sharing, under our system, is also a direct reflection of the success and contributions of the leadership of the clinic(s) that receive profit sharing. This needs to be recognized and rewarded.

   a. Profit sharing will be paid per RA policy.
   b. O/P/SP will receive one URB point for every $1,000.00 of profit sharing received.

6. The final column in the matrix recognizes growth.

   a. Growth is the life blood of every organization, and RA is no exception.
   b. We are a partnership company that is “pleased but never satisfied!”
   c. Growth requires more physical therapists. More physical therapists yield more clinics. More physical therapists and more clinics will result in more great partners to help us drive our Vision.
   d. Every O/P/SP is rewarded, indirectly, for growth by increased salaries, increased benefits, increased dividends, and increased profit sharing.
   e. Every O/P/SP is directly rewarded for contributing to the long-term success of RA.
   f. We will reward and recognize partners for contributing directly to the growth of the company by bringing new clinics and/or new partners.
   g. The board of directors will assign the growth points.
   h. Each new clinic/entity will result in the issuance of about 100 growth points.
   i. Each new Senior Partner recruited/attracted will result in the issuance of about 100 growth points.
   j. The points will be officially awarded at the annual shareholder meeting.
   k. The board of directors may also choose to recapture growth points if a clinic closes without ever reaching a profitable level, and/or if a Senior Partner leaves RA prematurely and that Senior Partner is penalized for early departure.

7. Next is the total number of points earned by each partner.

8. Next is your percentage based on the total earned. Keep in mind that as we progress, your percentage may go down, but your actual value—the net worth, the bottom line of your URB—should grow!

9. URB pool is the pool of money available to pay out to anyone deciding to retire. Your percentage of points will dictate what percentage of URB pool dollars you are eligible for. We will calculate this amount annually as a multiple of two times total equity (found near the bottom of the balance sheet) for the prior calendar year. Last year we were at about $1,200,000, so, $1,200,000 x 2 = $2,400,000.

10. Your total URB is subject to vesting and potential penalties if your dissociation causes undue financial distress to RA and/or its partners. The intent is to reward loyalty and longevity.

11. Next is the Class A shares. This is the total cash invested in RA.

   a. Class A shares will be fixed at $1.00 each.
   b. The difference in share value, based on an annual net asset valuation, will be distributed pro rata in the form of dividends.
   c. When a partner is dissociated, the value of their Class A shares will be returned to the partner over a five-year period, sixty equal installments, no interest.

12. Lastly is total retirement, the amount you will receive if you leave RA.

   a. This column offers total value of the retirement package.
   b. The second line offers the amount of the sixty monthly installments to buy back the Class A shares.
   c. Next in that same row is the amount of the monthly URB installment, based on 120 equal monthly payments.

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Esq., PT, OCS, FAAOMPT

Impact - 17

November 2009
An Employee to Partner Pathway

By Julie Ellis, PT, SCS, CSCS

Executive Summary
This article outlines three key points to consider before offering a partnership to a physical therapy employee. The author then outlines the process her practice employed to add additional partners to the organization.

Are you an owner of a successful private practice? Do you have physical therapists in your practice who display qualities that would make them a great addition to your partnership? Have any of these physical therapists expressed interest in joining your partnership? Have you planned how you will handle your transition from working partner to retirement? All of these questions will need to be addressed as your practice grows and matures. The purpose of this article is to outline the method that we chose as our transition plan.

Before I describe the method that my co-owner and I used to bring in new partners, I would like to highlight three important points:

1. Bringing in a new partner requires careful thought and planning. In my opinion it is a good idea to work in the clinic and in the management arena with the physical therapist for a year or more so you both feel secure that your treatment and management styles blend well. You may risk failure if you do not know your future partner’s skills and personality traits. In the August 2009 issue of Impact (p. 38), Erika Trimble outlined the ten qualities of a partner. I encourage you to read this article and take the quiz. If you don’t have the August issue at hand, find it on the PPS website in the Impact archives.

2. Transition planning takes skill and knowledge. In his book Transitions, James E. Glinn, Sr., PT, describes how to position your physical therapy practice and create your succession plan. I encourage every practice owner to read this book before planning an exit strategy. Glinn points out that there are many choices to make when transitioning. He explains how to understand the “goodwill value” of your practice. Glinn’s book leads you through the preparation, implementation, and completion of the sale of your practice.

3. You will need to hire experts. You will need an accountant skilled in valuation and tax issues and a lawyer who can write your buy/sell agreement.

My partner and I began our practice in 1987, and by 1999 we knew we had a great opportunity and wanted to bring in a third partner. We used our accountant to help us value our practice and began the process of creating a practical method to allow our third partner to buy into the practice. This process took almost a year because we took the time to work on a very thorough agreement that would

![Diagram showing 1987: Opened practice. Two equal partners split profits equally, worked equal hours. 2001: Third partner buys in at 33.3%]
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The function of a good buy/sell agreement is to allow this transition to occur smoothly, without additional financial stress on the business.

2008 we brought in two additional partners at a different percentage than the original three partners. We envision that one partner may want to exit in the next ten years. The function of a good buy/sell agreement is to allow this transition to occur smoothly, without additional financial stress on the business.

Our accountant believed that valuations should be kept as simple as possible. He explained that experience taught him that if you have three different persons valuing the business, then you usually get three wide-ranging valuation amounts. The first questions he asked were what do you believe the business is worth, and what do you feel would be a fair price to sell at? It may be that you need go no further if you can come to an agreement at this time.

We needed help to value the goodwill, or “blue sky,” of the business. Valuing the assets such as the equipment and accounts receivable was something we could be exact about, as we knew what percentage we collect on average, how much it costs to replace equipment, and how much equipment can be sold for. The accountant used various methods to come up with the goodwill valuation. Present value of cash flows and percentage of net revenues are examples of some methods used. We used this expertise only the first time we needed a valuation.

Since then, we have a yearly meeting after the previous year’s financial statements and tax returns are completed and decide between the partners if the amount of goodwill we had determined the previous year should be increased or decreased. Factors we would consider upon revaluing include any increase in profits, business climate, potential for gaining or losing new revenue sources, and legislation affecting insurance reimbursement. We then formally put that into the minutes of our partners’ meeting and the partners sign off on that amount, thereby agreeing that this is the amount of goodwill we will use if a buy/sell event should occur.

This goodwill valuation number also was discussed whenever we decided to add partners. Essentially we would take the goodwill number and add to that the fair market value of the equipment and other assets and the collectible value of the accounts receivable, subtract the fair value of the liabilities of the partnership, and multiply this times the percentage offered for sale. This was a take-it-or-leave-it offer, and we would not negotiate price. If the potential partners agreed to the buy-in amount, we would negotiate the terms, such as the amount down, the length of payoff, and the interest rate. We chose seven years with no down payment and an interest rate equal to what we used within our partnership agreement to allocate profits. The terms we would offer would take into account the potential new partners’ ability to pay. We also looked at the buy-in installment payments embodied in the deal to see, based on our financial history, if the potential partners could make the payments through their increased cash flow from the business. We did not want them to endure undue stress to make the payments, but on the other hand, we wanted them to have an investment of their own money in the partnership so a decision to leave the partnership would have financial considerations for them.

The graphs below outline the history of the introduction of partners into the business and also project the buy-out of the senior partner in the future.

Julie Ellis, PT, SCS, CSCS, is co-owner of Center For Physical Rehabilitation in Twin Falls, ID. She is currently serving as the PPS secretary and has been on the Board of Directors for five years. She can be reached at jept@magiclink.com.
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Executive Summary
This article outlines a compensation strategy in which staff physical therapists participate in a revenue-sharing plan. The author elaborates on the thought process she used to develop this plan as well as the approach she used to present the plan to her team of physical therapists.

