

CHAPTER 12

Using Simple Bookkeeping Principles and Reports to Analyze Allergy Practice Performance

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INTRODUCTION

Most people finish their training in medical school, residency and an A/I fellowship without receiving any instruction in the business aspects of running a medical practice. Unfortunately, this shortcoming occurs despite the fact that once a vast majority of physicians leave training, they go into situations where they actually have to run private businesses, or at the very least have to master the ability to evaluate practice opportunities. This lack of training and preparation can lead to poor decisions that ultimately can cause career dissatisfaction and less-than-optimal patient care. Feedback from fellows attending the AAAAI practice management workshops also indicates that this uncertainty is a major cause of anxiety.

This situation is further complicated by the current political climate of impending healthcare reform, which likely will mean decreases in physician reimbursement for services provided. The need to clearly and quickly be able to evaluate whether the medical practice you participate in is run efficiently is a skill that all future physicians will have to master.

Fortunately, skills taught in medical training can be used to help make clearly thought-out business decisions that will help physicians run efficient, high-quality practices, and allow even the novice to distinguish between job opportunities. Doctors, after all, have been trained to be analytical and to solve problems. Physicians can be more successful if they look at their business operations in the same way they evaluate patients and quickly identify when the business performance is deviating from the norm. This analysis can be achieved by comparing the performance in billing, collections and expenditures to average standards that others in the field have generated, and by comparing present business performance to its own past performance.

Physician/owners also need to “know what they don’t know” and seek out and listen to good business advice from reliable consultants, lawyers and accountants once a problem in practice efficiency has been identified. This advice also holds for those entering a business opportunity, because such an agreement usually represents a binding contract.

The goal of this chapter is to help you understand how you can systematically review a practice’s financial records, and if you choose to start your own practice, how to generate your own benchmarks to allow you to compare your practice operations with those of others. Once these benchmarks are identified, all that is needed is routine self-evaluation to ensure

that your practice operations are functioning as expected.

THREE BENCHMARKS TO FOLLOW

This basic equation is the cornerstone of all businesses:

$$\text{Profit} = \text{Income} - \text{Expenses}$$

Therefore, the first benchmarks to create are annual profit, revenue (income) and expenses, calculated for each physician and for the total practice. The most important benchmark is comparing the practice's current performance to its past performance. The main point of this chapter, therefore, is that all allergists interested in reviewing their business performance should start a budget process for their businesses. Every budget monitors income and expenses and, therefore, profit. If one is looking at a business opportunity, it is reasonable to request budget and performance data from previous years to give broader evidence of the long-term performance of the practice in question.

Keeping track of these variables allows anyone to know where their business stands at any point in time. At the very least, physicians should review the reports created by their bookkeepers or accountants to become aware of how the practice is doing compared to budgeted figures. (Budget projections can be created from past behavior or from anticipated performance that was estimated at the start of the fiscal year.) Another advantage of creating a budget process and review is that the exercise allows any business person to anticipate cash flow needs and make decisions that will allow for efficient business operations. Money

is needed in checking accounts so that payroll can be met and bills can be paid. Anticipating expenses allows businesses to determine if they will have enough money on hand to cover the bills.

Modern computer technology has made it possible for anyone to start recording and following data related to these three variables. Accounting programs like QuickBooks®, Quicken®, and many others provide easy directions to start categorizing revenue and expenses and to instantly tabulate the sums of these categories by month or year. These programs enable creation of annual budgets and produce reports showing deviation from the budget with a single mouse click. Spreadsheet programs, such as Microsoft® Office Excel, allow the user to create forms that allow for individual style preferences.

Presentation of the equation above in no way suggests that the goal of a medical practice is to maximize profit. Most physicians chose to enter medicine for reasons other than profit and are uncomfortable when medical practices are described as businesses. However, most of us have to make a living, and reality requires us to consider these variables to protect our self-interests. When physicians decide to see patients who might not be able to fully afford the services, or accept contracts with third-party payors who reimburse at much lower rates, the income stream is diminished. Likewise, buying equipment that will help provide better care and that simplify life, increases expenses. Physicians **must** remember that these decisions affect profit. This will become even more important as pressure to decrease reimbursements by the federal government and private insurers continues to increase.

