When a medical practice changes hands, buyers and sellers usually focus first on the large, visible items: purchase price, patient charts, staff retention, equipment, lease assignment, and restrictive covenants. Yet one of the most negotiated assets in the entire transaction is often less visible and more frustrating to value, accounts receivable.

In medical practice sales, accounts receivable can look deceptively simple. The practice performed services. Claims were submitted. Money should come in. On paper, that sounds like an asset with a clear dollar amount. In real transactions, it is rarely that clean. Receivables are tied to payer rules, coding quality, patient collections, write-off history, and timing. A stack of claims sitting in the billing system may have a face value of $500,000, but no experienced buyer or seller assumes that $500,000 will actually be collected.

That is why accounts receivable are usually handled separately from the rest of the sale. The mechanics matter, and so does the judgment behind them. If the parties are careless, the result can be months of disputes over who owns post-closing cash, who is responsible for denied claims, and whether the numbers used to support the deal were realistic in the first place.

Why receivables create so much tension in a practice sale

Medical receivables are not like inventory on a shelf. Inventory can be counted and inspected. Receivables represent work already performed, but payment depends on events that may occur well after closing. A claim could be paid in full in ten days, reduced after payer review in sixty days, or denied and sent into appeal. Patient balances may linger for months. Some may never be collected at all.

That uncertainty creates a basic tension between buyer and seller. The seller usually believes the receivables reflect the value of services already delivered before the sale and should therefore belong to the seller. The buyer, on the other hand, knows that someone will need to continue working those claims after closing. Staff must post payments, answer payer requests, send patient statements, chase underpayments, and sometimes correct claim errors. If the buyer’s team is doing that work, the buyer does not want to become an unpaid collection agent for the former owner.

This issue appears in transactions of all sizes, from a solo physician selling a private practice to a regional platform acquisition. In Medical Practice Sales, the same questions come up repeatedly. Who owns the money collected after closing for pre-closing services? How long will collections continue to be remitted to the seller?

Who pays the cost of billing staff or a third-party billing company? What happens if a payer recoups money after the sale for services rendered before closing?

Those questions need clear answers in the purchase agreement and in the transition planning that follows.

The usual rule, pre-closing receivables stay with the seller

In many asset sales, the default approach is straightforward: the seller keeps accounts receivable arising from services provided before the closing date, and the buyer acquires the operating assets needed to continue the practice going forward. That separation makes intuitive sense. The seller earned the receivable, even if the cash has not arrived yet.

Still, there is a difference between legal ownership and practical collection. A seller may own the receivables, but the money may still be deposited into the practice account now controlled by the buyer, especially if payer enrollments, lockboxes, merchant accounts, and billing systems remain in use after closing. Without a carefully managed process, post-closing cash can become commingled almost immediately.

That is why experienced counsel, accountants, and healthcare transaction advisors spend so much time on collection mechanics. The question is not only who owns the receivable. The question is how the parties will identify, collect, reconcile, and distribute cash tied to services performed before the transfer.

In some Medical Practice Sales in La Jolla, this becomes even more sensitive because practices often have a heavier mix of commercial insurance, concierge arrangements, elective services, or higher patient-responsibility balances. Each revenue stream behaves differently. A dermatology or plastic surgery practice with significant patient-pay activity will face a different collection pattern than an internal medicine clinic with mostly contracted payer revenue. The same sale structure will not fit every specialty.

How receivables are valued before the deal closes

No disciplined buyer values receivables at face amount. The proper starting point is aging, adjusted by historical collection performance. A receivable that is 15 days old is not the same as one that is 120 days old. Nor is a Medicare balance equal to an uninsured patient balance, even if both show the same dollar amount.

The seller will usually provide an accounts receivable aging report broken into time buckets, often current, 30 days, 60 days, 90 days, 120 days, and sometimes older. But the raw aging report is only the first layer. A buyer or advisor will want to know how much of each bucket has historically converted to cash. They will also want to understand whether the practice tends to write off old balances aggressively or leave dead balances sitting in the ledger for months.

A practice with $400,000 in gross receivables might actually have only $240,000 to $300,000 in realistic collectible value, depending on payer mix, documentation quality, denial rates, and the age of the balances. If the billing operation is strong and most of the receivables are fresh, the collectible percentage may be at the high end. If the practice has poor follow-up or stale patient balances, the discount can be severe.

This is one area where lived operating experience matters more than theory. I have seen sellers present an aging report with impressive totals, only for a closer review to reveal that a meaningful slice consisted of old secondary claims, workers' compensation disputes, or self-pay balances that had not moved in six months. On paper, the receivables looked healthy. In practice, much of that amount was already economically gone.

The buyer's concern is not just value, it is labor

Even when the seller retains pre-closing receivables, the buyer often inherits the administrative burden of collecting them. That burden has real cost. If the buyer's front desk fields patient calls about old balances, if the billing team spends hours rebilling legacy claims, or if the new owner absorbs merchant processing fees on patient payments for prior services, those are not abstract annoyances. They reduce the economic value of the deal.

