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From the Publisher

Thank you for taking the time to review our new publication, Ophthalmology Business (OB). Ophthalmology Business is an ASCRS publication focusing on business matters relevant to the ophthalmic surgeon and his practice. OB will be published quarterly and as an e-book the remaining eight months of the year.

From detailed aspects of managing a practice, including employee growth and development, partnership, and achieving a platinum level of customer service to wealth management and estate and tax planning, this publication will become a “go to” resource for helping your practice excel. OB will also provide expert insight on government health care reform. In addition, this magazine will target newer doctors and help them develop their businesses from the ground up: setting up, maintaining, and growing a practice.

OB was created in answer to a need expressed by anterior segment surgeons for a practice management magazine addressing their specific concerns. Each article is specifically selected to provide comprehensive and detailed information valuable to the ophthalmic surgeon. OB will draw from the knowledge and experience of the ASCRS clinical committees and our editorial board, as well as financial, technology, and human resource consultants and writers to develop timely, robust articles.

We hope you enjoy the preview issue of OB and are sure you will anticipate its launch later this year.

Like all ASCRS publications, we are here to serve your needs. We welcome your ideas, comments and suggestions as your input will newer doctors and help them develop a publication that will answer the needs of the ophthalmic surgeon. We look forward to hearing from you.

Sincerely,

Donald R. Long
Publisher, Ophthalmology Business
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SAN DIEGO 2011
The American Society of Cataract and Refractive Surgery
The American Society of Ophthalmic Administrators
It is a well-accepted idea that poor service will destroy a medical practice. Earlier this year, the
Research Institute of America conducted a study on behalf of the White House’s Office of Consumer Affairs
to measure service. While not pertaining specifically
to medicine, I think some of the results are quite compelling and can be used as a guide in managing a medical practice.*

Here are some of the results:

Only 4% of unhappy patients bother to complain. To look at it another way, it essentially means for every complaint you hear, there are approximately 24 other patients who were unsatisfied in some way but didn’t bother to complain directly to you. And, while all of those other unhappy patients didn’t complain to you, they will likely air their grievances to other potential patients.

Word of mouth is a powerful source. Put yourself in the position of a potential patient. If you hear something negative about a practice, wouldn’t you likely avoid it and go to a practice where you heard positive (or neutral) reviews? Make sure a patient doesn’t walk out the door with a frown.

Ninety percent of patients who are dissatisfied with the service they receive will not be back again. If you have four complaints, the numbers indicate you may actually have up to 100 unsatisfied patients, and 90 of those 100 unsatisfied patients may not return.

In some businesses a consumer walks out the door with a product. If the product is defective it can be returned. However, in a service industry like medicine, the “feeling” patients have when they walk out

you can do is try to make their experience better the next time, but if they leave unhappy or unsatisfied, there may not be a next time to make it right.

The numbers also indicate that each unsatisfied patient will tell his/her story to up to nine other individuals. As I stated previously, word of mouth

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Quantifying the results of poor service

Brad Ruden, MBA

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“Recognizing an unhappy patient and resolving his or her complaint in a timely manner will go a long way toward patient retention.”

is a powerful force. A negative experience can be difficult to overcome. It can take up to 12 positive interactions to overcome the lingering effects of one negative interaction.

Everyone in your practice is a point of contact for a patient: the person who schedules the appointment, the person who does check-in, the tech who prep the patient, the doctor who treats the patient, and the billing person who sees the patient before s/he leaves. A contact isn’t just one patient visit but every interaction the practice has. There can be three to five contacts in a single visit. If one is negative, it can taint the entire experience. At the same time, if all contacts are positive, this can go a long way toward alleviating a previous negative experience.

Sixty-eight percent of people who stopped doing business with an organization did so because of perceived company indifference. In short, they didn’t want to frequent a place where they didn’t feel valued.

Do your patients feel valued? How so? I hope “value” is more than just a sign in the waiting room stating that patients are valued.

A patient who feels valued will give a practice more leeway in the instance of a negative occurrence.

The survey also indicated that of the small number of people who registered a complaint, between 54% and 70% would come back again if their complaint was acknowledged and resolved. Acknowledging and attempting to amicably resolve a complaint is a powerful way of showing patients they matter and that you value them.

The recapture rate jumps up to 95% if the person believes the complaint was handled adequately and resolved in a reasonable time.

How does your practice handle complaints? Do the people who handle the complaints have the authority to resolve them? If not, what is the timeline to achieve a resolution? The sooner a complaint is resolved, the quicker it is not a distraction to the practice and the patient is satisfied.

We live in an era of declining customer service. Many of us have come to expect the minimum in customer service and are frequently surprised when we get more. Recognizing an unhappy patient and resolving his or her complaint in a timely manner will go a long way toward patient retention. And higher patient retention can lead to a financially healthier practice.

*For purposes of this article, I have substituted the word “patients” where the report by The Research Institute of America referenced a consumer.

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Incorporating premium IOLs into your practice for the young cataract surgeon

Rob Melendez, M.D., M.B.A.

Background

I started implanting premium IOLs (toric and multifocals) in my fourth year of practice after residency. Why did I wait until my fourth year of practice to incorporate these lenses? I was nervous about failing and did not want to deal with unhappy patients.

As a young surgeon, it is exciting to try new technology, but it should be methodically incorporated into your repertoire. Remember, you are trying to build a practice and your reputation. It’s not that implanting a premium IOL is more difficult, but diving in too quickly can generate one too many unhappy patients. My goal was to convert as many of my variables to constants.

