AMSSM Practice Management Resources

Establishing Your Sports Medicine Practice:
Considerations for Being the Only Non-Operative Sports Medicine Physician in Your Practice

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Helpful advice for primary care sports medicine physicians who are starting in a practice where they are the only non-operative sports medicine physician in an orthopedic practice or in a primary care practice.

Disclosure: The below outlines common examples that were listed by our working group; any products listed are not necessarily endorsed by AMSSM or the members of this working group.

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Prior to Hire: Contract Negotiations – Considerations

A. Physician Compensation: when entering an employment agreement, know the following at minimum:
   i. Your compensation is comparable to physician with your skills and experience in the region you are practicing. There are surveys done by the AMSSM that can help. MGMA is also a good resource
   ii. You should attempt to get a guarantee for your base salary for the first several years of your employment to allow you to build your practice. This can range from 1 to 5 years
   iii. Specific requirements regarding all activities and metrics (e.g., productivity, quality, cost) that will affect your compensation are included in the employment agreement or in an established written policy
   iv. A written policy should be applicable to all similarly situated physician employees and not subject to the employer’s discretion
      1. You should be allowed to discuss your contract among other physician employees and physician owners. If it is written in your contract that you cannot discuss your contract components with others in the practice, you should negotiate this out. You need to be able to have these discussions to ensure you are signing a fair contract
v. Incentive plans should be clearly spelled out. This is an area that is rapidly changing so have someone walk you through it
   1. Some places recognize you may not qualify for the incentives in your first 1-2 years as you are trying to build your practice. Some may offer a set bonus/supplemental income (usually lower than what you would earn if you were to achieve the incentive) that you could opt into for your first 1-2 years in lieu of participating in the incentive plan
vi. May be able to negotiate supplemental income for certain leadership roles (e.g. director of sports medicine center)
vii. Sign-on bonus (varies greatly by practice. Some places do not offer a sign-on bonus but may offer alternatives, such as a higher moving expense allowance that you can receive in full)
viii. Understand qualifications and process of how to become partner, get promoted, or attain tenure (can all physicians become partner? Are partnership terms different depending on primary specialty? Do current contract terms (admin, research, clinic volume) set you on track to become partner or receive tenure? What do you need to accomplish to get promoted in academic settings? What are the different tracks (e.g. clinical, research, hybrid) you can have in academic settings?)
ix. Ask about clinic revenue, overhead costs and what is included in calculating overhead. If sports medicine supplies are disproportionately used among providers how is this calculated. Ex: If you are only sports medicine provider in primary care clinic setting recommend discussing formula for overhead of sports medicine vs primary care supplies/marketing
x. Be sure you are contracted/recognized as a sports medicine physician with insurance companies. Will aid in referrals when patients are searching for sports medicine provider within their insurance plan
   1. Technically this is done after hire, but can take up to 6 months to be contracted with insurances (especially Medicare and Medicaid), so it is important to address this at the time of your contract negotiations or when you sign so that administrators can make sure this is being done as early after hire as possible

B. Sports/Team Coverage Negotiations
   i. If you have a contract or are getting compensated with any sports/teams you are covering, make sure you work this out with your employer
      1. Some employers may allow you to have the additional contract with the team and receive the extra compensation directly
      2. Others may require the additional contract with the team go through your main employer. The practice/department may keep the funds but still count your sports coverage days as work days and not days off (and so even though you are not getting the compensation from your sports coverage/team contract directly, your main employer is still compensating you)
      3. Others may not allow you to count sports coverage days as days off and may make you take vacation or unpaid time off
4. There are various different models out there on how sports coverage compensation is handled with your main employer, so make sure to research different models and know what to negotiate in terms of how you are compensated and amount of time you can have off for these responsibilities (also make a point that sports coverage should help market the practice/department and is a good source for patient referrals).

ii. Other negotiations with sports coverage:
   1. Malpractice coverage – some employers will cover this for you, especially if the sports/team coverage contract goes through them. Sometimes the sports/team organization may be able to cover your malpractice insurance. Sometimes you need your own malpractice coverage for sports coverage. In your primary employer contract, may be able to put in general phrasing that sports coverage/serving as a team physician (could leave it vague and not state specific organizations/teams as this is always changing) is part of your employment responsibilities and therefore will be covered by the malpractice insurance policy you have with your primary employer.
   2. Advertising/marketing your practice at sporting events.

