PHYSICAL THERAPY DEPARTMENT, DOES THE ORTHOPEDIC PRACTICE NEED ONE?

FOCUS PAPER

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Introduction

The purpose of this focus paper is to examine an eight physician, four mid-level provider orthopedic practice that for two years had been struggling with the decision of whether it still made sense to own its own physical therapy department.

The practice had owned a physical therapy department for six years. It was a valued ancillary service for the practice and the patients and had been profitable up until the past two years.

Once profitable, the department, located in the northeast in a regional service center with a population of approximately 100,000, had been losing money for two years at approximately $10,000-$20,000 per month. The physicians were faced with the decision to keep it or close it. This decision was to be made within six months.

Physical Therapy Historical Background

Historically, physical therapy has always been closely aligned with the orthopedic branch of medicine. The profession of physical therapy began “by a small band of daring young reconstruction aide technicians” (6) in 1917. Fifteen programs were started to respond to the need for soldier rehabilitation in World War I. The relationship between therapists and the medical and surgical communities grew during the 1920s causing public recognition and validation of the profession.

The 1930s and through the 1950s, the profession was influenced by the Korean War and the polio epidemic. This was also a critical time for the profession in terms of gaining independence and professionalism. 1967 brought state licensure to the profession and 1968 was influenced by the addition of outpatient physical therapy benefits in the Medicare program.

Physical Therapy Department Background

To begin the evaluation of reasons for continuing losses, the first area to be reviewed was the structure and management of the department.
At the time of peak profitability, the director of the department was also one of the physical therapists. That person took complete control over all operations of the department, including managing the schedule and the other therapists and staff. During that period, there were two full time therapists (one the director), one full time therapy assistant and one medical secretary/receptionist. The department hours were Monday through Friday 8:00 AM – 4:30 PM. The director monitored the schedule with little or no input from the rest of the staff and the days were booked very heavily, in some instances up to 15 or 16 patients per day.

The department did have a comprehensive marketing plan. This plan included scattered radio, bulk mailings, and print ads in the daily paper, scattered ads in free weekly publications and scattered sponsorships for local school events. However, the only measurement for effectiveness of this plan was the customer survey question, “How did you hear about us?” Hind-sight of the inefficiencies of this plan included the fact that it was very scattered or hit and miss. Radio times were scattered over different stations and at different times of day, which made it difficult to evaluate the demographics of listeners and the results of the marketing. There also appeared to be no theme; nor were the campaigns tied together. The belief was that all of this was effective in increasing referrals and practice recognition. One must remember that the whole department was functioning at their peak and may not be attributed to just the marketing plan. The outside marketing plan did not just rely on in house physician referrals, and a large number of referrals were received from outside providers and patients who were self-referring. There were also requests received for special sports clinics from area schools. The clinics were held on the premises of the requesting school and included Sports Safety, Safe Stretching Exercises, and Easy Steps to Avoid the Common Sports Injuries. The department was very profitable and because of this, the director had free rein on managing the department. There were few staff meetings or meetings with the physician owners.

When the director left for another position, the remaining staff expressed how unhappy they had been under that director’s management. The staff felt over-worked and under-appreciated. These staff members approached the physician owners with the belief that they could manage themselves and asked to oversee
the department. Because the department had been doing very well financially, the physicians granted the therapy staff’s request and agreed to try this arrangement.

With the staff now overseeing the operation of the department, they insisted that a full time therapist be hired to replace the director who had left. This was approved, a new therapist was hired, and the staffing mix remained at two full time therapists, one therapy assistant and one medical secretary/receptionist. Also, the afore mentioned marketing plan was discontinued.

Internal referrals, that is, referrals from the orthopedic specialists in the practice, declined, which were correlated to patient satisfaction. Under this current operation patient satisfaction was declining, many patients transferred to outside facilities with claims that it was difficult to get an appointment for physical therapy in a timely manner. The patients also reported there appeared to be little communication between the physicians and the therapists. Patients also reported struggling with insurance processing.

