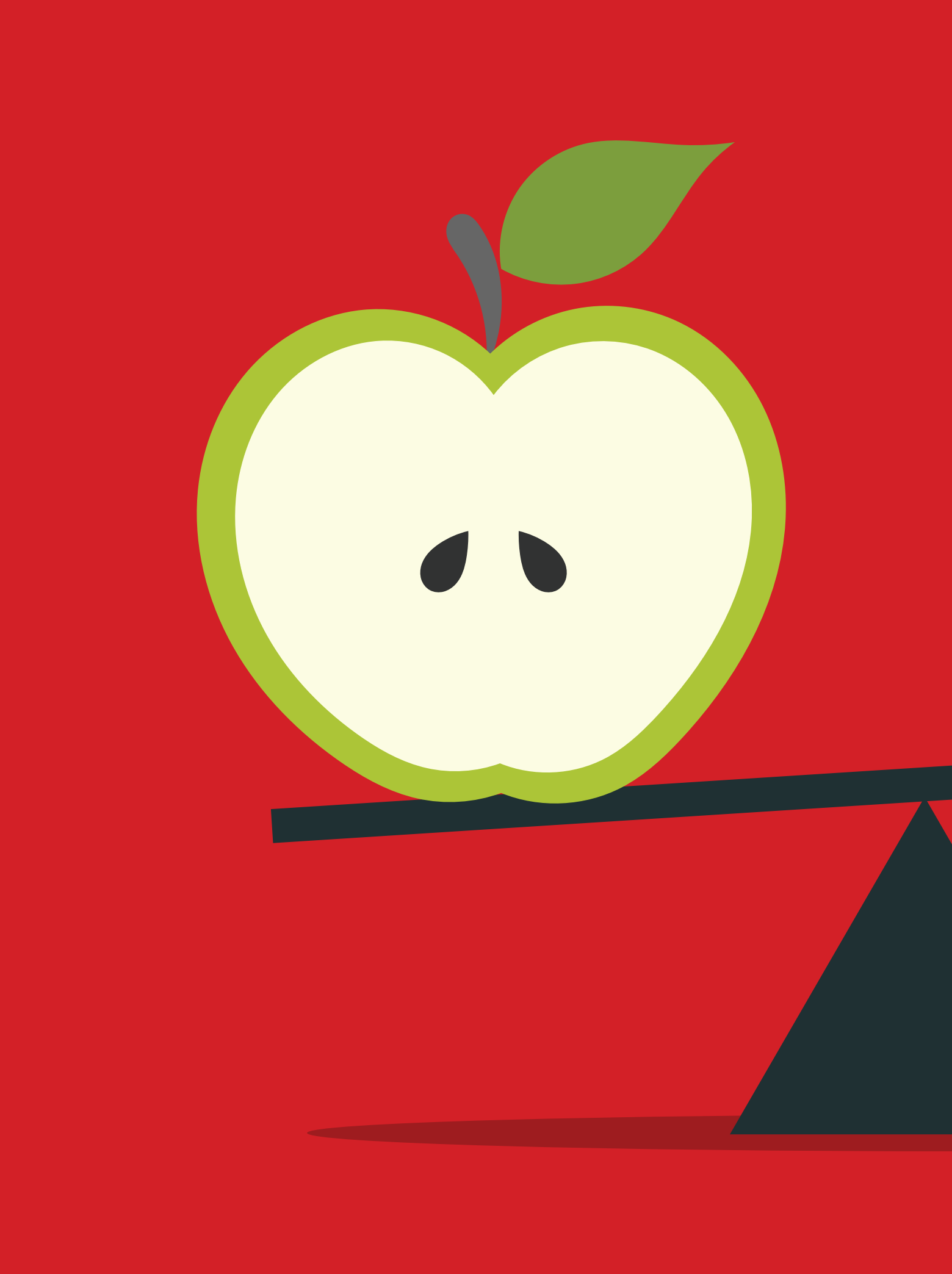

BENCHMARKING *for* RETINA PRACTICES

Andrew Maller, MBA, COE

“The largest challenge facing retina practices when performing any type of financial analysis (like benchmarking) is how to manage the impact of injectable drugs on productivity and efficiency metrics. When not handled properly, high drug costs can artificially inflate revenue and expenses while providing a false sense of security.