One of the few positive things to come out of the University of Washington’s dismal football season was a conversation I had with my sister-in-law, a physician, as we tried to distract ourselves from another beat-down of the Huskies. We may have been discussing motivation (“What does it take for Willingham to coach this team to a win?”) or salaries in general (“We paid $1.43 million for this?”), when she mentioned that she, like many physicians in a group practice, is paid a percentage of her charges. In contrast, my staff physical therapists were paid a set salary with a bonus based on the number of patient visits. In outpatient physical therapy, however, this was making less financial sense, as our reimbursement was languishing and even declining with some carriers, causing revenue to stagnate—even with high patient visits. Our profit margin was shrinking and staff expected progressive wage increases; they did not realize the effect of the current health care climate on the bottom line. Why not adopt a profit-sharing compensation plan for my physical therapists, similar to physician models?

After researching a variety of compensation plans and formulas, I chose to revise our current compensation policy to a revenue-sharing plan. Simply put, each physical therapist is paid a percentage of the expected revenue of their monthly billing, based on current reimbursement fee schedules. As physical therapists continue to move toward autonomous practice, I felt that this compensation plan fit with the goals of Vision 2020 (American Physical Therapy Association, June 2007, www.apta.org). In establishing this compensation plan, I followed these guidelines:

1. Compensation should build professional respect and independence by rewarding excellent clinical practice and customer service.
2. Compensation should be fair and equitable to the company and physical therapist while increasing awareness of current health care reimbursement issues.
3. Compensation should encourage teamwork and group practice in order to share overhead costs and provide practice stability.

In staff meetings, units per visit and visits per month were routinely discussed, and physical therapists had a rough idea of how much was billed per visit. However, more specific knowledge of our clinic’s fee schedule and expected revenue, or discounted amounts, was needed for them to feel comfortable with this compensation plan. Using data from three prior months, the physical therapists were shown what they billed out, expected revenue, as well as the more familiar numbers of units per visit and total visits. These numbers were plugged into a spreadsheet showing them expected compensation for those months under this new plan. I also reviewed current reimbursement fee schedules for our major carriers, including Medicare and Medicaid, and the average discount our clinic took on charges.

To present a complete picture of both revenue and expenses, I compiled a summary of each physical therapist’s total cost to the company. This included salary, medical and dental benefits, paid time off, employment taxes and federal
contributions made by the company, professional liability insurance, continuing education, and other fringe benefits. This total sum was considered their individual overhead expense.

There was some concern that moving to a compensation system based on individual performance would create competition or encourage a physical therapist to start his or her own practice. To demonstrate the benefit of staying in a group, I also showed them a simplified expense report for administrative overhead. This included administrative and support staff wages, supplies, rent, advertising, and all other overhead expenses. When divided among the physical therapists, they could see the benefit of remaining in the group to collectively pay for these unavoidable expenses.

For many owner/physical therapists, the idea of profit can be a difficult subject to discuss with employees. Employees see us working as physical therapists, but often do not see the extra hours put in performing administrative duties or understand the element of risk. There are loans to repay, planning for the future, payroll that must be covered even when Medicare decides to freeze payments for a week, and a myriad of unseen risks with private practice ownership. Fortunately for us, risk is offset with many rewards, one of which is profit. I explained to the physical therapists that some profit should remain in the company coffers to cover unexpected expenses, capital expenses, and growth opportunities; and, that as the owner, with my name on the line and the ultimate responsibility of the company in my hands, some profit returns to me. However, under this plan, more profit returns to them as well.

This type of compensation plan and how to implement it becomes very specific to each practice’s financial and patient care goals, as well as the physical therapists involved in the program. Because it is a sharp departure from a typical salary plan, a transition period that allows physical therapists and owners to evaluate the possible changes is recommended. Another option would be to have a lower guaranteed base salary with a bonus based on a percentage of revenue. However changes are implemented, compensation should always encourage a higher level of professional respect and responsibility and advance our profession as a whole.

Holly Gullickson, PT, OCS, CSCS, is President/CEO of Cascade Sport and Spine Rehabilitation, Centralia, WA. She can be reached at hollyfritzpt@comcast.net or via U.S. mail at PO Box 1338, Centralia, WA 98531.
A Compensation Plan for Vision 2020

By Patrick D. Graham, PT, MBA

Executive Summary
Payment is flat. Salary expenses are increasing. Read this article to learn about an innovative compensation strategy that emphasizes shared risk and reward.

As the profession of physical therapy approaches Vision 2020, one of many issues that continues to move to the forefront of practice in our field is compensation. Historically, compensation has been under the auspices of the employer/employee model. Our profession has focused on physical therapists getting a job rather than going into a profession. This concept causes a contradiction in Vision 2020 and how I believe we are evolving as a profession. If we are to be an autonomous profession, should it not include the entire spectrum of our profession, including methods of payment?

The average payment for an outpatient visit over the last fifteen years has increased 1 percent to 10 percent. The average starting salary has increased by 100 percent to 120 percent, and the minimum wage has increased 71 percent. It doesn’t take a mathematician to figure out that if our expenses continue to grow at these astounding rates and payment stays flat or decreases, our profession is in a losing position.

In private practice, there are some major hurdles to overcome. If you have spent the better part of your career personally sacrificing time and finances to build a practice, you may find it difficult to allow a “newcomer” to come in and benefit from all your labor. Independent control and the name you have built are a large part of your practice’s success. We often conclude that the only thing to offer people is partnership (ownership). I believe that there are other ways to reward employees. So how do we elevate to an autonomous profession without always having to look at ownership?

My practice has chosen to reward professionals according to their body of work and to hold down fixed costs. This system establishes a shared risk-and-reward compensation model that is quite different than the traditional employee/employer model with a salary and a 9-to-5 mentality. The basis of our plan is to encourage people to be accountable in the way they practice and deliver their individual services. We have monthly visit and procedure floors and targets. Once physical therapists exceed both of these measures, they are paid a per-visit fee. There are multiple levels at which they are rewarded beyond the base numbers. The reward is paid monthly so it is more frequent, and the entry levels in the program are achievable. This provides room for professionals to develop “their practice” and have a direct reward for their efforts. The base salaries and per-visit fees increase as tenure with our company increases, as well.

Our plan is also designed to encourage accountability for professional behavior. This includes understanding the various payers and how they reimburse for services. We also look at customer satisfaction. We do this by evaluating the ratio of patients seen to the number of patients scheduled. Our plan creates an environment in which physical therapists are encouraged to call their patients to remind them of their appointments rather than settle for openings in their schedule caused by no-shows. This also promotes professional accountability, as patients who receive poor care tend to miss or cancel appointments, suggesting a problem with the physical therapist. Clinical documentation is also a critical component, as compliance and ethical treatment are a must for professional and autonomous behavior. Monthly chart audits that examine frequency, procedures, documentation, and outcomes are performed to hold the physical therapist to a high professional standard.
In our system, professionals are encouraged to excel in these areas, many of which are the founding pillars of our company. Through this method, professionals develop a sense of ownership and accountability, as well as receive direct reward for their efforts. This sense of ownership enables them to contribute to the overall management and operation of the entire practice. Our model works for all of the health care settings in our spectrum of care. It has provided the sense of ownership, accountability, and autonomy that I feel is needed to be a successful profession in the future. Actual ownership can be a part of this model, but not a necessity.

If we do not make this paradigm shift as a profession and welcome fellow professionals with a compensation system that encourages excellence, then I don’t believe there is any way to accomplish Vision 2020 and truly be autonomous. We need to promote the concept that physical therapy is more than just a job, it is a profession. As practice owners, we must be more than employers looking for employees.

Patrick Graham, PT, MBA, is president and chief operating officer of Human Performance & Rehabilitations Centers, Inc., Columbus, GA. He served as PPS vice president from 2005 to 2007. He can be reached at pgraham@hprc.net.
“Expect the unexpected” was a common recommendation made by speakers at APTA’s 2009 State Government Affairs Forum. Hosted in Phoenix by the Arizona chapter, this year’s forum attracted a record number of attendees from across the country to discuss issues that chapters are facing in their state houses and to share the lessons learned from experience.