For that reason, sale documents often address collection support in concrete terms. The parties may agree that the buyer will provide billing assistance for a limited period, sometimes 30, 60, or 90 days, and that the seller will either reimburse the associated costs or accept a servicing fee deducted from collections. In other transactions, the seller keeps access to the old billing company or hires a separate team to collect the receivables independently.

The right answer depends on scale and system access. A single-physician practice with one biller may not be able to spin up a separate collection process easily. A larger group with a sophisticated revenue cycle vendor may be able to carve out legacy AR and run it in parallel. The legal structure is important, but so is basic operational feasibility.

Common ways accounts receivable are handled

The market tends to rely on a handful of practical structures:

1. The seller retains all pre-closing receivables, and the buyer forwards any money received after closing that relates to pre-closing services.
2. The seller retains receivables, but the buyer collects them for a defined period and charges a servicing fee or deducts actual collection costs.
3. The buyer purchases the receivables at a negotiated discount, usually based on aging and expected collectibility.
4. A third-party billing company or escrow-like process is used to separate and remit post-closing collections.
5. The parties use a short reconciliation period, after which uncollected receivables remain solely the seller's risk.

Each of these structures can work, but each also has failure points. A discounted purchase of AR seems tidy, for example, because it avoids months of remittance accounting. Yet it can create arguments if post-closing collections materially outperform or underperform the assumptions used in pricing. A seller-retained structure feels equitable, but only if the buyer has systems in place to identify what cash belongs to whom.

The importance of the cutoff date

One of the most overlooked issues is the precise cutoff rule. It is not enough to say that pre-closing receivables belong to the seller. The agreement should define whether ownership depends on the date of **aestheticbrokers.com Medical Practice Sales in La Jolla** service, date of claim submission, date of billing, or some other event. In most cases, the cleanest rule is date of service. If the patient was seen before closing, the receivable is treated as pre-closing. If the service occurred after closing, it belongs to the buyer.

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That approach usually works, but there are edge cases. What if a surgery package spans multiple dates? What if global billing rules apply? What if capitation payments are received monthly but relate to a patient panel straddling the closing date? What if a pathology or lab component is billed after closing for a pre-closing encounter? The more specialty-specific the practice, the more carefully these scenarios need to be mapped.

A good transaction team does not leave those issues to assumption. They identify the revenue categories likely to create ambiguity and address them directly.

Post-closing cash management can make or break the arrangement

Most disputes over receivables do not arise from bad intent. They arise from poor process. Money comes into the same bank account. Explanation of benefits are posted without enough detail. Patient credit card payments are applied to mixed balances. Then, sixty days later, the seller asks why only $48,000 has been remitted when the receivable aging suggested much more would have come in by now.

The fix is usually procedural. The parties need a disciplined remittance process, a designated point of contact, and a consistent method for matching collections to pre-closing or post-closing services. If the buyer is forwarding funds, the cadence matters. Monthly reconciliations are common. Weekly can work in a larger practice. Quarterly is usually too slow and invites mistrust.

The buyer also needs protection from becoming indefinitely responsible for someone else's old claims. There should be a practical stop date, after which the buyer has no further duty beyond forwarding funds actually received, or perhaps no duty at all if a legacy process has been established. Otherwise, the collection obligation can drag on far longer than expected.

Denials, refunds, and recoupments are where many deals get messy

Receivables are easy to discuss when they convert to clean cash. The harder questions arise when money goes the other direction. Suppose a payer pays a pre-closing claim after the sale, then audits it three months later and takes the money back. Or a patient who overpaid before closing requests a refund after closing. Or a coding issue from the seller's period triggers a recoupment against future payments now flowing to the buyer.

These are not rare events. In healthcare, they are part of the normal revenue cycle. A well-drafted sale agreement addresses them. If the seller owns the benefit of pre-closing receivables, the seller should usually bear the burden of pre-closing refunds, chargebacks, and recoupments as well. But that principle must be implemented operationally. Otherwise, the buyer can end up funding old liabilities simply because the bank account or merchant processor changed hands.

This is one place where sellers sometimes underestimate their continuing exposure. Selling the practice does not erase the history embedded in the claims. If pre-closing billing was aggressive, sloppy, or poorly documented, those problems can survive the transaction.

Patient experience matters more than many sellers expect

Receivables are not just an accounting issue. They touch patients directly. If a patient receives a statement after the practice changes ownership, confusion is common. Patients may wonder who they owe, whether the new doctor can answer billing questions, or whether an old balance is legitimate.

That is why the collection strategy should not be designed purely for internal convenience. A hard-edged push to collect every old patient balance can damage goodwill right as the buyer is trying to retain the patient base. A buyer who acquires a family medicine office, for example, may decide that very small legacy balances are not worth the friction. A seller may want every dollar pursued. Those interests are not always aligned.

