

Current Orthopaedic Ancillary Service Opportunities: Access Points and Options for Revenue Distribution

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Objectives: To describe real-world utilization volumes and surgeon-level financial distributions for major orthopedic ancillary service lines within a large, single-specialty group practice, and to outline operational “access points” and Stark-compliant revenue distribution models that support sustainable ancillary development across practice settings.

Design: Retrospective, observational, single-practice economic outcomes analysis with a narrative synthesis of regulatory considerations and implementation strategies.

Main Outcome Measurements: Calendar-year 2024 ancillary utilization volumes (encounters/units by service line) and corresponding surgeon FTE/partner distribution estimates; descriptive benchmarks of revenue potential across radiography, MRI, CT (planned), DME, physical therapy, orthopedic urgent care, and ambulatory surgery center (ASC) operations; and a qualitative assessment of access strategies and Stark-compliant distribution approaches (equal, productivity-based, hybrid).

Results: In 2024, the practice (35 surgeons; 26 physician extenders; 2 clinic sites; 5 PT sites; 2 urgent care sites; one 7-room ASC) recorded 270,217 patient encounters and 17,009 surgical cases. Observed ancillary utilization included 79,046 radiographs, 11,905 MRIs, 20,058 DME items dispensed, 77,813 PT visits, and 21,693 orthopedic urgent care visits; the ASC performed 7,309 surgical cases. Reported annual distributions for these service lines were approximately \$23,429 per partner for radiography, \$27,030 per partner for MRI, \$31,908 per surgeon FTE for DME, \$32,971 per surgeon for PT, \$75,433 per partner for urgent care, and \$493,109 per surgeon for ASC. The practice projected additional opportunity from in-office CT acquisition (planned for 2025), citing the need for adequate arthroplasty/trauma volume to justify capital costs and support utilization. Across service lines, operational access points associated with higher capture included a pre-rooming radiography workflow, same-day availability of advanced imaging, a convenient multi-site PT footprint, extended-hours urgent

care as an entry point for new patients, and ASC expansion to safely accommodate higher-acuity cases (including select ASA III). Stark-compliant revenue distribution models emphasized equal pooling to avoid referral-linked allocation, with permissible productivity or hybrid modifiers based on neutral metrics (e.g., RVUs, total visits, leadership roles) when applied uniformly.

Conclusions: In a high-volume, single-specialty orthopedic group, ancillary services produced substantial, directly observed surgeon distributions and functioned as strategic access points that increased system capture across the episode of care. Given the scarcity of published, real-world orthopedic ancillary financial benchmarks, these results provide pragmatic reference points for private, employed, and academic surgeons evaluating ancillary development, negotiation leverage, and compliant revenue-sharing structures.

Level of Evidence: Level IV; Retrospective observational economic outcomes (single-practice case series).

Keywords: Ancillary services, orthopedic practice management, financial productivity, revenue distribution, Stark Law, physician self-referral, ambulatory surgery center, orthopedic urgent care, in-office imaging, physical therapy, durable medical equipment, value-based care.

INTRODUCTION

As physician salaries continue to shrink, most orthopedic surgeons are seeking alternative ways to supplement their income^{1,2,3}. Ancillary services are a proven way to do so⁴, and new opportunities are on the horizon. Due to robust ancillary service development at the authors’ large, single-specialty orthopedic group practice, surgeon salaries have continued to increase over the past 20 years despite a declining national average. At our practice, ancillary services account for 65% of the average surgeon’s compensation. This

Table 1. Revenue Potential and Access Strategies Across Common Ancillary Services