Being prepared for the unexpected in state legislative affairs is not only a good idea, it’s critical. Chapters cannot afford to be caught off guard when there is so much at stake. Recognizing that chapters need information and support, APTA’s State Government Affairs Department coordinates this annual forum so that chapter members, staff, and lobbyists can network with colleagues and enhance their awareness of both ongoing and emerging issues.

The forum opened with a discussion of health care reform. An up-to-the-minute briefing on reform efforts in Congress was provided, and those efforts were critiqued by two Arizona state representatives. The priorities of APTA’s Government Affairs Committee were described and discussed. On the state level, the Health Care Home model of primary care being implemented in Minnesota was described at its current point in development.

Attendees heard about the Kentucky state board’s legal process involving an orthopedic practice that offered “PT services” provided by an athletic trainer and billing 97001 and 97002 CPT codes. This discussion of statutory protection of the term “physical therapy” revealed how exemption clauses in statutes can expose the risk of threat to terminology protection.

In support of chapters’ efforts against the ongoing attempts by chiropractors who seek to make manipulation unlawful for physical therapists, the work of the APTA Manipulation Task Force was described. Its multifaceted approaches serve to help defend the scope of physical therapy practice and promote thrust manipulation training.

The Wisconsin chapter shared the results of its physical therapy workforce survey, which looked at the various practice settings and geographic areas within the state. APTA’s Research Department’s support in addressing workforce issues was discussed, and assumptions about causal factors were explored. Various solutions such as increasing class sizes in physical therapist and physical therapist assistant programs were critiqued, and each state was challenged to collect employment data on all licensees.

Three workshops highlighted potential areas of legislative action relating to emerging technology and scope of practice. Diagnostic sonography by physical therapists was discussed in the context of legislation that may prohibit the use of therapeutic ultrasound by physical therapists as states attempt to define qualified sonographic providers. The workshop on animal rehab raised issues around the regulation of physical therapists and others who provide these services. These issues included scope of practice and term and title protection of physical therapy. The low-level laser workshop highlighted the need to examine related and little-known statutes that impact physical therapy scope of practice as newly developed technologies emerge.

Being prepared and vigilant as chapters seek elimination of referral for profit is more important than ever. While chapters research and debate legislative and legal approaches to this concern, the American Academy of Orthopaedic Surgeons is actively pursuing a strategy of inserting language into physical therapy practice acts that would guarantee a physician’s right to own a physical therapy practice.

This year’s forum also focused on an analysis of the Iowa chapter’s efforts to curtail physician referral for profit through the rulemaking process and on a lawsuit in the state of Washington against a physician-owned physical therapy practice. These differing approaches and their risks were examined and followed by small group discussions and an open forum.

In light of the notion that referral for profit affects the practice of physical therapy in settings beyond private practice, participants generated ideas and strategies to increase awareness of request for proposal among members and nonmembers. Compliance issues were identified that expose our practices to the same criticism by regulators as are being leveled against physician-owned physical therapy services. This prompted an examination of our own practice-and-referral arrangements as they relate to referral for profit.

Find out which physical therapists and student physical therapists attended the forum for your state and find out what they learned that can help protect and promote physical therapy in your state. And think about attending next year’s forum in Portland, OR, or consider sponsoring someone else to attend. So much is at stake and it will pay off to be prepared.

Kathleen Picard, PT, is vice president of OSI Physical Therapy in Stillwater, MN. She can be reached at kpicard@therapypartners.com.
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Tom DiAngelis, PT, President of HCS Consulting

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When we read the pages of Impact, the importance of successful marketing and the work that goes into developing a successful marketing program are readily apparent. When considering marketing options and determining the appropriate individual or firm to market a particular practice, remember that certain federal and state laws may affect the way a marketing relationship can and should be structured. One of the key considerations in structuring such a relationship is maintaining compliance with the requirements of the federal Anti-Kickback Statute and its regulations (collectively, the Anti-Kickback Rules).

The Anti-Kickback Rules make it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration (commonly thought of as a payment or reward) to induce referrals of items or services reimbursable by federal health care programs. At first glance, this language appears to describe a marketing relationship. Partly because of this apparent conflict between the Anti-Kickback Rules and the need to market health care generally, the Department of Health and Human Services, Office of Inspector General (OIG) has addressed this issue to assist private practices and others with compliance in this area. One of the key differences addressed in the OIG’s guidance, at times directly and at times indirectly, is whether the practice’s marketer is a bona fide employee of the practice or an independent contractor retained by the practice to provide marketing services. The OIG analyzes these relationships differently under the rationale that an independent contractor has less accountability to the practice than an employee, a factor that may raise additional concerns for the OIG.

In the independent contractor context, the OIG has stated that while it believes that many marketing and advertising activities may involve at least technical violations of the statute, it recognizes that many of these activities do not warrant prosecution. The OIG has indicated that many advertising and marketing activities warrant safe harbor protection (protection under which a payment is not treated as a criminal offense under the Anti-Kickback Rules) under the personal services and management contracts safe harbor. To satisfy the safe harbor, there are a number of requirements, including, but not limited to, that the agreement be in writing and signed, set out the services to be provided, not be for a period of less than one year, and set the compensation in advance consistent with fair market value in an arm’s-length transaction. Additionally, the compensation cannot be determined in a manner that takes into account the volume or value of referrals or business otherwise generated between the parties. As to the issue of compensation in this context, the OIG has indicated that suspect characteristics of these arrangements include compensation-based factors such as percentages of sales. Whether the requirements of the safe harbor are met or whether the Anti-Kickback Rules are otherwise violated is determined on a case-by-case basis.

In the employee context, remuneration under the Anti-Kickback Rules specifically does not include an amount paid by an employer to an employee who has a bona fide employment relationship. Since an amount paid to a bona fide employee is not remuneration, and remuneration is an element of the Anti-Kickback Rules, the Anti-Kickback Rules are generally not the controlling factor in analyzing a marketing relationship in the employer/employee context. As a result, there may be increased compensation options in a marketing relationship with an employee as opposed to that with an independent contractor.

Overall, there are a number of different arrangements through which a marketer, whether as an employee of the practice or through an independent contractor relationship, can offer services to benefit the practice. When structuring such an arrangement, it is important that a practice consider the Anti-Kickback Rules and assure that its particular arrangement is compliant with those rules, as well as any state laws or other federal rules that may be implicated.

Paul Welk, PT, JD, is a Private Practice Section member and a physical therapist attorney with Tucker Arensberg, P.C., where he frequently advises physical therapy private practices in the areas of corporate and health care law. Questions or comments can be directed to pwelk@tuckerlaw.com or 412-595-5536.

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Private Practice Website Essentials

By Tannus Quatre, PT, MBA

As with most things of importance, there's a lot to know when developing an online presence for a private physical therapy practice. And as the relevance of the Internet continues to grow for both practices and patients, the need to keep up to speed with a number of essential elements required for good website development grows, too.

This article covers a number of these elements, providing an overview of the aspects of the private practice website that truly matter to you and your patients. Specifically, we’ll look at design, navigation, information, and integration—each of which plays an important role in giving your audience an online experience that will attract them to your practice and keep them there.

Design
The most important aspect of the private practice website, design is the first element your audience will see, and it will frame the rest of their online visit. Design is the element that engages and keeps visitors on your website long enough to evaluate you as a potential provider, and it is often the first impression that they’ll get of your practice. Regardless of your practice size or website budget, you should keep the design elements below in mind when designing your website.

Branding. Your website is an extension of your practice’s brand identity. Make this extension rich with your brand essence through the use of a color scheme and design elements that clearly identify your brand. Communicate your brand identity by including key messages that are essential to your brand identity, such as taglines, slogans, and testimonials.

