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AI in Anesthesia: Disruption, Opportunity and the Future of Care Delivery

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INTRODUCTION

Artificial intelligence (AI) has moved from the periphery of healthcare into daily reality. Radiology, pathology and dermatology have all seen algorithms augment human expertise in diagnostics. Now, anesthesia—a specialty uniquely positioned at the intersection of high-stakes patient monitoring, complex pharmacology and delicate reimbursement models—is beginning to feel AI's impact.

The promise is alluring: algorithms that predict adverse events before they happen, revenue cycle systems that fight payer denials automatically, and smart scheduling platforms that optimize every minute of OR time. Yet, the implications are far-reaching. AI may change how anesthesia groups are staffed, how anesthesiologists supervise cases and even how groups negotiate contracts with hospitals and insurers.

This article explores two primary domains:

1. The impact of AI on the anesthesia care team model.
2. Broader implications for anesthesia delivery, efficiency and revenue generation.

AI AND THE ANESTHESIA CARE TEAM MODEL

For decades, the anesthesia care team model has paired anesthesiologists

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with nurse anesthetists (CRNAs) or anesthesiologist assistants (AAs). In this model, anesthesiologists supervise multiple cases simultaneously, while advanced practice providers deliver direct care. Federal rules—specifically CMS's "seven steps" and the medical direction reimbursement structure—limit anesthesiologists to supervising a maximum of four concurrent cases.

AI as a Clinical "Autopilot"

Recent advancements hint at a future where AI systems act as real-time co-pilots for anesthesia delivery. Platforms already under development analyze continuous streams of vital sign data and can predict hypotension minutes before it occurs. Others use pharmacological models to adjust anesthetic depth automatically. In Europe, closed-loop anesthesia delivery systems have already shown promising results in pilot studies.

If these technologies prove reliable, anesthesiologists may be able to safely extend oversight to more rooms. Instead of relying solely on human vigilance, an AI system could flag only meaningful deviations, allowing the supervising anesthesiologist to intervene when necessary.

Will the Four-Case Limit Expand?

Here lies a key question: will Medicare and commercial carriers adjust reimbursement rules to recognize AI as a force multiplier? The current four-case limit is regulatory, not clinical—a line drawn decades ago to balance safety and cost. With AI providing continuous monitoring and predictive analytics, some argue it would be reasonable for an anesthesiologist to direct five, six or even 10 cases, provided quality and safety metrics are met.

However, regulatory change is unlikely to move quickly. CMS tends to lag behind technology adoption, and any adjustment would require strong evidence from large-scale trials showing equivalent (or superior) safety outcomes. Professional societies like the ASA would also need to weigh in, balancing the opportunity for efficiency against the risk of eroding the role of physician anesthesiologists.

In the short term, AI is more likely to strengthen the argument for maintaining the care team model rather than replacing it. If anesthesiologists can demonstrate that AI-assisted oversight leads to fewer adverse events and better resource utilization, it may become a differentiator in contract negotiations—even if the "four-case" ceiling remains fixed.

Liability and Accountability

Another wrinkle is liability. If an AI system recommends a course of action that is ignored or followed with a poor outcome, who is responsible? The provider? The hospital? The AI vendor? Until this is clarified legally, anesthesiologists may be reluctant to fully rely on automation for expanded supervision ratios.

BROADER IMPACTS ON ANESTHESIA DELIVERY & REVENUE

Beyond staffing and billing, AI is poised to influence almost every corner of anesthesia practice.

Operating Room Efficiency

Hospital administrators are under immense pressure to maximize OR throughput. AI-powered scheduling platforms can predict case durations, turnover times and bottlenecks with far more accuracy than manual methods. For anesthesia groups, improved efficiency means higher case volumes and stronger leverage in contract negotiations.

Preoperative Risk Stratification

AI can also transform pre-op workflows. By analyzing patient history, labs and comorbidities, algorithms can flag patients at higher risk for complications, allowing anesthesia teams to tailor plans, reduce last-minute cancellations and prevent costly adverse events.

Postoperative Outcomes

Post-op nausea, pain control and ICU admissions are costly complications. AI systems that predict which patients are most likely to experience these issues could guide interventions, improve patient satisfaction scores and reduce hospital penalties under value-based care models.

Contract Negotiations & Market Positioning

Hospitals and payers increasingly demand data. Anesthesia groups that can show AI-enhanced efficiency, lower complication rates and stronger denial defense will have a distinct advantage in contract negotiations. Instead of being seen as a cost center, groups can position themselves as strategic partners in hospital performance.

Cost Pressures & Role Erosion

The flip side: administrators may use AI as justification to rely more heavily on CRNAs and fewer anesthesiologists. If AI systems prove effective as safety nets, the argument for physician-heavy models could weaken. Groups must therefore frame AI adoption not as a reason to devalue anesthesiologists, but as a tool that amplifies their expertise.

AI AND COMPLIANCE: SUPPORTING CONSISTENCY AND CONFIDENCE

As regulatory expectations grow more complex, AI offers anesthesia practices a valuable tool for maintaining compliance across clinical and administrative workflows. Rather than replacing human oversight, AI enhances it—helping ensure that documentation aligns with established standards, protocols are consistently followed, and potential gaps are identified early. By embedding compliance checks into everyday processes, AI supports a more proactive, reliable approach to regulatory integrity, giving practices greater confidence in their operations and reducing the risk of costly errors or audits.

CONCLUSION

AI is no longer a futuristic concept in anesthesia—it is an active force reshaping the specialty. From the OR to the business office, algorithms are redefining how care is delivered, supervised, and reimbursed.

- The care team model may evolve, potentially enabling anesthesiologists to oversee more cases—though regulatory change will lag behind technological readiness.
- Efficiency, patient outcomes and revenue are all influenced by predictive analytics and automation. AI's ability to capture and integrate billing and clinical data in real time opens the door to a truly dynamic business model. By linking clinical decisions with documentation and coding workflows, anesthesia groups can ensure billing accuracy, reduce denials and generate actionable insights for operational improvement. This data-driven approach not only strengthens financial performance but also positions groups to respond quickly to changing payer requirements and hospital priorities.

The central question is not whether anesthesia will embrace AI, but how groups will position themselves to control its adoption rather than being controlled by it. Anesthesiologists who harness AI as a tool for safer care, stronger financial performance and more powerful contract negotiations will thrive. Those who ignore it may find themselves replaced—not by machines but by other groups who wield them more effectively.

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Anesthesia and Colonoscopy: A Fascinating Evolution of Practice and Policy

BY JODY LOCKE, MA
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Every year, approximately 15 million colonoscopies are performed in the United States. Few surgical procedures have experienced such anesthesia consideration and policy review. It has been an extensive evolution since the 1960s, the result of which has created one of the most profitable lines of business for anesthesia practices. First, there was the refinement of the endoscope, which allowed for its universal adoption by endoscopists as the most effective tool to scan the colon and rectum and remove potentially cancerous polyps. Because of the nature of the procedure, anesthesia providers began to promote the ability to enhance the surgical experience with the use of propofol resulting in a more comfortable and clinically effective screening. As the volume of anesthetic cases rapidly expanded, the real question was whether anesthesia was really necessary. It took a Medicare policy update to confirm the value of anesthesia services and with this the flood gates sprang open: anesthesia providers flocked to endoscopy clinics like lemmings to the race. As is so often the case, however, more volume meant more challenges, especially from payers who questioned the value of an additional charge for such a common procedure. The result has been new procedure codes and policy changes intended to manage the potential cost of the additional service. As the debate and policy revisions continue to unfold, colonoscopy revenue has become one of the most closely monitored aspects of anesthesia care.

