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# COMPREHENSIVE MEDICAL PRACTICE ANALYSIS

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# Comprehensive Medical Practice Analysis

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## WHAT IS A COMPREHENSIVE MEDICAL PRACTICE ANALYSIS?

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Physician practices account for about a quarter of the total dollars spent on healthcare in this country, yet 80% of the regulatory focus has rested squarely in the lap of the provider. Since 1991, the net revenue for physicians has steadily declined and many medical practices have become unprofitable. And this trend affects small and large practices alike.

E/M guidelines are administratively complex, medically unnecessary and overly elastic. In national studies, only 50% of professional coders can agree on the proper code, making utilization studies critical for risk assessment. More and more payers are relying on RBRVS as a foundation for establishing their fee schedules and as such, practices need to be expertly versed in its use and application. Over the past few years, payers have engaged in such unscrupulous practices as unauthorized rental networks and silent PPOs, stealing millions of dollars directly from the providers' pockets. Being able to analyze multiple allowable schedules is the only way to identify and prevent this practice from occurring. The OIG has made it very clear that they are looking harder at the use of modifiers for potential violations of fraud and abuse statutes and coding utilization has moved up several notches in their toolbox for profiling practices. To counter this attack, it is necessary to have access to benchmark data and comparative analytical tools designed to identify potential problems. Many practices have proven that it is possible to negotiating fees within managed care contracts but only if they have substantiated cost data and RBRVS is an inexpensive yet effective tool for this type of business process. The recent popularity of using RBRVS to develop productivity-based physician compensation plans contrasts with the government's move to examine these models against fair market value benchmarks. And the list of challenges goes on and on and on.

Our Comprehensive Medical Practice Analysis (CMPA) is the most advanced health care consulting system of its kind. By focusing on the analytical processes responsible for generating revenue, addressing compliance and increasing efficiency, CMPA provides a total solution for nearly every medical practice. Using expert system technology and through advanced data integration techniques, the health care consultant is able to seamlessly perform more complex analyses faster, more efficiently and at a fraction of the cost. Using CMPA, large firms are able to what they already do more profitably and smaller firms are able to compete effectively with a stronger competitive advantage.

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## ANALYTICAL COMPONENTS

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CMPA, because of its compartmentalized development properties, can be performed in whole or in part. Some of the analytical components are inclusive with respect to the basic data set and others are separated by either additional data or disparate relationships. Of significance is the level of research that goes into CMPA. In addition to performing analyses based on traditional and accepted industry standards, we are recognized as pioneers in the area of development of new and exiting analytical tools. One of these is the acuity factor, a concise methodology for measuring the level of complexity of the services and procedures assigned to any patient population by any individual provider or specialty within the practice.

### ACUITY FACTORING

The most significant challenge with respect to comparative analyses is defining what constitutes a valid sample. This is particularly true when comparing by specialty by location as this requires a larger universe of data that is commercially available. The CMS database, called the Physician/Supplier Payment System (P/SPS) Master file, contains every Medicare claim filed within a calendar year. For CY 2004, this equates to nearly 5 billion claims, the most significant database of its type. Imagine having access to a database of claims

that represents nearly every physician in every specialty in every zip code in the United States submitted from over 40 million patients. The only problem is that this database is almost exclusive to adults aged 65 and over.

The Acuity Factor, when applied through CMPA, normalizes this database so that any practice, irrespective of their Medicare payer mix, can use this data for important comparative analyses. From E/M to coding to modifier utilization, the acuity factor takes a large database and turns it into a useful database; certainly an advantage for any medical practice.

When applied to E/M coding and utilization, acuity factoring can be used to adjust the national distribution for any patient population, rendering the national Medicare data set useful for compliance as well as financial analyses. When applied to physician productivity, the acuity factor can be used to demystify the 'my patients are sicker than others' dilemma that faces most administrators and consultants engaged in physician compensation efforts.

In general, acuity factoring helps to prevent the practice from becoming compartmentalized with respect to relational databases and standard comparative methodologies and is proprietary to the CMPA system.

The following describes each of the analytical components as they stand individually and in relation to the entire process.