On the other hand, when seeking out new business opportunities, the culture of the practice you might join has to be considered. Will you be comfortable if stress to increase profit overwhelms you? Will you be made uncomfortable when you choose to spend more time with an individual patient who might need the extra attention, or if you are not allowed to care for indigent patients?

EVALUATING INCOME SOURCES

Physicians generate revenue by billing for the time personally spent interacting with patients. Whether the hours made available to provide patient care are most efficiently utilized needs to be analyzed. (Are the patients showing up for the scheduled appointments? Are there hours that are more desirable to patients, like weekends, nights or early mornings, and do you want to work those hours?) Analysis of whether all services provided are accurately and consistently coded is essential too.

It is also important to realize that physicians who will have to start using the ICD-10 CM Diagnostic codes, as of October 1, 2015, will be expected to spend more time collecting and reporting data without any increase in revenue generation for these visits. The ICD-10 system will increase the available codes by at least six-fold. All this will do is better describe the patients seen in a computerized database, but will have no effect on patient care, or physician-patient interaction. Expect more time at work, for at best the same revenue. Also be aware that the diagnosis codes (the ICD systems) are not utilized by payers who reimburse physician based on the procedure codes used (CPT codes), but

generally are needed to rationalize the procedure codes used. For example, in order to be paid for a pulmonary function testing procedure code, the patient must have an accurately documented diagnostic code that reflects respiratory disease.

Other sources of potential revenue also must be considered. Is it possible to sell durable medical equipment? Is it possible to participate in clinical pharmaceutical research trials? Can cash reserves needed for future practice operation expenses be invested until those funds are needed, allowing for generation of interest income? Is office space being maximally utilized, or can you sublet unused space? Although the options to generate revenue are restricted, it is necessary to closely monitor revenue streams and performance.

Because the time spent with patients provides the vast majority of practice income, the efficiency of that time must be analyzed. It is understood now that the amount billed to a patient does not usually equal what is collected. In the past, there were always patients who didn't pay for services rendered, and today most physicians primarily interact with third-party payors, who demand a discount for a physician's time in exchange for the opportunity to interact with their patient base. This discount is usually accounted for as fee adjustments after the third party sends a payment with a report called an **explanation of benefits**, or EOB. The need to follow the **collection ratio**, therefore, has developed. This ratio is the quotient of the total amount collected for services rendered divided by the total charges billed for those services:

Collection Ratio = Collections ÷ Total Billing Charges

Because of the delay between time of services rendered and payments for those services, and the fact that most business management software generates reports over specific time periods, the logistical need to alter this ratio becomes clear. By replacing “total billing charges” in the denominator of the above equation with the sum of total collections plus the total written-off adjustments given during the time frame in question, the time discrepancy that otherwise would occur can be eliminated. Monitoring the collection ratio and ensuring that your experience is similar to that of others is helpful. The AAAAI’s Practice Management Committee surveyed its members starting in 2006 regarding their collection ratios for the prior year. Data were effectively analyzed for the years 2005 through 2007. The mean value of the collection ratio for both 2005 and 2006 was 70%, with a range of 39-92%. In 2007, the mean for the ratio value seen was 68%, with a range from 44-100%.

Ongoing evaluation of income requires reviewing a report that usually is entitled **payor analysis**. This report gives the breakdown by percentage of a practice’s total charges from each third-party payor and private payor. The collection ratio for each third-party payor should be included in the report. Analysis of this report forces routine evaluation as to whether continued participation with each third-party payor is worthwhile.

Another report that needs to be reviewed at least monthly is the **aged-trial balance**. This report provides information on outstanding charges

that are awaiting collection (also called **accounts receivable**). The data are usually presented in a form that notes outstanding charges from date of original service, grouped from up to 30 days from date of service, 31-60 days, 61- 90 days, 91-120 days, and then either >120 days or >150 days. This report clarifies whether the practice is collecting its fees. The data are sorted by outstanding charges to each third-party payor, so this report also clarifies if there are problems with a particular payor. Most outstanding charges should be for services performed <30 days ago. A general rule of thumb is that no less than 75% of total outstanding charges should be for services provided less than 30 days in the past, and no more than 10% of the outstanding charges should be for services over 120 days past due, because these old debts frequently go uncollected. Another figure that can be calculated and followed is the **quotient of total outstanding charges** (or accounts receivable) **divided by the average daily charges** (which can be calculated by dividing the annual charges by 365 days per year). In the form of a formula, this translates to:

$$\text{Accounts Receivable} \div (\text{Annual Charges} \div 365 \text{ Days})$$

This figure, reported as number of days, should be **<30 days**. Note that these general rules of thumb are changing because of the impact of electronic billing, which has sharply increased the speed of claim reimbursement.