As financial benchmarking becomes more widely adopted in ophthalmology, physicians and administrators of sub-specialty clinics are increasingly seeking benchmark ranges specific to their business type. Retina practices are no different. Evolving practice patterns combined with new technologies are changing the landscape of the retina specialty, making it more challenging to benchmark results against industry standards. This article serves two purposes: (1) to address several specific challenges that retina practices face when benchmarking and (2) to highlight ways to start reviewing your practice's results.

BENCHMARKING REVIEW

Benchmarking is the process of measuring and comparing one practice with other “like kind” and/or better-performing practices. To get to this level of comparison, specific metrics serve as a barometer of a practice's health.

The benchmark ranges in this article come from the 2014 Benchmarking Survey sponsored by the American Academy of Ophthalmology and the American Academy of Ophthalmic Executives (using 2013 data), and from the work BSM Consulting does with its clients. The ranges represent the 25th and 75th percentiles and are from the comprehensive ophthalmology and retina practice segments. Please note that the ranges are not absolute and are presented for educational purposes only.

IMPACT OF INJECTABLE DRUG REVENUE AND EXPENSES

The largest challenge facing retina practices when performing any type of financial analysis (like benchmarking) is how to manage the impact of injectable drugs on productivity and efficiency metrics. When not handled properly, high drug costs can artificially inflate revenue and expenses while providing a false sense of security.

To illustrate this point, let's examine two different practices. Both practices generated $1,300,000 in professional revenues and performed 300 injections during the year, and both practices spent $650,000 in operating expenses. Practice A uses a high-cost drug that costs $2,000 per injection, adding $600,000 to its revenues and the same amount to its expenses, while Practice B uses a drug that costs $50 per injection, so it only has $15,000 in drug costs and revenues. The operating expense ratios (expenses divided by revenues) for the two practices are as follows:

- Practice A: $650,000 expenses + $600,000 in drug costs = $1,250,000 in total costs ÷ $1,900,000 in revenues = 66% operating expense ratio
- Practice B: $650,000 expenses + $15,000 in drug costs = $665,000 in total costs ÷ $1,315,000 in revenues = 51% operating expense ratio

Note that the difference in the two operating expense ratios under this example comes only from the doctors' choice of injectable drugs, and that choice distorts the ratios and makes it impossible to compare the two practices in a meaningful way.

With this in mind, the AAO Benchmarking Survey and BSM both instruct practices to remove drug revenues and expenses for benchmarking purposes to ensure an “apples-to-apples” comparison to national benchmarks.

PHYSICIAN PRODUCTIVITY

There are many common productivity benchmarks that are used across all ophthalmology specialties, including retina. Probably the most common is **Net Collections per FTE MD**. In this ratio, net collections (less drug collections) get divided by the number of full-time equivalent (FTE) ophthalmologists in the practice. To subtract out drug collections, the simplest way is to remove all J code revenues (however, the professional fee component for CPT 67028 should not be removed). For benchmarking purposes, one FTE MD works at least 180 days in the clinic or surgery providing patient services. When looking at the benchmark ranges, the difference between comprehensive and retina practices is telling; the range for retina practices is $1,020,000–$1,614,000 compared to $800,000–$1,300,000 for comprehensive practices.

The higher range for retina practices can logically be explained by the differences in the patient base between a retina and a comprehensive practice. The need for additional diagnostic testing, the types of procedures performed, as well as more frequent patient visits for recurring procedures all add up to a higher revenue potential for the retina surgeon.