### **PROVIDER PRODUCTIVITY ANALYSIS**

In this module, CMPA uses actual revenues and calculated gross charges by provider to measure a myriad of metrics used to identify overall provider productivity. It will automatically calculate the upper and lower quartiles, median, mean and standard deviation for each provider based on the specific metrics represented. The primary worksheet is broken into eight major components, as follows:

#### FINANCIAL ANALYSIS

This component analyzes basic financial information. Using the calculated charges and requested revenue by provider, this component analyzes expense distribution and collection ratios to calculate profitability; a key marker for many performance-based compensation programs

#### RVU ANALYSIS

The RVU component uses special factoring edits and logic to create the most accurate representation of RVU consumption available. Considering the use of specific modifiers, each provider's RVU values are calculated for work, practice expense and total components. Considering the number of practices that pay providers based on work RVUs, we also calculate the work-to-total RVU ratio and compare it to national averages by specialty.

#### COMPENSATION ANALYSIS

The compensation analysis is the most comprehensive of its kind in that we consider data that are often missed in other similar types of analyses. For example, we calculate a metric for minutes-per-work-RVU based on the national Harvard/RUC time study. This allows for an accurate assignment of work RVUs to define 1 FTE for every specialty. Using inferential statistics, we calculate a 95% confidence interval; far more important than point estimates when assessing a provider's relative performance. Other metrics include comparative compensation, including our proprietary Effort Adjusted Compensation value and, a Fair Market Value assessment.

## PRODUCTIVITY AND PERFORMANCE ANALYSIS

This component uses both RVUs and expenses to calculate the relative productivity of each medical provider. The basic concept centers around the ratio of what the provider puts into the practice as a percent of total compared to what the provider takes out of the practice as a percent of total. This is a great tool for assisting providers with understanding and improving their overall financial productivity.

## TIME-BASED ANALYSIS

Using the Harvard/RUC assessed time study, this component looks at the component (pre-, intra- and post-) and total time assessed to each provider. This is a great way to rapidly identify potential compliance risks based on the OIG audit standard of 5,000 hours. It also compares charges per hour and collection per hour for each provider against the national average for their specialty.

## VOLUMETRIC ANALYSIS

This component combines the volume of procedure reported by provider with the time study to obtain such metrics as time per procedure and procedures per hour and then compares these against national averages by specialty. When studying ratios of E/M to non-E/M procedure, the raw data is also useful in identifying potentially high-risk trends.

## DHS ANALYSIS

Fairly clear-cut, DHS procedures are of concern when providers are compensated using procedural or RVU-based productivity models. DHS procedures need to be considered in order to avoid legal issues under Stark II and other self-referral rules and regulations. This component calculates the greatest risk by reporting the total potential DHS procedures and charges by provider.

## ACUITY ANALYSIS

Using our proprietary Acuity Factor calculation, this component analyzes the relative complexity level of services and procedures reported by each provider and then compares this to the national average acuity factor by specialty. Our Acuity factors are now widely used by practices to justify higher fees, normalize national and comparative databases and justify provider compensation based on more than just assessed work effort.

## **PROCEDURE CODE COMPLIANCE/UTILIZATION ANALYSIS**

During this component, each procedure code is checked to insure it is valid for the current year and represented by the correct description. Then, it is compared with Medicare and other government regulations to insure that it is being used properly. CMA identifies codes subject to the National Correct Coding Policy, fraud exclusionary areas and reasonableness of use. In addition to basics such as status and validity, this module reports important regulations such as those covering the use of assistants at surgery, co-surgeons, multiple surgeons, multiple procedures, etc. These types of details are often overlooked, particularly by larger practices, because of the difficulty in obtaining all of the data from one source. Other reports show such specifics as the financial impact and deletion dates for codes that are no longer valid for the current year and also for codes that have never been valid HCPCS codes. In essence, this component replaces the need to be a coding expert with experiential knowledge.

After the qualitative assessment, CMPA then performs a quantitative analysis by comparing the top 50 procedures for the practice against its specialty peer group nationally. This provides information useful in identifying areas of financial opportunity as well as compliance risk. This analysis is customarily conducted by specialty and a drill-down worksheet conducts the same analysis, only by individual provider.

