Practice Management in Oral and Maxillofacial Surgery

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KEYWORDS

• Practice management • Marketing • Electronic medical records • Revenue cycle management • Coding • Benefits

KEY POINTS

- This article reviews the rise and role of dental service organizations, management service organizations, private equity, and trends in practice transitions.
- This article reviews marketing oral and maxillofacial surgery services, including search engine optimization and reputation management.
- This article reviews practice revenue cycle management, including changes in the insurance industry, coding, billing, and the role of the electronic health records and real-time insurance authorization.
- This article reviews essential terms and past and current trends in the management of oral and maxillofacial surgery practices to discuss the current state of practice and to develop predictions about the future of the specialty.

INTRODUCTION

Managing an oral and maxillofacial surgery (OMS) practice has undergone dramatic changes. Electronic health records, privacy laws, revenue cycle management, online marketing, and the rise of dental service organizations (DSOs) present increased daily complexity for oral and maxillofacial surgeons in private practice, hospital-based employees, and academic surgeons. This article is structured to discuss the role of DSOs, private equity in OMS, online practice marketing, accounting and tax considerations, and modern essentials of practice management.

DENTAL SERVICE ORGANIZATIONS

DSOs, also referred to as dental support organizations, represent the fastest growing segment in oral health care.[1] Strategies for network growth vary from a de novo practice development model to acquisition-based growth or a combination thereof. Services provided often include revenue cycle management, information technology, marketing, human resources, and financial reporting. Services are provided on an a la carte or comprehensive basis. DSO funding may be through private equity or venture capital or evolve from a group of one large or multiple existing practices. The objectives of a DSO are to standardize the provision of health care to patients through reducing nonclinical burdens on the providers. Student loan burdens on new providers reduce the likelihood of purchasing a practice or starting a de novo solo practice on the completion of training. A general trend in health care toward increased consolidation and decreased private

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ownership continues.[1] This trend is partly fueled by the challenges of maximizing insurance reimbursement, variations in scope of practice, increasing population, limited negotiating power of individual practices, complexity of staff management and benefits, and generational psychology. DSOs provide the organizational capacity to facilitate increased practice revenue through economies of scale and represent a growing and substantial component of delivering OMS services in the future.

The authors' experience has determined a cost of approximately 9.5% of practice revenue to deliver services in this type model. Services provided under this structure vary by the DSO but should include revenue cycle management, credentialing, annual fee analysis, human resources, payroll, payment of practice bills, employee and doctor benefit management, information technology support, accounting—monthly profit and loss or financials through corporate tax returns, regulatory compliance, and cash flow management. Services provided and fees charged vary by the DSO involved.

New versions of DSOs are now entering the market and provide services in addition to the aforementioned list, which now include direct-to-consumer marketing, group purchasing organizations, quality-of-life products, regional surgery centers, call coverage, insurance negotiation, and the facilitation of practice transitions. Fees currently marketed are in the 15–18% of total practice revenue. One theory supporting this growth is that the excess revenue to the DSO creates a large enough profit that can be sold at a multiple large enough to provide more to the OMS selling their practice in the marketplace as well as a return to the DSO. Several examples of this DSO model are funded by outside investors, such as private equity. Some models involve a sale of the practice assets that may involve a funding mechanism through a hedge fund or other entity. Other similar models exist that do not require a practice asset sale but do involve a larger fee, with the same goal of gaining a return on the excess revenue greater than the OMS has relinquished for the service.

Complexities facing private practice oral and maxillofacial surgeons and new graduates alike are resulting in a shift toward the DSO model. The type of practice model that will be commonplace in the future is to be determined and historically has been subject to political and regulatory changes.