Ancillary Service	Approximate Revenue	Distribution Notes
Radiography	\$23,000 per FTE	Equal distribution favored; avoids referral-volume bias
MRI	\$27,000 per FTE	Equal or hybrid distribution; tied to practice-wide access
CT	\$35,000 per FTE	Shared equally; cannot tie revenue to case mix
Durable Medical Equipment (DME)	\$32,000 per FTE	Typically equal distribution; hybrid possible based on visits
Physical Therapy (PT)	\$33,000 per FTE	Equal or productivity-based (RVU/visits); hybrid models incentivize therapists
In-Office Pharmacy	Highly variable	Equal distribution due to regulatory complexity
Osteoporosis Management	Modest, variable (profit from infusion therapy)	Equal distribution; aligns with quality/outcomes metrics
Orthopedic Urgent Care	\$75,000 per surgeon + \$7.5M downstream/site	Equal distribution or hybrid tied to total visits
Ambulatory Surgery Center (ASC)	\$493,000 per surgeon	Equal distribution common; hybrid models reward case volume efficiency

mirrors a 2023 GMA and AAOE benchmarking report, which states that ancillary revenue accounts for up to 60% of orthopedic surgeons’ compensation in large group practices when they own an ASC and up to 30% when they do not.

For private practice surgeons, ancillary revenue highlights areas where additional business opportunities can be developed – a concept well understood in that setting. In contrast, for academic or hospital-employed surgeons, ancillary revenue serves a different but equally important function. It demonstrates the value they contribute to their institutions beyond direct clinical care. This information can provide critical leverage in salary negotiations, call stipend discussions, and the allocation of institutional resources.

Having established why ancillary revenue matters across practice settings, it is appropriate to consider the specific service lines that generate such

revenue and the strategies that support their effective implementation. Key ancillary service opportunities include radiography (X-rays), magnetic resonance imaging (MRI), computed tomography (CT), physical therapy (PT), durable medical equipment (DME), in-office pharmacy, osteoporosis management, orthopedic urgent care, and ambulatory surgery centers (ASCs). This manuscript will (1) review how each service generates revenue, (2) describe access points that maximize utilization, and (3) discuss compliant and equitable methods for distributing revenue among partners.

METHODS

This manuscript presents a retrospective, observational analysis of ancillary service revenue within a single large, single-specialty orthopedic group practice. Financial distributions, utilization volumes, and encounter counts were extracted from internal practice

Table 2. Models for Distributing Ancillary Revenue Among Orthopedic Partners

Model Type	Description	Key Features	Example
Equal Distribution	Ancillary revenue shared equally among all partners.	Simple, avoids conflict, Stark-compliant, reinforces shared ownership.	Example A: Imaging revenue pooled and divided equally among 40 partners, despite subspecialty differences in utilization.
Productivity-Based	Revenue tied to productivity measures such as RVUs or total patient visits.	Incentivizes efficiency and engagement; must not link directly to referral volume.	Example B: DME revenue allocated in proportion to overall patient visits, rewarding high-volume surgeons without violating Stark.
Hybrid	Combines equal distribution with modifiers based on productivity, leadership, or quality.	Balances fairness with incentives; aligns revenue with both group equity and individual contributions.	Example C: PT revenue split 50% equally and 50% by new patient volume, with leadership stipends for medical director roles.

financial and operational records. No patient-level identifiers were used. Outcomes were descriptive and reported at the practice and surgeon-FTE levels. Distribution figures are reported as the practice’s average annual distributions per physician partner or per surgeon FTE, consistent with internal compensation accounting; ‘FTE’ reflects a full-time surgeon equivalent as defined by the practice’s compensation plan.

FINDINGS

Our Practice

The practice is a large, single-specialty orthopedic group with 35 surgeons and 26 physician extenders. We have fellowship-trained surgeons in all orthopedic disciplines, including Trauma, Sports, Arthroplasty, Spine, Hand, Foot and Ankle, Pediatrics, and Oncology. There are 2 clinic locations, 5 PT locations, 2 urgent care locations, and one 7-room ASC. Additional locations are planned for expansion in 2025. In 2024, there were 270,217 total patient encounters and 17,009 surgical cases. Over the past 15 years, the practice has gradually evolved from a smaller group

practice into an orthopedic health system as we seek to encompass all aspects of the orthopedic care episode. Ancillary services have been a major contributor to this growth.

General Rules and the Stark Law

Before delving into specific financial opportunities, it is essential to outline the general regulatory and operational principles that govern ancillary services. These rules provide the framework for compliance, ethical practice, and the sustainable distribution of revenue.