I had the added benefit of seeing the results of earlier multifocals implanted in other patients in our practice with good results, but they’re not as predictable as toric IOLs and now the newer multifocals. I learned that patient selection was extremely important and was very similar to that of LASIK surgery patients. I found hyperopes tended to be the happiest patients with any type of lens implant. Patients with a mild to moderate amount of astigmatism were equally as happy with the toric IOL. Patients that read a lot about the lens technology and understood that nothing is 100% were the best patients.

Explaining to your patients that they still might need to wear glasses for some activities (reading extremely small font and possibly while driving at night) is very important in the discussion of premium IOLs. More importantly, read their facial expression and body gestures after making the statement, “You still might need to wear glasses”. If they made a comment such as, “I don’t want to wear glasses!” your response should be, “I cannot guarantee that you will not need to wear glasses after surgery. If
that is your understanding, then you are not a good candidate for a premium IOL. We can perform a near perfect surgery, but we are always dependent on the technology and how your eye sees with it.” Conversely, if the patient states, “That’s fine, I understand that I might need glasses,” document this in the chart: “Patient understands that he still might need to wear glasses after surgery and wishes to proceed with the premium IOL.”

My first four years of practice were devoted to learning new techniques and performing cataract surgeries consistently with reproducible results. In my first two years of practice, I spent time with my senior partner, Arthur J. Weinstein, M.D., nearly every week in the OR observing and taking notes of his many pearls. I can recall one time when he told me, “Rob, I’m going to show you how not to make this mistake I made for 10 years.” He was showing me the importance of wound construction and of not creating it too short. He performs ~100 cataract surgeries every week and is always committed to learning something new. He emphasized the importance of not focusing on speed, but rather consistency. He shared his observation that young cataract surgeons tend to get overconfident when they reach around the 500th surgery and begin to have more complications. I learned that speed comes with a technique that is precise and purposeful.

Presently, it takes me less than 10 minutes per cataract case for standard cases, up to 15 minutes with more difficult ones, and of course even longer for the most difficult ones. As a young surgeon, we tend to focus too much on speed, and not enough on quality. Speed comes later with repetition that is precise and purposeful. Dr. Weinstein shared with me how young eye surgeons can get overconfident after a couple of years and focus too much on speed. Therefore, resist the temptation to rush. Patients can care less whether you can perform a surgery in 5 minutes or 10 minutes. They are looking for a caring and conscientious surgeon. Focus more on consistency with your technique.

Converting variables to invariables (Constants)

Next, I will focus on the variables that must become invariables (constants) with your surgical cases before introducing premium IOLs into your practice. Of course, this will be variable for every surgeon.

Equipment: Choose one phaco machine and learn all of the parameters of the machine before introducing premium IOLs into the mix. Create settings for different types of cataracts (standard cataract, very dense 4+ brunescent, and loose lens).

Surgical instruments: I recommend using the same instruments all the time. Remember, it’s OK to try something new and this is encouraged, but do not incorporate a premium IOL into the mix when you have too many new variables (i.e., new phaco machine, new instruments, new wound construction, etc.).

Wound construction: In my early years, I was using a 3.0 diamond blade to create a 3 step incision. Over the last year, I moved to a smaller wound using a 2.4 mm blade that literally changed my entire surgery. I felt as if I was a resident learning a new technique again. Why? In one of my early cases, I created an extra short wound because I was not familiar with the blade and entered the eye too soon. You can understand the implication of this error (iris prolapse and potentially a wound leak, and even post-op endophthalmitis). Only the former occurred in this case and was remedied easily with a sub-incisional iris hook.

The next hurdle that I faced with switching to a smaller wound was the fluidics. The smaller sleeve around the tip resulted in post-occlusive surges where the chamber was shallowing during phacoemulsification (the rate of outflow was greater than the rate of inflow). Once I learned the new phaco machine, I made adjustments to compensate for the changing fluidics. On very dense cataracts, I simply used a larger sleeve to increase the rate of inflow. More recently, I switched to an even smaller wound of 2.2 mm using the Kelman tip and this has been better for more dense cataracts and removes them efficiently.

I also had some difficulty with the Utrata forceps during the capsulotomy because of the smaller diameter of the wound. This resulted in oar locking. This was remedied by ordering smaller sized forceps. However, there are some cases that present where we still only have a standard Utrata forcep in the surgical tray. This would be a variable in your day, but you just roll with the punches. If you are creating a smaller wound to use a smaller phacoemulsification device and then have to increase the wound size because your lens implant will not

Continued on page 10
fit, then you should reconsider your wound size. Although the risk is minimal of creating too large of a wound or an irregular wound when enlarging, my goal is to minimize additional manipulation to the eye when possible.

**Staff:** It is of paramount importance to have experienced and confident surgical scrub technicians/nurses. Remain optimistic and patient with your staff. Greet everyone at the start of your day and explain what types of cases are planned for the day. My surgical coordinator creates a list of the patients for the day and provides a copy for both myself and the OR staff of each patient’s name, grade of cataract, anesthesia type, IOL type, axial length, anterior chamber depth, topography, and amount of astigmatism and location. Confirm the staff is knowledgeable with folding the lenses to minimize any potential error such as a scratch on the IOL from the lens inserter or a haptic that is misplaced under the optic while in the lens inserter. Remember, always thank the staff for their assistance. We cannot do this alone. They are a critical part of the eye team. As a young surgeon, you might think that it is all you performing the surgery; resist that thought process, you are now part of a team.