PRIVATE EQUITY

Private equity investors seek to generate a return on high-growth investments for pension funds, high net worth individuals, institutional investors, and sovereign wealth funds. Although private equity and venture capital are sometimes discussed in the same context, they are very different funding mechanisms. Private equity rarely invests in start-ups, focusing on mature companies, whereas venture capital commonly invests in start-ups. Private equity typically acquires the majority of a company, whereas venture capital typically owns a small percentage of a company. Dermatology and ophthalmology underwent extensive private equity acquisitions in the late 1990s and early 2000s. The model for investment was an upfront payment to the practice as a multiple of collections, followed by a reinvestment in the group by acquired practice owners and a contract to continue to work for the new group at a reduced income to improve earnings before interest, depreciation, taxes, and amortization (EBIDTA). Once the practice financials demonstrated growth and profitability, a second sale is undertaken to a third party at a larger multiple than the initial buyout, thus financially rewarding the private equity investors and those practitioners who reinvested and participated in the second sale.

MARKETING

Google was founded 20 years ago. Since that time, OMS practice marketing changed dramatically. Health care consumers began the transition from trusting their provider recommendation to shopping for health care. A simple search query now yields millions of results in milliseconds, processing 40,000 searches per second, 3.5 billion per day, and 1.2 trillion searches per year. Patients discover practices in a geographic designation based on the parameters set by their ad campaign. This trend does not show signs of slowing, with older computer-illiterate generations leaving the marketplace and younger computer-savvy generations fully embracing technology. Search engine optimization marries the information displayed by a practice Web site with those search queries initiated by the individual. Furthermore, targeted advertisements may appear as banners on social media because of recent queries, GPS tracking, or passive smartphone listening capabilities.[2,3] Optimization requires active participation in Web site design and formatting as well as communication and marketing through major search engines. Reputation management has also evolved as dissatisfied patients are able to use the Internet as a platform to discuss their particular complaints in an open forum, often resulting in a star rating for the practitioner. Several companies now provide reputation management

and offer strategies to avoid or eliminate negative reviews. One mechanism for reputation management involves contacting patients via text or email after services are rendered, requesting a review. The screen is often a simple thumbs-up or thumbs-down icon or a recommended or not recommended icon. Patients select the icon that best fits their experience. If patients selects a negative review, the service redirects their review to an internal quality-control response that requests additional information about their experience, forwarding the results to the practitioner. Should patients report a positive review, they are redirected to a public external domain with a request to elaborate on their positive experience. This mechanism improves practice reviews by redirecting those with negative experiences to a site isolated from the public domain.

Search engine optimization works through a combination of outbidding competitors within a marketplace, insight into the timing and nature of client searches, demographics, keywords, type of device accessed, and Web site design. Cost per click, impressions, and click-through rates are tabulated to assess advertising effectiveness (Fig. 1). The click-through rate measures how often people click an ad on viewing. Impressions are recorded each time the advertisement is presented online to an individual browsing the Internet. Cost per click is the amount paid to the advertising agency after an individual clicks the link to access the advertisement. This amount