The aged-trial balance report also should include a category for balances owed by patients. Patients may have a balance because they have no insurance, they submit their own bills to insurance companies that the practice does not participate with, or they owe a

portion of the balance not covered by the third-party payor. The high-deductible plans, for which a patient is expected to pay the first few thousand dollars of their health care expenses before any insurance coverage kicks in, is becoming common. This has created a burden on medical practices to keep track of these amounts and collect them from the patient. The charges have to first be sent to the insurance carriers for review, and only after the carriers calculate the agreed-on standard reimbursement for a level of service and the deductibility levels have been met, does the practice know what it can charge and collect from the patient. These amounts plus the usual copayment amounts due from the patient that were not collected at the time of the visit should be included here as well. It is essential that this category be watched closely and dealt with efficiently to ensure collection of what is becoming a larger portion of all fees.

An additional approach to understanding revenue is to analyze the codes used by each physician. An important report is one that breaks down the frequency of the current procedural terminology (CPT) codes used in billing by complexity level, and categorizes patient visits as consultations, new patient evaluations, follow-up visits, and testing or treatment services. This report should allow you to compare your pattern of charges with those of other allergists. The JCAAI has collected data on the frequency of CPT codes used by their membership in the past, and has made these data available to all members on their website (www.jcaai.org). Hopefully, this survey will be repeated regularly in the future. Medicare also posts coding frequency for different subspecialties. Comparing frequency of charges within a group allows identification of

individuals who overutilize a test or code compared to others in the group or nationally.

Other components of revenue that can be looked at as potential benchmarks to follow over time could include percentage of total charges generated by specific type of service. The AAAAI financial survey specifically asks for the percentage of revenue generated from immunotherapy services, which was found in 2007 to have a mean value of 33%, and total charges with a standard deviation (SD) of 15%. (A slightly higher mean value of 35% was found in 2006, and a slightly lower value of 28% was found in 2005.) Monitoring any component of charges, from testing to types of visit charges, can be instructive and informative. Looking at breakdowns in this way can give a young physician looking at practice opportunities a better understanding of the approaches that the physicians already established in that practice are using in caring for their patients. Some also strongly suggest that “charge adjustments,” are made; these are the bookkeeping corrections a practice makes to outstanding bills when their charges are greater than the **allowables** determined by the third-party payors. This figure, as revenues become more restricted, could provide an important variable worth monitoring in assessing how revenue streams are doing.

One final point that needs to now be considered is that the passing of the Affordable Care Act has created new insurance carriers, as well as encouraging the regional development of Accountable Care Organizations (or ACOs). These organizations will have to be dealt with, and participated in, and ultimately will change the reimbursement we as physicians receive. The ACOs will be mandated to insure efficient

(“less expensive”) health care, saving the system money, where previous organizations (HMOs) failed completely. Unfortunately, although many hypothesize how these organizations’ management of regional healthcare funding reimbursement will affect us, the reality is no one actually knows. Our only hope is that those who continue to provide high quality, efficient care to patients currently, and ethically evaluate appropriate testing and treatment, will be rewarded at the expense of physicians who perform unnecessary and thoughtless procedures and treatments.

EVALUATING EXPENSES

Expense data also need to be monitored regularly. The question that every practitioner should know the answer to is, “Of every dollar that comes in, how much goes out in expenses?” The answer to this question can be obtained with the **overhead ratio**:

$$\text{Overhead Ratio} = \text{Expenses} \div \text{Collections}$$

This ratio is the quotient of general administrative expenses divided by total collections. The expenses should not necessarily include any physician salaries or benefits (such as retirement plan contributions or personal business expenses), because these expenses are variable and arbitrary. Eliminating physician costs also allows for more meaningful comparisons from surveys that try to collect and report these data. An overhead ratio of 60% is a good rule of thumb. Knowledge of this ratio also allows a novice to estimate the general efficiency of an existing practice’s operation. The AAAAI financial data survey found similar overhead ratios in both 2005 and 2006 (with a mean value in 2006 calculated at

56%, an SD of 14% and a median value of 58%). An increase in this ratio was seen in 2007 data, when the mean value was calculated at 62% with an SD of 28%, and the median value was calculated at 59%. Medical Group Management Association (MGMA) data for 2010 (published in 2011) suggested a compensation: collection ratio mean of 57.8% with an SD of 22.3% (on data provided by 39 practices with 66 allergists).