### **MODIFIER COMPLIANCE/UTILIZATION ANALYSIS**

After the global codes have been analyzed, the system performs a specific examination of the use of modifiers in relation to their counterpart codes. For example, it will identify code/modifier combinations that are inappropriate and that may result in denials and even violations of the law. It looks at all E/M codes to insure that they are used only with appropriate E/M modifiers and then examines the rest of the codes to insure that they are not used with E/M-only modifiers. If the frequency data is available by provider, this analysis will report the frequency of violations for each specific provider in addition to the total frequency and global charges, making it easy to identify both the source and the pattern of potential violations. And because the process of analyzing what can be a nearly infinite number of possible modifier iterations, most practices lack the resources to achieve this level of compliance.

As with the procedure code analysis, after the quantitative portion is complete, CMPA will also look at the quantitative use of modifiers, analyzing the utilization of each modifier against all procedures and comparing the results against the national data for each specialty reported. This analysis is customarily conducted by specialty and a drill-down worksheet conducts the same analysis, only by individual provider.

### **EVALUATION AND MANAGEMENT CODE UTILIZATION REVIEW**

The only thing more important than E/M coding is the patient! Responsible for more reviews, audits and overpayment demands than any other single element, E/M code utilization is the most important compliance issue in the medical practice. Improper E/M coding will result in one of two outcomes; cost the practice money through unrealized revenues in cases of under coding or cost the practice money in as the result of overpayment demands due to over utilization. Providing the most complete and comprehensive E/M utilization analysis in the industry, CMPA employs three degrees of analysis, going well beyond what most practices and consultants even consider. In addition to looking at intra-category utilization, CMPA also analyzes inter-category and global relationships to more specifically identify aberrant behavior. These relational areas are monitored by carriers and outside reviewers to profile practices for audits and reviews.

For large practices with many providers, the CMPA produces a flat-file matrix that can be used to instantly identify anomalies by individual code or coding category for each provider or aggregate specialty. This matrix can be used for more in depth investigational analyses, such as scatter graphing for cluster analysis, rapid data modeling for compliance reviews and resource allocation. In addition, for multi-specialty groups, a separate worksheet is generated that catalogs all critical E/M utilization statistics by specialty for eight different metrics.

### **UTILIZATION DIFFERENTIAL**

While standard E/M utilization techniques can define potential over and under utilization tendencies, they do not quantify that differential as a value relative to the control group. Using a proprietary mathematical algorithm to assign a total distributed resource value for each E/M category and by comparing that to national values, CMPA can actually assess the level of under or over coding for that specific group as a percent variance of the control.

## ACUITY ADJUSTED CHARGE DIFFERENTIAL

In the E/M analysis, CMPA takes the acuity model one step further; it separates acuity based upon E/M and non-E/M codes. Using the assumption that non-E/M procedures are coded more accurately than E/M codes, the CMPA is able to develop a variance differential based upon patient-specific characteristics to calculate what we refer to as an acuity-adjusted charge differential. This resultant value defines for the practice the level of revenue that the practice should be generating by E/M category if the level of E/M coding was commensurate with the level of complexity assigned to their patient population. The CMPA is the only system in the country that can accurately assess the financial potential or liability based upon E/M specific coding practices.

## **CORRECT CODE INITIATIVE COMPLIANCE ANALYSIS**

The Correct Coding Initiative (CCI) was developed for the purpose of eliminating the practice of unbundling procedures by establishing an exhaustive set of restricted coding pairs. Currently, the database contains nearly half a million records, each representing a pair of procedure codes that if billed together will either be rejected outright or paid at an amount equal to the lowest reimbursement of the two codes in the edit pair. If a practice has noticed a seemingly unexplained increase in rejections and denials from all payers over the past year or so, they can be relatively certain that it is due to the CCI restrictions.

CMPA is the only integrated system that produces a set of cross-referenced reports for the practice that are filtered by the practice's fee schedule. By making the reports far more user-friendly and manageable, it all but guarantees the practice will use this as a reference to increase Medicare collections and cash flow. In addition, CMPA offers a free-standing CCI search engine that can be used real-time by the practice to check the presence of restricted pairs prior to submitting the claim.