Physician-owned entities are legal in today’s healthcare environment but must adhere to strict regulatory standards to remain compliant. The Stark Law, also known as the physician self-referral law, prohibits physicians from referring Medicare patients for certain designated health services (DHS) to entities in which they or their family have a financial interest, unless a statutory exception applies (42 U.S.C. §1395nn; Centers for Medicare & Medicaid Services [CMS], Physician Self-Referral Law). In other words, patients

must always be given the option to obtain services elsewhere, ensuring that the decision to use in-house imaging, physical therapy, or other ancillary services is made of their own volition. In practice, this means that physicians may provide a prescription for therapy or imaging, but the patient retains the freedom to decide where to obtain those services. Surgeons can explain why services in their office may be preferable, but they cannot direct patients to use them.

Revenue distribution is also tightly regulated; it cannot be allocated among physicians based on referral volume. For example, a sports physician cannot receive a greater share of MRI revenue than a trauma surgeon simply because the nature of their practice generates more MRI scans. Most groups address this by equally distributing ancillary revenue among partners. Some groups, however, use alternative models, such as productivity-based or hybrid models (more details in *Section 3*), tied to relative value units (RVUs), total patient visits, or leadership responsibilities – structures that are permissible if applied fairly and without linking directly to referrals. These structures can also incentivize physician productivity and engagement.

In addition to regulatory limits on revenue sharing, critics often caution that physician ownership may spur overutilization. However, the empirical evidence does not clearly support that concern. The AAOS position statement on physician-owned specialty hospitals underscores that physician ownership is compatible with high-quality, cost-effective care when appropriately regulated ⁵. Similarly, the U.S. Government Accountability Office (GAO) has issued multiple reports on self-referral. In a 2012 review of advanced imaging services, they found higher use among self-referring providers, but emphasized that inappropriate utilization was difficult to establish definitively (GAO-12-966). A subsequent 2014 report on physical therapy concluded that self-referred PT

services grew more slowly than non-self-referred services between 2004 and 2010 and did not demonstrate systematically higher billing per patient (GAO-14-270). Beyond GAO and AAOS analyses, peer-reviewed studies have found that physician groups owning imaging equipment do not necessarily overuse testing inappropriately ⁶, and that physician-owned entities often charge lower prices than non-physician-owned hospitals in the same market ⁷. While some literature has documented higher utilization in self-referral contexts ⁸, more recent work suggests that hospital consolidation is a more significant driver of spending growth than physician ownership itself ⁹. Overall, the weight of evidence indicates that Stark-compliant physician-owned services are generally more cost-efficient and not inherently more prone to misuse than hospital-based entities.

2020 Reforms to Stark Law

In December 2020, federal regulators (CMS) updated the Stark Law to make it clearer and more flexible ^{10,11}. One of the most important changes was the creation of new “value-based” exceptions, which allow doctors and hospitals to design financial arrangements that reward improvements in quality of care, cost reduction, and better coordination of treatment. The update also clarified important legal terms such as “fair market value” and “commercially reasonable,” which had often been confusing and left practices uncertain about what was permitted.

Another major change was the creation of the *Limited Remuneration Exception*, which permits physicians to receive up to \$5,000 annually (inflation-adjusted) from an entity without completing the formerly required paperwork or entering a formal written contract. This exception was designed to simplify small or short-term financial relationships while remaining compliant. For example, in Orthopedics, this might apply if a

surgeon receives a modest payment for helping set up a new physical therapy clinic or covering occasional urgent care shifts before a long-term contract is finalized. If the total compensation stays under the threshold and is not tied to referral volume, it qualifies under the exception.

Finally, the reforms expanded flexibility for group practices, giving orthopedic groups greater latitude in how profits from in-house services are shared, provided that distributions remain Stark Law-compliant. Before 2020, groups often had to allocate profits from each ancillary service line (e.g., MRI, PT, DME) separately, sometimes only to physicians in the same subspecialty “pod.” This siloed system was administratively complex and could create divisions, as certain subspecialties naturally generated more ancillary use. The 2020 reforms allow practices to pool ancillary profits across the entire group or within larger subgroups and distribute them by any fair method—such as equal shares, RVUs, or hybrid models (explained more in *Section 3*)—so long as the approach does not directly tie to referral volume.