In a short time, the therapy department changed dramatically. No longer were days filled with appointments, many days had large blocks of empty time, the therapy staff were scheduling their own appointments and there was no consistency in the clinic start and stop times. The medical secretary/receptionist was now unable to schedule appointments without the prior approval of one of the therapists. Two areas that financially affect the revenue of a practice are collection of copays and the insurance authorization process. Collection of copayments had dramatically declined due to the therapists releasing the patients from the treatment areas and not having them stop to check out. Insurance authorizations were also being missed which increased the number of services that were not covered by the insurance and added to the lost revenue.

Advantages/Disadvantages of Ownership

There is no doubt that physical therapy had played an important role in the practice of orthopedic medicine; however, this practice was losing money monthly and could not continue sustaining these losses.
To begin an in-depth review of the structure and operations of the physical therapy department that is the subject of this paper, the physicians reviewed what they saw as advantages to owning a physical therapy department. The advantages were listed as follows:

A. There was agreement that the use of the overall space, resources and technology led to improved patient care quality and satisfaction and showed a better use of the fiscal resources.

B. There is improved physician oversight, ease of scheduling, improved communication among the health care team and increased patient compliance.

C. With the addition of the Electronic Health Record there is the sharing of a common patient record, leading to better quality of care.

D. Increased revenue for the practice. Reimbursements for the physical therapy department range from $2,000 to $3,000 per patient. According to data released in a 2010 (2009 data) report from Medical Group Management Association, the mean collection for a physical therapist is $235,000 and $199,000 for an occupational therapist, with an average profit of nearly $160,000 for both. (20)

E. Cost of any needed equipment is relatively low compared to other equipment costs in the practice.

The disadvantages of owning a physical therapy department were also reviewed and are listed as follows:

A. The physicians determined that management of and fiscal responsibility for yet another area of the practice would definitely be a disadvantage of owning a physical therapy department.

B. Thousands of dollars were spent in the setup of the therapy department and more revenue would be needed over time to maintain and update the space as well as the equipment.

C. The physicians also expressed legal concerns, one of which was the push to remove physical therapy from the Stark Law exemption list that could cause these physician-owned departments to be in violation of Stark Laws. Two State Supreme Courts, Delaware and
South Carolina, have prohibited physician-owned physical therapy services. The physician owners feared that any additional changes in the Stark Law would negatively affect the Physical Therapy Practice.

**Regulatory Impact**

The Ethics in Patient Referral Act, also known as the Stark Law, was passed in 1989 to minimize physician referrals motivated by financial gain. (21)

The law created an exception that allows a physician to own in-office ancillary services (IOAS). (21) This exception accounts for approximately $8 billion out of the $1.9 trillion spent in annual healthcare costs. (20) Physician Owned Physical Therapy Services (POPTS), which account for 3% of the Medicare Part B Orthopedic dollars, is one model for the delivery of PT services. (21)

A change in the Stark Laws that would not allow physician ownership of physical therapy practices would have extreme consequences to the practice that is the subject of this paper. However, in 2014 the Government Accountability Office (GAO) released their report “Medicare Self-Referral of Physical Therapy Services.” At the request of Congress, this report used Medicare Part B claims data to assess trends for “self-referred” (POPTS), which are clinics that have a physician owned physical therapy department, and “non-self-referred” Medicare PT Services, are clinics that are not owned by the physician, and how use of these services differed among providers. The total number of self-referred PT Services showed essentially no increase from 2004 to 2010, whereas, non-self-referred services increased by 41%. According to the report, the relationship between provider self-referral status and PT referral patterns was mixed and varied on the basis of the referring provider specialty, Medicare beneficiary practice size and geography, but the GAO “Did not find a direct correlation between self-referral and per patient services.” (14)

Self-referring orthopedic surgeons on average referred fewer PT services than non-self-referring Orthopedic Surgeons. (18)
The American Academy of Orthopedic Surgeons (AAOS) in a position statement reported “The AAOS fully supports efforts to increase the value of musculoskeletal care by improving quality and lowering costs. Physician ownership allows for appropriate, timely and scaled delivery of these important services consistent with maximizing their value”. (1) As the GAO report demonstrates orthopedic surgeons offering the option of PT in the physician office reinforces the fundamental aspects that optimize patient-centered care. (14)

Due to these studies and position statements, the physician owners were comfortable that “self-referring” would not negatively impact a decision to continue providing physical therapy services within the practice.

