



IN THIS ISSUE

Watch Out for the
'Gotchas'

Vital Signs

2010 Brings Roth IRA
Option for High Earners



*A Member of the
Wolf Financial Group*

Healthcare

Better Ways ▲ Better Results

A NEWSLETTER FOR THE HEALTHCARE INDUSTRY

FALL 2009

To Merge or Not To Merge



Successful practices — big or small — strategically plan their future. For many, this means merging with another practice. This article is the first in a series exploring the elements that contribute to a successful practice merger.

At some point in their careers, most physicians in private practice will face the question of whether or not to merge. In fact, the increased complexity of running a medical practice in today's managed-care environment and the ever-present squeeze on practice profits are driving more providers to merge, acquire or sell their medical practice.

And while it's easy to become entranced by the potential benefits of a merger (such as lower overhead and an increased patient base), physicians on both sides of

a merger must consider key issues. For example:

- How will overhead be divided?
- How will income (including ancillary income) be distributed?
- How will call schedules be handled?

The stakes are high: Extracting yourself from a bad match can cost two to three times more than a successful merger.

Why Merge?

The answers to this question are as varied as the reasons physicians set out to practice medicine in the first place.

It may be as basic as a small practice finding the administrative side of medicine growing too complicated. Joining forces with a practice that has administrative support staff could allow the physicians more time to practice medicine because they spend less time negotiating with insurance companies.

Other times, groups merge to achieve more clout in negotiating insurance reimbursement contracts and the opportunity to increase their market power.

What does growth bring?

With increased size — whether through merger or acquisition — comes increased opportunity for savings, development and resources.

Increased leverage. Greater volume means more leverage — and not just for negotiating with supply and equipment

Continued on page 3

Provider Enrollment

Watch Out for the ‘Gotchas’

New rules enacted by the Centers for Medicare & Medicaid Services (CMS) earlier in 2009 place even tougher restrictions on provider enrollment/re-enrollment as well as retroactive billing and reporting of certain practice-related changes. As of April 1, 2009, they apply to both physicians and nonphysician practitioners (nurse practitioners, physician assistants, anesthesiology assistants, etc.).

Steve Lutz, Partner-in-Charge, **Healthcare Services Group** at Wolf & Company LLP says, “Unfortunately, the new rules have the potential to catch providers in unexpected “gotcha” situations. Even a minor clerical error can snowball into a noncompliance nightmare.”

For example, let’s assume that Dr. Jones relocates his practice on April 1, but forgets to send in an address change to Medicare until July 1. Under the new rules, which limit retroactive billing to just 30 days, he cannot bill for any patients he saw during the 60-day period after the move but before the change of address was filed. While he can bill retroactively to June 1 (30 days prior to submitting the address change), he misses out on two months of Medicare billings under the new requirements. “Clearly, failure to comply can create substantial gaps in a provider’s ability to bill Medicare, says Lutz.

What Changed

Enrollment/Re-enrollment: A provider can file an enrollment application up to 30 days before providing services at a new location. Under the new rules, a provider can bill Medicare the later of:

- The “date of filing” of a Medicare enrollment application that is subsequently approved, or
- The date the enrolled provider first begins furnishing services at a new practice location.



Gotcha: If errors are found in an enrollment application, they must be corrected within 30 days after notice of the error or the application will be denied.

Retroactive Billing: The new rules substantially decrease the time that providers can retroactively bill for services under Medicare. In the past, physicians had a 27-month window in which they could bill for services they provided before receiving their billing ID from Medicare. The new rules shorten the retroactive period to the later of 30 days before the filing date of the provider’s (approved) application, or the date when the physician began providing services at a specific practice location.

Gotcha: Not complying with the new retroactive billing rules could result in losing payment for any services billed before the 30-day limit.

Notification: In the past, providers had 90 days to report certain changes to practice information. Under the new rules, physicians must notify CMS within 30 days of the following changes:

- A change of ownership in the provider’s practice
- Any change in practice location

- Any adverse legal action affecting the provider, such as suspension or revocation of a state license, exclusion from participation in a federal or state health care program, or conviction of a felony.

Gotcha: Failure to comply with the notification rule can result in suspension from the Medicare program for up to two years.