Implications for Orthopedic Practices

These reforms have made it easier for physician-owned entities to remain compliant while pursuing growth. Orthopedic groups can confidently operate in-house imaging, PT, DME, urgent care centers, and ASCs as long as patients retain freedom of choice and revenues are distributed through compliant models. Importantly, CMS has signaled support for physician ownership when it demonstrably enhances value, efficiency, and patient outcomes^{11,12}.

Successful ancillary service delivery depends heavily on hiring reputable, ethical employees. Personnel must be motivated and capable because the pace and demands of private practice far exceed those of hospitals. For example, in private practice, radiology

technologists obtain over 60 films per day, while similar employees in the hospital setting perform 20 or fewer. The same trend is evident for physical therapists, MRI technologists, and surgery center employees. Competitive compensation, robust benefits, and a positive workplace culture that fosters team ownership are essential to maintaining high performance.

While the profitability of ancillary services has attracted third-party administrators and management companies, these intermediaries often provide limited value relative to their cost. Such firms frequently divert up to 30% of the profit and apply “one-size-fits-all” business models^{13,14}. In contrast, large practices with competent internal leadership are well positioned to manage these services independently. Appropriately compensating in-house practice executives – including the chief executive officer (CEO), chief operating officer (COO), and chief financial officer (CFO) – is more cost-effective and ensures that millions of dollars in revenue remain within the practice rather than being lost to outside firms.

SECTION 1: Revenue Generation by Ancillary Services

With the regulatory and operational framework established, the question of how ancillary services generate revenue for orthopedic practices will be addressed. Each service line has distinct financial characteristics, capital requirements, and profit potential. The following subsections review the major ancillary services, highlighting their revenue profiles and the conditions that support their success.

Radiography

X-rays remain an indispensable part of any orthopedic evaluation, yet some practices continue to rely on outside imaging, sending patients to nearby hospitals or freestanding facilities. In-office radiography is not only convenient but also essential for efficient

clinical care. The authors' experience has shown that a dedicated X-ray department on the first floor (entry level) improves workflow. By obtaining imaging before patients are placed in exam rooms, the total office visit time is reduced by approximately 30 minutes. In this model, patients don't need to walk down multiple hallways or take up space that can be used for more effective throughput. They are placed in exam rooms only when all information is available for the surgeon to make informed clinical decisions. Effective utilization requires good preparation by medical assistants to order appropriate films. The authors' practice has independent X-ray on each floor for reduction assessment or additional views, but the majority of films are taken before rooming. This system has allowed each physician to see at least ten more patients a day.

From a compliance standpoint, orthopedic offices should recognize that in-office imaging is billed globally—that is, it includes both the technical and professional components. For plain radiographs, the interpreting orthopedic surgeon bills the global fee directly. For MRI, practices also bill globally but typically contract with an outside radiology group to provide official interpretations, reimbursing them separately. Despite this additional expense, the financial contribution of in-house imaging remains substantial. In 2024, 79,046 X-rays were taken at the authors' center, which equated to yearly distributions of \$23,429 per partner.

MRI

Although reimbursement for MRI has declined in recent years—with Medicare payments decreasing by more than 60% between 2005 and 2020 when adjusted for inflation—physician-owned MRI remains a financially advantageous service line when structured appropriately^{15,16}. Practices have multiple options, ranging from leased scanners to full ownership. Costs

vary by size, image quality, and manufacturer, with extremity-only scanners offering lower-cost alternatives and greater patient comfort for patients with claustrophobia. However, installation can be expensive, often requiring specially shielded rooms or even structural modifications such as removing walls and ceilings to accommodate delivery. In some practices, free-standing MRI units housed in adjacent modular or parking lot structures represent a viable solution when office space is limited or construction costs are prohibitive.