Once the benefits of a physician-owned physical therapy department were identified, the decision was made to conduct a strategic analysis of the physical therapy portion of the practice. First, they wanted to identify options for the Physical Therapy Department, evaluate the pros and cons of each defined option, and to examine trends, both locally and nationally, of orthopedic practices. In discussions of the various options for the department, the physicians questioned the value of providing physical therapy services as opposed to outsourcing to local physical therapy businesses.

Market Forces

An evaluation of other physical therapy departments currently owned by orthopedic practices across the country was reviewed. These reviews included how many of these practices owned physical therapy departments, where they are located, the individual business operations, industry trends and forecasts and the potential legislative issues. Results of this review were compiled and included in the decision making process. Many of these results are referenced in the text of this paper. (15)

A physical therapy market overview done nationally in February of 2014 by Harris Williams & Co., gave the practice a great deal of information which they were needing. The Harris Williams & Co., Middle Market Report states the following: (15)
1. Outpatient Rehabilitation is a 29.6 billion dollar industry that is expected to grow 7% annually through 2018. See Graph, Appendix III, Pg. 24.

2. Physical Therapy accounts for an estimated 26.6 billion dollars or approximately 90% of all outpatient rehabilitation spending.

3. The physical therapy market is highly fragmented, with the largest 50 competitors comprising less than 25% of the market. See Chart, Appendix VI, Pg. 27.

4. Numerous, positive factors will drive the long-term growth:

   A. Aging U.S. population
   B. Unhealthy youth lifestyle trends
   C. Growth in employment
   D. Increasing penetration of physical therapy
   E. New government regulations
   F. Outpatient rehabilitation is significantly less costly than surgery or hospitalization, but with similar clinical effectiveness.

   Physician-owned physical therapy (POPT) practices are estimated to be 10-15 percent of all physical therapy clinics and represent a large, compelling market opportunity. (15) See Table, Appendix IV, Pg. 25.

   POPT practices provide an attractive opportunity for physician groups to provide their patients with greater convenience, improved outcomes and continuity of care by offering therapy in their office setting. (15)

   The Industry Reimbursement Mix is depicted in the Chart in Appendix V, Pg. 26.

   The competitive landscape shows a highly fragmented market primarily comprised of smaller independent providers, no single participant captures more than a 5% market share and smaller independently owned clinics account for roughly 45% of all physical therapy clinics. (15) See Chart, Appendix VI, Pg. 27.
This shows a large opportunity for growth and provides physician opportunity to increase services to their patients through offering the convenience, improved outcomes and continuity of care. (15)

This data was significant to the physician-owners in bringing realization to them that a physical therapy department in this region is representative of this data and should be considered a viable possibility.

Industry Benchmarks and Trends

Industry-wide benchmarks presented by the American Academy of Orthopaedic Surgeons, Benchmarking Physical Therapy Programs by Cary B. Edgar, were evaluated and are listed here: (12)

A. Average therapist sees 11 visits per an eight-hour day.
B. Average visit is approximately 45-60 minutes.
C. Average return visits for the orthopedic patient is nine.
D. Average for compliance in follow up visits is 88%.
E. Average payments per visit is $90.
F. Average total compensation is $34.50 per visit, includes therapists and support staff.