**Observers in the operating room:** I enjoy having students with me during surgery. I currently have medical students rotate with me during surgery and clinic. Some might consider this a distraction, however, it is fun and educational for them and me. If you are implanting a premium IOL on a day when you have an observer (new doctor, potential employee/partner, student, nurse, employee, and/or surgical representatives), speak to them before the day begins and tell them you are glad they are joining you.

Additionally, tell them you like the room noise to be kept at a minimum. Inevitably, you will have a guest in the OR that does not know proper OR etiquette (do not speak unless spoken to, keep private conversations outside of the OR unless the surgeon initiates it). If you are training the observer, then alert them to be attentive to your needs and to the scrub technician/nurse. For example, if the doctor states, “This is a floppy iris,” the ancillary staff should be alert to floppy iris syndrome and the surgeon may need intracameral Lidocaine with preservative free epinephrine or iris hooks or a Malyugin ring. The trainee should be taught to anticipate the surgeon’s needs.

Have your staff tape the IOL calculation sheet on the microscope above your head and/or topography sheet whichever you prefer. This is placed there for several reasons.

- Primarily, it reminds you of the patient’s name. I use it to check anterior chamber depth (should be similar between both un-operated eyes). Shallow chambers give you less working room at times and increase your risk for corneal edema. Therefore, you may need to place additional viscoelastic material in the middle of the case and be extra certain that the phaco is in the bag during removal of the densest part of the cataract.

- Secondly, I check the axial length. If the axial length is greater than 24 mm, the risk of aqueous misdirection resulting in a very deep chamber increases. This occurs when the phaco tip is placed in the eye with the continuous irrigation on and the chamber deepens. Placing a sinsky hook through the paracentesis wound to tickle the posterior iris usually causes the over-dilated pupil to constrict and corrects this problem and remedies the deepened chamber. If it doesn’t, then lower the bottle to reduce excess stress on the bag. In one case I had, I lowered the bottle to 50 cm when I entered the eye and slowly increased it during phacoemulsification. A longer eye can also generates a larger than normal capsulotomy. Remember to make a slightly smaller capsulotomy with a longer eye, that is, be cognizant of the fact that we can create an

"As a young surgeon, you might think that it is all you performing the surgery; resist that thought process, you are now part of a team."
my surgical coordinator will print the calculation sheets in blue (for males) and pink (for females). This is helpful when the patient is covered and you simply want to refer to the patient as sir or ma’am; this can quickly be assessed by the color of the paper even from across the room (credit to Dr. Weinstein).

**Lens type**  My most commonly used lens is Alcon’s SNWF60 (Fort Worth, Texas). I have used all of the toric IOLs from Alcon as well. I use the Alcon Acrysof ReSTOR IQ 3 Add. I started using this lens when it first became available in January 2009 with excellent results. I have been most surprised at how patients have a near range of vision. I can recall with Alcon’s 4+ Add, the near point was just that, a point in space and not a range. Additionally, these same patients also had to hold their reading material too close and required extra light to read, presumably because that light caused pupillary constriction and therefore made use of the most central rings of the IOL.

**Conversion rate**  I do not like to focus on a conversion rate value. I prefer to focus on what is best for each patient, but I will comment on why I think the conversion rate has increased over a 12-month period.

Next, I will highlight what our clinic does to educate patients. I think the single most important factor is the confidence level of the surgeon. This confidence only comes from enough premium IOL patients who are thrilled. I can recall on several instances when the premium IOL patients were so ecstatic about their vision, they were sharing their excitement with the other patients in the waiting room. I had one patient who was a cataract consult patient who insisted on a premium IOL after speaking with my ecstatic premium IOL patient.

Fortunately, she was a good candidate for the premium IOL and did equally as well. My unhappiest patient with a premium IOL is a gentleman who can read without glasses and had early epiretinal membranes in both eyes with 20/40 distance vision and BCVA at 20/25 OU with low grade myopia. The learning issue here is that patients with epiretinal membranes need to be counseled that they are not the best candidates for a premium IOL because they may not achieve as good vision because of the abnormality in the retina.

From now on, I will perform an OCT of the macula as a baseline before surgery (no charge).

**Education**  We send patients a brochure on cataract surgery and IOL options prior to the visit in most cases. Most patients that are seen for a cataract consult received the brochure before the visit and bring it with them on their visit. We have a flat panel TV informing patients what is cataract surgery and lens options as they enter the clinic (Eymaginations, Towson, Md.). The technician also assesses how knowledgeable they are about lens options as they enter the clinic. The technician also assesses how knowledgeable they are about lens options. If they are not knowledgeable about the lens options, the technician will briefly share information about lenses before I enter the room. I do my best not to discuss any lens options until I complete the eye
What is a cataract?

I have an eye model in every room and show them the eye and explain that we are born with a clear lens and when most of us reach about age 60, we all develop cataracts which is a cloudy lens. Then I replace the clear lens in the model with a cloudy one and show patients. I ask them, “Do you have any questions about cataracts?”

What is cataract surgery?

The second step is cataract surgery. I make a small incision and create an opening in the cataract to remove the cloudy material with an ultrasound, called phacoemulsification and replace it with a clear lens. I discuss the risks, benefits, and alternatives to the surgery at this point.

What are your lens options?