A second important physician productivity metric is **Patient Encounters per FTE MD[1].** The purpose of this ratio is to measure productivity in terms of patient visits. In prior years, retina specialists typically saw a lower volume of patients than their comprehensive counterparts. Today, however, the average numbers of patient visits per year have become almost identical between the two specialties, with retina doctors now seeing about the same number of patients per year as does a comprehensive ophthalmologist.

When looking at the correlation between these two productivity metrics, it is not surprising that a third ratio—**Collections per Patient Encounter**—produces a much higher range for the retina surgeon ($238–$465) compared to comprehensive practices ($175–$250).

OPERATIONAL AND STAFFING EFFICIENCY

With a few exceptions, the cost of running a retina practice should not be much different from any other practice

once drug adjustments have been made. The cost of rent, office supplies, computer expenses, and most other fixed expenses should be fairly consistent. However, there are some differences. For example, retina practices most likely will not have significant marketing expenses; however, they might require more staff than a comprehensive group. When reviewing the **Operating Expense Ratio** (also known as the Overhead Ratio), the range for both retina and comprehensive practices happens to fall in the 50%–70% range for the 25th through the 75th percentiles. This metric is calculated by taking all practice operating expenses (not including provider salaries) and dividing by total net collections as shown in the examples above. Again, drug revenues and expenses should be excluded for this ratio. Note that this overhead range is higher than measured in the past for retina practices, and probably reflects the drop in reimbursement experienced in the past several years for professional fees for injections.

From a staffing perspective, it is not uncommon to see a higher number of FTE staff in a retina practice when compared to a comprehensive ophthalmology practice. The added head count is usually found in the back office because additional technicians are often required in retina practices to account for the higher volume of diagnostic testing. Many practices have added additional head count in the billing department due to the increased pressure to successfully manage claims involving injectable drugs.

It should be noted that, due to the higher revenue levels often seen in retina practices, the **Staff Payroll Ratio** (staff wages divided by net collections) is often lower than in comprehensive practices. The typical range is 16%–26% in retina practices compared to 20%–26% in comprehensive groups.

STARTING POINTS

The ratios introduced in this article represent just a few of many available when looking to assess performance in the retina practice. If a practice is ready to compare its results to national benchmarks, here are a few recommendations to get started:

1. **Start by tracking monthly**: Most of the benchmark ranges introduced in this article are annually based. A good first step would be to start tracking on a monthly basis. Once the results have been tracked for six months, it is possible to create internal benchmark ranges for comparison purposes.
2. **Start with two to three metrics**: The exercise of benchmarking can be overwhelming, especially if it is your first time tracking everything. Administrators should start small and only choose two to three metrics at first. After consistent tracking for a number of months, it is fine to add new ratios to the list.
3. **Be consistent with definitions**: When benchmarking, it is important to compare "apples to apples." This requires the use of consistent definitions. As mentioned above, the proper handling of injectable drug revenue and expenses must be done to compare a practice's results with national benchmarks.

ENHANCED BUSINESS DECISIONS

The true purpose of benchmarking is to use practice-specific information to enhance business decisions. The benchmark ranges introduced in this article should help in this process, but they should not be viewed as absolute indicators of whether or not a practice is healthy. Every retina practice faces unique challenges in today's dynamic medical environment. The key is to use metrics and internal practice results as barometers to help make those challenges a little easier to overcome. *AE*

NOTE

Patient encounters include the following CPT codes: 92002, 92004, 92012, 92014, 99201–99205, 99211–99215, and 99024.

Andrew Maller, MBA, COE (480-292-9850; amaller@bsmconsulting.com) is a consultant with BSM Consulting, located in Scottsdale, Arizona.

IN A BLINK

- Proper handling of injectable drug revenue and expenses needs to be considered when benchmarking for the retina practice.
- Although a retina practice has a higher revenue potential than a comprehensive practice, the overall cost of running both type of practices is very similar.
- The benchmark ranges presented should not be considered absolute. Tracking internal results over time should always serve as the barometer for measuring the financial health of the practice.