Review and evaluation of industry trends included the following:

A. According to the Harris & Williams study, there is expected to be growth of 7% annually through 2018. (15)
B. Currently the outpatient rehabilitation is an approximate 30 billion dollar industry.
C. Of all rehabilitation spending nationwide, physical therapy makes up approximately 90% of that spending.

Factors that support the growth figures are an aging population, unhealthy lifestyles, and growth in employment. Also factored into these numbers are the increase in physical therapy sites, increased patient access (not all sites require physician referral) and the cost effectiveness of outpatient services. (15)
Forecasted Reimbursement Trends

Physical therapy is a highly competitive market. The market is highly fragmented made up of smaller independent providers. These smaller independent clinics account for approximately 45 percent of all physical therapy clinics. No single provider captures more than 5 percent of the total market share.

Forecasts for reimbursement trends were as follows: (15)

A. Providing outpatient physical therapy has proven to be cost effective and the outlook for reimbursements is favorable.

B. Commercial payers use the “usual and customary” rate or the payer will contract on a per service basis.

C. Medicare and Medicaid reimburse on the Medicare Physician Fee Schedule that can cause reimbursement to fluctuate.

Physical Therapy Department Options

Completion of the financial review of the Physical Therapy Department demonstrated monthly losses that led the physician owners to a consensus of three options:

1. Close the department. The physicians feared that closing the department would diminish patient satisfaction with the practice. There was also the realization that several new physical therapy practices had opened in the area causing the physician owners to question if this would affect their success.

2. Re-structure the department. If this option were chosen, it would require a complete department overhaul with respect to employee accountability, department management, management of the schedule, marketing the department and overall formation of a team approach to doing business.

3. The third option was to do nothing. To do nothing would mean the physicians were willing to continue to accept a monthly loss from this department.
In order to make an informed decision the physician owners identified the need for patient input regarding the value of physical therapy services within the office setting, as well as providing a written survey to local orthopedic practices. The survey consisted of just four questions that participants could answer quickly. See Appendix I, Orthopedic Practice Survey, Pg. 22, for the survey and its content. The survey results were compiled and included in the decision making process. The survey results can be found in Appendix II, Orthopedic Practice Survey Results, Pg. 23.

In the review of the closure option, the physicians were concerned first that it would affect patient satisfaction. The patients’ comments reflected that they felt a sense of team care with the surgeons and physical therapists in one location. The ability for the physician and patient to have face-to-face conversations meant a great deal to the patients.

The option of doing nothing was examined and it quickly became clear that to accept this option would also mean accepting the financial loss every month. This approach had been tried once after discussions with staff in that department that the way of doing business needed to change and a loss could not be sustained every month. It became apparent that no changes had been or were being discussed in the operations of this department and the losses continued. The physician owners concurred that this was not a viable option, however, it was important that the physician owners understand why the practice had continuing losses from this department.

Review of Operational Strategies
The practice that is the subject of this paper did not currently outsource insurance authorization and verification, but this was considered during the analysis of the Physical Therapy Department losses. The benefits of outsourcing would produce:

1. Lower write offs.
2. Increase of the referral success rate.
3. Reduction of operational costs.

An increase in turn-around times of the authorization process allows staff to spend their time on the scheduling of patients with confidence that the authorization will arrive before the visit.

In a Council for Affordable Quality Healthcare Study, it was estimated there were 24 million authorization and referral transactions yearly. The manual process of obtaining authorizations costs healthcare providers $45.49 per authorization transaction. (11)

A study reported in Health Affairs indicated that practice staff spends 20 hours per week per physician interacting with authorization requirements. Converting this to dollars, the cost to practices is at least $23 to $31 billion per year. For practices, this means for every two physicians there is a full time staff member spending their time on health plan interactions alone. (16)

Outsourcing insurance authorizations can reduce operational costs. Staff will have more time for other more valuable tasks of patient care.