MRI has also been investigated for its role in arthroplasty planning, as certain implant systems and research protocols use MRI-based preoperative templating and implant selection^{17,18}. While these applications highlight MRI's potential to support precision surgery, its use in the United States remains limited, and reimbursement structures have not been widely established to support routine adoption. In the authors' group, collective demand has supported the acquisition of 3 full-body scanners, with purchase costs typically ranging from \$1 million to \$2.5 million, depending on manufacturer and specifications. Some practices mitigate this expense by purchasing refurbished machines, which can meaningfully reduce upfront capital requirements. Despite declining reimbursement trends, MRI remains a viable ancillary service. 11,905 MRIs were performed at the authors' center in 2024, which equated to yearly distributions of \$27,030 per partner.

Keys to success include planning MRI integration during new construction, as retrofitting is difficult and costly. Also, same-day availability is important for subspecialties such as sports medicine, as sports patients tend to appreciate the convenience of expedited care. It is also important to offer cash-pay options for uninsured or underinsured patients, which expands accessibility.

CT

In-office CT represents a growing opportunity, particularly for large practices with substantial trauma volume. Careful volume analysis is required to ensure that utilization is sufficient to be cost-effective and a revenue generator. Historically, patients with tibial plateau, distal radius, elbow, and pilon fractures presented to the emergency department (ED) at large hospitals. Increasingly, however, these patients are seen in orthopedic urgent care centers or directly in private offices, where CT scans are essential for preoperative planning. By offering one-stop care, practices improve efficiency while providing patients with timely, convenient service.

Similar to MRI, CT plays a key role in arthroplasty planning, especially for robotic-assisted knee arthroplasty, where preoperative CT-based templating maps bone geometry and guides implant positioning^{19,20,21,22}. This application supports in-office CT use in practices with sufficient volume. Revenue generation depends heavily on utilization rates. In groups with strong trauma and arthroplasty volume, CT scanners can generate up to \$35,000 per FTE. In the authors' practice, with seven arthroplasty and five orthopedic trauma surgeons, the collective workload justifies acquiring a dedicated CT scanner, planned for 2025.

Durable medical equipment (DME)

Durable medical equipment (DME) is one of the most profitable and underutilized ancillary services. DME services can take many forms within an orthopaedic practice, and when managed appropriately, they have a high profit margin (up to 60%).

Ongoing negotiations with vendors for competitive pricing may yield substantial cost reductions for practices and patients alike. Simple measures, such as providing preoperative bracing, Velcro wrist splints,

and postoperative walking boots, help practices retain revenue that might otherwise flow to hospitals or outside vendors. Our office offers preoperative packages for anterior cruciate ligament (ACL), rotator cuff, and total knee arthroplasty (TKA) that include necessary braces, cold therapy units, and gait aids such as crutches or walkers. Custom bracing options benefit patients and can be equally lucrative. Larger group practices, such as the authors', benefit from employing a dedicated orthotist to oversee bracing, orthotics, and prosthetics, ensuring both clinical quality and financial optimization.

In-office dispensing also improves patient care, as individuals leave with the equipment they need rather than facing delays at hospital-based DME centers. At the authors' center in 2024, 20,058 items were provided to patients, and annual distributions from this ancillary equated to approximately \$31,908 per FTE.

Physical Therapy

Physical therapy is a cornerstone ancillary service that benefits many patients and generates substantial revenue for practices. Physician-owned PT is legal in most states, though the Stark Law requires that patients be given the option to receive therapy elsewhere—typically through a prescription that can be taken to any PT office, as stated in the *General Rules and Stark Law* section. While physicians cannot mandate in-house PT, they may explain the advantages of therapists who work closely with the surgical team. With this education, most patients will elect to use in-house PT, provided the location is convenient.

Certain states, however, impose stricter rules. Missouri and South Carolina maintain their own self-referral statutes that prohibit physicians from referring patients to PT services they own, even though ownership itself is permitted. In these jurisdictions, PT clinics may still be operated by orthopedic groups, but patients must be referred through self-referral or by an outside

physician rather than by the ordering surgeon (Missouri Revised Statutes §334.506; South Carolina Code §44-113-30). These exceptions underscore the importance of local regulatory awareness when developing PT service lines.