THE EVOLUTION OF THE FLEXIBLE COLONOSCOPE

The procedure has a decades-old history with significant successive endoscopic innovations that eventually led to the development of the current colonoscope. Colonoscopy first commenced in 1960s, stemming from innovations in upper endoscopy. Gradual innovations into imaging technology, guideline developments and increased awareness led to increases in access and utility expansion. The first scopes were stiff and awkward to manipulate through the colon, but the current technology allows a complete screening of the rectum and colon, despite its curves and anatomical idiosyncrasies.

It is an optimal procedure for identifying precancerous polyps and recommended for screening individuals with risk factors, such as a family history of polyps or cancer. The impact of the current screening protocol greatly reduces the risk of colon cancer.

According to the American Cancer Society, the estimated incidence of colon cancer in the United States in 2023 is:

- **153,020 new cases**
- **106,970**: in the colon
- **46,050**: in the rectum

Colorectal cancer is the second most common cancer diagnosed in both men and women in the United States. The incidence rates vary by age, race and ethnicity. For example, the rate is higher in older adults and among non-Hispanic white, African American and American Indian/Alaska Native populations.

The general lifetime risk of developing colorectal cancer in the United States is about 5% to 6%, with estimates around one in 23 men and one in 25 women, according to the American Cancer

Society. Risk factors such as age, family history, certain genetic mutations, inflammatory bowel diseases and specific racial and ethnic groups, can increase an individual's risk above this general population average.

THE ROLE OF ANESTHESIA

While many endoscopists would provide their patients a degree of sedation, this was not always adequate and often impacted the quality of the screening. Anesthesia providers saw this as a great opportunity. Numerous clinical mishaps, such as the death of Joan Rivers, underscored the need for a separate provider to monitor the patient through the procedure.

Anesthesia is valuable in colonoscopy because it increases patient comfort and procedural safety, improves adenoma detection rates (ADR) and completeness of the procedure, and allows for better patient cooperation. While some procedures can be performed without it, anesthesia's benefits in reducing patient discomfort and improving the quality of the examination often outweigh the associated costs, though there is ongoing discussion about standardization and appropriate use.

Key Benefits of Anesthesia in Colonoscopy

Patient Comfort and Safety:

- Anesthesia ensures patients are relaxed, comfortable and have little to no memory of the procedure, enhancing the overall experience. The anesthesia team monitors vital signs to ensure patient safety.

Improved Quality of the Procedure:

- Sedation provides optimal conditions for the endoscopist, which can lead to increased ADR and a higher likelihood of complete examination, including reaching the cecum and ileum.

Enhanced Patient Cooperation:

- Patients under anesthesia are less likely to move or be distressed, allowing for a more thorough and efficient procedure.

Facilitates Treatment:

- With a more comfortable and cooperative patient, procedures like polyp removal become more manageable and less likely to be perceived as painful by the patient.
- Most endoscopists will also admit that having a separate anesthesia provider allows them to be more efficient.

ANESTHESIA PAYMENT POLICY

As anesthesia providers started to get more involved with endoscopic procedures, the question of the day became simply will there be payment for anesthesia? Payer policies varied, and a number of major health plans refused to pay for anesthesia for endoscopic procedures. This became a source of considerable frustration. Then, in 2015, Medicare provided a definite answer with a policy announcement.

> *If you provide anesthesia for a Medicare patient undergoing a screening colonoscopy, you will be able to collect 100 percent of the allowable amount from Medicare and will not need to bill the patient for any co-payment or deductible, beginning on January 1, 2015. You must, however, identify the service as screening rather than diagnostic or therapeutic through the use of the appropriate modifier on your claim.*
>
> *In the interest of making preventive care more widely available, a provision of the Affordable Care Act, Section 4104, waived "colorectal cancer screening test" co-payments and deductibles for Medicare beneficiaries. For the same reason—to avoid patient cost-sharing's becoming "a significant barrier to these essential preventive services"—CMS extended the waiver of coinsurance and deductible to anesthesia services furnished in conjunction with a screening colonoscopy in the Final Rule on the Physician Fee Schedule for 2015.*

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Anesthesia and Colonoscopy

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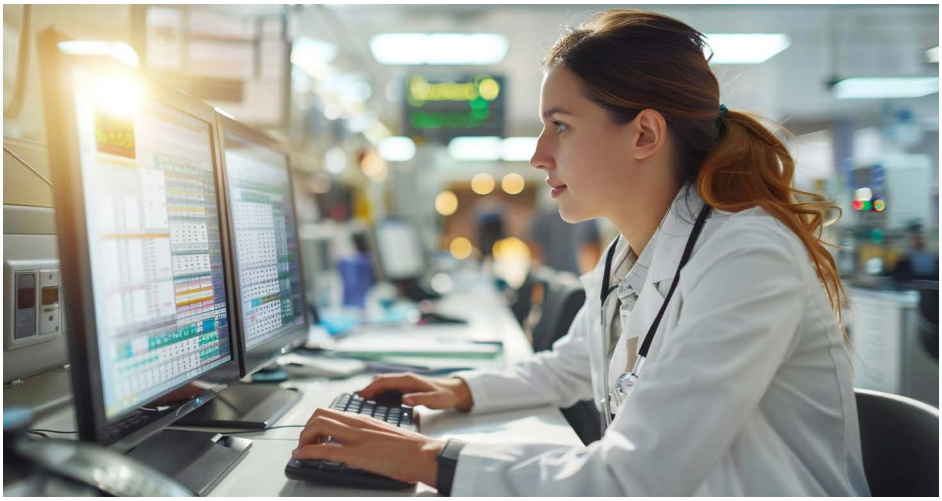
This had a profound impact on the market. Acting on the assumption that, as goes Medicare, so go the rest of the payers, anesthesia providers began increasing their role in providing care for endoscopic procedures. All across the country, endoscopy became the new frontier.



NEW ENDOSCOPIC CODES

The Relative Value Guide (RVG), published by the American Society of Anesthesiologists (ASA), had included two ASA codes for endoscopic procedures: ASA 740 for upper GI procedures and ASA 810 for lower GI. Both had a base value of 5. In 2018, the CPT coding manual introduced five new codes for endoscopic procedures to replace the two historical codes. See Table 1.

The focus of these new codes was essentially to lower the base value for lower GI procedures, including colonoscopy. The impact of these new codes resulted in about 10% reduction in endoscopic revenue. The curious issue here is that Medicare dropped the base value for 00812 to 3 units. As is so often the case, new codes are designed to help control and manage the revenue potential of these procedures.

THE NET IMPACT OF POLICY CHANGES

A review of five years of data for colonoscopies from ten large Coronis Health clients indicates the basic trends of this part of the business. The majority of patients have commercial insurance, which pays well. Medicare patients represent about one-third of all cases at discounted Medicare rates. Self-pay patients with no insurance are a very small piece of the overall pie. See Table 2.

The volume of colonoscopies started to grow in 2020, just before the pandemic. But once it ramped up, case volumes have been quite consistent.

As is often the case, Medicare and Medicaid rates have a significant impact on the overall net yield per case. Payer mix is always determinative in the calculation of the profitability of the service. As indicated in Table 3, the overall average yield per case is approximately $260. Clearly, the efficiency of the venue and the average number of cases performed per day is the most critical factor in determining profitability.

