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ILLINOIS SURGICAL ASSISTANT REIMBURSEMENT ACT

The signing of the Illinois Surgical Assistant Registration Act of 2003 by Governor Blagojevic on July 24 was met with some fanfare, but less attention has been paid to an equally important new law, the Surgical Assistant Reimbursement Act of 2003, passed concurrently.

This bill (HB 3618) modified Public Act 93-0352, requiring that payment for services rendered by assistants at surgery, who are not employees of an ambulatory surgical treatment center or hospital, be paid at the appropriate nonphysician modifier rate if the payor (insurance company) would have made payment for the same services if provided by a physician.

Eligible assistants include licensed advanced practice nurses, licensed physician assistants, licensed registered nurse, licensed practical nurse, surgical assistant, and surgical technologists.

This legislation is only the second of its kind (including Kentucky), and along with the Illinois Surgical Assistant Registration Act, helps to ensure the ongoing viability of the profession in Illinois for years to come. The signing of the new law was the culmination of at least five years of work for many surgical assistants in Illinois, working under the auspices of the Illinois Surgical Assistants Association (ISAA) and with the assistance of lobbyist Margaret Vaughn, whose services were partially underwritten by the Association of Surgical Assistants.

While the goal of ISAA had always been the protection of the patient and the provision of quality patient care through the regulation of nonphysician surgical assistants including CST/CFAs, CSAs, and SA-Cs in their state, decreasing reimbursement rates for services performed have been a recognized threat for quite some time. ISAA presented a very simple case to the legislature. Services are being performed every day by highly skilled, well trained, properly credentialed surgical assistants in operating rooms across the country, who are providing a vital and life-saving service, that all to often goes unreimbursed. The lack of reimbursement for these services is not only unfair, but could create a potential shortage of qualified assistants at surgery, as they are forced to seek employment in other areas or in a field completely outside of healthcare. After several years of work, the Illinois legislature heard this message and acted. Congratulations to the Illinois Surgical Assistants Association.

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As many ASA members are aware, House Bill 1, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, was signed into law by President Bush early in December 2003. The ASA government affairs department became aware of a potential amendment to the bill late in the summer, while the bill itself had already been passed by the House and the Senate, and was in conference committee, the final step in the passage of a new law. Final language changes are agreed upon in conference committee, and with a bill as large and controversial as this one, a lot can be changed at this final step.

The amendment in question would have set up a pilot study for CRNFA reimbursement for "services would consist of assisting a physician with surgery and related preoperative, intraoperative, and postoperative care furnished by a certified registered nurse first assistant." The secretary would have been required to report to Congress on the evaluation of patient outcomes and on the cost-effectiveness of the demonstration by January 1, 2007.

In the final version of the bill, which was passed into law, the language was significantly changed, and the idea of a pilot payment project was abandoned by Congress. The final language requires that "MedPAC study the feasibility and advisability of Medicare Part B payment for surgical first assisting services furnished to Medicare beneficiaries by a certified registered nurse first assistant. MedPAC is required to submit the report by January 1, 2005, and to include recommendations for legislation or administrative action."

While ASA had discussed the pursuit of an amendment to this bill at the ASA forum in Washington, DC, early in September 2003, the nursing amendment was changed over the course of the session from a demonstration project in five states that would provide direct data on reimbursement for RNFAs to a study to be performed by the Medicare Payment Advisory Commission (MedPAC). This study would not provide for reimbursement during the period of the study, and is virtually identical to one already performed and completed in 2002 for non-physician surgical assistants including CST/CFAs. Because there would have been no benefit to a repeat of this study, ASA did not pursue a last-minute "amendment to the amendment" that would have added CST/CFAs and other surgical assistants to the language of the bill.

In 2001, Congress passed a bill that mandated a study by the Medicare Payment Advisory Commission on reimbursement for nonphysician surgical assistants, including CST/CFAs. AST/ASA participated in the process, providing data and other information, as well as testimony at several MedPAC meetings during the course of the 18 month study. It had been our hope that MedPAC would recognize the need for and cost-effectiveness of the utilization of nonphysician surgical assistants.