Expenses further can be divided by category, separating the “big four” components of expense: staffing expenses (payroll and employee benefits), which usually account for around 60% of total expenses; space or facility expenses (rent and maintenance), which usually account for 15% of expenses; supplies and equipment, which account for around 15% of expenses; and fees (consultant services and malpractice insurance fees), which usually account for 5% of total expenses. Practice consultants suggest that 3-5% of total expenses can be budgeted to cover marketing and promotional expenses. Constant review of these individual expenses can lead to choices that will cut expenses as needed. It is important to note that regional market forces also can have dramatic effects on these categories; for example, nursing shortages greatly increase staffing costs, and renting office space in New York City is much more expensive than renting space in the suburbs of Hartford, CT. Cutting costs on smaller, miscellaneous items may be easier than focusing on larger, more essential and obligatory expenses, such as long-term lease rates and malpractice premiums. Again, as a novice to this exercise, you simply should ask, “Are the expenses regularly reviewed?”

Table 12.1 provides a list of general ledger categories that the author’s practice (the CT Asthma & Allergy

Center LLC, a group practice with nine allergists) uses to monitor expenses. This list can be used as a preliminary guide to plan for practice expenses.

Realizing that staffing expenses are the largest expense, the question each allergist needs to ask and answer is, “How much help do I need?” This is usually a subjective answer and is covered in more detail in Chapter 5. Remember, tasks that are not performed by hired help ultimately become the responsibility of the physician, which affects the number of hours

spent seeing patients (and generating revenue). A benchmark regarding staff use is the full-time equivalent employee unit (or FTE): physician ratio.

$$\text{FTE: Physician Ratio} = (\text{Hours Paid in Salary} \div 36\text{-}40 \text{ Hours per Week}) \div \text{Number of Physicians}$$

This ratio can be calculated by first dividing the total number of employee staff hours paid out (assuming a 40-hour workweek for any full-time salaried employee not paid an hourly wage) by 36-

TABLE 12.1. GENERAL LEDGER CATEGORIES

Personnel

- Payroll for staff (can categorize by department into clinical, administrative, bookkeeping or billing, receptionist)
- Staff gifts or bonuses
- Payroll taxes (Social Security; Medicare, SUTA, FUTA)
- Benefits: retirement plan contributions; health insurance premiums; life and disability insurance premiums
- Staff recruitment advertising expenses
- Workers’ compensation insurance premiums
- Employee liability insurance premiums
- Payroll processing service fees
- Health savings plan processing fees
- Society dues and state licensing expenses
- Electronic billing expenses

Facilities and upkeep

- Rent or mortgage expenses
- Condo fees
- Common charges
- Utilities
- Real estate property taxes
- User sales and business property taxes
- Depreciation
- Equipment leasing or upkeep
- Maintenance and cleaning charges

Technical equipment and phones

- Phone bills
- Internet provider fees
- Answering service expenses
- Computer program licensing fees
- Equipment maintenance contract fees
- Computer consultant fees
- Computer supplies

Supplies

- Medical supplies
- Antigen expenses
- Drug expenses
- Office supplies (stationery)

Advertising

- Marketing
- Promotion

Miscellaneous office expenses

- Printing expenses
- Postage
- Transcription expenses
- Subscription costs
- Library upkeep expense

Professional fees

- Accounting and legal fees
- Consultant fees
- Professional development expenses
- Professional organizational dues and licensing fees

Insurance

- Malpractice premiums
- Business owner liability
- Commercial umbrella policy
- Retirement plan bond