Next, I will discuss lens options. Assuming no astigmatism (i.e., cylinder < 0.75 D), I will tell them there are two types of lens options, a standard lens and a premium lens. I tell them they are a candidate for one or the other lens or both at this point. The standard lens option is a great lens, but it can only focus at one distance, either far away or up close, but not both. Conversely, the premium lens has the ability to allow patients to focus at distance and near in 80% of cases. Nothing is 100%, but if they want to be less dependent upon glasses then the premium lens option is the best bet. I simply wait for a response and read their body language. If patient rubs their neck or squirm in the chair, then I take this as, “I’m not ready to make a decision, doctor.” I tell them, “You do not have to make a decision today.” I tell them, “We are going to watch a video on cataract surgery and lens options (Eyemaginations) next.” If the patient is undecided and wishes to discuss the lenses further, then I will provide all the details they want. After several minutes and sometimes 10-15 minutes later if they are still undecided, I simply tell them that I am going to ask them one question that will tell me whether they are a good candidate for the premium lens or the standard lens. They usually sit up and become more attentive to the following question: “Do you mind wearing glasses?” If they say emphatically, “No, I don’t mind wearing glasses.” Then, I tell them, “I would proceed with the standard lens.” It is our job to provide recommendations to patients that are best for their needs. The patient proceeds to view the video and then my surgery coordinator arranges the surgery date. She is knowledgeable about the lenses because we have discussed them and she has read a lot about them. She is also knowledgeable about financing options. In my experience, most patients (75%) convert in the exam room and the remaining convert to a premium IOL while visiting with the surgery coordinator. We have a no pressure approach and simply tell them whether they are a good candidate and leave the decision to them. In several cases, I have had patients come in for additional visits to clarify questions about the premium IOLs. Typically, the second visit type patient should raise a red flag as a poor candidate and possibly be discouraged about the premium IOLs. Although my most ecstatic patient that I mentioned before came in for an additional visit, I added this caveat simply to alert you to a possible red flag for a poor premium IOL candidate. Finally, it’s important to assess the patient’s level of expectations and to match it with the appropriate lens options.

Do you use the term standard or premium or multifocal? As surgeons, it is our job to inform patients about their lens options. I think an important caveat here is that the term “premium” does not necessarily equate to premium vision because some patients will see very well with a monofocal lens. Understanding your target audience is key. If the individual uses monofocal and multifocal in their terminology while asking questions, then I suggest continuing with these terms. I like to start off using “standard” vs. “premium” terms and then define them as monofocal and multifocal. The art of medicine is the ability to connect with the patients and to educate them to provide the best recommendation that matches the patients’ needs.
Please join us next year!

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B rad Britton, M.D.

I have a secret weapon in my practice. I have a great “right hand.” No, I’m not a hand model. No, I’m not just a typical, cocky ophthalmologist bragging about my surgical dexterity (although I am a competent ophthalmic surgeon only because God blessed me with a good mind, fine stereopsis, and a steady pair of hands skilled at doing meticulous microsurgery). When I talk about my “right hand,” I’m referring to something quite different.

I want to share with you one of the best business decisions I’ve made in almost 18 years of practicing medicine. It is a decision I continue to make and commit to on an on-going basis. It is a decision frowned on by some, praised by others, and one I frequently field questions about when I speak at ophthalmology or practice management meetings. This decision has prompted occasional open criticism by employees, peers, and even partners when its ramifications impacted their version of the status quo.

Are you ready for this profound secret? Here it is:

I admitted to myself that I’m a poor manager and hired and fully empowered a “right hand”—a very good professional administrator.

Other than making the decisions to expand the practice of refractive surgery and bring in other excellent doctors as employees and partners, no other decision has changed the practice more. I am still very involved in the strategic direction and leadership of the practice but am now free to be less concerned about the minutiae. I enjoy the practice of medicine more, worry less

"I would recommend hiring a professional administrator even if the position didn’t pay for itself financially because the real value to me is in improved lifestyle, fewer headaches, higher employee morale, and a better quality practice than I could achieve if I tried to manage it myself.”
about specific operational details, and now have help with some parts of the business I don’t enjoy. The most immediately tangible effect I’ve noticed since empowering a professional administrator is the feeling that I can now go on vacation with less concern about the practice when I leave town and try to relax.

Why should one be surprised when an administrative specialist does a great job? As surgical specialists, we doctors know we have unique talents and skill sets that many physicians don’t possess. We have specific skills, honed with special training and years of practice, that translate into beautiful surgical outcomes. Professional managers also have specific skill sets, unique perspectives, and talents that can be enhanced with experience and formal training through organizations such as ASOA that make them management “specialists.” I readily admit that “my right hand” (Sandy Boles, COE) is a much better manager than I am.

The current medical education system does a great job of training doctors to be good clinicians and technically excellent surgeons. When I completed college, medical school, and residency, I felt I was well prepared to diagnose and treat patients. On the other hand, I knew virtually nothing about what was needed to be a good businessman.

Thus, after finishing my medical training, my personal strategy was to be an employee of a larger medical group so that the business decisions would be handled by more experienced doctors and the professionals they hired. After several years in the group, I felt the pangs of a frustrated entrepreneur and struck out on my own as a private practitioner. The early days of private practice were heady, and I was initially able to keep up with the medical and business sides of a practice because I was married to a supportive saint and was excited and willing to work 65–80 hours a week doing all the necessary functions required to keep a practice and business afloat.

It wasn’t long before I began to realize I wasn’t a very good manager. My natural inclination was to avoid confrontation with vendors, patients, and employees, and to throw money (or another FTE employee) at problems. I was a pushover for good salespeople. I was good at “the vision thing” but had trouble with implementation and follow-through. I felt that I was a good leader but needed someone to complement my weaknesses in management. I needed someone who was strong enough to sometimes tell me “No.”