C. Clinical/Administrative/Academic/Research Time
   i. Negotiate how your time may be split up in clinical vs administrative vs academic vs research time, if applicable (may be able to negotiate more academic/research time in academic setting).
   ii. Negotiate percentage of your FTE that will be dedicated to your sports practice vs your primary specialty and how that will be allocated, (i.e. how many clinic days or shifts will be dedicated to sports medicine vs your primary specialty and how will your sports patients be scheduled).
   iii. If starting a new program and spending time doing program development, may be able to negotiate more administrative time for this.
   iv. If applicable, negotiate how much call you will be taking (e.g. some practices/departments may expect you to cover inpatient or consults call for Orthopedics, Internal Medicine, Pediatrics, Family and Community Medicine, or Physical Medicine and Rehabilitation (PM&R)).
      1. May be able to negotiate less or no call because of your sports coverage duties on weekends and evenings. Some have negotiated that ‘x’ number of hours of sports coverage = ‘y’ number of days of call to make it fair if you are joining a practice that has other providers who do call but don’t do sports coverage.

D. Benefits: employer can cover a wide variety of benefits. These can include:
   i. Health insurance for you and your family. Lots of variety including high deductible plans and HSAs. Know the details here!
   ii. License fees
   iii. Continuing medical education (CME)
iv. Stipend for CME
v. Stipend for research
vi. Malpractice coverage and tail coverage should you leave or your contract terminated
vii. Paid time off and sick leave, ask for new COVID-19 policies
viii. Retirement plan/401K/403b and employer match
ix. Moving expense allowance (if you’re taking a position in a different area)
   1. Some places allow you to get the total amount you negotiated as a lump sum, while others only give you the amount you actually spent based on receipts
x. Reimbursement of Board exams
xi. Society memberships
xii. Office equipment including ultrasound machine

E. Termination Considerations
   i. **Termination without cause** – This allows you or your employer to terminate the employment agreement. This is typically done in a written notice 30 to 90 days prior to termination of the agreement
   ii. **Termination for cause** – Your employer can terminate you for cause. There can be language in this section of the contract regarding whether you will be given the opportunity to “fix” the problem within a reasonable time frame

F. Restrictive Covenants
   i. Many states have this. It prevents you from leaving your practice and joining a competitor or setting up a solo practice near your previous employer
   ii. **Duration** – Typically these last 1-3 years
   iii. **Geographic radius** – The area depends on practice location. In an urban area it may be 30 miles and in a rural area it could be 60 or 100 miles
   iv. Negotiate for as short a time period and as few miles as you can

**After Hire – How to Start Setting Up Your Own Sports Medicine Practice**

A. Must establish with the department early what your roles and advantages are
   i. You are not a physician extender/advance practice provider to orthopedic surgeons. You are able to see same patients they see and many they cannot
      1. Recent AMSSM study showing fracture management equivalent from orthopedic surgeon vs. sports medicine specialist
         (Sweeney EA, Potter MN, Gagliardi AG, Howell DR, and Provance A. (2019).
         https://dx.doi.org/10.1177%2F2325967119S00106)
      2. Review specific roles/conditions you can add to the practice (beyond trying to establish that you’re only able to do what they can in nonsurgical orthopedics)
a. E.g., concussions, female athlete triad, comprehensive team physician management, initial sports psychology management triage, higher level orthopedic infectious disease/infection management, exercise induced asthma/vocal cord dysfunction, ultrasound-based evaluations/injections, etc.

ii. Offer to present talks or grand rounds

iii. Provide one-pager of conditions you see and procedures you perform

B. Establish relationships early with necessary ancillary health services/practice components

i. Physical therapy: consider offering presentations at local physical therapy groups
   1. Establishes referrals and greater awareness of presence

ii. Radiology
   1. Relationships with local private MRI/CT in addition to your home institution if available
   2. Having the ability to obtain faster imaging/discuss reports/review images, etc. will improve total experience for physician/patient
   3. Obtain access to images on PACS

iii. Neuropsychology, mental health: psychology, psychiatry, mental skills/performance

