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Communication Innovation

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Expanding through Subspecialty Services

Offering additional specialized medical services can benefit both your practice and your patients. The practice adds a revenue source to help offset overhead costs. And patients gain convenience and continuity of services.

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For example, you might offer access to a fertility specialist within an OB/GYN practice, or to a cardiologist within a primary care practice. Whichever medical services you add, the resulting professional interaction facilitates caring for patients' needs, and the integration of patient records can improve the continuity of their care.

On the income side, adding a specialist can allow your practice to charge for services that previously were referred out. But note that subspecialty services must be carefully structured in order to avoid legal problems due to fee splitting, kickback, or Stark law violations. A principal requirement is to pay or receive no more than a "fair market value" for the services.

. . . CHARGE FOR SERVICES THAT PREVIOUSLY WERE REFERRED OUT.

Employee

One practical arrangement is simply to hire a specialist full-time — assuming you can find a suitable and willing physician — and bill for his or her services. However, to justify a full-time specialist, you will need a patient base that is large enough to generate sufficient volume.

If you anticipate lower volume, part-time employment may be more suitable. You can choose to pay a set salary, a per diem rate, or a percentage of amounts collected, or you could pay on another basis.

A part-time arrangement may work out well if the specialist ordinarily practices outside of your primary market. Otherwise, you risk having your patients followed up at the specialist's primary office.

Independent Contractor

Making an independent contractor arrangement is another possibility. You would share space with a specialist whom you pay on a 1099 basis without tax withholding rather than on a W-2 salary basis.

In this situation, your practice would bill and collect from the independent contractor's patients, as you would if the contractor were a full- or part-time employee. Alternatively, patients could pay the physician's professional corporation that has a contractor arrangement with your practice. Before engaging an independent contractor, however, talk to us about the tax rules that must be met.

Support Services

You also might arrange for the specialist to bill and collect, while you provide staff time for scheduling, obtaining insurance information, filing, etc., plus space and supporting facilities for the specialist's office visits. For your services, you would receive a percentage ("fair market value") of the amounts collected. Note that, with this support services arrangement, you avoid malpractice exposure for the specialist's activities, which may help compensate for generally receiving less revenue than the other specialist arrangements would generate.

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Adding subspecialty services is both a business and a medical decision. On the business side, careful planning to avoid regulatory pitfalls and maximize potential revenue is essential. Please call us if you want to learn more.

Reducing Health Plan Eligibility Problems

Treating patients without knowledge of their* current *health plan coverage status can lead to time-intensive bill collection efforts, bad debts, and write-offs. Here's how you can help your practice reduce plan eligibility difficulties.

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When patients become ineligible for health plan coverage, the news may creep from the employer to the plan to you, sometimes over an extended period of time. Other patients simply change their plans or jobs without mentioning it to your staff. To avoid the resulting collection difficulties, look to your health plan contracts and office procedures.

Often, plans are contractually obligated to pay for treatment given between the end of eligibility and receipt of notification. If needed, make adding such language a priority at your next renewal.

Consider adjusting your office procedures to systematically verify patients' eligibility. When making appointments, have the schedulers reconfirm each patient's coverage — by asking or, if available, by using the plan's website or automated voice response system.

> . . . LOOK TO YOUR HEALTH PLAN CONTRACTS AND OFFICE PROCEDURES.

At check in, have your receptionist always make a new copy of the patient's current insurance card and ask whether coverage has changed. Some plans offer a terminal for confirming eligibility. If your office has one, make sure its use is integrated into the check-in sequence.

Even though health plan enrollee lists may not be completely up-to-date when you receive them, have your staff promptly check for missing (and new) names. And transfer the data without delay to your billing and scheduling systems.

Confirming eligibility in advance takes some time and effort, but the potential reduction in collection problems can make it worthwhile.

Speeding Remittances into Your Bank

An efficient billing function is key to your practice's financial health. And just as important is promptly posting all remittances to your bank account.

Less Cash — More Work

With incoming checks and cash copays, posting and deposit are tasks that busy staff can easily put aside. And if remittances pile up on a desk or in a drawer, you won't see a warning flag on your bank statement that your balance is lower than it should be.

Delayed posting may do more than reduce your bank balance. If your billing system automatically generates statements showing outstanding balances that have already been paid, some patients may make duplicate payments that will have to be posted and then refunded or credited. Others may call with time-consuming inquiries or complaints.

> . . . IF REMITTANCES PILE UP . . . YOU WON'T SEE A WARNING FLAG . . . .