This review clearly demonstrates the potential value of endoscopy to the anesthesia practice. The thing to

TABLE 1: NEW CODES FOR ENDOSCOPIC PROCEDURES

CODE	BASE VALUE	DESCRIPTION
ASA 731	5	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum
ASA 732	6	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography(ERCP
ASA 811	4	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum
ASA 812	4/3	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy- (3 units for Medicare)
ASA 813	5	Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum

TABLE 2: CASES BY PAYER					
	2020	2021	2022	2023	2024
Medicare and MR HMO	11,463	16,078	19,183	18,539	18,809
Medicaid and Medicaid HMO	2,717	4,512	5,643	5,948	5,073
Participating Plans	15,122	21,731	26,370	28,348	27,424
Others	3,046	4,521	5,174	5,010	4,557
Self-Pay	140	228	275	291	311
Totals	32,488	47,070	56,645	58,136	56,174

TABLE 3: AVERAGE YIELD BY PAYER					
	2020	2021	2022	2023	2024
Medicare and MR HMO	$158.70	$156.31	$151.30	$153.96	$167.69
Medicaid and Medicaid HMO	$99.50	$99.50	$81.81	$98.81	$93.83
Participating Plans	$397.12	$407.26	$405.19	$418.78	$444.99
Others	$307.96	$307.88	$292.11	$277.13	$287.18
Self-Pay	$274.12	$191.85	$122.84	$244.94	$379.03
Overall Average	$262.44	$263.71	$256.41	$254.79	$259.51

CHART 1: COLONOSCOPIES BY PAYOR

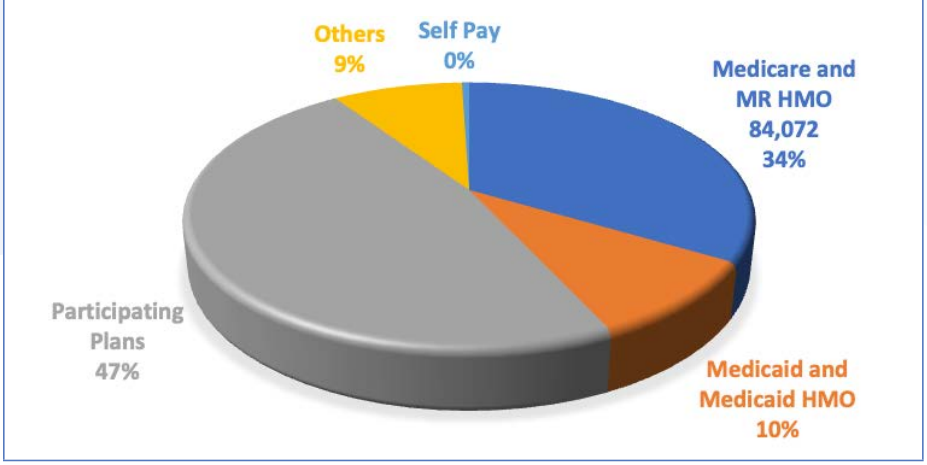
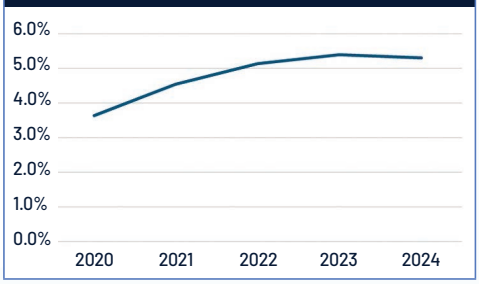


CHART 2: % OF PRACTICE REVENUE



remember is that success in endoscopy is all about volume and efficiency of the clinic.

FINAL THOUGHTS

As Chart 2 indicates, about 5% of most practice revenue comes from colonoscopy, and this trend is gradually increasing. In other words, endoscopy is always likely to be an important component of an anesthesia practice, despite inevitable payer policy changes. The evolution of anesthesia payment for endoscopy is a typical case study but is not unique. Managing an anesthesia practice optimally is a never-ending process that requires constant vigilance and attention to detail.

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Flip Rooms in the OR: Why Administrators Push for Them—and Why Anesthesiologists Often Don't

BY GARY KEELING, CPA, MBA
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A "flip room" assigns one surgeon to two adjacent ORs with two full OR teams. While one case is finishing in Room A (closing, emergence, cleaning), the next patient is induced and prepped in Room B. The surgeon "flips" between rooms so knife-to-skin time is maximized for that surgeon.

FROM THE FACILITIES PERSPECTIVE, EACH MINUTE OF UTILIZATION IN THE OR IS EXPENSIVE.

A variety of cited analysis of hospital cost reports estimates the **mean cost of OR time is $36–$37 per minute,** which includes all direct and indirect costs. Still other studies have put the cost much higher, in the $46 to $60 per-minute range.

Surgeons are proponents of flip rooms and, in theory, flip rooms should improve efficiency and profitability. For example, assuming room turnover time is 20 minutes per case at $37/min, 20 minutes saved is $840 of OR time for each case.

The goal of many facilities is to achieve combined OR utilization rates greater than 60% in order to meet the clinical needs and financial targets of the facility. This requires OR capacity be backfilled with more OR cases, requiring effective scheduling and planning.

WHY ADMINISTRATORS LIKE FLIP ROOMS

Surgeons are among the highest revenue generators in hospitals. Flip rooms reduce surgeon downtime and allow more cases per day, which translates into higher throughput and financial returns. This, coupled with reduced downtime of idle ORs, saves significant OR operating costs. Many health systems are under pressure to shorten wait time, and flip rooms are appealing in that they aid in reducing surgical backlogs, expand patient access and meet volume targets.

In addition to the direct financial incentives, hospital administrators benefit by offering efficient schedules that attract and retain busy, high-volume surgeons. Hospitals can market this efficiency as a perk, strengthening their reputation in competitive markets. Since orthopedic cases are often major utilizers of flip rooms, recruiting and retaining orthopedic surgeons is a high priority to most health systems. For example, a 2019 survey published by Merritt Hawkins estimated that the average orthopedic surgeon generates $3.3 million in hospital revenue annually. If a health system can recruit and retain a robust orthopedic team of surgeons the profitability of the hospital increases significantly.

WHY ANESTHESIOLOGISTS DO NOT LIKE FLIP ROOMS

Unlike surgeons, anesthesiologists do not have a main task in surgery, and they remain responsible until emergence, transfer and recovery are complete. With flip rooms, they're often pulled between induction in one OR and emergence in another, creating unsafe overlaps. Anesthesia requires constant vigilance, and rushing to complete pre-op assessments or dividing attention between rooms increases the risk of missed complications during induction or emergence, which are two of the most critical phases of anesthesia care. Since anesthesia care is continuous, flip rooms often ignore this reality, prioritizing surgical efficiency over anesthesia safety and workflow. This mismatch creates tension between surgical and anesthesia teams.

From a documentation prospective, anesthesiologists must complete real-time, detailed records; and managing

two rooms raises the risk of delayed or incomplete documentation, which can impact compliance, billing and medico-legal safety. Since anesthesia is already a cognitively demanding specialty, flip rooms eliminate natural pauses, heighten pressure and increase fatigue, which may contribute to burnout and reduced job satisfaction.

Case Example:

Facility: Community hospital orthopedic service. Busy arthroplasty surgeon requests a flip room. The surgeon expects to complete 12 cases by noon.

Setup: Two ORs, two anesthesia providers.

Metrics to evaluate:

- **Additional anesthesia hours**: If the second operating room is utilized sporadically, care team productivity (ASA units per provider day) is negatively impacted.
- When the second room is less productive, the costs of anesthesia care are greater than revenues, which becomes financially challenging for the anesthesia department.
- If combined utilization slips to 50%, the hospital ties up two rooms to get the output of one, while anesthesia schedules two providers to provide coverage. Since staffing costs of anesthesia providers continue to soar due to a national anesthesia staffing shortage, underutilized anesthesia providers become a loss to the group and the health system since many departments are subsidized.

WHAT'S THE SOLUTION?

Ultimately, sustainable efficiency requires collaborative solutions developed by anesthesia clinicians and hospital administration. Regular meetings need to be scheduled with robust OR efficiency reporting, the evaluation of case scheduling backlogs and the budget impact of each flip room strategy.