Also, there is significant documentation concerning the collection of copays at the time of visit. According to Nancy White in an APTA Podcast, studies show that the chance of collecting a copayment drops by almost 20% as soon as the patient leaves the office. (5) There are offices that find it easier to mail a statement for the copayment; however, this as well can be costly. Nancy White states, “There is data that indicates a cost of $5.00 to $10.00 per statement.” (5)
Waiving the copayment and the deductible may be viewed as misrepresenting the true charge for services and is not a recommended practice.

In addition to the collection of co-payments and insurance verification, staff must be trained to collect all payments that are due at the time service is rendered. To do this staff must be able to handle the following:

1. All front desk staff must be trained in the insurance policies of the practice and the requirements of those policies.
2. Staff should also have training in the specific specialty of the practice and the services provided there.

To assist in the collection efforts by the staff the practice should implement a payment policy. The policy will inform the patients what is expected of them with respect to payment of services and what the patient can expect from the practice. This policy should be adapted to the practice and include the following:

A. When the payment is due:
   1. At the time of service.
   2. When advance arrangements have been made.

B. Who is responsible for payment (self-pay patients are responsible for the entire bill)?

C. How co-payments and deductibles are handled (collected at each visit without exception).

D. What forms of payment the practice accepts:
   1. Personal checks
   2. Debit cards
   3. Credit cards
   4. The practice policy regarding non-payment (is sent to collection after three months).
Before proceeding with choosing an option for the Physical Therapy Department, the physician owners wanted to review the physical therapy departments currently owned by orthopedic practices across the country.

The review of business operations of these physical therapy departments across the country was conducted by the practice, through the reading of journals and articles pertinent to physical therapy practices, Internet articles, posting on the MGMA site for members only, and discussions with other providers of physical therapy. The practice did a small, regional market study, and an extensive review of the Harris Williams Study. This research showed that predominantly these departments have a director, who is in charge of the operations. These were not therapist positions. A few practices outsourced the management function to local management companies.

Staffing of these departments that were reviewed varied slightly, the norm was two therapists, some had physical therapy assistants and all had secretarial/receptionist support. The ratio in these departments typically was 2:1 therapists to physicians.

The directors of the physical therapy departments monitored scheduling, but the function was carried out by the secretary/receptionist. The average number of appointments per day, per therapists, for an eight-hour day was 11, which is the national benchmark. The use of “dovetailing” was prevalent in the physical therapy departments that were researched. Dovetailing is the practice of adding a patient in between two scheduled patients if the treatment warrants. For example, a therapist can be working with an evaluation or follow up patient and a second patient, who could work independently (a gym patient), as long as the therapist could visually evaluate them (a requirement of Medicare). This was a concept that had not been used in the Physical Therapy Department but the physician-owners were interested in implementing.

**Decision**
After thoughtful review of all information presented to them through this analysis, the physician owners made the decision to re-structure and continue ownership and operation of the Physical Therapy Department.

Implementation

Still within the six-month deadline, the implementation of the re-structure plan was immediate. Guidelines for these changes were crafted from national benchmarks, current trends both regional and national and the projected industry trends.

A successful physical therapy department must have effective management in handling provider productivity, scheduling to include no shows and cancellations, capturing all insurance information and processing that data, and consistently collecting all monies due the department.

To begin the re-structuring process, the physicians hired a department director. All staff in the physical therapy department was expected to work within the posted practice hours. Each staff member, as in all other departments in the practice, was expected to punch a time clock in and out. Clear expectations and guidelines were given and reviewed with each physical therapy department staff member. These expectations and guidelines were formally spelled out in new job descriptions.

The department director and the secretary/receptionist were now monitoring the schedule. The template was based on the national benchmark of 11 visits per day per provider. (12) Training on the appropriate scheduling of patients was given to the secretary/receptionist so the secretary/receptionist did not have to have every appointment approved by a therapist. Dovetailing was implemented into the schedule for the first time. Cancellations and no shows were monitored. Follow up visits were within the national benchmark of 88% with personal calls and/or reminder letters. (12)

After researching the outsourcing of insurance verifications, it was decided to offer extensive training to the secretary/receptionist as well as the physical therapists in insurance verifications. A member of a local health insurance company provided the training. This decision to keep the function of insurance
verifications in the Physical Therapy Department was based on cost. To outsource is very expensive and with the department showing only losses it was not considered a good option at this time.