Avoiding Delays

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When ordinary tasks require more than the available time, your staff may put off less pressing duties, such as posting and depositing remittances. So, assuring prompt processing starts with employing enough staff for the size of your practice. Also, consider making the posting function more than an entry-level position. In most situations, you need someone who is able to:

- Post payments accurately and reliably
- Check the accuracy of payments from insurance carriers and follow up on any variances
- Rebill or appeal denied insurance claims
- Promptly process payments that lack sufficient identification

Preventing Problems

Whenever staffing permits, separate the remittance processing functions. The person posting remittances should not also post charges, receive copays and other time-of-service payments, or handle statements. Billing and collection records require your regular attention, especially in regard to write-offs, so you can make sure that collectable items are not being conveniently disposed of.

OPPORTUNITY IN PENSION LAW CHANGES

The most recent pension law changes — enacted last summer — can be a welcome development for a medical practice with a 401(k) or defined benefit pension plan.

Limits on Contributions Extended

The current, generous contribution limits for 401(k) plans *that were scheduled to expire in 2011* became permanent. So did the limit for contributions to defined benefit plans and the ability of owners and partners to borrow from their retirement plans on a basis similar to employee participants. The annual dollar limits that continue to apply are $15,500 for 401(k) plan contributions, $5,000 for 401(k) plan catch-up contributions, and $180,000 for defined benefit pension benefits — increased from $175,000 in 2006.

Less Costly Safe Harbor

Starting next year*, by requiring automatic enrollment** of new participants in your 401(k) plan, you can qualify for a new non-discrimination testing safe harbor with lower employer contribution amounts than the current 401(k) safe harbor.

401(k) plan non-discrimination rules require two annual tests comparing the average contributions — including salary deferrals and matching — of highly compensated employees and non-highly compensated employees. Failing either the actual deferral percentage (ADP) or actual contribution percentage (ACP) test has unwelcome tax consequences for highly compensated participants. Their excess contributions must be refunded (and, therefore, taxed) or recharacterized as taxable instead of tax-deferred income.

Currently, a 401(k) plan can avoid testing by meeting the law's safe harbor requirements:

- A 3% nonelective employer contribution for each nonhighly compensated employee *or*
- A specified matching contribution for all eligible employees — 100% of the first 3% of earnings deferred plus 50% of deferrals between 3% and 5% (or an "enhanced match") and
- The immediate vesting of all employer safe harbor contributions

The "qualified contribution arrangement" automatic safe harbor includes:

- Either an employer contribution for all employees of at least 3% *or* a matching contribution that is 100% of the first 1% of compensation deferred plus 50% of deferrals between 1% and 6%
- Vesting of employer contributions after two years of service
- An automatic employee contribution percentage — ranging from a 3% to 6% minimum to a 10% maximum (Other requirements also apply.)

. . . A NEW NON-DISCRIMINATION TESTING SAFE HARBOR WITH LOWER EMPLOYER CONTRIBUTION AMOUNTS . . . .

Increased Defined Benefit Deduction

The tax deduction limit for annual defined benefit plan contributions was raised in order to encourage corporations to fully fund their plans. In 2007, within the tax code's maximum funding limits, your practice may contribute and deduct up to 150% of your normal amount. After 2007, the limit and deduction will be even higher if your plan is not fully funded. Note that professional advice is essential to determine the amount that your practice may contribute to your defined benefit plan and deduct as a contribution.

Please ask us if you want to know more about opportunities for enhancing your retirement plan.

* Plan years that begin on or after January 1, 2008.

** A specified percentage of pay is automatically withheld unless the employee chooses not to participate.

When a Safe Harbor Plan Makes the Most Sense

Choosing a safe harbor plan design may be desirable for your practice if:

- The value of the benefits accrued for the partners or owner is more than 60% of the value of the total benefits accrued for all participants, or
- Contributions are already at or near the amounts required by the safe harbor. Moving to a safe harbor design now can help avoid testing problems in the future even if no current problem exists.

The general information in this publication is not intended to be nor should it be treated as tax, legal, or accounting advice.

Additional issues could exist that would affect the tax treatment of a specific transaction and, therefore, taxpayers should seek advice from an independent tax advisor based on their particular circumstances before acting on any information presented.

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Medical Briefs

Growth in Physician-patient E-mail

The Center for Studying Health System Change recently reported that, while physician-patient e-mail is most common in larger practices, overall about one in four physicians used e-mail to communicate clinical issues with their patients in 2004-2005. This is a 20% increase from 2000-2001 when one in five physicians used e-mail for patient communications. However, the use of e-mail for physician-patient communications still lags far behind its acceptability to patients. A Harris Interactive Healthcare Poll in 2005 found that 80% of the online respondents would welcome communicating with their doctors by e-mail.

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Revised CMS-1500 Claim Form Required

Starting April 2, 2007, providers must use the new CMS-1500 claim form to submit their charges to Medicare carriers, health plans, clearinghouses, and other payers. Usually, billing systems need a software vendor update in order to incorporate the new form, which includes the new National Provider Identifier numbers. Payers will require the use of these numbers after May 23, 2007.

Can We Help?

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