Some collaborative strategies may include the following:

- **Dedicated anesthesia teams**: Assigning two anesthesia providers (e.g., anesthesiologist and CRNA) to each flip room to ensure safe coverage of both induction and emergence.
- **Anesthesia tech and PACU support**: Expanding the role of anesthesia technicians or PACU staff can reduce the workload of anesthesiologists during turnovers.
- **Smart scheduling**: Limiting flip rooms to certain types of procedures (e.g., shorter, lower-risk surgeries) may reduce safety risks.
- **Cross-disciplinary planning**: Involving anesthesiologists in OR efficiency planning ensures their concerns are factored into scheduling decisions.

CONCLUSION

Flip rooms illustrate the ongoing tension between efficiency and safety in healthcare. For administrators, they promise improved throughput, higher revenue and happier surgeons. For anesthesiologists, they pose risks of overload, compromised vigilance and burnout.

The truth lies somewhere in between: while flip rooms can improve numbers on paper, they must be implemented with careful consideration of staffing, safety and the realities of anesthesia care. Hospitals that prioritize short-term efficiency over long-term team sustainability risk alienating critical staff and, more importantly, compromising patient safety.

GARY KEELING, CPA, MBA

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Practice Economics in Anesthesiology: A Framework for Optimization

BY DAVID J. PLATT, MPA
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The practice of anesthesia has seen a dramatic evolution during the first quarter of the 21st century. While anesthesia provider shortages have been a persistent issue for decades, the crisis has now reached an unprecedented peak. The trend is driven by myriad factors, including an aging population, retiring anesthesiologists outpacing residents and an expansion of anesthesia services, particularly in outpatient settings. The American Society of Anesthesiologists (ASA) has reported "The percentage of facilities reporting an anesthesia staffing shortage increased from 35% in early 2020 before the pandemic to 78% in late 2022".[1]

Because of this shortage, practices must optimize their economic models for long-term viability. This article explores the key drivers in this optimization: practice revenue and costs.

OPTIMIZING PRACTICE REVENUE

According to the latest major industry compensation surveys published in 2025, anesthesiologist and CRNA salaries are at an all-time high. As a result, every anesthesia organization, regardless of employment structure, must closely monitor revenue performance to ensure optimized revenue to support recruitment and staff retention. The

major driver in this regard: revenue cycle management (RCM) operations.

Front-End RCM. The revenue cycle begins here, making it the most critical point for optimizing reimbursement. This RCM segment gives the most control over a smooth collections process by preventing pre-claim errors and omissions. This begins with accurate and complete reception of all anesthesia case components. When available, the billing platform should integrate with facility electronic medical records (EMRs) for greater efficiency, accuracy, and shorter Days in AR.

- Secure Health Level Seven (HL7) feeds for **patient demographics** are ideal, as they auto-populate protected health information (PHI) into the billing system, improving efficiency and accuracy while eliminating manual data entry. This ensures patient billing information is as accurate as the data within the facility's EMR.
- For accurate and compliant billing, **clinical anesthesia data** should be automated whenever possible. If structured data cannot be ingested by the billing platform, an electronic image of the anesthesia record will often suffice for the medical coder.
- After all patient data is received, **full case reconciliation** is essential to ensure complete case capture, for both operating room (OR) and out-of-OR cases. This is done by receiving each day's final surgical schedule, inclusive of add-on cases or cancellations, and comparing patient data received to confirm all anesthesia services provided were received. Out-of-OR services may not be included in the EMR's schedule received. Therefore, collaboration between the billing operation and facility is required to ensure these services are captured and reported effectively.
- **Patient insurance eligibility verification** is a crucial step prior to claim submission to prevent denials and payment delays due to inaccurate insurance information. This goes far toward the goal of the cleanest possible claim, minimizing rework on the back-end, where focus can be directed toward proactive AR follow-up.

1 American Society of Anesthesiologists (ASA), "Anesthesia Workforce Shortage Poses Threat to Health Care," news release, June 17, 2024, https://www.asahq.org/about-asa/newsroom/news-releases/2024/06/anesthesia-workforce-shortage-poses-threat-to-health-care

- **Anesthesia-exclusive certified coders** are the standard to accurately capture the unique nuances of anesthesia coding. Additionally, remote access by the coder directly into the EMR for the surgeon operative report is highly recommended (if not provided in the transmission) since anesthesia providers do not consistently depict exactly how a surgical procedure is performed. Experienced anesthesia coders can capture additional revenue by confirming complex case elements in operative reports, allowing them to code higher ASA codes. Preventing repetitive coding oversights can prevent substantial annual missed revenue across a practice's case mix.

Back-End RCM. Once claims are submitted, edited and received by the payer in the correct format, the back-end processing commences. This is where the fruits of the front-end labor are recognized.

- **Insurance denials and rejections** will continue to happen, though fewer, despite the cleanest front-end processes. Errors must be corrected, and any supplementary patient data provided promptly to meet appeal deadlines and minimize lost revenue. Analyze denial patterns and optimize front-end workflows accordingly to ensure consistent, healthy cash flow.
- **Automating patient responsibility follow-up** to the extent possible, through text messaging of statements and reminders interspersed between mailed statements can expedite the patient AR process. Increase effectiveness by offering an online payment portal, accessible via a link within text reminders or a QR code on paper statements.
- **Automated contractual payment accuracy** logic embedded within the billing system should be utilized to rectify insurance underpayments. Insurers' failure to update adjudication systems after unit reimbursement increases is a leading cause of underpayments. Further, payers may overlook single billable units, like those for physical status or modifying circumstances, even when contractually required to reimburse.

MANAGED CARE CONTRACT NEGOTIATION: OBSTACLES & OPPORTUNITIES

While the No Surprises Act (NSA), effective 1/1/2022, provides patient protection by eliminating balance bills for out-of-network (OON) services, it has also undermined managed care contracting for anesthesia groups. The end of balance billing removed a powerful negotiation tool for groups—terminating a payer contract to seek higher OON payments. This shift has unintentionally empowered payers, making negotiations more challenging. Still, groups must be proactive with their contracting approach.

- Begin renegotiations well in advance of a contract's renewal, especially for payers representing a substantial portion of the payer mix. Renegotiation is now more difficult and prolonged.
- Conduct thorough market research, leveraging all accessible information, with a regional focus. Public surveys identifying such data for anesthesia are published annually by the ASA Committee on Economics. Understand where your practice sits in relation to this benchmark data. This will give you a sense of the reasonableness of the proposed unit rate.
- Make efforts to renew for three-year terms with annual escalators, which will help offset increasing costs and reduce the administrative burden of yearly negotiations.
- Engage experts. In this challenging managed care contracting climate, these professionals can be invaluable, given their experience and access to data and market trends. This is most warranted when dealing with insurance plans that represent a substantial portion of the payer mix.
- While the above strategies may be less fruitful than pre-NSA, the anesthesia group must still exhaust all options to strive toward healthiest cash flow. When a payer refuses to offer reasonable rates, however, OON is still an option.

NSA and the IDR Process. After the practice has diligently researched market rates for their region and believes the best offer from a payer is below market, or the qualified payment amount (QPA) for that payer, they have the option to go OON. According to federal

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guidelines, the QPA is the median of the contracted rates recognized by an insurance plan on January 31, 2019, for a similar service provided by similar specialties in the geographic region where the service is furnished, increased for inflation in each subsequent year.[2] Payers are required to reimburse OON services at this QPA.