Cleanliness. If you were providing a tour of your practice to a potential client or referral source, you’d tidy it up, right? Ensuring that your website is neat and tidy is equally important—and it takes an eye for detail. Cut out the clutter of long, bulky descriptions of services, and use ample white space to offer the visitor an experience that speaks softly yet confidently of your services, without the visual “noise” associated with the use of too many words, images, and icons.

Consistency. Because people browse quickly through web pages, layout consistency between pages is key to providing visitors with a structured, visually appealing experience on your site. Important elements of consistency include the location of site-specific information such as site links and navigation bars, as well as page-specific information such as the location of images and content. Using a consistent image size and location of page-specific information will provide the visitor with an experience that is both reliable and easy to navigate.

Navigation
Second only to design, navigation is critical to the development of a good private practice website. Navigation makes the difference between a user experience that is efficient and productive, and one that is frustrating and leaves users without the information they are seeking. To ensure fluid site navigation on your website, consider the following principles.

Leverage intuition. When navigating from one page to the next, make it easy on visitors by providing an intuitive navigation scheme that makes sense to virtually everyone. Use classic navigation schemes that are oriented to either the left or top margins, and leverage dropdown menus to provide useful navigation information without requiring extra clicks.

Provide options. Not everyone thinks alike, so providing users with more than one way to get to the information they are looking for is often a good idea. The use of classic navigation (described above) combined with navigation based on your visitors’ reasons for visiting can work well. A visitor who can quickly identify sections for “New Patients” and “Existing Patients” can efficiently get to the appropriate section of your website without having to negotiate through several pages via a classically oriented navigation menu.

Don’t allow users to get lost. “Breadcrumbing” is the term for offering visitors constant information about where they are located within your site. A breadcrumb is a hyperlinked path that allows users to quickly identify where they are and allows them to return to earlier stages of the path simply by clicking on the appropriate hyperlink. For example, the breadcrumb “Home > Services > Manual Therapy” tells users that they are on the Manual Therapy page, which can be found within the Services section of the website.

Don’t show visitors the door. A simple click of the mouse can close your visitor's browser window, and your website becomes history. Don’t make it even easier by placing links to external sites from your website without ensuring that those links open into a new browser window or tab. If you want to link to the APTA website from yours, that’s a great idea—just make sure that your visitor doesn’t leave your site to get there.

Information
Believe it or not, information is not the most important element of the website. In the absence of good design and navigation, information can be intimidating or confusing to website visitors. This said, information is what your visitors are after, and for this reason its importance shouldn’t be understated. Below
are some of the most important page sections that should exist within your website, as well as the information that each should include.

**Home.** The home page should form a good impression through clean design and simple, catchy text that emphasizes a high-level overview of the benefits that will be gained from your services. Effective home page content will engage readers and get them to click through to another page of your website.

**About.** An about page is important to building the foundation of a trusting relationship with your audience. Visitors who look at your about page will be there because they want to learn more about your company and your staff, so don't be afraid to leverage your unique characteristics, credentials, and accolades.

**Services.** Your services page(s) should be detailed and accurate, reflecting the actual services your practice renders. It is common to break this section out into subpages that are dedicated to each service. However, be sure that you have enough engaging, relevant information to dedicate to each if you will organize your site this way.

**Payment.** Payment options are on everyone's mind these days, and providing your visitors with a list of accepted payers...
and methods of payment will help to eliminate unwanted surprises during the office visit. It is also a good idea to include your practice’s financial policies in this section, informing your patients of their financial responsibilities following their care.

**FAQ.** Especially among small practices, a section devoted to frequently asked questions (FAQs) is commonly underused, leaving visitors with questions that sometimes result from holes or omissions in a website’s content. The FAQ acronym is widely regarded by online users as a place to go to see what questions visitors have had and to get answers to those questions in a simple, Q & A format.

**Forms.** Long viewed as an enhancement to the private practice website, the ability to download necessary forms and documents has become an expectation of most visitors to physical therapy and medical websites. A common reason for clients to visit your website in the first place, the ability to download forms from your website is simple to accomplish and can save you hours of administrative time in the office over the course of a few months.

**Testimonials.** The easiest and most effective piece of your marketing efforts comes directly from your patients’ mouths; it should land directly on your website. It costs nothing to elicit positive testimonials from your patients and should cost the same to upload that valuable information onto your website. Don’t miss this effective and easy opportunity to allow your patients to speak on your behalf online.

**Promotion.** As consumers, we are programmed to be on the constant lookout for products and services that are new, unique, or specifically relevant to our lives. Adding and changing promotional items on your website that display relevant service offerings is an effective way to attract interest from your visitors.

**News.** You might not be aware of it, but news about your practice is actually of interest to your visitors. News about your recently hired receptionist or the addition of your new sports specialty offerings is an effective way to attract interest from your visitors.

**Contact.** The ultimate objective of a good website is to generate enough interest so that prospective clients will contact your office, expanding your business. To facilitate this, your contact page should include a simple online form that visitors can fill out in less than 30 seconds, as well as maps and driving directions to your practice location(s).

**Integration**

As much effort, time, and money as you sink into your website, it’s important to realize that an entire world exists beyond your website, and tapping into this world can be a lot easier than you think. Applying some of the web integration principles outlined below will open the door to a whole new world of web traffic and potential clientele.

**Social media.** Social media sites such as Facebook™ and Twitter™ are engaging hundreds of millions of online visitors worldwide. Regardless of your practice location, residents in your area are probably using these tools to connect with others. By connecting your website to these online networking portals, you can easily showcase your relevance with today’s technology and have the opportunity to engage with your clients and community in a way that distinguishes your practice from competitors.

**Keyword advertising.** The use of keyword advertising enables you to target your specific audience segment. By placing targeted ads next to keywords that are relevant to your audience (“physical therapy,” “your city,” “injury,” etc.), you can capture some of the online research that is going on in your market, converting it to traffic on your site and patients in your practice.

**Blogs.** You may read blogs, you may write blogs, but have you ever used a blog to drive traffic to your website? It turns out that blogging can be one of the most effective strategies for driving relevant traffic to your website, simply by blogging about topics that are rich in keywords that your audience is searching online.

**Online listings.** Did you know that information about your practice exists among a number of popular online directories located on the Internet? Sites such as Yahoo!’s Local, Google’s Maps, and Bing™ contain information about thousands of businesses online, including yours. By properly maintaining these listings, including working links to your website and positive reviews from your clients, you will truly leverage the power of these sites as a potential traffic source for your practice.

**Search engine optimization.** Perhaps the most complex principle to understand for the development of an effective online presence is that of search engine optimization (SEO). SEO cannot be fully be detailed in this brief overview; however, the use of proper website coding and content management in a way that optimizes the placement of your website in search rankings (Google®, Yahoo!®, etc.) will go a long way toward facilitating traffic to your website.

With all that is available online for the private physical therapy practice, it’s important that practice owners take the simple steps to use this technology to attract and retain clientele. The principles outlined in this article are intended as a starting point from which this can be accomplished, regardless of practice size, specialty, or budget.

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Tips for Managing Email

By Dena Kilgore

Used efficiently, email can be a powerful business tool. Take advantage of these helpful tips to improve your management of email. The results may be extraordinary. Note: some of these tips may apply only to Microsoft Office Outlook and Outlook Express.

1. Set up “always check spelling before sending” in your email.
   From the inbox page, click on Tools/Options/Spelling/Always check spelling before sending. To add a grammar check, click on the “Spelling and Auto Correction” box.

2. BLUF: Bottom Line Up Front.
   Clearly state what you need from someone at the beginning of an email. Use the ABC format: state Action needed first, then Background info, and Close at the end.

3. Be very specific in the subject line, so a recipient knows exactly what the email is about.
   It will help to get your message noticed if the recipient gets a lot of email. Consider using action words at the start of the subject line—ACTION: INFO: REQUEST: URGENT: CONFIRMED: DELIVERY: to help the recipient know whether action is needed.