To maximize efficiency, large practices should operate multiple PT locations if patient volume supports expansion. PT space is relatively cost-effective, often requiring little more than exam tables and basic equipment. To ensure productivity and retention, physical therapists should be appropriately incentivized. The authors' group has found that RVU-based payment models encourage higher work output, while bonus structures tied to patient satisfaction and timely billing promote appropriate practices. Cost efficiency can also be enhanced by using therapy aides or by sharing certified athletic trainers (ATCs) with local high schools, provided they operate within their scope of practice.

When optimized, PT can be highly lucrative, though results vary by therapist staffing, payer mix, and subspecialty case mix. Broader benchmarking frameworks, such as those developed by the American Association of Orthopaedic Executives (AAOE), also support tracking PT revenue per visit, therapist productivity, and practice-level variation, underscoring the wide financial range observed in the field. At the authors' practice in 2024, there were 77,813 therapy visits, and yearly PT distributions equated to \$32,971 per surgeon.

In-Office Pharmacy

Convenient access to a pharmacy is another way to create a one-stop shop for patients. A smaller pharmacy that distributes NSAIDs, antibiotics, osteoporosis medications, and opioids can generate income for partners. As expected, there are legal considerations depending on the medication. Distribution requires additional regulatory paperwork

and oversight. In-office pharmacies also carry the risk of theft or crime by patients, employees, and the community at large. The authors' practice has not invested in this ancillary to date, so we are unable to report on revenue generation.

Osteoporosis Management

Orthopedic offices seeking to provide the full spectrum of orthopedic care have begun operating osteoporosis management centers. These centers offer dual-energy x-ray absorptiometry (DEXA) scans and consultations with an osteoporosis specialist. This practice is rooted in the American Academy of Orthopaedic Surgeons (AAOS) "Own the Bone" program, which has only expanded since its launch in 2009.

This ancillary service line may not have the profit margin of other ancillary services, but it does offer the opportunity for profit if managed appropriately. Patient identification is straightforward – all patients over age 60 with fractures seen at office-based clinics or urgent care settings are referred. DEXA scans have minimal reimbursement, and the associated office visit evaluation and management (E&M) charges generate \$2,200 per day for a full clinic. Moreover, infusion therapy can be profitable but requires the necessary personnel to support its use.

Orthopedic Urgent Care

Many offices have established dedicated bone and joint urgent care centers. These centers have been highly successful, diverting ambulatory patients from expensive, inefficient local emergency rooms. This shift provides immediate access to orthopedic specialists, reduces wait times, and dramatically lowers costs. Importantly, diagnostic efficiency is higher when musculoskeletal injuries are evaluated directly by orthopedic providers. Studies have shown that a notable

proportion of fractures are initially missed in the ED: one review found that 13–20% of pediatric fractures on ED radiographs were not identified on first interpretation²³, and another reported miss rates of up to 26% for certain fracture types, such as hand phalanges²⁴. These findings underscore the potential advantage of orthopedic urgent care centers in improving diagnostic accuracy and timely management.

Injury-to-surgery times are also shorter because patients are paired with the appropriate specialists immediately. A study by the authors' group found that the average cost of an ED visit was \$8,000, while a dedicated orthopedic urgent care visit cost only \$287. With up to 70 patients per day seen at each site in the authors' system, extrapolated data showed that in their city the healthcare system saved \$97 million in a single year²⁵.

Urgent Care centers offer a beneficial model for physicians as well. An optimized center can generate \$2.5 million in direct revenue and \$7.5 million in follow-up revenue annually from surgeries, office visits, advanced imaging, and therapy for patients who first accessed the practice through urgent care. In 2024, there were 21,693 urgent care visits, and this ancillary generated yearly distributions of \$75,433 per partner.

