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Medical Alert

*Face it... you pay Uncle Sam dearly each year. So now it's time to see how Uncle Sam can pay you back.*

## GETTING THE MOST OUT OF THE TAX LAW

Face it... you pay Uncle Sam dearly each year. So now it's time to see how Uncle Sam can pay you back. This article explores several provisions in our tax law that can benefit you and your practice greatly.

### New Bonus Depreciation

The 2002 tax law provides a favorable new write-off that allows businesses to immediately deduct 30% of the cost of qualifying assets. The remaining 70% is then depreciated or amortized according to normal tax rules.

The rule is retroactive, generally applying to purchases made between September 11, 2001 and September 10, 2004. Qualified property includes:

- Most property having depreciable life of 20 years or less (buildings do not qualify),
- Most computer software,
- Qualified leasehold improvements, or
- Water utility property.

The property must also be new. If you buy used property (including buying a business), that property isn't entitled to the additional 30% depreciation. But, if you recondition or make improvements to property you own, those expenditures will qualify for the bonus depreciation.

Qualified leasehold improvement property includes improvements to the interior of a non-

residential property that has been in use for more than 3 years. The following don't qualify: enlargement of a building, elevators or escalators, structural components of common areas, or internal structural framework.

More good news... the 30% bonus depreciation applies for both regular and alternative minimum tax purposes.



### Business Vehicle Purchases

If you designate your automobile as a business vehicle, you should take a look at how provisions of the tax code affect you. The IRS classifies certain vehicles as luxury items and limits the amount of depreciation taken based on the year the car is placed in service. In general, this affects cars priced at more than \$15,000.

Annual depreciation limits (including Section 179 expenses) will be \$7,660 with the new 30% bonus depreciation mentioned earlier. Limits are then \$4,900 in the second year, \$2,950 in the third year, and \$1,775 in later years.

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## THE BATTLE FOR YOUR BOTTOM LINE

Medicare cuts, sky-high malpractice premiums, the push for computerization... it's amazing how many people are after chunks of your bottom line. Here's how to win the battle for your bottom line in 2003 and beyond.

### Back To Basics

Medicare reimbursements took a 180° turn in late February with the passage of legislation increasing physician payments by 1.6%. This instead of a previously announced decrease of 4.4%.

While this is good news for 2003, the prospects for 2004 are somewhat dim. Considering this environment, it's time to consider some business basics to protect your bottom line, including:

**Review staffing levels.** This is your biggest expense, especially for primary care. Too often, it's the first thing physicians think about when cutting overhead. Data from the Medical Group Management Association indicates profitable practices have a *higher* level of staffing. The trick is to hire the best staff you can afford, and to make sure the staff performs the right tasks at the right time and to a level commensurate with their education and expertise. That means reviewing your approach to everything from scheduling appointments to collecting copays. The bottom line to protect your bottom line? Hire the right mix of staff and motivate them to perform.

**Office space.** This may be the time for you to consider whether your office space truly meets current and future needs. For primary care physicians, perhaps it's time to consider adding a new exam room, enabling three or four more patients a day to easily cover additional cost. On the



other hand, specialists may have too much space and should look into sharing or subletting or even giving some back and renegotiating the lease.

**Purchasing supplies.** Clinical and clerical supplies can be purchased through buying programs and cooperatives. Additional options may be available online. The bottom line? Make sure you have a centralized ordering process and take advantage of bulk-ordering discounts.

**Everything is now negotiable.** The market is tough for those entities providing technical services such as lab, transcription, and billing. It's time to approach them about breaks they can provide you to keep your business.

### Turning To Technology

Some physicians still hesitate when it comes to using technology to improve the business and clinical aspects of their medical practices. For example, surveys show that only 5% of medical offices use electronic records. This in spite of the fact that studies show the right technology will improve patient care, reduce medical errors, and cut healthcare costs in the long run.

Cost, of course, is a major issue, along with making sure the right system is purchased. We can help you make the right choice.