4. For short messages, consider using just the subject line, ending with “-EOM” (End of Message). That will tell the recipient there’s no need to open the email.

5. To save emails onto your hard drive, hit F12. Limit the number of personal folders you use to house emails. Save important “keepers” on your hard drive, which has more storage capacity.

6. Consider adjusting the schedule for pop-up notification of a new email so that you’re not interrupted each time you receive an email.
   Go to Tools/Options/Mail Set Up/Send/Receive. It supposedly takes 64 seconds to recover from an email interrupt to workflow.

7. Auto Archive allows you to easily access any emails to or from any of your contacts.
   Open the contact and click on the “activity” tab. You will see a list of all sent and received items related to that contact.

8. Sort emails by person or subject when on a conference call or preparing for a meeting to see all relevant emails grouped together.
   You may also assign colors to emails from particular people to help group them.

9. Always answer emails promptly.
   We all know how frustrating an unacknowledged email can be. Don’t leave the sender hanging!

Dena Kilgore is director, Component Services, American Physical Therapy Association. She can be contacted at denakilgore@apta.org.

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Before you decide whether to outsource your billing or do it in house, you must have a clear understanding of the entire billing function. Whether you are dealing with various insurance companies, direct-access patients, home care, nursing homes, or cash-paying customers, you must be sure that your services are correctly charged and your billing function is properly managed and in compliance with established guidelines.

If you don’t understand the billing process, then it is difficult to either hire someone to do your billing in house or outsource the function because you won’t know what to expect or how to hold either your employee or the third party accountable. It’s easy to find a person or a company to talk the talk, but how do you know if they can walk the walk?

Hiring a competent business management consultant who is intimately familiar with physical therapy operations will help you to make informed decisions that will fit your style. The more informed you are, the better decisions you will make. Many private practice owners need assistance in running the business side of the practice, and that includes understanding billing and collection policies and procedures. And there is a lot to know! A consultant can help you set up efficient billing and collections processes in house or help you choose an appropriate billing company for your practice. This is a very important decision.

The “entire” billing process includes

- Collecting at time of service from patients with no insurance
- Checking the patient’s insurance benefits before treating the patient
- Checking for a referral or authorization
- Collecting copays at the time of service from patients with a copay responsibility
- Entering charges for the services provided by the therapist
- Ensuring claims are sent timely and that they are received
- Ensuring all rules of compliance are followed
- Posting payments and making contractual adjustments
- Billing balances to patients or a secondary or tertiary insurance
- Following up on daily denials
- Following up on claims not paid: managing accounts receivable (A/R)

Assuming you have adopted best business practices and have reviewed your options for a competent outside billing company, let’s look at some of the positive things that in-house billing and outsourcing offer.

**In-house billing—You control the day-to-day operations.**

- You know who is responsible for the processes.
- You know if your charges are being entered daily and billed out the same day.

**Outsourcing billing—You leave the billing process to a professional service company.**

- You hire a professional billing company with the experience to manage the billing and collection process:
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  - They have appropriate coding experience.
- They manage any denials and consistently follow up on unpaid claims.
- They provide reports to help you manage your practice.
- They are consistently up on changes in the industry.
- They know and understand all compliance issues.

- You have less staff to pay, train, and manage.
- You save on the hiring process.
- You have no loss of productivity for training new billing staff.
- You do not have to pay for a billing system (although you could purchase your own billing system and have the billing company process through your program if that option is available).
- You pay a monthly fee.

**In-House Option**
The major complaints of doing in-house billing include time to manage the staff, the cost of the staff (payroll and benefits), not knowing how to hire the right staff, lack of proper training, out-of-control A/R, lack of time for meetings, and not being sure that your staff is consistently up to date on changes and compliance issues in the industry.

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Here are some suggestions for doing your billing in house:

- Learn the entire process.
- Put billing and collection policies and procedures in place to ensure accountability.
- Learn how to hire the most appropriate staff for the job.
- Have a comprehensive training and development program in place.
- Create billing and collection handbooks and make sure they are consistently updated with current insurance and reimbursement information.
- Hold weekly staff meetings to ensure there are no major issues that will delay the billing process (computer problems, electronic billing issues, etc.).
- Bill out your charges and post your payments daily.
- Review month-end statistics with the biller so you can understand and identify any pitfalls.
- Ensure that staff is collecting from patients at time of service.
- Ensure that statements are sent at least monthly to all patients with balances.
- Ensure that collections are consistently done beginning at thirty days.

**Outsource Option**

The major complaints of outsourcing your billing include unreliable companies, not knowing if billing and posting payments are done daily, no reconciliation processes, lack of communication, not knowing where your money is (out-of-control A/R), not getting outcome reports that allow you to run your business effectively, and little to no feedback from the company.

Here are some suggestions for outsourcing your billing:

- Choose a billing company that can give you some physical therapy billing references.
- Check references; ask about outcomes of the services.
- Ask about the system the company uses for physical therapy billing. (You do not want your billing done on a physician billing system.)
- Ask for a sample of reports the company will be giving you.
- Look for a company that will offer you options:
  - You own the system and it will bill remotely or come onto your site.
  - It will train your staff on your system to enter demographics and do the referral management.
  - The billing company owns the system and will train your staff to ensure the flow of information it needs to do the job is obtained.
  - It will help you move from in-house billing to the company or move you from your current billing company to the new company.
- The company will consistently schedule month-end meetings to explain and review reports.
- It gives you the tools to hold the company accountable to you.
- It can assure you that no accounts will be written off without your consent.
- It will train your current and new staff to ensure the company gets the information it needs to do the job.

Whether you do billing in-house or outsource, here are some tips for holding both approaches accountable:

- Know how to check the system to ensure billing is consistently up to date.
- Know how to check to ensure payments are posted as they are received.
- Ensure that all charges and payments have a reconciliation process and that process is always followed.
- Ask questions.
- Know how to interpret your A/R: check the changes and understand why the A/R is going up or down.
- Do not accept excuses—get results.
- Consistently check the denials: why are you getting them?

Whatever way you go, you must have highly efficient systems in place to ensure that you are paid for the services you provide, you are compliant, and you always know where your business stands financially. Take the time to learn what tools will help you the most. Don’t rely on others to run your business unless you have the tools in place to ensure accountability and reduce your liability. Use the best resources to help you make your decision.

*Diane McCutcheon is president of Business Management Consulting Services, Inc., in Milville, MA. She can be reached at dmccutcheonbmcsi@aol.com.*
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The Power of Nice: How to Conquer the Business World with Kindness

By Linda Kaplan Thaler and Robin Koval
Bantam Books, 2006
Reviewed by Kelly Sanders PT, DPT, OCS, ATC

The title of this book speaks for itself. The authors draw from both personal anecdotes and professional experiences in building one of the fastest-growing advertising agencies in the country. Their premise: The old adage “nice guys finish last” often does not hold true in business.

Kaplan Thaler and Koval open the book describing what they note as the six “power of nice” principles:

1. **Positive impressions are like seeds.**
   They describe these as the little things you do: saying hello to the parking attendant, picking up something someone has dropped, and so on. These are actions that you don’t anticipate getting anything directly out of at the moment. Rather, “you plant them and forget them, but beneath the surface, they are growing, often exponentially.”

2. **You never know.**
   Many people assume that a person they meet is unimportant or cannot help them. The book illustrates that you never know who you will come in contact with and what doors they will open up for you if you are nice.

3. **People change.**
   The authors note that some individuals choose to be nice only to those who are peers or superiors, but not those they see as subordinates. Principle #3 observes that people, as well as their positions and motivations, change, which may put them in a position to help you at some future point if you have created a positive relationship or impression.

4. **Nice must be automatic.**
   Nice should be something you are to everyone, all the time. If it is not a part of your everyday attitude, it will not likely be something that brings consistent benefit.

5. **Negative impressions are like germs.**
   Negative behaviors may get you the immediate action you are looking for, but like germs, they will quietly affect you and those around you.