There are many keys to success for orthopedic urgent care centers. Extended evening and weekend hours enable access for working adults and capture pediatric patients injured during sports or recreational activities. Staffing models that rely on physician assistants (PAs) or nonoperative orthopedists under close clinical supervision help maintain efficiency while lowering costs. Patients should leave with clear instructions and a plan for timely follow-up in the outpatient office. Finally, expanding urgent care sites into strategic neighborhoods or communities strengthens competitive positioning against other orthopedic groups and hospital systems. These sites are also a good

introduction to rural communities, providing specialty care at a reasonable price and improving access for a patient population in need.

Ambulatory Surgery Center

In the United States, orthopedic surgery has increasingly migrated to the ASC setting because of lower infection rates, reduced costs, and an equivalent or improved safety profile compared with traditional hospital-based surgery^{26,27,28}. Several factors have fueled this trend, including the growth of physician-owned ASCs, advances in regional anesthetic techniques, the availability of value-based implants, and an expanding number of procedures approved for outpatient management. A critical driver has been the CMS annual ASC Covered Procedures List, which removes designated CPT codes from the “inpatient-only” list and authorizes their performance in the ASC setting. Insurers typically follow CMS's lead, thereby broadening payer coverage and significantly accelerating ASC growth^{29,30}.

Currently, over 85% of orthopedic procedures can be performed safely in an ASC, a percentage that continues to grow as more procedures migrate from hospital outpatient departments to ambulatory centers. Spine surgery and arthroplasty are among the most profitable ASC service lines, and early evidence suggests that select trauma procedures, such as pilon and plateau fracture fixation, may also be safely and cost-effectively performed in ASCs³¹. Medicare rules require that surgeon partners in an ASC perform at least 30% of their eligible cases at the ASC, which requires all physician owners to coordinate schedules and maintain active participation to remain compliant.

Physician-owned ASCs remain among the most profitable and strategically valuable ancillary services for group practices when managed effectively. Successful centers can generate \$50,000–\$700,000 per surgeon FTE annually. Keys to success include

employing anesthesiologists with standardized clearance protocols, avoiding unnecessary restrictions on ASA class I–II patients, and adopting policies that safely accommodate ASA III patients—an approach that significantly increased revenues at the authors’ ASC. In 2024, the authors’ surgery center performed 7,309 surgical cases and generated \$493,109 in distributions per surgeon.

Surgeon-owned ASCs also foster strong economic alignment among physicians. Single-source vendor contracts are highly effective at lowering implant costs for arthroplasty³², and the adoption of high-value or generic implants has substantially reduced trauma implant costs^{33,34}. Electronic medical records such as Epic can enhance transparency by offering “surgical receipt” tools that provide case-level cost data and enable peer comparisons, fostering healthy competition and accountability³⁵. Furthermore, approval for 23-hour observation or the construction of care suites extends ASC capability, enabling more complex cases without compromising safety.

SECTION 2: Access Points for Ancillary Services

Sustaining growth in orthopedic practice depends not only on generating revenue but also on expanding access for patients. In today’s competitive healthcare environment, convenience and immediacy often matter more to patients than physician reputation. Once patients enter a system that offers timely, comprehensive care, they are more likely to stay. For this reason, ancillary services serve as both revenue drivers and strategic entry points into the practice.

Urgent care centers are the clearest example. By offering extended hours and strategically locating sites in communities, they draw patients away from crowded EDs and competing practices, reduce costs, and provide faster access to orthopedic specialists. Similarly, PT centers, when positioned for convenience and supported

by high-quality, coordinated care, attract patients from outside systems who may later choose affiliated surgeons for their future needs.

Imaging services—radiography, MRI, and CT—also play a central role. Freestanding or conveniently located units, same-day scheduling, and transparent cash-pay pricing broaden access, particularly for athletes, working adults, and uninsured patients. DME, in-office pharmacies, and osteoporosis programs create additional touchpoints by ensuring patients leave with the resources they need, reinforcing continuity of care within the practice.

ASCs are the most significant access point at the procedural level. Their efficiency, cost savings, and ability to handle increasingly complex cases have made them a cornerstone of private practice growth. If other specialties, such as plastic surgery, are given the opportunity to work in the orthopedic ASC, these patients will be exposed to the center and are likely to come there for their orthopedic needs.