The battle for your bottom line never ends. We're here to help you attain your business goals while you concentrate on the clinical side of your medical practice. ●

## CODING FOR DOLLARS

Coding is confusing. Just ask the four coding companies that were the subject of a survey published in the September 2002 *Annals of Emergency Medicine*.

Each company was provided 389 medical records. Each was asked to make a coding decision on five Evaluation and Management (E&M) codes representing 70% of services provided by emergency physicians.

The companies surveyed agreed on 15% of the charts, 6% of the charts were coded differently by all four firms, and in 29% of the records, coders disagreed by more than two code levels.

So with all of this confusion on the part of coding professionals, how can physicians be expected to code correctly? Good question with a frustrating answer – it's the law. And the better you understand coding, the better chance you'll have of avoiding audits and actually collecting reimbursements you've earned.

### The Basics Will Set You Free

Proper coding comes down to taking the time to understand the basics. The basics include a good understanding of the elements required to choose the right code and using the correct language to delineate between a referral and a consultation.

Three elements drive the assignment of the proper code for a patient visit – history, exam, and medical decision-making. Some doctors think time is a factor, too. It can be, especially when it comes to hospital observation and discharge services. Look at the day of service for hospital observation code selection. When discharging a patient, code for time spent with discharge planners, nurses, home health agencies, and family planning.

Many physicians confuse the issue when it comes to coding for a patient referral or a patient consultation. In these cases it's important to carefully choose the language on a patient chart. A consultation

requires a request from another physician, with that request documented in a patient encounter, and proof that an opinion has been returned to the requesting physician. A referral indicates one physician is transferring the care of a patient to another doctor for further treatment.

Confusing the language in the chart naturally confuses the coding. It pays to get it right because, generally, consultations are compensated at higher rates.



## Mistakes To Avoid

- Date of service billed doesn't match date of service documented in patient chart.
- The physician documents more than one diagnosis but only one is billed; both should be billed with proper documentation.
- Lab tests performed and documented but not billed.
- Illegible handwriting. Unreadable records may be considered unbillable.

## Commit To Coding

Too many physicians try to take shortcuts with coding. Some even undercode, thinking they can avoid payment hassles and charges of fraud and abuse. These doctors lose on both counts because they're throwing money away and could have their quality of care come into question because their documentation does not reflect it.

So it's worthwhile to study the codes, keeping in mind that some are revised or even deleted each year.

Remember – you're in charge and ultimately responsible for how you code. ●

## MANAGED CARE: ADVANTAGE, PHYSICIANS

Physicians may loathe managed care, but the fact is almost 90% of doctors in America contract with at least one health plan. Studies show managed care revenues are up slightly while financial incentives such as capitation have eased dramatically. Does this signal a kinder, gentler managed care? Maybe so, but for the most part, it's an environment where doctors should recognize they have more leverage in managed care contracting than ever before.



## Know Costs And Fee Structure

Taking advantage of this newfound leverage requires an internal focus. It starts by making sure your fee structure makes sense for your medical practice.

Check data supplied by health plans against independently calculated data. While some health plans like to make this task difficult, in reality, a small number of CPT codes (about 20 to 35) typically account for 90% or more of your insurance revenue. This is especially true for single-specialty clinical practices.

Who should collect this data for your practice? Some medical practices do it themselves and have the wherewithal to purchase the right software and access independent studies to do the calculations on their own. Others rely on CPA medical practice consultants who are uniquely qualified to crunch the numbers.

Some practices use the RBRVS system as a basis for comparing their fees with the plan's calculations. This approach provides several benefits:

1. Identify RBRVS fees "tweaked" by the health plan. Health plans have been known to tweak an RBRVS fee for any number of reasons. Physicians should view returning the fee to the RBRVS-based payment as a negotiable item. It's entirely reasonable for the doctor to ask the plan to restore the correct value or produce data that explains the lower payment.
2. Identify new CPT code superseding the code in the RBRVS version used by the plan. You can also gauge the reasonableness of pricing the new code.
3. Identify whether a geographic practice cost adjuster has been applied. Depending on practice locations, doctors may want to argue for or against this adjustment.