Several groups, including the American College of Surgeons, became involved in opposition to the proposal being discussed, primarily because the MedPAC Commissioners expanded the study to include a potential proposal to "bundle" fees for nonphysician surgical assistant services into either the physician or the hospital's payment for their services. AST/ASA expressed at that time the opinion that the consideration of this recommendation was an expansion of the study that Congress had commissioned MedPAC to undertake. MedPAC had simply been asked to examine and recommend on direct reimbursement to surgical technologists as assistants at surgery.

In its final report, MedPAC recommended against (1) direct reimbursement to surgical technologists as assistants at surgery and (2) increased payments for advanced practice nurses and physician assistants. Under current laws surgeons get 100% of their sole surgery fee, two or more surgeons operating jointly receive 125% of the solo fee, surgeons acting as first assistants at surgery receive an additional 16% of the solo fee, and advanced practice nurses (ie CRNP, PA, and CNS) receive 85% of the 16% that the physician surgical assistant would receive.

A primary reason for the recommendation was inconsistent state licensing. MedPAC also recommended against bundling the nonphysician fee with the surgeon or facility fee. The issue that stirred ACS and other physician groups at the time of the MedPAC study related to

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the CST/CFA was not whether nonphysician surgical assistants were qualified to serve as surgical first assistants or whether they should be reimbursed, it was the bundling of fees. The issue that the MedPAC commissioners had seemed also to not be about qualifications, but in their case, it was about the need for state-run regulatory mechanisms. In other words, while MedPAC might have wished to recommend reimbursement for the nonphysician surgical assistant, they felt that the lack of state licensure or registration laws would prevent the federal government from being able to identify qualified practitioners for reimbursement in a cost-neutral manner.

It has been our analysis since the completion of the 2002 MedPAC study that a "critical mass" of state-level surgical assistant regulation like that already in place in Texas and Illinois is needed for our organization to more effectively pursue Medicare reimbursement from the federal government. While we continue to seek legislation each session in Washington, our primary focus has been on legislative success at the state level, in hopes of achieving 12-15 state laws, a "magic number" we believe will greatly increase the effectiveness of our lobby in Washington, DC. It's a win-win situation for everyone involved, in the opinion of ASA leadership.

Our primary goal has always been patient safety and protection through state-level regulation of CST/CFA and other nonphysician surgical assistants. We believe that licensure and/or registration laws begin to make surgical assistants responsible for their actions in the operating room, and the requirement of certain educational and credentialing standards enable us as a profession to provide higher quality, safe patient care. At the same time, we have to make a living, and increased state-level regulation will inevitably lead to a more effective voice in Washington, DC, for all nonphysician surgical assistants.

That said, the lack of state-level regulation is not something nurses are faced with. The inevitable fee bundling discussion at MedPAC, however, will doubtless be a hurdle to the RNFA during the course of their newly mandated study. ASA will continue to monitor the progress of RNFAs and other surgical assistant groups in their pursuit of Medicare reimbursement.

MEDICAL MALPRACTICE REFORM LEGISLATION

Increasing medical malpractice expenses remain in the forefront of medical news and physician concerns. ASA has witnessed the effects of rising medical malpractice insurance rates for physicians, as several have contacted the organization to report that they have considered relinquishing their licenses and becoming Certified First Assistants, rather than continuing to practice as physicians and face continued rising costs.

On July 9, Senate Democrats blocked a Republican-backed medical malpractice bill that would have capped noneconomic damages in malpractice lawsuits at $250,000, similar to bills proposed in several states last year. The 49-48 vote fell 11 votes short of the 60 required to bring the measure up for a formal vote, and came at the end of a Democratic filibuster.

The House earlier this year passed a bill similar to the Senate legislation. The House bill, sponsored by Congressman Jim Greenwood (R-PA), would have capped noneconomic damages in malpractice lawsuits at $250,000 and would have allowed punitive damages of $250,000 or twice the amount of economic damages, favoring the higher amount. The legislation covered lawsuits filed against physicians, HMOs, pharmaceutical companies and medical device companies. The bill also would have allowed state governments free reign to increase this cap, as well as to decrease it, and economic damages including medical costs and lost wages would not have been capped.

It appears unlikely that that the Senate will return to this issue in the near future. However, President Bush recently reaffirmed his interest in pursuing this type of legislation further, improving the chances that similar legislation will surface in 2004.