I was blessed to find an excellent, experienced manager who wasn’t afraid to confront problems (even when I was the problem), put “wheels on ideas,” and efficiently manage the practice in ways I was unable (or unwilling) to do. Sandy and I, with our complementary skill sets, work better together as a team than either of us could perform independent of the other. To paraphrase Steven Covey, the manager is responsible for being sure “we do things right.” It’s my responsibility as leader to be sure the practice “does the right things.”

The irony? By hiring a well-trained and highly paid professional administrator, I actually make more take-home profit. But I would recommend hiring a professional administrator even if the position didn’t pay for itself financially because the real value to me is in improved lifestyle, fewer headaches, higher employee morale, and a better quality practice than I could achieve if I tried to manage it myself.

If I’m ever invited to contribute to this column again, I would tell you about the other key component to making the practice successful—accurate and timely financial information (aka Terri Smith-Hutchings, CPA, MBA, my other “right hand”). But that’s another story for another time. OB

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Creating a Practice
Where Leaders Thrive

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For a subscription for your practice call 703-591-2220.
f you think medicine is a difficult business today, you ain’t seen nothing yet. You are about to face your largest financial challenge ever. There is an approaching confluence of events that could have a significant financial impact on most doctors—unless you do something to protect yourself.

Medicare reimbursement cutbacks will reduce the income of most doctors. Even if you don’t treat Medicare patients, you are not immune to this cut. If your private insurance contracts offer you some percentage (say 120%) of Medicare, a cut in Medicare reimbursements will lower your insurance reimbursements. In addition, the anticipated healthcare overhaul will further reduce physician income. On top of both of these “gross” income reducing events, there is a significant “net” income reducing threat that shouldn’t be ignored.

The federal government is on the verge of significant tax increases for high wage earners. They are also talking about reducing the value of itemized deductions to 28%. That means that you could pay federal income taxes at rates of up to 39.6%,
but only be able to write off your itemized deductions at a rate of 28%. This is almost a 30% REDUCTION in the value of your deductions! If you have a large mortgage, significant health expenses, or other itemized deductions, this change could cost you $5,000 to $50,000 each year! This is in addition to income tax changes.

Furthermore, most states are facing financial difficulties that may result in a variety of direct and indirect tax increases. Some doctors live in high state income tax environments. Others live in states that are already threatening tax rate hikes—especially in the higher tax brackets. Even states that are supposed to be “no state income tax” states have hidden taxes. Many counties are delaying adjustments in property tax assessments to reflect the downward turn in the real estate market. As an example, one of our partner’s has had his house assessed at 50% MORE than what he purchased the house for less than three years ago—and denied an appeal to revalue the home for tax purposes.

In addition to declining reimbursements and escalating taxes, the final “triple threat to success” concerns doctors in medical groups. Larger groups often fail to react quickly and plan against challenges. In the vast majority of group practices with more than three or four physicians, they suffer from what we will call “lowest common denominator” or “LCD” planning. LCD planning occurs when the practice will only implement the asset protection, tax-reduction, qualified or non-qualified planning techniques that everyone can agree on. This is not surprising as doctors are notoriously independent, intelligent and very busy. There are often too many opinions and distractions for a group of doctors to unanimously agree on anything other than the simplest (and least beneficial) strategies.

We have spoken to thousands of doctors who are frustrated with their practice’s LCD planning. The very physicians who want to implement more advanced and beneficial planning ideas are usually the same ones who are doing most of the work and generating most of the revenue for the practice. They are often “caught in the middle” in their practices. Their younger partners are usually busy paying off student loans or paying for a big new house. They can’t afford to fund retirement tools that may reduce taxes because they need ever dollar they earn. The older doctors have the “if it ain’t broke, don’t fix it” mentality. The problem is that under the new medical economic environment, it is “broke.” The old ways cannot continue to be standard operating procedure.

If you are a physician who would like your group to consider more proactive planning, continue reading. It introduces a few concepts that can be implemented to help you avoid LCD planning and address these significant financial threats. We have seen these techniques work for solo practitioners up to very large groups. If any of these techniques are of interest to you and you would like to know more about how it may work for you, please do not hesitate to contact us for a free consultation.

“Medicare reimbursement cutbacks will reduce the income of most doctors. Even if you don’t treat Medicare patients, you are not immune to this cut.”

Employ a more flexible corporate structure

The plan above is the only significant plan a practice with a “one entity structure” (P.C., P.A., etc.) can utilize. This one entity structure promotes LCD planning gridlock. A common way to solve this problem is to alter the practice’s legal structure so that it allows individual physicians their own planning flexibility, without disrupting your day-to-day operations or requiring new insurance contracts of Medicare provider numbers.

In the typical medical group structure, there is one legal entity—like a corporation, LLC, or professional association (PA). Physicians are either owners of the entity (infor-
mally referring to themselves as “partners”) or non-owner employees. In all such cases, the physicians have no ability to separate themselves from the central legal entity. If the central entity does not adopt a planning strategy, no individual doctor has any flexibility to adopt corporate planning strategies for his or her benefit.

If this is the case in your practice, you might consider a superior structure.—Doctors can own their share of the practice through their own professional corporations (PCs) or PAs. In this way, the group is paid by the insurers, pays its bills and overhead and then pays the physicians’ PCs—best through 1099 independent contractor income. For the physicians who want to implement planning strategies beyond LCD, they may do so through their own individual PCs without any impact to partners’ planning or operations. The strategies will be implemented at each doctor’s PC level, leaving the central entity and its operations unchanged. We have seen this strategy used successfully in some of the largest medical practices in the United States.