Interest on loan balances

40 hours per week to come up with an FTE for the practice. Then divide this number by the number of physicians working in the practice. If possible, monitor the support staff hired specifically to help any individual physician in a group practice to make sure that a group does not have an “FTE creep” — a physician who demands more support than anyone else in the practice. However, it is also important to remember that it might be beneficial to the practice as a whole to maximally support a physician who might be generating greater revenue for the practice. There have not been many studies of FTE: physician ratio specifically for allergists, who require more staff support than many other physician specialists because of the nature of their practices. The AAAAI financial data survey results from 2006 and 2008 in this area report a mean value (ratio) of 5.3, with an SD of 2.2; the median value was 4.9 FTE: physician ratio in 2006, and a mean value of 6.0, with an SD of 4.1; the median value was 4.9 FTE: physician ratio in 2008. Additionally, these data demonstrated an increasing trend for practices to incorporate physician extenders (physician assistants or nurse practitioners). In 2006, approximately one-third of the responding practices (26 of the 74 responding practices) reported their utilization; in 2008, >40% of respondents (33 of the 76 responding practices) reported employing physician extenders.

Salary structures can vary dramatically and are affected by regional market forces. Information on the hourly salary range for different medical staff tasks based on region, zip code and experience is available from The Health Care Group in Plymouth Meeting, PA. This group produces results from an annual “staff salary” survey of medical practices

across the country. Their website address is www.healthcaregroup.com.

AAAAI PRACTICE MANAGEMENT FINANCIAL DATA SURVEY RESULTS AND RECENT DATA REPORTED BY THE MGMA

As already described in this chapter, the AAAAI Practice Management Committee initiated a survey of its members to collect information on how much practices charged, collected and spent. The survey also collected data on support staff use. The results have been reported on the AAAAI web site (www.aaaai.org) and were published in the *Academy News* (Nov. 2006, 12(10), 12; and Nov. 2007, 13(10), 16-17), and presented at AAAAI Annual Meetings and at the Practice Management Workshop over the years. Although the results of these surveys rely on the accuracy and consistency of the respondents and may not reflect an accurate sampling of society members, the goal of the committee was to create worthwhile benchmarks that could be used for comparison by any AAAAI member. Unfortunately, very small responses to the survey in 2009 and 2010 made evaluation of figures for comparison impossible for the fiscal years since 2008. We do hope to reinstitute the survey among AAAAI members to compare trends, but still most rely on our past data. The data from other sources (specifically from MGMA or the American Medical Group Association (AMGA), which also do ongoing annual surveys) will have to be used to help evaluate where a practice stands based on information since 2008.

Utilizing the effective data previously collected by the AAAAI Practice Management Committee, we have found the following: In 2006, responses from 74

practices representing a total of 196 physicians (with 38 of the practices representing solo practitioners) were received. In 2007, with 111 practices representing a total of 267 physicians (and 56 of the practices representing solo practitioners) responded. In 2008, responses were received from 76 practices representing a total of 237 physicians (of which 29 were in solo practice). Although not all respondents provided information on charges and expenses, and some gave estimates while others gave exact figures, the survey responses seem to represent a broader group of allergists than any other previous survey of its kind.

Ultimately, information on charges, collections and expenses was reported from 54 practices

representing 146 physicians in 2005, from 89 practices representing 210 physicians in 2006, and from 57 practices representing 180 physicians in 2007. Some of the results regarding manpower utilization, collection ratio and overhead ratio were reported previously in this chapter.

The 2005, 2006 and 2007 results appear in Tables 12.2, 12.3 and 12.4. These figures are reported in dollars as a “per physician per year” value, as reported from 54 practices representing 146 physicians in 2005; from 89 practices representing 210 physicians in 2006; and from 57 practices representing 180 physicians in 2007.

The survey results showed regional differences. The results could be divided into five comparable regions:

TABLE 12.2. 2005 AAAAI PRACTICE MANAGEMENT SURVEY RESULTS

	Median	Mean	Range
Charges	\$981,378	\$1,038,238	\$75,000-\$2,448,459
Collections	\$695,101	\$697,518	\$45,000-\$1,615,011
Expenses	\$387,500	\$410,664	\$42,000-\$983,339
Profit	\$270,000	\$306,666	\$3,000-\$940,000

TABLE 12.3. 2006 AAAAI PRACTICE MANAGEMENT SURVEY RESULTS

	Median	Mean	Range
Charges	\$997,564	\$1,177,324	\$200,000-\$3,326,073
Collections	\$736,930	\$819,960	\$125,000-\$2,597,020
Expenses	\$420,000	\$466,168	\$95,000-\$1,000,000
Profit	\$319,717	\$351,984	\$46,000-\$1,000,000