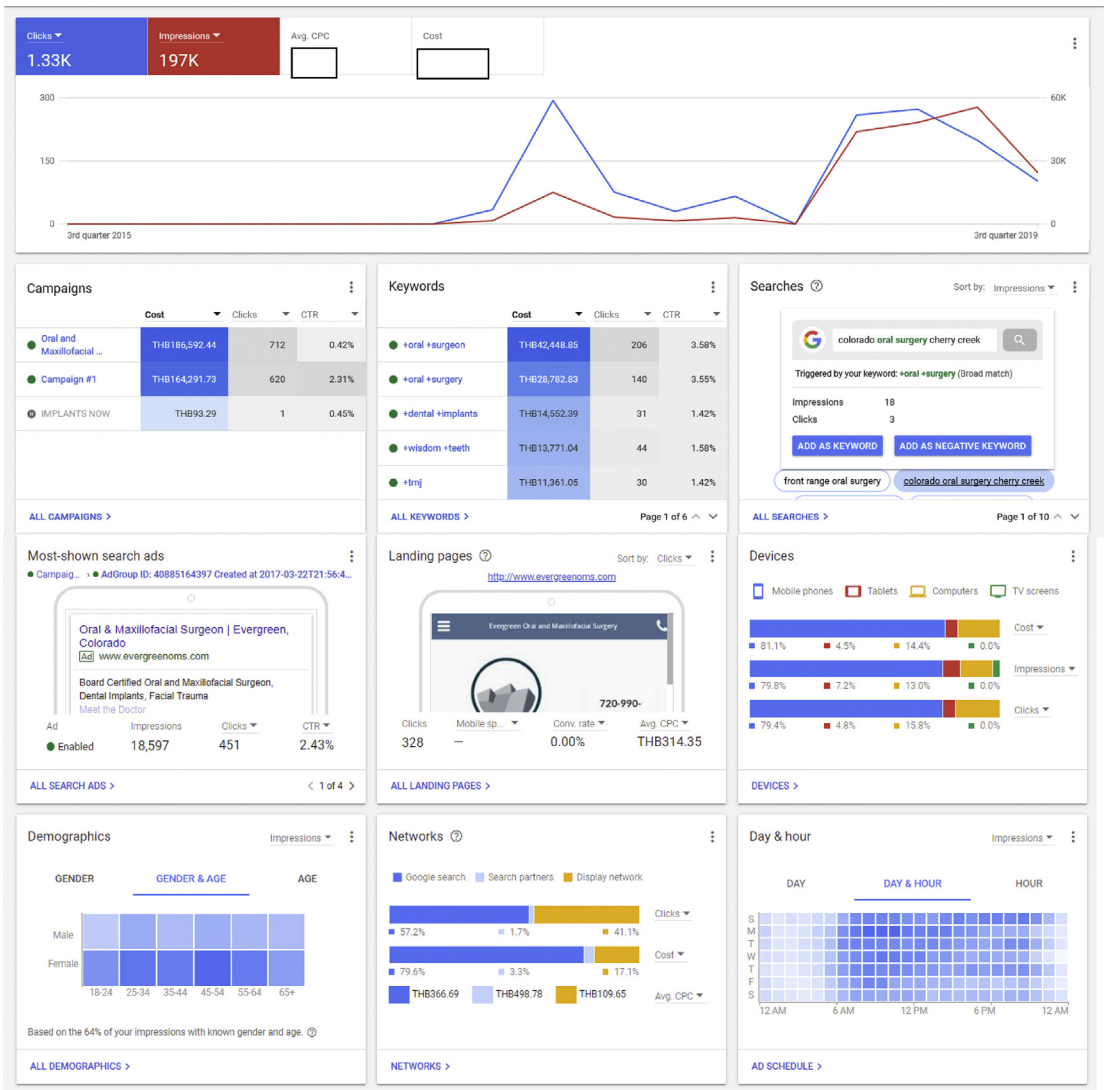

Fig. 1. Google ads dashboard.

is stipulated in advance with limits. Competitors are limited through intelligent algorithms that detect repeated clicking to exhaust a budget with the intent of removing the ad. In the continually expanding era of "Internet of things," patients likely will own their chart information on their personal devices and schedule appointments, follow-ups, procedures, medications, and complications on their personal devices.

PRACTICE FINANCE

Countless developments in research through regenerative medicine, 3-D printing, real-time robotic surgical adjuncts, and advanced imaging portend a bright future replete with enhanced surgical ability and improved patient outcomes. Societal needs for specialist services constitute a pinnacle in the hierarchy of patient care, which remains relevant. Providing those services to the public requires functional and effective business models to implement care efficiently, safely, and in a manner that sustains the practitioners and attracts new talent to the field. Without an understanding of accounting, taxes, profit and loss, and revenue cycle management, the financial health of a practice could be in jeopardy.