A team approach was adopted with all staff being accountable for their duties. Communication lines were opened up with the providers, the physicians and management. Regular meetings were scheduled to discuss the department operations and to discuss goal setting and long-term department strategies.

With the new schedule and holding staff to defined hours, it was clear that the department was over staffed for the current number of referrals and the month end figures. The department was down-sized with the reduction of one full time therapist.

What has been presented indicates that physical therapy is a highly competitive market. A practice must compete with many other practices in their respective areas. The adoption of a formal marketing plan is essential for the success of the practice.

Suggestions for inclusion in a marketing plan according to the American Physical Therapy Association, Practice Positioning Strategies: (3) See Appendix 7, Pg. 28.

A new approach was taken with respect to marketing. Management first concentrated on internal marketing, (marketing to their own physicians). Questions posed to the physicians included: 1. Do the services offered in this department meet your needs? 2. If the provider refers to an outside physical therapy facility, why?

The practice website was re-designed and used extensively for marketing. Physical Therapy had a whole section of the site for its purposes to promote the staff, the facility and the services offered. The site was also used as an educational forum with articles and other readings.

Using the website for marketing was recognized as an important part of the market plan and was recognized as needing to be current, interactive and accessible. One of the top reasons a practice may not be getting more patients from the Internet is the speed of loading onto phones, iPads and tablets. If the
website does not load in less than 4-5 seconds many prospective patients will move on. (18) A local website vendor was contacted to come in and evaluate the system. This vendor’s review showed favorable results for the website and the speed at which it operated.

After all changes were implemented and the team was on the same page, the department has grown and continues to once again show month-end profits. Referrals, both internal and external, have risen. Prior to the re-structuring internal referrals had dropped to one to two daily and the external referrals had dropped to 4-7 per week. After the re-structuring internal referrals are up to 4-6 daily and the external to 10 – 15 per week. The staff is more congenial and more productive. The Physical Therapy Department has new life.

Recommendations

Recommendations for other physical therapy departments experiencing the same issues:

A. Proper staffing mix and staff accountability is crucial for survival of any department.

B. Physical therapists are not always expert in the day-to-day operations of a business. Utilize the staff for their field of expertise.

C. Altering of the schedule should be in relation to the number of patient referrals. Be aware of these numbers and realize it may also mean altering the number of days of operation.

D. All departments need some form of over sight. Do not allow a department to function with a loss for very long. It is difficult to re-structure as needed and come back from those losses.

Conclusion

In conclusion, this six-month analysis process was extremely labor intensive. In the review of all aspects of the Physical Therapy Department, many new policies were written and implemented that encompassed the clinic operations and expectations with regard to the scheduling, treatment and the processing of the physical therapy patients.
The new director took over the financial management of the department. He was to monitor the patient numbers, as well as the income and the expenses for the department. The director would be meeting frequently with the physician-owners and reporting on activities of the department.

New policies were written and implemented for the operation of the clinic, regarding the management of the department, the job descriptions for the staff and the frequency for meetings with the providers.

However, time consuming and at times frustrating, the result of the process has given new life to the Physical Therapy Department.

Through the implementation of the concepts discussed in this paper, such as increasing the frequency of collection of copays at the time of visit, following the guidelines for obtaining insurance verifications, and ensuring that these are done prior to the visits, and implementing the scheduling techniques such as dovetailing and monitoring of the schedule, the Physical Therapy Department is once again showing a profit.