**Bring in an expert**

In our interactions with over 1,000 physicians each year, we find the most common hurdle to implementing advanced planning to be planning gridlock. Unfortunately, most find no solution to this dilemma as their practice planning gridlock is what stops them from creating a structure that allows them to avoid gridlock—a Catch-22. Because of practice politics, the doctors who are able to navigate past the gridlock generally have the help of outside experts (with whom none of the partners or other legal or tax advisors have any negative history). Experts in the fields of tax, benefits planning and corporate law have the credibility and expertise that increase the probability that you will be able to convince your partners to “see the light” in a way that fellow physicians cannot. These advisors can often explain the suggested structure from attorney-to-attorney or CPA-to-CPA so that the local advisors are on board, agreeable and involved in the planning. Often, we are asked to play such a role and are honored to be chosen to help physician practices. Whether you contact us or another advisor or firm that specializes in this type of planning, we strongly urge you to consider bringing in an expert to speak to your group to initiate productive discussions.

**Push your partners now!**

The changes are coming. Financial success in the practice of medicine is going to be harder than ever. Even if you are grappling with financial gridlock in group practice, you can explore advanced planning options to address these challenges. The authors welcome your questions. 0B

**Contact Information**

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As a physician, do you realize that—between income, capital gains, Medicare, self-employment, and taxes, you spend 40 to 50% of your working hours laboring for the IRS and your state? That is a lot of time with patients for someone else’s benefit. Given the significance of this fact, shouldn’t your advisors be giving you creative ways to legally reduce your tax liabilities? How many tax-reducing ideas does your CPA regularly provide you? If you are like most physicians, you probably get very few tax planning ideas from your advisors.

Given these sobering facts, the purpose of this article is to show you five ways to potentially save and possibly motivate you to investigate these planning concepts now, before the end of the year. Let’s examine them now:

1. **Use the Right Practice Entity/Payment Structure/Benefit Plans**

   These areas are where the vast majority of tax mistakes are made by doctors today—and where many of you reading this could benefit by tens of thousands of dollars annually with the right analysis and implementations. Issues here include:

   - Using the legal entity with maximum tax/benefits leverage—whether that is an “S” corporation, “C” corporation, LLC taxed as “S”, “C”, or partnership
   - Using a multi-entity structure to take advantage of 2 types of entities
and their tax/benefit advantages

Managing the payment of salary, bonus, distribution, partnership flow-through to take advantage of maximum retirement benefits and minimize income, social security and self employment taxes

Having a game plan in place as the tax proposals of the new President are implemented

Don’t Lose 17-44% of Your returns to taxes—explore investment managers who manage with taxes in mind

It is quite well known that most investors in mutual funds have no control of the tax hit they take on their funds. What you might not know is how harsh this hit can be. According to mutual fund tracker Lipper, “Over the past 20 years, the average investor in a taxable stock mutual fund gave up the equivalent of 17% to 44% of their returns to taxes.” 17–44%! Obviously, over 20, 30+ years of retirement savings, losing one sixth to about half of your returns to taxes should be unacceptable to you. Nonetheless, too many physician investors settle for this awful taxation.

Even worse is what many of you mutual fund investors experienced last April 15th—when many of you paid significant taxes on the transactions within your mutual fund even though you lost 30% or more of your fund values. Is there anything worse than seeing your mutual fund decimated by a 30%+ value collapse and then getting a 1099 tax bill on “gains” inside that fund?

How to avoid this problem? Consider working with an investment firm that designs a tax-efficient portfolio for you and communicates with you each year to minimize the tax drag on that portfolio. In a mutual fund, you have only “one way” communication—the fund tells you what your return is and what the tax cost is. Working with an investment management firm, you get “two way communication”—as the firm works with you to maximize the leverage of different tax environments, offset tax losses and gains, and other tax minimization techniques. It is not by coincidence that we have two CPAs in our wealth management firm working on these issues with clients.

Asset-protect your practice’s most valuable asset and reduce taxes

As a physician, you face malpractice liability as well as general business risks (employee liability, etc.). What you may not realize is that a claim by a patient or employee will likely threaten ALL of your practice’s accounts receivable, including those you earn. Typically, this is a medical practice’s most valuable asset.

For this reason, physicians implement strategies for asset-protecting their receivables. While the details of the options go beyond the scope of this article, it should be mentioned here that one of these strategies may allow the practice to reduce its income tax burden as well. Thus, if asset protection is a concern of yours, in addition to tax reduction, we recommend that you investigate your practice’s options in this area.

Gain tax-deferral, asset protection through cash value life insurance

Above you learned about the 17-44% tax hit most investors take on their investments in stock mutual funds. Similar funds within a cash value life insurance policy will generate NO income taxes because the growth of policy cash balances is not taxable. Also, nearly every state protects the cash values from creditors although there is tremendous variation among the states on how much is shielded. Contact the authors at (877) 656-4362 to find out how much.

Conclusion

This article gives you a few ideas for how to save taxes. For larger practices with $5,000,000 or more of revenue, there are additional techniques that could offer significantly greater deductions. These are outside the scope of this article, but are mentioned in the articles on our website and are topics of our free e-newsletter. If you want to save on taxes, the most important thing you can do is start looking for members of your advisory team who can help you address these issues in advance. Otherwise, you will be in this same position this April 15th … and next April 15th and the one after that. The authors welcome your questions. 0B

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David B. Mandell and Jason O’Dell are principals of the financial consulting firm O’Dell Jarvis Mandell LLC where Carole Foos works as a CPA and tax consultant.
Choosing the form and structure of one’s medical practice is an important decision. Most advisors to medical practices believe that the avoidance of potential double taxation makes the S Corporation the logical choice. This “conventional wisdom” overlooks the potential benefits a C Corporation can offer. If you want to explore ways to reduce unnecessary taxes without subjecting yourself to double taxation AND would like to see how you can do this without having to change any of your insurance provider or Medicare provider numbers, this article is ideal for you.