ACCOUNTING AND TAX

Recent tax changes arose from the Tax Cuts and Jobs Act of 2017.[4] Pertinent aspects of this legislation to the practitioner include

- Increased standard deduction
- Elimination of personal exemption
- Reducing alternative minimum tax and eliminating it for corporations
- Increased state tax exemption for individuals and couples
- General decreases in ordinary income tax
- Decrease in C-corporation tax from 35% to 21%.
- Introduction of a 20% pass-through deduction for qualifying businesses
- Limiting the state tax deduction against federal tax to $10,000

One change that is frequently asked by practitioners, or S-corporations, that own member interests in a partnership is in regard to the 20% pass-through deduction or section 199A. Despite initial enthusiasm over potential benefits this could provide to surgeons, the final bill primarily benefitted manufacturers and other businesses not classified as "service" companies.

If taxable income married filing jointly (MFJ) is below $415,000, a phased-out deduction may be qualified for. For a majority of practitioners, however, the 20% pass-through deduction yields little to no additional tax benefit (**Fig. 2**). Regardless of the potential for decreased tax savings according to the aforementioned chart (**Fig. 2**), there may be benefits to maintaining an entity tax status as an S corporation. These benefits may include

1. Avoidance of double taxation associated with C corporations
2. The tax reductions from proactive tax planning and classification of form W-2 and schedule K-1 income from the entity. **Table 1** compares types of income and the applicable tax.

Income classified as form W-2 is subject to federal income tax, state income tax, social security tax, Medicare tax, and Medicare surtax. Schedule

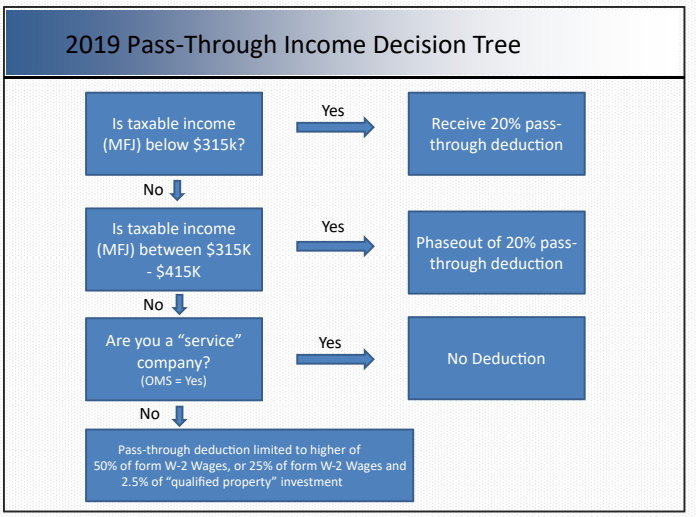

Fig. 2. Pass-through income decision tree.

Table 1
Tax comparison

Tax	Form W-2	Schedule K-1
Federal income tax	Taxable at ordinary income tax rate	Taxable at ordinary income tax rate
State income tax	Taxable at ordinary income tax rate	Taxable at ordinary income tax rate
Social Security tax	6.2%–12.4% taxable up to $132,900 (2019)	
Medicare tax	1.45%–2.9% taxable	
Medicare surtax	0.9% above $250,000 (MFJ, 2019)	

K-1 income is subject only to federal income tax and state tax where applicable. The temptation is to classify little to nothing as form W-2 income and classify everything as schedule K-1. This generally is not recommended. Although the Internal Revenue Service has not traditionally offered exact guidance on this issue, the idea is that surgeon owners should pay themselves a "reasonable salary" classified as form W-2 income, which fulfills the intended tax revenue goals of the treasury. Also, form W-2 income is considered earned income whereas schedule K-1 income is not. Earned income is necessary for the deferment and utilization of multiple and complex retirement vehicles. Without earned income, surgeon cannot defer. Because tax scenarios can vary widely, counsel of a certified public accontant (CPA) or trusted advisors should be sought on this issue.

TRANSITIONS

Surgeons at each phase of their career enjoy multiple opportunities and challenges. Whether retiring from practice, graduating from residency, or transitioning from associateship to ownership, it is important to meticulously analyze the opportunity prior to entering into a contract. Fig. 3 compares 3 practice settings available to new graduates.