- Note, there is no requirement for a payer to disclose their calculated QPA to an anesthesia group who is considering going OON with that payer. The only way to determine the QPA is for the group to be OON and submit a bill to the payer to learn their QPA from the explanation of benefits (EOB) received.
- The anesthesia group may commence the independent dispute resolution (IDR) process if they opt OON, and after viewing the EOB, deem the QPA to be unreasonably low or question the legitimacy of the calculation. During IDR arbitration, an arbiter awards the settlement by selecting one of the payment offers from either the provider or payer, often referred to as "baseball-style arbitration."
- A trend has emerged where anesthesia groups are successfully navigating the IDR process. When federal arbitrators were used for payment disputes in 2024, they sided with anesthesiologists over 80% of the time, leading to fair payments from insurers (American Society of Anesthesiology, 2025).[3]

COST OPTIMIZATION

For anesthesia practices, provider compensation is the single greatest cost. The national provider shortage has caused this to reach peak levels. Anesthesia practices have low overhead—typically under 10%, compared to 55 – 65% for surgical and office-based specialties. However, anesthesia collections are unlikely to cover practice expenses when providers' income is at fair market value. According to widespread industry reports, facility stipends are used to cover this revenue deficit for more than 80% of independent anesthesia practices. To optimize staffing, it is crucial to consider anesthesia locations and hours, case mix and acuity, the historical staffing model and provider availability in the market.

The four most common anesthesia staffing models:

- Physician-only: Anesthesiologists personally performing their own cases.
- Anesthesia care team: Anesthesiologists directing CRNAs or anesthesiologist assistants (CAAs)
- Collaborative: Physicians and CRNAs are part of the same group, but each performs their own cases independently. Modifier QZ is appended to the CRNA's bill. This model has seen strong growth over the last 10 years driven by provider shortages and rising provider costs.
- CRNA-only: CRNAs manage cases independently without medical direction from an anesthesiologist.

2 IRS Notice 2025-8, Internal Revenue Bulletin (IRB); p. 813. February 18, 2025; IRB 2025-08 (Rev. 2-18-2025)
3 American Society of Anesthesiology, Private Payer Policies. August 18, 2025; https://www.asahq.org/advocating-for-you/private-payer-policies

When provider expense is looked at in isolation, the physician-only model carries the highest cost, while the CRNA-only model, the lowest. However, cost is only one of many interrelated variables.

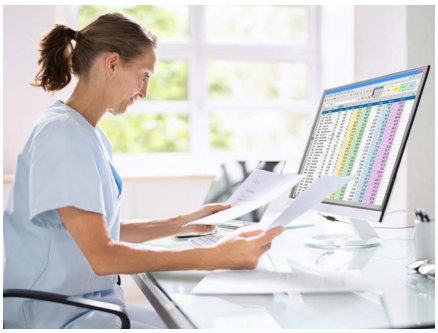
Case mix acuity. For facilities with a high acute case mix, maintaining a 4:1 anesthesiologist-to-CRNA ratio is unfeasible. A 3:1 ratio can also be challenging, particularly due to complex, high-risk patients requiring intervention from the anesthesiologist.

Historical staffing and mid-level provider availability. In situations where a physician-only model is in use, even if the case mix suggests a care team ratio of 3:1 or greater is achievable, transitioning to a care team model is often curtailed due to recruitment challenges around CRNA/CAA availability in the market. Often, this is a phased approach, starting with smaller segments of the anesthesia practice, such as ASCs or endoscopy suites. Additionally, CAAs are presently authorized to work in only 22 states.

Rising cost of provider salaries. CRNA cost-effectiveness is diminished as the care team ratio approaches 2:1, especially since CRNA total compensation is now about half that of an anesthesiologist. The consulting firm SullivanCotter reported a 21.9% increase in total cash compensation for CRNAs between 2021 and 2024 in its 2024 Advanced Practice Provider (APP) Compensation and Productivity Survey.[4]

Recent negative insurer trends toward CRNA services. Over the last three years, major insurance companies have imposed reimbursement cuts directly to CRNA's practicing independently with the QZ modifier. In 2023, Cigna implemented a 15% discount on QZ CRNA services in most states, with seven states being exempted due to state law. In 2024, Anthem imposed the same 15% discount in certain states (NY, OH, MO, CT, ME, NV). Finally, UnitedHealthcare has announced a 15% pay cut to QZ CRNA services, beginning in October 2025 (excluding eight states).

The facility is just as motivated as the anesthesia group to keep stipends manageable when optimizing the staffing model. Collaboration can lead to significant improvements, including optimizing OR efficiency, maximizing block time utilization, reducing delays and cancellations and turnover time. The anesthesia group can provide input for daily schedule adjustments that support these objectives.



THE PATH FORWARD

It is incumbent upon the anesthesia practice to ensure prudent management and effective operation in all aspects of their practice. This involves optimizing RCM by implementing effective strategies to enhance workflow to maximize collections, and strategic managed care contracting to drive the best potential reimbursements. The group must also manage staffing costs by optimizing its staffing mix while offering competitive market compensation to recruit and retain providers. By methodically optimizing each of these areas, the anesthesia group can justify that its stipend (or potential stipend request) is not a subsidy for inefficiency, but a data-driven calculation of the remaining financial gap required to deliver essential, high-quality services to the facility and its patients.

4 SullivanCotter, 2024 Advanced Practice Provider (APP) Compensation and Productivity Survey. October 23, 2024

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Pre-Operative Clinics and the Ascent of Perioperative Medicine

BY CHRIS STEEL, MD
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Chief Medical Consultant, E1 Precision Consulting and Long Game Health, Batesville, AR

Perioperative medicine is a multidisciplinary field, but the earliest formal pre-operative clinic models came out of anesthesiology. As early as 1949, anesthesiologists described dedicated outpatient assessment clinics; and, by the late twentieth century, both U.S. and U.K. standards placed pre-anesthesia evaluation squarely within anesthetic practice. Those roots helped today's perioperative programs—now co-led with surgery, hospital medicine and nursing—scale from screening to true medical optimization.

WHY PRE-OP CLINICS MATTER

Clinical reliability

Anesthesia-directed clinics reduce avoidable variability: unnecessary testing drops, medication reconciliation improves and day-of-surgery disruptions are less frequent. As pre-op becomes the "front door" for education and optimization, downstream care is more predictable.

Better outcomes and experience

Enhanced recovery after surgery (ERAS) pathways consistently link pre-op education, nutrition and anemia management, glycemic control, obstructive sleep apnea (OSA) screening and opioid-sparing plans to fewer complications and shorter length of stay. Patients also report a smoother journey when expectations, instructions and contacts are standardized upstream.

A common playbook

The American Society of Anesthesiologists (ASA) Committee on Perioperative Medicine, ACS Strong for Surgery, the Society of Hospital Medicine's co-management resources, and cross-disciplinary societies such as evidence-based perioperative medicine (EBPOM), American College of Preventative Medicine (ACPM), the ERAS Society and others have all contributed to an ever-increasing body of knowledge making scaling possible.

REAL-WORLD EXAMPLES

New Hanover Regional Medical Center, Wilmington NC

They began their perioperative surgical home (PSH) with the orthopaedic total joint replacement service line. They went from paying a readmission penalty to at one point having the lowest readmission rate in North Carolina. They subsequently scaled their clinic to optimize 16 different surgical service lines.

Duke (PASS/POET Clinic)

This preoperative anesthesia and surgical screening (PASS) clinic serves 90% of their 50,000 cases, and flags 15-20% of patients for additional optimization. Much of that can be done by their perioperative enhancement team (POET). This has resulted in reductions in length of stay, 30-day readmission rate, blood transfusions, along with many other published benefits.

BILLING: WHAT'S BUNDLED VS. WHAT'S BILLABLE

A persistent source of confusion is the difference between the pre-anesthetic evaluation and separate, medically necessary evaluation and management (E/M) services:

Bundled: Under Medicare and most payers, anesthesia base units include the usual pre- and post-operative visits. Your standard pre-anesthetic evaluation is part of the anesthesia service and not separately reportable.

Billable when distinct: If your clinic provides medical optimization that is

separate and medically necessary (e.g., chronic disease tuning, medication adjustments, anticoagulation planning, perioperative risk counseling), you may report evaluation and management (E/M) (9920x/9921x) when documentation supports medical necessity and medical decision making (MDM)/time. Teams using physicians and advanced practice providers (APPs) should align to current split/shared rules where applicable.