TABLE 12.4. 2007 AAAAI PRACTICE MANAGEMENT SURVEY RESULTS

	Median	Mean	Range
Charges	\$1,000,000	\$1,173,743	\$50,000-\$5,144,630
Collections	\$714,896	\$780,495	\$32,389-\$3,264,948
Expenses	\$400,000	\$464,523	\$16,667-\$1,862,121
Profit	\$291,198	\$356,263	\$73,525-\$1,402,827

Northeast, South, Mideast, Rocky Mountains/Central and West. These results are reported as median values (as a “per physician” figure) in Table 12.5 from data from 2006, and in Table 12.6 from data from 2007.

Data from past years that separated group practice results from the solo practices showed an interesting trend that refutes the suggestion that group practices might be more cost effective because of “economies of scale.” Rather, group practices appear to cost each physician more per person, but this increase

in cost seems to be compensated for by increases in collections generated, probably because more time is spent seeing patients rather than doing administrative work. Table 12.7 presents results from the 2005 survey. Because of the smaller sample size, groups of two and three physicians were not excluded; the results were divided into all groups versus solo practices. Mean values for solo practices were first compared with groups of more than two physicians. The group data then were recalculated by only looking at groups of four or more physicians.

TABLE 12.5. 2006 AAAAI PRACTICE MANAGEMENT SURVEY RESULTS BY REGION

	Charges	Collections	Expenses	Profit
Northeast (n = 25/46 physicians)	\$866,829	\$604,263	\$400,000	\$335,539
South (n = 23/58 physicians)	\$1,131,412	\$780,067	\$478,562	\$322,800
Central (n = 16/54 physicians)	\$950,937	\$1,138,793	\$555,564	\$319,717
Mideast (n = 16/32 physicians)	\$1,183,712	\$757,192	\$455,464	\$340,980
West (n = 9/20 physicians)	\$900,000	\$675,000	\$257,350	\$252,800

TABLE 12.6. 2007 AAAAI PRACTICE MANAGEMENT SURVEY RESULTS BY REGION

	Charges	Collections	Expenses	Profit
Northeast (n = 16/46 physicians)	\$852,793	\$664,954	\$395,145	\$242,787
South (n = 8/16 physicians)	\$1,214,641	\$868,442	\$478,975	\$403,360
Central (n = 12/60 physicians)	\$1,160,000	\$700,000	\$400,000	\$214,286
Mideast (n = 13/30 physicians)	\$970,801	\$677,396	\$302,625	\$325,000
West (n = 8/30 physicians)	\$1,066,189	\$792,910	\$419,089	\$289,604

TABLE 12.7. 2005 AAAAI PRACTICE MANAGEMENT SURVEY RESULTS BY PRACTICE SIZE

	Solo (n = 38)	Group >2 (35 groups/151 physicians)	Group >4 (16 groups/108 physicians)
FTE: physician ratio	5.1 + 2.8	5.4 + 1.5	5.4 + 1.5
Charges	\$991,578	\$1,084,899	\$1,141,237
Collections	\$668,814	\$725,297	\$809,592
Expenses	\$377,497	\$441,727	\$477,033
Profit	\$320,386	\$295,369	\$358,328

TABLE 12.8. 2006 AAAAI PRACTICE MANAGEMENT SURVEY RESULTS BY PRACTICE SIZE

	Solo (n = 50)	Group of 2-3 (21 groups/47 physicians)	Group ≥4 (18 groups/113 physicians)
Charges	\$1,181,307	\$932,021	\$1,439,263
Collections	\$804,955	\$643,826	\$1,058,601
Expenses	\$469,028	\$355,371	\$576,726
Profit	\$354,063	\$301,390	\$404,012

TABLE 12.9. 2007 AAAAI PRACTICE MANAGEMENT SURVEY RESULTS BY PRACTICE SIZE

	Solo (n = 29)	Group of 2-3 (23 groups/52 physicians)	Groups > 4 (14 groups/103 physicians)
Charges	\$1,366,533	\$1,037,963	\$1,145,560
Collections	\$915,272	\$697,367	\$709,162
Expenses	\$588,484	\$359,282	\$446,052
Profit	\$394,332	\$338,086	\$326,140

In 2006 and 2007, three separate groups could be compared to evaluate the trend. The mean results are reported in Tables 12.8 and 12.9.