6. **You will know.**
   The authors say it best when they note the power of nice is “about valuing niceness—in yourself and others—the same way you respect intelligence, beauty or talent.” Basically, you can’t fake it.

After outlining the principles above, the book dedicates a chapter to each of the tools the authors feel are needed to begin using the “power of nice” successfully. A brief summary of each tool follows:

1. **My favorite idea:** The author’s term, “baking a bigger pie.” This involves supporting other people, sharing resources, and helping them to realize opportunities. One of my favorite quotes from the book: “…when you let others share the ownership of an idea, you create a community of people who will help to nurture and grow those ideas into something far greater than you ever imagined.”

2. **The authors remind readers to “sweeten the deal.”** This includes everything from having a bowl of chocolates at your office to telling jokes, saying it with a smile, and remembering to compliment people.

3. **“Help your enemies” reminds readers that enemies can turn into friends, and approaching everyone with kindness generally promotes better outcomes than spending energy tearing down a competitor.**

4. **“Tell the truth” and be able to hear it from those around you. This is not limited to honesty as a general trait; it also includes being sincere in your actions and conversations. When communicating hard truths, lead with some positive truths. Sometimes we may have to help others realize the truth on their own when it’s too hard for them to hear it from someone else.**

**BOOK REVIEW, continued on page 43**
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Whenever you are engaged with another party whose goals may conflict with yours, you could end up sabotaging your own position if you don’t have enough information—information about the standard practices, the requirements of the other party, or your own essential needs. Health plan contracting is no different. It’s better to know the lay of the land before you enter into the process than to find yourself at a loss in the thick of it.

Unfortunately, many physical therapists don’t do the proper espionage when it comes to health plan contracting and end up with contracts that are not only disadvantageous to their practices, but also contribute to the downward pressure on contracted rates for the profession as a whole. Sometimes it’s because they don’t understand the payment mechanism or the contract terms. I once received a call from a physical therapist who didn’t understand how he could be losing money when he got a capitation check for $10,000 each month. When we walked through the numbers, it turned out that he was getting approximately $14 per visit. He didn’t understand how capitation really worked. All he knew was that the health plan gave him the prevailing rates at the time. Unfortunately, he had accepted a deal he really should have walked away from.

Avoid contracts that don’t cover costs
Sometimes physical therapists accept poor contracts because they don’t understand their own cost of doing business and so accept less than it costs to provide the service. Or they look at the contract as “fill-in” business, but it becomes “fill-up” business over time, crowding out better-paying patients. When physical therapists accept low-paying contracts, the health plans consider these rates the new norm and expect other offices to take them as well. A physical therapist may believe he or she will balance out lower-paying contracts with higher-paying business; however, that can lead to a downward spiral when total reimbursement is reduced and nothing’s left to balance out.

Finally, physical therapists often sign contracts because they are afraid of losing access to a particular group of patients. But it’s usually more advantageous to walk away from deals that don’t cover your costs and instead let your competitors fill up their practices with these patients.

Here are some key items to consider when contemplating a contracting opportunity:

- **The cost of providing a visit.** This is basic. Physical therapists need to know their fixed and variable costs and what it truly takes to deliver a treatment visit. Resources like the PT Benchmark Study (http://www.hcsconsulting.com/bench2010.html) can assist here.

- **Excess capacity (or lack thereof) within the practice.** Is there really excess capacity that cannot be either reduced or filled in another fashion (e.g., with cash-pay wellness services)? If so, and the physical therapist feels that some business is better than no business, can the amount of business under this contract opportunity be controlled so it doesn’t crowd out better-paying patients?

- **Payment amount and methodology.** Does the payment cover costs? Is the fee schedule made an explicit part of the contract? Is it understandable and transparent, or does it rely on vague diagnostic categories or references to internal fee schedules?

- **Payment and claims submission timelines.** How long does the payer have to pay and how quickly does the practice need to submit claims?

- **Overpayment recovery methods/time frame.** Can the payer reclaim overpayments from current patients? How far back can recovery efforts go?

- **Provider fees or withholds.** Are any fees or withholds mentioned in the body of the contract? The payment schedule is normally an exhibit to the contract, but these fees are usually “hidden” within the body of the document.

When physical therapists accept low-paying contracts, the health plans consider these rates the new norm.
Methods for directing patients to the practice and number of covered lives in the area. The tighter the direction, and the greater the number of covered lives, the more it’s worth giving a discount.

Amendment. Can the contract be amended unilaterally by the payer, including amending the fee schedule?

Termination clauses. The most important part of any contract is how to get out of it. Does the contract lock in the practice for an overly long term? How difficult is it to get out of the contract?

Your deal-breaker points. On what points will you not compromise? As with any deal, you have to know when to walk away.

Finally, if a practice belongs to a network, the first thing to do when approached with a contracting opportunity is to contact the network to see if a group contract is being considered. Individual practices have much less clout when it comes to rates and contract terms, and it is almost always more advantageous to have a network work on a contract for the entire group.

Nancy Rothenberg is vice president of PTPN, a national therapy network headquartered in Calabasas, CA. She can be contacted at nrothenberg@ptpn.com or 818-737-0225.

BOOK REVIEW, continued from 40

5. “Yes’ your way to the top” is a chapter that reminds us that “yes” opens doors and possibilities and “no” breeds negativity. We want to interpret and react to issues in a positive way and find a way to say “yes” to some part of each situation.

6. The “shut up and listen” chapter is straightforward, as the title implies. It also demonstrates the power of asking instead of telling.

7. Finally, the authors say to “put your head on their shoulders” when interacting with others. Basically stated, employ empathy!

The book provides countless easy-to-read examples of how these principles have benefited the lives of individuals and businesses.

Kelly Sanders, PT, DPT, OCS, ATC, is president of San Luis Sports Therapy & Orthopedic Therapy, San Luis Obispo, CA, and an Impact Editorial Board member. She can be reached at kelly@slsportstherapy.com or 805-788-0805.
Weathering a Changing Payment Environment
What’s the Forecast for Health Care Reform and Payment Policy in 2010?

By Justin Moore, PT, DPT

As the leaves turn and the temperature drops, many practice owners and physical therapists in private practice begin their business planning for 2010. Forecasting in this uncertain environment challenges one’s nerves and confidence. This year this exercise is complicated by the ever-changing landscape of health care reform and the dynamic regulatory environment at the federal level.

As this article is being written, health care reform is weathering the complex legislative process, with no predictable outcome on the radar. The U.S. House of Representatives has reported out legislation, HR 3200, America’s Affordable Health Choices Act, from the three major committees that have jurisdiction over health care. This legislation would include a public plan option in the health care exchange and several key provisions that advance APTA’s policy priorities.

Essential to physical therapists in private practice are provisions to change the flawed fee schedule formula that has been building annual cuts in Medicare payments of about 5 percent per year over the past several years. Without congressional action, these cuts will compound to a 21 percent reduction in the Sustainable Growth Rate (SGR) portion of the fee schedule formula to calculate the conversion factor. HR 3200 replaces this flawed formula with an update for 2010 of the percentage of the Medicare Economic Index. Beginning in 2011, the SGR would be replaced with two updates: (1) evaluation and management services and Medicare-covered preventive services, and (2) all other services not described in (1). This revised formula is to be updated by the change in gross domestic product (GDP) plus 2 percent for evaluation and management services, and GDP plus 1 percent for all other services.

Other provisions to note in HR 3200 are the two-year extension of the current exceptions process on the therapy cap under Medicare Part B, an extension of the updated payments for rural areas related to the geographic practice cost index (GPCI), and continuation of payments for quality reports under the Physician Quality Reporting Initiative (PQRI) through 2012. APTA continues to work with House leaders on provisions to improve access to physical therapists by elimination of the certification of the plan of care or referral under Medicare; provisions to curb fraud and abuse through physician self-referral/referral for profit; and other regulatory reform and administrative simplifications, such as opt-out provisions under Medicare.