The predicted trend for physical therapy is that the profession continues to grow to stay current with the healthcare trends and continues to enhance the knowledge, skills and abilities of the physical therapist and the physical therapy assistant. This work will continue into the second decade of the modern century, as the health care system is reformed and the role of the physical therapist in contributing to the health and well-being of members of society is ever more important. (6)
PHYSICAL THERAPY DEPARTMENT,

DOES THE ORTHOPEDIC PRACTICE NEED ONE?

WORKS CITED


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APPENDIX I
ORTHOPEDIC PRACTICE SURVEY

The purpose of this survey is to assist in determining if an orthopedic practice should own a physical therapy department. Your participation is appreciated. Please return surveys in the envelope provided by June 1.

Please circle your response.

1. Does your practice currently own a physical therapy practice?  Yes  No

1A. If yes, who manages this practice?
_____________________________________________________

1B. What is your staffing mix?
_____________________________________________________

2. If you do not currently own a practice, did you ever own one?  Yes  No

3. If previously owned and no longer owned, why did you close it?
_____________________________________________________

4. Have you found on site physical therapy to be an element in increasing patient satisfaction?  Yes  No
This survey was done by the practice. The survey was small and was only sent to other physical therapy practices in the region. This region covered four counties. Total surveys sent were 35. This was a four-question survey, with online responses back to the practice.

Results of the practice survey were as follows:

Respondents totaled five, approximately a 15% return.

Of those, responding only two owned a physical therapy department.

Of the two, both had a physical therapy department manager and the staffing mix was 1-2 therapists, (depending on practice size) and both employed a physical therapy assistant.

None of the respondents had previously owned a physical therapy department.

The two practices that owned a physical therapy department reported that on site physical therapy assisted in patient satisfaction.

The results were as expected. Many of the physician practices in the region are employed by the local hospitals and owning physical therapy departments is not a trend in those practices.
APPENDIX III

U.S. OUTPATIENT REHABILITATION EXPENDITURES

For the Years Ended and Ending December 31, 2004-2018P
($ in billions)

2004-2013E CAGR: 5.5%
2013-2018P CAGR: 7.0%

Source: IBISWorld.
## APPENDIX IV

### PHYSICIAN-OWNED PHYSICAL THERAPY PRACTICES

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<thead>
<tr>
<th>Orthopedic Market Sizing</th>
<th>Multi-Specialty Market Sizing</th>
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<td>Orthopedic Surgeons in the U.S.</td>
<td>Multi-Specialty Surgeon Groups in the U.S.</td>
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<td>Less: Surgeons in States with Anti-PCPTS Legislation(2)</td>
<td>Less: Practices in States with Anti-PCPTS Legislation(2)</td>
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<td>Addressable Population</td>
<td>Addressable Population</td>
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<td>Percentage of Orthopedic Surgeons in Private Practice</td>
<td>Percentage of Multi-Specialty Groups in Private Practice</td>
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<td>Addressable Market Size - ( # of Private Practice Multi-Specialty Groups)</td>
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<td>Total Addressable Market - ( # of Groups)</td>
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1. Does not include groups owned by hospitals, neurology groups, or family practice groups.
2. States with Anti-PCPTS Legislation include SC, MO, and DE.
APPENDIX V

INDUSTRY REIMBURSEMENT MIX

Source: American Physical Therapy Association (APTA).
(1) Based on American Physical Therapy Association (APTA) estimates.
APPENDIX VI

COMPETITIVE LANDSCAPE

Source: IBISWorld.
Suggestions for inclusion in a marketing plan according to the American Physical Therapy Association, Practice Positioning Strategies: (3)

1. Website for the practice. This website address should be in all practice materials and publications.

2. Establish a budget. Review all opportunities for marketing to include: Radio, TV, Direct Mail, Print Advertising and Sponsorship Opportunities.

3. Communication with patients through newsletters.

4. Community Involvement, such as memberships in the Chamber of Commerce, Lions, Rotary Club, and other community based organizations.

5. Open houses at the practice.

6. Volunteer at Local Schools.

7. Writing a weekly or monthly column in local paper.