Don't forget advance care planning (ACP). For higher-risk patients, pre-op is an ideal moment to clarify goals of care. CPT 99497 (first 16–45 minutes) and 99498 (each additional 30 minutes) are separately billable when time and required elements are documented. Many systems underuse these codes despite clear clinical value.

ARE WE LEAVING MONEY ON THE TABLE?

Yes—many perioperative programs do the work but don't consistently capture appropriate revenue:

Pre-optimization underbilling

National surgeon surveys show that large majorities do not bill for pre-optimization despite meaningful time spent on risk modification and coordination—signals that similar gaps likely exist in anesthesia-led pathways when E/M is clinically appropriate but not distinguished from the pre-anesthetic exam.

ACP and counseling codes are underused

System-level analyses repeatedly find low uptake of ACP (99497/99498) even in populations where these services are relevant and covered. Pre-op clinics routinely address these topics; failure to document time/content means missed quality and missed revenue.

Bottom line

There's no published national percentage of pre-op clinics that bill; however, multiple datasets show very low billing rates for billable perioperative services, suggesting most clinics are leaving money on the table while doing the work.

PRACTICAL STEPS TO MATURE YOUR CLINIC

1) Start with the business & billing framework. Stand up governance, compliance program and infrastructure that let you bill when indicated:

- Define which visits can be separate E/M vs. bundled anesthesia evaluations.

- Create distinct note types/headers (e.g., "Perioperative Medicine E/M") and smart-phrases that prompt for medical decision-making (MDM) or time documentation.
- Build order sets and charge-capture workflows for E/M and ACP; map who can bill what (MD/DO vs. APP) and when split/shared applies.
- Educate coders/clinicians; run monthly audits with feedback loops.

2) Define the clinical scope. Publish a one-page charter: who gets seen, which risks are targeted, what testing is indicated (and what is not), and where optimization handoffs go.

3) Build standard content. Smart-phrases and checklists for patient education; medication holds/bridges; nutrition and anemia; diabetes and OSA algorithms; opioid-sparing plans; and perioperative anticoagulation pathways.

4) Operationalize documentation. Distinguish the pre-anesthetic evaluation from any separate E/M visit (problem-oriented documentation; explicit time/MDM; clear chief complaint/assessment). Add quick-selects for ACP and counseling with required elements.

5) Measure and iterate. Track timeliness, adherence to testing algorithms, LOS, complications, patient-reported experience—and the rate of appropriate

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Pre-operative Clinics and the Ascent of Perioperative Medicine

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E/M/ACP capture. Share run-charts with surgeons, nursing, hospitalists, and executives.

TAKEAWAY

Pre-operative clinics are now the operational center of perioperative medicine. When anesthesiologists lead these clinics—anchored to ASA Committee guidance and ERAS/EBPOM/ACPM principles, aligned with surgeons and hospitalists, and supported by clean documentation—they deliver safer care and better patient experience. And when legitimately distinct services are captured as E/M (and ACP when appropriate), the clinic sustains itself on the value it creates.

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Murky Waters: Where the Medical Record Meets AI

BY JUSTIN VAUGHN, MDIV
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Down in bayou country, where the maze of marshlands meets the open gulf, there are bodies of water with inconsistent properties. These are lakes and inlets and bays that are essentially hybrid in nature. Known as brackish waters, they are part salty and part fresh. What should one make of such an amalgam? What kind of aquatic creatures are fitted by nature to survive that kind of mix?

With the advent of artificial intelligence (AI) and the realization of all its enormous potential, some medical providers have undertaken to use AI in the creation of their medical records. This brackish-waters approach, combining human intelligence with machine learning, raises some important questions as to overall propriety and bottom-line legality. Is the use of AI in the completion of a detailed medical record or limited progress note appropriate from a compliance perspective? Can a medico-legal document, whose contents are partly authored by a machine's logic and linguistic acuity, be deemed acceptable from a clinical, regulatory or facility by-law perspective? It's all a bit murky.

THE LEGAL LANDSCAPE

According to a recent article from *Johns Hopkins Medicine*, "the regulatory frameworks needed to govern clinical implementation of AI in safe, ethical and equitable ways are still being constructed." The federal government and certain states are in the beginning stages of assessing the situation from a legal and regulatory standpoint. As of this writing, several states have enacted laws that cover the use of AI in the medical context. Here is a brief sampling:

- Texas passed HB 149 in 2025, which mandates disclosure to patients when providers leverage AI for healthcare services or treatments.
- Utah enacted legislation that includes provisions on mental health chatbots, requiring suppliers to disclose the use of AI and implement safeguards for personal information.
- In Nevada, the legislature passed into law AB 406, which prohibits AI systems from representing themselves as licensed providers for mental or behavioral healthcare. It also restricts licensed professionals from using AI to directly deliver therapy.
- Illinois recently passed a law prohibiting AI from replacing the independent judgment of registered nurses in clinical decision-making.

While none of these laws directly speaks to the use of AI in the completion of the medical record, it is notable that various jurisdictions around the country are at least contemplating AI's place in the medical space. Back in March, legislation was introduced in Arkansas (H 1816) that would have restricted the use of AI in providing healthcare services **or generating medical records** unless specific conditions were met. However, the bill was ultimately pulled; and, so,

the question remains open-ended in the Land of Opportunity.

According to multiple sources, other states are actively engaged in shaping the legal and regulatory landscape surrounding AI in healthcare, generally. But, again, this author has yet to find a law that directly addresses the use of AI in the completion of medical records. The presumption, then, is that using these systems for such purposes is not explicitly prohibited—at least in most jurisdictions.

IT WAS INEVITABLE

According to one national auditing firm, there is a growing number of clinical providers making use of AI in the completion of the medical record. One source asserts that AI-powered documentation tools are now being used in nearly 30% of physician practices. The way it typically works is the physician will dictate or type in certain key words or short-hand phrases, and the AI app turns those terms into complete sentences. Since AI has the capacity to learn and become more sophisticated in

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Murky Waters: Where the Medical Record Meets AI

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its aggregation of information and more nuanced in its generated output, one might come to the conclusion that these AI insertions into the medical record are actually quite intuitive. But are they accurate?

It's clear that the accuracy of traditional (fully human generated) medical notations are not always inerrant. A 2023 Veterans Administration study found that 90% of handwritten notes contained at least one error. In the ER, "phantom exams" (documented but not done) were found in over 40% of records. So, humans—even smart, well-educated humans—are going to make mistakes, and those mistakes are sometimes going to be transferred onto the medical record. It must be said, however, that since AI is designed by humans and deployed by humans, these systems will inevitably be prone to making mistakes, as well. But to what degree? According to researchers at the Rand Corporation, "As flawed as AI notes may be, it's entirely possible that human-generated medical notes could be more flawed."

Despite their imperfections, the use of these widely available applications do provide a level of convenience and speed, which is why it was only a matter of time

before large numbers of clinicians began incorporating them into their practice. But are there hidden pitfalls in their usage?

A HIDDEN HITCH

It is the understanding of those familiar with these applications that some of the leading AI resources that medical providers use in the completion of their patient records store queries, as well as the answers they create, in "the cloud." Rather than a billowy stratocumulus realm where winged horses effortlessly fly, here, "cloud," refers to an array of computer servers located worldwide and accessed over the internet. Having medical data reside in the cloud allows users to perform tasks without having to store their data or run programs on their own local servers. Using the cloud does have a couple of advantages: it allows more data to be stored and often acts as a back-up with some applications.