## **FEE ANALYSIS**

The practices' fee schedule should be based on the value of its services, the cost to deliver those services and market dynamics, not held hostage to what payers are willing to reimburse. The fee schedule is the most important financial tool within the medical practice. It is from here that the entire billing and collection process begins. And while EOBs are required in order to validate reimbursement, much can be done in their absence to establish a fee schedule that is quiet, consistent and passes muster in relation to several important internal and external benchmarks. This process of balancing the fee schedule is referred to as profiling and it is designed to assist the practice with the development and maintenance of a fee schedule that optimizes revenue and minimizes exposure. First, and most importantly, fees are compared against the Medicare Fee Schedule amount to insure that no procedures are being charged below that benchmark. Next, fees are compared against the cost of delivering the service to insure that what is being collected at least exceeds the cost. Then, fees are compared against the Minimum Charge Threshold (MinCT), a factor established by the practice as a relational minimum amount above which the procedure should be billed, and the Maximum charge Threshold (MaxCT), a value above which might be considered at risk. The final benchmark is to compare the practice's fees against national fee statistics and against the mean fee amount for that specific geographic locality. This also includes comparison of the practices conversion factors by category to that of its peers within the same geographic market.

The importance of establishing a defensible and reasonable fee schedule cannot be overstated. The benefits of such are perhaps the most notable in any medical practice. The ability to defend fees against potential payers, patients and local industry is a matter of survival and the increased ability to negotiate more meaningful and profitable contracts is essential to thrive in a highly competitive market.

### **REIMBURSEMENT VALIDATION/CONTRACT ANALYSIS**

This is an EOB driven model designed to validate reimbursement and assess contract value for virtually any payer or payer type. The industry is rife with all sorts of payer schemes and shenanigans, such as silent PPOs, rental networks, broker contacts, etc. Each of these has a single purpose; to subvert the process of paying the provider their contracted amount for the services they provide to the patient. In this analysis, CMPA imports EOBs to develop a financial and statistical picture of payer compliance. To establish contract amounts, the actual fee schedules can be imported or, better yet, calculated by using a number of different possible calculations, including percent of usual fees, ratio of Medicare or RBRVS, a fixed conversion factor or even a procedure-by-procedure entry. This analysis has two purposes; to ensure that the practice is being reimbursed the appropriate amount based on each payer contract and to assess the value of a contract outside of traditional models. We allow the practice to enter such metrics as A/R days and hassle factor to create a unique rating of each payer contract so when the time comes to start culling, the practice will have the information they need to dump the worst contracts to make way for better contracts.

There are two worksheets for this component. The first is a simple flat file that compares the contract fee amount by payer. The second is a more complex matrix that summarized critical financial metrics by payer, such as total payments, ratios to allowable and usual fees, RVU values and our unique ranking system. Each payer is then represented on a separate tab, reporting more detailed data by procedure code, including metrics for allowable, payment, utilization frequency, statistical metrics and other very useful information.

### **PROCEDURAL COST ACCOUNTING/BREAK-EVEN ANALYSIS**

Cost accounting techniques take on a number of different forms. In fact, entire books have been written about the topic. In the CMPA, the focus is on the relationship of costs to the revenue base of the practice, including line item procedural relationships and overall costing of procedures and services. Using the RBRVS as the basis to this relational model, CMPA compares utilization levels, resource allocation, profit and loss levels, common costing and other bits of critical information for the practice. The analysis is conducted on both a macro level (global amounts such as total billing, collections, cost per RVU, etc.) and on a micro level (per procedure and per unit comparisons, such as break-even amounts).

This analytical component will show most practices (many for the very first time) what it costs in real dollars to perform a procedure or deliver a service. It also develops line-item P&L and break-even values that are critical for analyzing the profitability of managed care contracts. It will also calculate both the cost and collection per RVU; perhaps the most important metrics available for measuring effectiveness of revenue generation and cost containment efforts in a dynamic system. Then, using the component structure of RBRVS, CMPA compares the cost relationship between operational issues and provider expense, granting the practice that ability to design methodologies for improving profitability without affecting quality.