Separate from determining what kind of work a surgeon wants to pursue, there is also the question of association with third-party firms for fulfilling business processes. As evidenced in other specialties, an ever-increasing compliance burden and decreasing insurance reimbursement environment is leading many surgeons to engage in larger practice partnerships, DSO groups, or management service organizations (MSO). Each of these come with risks and benefits that should be contemplated prior to entering into a new engagement. Fig. 4 compares traditional partnerships with the DSO and MSO models of practice.

For an acquisition and depending on the entity type acquired, there may be more than 1 option for completing the transaction. Although beyond the scope of this article, certain transactions may yield higher post-tax benefit through capital gains treatment as opposed to ordinary income. Any contemplated transaction should also be reviewed

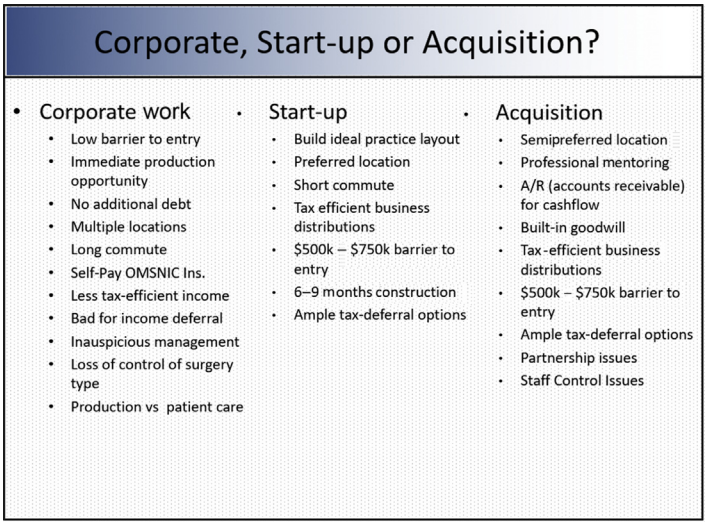

Fig. 3. Transition comparison.

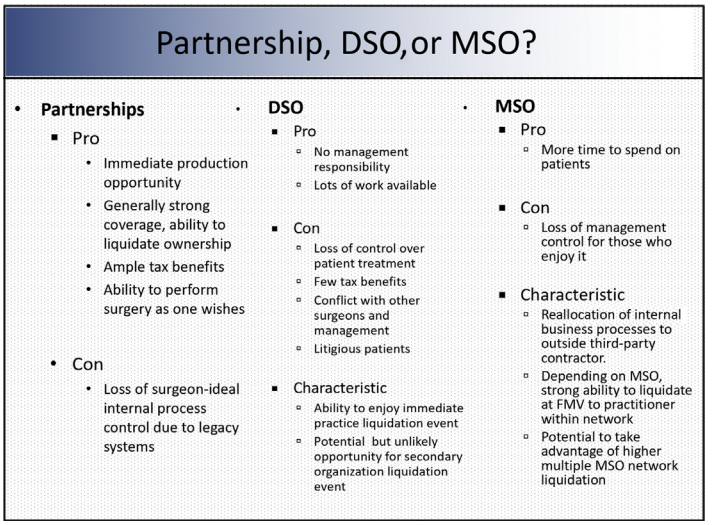

Fig. 4. Partnership, DSO, and MSO comparison. FMV, Fair Market Value.

thoroughly by legal counsel, CPAs, certified financial planners, and trusted advisors with knowledge on the subject.