HR 3200 is the standard-bearer on the House side, but it will undergo significant modifications and debates as it heads to the House floor for a vote. Across the Capitol, the Senate has moved its version of health care reform through one of the two committees of jurisdiction. The Senate Health, Education, Labor, and Pensions (HELP) Committee has approved its version of health care reform, which includes the framework for insurance reform, including a public plan option in the health care insurance exchange. In addition, this version has extensive provisions on investments in health information technology, prevention and chronic care management, and workforce initiatives. The Senate HELP Committee does not have jurisdiction over tax-writing provisions and therefore did not have policy changes or provisions related to Medicare and Medicaid.

The Senate Finance Committee released its version of health care reform, America’s Healthy Future Act, in early September. This legislation includes a one-year fix on the fee schedule at a 0.5 percent update and a two-year extension of the current therapy cap exceptions and GPCI payments. It also makes significant modifications to the PQRI program, in which physical therapists in private practice are eligible to participate. The program would continue bonus payments through 2011 and then begin to penalize providers for not meeting quality reporting requirements in 2012 with a 1 percent penalty in the first year and a 2 percent penalty in subsequent years.

APTA is also engaged in the emerging issue of bundled payments for postacute care and their impact on outpatient physical therapy services. Both the House and Senate versions of health care reform outline national pilots on this model of payment for postacute care. The bundling proposals look at current services provided in long-term acute care hospitals,

WEATHERING CHANGE, continued on page 46
During the reorganization at APTA in 2008, the Reimbursement Department was combined with the Federal and Regulatory Department to form a new department called Payment Policy and Advocacy. This move combined the federal payment area, including Medicare, Medicaid, and State Children’s Health Insurance Program (SCHIP), with the private insurers. The private insurers also included the workers’ compensation and motor vehicle insurers. These departments were brought together owing to the many similarities payers have, including payment policy issues, coverage determinations, and fee schedules. It was also decided that the term “payment” better reflected our vision for the future and expanded our view of how physical therapists would be paid for their services.

If you look at the definitions, “reimbursement” involves a repayment or compensation by others for an expense. Paying back, refunding, and repayment are all words associated with reimbursement. “Payment,” on the other hand, is an exchange of money for services provided, regardless of who pays for the services, which means in our case that the patient remains responsible for paying for the physical therapy services.

Most physical therapists believe we should be paid for our services and that the overarching responsibility for this payment lies with the patient. We understand that frequently an additional party is involved in this transaction (any form of insurance), but the ultimate responsibility for payment lies with the patient. If the insurer denies or rejects the bill, then the patient remains, in most cases, responsible for payment of the bill because of the financial responsibility the patient agreed to during the intake.

There are also many instances when the physical therapist might be paid directly by the patient. Many physical therapists are now asking for cash at the time of service because they have no contractual relationship with a particular insurer or because the services provided are not covered by the insurer. The patient/
On September 16, the Centers for Medicare and Medicaid Services (CMS) issued a final rule (74 Fed. Reg. 47458) that prohibits Medicare from recouping provider and supplier overpayments during the first level of appeal—the redetermination—if the provider or supplier files a timely request for appeal.

The final rule implements a provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that required certain changes to the recoupment process.

Before the MMA, CMS could recoup overpayments regardless of whether a provider or supplier had appealed the determination. The MMA prohibits the recoupment of Medicare overpayments during a provider or supplier appeal to a qualified independent contractor (QIC).

CMS said it received eleven comments on the proposed rule implementing this provision, which was issued in September 2006 (71 Fed. Reg. 55404).

The fee-for-service appeal process consists of redetermination by a Medicare contractor, reconsideration by a QIC, and a hearing before an administrative law judge, followed by the Department of Appeals Board, and finally federal district court review.

In the final rule, CMS said it included revisions to make clear that it was implementing the statutory requirement to limit recoupment during reconsideration (the second level of appeal), as well during redetermination (the first level of appeal).

Under the final rule, providers or suppliers must file a first-level appeal within forty-one days and a second-level appeal within sixty days to halt recoupment.

The final rule also specifies that if an overpayment determination is overturned in administrative or judicial appeals above the QIC level of appeal, CMS is liable for interest on recouped overpayments that has accrued since the original determination.

CMS added that it does not interpret the new statutory provision as amending its authority to recover overpayments from providers or suppliers that have been placed on payment suspension.

The final rule is effective November 16, 2009.

WEATHERING CHANGE, continued from 44

inpatient rehabilitation facilities, and skilled nursing facilities. The House bill extends to home health and hospital outpatient services. The pending Senate Finance Committee bill extends to physician services. APTA is working with congressional leaders to ensure access to outpatient services, decrease facility base incentives, and provide patient safeguards to ensure choice and equity across the health care continuum. APTA is also working to ensure that other innovative models of care delivery, such as accountable care organizations or medical homes, do not limit access to a patient’s physical therapy provider of choice.

As outlined above, the forecast for congressional action on health care reform is cloudy. By publication date, the details could drastically change. In addition, the next couple of months hold a significant challenge for congressional leadership. To move legislation in 2009 will take an aggressive calendar this fall on Capitol Hill, and the odds for success are up in the air.

Beyond the media headlines and sound bites, health care reform is occurring on a daily basis on the regulatory level. In the proposed calendar year 2010 Medicare Physician Fee Schedule rule, several policies impacting physical therapists in private practice were outlined. APTA will work to support provisions that advance physical therapy and work to modify areas of concerns. After years of static or declining payments, the proposed rule outlines the possibility of a 10 percent increase in practice expense relative value units (RVUs) and work RVUs. The practice RVU impacts are primarily from the proposal in the rule to incorporate PE data from a new survey, the Physician Practice Information Survey (PPIS). In addition, the proposed fee schedule rule would continue the PQRI program for physical therapists in private practice with a 2 percent bonus for successful compliance with the program. There are currently 168 approved measures, including eight that physical therapists can report. The rule also includes provisions outlining policies on cardiac and pulmonary rehabilitation and canalith repositioning.

As the fall turns toward winter, we should begin to see some clarity in the payment policies for 2010 and their impact on physical therapists in private practice. The numbers range from a 21 percent cut to a positive update of double digits. The swing from the potential cuts to the potential update is as wide as
we’ve seen in physical therapy. This volatility does not comfort anyone in this profession or related to the business of this profession. Its potential of a double-digit positive update under Medicare is encouraging news in a decade of diminishing margins and static payments. This could set a new framework for the years to come for physical therapists.

A full analysis and assessment of the payment policies impacting physical therapy will be held in conjunction with PPS’s conference in Colorado Springs. The fall will see many twists and turns on Capitol Hill and in the Centers for Medicare and Medicaid Services and other policy arenas. Keeping informed and engaged is essential. APTA and PPS’s websites are the best sources to keep on top of the details as the policies change over the next couple of months.

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PAYMENT NOT REIMBURSEMENT, continued from 45

client elects to purchase these services directly from the physical therapist. Examples of these services are wellness, prevention, sports enhancement, or sport-specific conditioning programs.

Use of the term “payment” better reflects all the different ways physical therapists get paid for their services. Although reimbursement through third-party payers is one of these methods, it does not reflect the full scope of different payment mechanisms that currently are being used to pay for physical therapy services. Therefore, “payment,” rather than “reimbursement,” is now the standard terminology adopted to describe the exchange of money for services provided in physical therapy.

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I’m always amazed at the reaction I receive when I first meet someone and tell them my occupation. Often, it begins with a laundry list of current problems and previous injuries. In the majority of cases, the patient’s experience was a positive one, filled with such statements as “I have a deep appreciation for what you do” or “I credit my recovery to people like you,” and my personal favorite, “It must be very rewarding to watch people recover and know you made it possible.”