The final data breakdown found to be informative compared figures presented by respondents who hired physician extenders to those who did not. There was a clear financial benefit demonstrated by hiring extenders, and this was seen whether the practice was a group or solo. (Eight of the 25 practices reported to have hired physician extenders were solo practices.) The **number** of extenders hired per practice was not quantified, however. In

2005, the difference in profit per physician with a physician extender was a median value of \$309,029 for practices with extenders, compared to \$250,000 for practices without. The mean values showed a lower difference, with \$312,268 for practices with extenders, compared to \$304,175 for practices without. The “n” values for these groups were 25 practices for 95 physicians with extenders, versus 48 practices for 52 physicians without. In 2006, the data breakdown from 36 practices representing 103 physicians who utilized physician extenders showed a median profit of \$351,718 and a mean profit of \$401,500 per physician, while the 53 practices of

TABLE 12.10. MGMA A/I PHYSICIAN COMPENSATION BASED ON 2010 DATA (REPORTED 2011)

	Mean	Standard Deviation	Median
Overall (145 physicians/79 practices)	\$309,751	\$153,367	\$261,396
Eastern (15 physicians/10 practices)	\$271,061	\$88,023	\$253,779
Midwest (55 physicians/31 practices)	\$335,845	\$169,896	\$280,759
South (35 physicians/15 practices)	\$324,576	\$179,294	\$268,850
West (40 physicians/23 practices)	\$275,409	\$114,598	\$249,790

TABLE 12.11. MGMA A/I PHYSICIAN COMPENSATION BASED ON 2012 DATA (REPORTED 2013)

	Mean	Standard Deviation	Median
Overall (144 physicians/81 practices)	\$333,294	\$149,332	\$285,847
Eastern (15 physicians/12 practices)	\$352,325	\$206,306	\$240,211
Midwest (58 physicians/28 practices)	\$343,104	\$148,541	\$312,420
South (41 physicians/20practices)	\$317,095	\$147,997	\$266,625
West (30 physicians/21practices)	\$326,953	\$122,614	\$279,024

103 physicians not employing physician extenders showed a median profit of \$279,000 and a mean profit of \$313,819 per physician. Utilizing data for fiscal year 2007, 39 practices that employed physician extenders representing 111 physicians showed a median profit per physician of \$323,579 and a mean profit of \$428,054 per physician, while the 39 practices representing 83 physicians not employing extenders generated a median profit of only \$247,809 per physician and a mean profit of \$302,999. It should be noted that these data represent established practices and probably do not apply to a physician trying to establish a new practice.

MGMA has allowed us to provide their data for A/I compensation for 2010 (published in 2011). They found that in 79 practices (that utilized 145 allergists), the mean physician compensation was \$309,751 with an SD of \$153,367 (median value was \$261,396). Per

the MGMA data, allergist compensation was highest in the Midwest (median value of \$280,759) and lowest in the West (median value reported as \$249,790).

The MGMA also recently published data from their 2013 survey reporting 2012 results. That survey showed an apparent increase in allergists’ “profitability”, finding that in 81 practices (that utilized 144 allergists), the mean physician compensation was \$333,294 with SD of \$149,332 (median value was \$285,847). That year’s data showed allergist compensation was highest again in the Midwest (median value of \$312,420) and lowest in the East (median value reported as \$240,211). These alternative data are consistent with the earlier years of AAAAI financial survey data, and would suggest that for at least 2010 and 2012 overall, compensation for allergists has not fallen (see Table 12.10;& Table 12.11; data reported with permission of the MGMA):

SUMMARY

Utilizing the analytical skills learned to evaluate human pathophysiology can compensate for the lack of formal business education provided by medical training. By evaluating the practice budget, reviewing any deviation from past and expected performances, calculating some important ratios like the collection ratio and overhead ratio, and comparing performance with nationally derived benchmark values (such as those that the AAAAI is trying to calculate and provide), any allergist will become more effective in analyzing his or her practice's business performance, thereby increasing efficiency in providing care. This approach also may be useful when analyzing available practice opportunities.