

# Hospitals to Anesthesiologists: Our Way or the Highway!

*By Patricia A. Dailey, M.D., CSA Past President; Associate Editor, CSA Bulletin*

*The following is a “how-to guide” for presenting anesthesia billing and reimbursement issues to hospital administration and board members as well as other physicians. The aim is to encourage reasonable, fact-based deliberations.*

**[All charts and pie graphs are contained in the next item on the list in PDF format.]**

**A**s demonstrated by the recent events at a hospital in the San Francisco Bay Area, hospital-based anesthesiologists are being pressured by hospitals to contract with **all** the insurers with whom the hospital contracts. Unfortunately, there are insurance payers who are unwilling to contract at reasonable rates. When anesthesiologists refuse to accept below market reimbursement by these payers, patients who have selected a contracted hospital and a contracted surgeon may find themselves anesthetized by a non-contracted anesthesiologist.irate letters have been written to hospitals, payers, physicians, and legislators with retribution threatened against the billing practices of non-contracted anesthesiologists. This now has escalated to one group of anesthesiologists being escorted from their hospital and replaced by other anesthesiologists who agree to accept all contracts.

How can anesthesiologists educate their hospital administrators, board members, hospital district leaders, surgeons, and legislators to understand our often daunting contracting issues? Let's consider a hypothetical situation using data from the 2003 CSA Reimbursement Survey. CSA members may go to the Members Only section of the CSA Web Site at [www.csa.hq.org](http://www.csa.hq.org) to obtain the results of the survey which compiled data from thirty groups representing 1,100 anesthesiologists.

Suppose your hospital administration is demanding that all hospital-based physicians contract with at least 75 percent of the hospital's contracted PPOs. Your hospital administration comes to your group with a pie chart (Chart 1) showing the hospital's top 10 PPOs (by patient volume) and has shaded the pie chart showing the PPOs with whom your group contracts. Presented this way, it doesn't look like your group is a team player. Instead of being labeled as such, you need to educate your administration about the realities of your payer mix.

Change the focus from PPOs; let the administrators know that you actually are a “team player.” Document the payers with whom you are contracted or have regulatory set rates (i.e., Medicare, Medi-Cal, Workers' Compensation, etc.).

## **Hospitals to Anesthesiologists–Cont’d**

---

For groups who practice only at full-service hospitals, PPO patients may be a small proportion of patient volume. Medicare may constitute the largest percentage. Indeed, in some hospital practices, Medicare may, in fact, comprise almost 50 percent or more of the patient volume. Compare the proportion of PPO patients to the total patient volume. Chart 2 shows median payer profile data from the CSA 2003 Reimbursement Survey. Presented this way, anesthesiologists appear very much like team players. If the anesthesiologists have contracted with the community HMO/IPA as well as some of the PPOs, then they are team players for more than 75 percent of the patients.

Next, educate your administration about the inequity in payment by Medicare and Medi-Cal for anesthesia services. All physicians receive poor reimbursement for Medi-Cal services; as a result few physicians open their practices to Medi-Cal patients. Anesthesiologists have little choice but to accept Medicare and Medi-Cal payment. Few administrators and board members know that Medicare pays anesthesiologists as poorly as Medi-Cal. Bar Graph 1 compares Medi-Cal and Medicare payment to the standard charge per unit in the absence of a contract (the traditional usual and customary rate–UCR). The data in Bar Graph 1 for anesthesiologists is based on the CSA Survey and for internists and surgeons is based on my family’s bills, compared with Medicare and Medi-Cal published rates. Medi-Cal pays 25 percent or less of UCR for surgeons, internists, and anesthesiologists. However, contrast this with Medicare, where anesthesiologists receive only 23 percent of the median UCR versus the significantly higher reimbursement for almost all other specialties. For example, Medicare pays my husband’s internist 72 percent of his UCR. The Physician Payment Review Commission (now MedPAC), a congressional advisory group, has determined that Medicare payments represent approximately 71 percent of commercial payments across all specialties. (No wonder internists are happy to receive PPO payments of 125 percent of Medicare—they end up with 90 percent of their UCR, while for anesthesiologists, 125 percent of Medicare payment would result in their receiving only 29 percent of UCR.)

Finally, point out that your group has successfully negotiated with PPO payers for reasonable reimbursement. Bar graph 2, using fictitious data, demonstrates how this may be presented. When presenting this data, be sure to point out to board members and others that Medicare and Medi-Cal are government programs for the elderly, indigent, and disabled. Furthermore, workers’ compensation is a hybrid between government and private insurer, funded by premiums paid by employers but with reimbursement rates set by state governments. In this example, PPO #6 is paying much less than other PPOs. This economic disparity among PPOs must be highlighted to avoid your being labeled as “non-cooperative.” If your hospital insisted that your group contract with all PPOs, including

## **Hospitals to Anesthesiologists–Cont’d**

---

PPO #6, this would not be reasonable. Furthermore, consider the disadvantage in negotiating when the word gets out that you “must” take all contracts.

There are PPO carriers who refuse to negotiate in good faith. Some PPOs have cost-shifted their responsibility to pay physicians to the patients. By not contracting with providers, these PPOs often wind up paying less than they would if they were contracted to those providers, thus leaving the patient with the responsibility to pay a much larger balance.

Anesthesiologists need the support of the medical community. If possible, determine the payer contract status of pathologists, radiologists, emergency medicine physicians, hospitalists, and even perinatologists and interventional cardiologists at your hospital. All too often, anesthesiologists are miscast as the poster child for non-contracting, when other specialists accept even fewer contracts. Anesthesiologists should not fight this battle alone. You should warn other specialties that they also may be forced to accept unreasonably low paying contracts or be subject to economic “decredialing.” In fact, in the now well known Ventura conflict in 2003, a group of radiologists left Community Memorial Hospital, citing onerous contract demands from the hospital.

In my 2003 Presidential Address to the CSA House of Delegates, I emphasized the importance of being “reasonable” in billing and reimbursement.

If we want to keep anesthesiologists in California, we must be paid reasonably for our services. Public and private entities must pay reasonable fees for our services, just as we have a duty to bill reasonable fees. Anesthesiologists should not be priced out of California by unreasonably low fees paid by insurance plans. Equally important, anesthesiologists should not price themselves out of the market by billing seemingly unreasonably high fees.

We need to listen and respond to complaints. We need to police ourselves; we need to explain ourselves. Patients and hospitals need to know that Medicare and Medi-Cal are not paying their fair share. As a result, anesthesiologists and hospitals are finding themselves forced to increase their fees to non-Medicare and non-Medi-Cal patients. We have no choice if we want to keep anesthesiologists in California. The key is to be reasonable in our billing practices.

This will keep us from the highway!