MODERN ESSENTIALS OF PRIVATE PRACTICE

Following the 3 As of new practice development was a private practice adage for many years. Availability, affability, and ability were the key elements of a successful medical practice. Accounting and advertising are becoming increasingly important in the modern practice and may expand the 3 As to 5 As. This list contains some basic terms essential to understanding the financial health of a practice (**Table 2**). These terms provide information on practice metrics like profitability and earnings for a practitioner. These include

- Base salary
- Taxes
- Travel and lodging
- Continuing education
- Auto
- 401(k)/profit sharing
- Defined benefit or cash balance plan
- Insurance
- Marketing

A plan should be in place to legally minimize the tax burden by maximizing all the other items listed.

Direct operating costs deserve analysis. Approximately 80% of direct operating costs are fixed costs, such as rent, that do not vary based on how many patients are seen or procedures performed. Only approximately 20% of these costs vary based on the volume of patients seen or procedures performed. A simple way to illustrate this helps understand its importance.

In an average OMS practice, collecting $100,000 per month with a 50% overhead, $40,000 is spent because the practice exists. Another $10,000 is spent on available direct cost, leaving approximately $50,000 for the OMS to utilize. Indirect costs amount to another $5000 to $10,000 per month, reducing available compensation to approximately $40,000 to $45,000. This example illustrates the power of marginal revenue. Once the fixed costs are covered, additional

Table 2
Financial terms

Term	Definition
Gross revenue	Total receipts
Net revenue	Total receipts minus patient and insurance refunds
Adjustments	The difference in the fee schedule and what the third-party payer contracted with allow or pays for a code
Production	Total charges based on fees
Collections	Total amount of money received
Direct operating cost	Actual expenses to have a practice open
Indirect operating cost	Interest, depreciation, taxes, amortization
EBIDTA	Earnings before interest, depreciation, taxes, and amortization
Accounts receivable	Fees billed but not yet collected

Table 3
Marginal revenue comparison

Revenue	$100,000	$120,000
Direct operating	$50,000	$52,400
Indirect operating	$10,000	$10,000
Available	$40,000	$57,600

revenue has only a 20% overhead. If an additional $20,000 per month is collected, approximately $16,000 goes to OMS compensation, with only $4000 of additional overhead. Table 3 demonstrates the relationship and power of marginal revenue.

In a group of more than 50 oral and maxillofacial surgeons whose practice data are available to the authors, the average net collection per OMS is approximately $1,360,000. After direct and indirect expenses, the available money to use for the OMS is approximately 45%, or $612,000.

Retirement plans, including 401(k) and pension funding, although included in overhead, do provide additional benefit to the business owner and should be considered when calculating an owner's total financial benefit. Derived from the sample group of practices, the average percentage of operating cost allocations as a percentage of collections is illustrated in the Fig. 5.

Profit and loss statements, balance sheet analysis, and entity tax returns comprise a standard practice financial analysis. A profit and loss statement is what most practitioners utilize to demonstrate overall profitability of the practice. After the available operating income (net from direct operating cost) has been determined, a few noncash adjustments for depreciation and amortization. With the remainder amount, form W-2 or schedule K-1 income can be classified with the help of a CPA.

REVENUE CYCLE MANAGEMENT

Revenue cycle management is the process of billing and collecting revenue. It has expanded to include credentialing. Credentialing has become a complex undertaking. This is how a doctor becomes a provider for third-party payers, obtains hospital staff privileges, obtains all licenses and permits at the state and federal levels, and joins various state and national organizations.

The revenue cycle begins with the patient encounter. The encounter is recorded with a diagnosis code, and any interventions performed, including an examination, imaging, or surgical intervention, require procedure code. Only 1 fee goes with each code with few exceptions. These exceptions are documented with a modifier, indicating a more simple or more complex procedure, and the fee can be higher or lower. A flow diagram may be beneficial to visualize the process, allowing for objective evaluation of the billing lifecycle, and provides an avenue to alter processes to maximize outcomes for the practice. A basic diagram (Fig. 6) should be followed to insure a proper workflow from consult to compensation.[5] Correct coding takes place both after the initial consult and is again verified after the treatment is completed.