But here's the catch, according to one prominent healthcare attorney: if a patient's protected health information (PHI) is stored in the cloud, you must have a business associate agreement (BAA) with the cloud service provider. The problem is that some of the leading AI applications have different plans, and not all of these plans may offer a BAA. Accordingly, if you are using such an app in the completion of your medical records, make sure that you execute a BAA with that cloud provider so that you remain HIPAA compliant.

It will be interesting to see if future legislation or rulemaking will clear up the current murkiness and provide greater guidance on the extent to which AI can be used in the creation of a patient's medical record, such as a surgeon's report or a nurse practitioner's visit note. An ever-changing world means ever-changing responses from the rule-makers. AI is changing, as well. In the words of a Rolling Stones ballad, where will it lead us from here?

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Should You Flip the Anesthesia Business Model?

BY MARK F. WEISS, JD
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It's not like we need an actual study to tell us that physicians across many specialties, including anesthesiology, are working harder but that earnings are not keeping pace. The simple way to say this is "more work, less pay." (Some say that the simplest way to say this is "burnout.")

Frankly, if that's your anesthesia group's business reality, then it doesn't much matter if everyone else or no one else is suffering from the same ills. Either you complain about it, suck it up or take the road less travelled and do something about it.

FIRST, SOME DATA

But for those who need a study, the Kauffman Hall consulting firm conducted one. They report that physician full-time equivalent (FTE) productivity measured in units increased 12% in the second quarter of 2025, over the second quarter of 2023. However, physician compensation per FTE increased only by 6% over the same time period.[1]

Projecting this unsightly trend into even the near future, if payer rates, both governmental and commercial, continue to decline, and if the ranks of the uninsured grow, physicians will suffer a further degradation in income.

It will become an instantiation of the Red Queen's warning in Lewis Carroll's *Through the Looking Glass*:

> *"Now, here, you see, it takes all the running you can do, to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that!"*

THE RELATIVELY QUICK AND EASY PATCHES

For anesthesiologists and their groups' leaders, there are some easily identifiable and achievable interventions for the work/pay gap.

Unfortunately, they are in the nature of palliatives. Although the healthcare chattering class is singularly focused on them, they don't guarantee much more than a slight extension of your business's half-life.

I'm speaking of initiatives such as aggressive negotiation for facility financial support, direct-to-employer, regularly renegotiating payor contracts, weighing out-of-network alternatives and exploring smart staffing models.

Note that I'm *not* saying that these patches don't have value, after all, a large part of my work with anesthesia groups across the country is focused on these matters, but that their value is somewhat akin to a "doughnut" spare tire or a can of Fix-a-Flat: They'll successfully get you on the road again, but not all the way from, say, Portland, Oregon to Portland, Maine.

Instead, I'm arguing that at some point the delta between your practice's collections and its costs of operation, including its largest category of expense, staff compensation, might become too large to fix via subsidy, the hospital or other facility, like many, might go bankrupt or be merged out of existence, or *your* usefulness to the facility might end.

It's trite to say that these efforts are like rearranging the deck chairs on the Titanic, but the reason the analogy has become trite is that it's true.

1 https://www.kaufmanhall.com/news/physicians-and-advanced-practice-providers-working-more-ever

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Should You Flip the Anesthesia Business Model?

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ASKING THE BIGGER QUESTION

Holding fast to the Titanic analogy, what if instead of rearranging the deck chairs, you ask whether you're on the right ship?

In other words, what if the prevailing anesthesia business model is upside down?

The Prevailing Business Model

Let's define what I mean by the anesthesia business model.

First, to get it out of the way, let's address what I'm *not* talking about.

I am *not* speaking of the hospital or health system *employment* structure, because it doesn't involve an anesthesia group at all, just, in some minority of cases, something that looks like one. Note that no *actual* employment is required; a "group on paper" controlled by a hospital or health system, whether via a so-called "friendly physician" or via wide, but illusory, ownership (i.e., no real equity) falls into the same pot.

Neither am I speaking of the situation in which a group or even a confederation of individual physicians has agreed to become captive to a management structure, whether it's called an management service organization (MSO), a physician practice management company or otherwise. In these management structures, business decision-making has been transferred to the parent entity. Of course, the parent entity could explore the alternative thinking that I'll describe below.

Instead, the prevalent model *that I am describing* is based upon the following required elements:

- The hospital controls access to the relationship. In other words, the hospital "permits" the group and its professionals to provide anesthesia services at its facility, generally pursuant to an exclusive contract.
- The anesthesia group exists and operates independently of the hospital at which it provides services.[2]
- In this model, groups were historically reliant upon collections for their gross income. That said, many can no longer operate without some form of financial support from the hospital. There are many ways to structure those financial arrangements, but, save for the most foolish, they all amount to cash infusions from the hospital in one form or another.

Thinking Outside of the George Box

The late George Box, the prominent British statistician, said that "all models are wrong, but some are useful."

I'd go one step further and add that some models *were* once useful but no longer are.

How's the "reliant on Medicare," or even the "reliant on commercial payors," model working out for you? They're choking what they'll pay you via rate reductions, payment delays and flat-out denials. Yet your expenses, especially the compensation paid to your physicians and other staff, keep going up.

For how long will the temporary fixes touched on above work? None of them do much, if anything, to fix the decay, the increasing uselessness, of the model itself.

Although many believe that hospital financial support is a long-term solution, the length of a contract's term,[3] and the hospital's ability to leverage you off of it, are tied to the fact that the prevalent model brands you as the supplicant. *But what if you're not?*

BOARDING THE RIGHT SHIP: ALTERNATIVE MODELS

There are multiple other business models for anesthesiologists and their groups to consider. They're not the prevalent model because most groups and most individuals fear doing anything outside of what's prevalent, of what's perceived as "safe."[4]

After all, they are following "best practices," falling for the ruse that the term actually means the *best* practice, when what it really means is copying everyone else, a race in which being first and last are the same thing.

Note that alternative models, whether those discussed below or others, are not all-or-nothing, yes-or-no, or in-or-out.

2 For convenience, I am using the word "hospital" to refer to any location at which the group provides services.
3 See the contract's termination provision, e.g., 90 days' without notice, not the "Term" provision (e.g., 3 years).
4 This perception does not necessarily comport with reality.

Anesthesia groups, as well individual anesthesiologists or small subsets of an existing group, can test out alternative models on the side, while still keeping one foot, or just one toe, in prevalent model practice.

Modeling the Migration of Office-Based Physicians Out of Employment

Some of our clients have drawn on the lessons of office-based physicians who faced similar dilemmas at an earlier point in time.

For example, we've modeled the work done with orthopedic surgeons who fell for the fallacy of hospital employment. We extricated those physicians from their circumstances and enabled them to start their own practices, often creating their own systems of multiple practice locations, surgical facilities and ancillary services.

There are multiple ways to translate that model into anesthesiology terms. One is the move into outside-of-facility practice, some examples being ketamine and other infusion clinics, mobile anesthesia practices and physician's office-based practices. Another is the move to out-of-network practice, whether or not at out-of-network facilities.

Reversing the RFP Reverse Auction Model

Several years ago, anesthesia business education focused heavily on responding to requests for proposal, i.e., RFPs.

Today, there's such a shortage of anesthesiologists and CRNAs that it's difficult to find anyone to respond to an RFP. Threats of replacing an incumbent contracted anesthesia group by issuing an RFP, are hollow.

But the leverage created by the staffing shortage opens the door to another strategy, one that I describe as "reversing the reverse auction," for that is what an RFP is, a reverse auction. Let me explain.

A normal auction, actually referred to as a "forward auction," involves a single seller and multiple buyers. That's the sort of auction with which most people are familiar, from fine art auctions at Sotheby's, to collector car auctions by Mecum to live auctions at elementary school fundraisers. The single seller attempts to pit multiple buyers against one another in order to obtain the highest price.