iv. Multidisciplinary concussion assistance in addition to you as a physician
   1. Neuropsychology and/or Mental health
   2. ENT/Vestibular therapist
   3. Neuro optometry/ophthalmology
   4. Social work
   5. School officials and athletic directors
   6. Consider having a model for how to triage concussion patients if multiple other specialties (e.g. sports medicine, PM&R, neurology, etc.) see concussion patients in your institution
      a. Age groups
      b. Acute vs chronic symptoms
      c. Need for a multidisciplinary concussion clinic if there isn’t one already and who goes to this clinic vs general concussion clinic with just the physician

v. Nutrition

vi. Pain management

C. Establish relationships early with potential referral sources in the community

i. Other primary care providers (Family Medicine, Internal Medicine, Pediatrics, OB/GYN)
   1. Offer direct contact information and business cards to give to patients
   2. Provide presentations for outreach
   3. Make sure you have a method set-up in your electronic health record (or via mail) to send your consulting clinic notes to the referral providers

ii. Urgent Cares and Emergency Departments not affiliated with sports medicine practices
   1. Offer direct contact information and business cards to give to patients
iii. Community (e.g. school districts, YMCAs, etc)
   1. Offer business cards
   2. Provide presentations for outreach

D. Event/sports coverage (in addition to popular team sports including football, hockey, basketball)
   i. Mass participation medical care: marathons, 5Ks/10Ks, triathlons, Ironman
   ii. Gymnastics
   iii. Dance/Ballet
   iv. Other Performance Arts (e.g. Cirque du Soleil)
   v. Help expand to provide coverage to other sports in the area that currently aren’t covered
   vi. Campus health: even teams with their own sports medicine providers still often need further assistance for imaging/evaluation of club teams, general student body that may not have access to ATCs/PTs/MDs associated w/ school
   vii. High school coverage: coverage can be variable depending on where you are. For example, some teams may have orthopedic surgeons covering, residents covering, or no one at all. High school ATCs likely would prefer a sports medicine physician be present regularly and develop a relationship. Know the landscape and fill in gaps. Also look for contracts for coverage coming up for renewals and be prepared to put in bids for your services vs their previous providers
   viii. Recruit assistance to help with the sports coverage schedule as you cannot do it all by yourself
      1. Fellows/residents
      2. Medical students
      3. Athletic trainers
         a. Note: Some practices hire ATCs to put in schools and help fund them for the downstream revenue
      4. RNs/MA/LPNs for assistance at mass events

E. Scheduling
   i. Set up meetings with call center/triage
   ii. Establish that you may be first available for ALL musculoskeletal concerns, even if concern for eventual surgical need
      1. Discuss this with primary care and surgical providers to figure out a triage flowchart
      2. Know how your primary care and surgical providers practice – what they are more likely to manage or not including non-operatively vs operatively. Each institution and practice is different and you need to learn the culture
      3. Consider giving your schedulers a presentation so they better understand who should be scheduled with you vs your primary care and surgical providers (e.g. if you don’t want to see patients with back pain not related to sports, let them know)
   iii. Helpful, especially early, to be a “yes” physician: if they call to see if you see ____, say yes first unless widely out of practice scope, and can refer appropriately if needed
      1. May start to narrow your practice as you get busier
2. If you see that you often refer patients with a certain diagnosis to a different specialty (e.g. chronic pain) and not adding much to their care, provide this feedback to colleagues sending these referrals
   iv. Consider open access scheduling to ensure same-day appointments are available and referrals can be seen quickly
      1. Consider having a dedicated phone line for local PTs or ATCs

F. Establish access to local educational/teaching opportunities
   i. Can find home for teaching within local Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics, and PM&R residencies or fellowships
   ii. Serves as referral resource from community clinics, opportunity for maintenance of certification (MOC), and additional academic homes for advancement
   iii. Helps build academic reputation and networking
   iv. Opens potential opportunities for research collaboration

G. Establish ultrasound presence and guidelines
   i. Practice needs to be clear on what you are able to do and what you are not able to do - caution on becoming funnel for difficult pain patients (unless this is what you like to do)
      1. Consider working with others in your practice/institution to set up a flowchart on how patients are triaged to which provider
         a. Make sure you don’t sell yourself short and get cut out of the diagnoses that you can appropriately manage
         b. Consider sending out a menu of ultrasound services you offer, or creating a drop down menu in your electronic health record referral order set to make sure you get appropriate referrals
   ii. Speak with hospital/practice regarding billing opportunities/requirements
      1. Determine where you will store images (PACS, network drive, etc.)
   iii. Speak with local/in-house Radiology to ensure you understand each other’s scope of practice