Last weekend while biking in a local benefit ride, I met a man who did not share that experience. He had fractured his fifth digit in a bicycling accident several years ago, and the injury required pins and plaster. He showed me his finger, and there was a significant flexion contracture present. Immediately, I assumed he hadn’t received physical therapy, so I asked if he was referred for treatment by his surgeon. The experience he related to me caused embarrassment for our profession.

“Oh of course I went to physical therapy,” he replied. “When I arrived, they were all wearing polo shirts and khaki pants—I thought they were all golf pros. They were all very nice, but it was obvious that most of the people there were ‘regulars,’ and they were more interested in chit-chat than taking care of my problem. The physical therapist put some heat on my finger and massaged it, then told me to come back three times per week; all in all I was there for only about 20 minutes. After a couple of sessions, I figured if that was all she was going to do, I could do that myself and didn’t go back. When I got my bill, I was shocked that it was for $120.00 per visit, because at my first visit I asked about the cost of the treatment, but they didn’t seem to want to talk about money—I guess they just assumed the insurance company would pay for everything. I would have liked to have known that up front, because I had to pay for the treatment out of pocket due to my insurance plan. The whole experience really left a bad taste in my mouth about the state of health care today.”

This was unfortunate on many levels. Obviously, I heard only one side of the story, but there are potentially many lessons to take from this.

1. Do we look like doctors of physical therapy or golf pros?
2. Do we explain our charges up front when patients inquire, or do we just gloss over them because we are uncomfortable talking about money?
3. Do we set up common goals with the patient, including scheduling, cost, and outcome, or do we merely go about “business as usual” without considering the patient’s wishes?
4. Do we explain the purpose of physical therapy and the need for the patient’s active participation, or do we just robotically apply treatment in a technical manner?
5. Do we discuss the pathology and stages of recovery to facilitate a therapeutic alliance with the patient, or do we just assume patients will trust our judgment?
6. Do we explore all possible options to regain optimal function, or do we just “do our thing” and ignore what is best for our patients?

If we are to be the preferred providers for neuromusculoskeletal disorders, we need to behave as professionals. Would you be willing to pay out of pocket for the service you just provided?

If we are to be the preferred providers for neuromusculoskeletal disorders, we need to behave as professionals. You can ask yourself a couple of tough questions. Would you be willing to pay out of pocket for the service you just provided? Would you recognize the professionals in your clinic, or does everyone look like a technician? Would your mother receive the most effective and cost-effective treatment from your clinic or the practice down the street? Did you take the whole patient into consideration when planning their treatment, or did you just look at the pathology in isolation?

The next time you walk into your clinic, try to see the practice through the eyes of a patient new to your office. What do you see, hear, and feel? What is the atmosphere? Remember, perception is reality. Let’s step up our game and become the real professionals we profess to be!

Kay Scanlon, PT, DPT, OCS, Dip MDT, of SpineAbility, Inc., Elkins Park, PA, can be reached at kssailaway@gmail.com.
Advancing and defending the physical therapy profession at the state level is a tough challenge that requires dedication and perseverance. APTA members involved with state legislative efforts are faced with tough opponents, challenging issues, and demands on their time. Too often such tireless volunteer work is unnoticed or unappreciated, so it is with a good deal of joy that once a year we are able to give some recognition to those members who go above and beyond the call of duty in their states’ legislatures.

The APTA State Legislative Leadership Award was established by the APTA Board of Directors to honor and celebrate those members who have demonstrated individual leadership in working toward making Vision 2020 a reality through state legislative achievements. The recipients of this award go above and beyond the norm in their commitment to protecting our profession in their respective states.

The challenges we face as a profession are also growing, and more and more members are rising to meet these challenges head on, dedicating personal time and resources more than ever before. The APTA Board of Directors believes it’s important to recognize the long-term commitment that many of our members devote to chapter legislative efforts. In 2007 the APTA Board of Directors created a second award to recognize long-term legislative commitment at the state level—the APTA Legislative Commitment Award. This award acknowledges individuals who have consistently provided assistance in their chapter’s state legislative activities over several years.

PPS member Kim Reid, PT, of Performance West Physical Therapy in Bountiful, UT, was one of the recipients of this year’s 2009 APTA State Legislative Leadership Award. Kim was instrumental in securing passage of legislation in 2009 to update the Utah Physical Therapy Practice Act after years of working with the Utah chapter board, the Utah Department of Professional Regulation, and state legislators. As chapter president during most of this process, Kim’s leadership, drive, and dedication to the field of physical therapy helped the chapter to accomplish its goal of improving the practice act. The final bill, which was signed by Governor Jim Huntsman on March 24, 2009, modernized the practice act to include protection of the title “DPT”; improved term protection provisions for “physical therapy” and “physiotherapy”; established licensure for physical therapist assistants, who were previously unregulated in Utah; and required continuing education as a condition of license renewal for physical therapists and physical therapist assistants.

Peter McMenamin, PT, of Physical Therapy Chicago, Chicago, IL, received the 2009 APTA State Legislative Commitment Award. Peter has been closely involved in the legislative arena in Illinois since the chapter’s initial direct access campaign in 1985. Since then he has been the driving force for prohibiting referral-for-profit arrangements in Illinois, and as chapter president has lead IPTA's efforts to enforce current laws on this issue. His leadership was also instrumental in greatly weakening a 2009 bill promoted by physicians and chiropractors to expand their opportunities for referral-for-profit arrangements. As a leader in APTA's efforts to curb physician-owned physical therapy services (POPTS) and referral-for-profit arrangements, Peter was an original member of the APTA POPTS Task Force, served two terms on the APTA Referral for Profit Committee, and has presented on this topic at past State Government Affairs Forums.

On behalf of all members, APTA is grateful to PPS members Kim and Peter for their extraordinary service to the profession.

Justin Elliott is director, State Government Affairs, American Physical Therapy Association. He can be reached at justinelliott@apta.org.
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Connect with Your Colleagues through APTA Communities

By Helene Ebrill

A PTA has introduced APTA Communities, a collaborative website where members can participate in discussions, share information and resources, and receive updates. All APTA members have automatic access to APTA Communities: simply go to www.apta.org/communities to log in, click on Tools & Resources, and select APTA Communities to be directed to your available communities. Brief video and text tutorials provide an overview of basic tasks that can be performed within the APTA Communities site. The site houses PPS’s five discussion boards, which take the place of the Message Boards that you may have been familiar with.

Once you are logged into APTA Communities, select the PPS Community to participate in PPS’s five discussion boards: General, Marketing, Practice Management, Practice Start Up, and Reimbursement/Billing. Be sure to activate alerts for each discussion board so that you can be notified by email of any new posts. When in a discussion board for which you wish to receive email notifications, simply click on Actions, select Alert Me, and choose the email delivery options that you prefer for that particular discussion.

Other community features include a calendar, document library and links list, as well as an announcements area. Check out APTA Communities and start sharing today!

Grateful acknowledgment for assistance with this article to Ron Tickerhoff, APTA’s web administrator.

Helene Ebrill is Impact editorial consultant. She can be reached at heleneebrill@apta.org.

Glinn Wins Section Service Award

T he Private Practice Section (PPS) Board of Directors is pleased to present this year’s service award to Jim Glinn, Sr., PT.

Jim has served the section as a director on the PPS Board, was co-editor of the PPS How-To Manual, and with his wife, Jan, co-authored the book Transitions for PPS. Most important, Jim has always strived to help the private practitioner. He is often seen offering free consulting services to a member who would make a PAC donation, or donating consulting services for auction to benefit the Educational Institute. In addition to being a speaker at PPS conferences, he is often seen at conferences offering advice to any members that ask. One member pointed out that Jim will do anything to help a private practitioner. It has been said that he gives away much more service than he ever gets paid for.

We are all indebted to Jim for his unselfishness. It is his ongoing giving to the section, the association, and, most important, the PPS members that makes him so deserving of this award.

Jim, congratulations, and we thank you for your commitment and service to the Private Practice Section and our members.
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