### **PRACTICE UTILIZATION/COST ANALYSIS**

Without question, managed care has become the driving force behind commercial health care. And while there continues to be opposing opinions as to the life cycle of capitation plans, they also remain a market force in some regions of the country. The CMPA includes a managed care/capitation cost analysis component that will identify the profitability of virtually any managed care contract, including PCP full risk contracts, specialty shared risk or just total contract rate proposals. Too many practices blindly sign managed care contracts without having the slightest idea as to what the cost of the contract will be or whether it will be profitable for the practice. In a substantial contract, one that accounts for more than 10% of revenue, a bad contract can financially destroy a practice. Using the practice's own expense amounts and number of active patients, the system calculates utilization per thousand by procedure and then both the variable and fixed cost per unit, per member and per member per month (PMPM), the most common payment methodology under capitation models. Then, by obtaining the number of insured lives under a proposed contract, the practice

can calculate the projected number of visits, diagnostic and therapeutic procedures and total and variable cost expected.

### **RELATIVE VALUE SCALE STUDIES**

Relative value scales (RVS), particularly the RBRVS, have been embraced for years by the health care industry as a way to statistically benchmark the medical practice and the individual physician. Relative value scales are used in almost every aspect of costing, revenue, compensation, utilization and resource allocation studies performed. As part of the total package, CMPA will perform a complete Relative Value Scale analysis to prepare the practice for further, more complex analyses. Information obtained includes component RVU data, conversion factors and Geographic Adjustment Factors (GAF) broken out by major HCPCS coding categories. In addition, CMPA is the only system that automatically adjusts RVU values by the mathematical factors assigned to specific modifiers in relation to their reimbursement potential. Without this step, an RBRVS analysis would very well result in a skew of all related analytical components.

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### **STATISTICAL MODELING BY LOCATION BY PHYSICIAN**

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For single-specialty practices, the default analyses are based on global practice data. That is, cumulative data for the entire practice or organization. This is referred to as an **aggregate** analysis. For multi-specialty practices or single-specialty multi-provider practices, CMPA has the ability to capture frequency information by location, by physician, by department or any combination as long as this data is available from the practice management system. This is referred to as a **segregated** analysis. This is a very powerful tool for looking at different profit centers within the organization. For example, the practice can look at the E/M analysis using the aggregate data (all physicians and locations as one group) or they can use the segregated frequency data to select different physicians within the E/M analysis to compare E/M utilization for aberrant behaviors. Remember, **it only takes one physician with poor coding practices to trigger a review for the entire group.** The practice may also want to compare cost accounting data by location to identify the profit generated by one location using the segregated frequency set and compare that to the overall aggregate cost analysis. The CMPA can also produce a resource allocation study segregated by physician that will compare the revenues generated by resource expenditure (costs) for each physician selected against any control group chosen. This is invaluable for building revenue/cost relationships for compensation and bonus determination.

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### **REPORTS AND WORK PRODUCT**

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One of the greatest benefits of the CMPA is the comprehensive work product that is produced from the analysis. The work product consists of detailed MS Excel spreadsheets for each analysis component, individual E/M utilization worksheets for each provider/specialty, a full analysis summary and a complete interpretation guide that defines and explains each field in each report/spreadsheet. Through specific organization and categorization of worksheets, the work product is optimized for Six Sigma, Lean Six Sigma, Kaizen and other process improvement techniques.

Reports and worksheets are broken down into four categories:

- Financial
- Fee Scheduling
- Coding
- Productivity

Possibly the most important report is the analysis summary report. This ten-page report contains hundreds of summary statistics which, used properly, can reveal an enormous amount of critical information about the practice in just a matter of moments. And used in conjunction with the associated worksheets, provides detailed drill-down data unique within our industry.

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## **CMPA OPPORTUNITIES**

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Now that you have a better understanding as to the power and capabilities of the CMPA system, we wanted to explore the ways in which you can take advantage and benefit from its use. What is obvious is that the CMPA system works to improve efficiency, increase profitability and perform compliance risk analyses specifically for the medical practice. What may not be as obvious is how it can be used to also benefit practice management organizations, hospitals, CPAs and other health care consultants. The following few pages discuss these opportunities in detail.

### **LICENSING**

Opportunities to license the software are restricted to those firms and/or individuals that can show an aptitude to work with the level of detail provided by the CMPA analysis. The majority of our licensees are CPAs and other highly qualified health care consultants that have a keen understanding of operational and financial processes within a medical practice. In addition, to qualify as a licensee, the consultant must have an existing medical practice or physician client base.