An RFP for anesthesia service is an auction, too. It's a reverse auction in which the party "buying" the services, i.e., the hospital, attracts multiple "sellers," i.e., anesthesia groups, pitting them against one another to provide the broadest scope of services for the lowest subsidy; in other words, in total, the lowest price.

Given the fantastic leverage that providers of anesthesia services now enjoy, the forward auction strategy involves pitting multiple facilities against one another for your group's services. Will this work in the middle of a large metropolitan area? Maybe, maybe not. But the cost to explore your answer is relatively low.

For naysayers, this strategy is essentially the same as that played out by large physician practice management companies and, outside of healthcare, businesses from Amazon to Volkswagen dealers.

A FEW MORE WORDS

The above are a few of the models that run counter to that prevalent in anesthesia business.

There are others, some of which bear little relationship to what anesthesia group leaders and chatterati might conceive. That's what makes them highly strategic and very profitable.

Most anesthesia group leaders are afraid to go there, which makes it all the better for those who aren't.

MARK F. WEISS, JD

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The Basics: Negotiating an Employment Agreement (From the Physician Perspective)

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Healthcare attorneys often work with physician clients to negotiate their employment agreements before entering a new arrangement, and to understand their rights and mitigate risk upon departure. A well-negotiated agreement is not just a legal document—it is a roadmap for a sustainable and mutually beneficial professional relationship. The right agreement can protect your career and your peace of mind.

ASSESSING THE PROVISIONS

Whether reviewing the agreement at the front end or the back end of a relationship, the first step is often to determine whether the provisions are compliant and enforceable. As we all know, healthcare is extremely regulated, and the enforcement environment is punitive. Any competent healthcare attorney should be able to quickly determine whether there are any concerns regarding the proposed employment agreement from a state and federal regulatory perspective. Think about the federal Stark law, the federal Anti-kickback law, federal tax requirements, HIPAA and numerous parallel state provisions. Although attorneys are generally not qualified to opine on fair market value, they often have compensation survey data at their fingertips that can assist a physician in determining whether compensation is within the range of fair market value (as defined by the federal health care programs). Attorneys can also help to understand whether the proposed provisions are enforceable and whether the provisions are market or overreaching.

Physicians need to ensure that their employment agreement includes the terms that are most important from a business perspective. Promises made during recruiting discussions are generally not enforceable unless they are set forth in the written agreement. It is important for an employment agreement to reflect a mutual understanding of employer expectations, compensation and benefits. Given increasing reimbursement challenges, financial constraints, private equity involvement and staffing shortages, employers are increasingly focused on productivity and the bottom line. Physicians need to advocate for themselves and ensure that the employment agreements provide sufficient protection regarding the location where they will work, the number of hours they are expected to provide clinical and administrative duties, paid time off for holidays and the amount of call coverage required. In the event that specifics regarding call coverage are not stated, it's important to at least include language that there be an equitable rotation of call coverage obligations among those in the same practice area.

Employment agreements often restrict physicians from engaging in outside activities unless the employer agrees after full disclosure on a case-by-case basis. If a physician plans to moonlight, engage in professional speaking or writing, pursue independent research, engage in volunteer activities, it is best to explicitly agree that the physician can engage in these activities at the front end of the relationship. Typically, physicians have the most leverage when they are entering the employment relationship and it's easier to address these issues before the agreement is entered then after the relationship has commenced.

Employment agreements should also provide sufficient security, and sufficient flexibility, to the physician employee so that reliance is reasonable. If the agreement provides for a five-year term but either party can terminate upon thirty days' notice without cause, consider whether the agreement *really* only provides thirty days of job security. Does this make sense if the employee is relocating across the country? In my experience, most employment agreements require thirty to one hundred eighty days of notice before either party can terminate without cause. The physician should understand whether the employer has an obligation to permit the physician to work during the entire notice period or whether the employer can then terminate the

physician immediately once the physician provides notice. Also, if a physician is locked into the agreement without the ability to terminate the agreement for convenience, the physician should have the ability to terminate the agreement during the term for good reason. These circumstances may include a financial decline or insolvency of the employer, lack of support in terms of staffing or equipment, past due payments of compensation, material change in location, compensation, schedule job duties or call coverage. The termination for cause provisions should be tight and the standards should be objective, so they do not create loopholes. To the extent that a termination is based upon a violation of an employer policy or procedure or a breach of the employment agreement, there should be an opportunity to cure.

GOING SEPARATE WAYS

Before entering an employment agreement, physicians also need to understand the impact of a termination of the agreement. Do relocation allowances or bonuses need to be paid back, and, if so, is there a tax consequence? Are bonuses prorated and payable for partial periods if the agreement terminates during a measurement period? This is especially important to consider if the bonus is a material part of the compensation package and the physician is relying upon it. Will the employer pay for tail coverage if the professional liability insurance is on a claim made basis? Sometimes the employer will only agree to pay for tail coverage if the physician has been there for a period of time. I would argue that the physician should not be required to pay for tail if she has been there for at least a year.

Most employment agreements will include basic restrictive covenants that apply during and after the term of employment. No physician should sign an agreement with these restrictions unless he/she is willing to live with them. Generally, in most states, these restrictions are enforceable. These include prohibitions on outside activities, competing with the employer, disparaging the employer and its other physicians, soliciting patients and workforce members, interfering with the business of the employer and sharing confidential information. In order to make them more tolerable, consider clarifying that general advertising of an employment opportunity does not constitute impermissible solicitation of employees. Similarly, general advertising and promotion of one's practice on websites, social media and elsewhere should not constitute impermissible competition. Some states, such as Ohio, have detailed regulations requiring that healthcare employers provide notice to patients of a physician's departure, including information regarding where the physician will provide professional medical services post termination. For those states that do not, incorporating a form of patient notice into the employment agreement to be used upon termination of the relationship may be a good idea. Also consider whether the duration or geographic area of the noncompete. What is a reasonable geographic area in rural Michigan is different from a reasonable geographic area in Manhattan. Also, consider including certain exceptions to the noncompete (e.g., working for certain non-competitive employers that serve a different patient population, working at a location to the extent required to maintain medical staff privileges, providing hospital-based services, providing services as an ambulatory surgery center, etc.)

When employment agreements are thoughtfully reviewed and negotiated before being entered, the parties can simultaneously be excited about the future but also assured that there is a clear plan for an unwind if that becomes necessary. Having a strong document to serve as the basis for the employment relationship can avoid unnecessary adverse career consequences, emotional stress and legal fees in the future.

KATHRYN (KATE) HICKNER, ESQ

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Professional Events

DATE	EVENT	LOCATION	CONTACT INFO
October 10-14, 2025	ASA Annual 25 American Society of Anesthesiologists Annual Conference	Henry B. Gonzalez Convention Center San Antonio, TX	https://www.asahq.org/annualmeeting
December 12-15, 2025	PGA 25 Post Graduate Assembly in Anesthesia	Marriott Marquis NYC New York, NY	https://www.pga.nyc/
January 19-23, 2026	CSA (California Society of Anesthesiologists) 26 Winter Conference	The Grand Wailea Wailea, HI	https://csahq.org/events/csa-2026-winter-anesthesia-conference/
January 23-25, 2026	ASA Advance 26 American Society of Anesthesiologists	Paris Las Vegas Las Vegas, NV	https://www.asahq.org/meetings/asa-advance
February 4-7, 2026	AANA EDGE 26 (American Association of Nurse Anesthesiology)	Omni Louisville Hotel Louisville, KY	https://www.aana.com/premier-event/edge/
February 28-March 7, 2026	Maui Anesthesia Seminar 26	Hyatt Regency Maui Resort & Spa Lahaina, HI	https://www.holidayseminars.com/anesthesia_seminars/maui_anesthesia_conference
March 16-20, 2026	University of Florida 2026 Spring Anesthesia Ski Summit	Antlers at Vail Vail, CO	https://anest.cme.ufl.edu/

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