## Negotiation Game Plan

Doctors are becoming much more sophisticated with managed care contracting. The important thing is to have a battle plan from first move to checkmate. As long as both sides act reasonably, both interests can get their fair share.

To limit disruption, a practice should target one health plan at a time, starting with the one paying the lowest rates. Target plans with less than 10% of patients. If yours is a large and busy practice, you might consider a lower percentage of patients as the trigger for dropping the health plan if you're confident you can quickly find new patients. Essentially, you should set your floor on what you can afford.

Even with the newfound leverage with managed care, dropping a health plan is not a move to be taken lightly. Don't let your emotions guide your decisions. There's always a pendulum in the marketplace, and right now, that pendulum is moving in the physicians' direction. Take advantage of it now before it starts moving the other way. ●

## GETTING THE MOST OUT OF THE TAX LAW

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*Taxes are not just a once-a-year inconvenience. It's important to increase your knowledge of the tax code, so you can use it to your benefit.*

Because of the new bonus depreciation, now may be a good time to buy a new business vehicle.

Keep in mind: Vehicles weighing more than 6,000 pounds don't come under the depreciation limitation. Such vehicles might include large pickup trucks, vans, and sport utility vehicles. Many SUVs weigh less than 6,000 pounds, so be sure to ask.

### New Equipment Costs

2003 may also be a good year in which to buy new equipment for your medical practice. You can write off up to \$25,000 of such equipment using the Section 179 expense deduction. You must have net business income to qualify, and if you purchase more than \$200,000 of assets in a year, the maximum deduction will be reduced dollar for dollar. So you can no longer deduct this expense once applicable purchases reach \$225,000.

You can choose each year whether to depreciate or deduct equipment purchases, and you can expense all or some. Once you file one way or the other, though, you cannot change the treatment of a purchase.

If you're considering this approach, plan your purchase before the end of the year in order to avoid what's called the "mid-quarter convention," which kicks in when more than 40% of the total basis of all personal property placed in service during the year goes into service during the last 3 months of the tax year.

Taxes are not just a once-a-year inconvenience. It's important to increase your knowledge of the tax code, so you can use it to your benefit. We make it our business to know and understand the tax rules. Call us. ●

## FAIR MARKET VS. STRATEGIC VALUE

What is your practice worth? The answer often depends on whom you're selling to. If you're selling to a tax-exempt entity, you must be paid fair market value. If the entity is public, strategic value can enter into the mix. So, where does your practice fit?

### Fair Market Value

Government regulators define fair market value (FMV) as "the price at which the property would change hands between a willing buyer and a willing seller, neither being paid under any compulsion to buy or sell and both having reasonable knowledge of relevant facts."

Straightforward definition? Again, that depends on the situation. If your practice is being wooed by a local hospital, regulators would look sideways on a purchase price including strategic considerations. Even more so if your practice is being acquired by a local HMO to enhance their market position. The FMV of your practice depends on:

- History and nature of the practice.
- Economic outlook generally and, in particular,

for the medical profession and your specialty.

- Financial condition of the practice based on 2 years of balance sheets and ratios and net book value of stock and assets.
- Cash flow levels.
- Earning capacity of the practice.
- Estimates of goodwill and other intangibles.
- Comparable sales of similar medical practices.

Other factors should also be considered, including liquidation value and the capitalization of earnings and excess earnings.

### Strategic Factors

So where does FMV end and strategic value begin? Basically, strategic value begins when the value of a practice is based upon the market advantages a specific buyer would gain from the purchase of your practice. It's an important distinction to make, especially in today's regulatory environment.

Not surprisingly, the value of your practice depends on multiple factors. If you don't know the value of your practice, give us a call. ●