The basics of corporations
First, let’s assume that your practice is either an S or C Corporation. There is NO reason to practice as a sole proprietorship or general partnership. This results in unnecessary lawsuit risk, in addition to the inability to take advantage of many valuable tax-deductible business expenses mentioned in this article.

Second, we need to compare and contrast C Corporations and S Corporations. All businesses that incorporate are automatically C Corporations absent an election to become an S Corporation. Both S and C Corporations have separate tax ID numbers and are required to file tax returns with the federal and appropriate state tax agencies. Both entities have shareholders. Both entities can be created in any state in the country.

When a C Corporation earns profit, it must pay tax at the corporate level. Profit is the difference between income and expenses. Compensation paid to physicians, as

Many practices can take advantage of both the C Corporation and the S Corporation by setting up two distinct entities to operate different aspects of their practice.”
long as it is reasonable, is deductible by the corporation on its tax return (and is therefore not taxable to the corporation).

The salary received by the owner is taxable to the owner as wages. After the C Corporation pays taxes, distributions of earnings already taxed at the corporate level can be paid to the physician-owners in the form of dividends. These would generally be taxed to the physician-owners as qualified dividends, thus leading to the “double taxation” of such earnings. As you will see below, this drawback is often overrated.

An S Corporation is also a separate entity that must file its own tax return. However, the S Corporation is often referred to as a “pass through” entity. Rather than paying tax at the corporate level, all income and deductions pass through to the shareholders and the shareholders must pay tax on any S Corp income at their individual rates. Whether the income to an S Corp is paid to the physician owners as salary or as a distribution will not impact the federal or state income tax rates that will be applied to that income for the physician. There is never any tax to the corporation, therefore there is no “double taxation” in an S Corporation.

**Double taxation – much ado about nothing**

Mistakenly, most physicians think of S and C Corporations as having exactly the same benefits. Since the C Corporation has a potential double taxation, most doctors and their advisors elect to make an S election to avoid one more potential problem. First, the double taxation problem can be easily avoided by reducing practice profits to zero, or close to zero, at the end of the year. Second, after you review the next section, you will see that the increased benefits the C Corporation offers medical practices. You will see that the cost (in time, not money) of zeroing out a C Corporation is far outweighed by the benefits.

**Lower tax rates for C corporations**

C Corporations enjoy their own graduated rates. The first $50,000 of taxable income in the C Corporation is taxed at a 15% federal rate versus the top marginal rate of the shareholder (currently 35%) that the owner of an S Corporation will be taxed. Even if the owner of a C Corporation forgot to “zero out” the corporation and left $50,000 in the entity, the corporate tax would be only $7,500. A dividend of the remaining $42,500 would only be taxed at a rate of 15%—resulting in taxes of another $6,375—leaving $36,125 (or 72.2%). If that 50% had been in an S Corporation and the owner had annual income over $300,000, the federal tax rate would have been 35% (or $17,500). In this example, leaving $50,000 to be taxed in a C Corporation would actually save the owner over $3,600 in taxes!

Personal service corporations (PSCs), such as attorneys, doctors, and accountants, do not receive the benefit of these graduated rates since PSCs are taxed at a flat 35% rate. Therefore, PSCs do not enjoy the same benefits of the graduated C Corporation rate structure that other types of businesses will enjoy. However, PSCs can take advantage of the full Section 179 expense deduction in writing off furniture and equipment in the year of purchase. C Corporations are afforded their own Section 179 deduction limitation. Shareholders of an S Corporation must accumulate the Section 179 deduction among each of their pass through entities, thus they could be limited in a given year.

If the practice has rental activity, a C Corporation which is not a PSC has the advantage of using rental losses to offset operating income.

**Additional deductible benefits of a C corporation**

Contrary to much “conventional wisdom,” a C Corporation can be the right choice for many small entities because of the deductions it allows. The corporate deduction for fringe benefits paid to employees is generally limited for shareholders owning more than 2% of an S Corporation. However, a C Corporation enjoys a full deduction for the cost of employees’ (including owner employees) health insurance, group term life insurance of up to $50,000 per employee, and even long term care premiums without regard to age based limitations. The C Corporation can also deduct the costs of a medical reimbursement plan. If one has a small corporation and a lot of medical expenses that aren’t covered by insurance, the corporation can establish a plan that results in all of those expenses being tax deductible. Fringe benefits such as employer provided vehicles and public transportation passes are also deductible.

In contrast, health insurance paid by an S Corporation for a more than 2% shareholder is not deductible by the corporation. The shareholder must generally take a self-employed health insurance deduction on his personal return. Long term care premiums paid through an S Corporation are also not deductible with regard to these shareholders. The shareholders, in deducting them personally, are subject to the age based limitations.
A SOA has proven to be a major asset for my practice. The annual meeting, publications and email forums provide our practice administrator with invaluable sources of information and a network of peers he can call upon for advice. Because our practice administrator’s membership in ASOA is as valuable to our practice as my ASCRS membership is to me, I strongly recommend it to my fellow physicians. Support your administrator’s membership in ASOA, and reap the benefits.