The CMPA system is a sophisticated engine designed to enhance the scope of services provided by and the profitability of an existing healthcare consulting firm, not as an entry-level tool for those interested in starting out in this discipline. For the larger firm, the CMPA will provide the types of complex data analysis necessary to obtain larger engagements at a fraction of the cost currently incurred. This means that the services you provide can be more affordable for the client, increasing the number of clients that can take advantage of your services while maintaining or increasing your profit margin for each engagement. For example, one firm recently accounted for 227 hours of staff and partner time for the marketing, data collection, data analysis, report preparation and presentation for a 38 physician orthopedic group. Their cost to get to the presentation point was nearly \$25,000. Using the CMPA system, their total time investment was 8.5 hours, bringing the total cost to well under \$2,500.

For the smaller firm, the CMPA system will significantly enhance the types of services offered and allow them to compete effectively with the larger firms by providing the experiential base necessary to include more sophisticated type analyses that encourage larger engagements. Even a solo CPA or health care consultant can have the appearance of a large organization with the help of the CMPA system.

The license fee includes the right to use all trademarks and service marks and access to all written marketing, advertising and technical materials, including text, copy and slide presentations. The licensee is also enrolled in the CMPA list serve and has the opportunity to become certified as a Medical Practice Analyst. The initial fee includes initial training program for up to three persons from the organization and the first year of technical and client support. The latter includes assistance with installation and operation of the program, marketing and advertising, analytical reviews and other support-related services.

### **RETURN ON INVESTMENT**

Our licensees use the CMPA as a revenue and/or productivity model in one or more of the following three ways.

## ANALYTICAL PRODUCT

As an analytical product, licensees conduct an analysis for a client and sell them the data set. While pricing is individually determined by each licensee, the typical model is \$2,500 for setup and between \$500 and \$1,000 per physician.

## CONSULTING TOOL

As a consulting tool, licensees conduct an analysis and use the data in order to secure down line engagements with the client. Our licensees average between \$1,600 and \$2,200 per physician.

## PRODUCTIVITY TOOL

As a productivity tool, licensees are able to reduce data mining, input and analysis time and resources by approximately 80%, significantly decreasing both lead time and throughput cycle time for each engagement. Reducing this overhead significantly improves profitability and makes it possible to secure more engagements within the same time period.

## ROI CALCULATION

To calculate ROI for CMPA, determine the type of engagement opportunity and multiply the average revenue value times the number of physicians engaged. For example, if you were going to conduct an analysis on a 4-physician orthopedic practice, selling them the data set, the average revenue value would be \$2,500 plus \$3,000 (\$750 per physician) or \$5,500. If the analysis was conducted in order to secure an engagement (coding compliance or developing a defensible fee schedule, for example), you would multiply the number of physicians times \$1,900 (average engagement value) for a total revenue value of \$7,600. Let's assume that, in the latter example, you spent a total of 60 hours on data mining, building worksheets and data analysis and the cost is \$75 per hour for a total of \$4,000. Multiply this by 80% (approximate productivity savings) and subtract from the \$4,000 ( $\$4,000 - \$3,200 = \$800$ ) and this would increase your gross profit from \$3,600 to \$5,400. Add opportunity cost back for reduced cycle time and some licensees double their profitability on CMPA-based engagements.

Repeat this exercise for each practice for whom an analysis would be conducted and you will be able to calculate total ROI for the first service cycle.

## LICENSE APPLICATION

All prospective licensees must complete an application to initiate the licensing process. In addition to the written section, each prospective licensee is required to interview with three existing CMPA licensees. We then make our determination as to the probability of success based on the information in the application and feedback from those interviews. If you would like to be considered for licensure, please contact us at [info@cpahealth.com](mailto:info@cpahealth.com) and we will forward you the license application form.

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**FOR MORE INFORMATION**

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If you would more information about having the CMPA performed for your practice, or if you are a consultant and would like more information about licensing the CMPA software for use with your medical clients, please visit our web site at [www.cpahealth.com](http://www.cpahealth.com), email us at [info@cpahealth.com](mailto:info@cpahealth.com) or call our offices at 800-851-CMPA (2672).