H. Clinic/Sports Coverage Supplies
   i. ACE wraps
   ii. Splinting
      1. Fiberglass padded splint in various sizes
   iii. Casting
      1. 2/3/4 inch fiberglass casting material – white +/- color 2 inch
         a. Non-waterproof
            i. 1/2/3/4 inch stockinette
            ii. 2/3/4 inch padding
         b. Waterproof
            i. 2/3/4 inch stockinette
            ii. 2/3/4 inch padding
2. Plaster casting material
3. Cast saw – w/ vacuum
4. Cast splitter
5. Shears, curved long scissors
6. Mole skin, 1” roll

iv. Durable Medical Equipment (DME)
   1. Braces (General Sizing: at least x-small, small, medium, large, x-large)
      a. Aluminum SAM splint
      b. Alumifoam variety pack
      c. Stax splint
      d. Cock up wrist splint
      e. Thumb spica wrist splint
      f. EXOS Thermoplastic moldable removable cast if your payers will cover (cock up, thumb spica)
      g. Tennis elbow strap
      h. Heelbo pad
      i. Mayo Elbow brace if you have a decent amount of throwers
      j. Shoulder immobilizer
      k. Shoulder sling
      l. Rib support
      m. Moldable ear splint
      n. Post-op knee brace
      o. Lateral J/patellar stabilizing brace
      p. Hinged knee brace
      q. Neoprene sleeve
      r. CAM boot (short +/- long)
      s. Achilles lift
      t. Post-op shoe
      u. Ankle stabilizing orthosis
      v. Carbon fiber/steel insole
      w. Ankle night splint

2. Crutches
3. Therabands

v. Injections
   1. Anesthetic Injectable Medications
      a. 1% Lidocaine without epinephrine (e.g. 5 ml vials, 10 ml vials, or more)
      b. 0.25% Bupivacaine without epinephrine (e.g. 5 ml vial or more)
      c. 0.25% Ropivicaine without epinephrine (e.g. 5ml vial or more)
      d. 1-2% Lidocaine WITH epinephrine (e.g. 5ml vial or more)
      e. Sterile Saline (e.g. 5ml vial or more)
   2. Injectable Medications
      a. Steroids
i. Kenalog 40mg/ml (e.g. 1ml vial, 5 ml vial, or multi-use vial)
ii. Depo-Medrol 40mg/ml (e.g. 1ml vial, 5 ml vial, or multi-use vial)
iii. Celestone 6mg/ml or Celestone Soluspan 6 mg/ml (e.g. 1ml vial, 5 ml vial, or multi-use vial)

b. Viscosupplementation
i. Hyaluronic acid/viscosupplementation derivatives
   1. Series
      a. Bacterial – Orthovisc, Euflexxa, Hymovis, Gelsyn-3, Genvisc 850, Trivisc
      b. Avian – Synvisc, Hyalgan, Sypartz, Visco-3
   2. Single
      a. Bacterial – Monovisc, Durolane
      b. Avian – SynviscOne, Gel-One
3. Syringes (3 ml, 5 or 6 ml, 10 or 12 ml, 20 ml, 60 ml, ones that come with preloaded plastic needleless med prep cannula “safety needle”, some with loops/aspiration handles)
5. Alcohol wipes, Chloraprep (wipes or single swabs), betadine or iodine swabs (3 pack), or some other skin cleansing solution/swab
6. Ethyl chloride spray (stream or spray type)
7. Gauze
8. Bandaids
9. Gloves (regular medical gloves, sterile gloves)

vi. Wound Care
1. Kerlix 1-2 inch rolls
2. 4x4 gauze (loose knit and tight knit)
3. Bandaids (standard +/- spot)
4. COBAN (1 and 2 inch)
5. ACE wraps (2/3/4 inch)
6. Petroleum infused gauze
7. Iodoform
8. Silver nitrate sticks