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Shareholders of an S Corporation must treat rental losses as a passive activity subject to the passive loss and at risk rules.

Get the best of both worlds—why not use both?

Many practices can take advantage of both the C Corporation and the S Corporation by setting up two distinct entities to operate different aspects of their practice. Perhaps the S Corporation will be used for the operating side of the practice (professional practice of medicine) while the C Corporation will be used for management functions (billing and administration). In this way, the practice as a whole can take advantage of both the tax deductions afforded a C Corporation and the “flow through” advantages of an S Corporation. This may also provide some additional asset protection. As long as all formalities of incorporation are followed, as well as compliance with rules for employee participation in all benefit plans, medical practices can benefit from this “dual” corporate structure.

The information contained in this article is general in nature and should not be acted upon in your specific circumstances without further details and/or professional advice. Contact your personal tax advisor for specific advice related to your tax situation.

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The authors welcome your questions. You can contact them at (877) 656-4362 or through their website www.ojmgroupp.com. 0B

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David Mandell is an attorney and principal of the financial consulting firm O’Dell Jarvis Mandell LLC where Carole Foos works as a CPA and tax consultant.
Panning for retirement gold with 2010 Roth IRA conversions

Determining whether it pays to make the switch

Maxine Lipner, Senior Contributing Editor

This year brings with it an opportunity that has eluded many practitioners previously—the ability to convert traditional retirement funds to those in a Roth IRA. Prior to 2010 there were strict income regulations that made most ophthalmic practitioners ineligible for such Roth conversions, according to Gregg S. Fisher, CFA, CFP, chief investment officer of Gerstein Fisher, New York, N.Y.

“In general if your adjusted gross income was greater than $100,000 in prior years you were not able to convert your retirement funds to a Roth IRA,” Mr. Fisher said. “Now, if you make one billion dollars or just one dollar a year, you can do a conversion.”

“With a traditional IRA the question of taxes is punted down the line. ‘You’re not eliminating the tax problem, you’re just differing it to the future,’” Mr. Fisher said. “With a Roth IRA on the other hand, the earnings are exempt from taxes, so the advantage off the starting line from the day it begins a Roth forward, all of the interest is exempt from tax.”

The other advantage of the Roth IRA is that account holders are not required to take money out when they reach a certain age as they would be with a traditional IRA. “With a regular IRA when you are roughly age 70 ½ you are required to start taking money out and at that time you have to pay tax on those

Potential pluses

There are of course a lot of considerations around potentially doing this. “It’s very much contingent on your personal circumstances and everyone should carefully review this for themselves in relation to their goals and objectives,” Mr. Fisher said.

Continued on page 26
A downside of converting a traditional IRA to a Roth is that the once deferred taxes on the money come due. “If I take $100,000 out of an IRA and then plug it into a Roth IRA, I’m going to have another $100,000 of income on my return taxed at my tax bracket in the year that I do that,” Mr. Fisher said. “However, there is a caveat to these rules changes which says that if the person would like to they are allowed to split the tax liability into two years.” Depending upon the state the tax liability here could be around $40,000.

In either case, Mr. Fisher recommends that those consider conversion pay the taxes using other monies. “In order for this to make sense you really need to pay the tax, the $40,000, from another source so that the $100,000 enters the Roth IRA as $100,000” he said. “If you can’t do it that way it probably in most cases really won’t make sense to do.”

To try to ease the tax pain, some of Mr. Fisher’s clients are trying to coordinate Roth conversion by timing this when income levels are down or in conjunction with other expenditures. “Maybe 2010 happens to be a year when they have less income then they might have had in the past or expect to in the future,” he said. “Or, they might time it with charitable contribution they were thinking of making or investments in their business.”

The right candidate
Mr. Fisher sees the best candidates for Roth IRA conversion are those who are not going to need the money for some time. “In our view most people have at least a 10 to 12 year break even on doing this,” he said. “The rule of thumb would be to say that most people should assume that it will take 15 or 20 years (to break even) to play it really safe.”

Other considerations that might play into the decision may be the ages of children and grandchildren who may ultimately inherit the fund. “The younger your beneficiaries, the better the mechanics,” Mr. Fisher said. With a Roth IRA the funds can grow tax free until both the account holder and the spouse dies—only then are some distributions required. “If you leave this to a grandchild or to a child the beneficiary is required to start making distributions, but those distributions are based upon the life expectancy of the beneficiary,” he said. “The beneficiary, let’s say a 90-year-old’s grandchild might be 60 when they die. There could be another 50 years of tax free growth where they’re only required to take a little bit out every year.”

In addition, those considering making the switch should check their risk tolerance. There is always the possibility that after ponying up the taxes for the Roth conversion that the account may plummet in value. “I remember back in 1998 when they created the Roth IRA everyone did conversion in 1998 and 99 and then the market corrected through the internet boom,” Mr. Fisher said. “So you did a conversion and you paid tax on $100,000 and two years later the account was worth $50,000. You want to check your comfort level knowing that that could happen to you.”

Such market corrections are by no means rare. “The odds of a 30 to 50% market correction are high,” Mr. Fisher said. “If you look back at our history, 30% market corrections happen pretty regularly.” If caught soon enough it is possible to do a recharacterization and undo the transaction but it may not always be possible to do so in time. “For the most part, if you do the conversion and one or two years later the market goes down, that’s something that you may have to grow a comfort level with, hoping that in the long run it will have been a good decision,” Mr. Fisher said.

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