Good judgment often means setting thresholds. If there are old balances under a modest amount, perhaps they are written off as part of the transition economics. If there are larger balances tied to surgical cases or

deductibles, those may justify more active follow-up. The right line depends on the specialty, demographics, and the tone the buyer wants to set with the patient community.

In affluent submarkets, including some Medical Practice Sales in La Jolla, reputation and patient continuity can be especially valuable. It can be shortsighted to win a small billing argument while creating lasting annoyance among long-term patients.

Due diligence should test the quality of AR, not just the total

A receivable aging report should prompt questions, not end them. Buyers should dig into trends. Are days in AR stable or worsening? Is there a spike in balances over 90 days? Are certain payers disproportionately slow? Have there been recent staffing changes in billing? Are adjustment codes being used consistently? Has the practice cleaned up old credit balances?

A seller with a well-run operation should be able to explain these patterns credibly. A few rough months are not unusual. Billing staff turnover, software migration, or payer enrollment delays can all distort the picture temporarily. What matters is whether the issue is understood and correctable, or whether it reflects a deeper weakness in the revenue cycle.

Here are the questions I consider essential before anyone relies on AR as a meaningful asset in the deal:

1. What percentage of receivables in each aging bucket has historically been collected?
2. How much of the balance is insurance versus patient responsibility?
3. Are there known denial patterns, payer disputes, or unresolved coding issues?
4. Who will perform the post-closing collection work, and at whose expense?
5. How will refunds, recoupments, and misapplied payments be handled after closing?

Those five questions do not solve every problem, but they expose most of the important ones early enough to price the risk intelligently.

When buyers purchase receivables outright

Sometimes the cleanest answer is for the buyer to purchase the receivables as part of the transaction, typically at a discount. This is more common when the buyer has confidence in the billing infrastructure and wants a clean break. It can also appeal to a seller who does not want months of trailing remittances or who is retiring and does not want to monitor collection reports after the sale.

The discount is where the real negotiation happens. It should reflect expected collectibility, the time value of money, and the cost of follow-up. If gross AR is $300,000 and the parties believe only $210,000 is likely collectible, the buyer might offer something below that expected net amount to account for collection effort and risk. The exact percentage will vary widely. There is no universal market rate because specialty mix and AR quality differ too much from one practice to another.

This structure can be efficient, but only when the underlying data is strong. If AR records are unreliable, the buyer will either lower the price sharply or refuse to purchase the receivables at all.

Seller financing and AR are separate issues, but they can interact

Some sellers mistakenly assume that if they are offering seller financing, the buyer should also take the receivables. Those are separate economic decisions. Seller financing addresses how the purchase price is paid.

Receivables address ownership of cash tied to prior services. Blending the two can cloud the negotiation.

That said, receivable performance can influence trust. If the seller's AR quality appears weak, a buyer may become more cautious across the entire deal, including payment terms, holdbacks, and indemnity protections. Conversely, a clean revenue cycle can support a smoother transaction overall.

Documentation is what keeps a practical arrangement from becoming a legal dispute

The best receivables provisions are not fancy. They are specific. They define ownership by reference to date of service. They spell out how money received after closing will be identified and remitted. They address timeframes, costs, access to billing records, staff cooperation, refund obligations, and recoupment risk. They also state when the buyer's administrative duties end.

A vague sentence saying the seller retains AR is not enough. In real life, someone has to open the mail, post the ERA, answer the patient, and move the money. If the agreement does not match the operational workflow, friction is almost guaranteed.

That is especially true in Medical Practice Sales where transitions are emotionally charged. A physician seller may feel deeply attached to the practice and assume the buyer will "do the right thing" with old collections. A buyer may assume that legacy billing issues are the seller's problem and devote limited attention to them after day one. Clarity prevents ordinary misunderstandings from turning into accusations.

The practical bottom line

Accounts receivable in a medical practice sale are not just a balance sheet line. They sit at the intersection of valuation, operations, compliance, and patient relations. Handled well, they can be separated cleanly and collected with minimal disruption. Handled poorly, they can sour an otherwise successful transaction.

The most reliable approach is to treat receivables as their own workstream. Test the aging. Discount for reality, not optimism. Define ownership precisely. Build a remittance process that people can actually follow. Allocate the burden of denials, refunds, and recoupments before they happen, not after. And remember that patient perception matters, especially in community-based transactions where goodwill is a core part of the value being sold.

That discipline serves both sides. Sellers are more likely to receive the value they genuinely earned. Buyers are less likely to inherit hidden labor and old billing risk. In Medical Practice Sales in La Jolla and elsewhere, that kind of clarity often marks the difference between a transaction that closes cleanly and one that keeps generating calls long after the papers are signed.