Taken together, these ancillary services are more than revenue streams—they are the means by which orthopedic groups compete with hospitals, reach new patient populations, and build long-term loyalty.

SECTION 3: Revenue Distribution

Most physicians agree on clinical treatment decisions and the overall ethics of patient care. In any private practice or large group practice, disagreement usually arises when large sums of money are at stake in distribution. While ancillary services generate significant revenue, the method of distribution among partners must comply with the Stark Law and remain equitable (as mentioned in the *General Rules* section). Revenue cannot be allocated based on referral volume, and patients must always be given the option to seek services elsewhere. Within this framework, several distribution

models exist, each with distinct advantages and limitations.

Equal Distribution

The simplest and most common approach is to distribute ancillary revenue equally among all physician partners. This model avoids potential conflicts, ensures compliance with Stark regulations, and reinforces a culture of shared ownership. Each partner works within their specialty of care, knowing that the best patient care will be provided, and all members work as part of a much larger team. There is a clear financial incentive to be part of a group and a disincentive for personal gain to supersede the well-being of the practice.

Example A: In one large orthopedic group, all imaging revenue was pooled and divided equally among 40 partners, regardless of subspecialty. This ensured fairness, even though sports medicine surgeons ordered more MRI scans than trauma or hand surgeons. If surgery center ownership is based on shares, each share must receive equal distribution, as it is similar to an investment.

Productivity-Based Models

Some practices tie ancillary revenue to productivity metrics such as RVUs or total patient visits. This incentivizes efficiency and engagement, rewarding physicians who contribute more directly to overall practice volume. Large practices can sometimes be victims of their own success. If ancillary payments reach \$500-700k a year, surgeons may have less incentive to perform that extra surgery or see more patients in the clinic, since they already have guaranteed ancillary income. Productivity-based models are good, but they can alienate younger partners building their practices or older partners who wish to slow down.

Example B: An orthopedic practice allocated DME revenue proportionally to patient visits. Surgeons with high-volume fracture care likely generated more brace prescriptions, but revenue was still tied to overall clinical activity rather than direct referral counts, keeping the model Stark-compliant.

Hybrid Approaches

Hybrid models combine equal distribution with productivity-based modifiers. A baseline portion of ancillary revenue is shared equally, while the remainder may be distributed based on RVUs, leadership responsibilities, or patient satisfaction scores.

Example C: A PT department owned by a 25-surgeon group distributed half of net revenue equally, while the other half was allocated proportionally to total new patient visits, assuming that new patients lead to more PT visits. Leadership roles, such as the PT medical director, also carried modest stipends. This approach balanced equity with incentive alignment.

Ethical Considerations

Critics of physician-owned entities argue that financial incentives could lead to unnecessary testing. However, as stated in the *Introduction*, research shows that physicians order fewer ancillary tests than hospitals and that physician-owned services are generally more efficient and less costly. Ethical revenue distribution depends on transparent policies, Stark compliance, and a group-wide commitment to patient-centered care.

Administrative Oversight

Oversight is equally important. While third-party management companies often promise to streamline ancillary operations, they may retain up to 30% of profits while offering generic solutions. In contrast, practices with capable internal leadership—

compensating their CEO, COO, and CFO appropriately—are better positioned to ensure compliance, efficiency, and the retention of revenue within the practice.

CONCLUSION

Multiple ancillary service options exist in orthopedic surgery. These are a valuable source of income for the entrepreneurial private practice physician and a vital part of negotiations for any employed physician. The success of these ventures depends on effective management, cost containment, and the ethical behavior of surgeons. Careful adherence to Medicare guidelines and the Stark Law is vital to avoid scrutiny or damage from a disgruntled employee, patient, or whistleblower. Not using a management company is a key factor in retaining revenues, but strict oversight is required from a strong administrative team. New ancillary opportunities will continue to arise, and orthopedic surgeons must be prepared and educated in business practices to take advantage of the changing and evolving healthcare landscape.

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