vii. Ultrasound
1. Machine (e.g. Sonosite, GE, Phillips, Siemens, Konica Minolta)
2. Probes
   a. Linear (high frequency 38-50mm length)
   b. “Hockey stick” aka Short linear (check frequency here, you want highest possible)
   c. Curvilinear (35-60mm, higher frequency better for MSK)
3. Sterile probe covers
   a. Can be tegaderm
   b. Separate sterile gel packets
   c. All inclusive sterile “condom” style, that includes gel packet
4. Gray top Cavi wipes or transeptic/T-spray
   a. Ultrasound gel (e.g. Aquasonic)

viii. Other Medications
1. Bacitracin Zinc ointment (e.g. 0.9 grams)
2. Bacitracin/Neomycin/Polymyxin ointment (e.g. 0.9 grams)
3. Ibuprofen (e.g. 200mg tablets; if treating pediatric ages, also have liquid e.g. 100mg/5ml)
4. Acetaminophen (e.g. 500mg tablets; if treating pediatric ages, also have liquid e.g. 160mg/5ml)
5. Oxycodone (e.g. 5mg tablets; if treating pediatric ages, also have liquid e.g. 5mg/5ml) or other pain medications

ix. Miscellaneous Other Supplies for Clinic
1. Sutures
2. Suture removal kit
3. Kelly clamp
4. Punch biopsy
5. Scalpels/I&D kit
6. Lab tubes for fluid aspiration
7. Trauma shears
8. Fluorescein
9. Sterile water for irrigation

x. Handouts for different home exercise programs/treatments based on condition
1. May get some from books like The Sports Medicine Patient Advisor (Pierre Rouzier) or online from AAOS or other online resources
2. May also develop your own or recruit others on your sports medicine team (e.g. athletic trainers) to assist in developing different handouts

xi. Handouts for post-injection care and when to call or go to urgent care/emergency department

xii. Staff Manuals
1. Ultrasound manual - guide for registering patients on your ultrasound machine, saving images, adjusting gain/depth/focal zone/frequency, color doppler, etc. This is especially helpful when you are doing ultrasound-guided injections and don't have buttons on your probe.
2. Injection manual - guide for how you like your setup for your specific injections or procedures (e.g. aspirations, cortisone, prolotherapy, hyaluronic acid, trigger points, PRP, etc)

xiii. Sideline/sports coverage medical bag
1. Medications
a. Albuterol inhaler  
b. Anti-emetics  
c. Aspirin  
d. Diphenhydramine  
e. Epinephrine/EpiPen (stock multiple if remote)  
f. Lidocaine  
g. Narcan  
h. NSAIDs  
i. Tylenol  
j. Other medications depending on your athlete population  
   i. Particularly if traveling with your team (nationally or internationally), may consider other medications like stool softeners, anti-diarrheals, common antimicrobials (e.g. amoxicillin, azithromycin, fluconazole, sulfamethoxazole and trimethoprim, etc), allergy medications  
   ii. Make sure to check World Anti-Doping Agency (WADA) list to make sure none of these medications are prohibited or need a therapeutic use exemption  

2. Splints (e.g. SAM splint, finger splints, buddy loops)  
3. Tape  
4. Thermometer (oral and rectal) and covers  
5. Blood pressure cuff  
6. Stethoscope  
7. Pulse ox monitor  
8. Penlight  
9. Shears  
10. Laceration tray  
11. Suture kit  
12. Suture removal kit  
13. Needles and syringes  
14. Chloraprep or betadine  
15. ACE wrap  
16. Gauze  
17. Normal saline  
18. Alcohol wipes  
19. Tongue depressors  
20. Tampons or cotton rolls for nose bleeds  
21. Bandaids  
22. Cotton tip applicators  
23. Gloves  
24. Plastic bags/zip lock bags  
25. Hand sanitizer
26. Sanitizing wipes
27. Tourniquet
28. Sharps box and red bag
29. Prescription pad (in case need to send someone to get imaging and can’t get into electronic health record)
30. Mouth-to-mouth mask
31. Airway (e.g. I-Gel airway)
32. 16 or 18 G angiocath (at least two; at least 5 cm, 8 cm for some patients with thicker chest walls) for tension pneumothorax
33. A quick clot product
34. Electrolyte chews
35. Bug spray
36. Flashlight
37. Nail clippers
38. Nail polish remover wipes (in order to get accurate pulse ox measurement)
39. Concussion SCAT on paper
40. Urinary catheters (if working with para sports population)