The codes are used to generate a bill to a patient who pays a portion and a third-party payer pays a portion. If the OMS is a contracted provider with a third-party payer, it is likely that the accepted fee will be lower than the standard fees. This difference is called an adjustment or write-off. Inherent in this process is an occasional overpayment by a patient or a third-party payer. This amount must then be refunded to the patient or insurance plan. At the end of each month, there is a cycle of production, adjustments, collections, and refunds, which results in net collections. Net

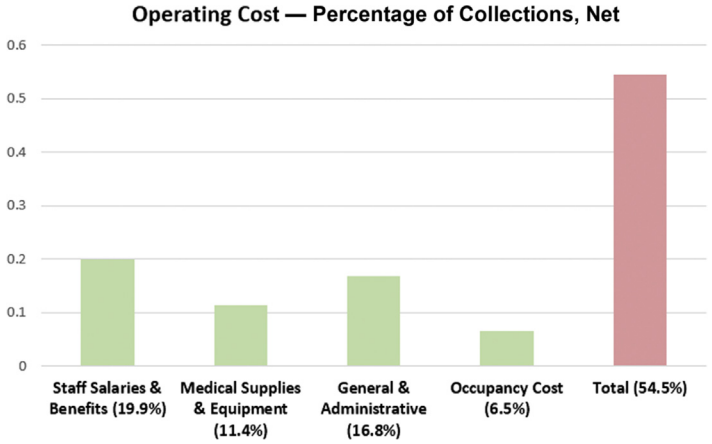

Fig. 5. Operating cost.

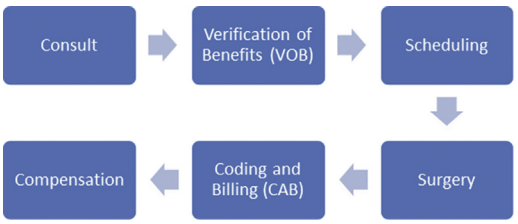

Fig. 6. Insurance cycle.

collections then pay direct and indirect operating expenses.

A practice generally is owed money by patients and insurance plans. The amounts are known as accounts receivable and a practice management system produces a monthly production/collection report that includes an aged accounts receivable report to those over 120 days. Amounts aged beyond 120 days are unlikely to be collected in a significant amount. **Table 4** lists examples of aged accounts receivable reports for a practice performing dentoalveolar only and 1 performing a mix of dentoalveolar and medically coded procedures. The percentage in the table represents an ideal or expected distribution of accounts receivable by age. The larger percent greater than 120 days with medical procedures is due to the large number of uninsured patients requiring treatment of facial trauma and infections through emergency treatment in this example.

Revenue to the OMS consist of accounts paid by patients in the office, known as time of service, and revenue paid from accounts receivable. An average practice receives 35% from time of service and 65% from accounts receivable. These percentages vary based on the variety of procedures performed and the amount of managed care plans accepted.

In the past, medical or dental services were provided and the patients paid the bills. As insurance matured and expanded, patients continued to pay the bills and received reimbursement by their insurance plan. These are precontract delivery models. Below is a list of common practice models:

1. Precontract models, now called out of network
2. In-network provider
3. Corporate employee
4. Hospital or large medical group provider/ employee

There also are at least 3 locations as potential practice patterns:

1. Office only
2. Hospital and office
3. Hospital only

Due to the large variety of procedures under the scope of OMS, all models have the ability to provide a profitable and gratifying career. In general, the greater the prevalence of dental procedures and codes, the simpler and faster the revenue cycle. As procedures commonly performed in a hospital or an outpatient surgical center increase, the revenue cycle slows. This is not a negative. With either situation, once the cycle has been running for 6 months or more, the revenue flow stabilizes, with the practice in solid financial shape. Revenue cycle management affords insight into the cyclical timing of cash flows. **Fig. 7** lists is the average cyclical cash flow timing for single provider with single-location engagements.