Save Time Online

Don’t let the new provider enrollment rules catch you. To avoid gaps in payment, promptly submit new applications and reportable changes. One way to speed the process is to use Medicare’s Web-based Provider Enrollment Chain and Ownership System (PECOS) enrollment system: http://cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp. Providers can use PECOS to enroll, make a change in their Medicare enrollment, view their Medicare enrollment information on file with Medicare or check on the status of a Medicare enrollment application via the Internet. ■

For more information please contact Steve Lutz at 630-545-4550.

vendors, but also insurers, payors and hospitals. Larger medical practices generally enjoy more opportunities for joint ventures, partnerships and affiliations, too. It's not unusual for them to attract the attention of neighboring hospitals and other organizations.

Economies of scale. Combined groups can reduce redundancy and cut the costs associated with duplicate facilities, equipment and staff. Just as important is avoiding duplication of services, such as lab and billing. In fact, with proper planning, overhead as a percentage of gross collections can decrease substantially.

However, it's important to recognize that combining cultures and operations can be complex and expensive. Even with a well-planned merger, significant economies of scale may not be realized during the first year, while all the kinks are being worked out.

Marketing clout. As patients become more informed and discriminating

consumers of medical services, effective marketing becomes an increasingly important means of differentiation. With a larger budget, the combined group may be able to fund more ambitious marketing efforts and experience a greater return on its investment.

Pooled resources. Larger groups can pool their resources to invest in strategic, but capital-intensive, activities such as adding new physicians, sophisticated clinical equipment or new facilities — for example, an ambulatory surgery center or medical office building.

More comprehensive care. A strategic merger can often provide greater continuity of care for patients. For example, a merger of a family practice with an orthopedic practice may result in a more robust range of services being offered.

Access to technology. With the total expenditure shared among more physicians, EMR and medical practice management systems become more cost effective.

Blocked competition. Smaller groups and solo practitioners may think twice before opening a practice in a market that's already populated by a larger physician group.

Improved quality of life. Shared call coverage and full utilization of physician extenders can provide the breathing room that leads to better work/life balance.

Professional development. Merging practices gives more opportunity to work with new colleagues and expand professional and clinical experiences.

A Case for Careful Planning

Successfully surviving in today's health care environment may require joining forces with other physicians. But because this often means significant structural and cultural changes, physicians considering a merger or acquisition are advised to seek the assistance of outside professionals — including consulting firms, accounting professionals and legal advisors. ■

How It Works

Let's look at a hypothetical case involving two practices considering a merger, Main Street Clinic (the buyer) and Westside Health Care (the seller).

Main Street collects \$500,000 annually and has overhead of 70 percent. Annual profit is, therefore, \$150,000. Westside collects \$300,000 annually.

Following a successful merger, Main Street should increase its annual collections to \$800,000 annually. By stacking Westside's practice

on top of its existing overhead structure, Main Street can expect to enjoy a significant decrease in its overhead percentage.

In the end, the net effect is that Main Street's variable expenses will go up (e.g., supplies, lab fees, assistants' salaries), but the remaining fixed expenses will be more efficiently utilized and profits should increase.

This additional cash flow can be used to further build the practice, or become a future annuity to fund the owners' retirement.



Wolf & Company LLP

Certified Public Accountants

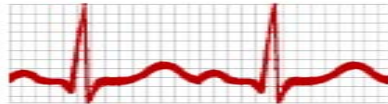
Healthcare Services Group

2100 Clearwater Drive
Oak Brook, IL 60523-1927
www.wolfcpa.com



Wolf Financial Group

Vital Signs



2010 Brings Roth IRA Options for High Earners

High-income individuals will be receiving a retirement planning gift from Uncle Sam next year.

Starting in 2010, you'll be able to convert your traditional IRA or SEP IRA to a Roth IRA, regardless of your income. Traditionally, high earners have been locked out of the Roth option. For example, married couples who make more than \$176,000 in 2009 cannot contribute to a Roth IRA.

Convert or Stay Put?

Your decision hinges on the difference between your pre-retirement tax rate and your expected rate at retirement.

Here's why: With a traditional IRA, you get the tax break upfront, in the form of a deduction equal to the amount of your annual contribution. However, you must pay taxes at your ordinary income tax rate when you begin taking distributions during retirement. You don't even get to take advantage of the lower long-term capital-gains rates.

By contrast, a Roth IRA offers tax breaks on the back end. There is no tax deduction for annual contributions, but these contributions grow tax-free instead of just tax-deferred. In other words, pay the tax

today and you'll never pay any tax in retirement.

The Good and the Bad

Here's the bad news: If you convert to a Roth IRA in 2010, you will most likely pay taxes on the entire amount that is converted because you were given a tax deduction when you first made the contribution.

Now, for the potentially good news: The federal government will allow you to spread the resulting tax bill over two years, 2011 and 2012. ■