PRACTICE TRANSITIONS

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Case Study: Transfer of accounts receivable, with a wrinkle

A recent practice transition that we handled included the purchase of the selling doctor's accounts receivable. The buyer inspected the accounts in order to arrive at a reasonable purchase price and the seller also contemplated an agreeable amount. Both parties found an amount they were satisfied with and the transaction was completed.

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However, there were issues that surfaced post-closing that are important to share. This article will shed light on the event so that others can be knowledgeable, and will hopefully help buyers and sellers of accounts receivable in the future.

In order to protect the identity of each party, I will call them Selling Doctor and Buying Doctor.

Selling Doctor had developed a well-respected general dental practice. The facility was well appointed with recently purchased durable medical equipment, servicing about 1,800 active patients. The office occupied 2,200 square feet, with five operatories and a private office for the doctor. Collections were in the neighborhood of $500,000 annually, with adjusted "Net Operating Overhead" between 55% and 57%.

Selling Doctor performed 80% of the production, and one full-time hygienist performed the balance. Sixty-seven percent of the collected revenue was from insurance reimbursement, which is a bit over the national average of 50% among general dentists. The practice had 13 PPO contracts in place, and new patient flow was around 40 per month. Fees were reasonable and mirrored other general practices' charges for services rendered in the area.

During the course of negotiations, Buying Doctor discussed purchasing accounts receivable rather than borrowing money for working capital, often considered sensible in practice purchases. To this end, Buying Doctor spent time inspecting the usual elements of the Accounts Receivable—namely, the age of the accounts from the date of service, the date of last payment, the amount of last payment, whether any accounts were on payment plans, if any primary or secondary insurance benefits were forthcoming, and if any of the accounts appeared to be uncollectable.

The buyer also made sure that the report did not contain any "credit balances" since these amounts were not going to be purchased. And one more item—Buying Doctor made sure bartered or "trade" accounts were excluded from the transaction. Buying Doctor believed the accounts were "clean." In other words, the accounts represented that which the office expected to collect on an ongoing basis post-closing.

At closing, Buying Doctor purchased the practice assets and the accounts receivable from Selling Doctor.

Here's the wrinkle.

When insurance payments started coming in after the transaction was completed, Buying Doctor discovered that the office filed all insurance claims with their usual and customary fees. This is fine if the insurance is a private indemnity plan that allows the doctor to collect the entire balance not paid for by insurance. Since the office participates with some insurance companies as a PPO provider, the office has committed to adjusting the difference between the submitted listed fee and the insurance company's allowable fee. As a result, when the adjustments were made, the collected amount was much less than Buying Doctor had anticipated. Buying Doctor did not feel this was a fair and equitable portion of the transaction because he was collecting less than anticipated.

There was a pleasant resolution to the problem. Both Buying Doctor and Selling Doctor agreed to refund the amount paid for the accounts receivable, and Buying Doctor agreed to collect the rest of the accounts on behalf of Selling Doctor.

The lesson learned—when inspecting accounts receivable for purchase or sale during a dental practice transition, inspect all aspects of the accounts, including the fee that is submitted, to be sure it represents that which the office expects to collect. Perform thorough and sensible due diligence prior to closing to ensure a successful transition. DE