Because of the delay in the timing of insurance receivables, the cyclical nature of procedures performed follows a similar pattern to average net collections illustrated in **Fig. 7**. The cyclical delay will be impacted by the percentage of insurance procedures performed (as opposed to the percentage of self-pay patients), the insurance companies a practice is contracted with, and the billing & coding processes & procedures utilized. Summer is often the most productive period for an OMS and the winter season less productive. As a practical business application, high collections in August may be used to complete any unfunded 401(k) or pension liabilities accrued from prior tax year because these need to be fully funded by September after the given tax year.

Now emerging is the OMS version of a concierge medical practice. The OMS is contracted to a hospital or large medical entity with the majority of the compensation delivered as a salary. At

Table 4
Aged accounts receivable expected values

	Current	31–60 d	61–90 d	91–120 d	Greater than 120 d
Dentoalveolar	58%	18%	6%	4%	14%
Dentoalveolar/medical	60%	10%	5%	5%	20%

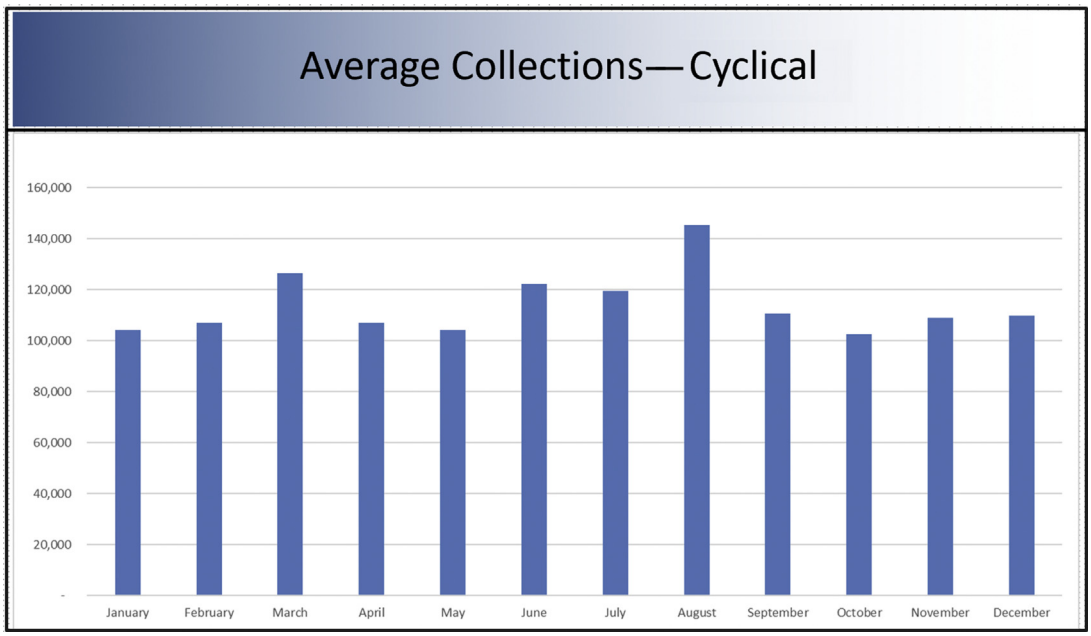

Fig. 7. Average cyclical collections, single practice.

this time there remains additional compensation per procedure performed, but most of the revenue comes as salary. The authors have observed this to be a growing niche, and it may develop into a major part of the intersection of the OMS specialty with the medical model.

SUMMARY

The practice of OMS continues to evolve. Private practice delivery of care is intrinsically dependent on sound financial processes and a robust understanding of the revenue cycle, marketing, purchasing, staff management, insurance nuances, and credentialing. Consolidation in medicine and dentistry by large corporations continues to gain market share at a time when student loan debts have reached historically high levels, leading to an increasing percentage of graduates seeking employment supplemented by independent contractor work at the offices of nonspecialists. If OMS as a specialty mirrors those of other surgical specialties, the increased complexity of delivering health care could result in a sustained decrease in private practice ownership.

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