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MEDICARE

Payment Changes Are Needed for Assistants-at-Surgery



G A O

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Highlights of [GAO-04-97](#), a report to congressional committees

Why GAO Did This Study

Medicare pays for assistant-at-surgery services under both the hospital inpatient prospective payment system and the physician fee schedule. Payments under the physician fee schedule are limited to a few health professions. In 2001, Congress directed GAO to report on the potential impact on the Medicare program of allowing physician fee schedule payments to Certified Registered Nurse First Assistants for assistant-at-surgery services. This report examines: (1) who serves as an assistant-at-surgery, (2) whether health professionals who perform the role must meet a uniform set of professional requirements, and (3) whether Medicare's payment policies for assistants-at-surgery are consistent with the goals of the program and, if not, whether there are alternatives that would help attain those goals. GAO analyzed information provided by physician and other health professional associations and Medicare payment data.

What GAO Recommends

GAO suggests that Congress may wish to consider consolidating all Medicare payments for assistant-at-surgery services under the hospital inpatient prospective payment system. CMS agreed that payment policy for assistants-at-surgery could be improved.

www.gao.gov/cgi-bin/getrpt?GAO-04-97.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Majorie Kanof (202) 512-7101.

MEDICARE

Payment Changes Are Needed for Assistants-at-Surgery

What GAO Found

Members of a wide range of health professions serve as assistants-at-surgery, including physicians, residents in training for licensure or board certification in a physician specialty, several different kinds of nurses, and members of several other health professions. Hospitals employ all the types of nonphysician health professionals who perform the role. Hospital employees likely serve as assistants-at-surgery for a majority of the procedures for which the American College of Surgeons says an assistant is "almost always" necessary. The number of assistant-at-surgery services performed by physicians and paid under the Medicare physician fee schedule has declined, while the number of such services performed by nonphysician health professionals eligible to receive payment under the physician fee schedule has increased.

There is no widely accepted set of uniform requirements for experience and education that the health professionals who serve as assistants-at-surgery are required to meet. The health professions whose members provide assistant-at-surgery services have varying educational requirements. No state licenses all the health professionals who serve as assistants-at-surgery. Furthermore, the certification programs developed by the various nonphysician health professional groups whose members assist at surgery differ. GAO found that there was insufficient information about the quality of care provided by assistants-at-surgery generally, or by a specific type of health professional, to assess the adequacy of the requirements for members of a particular profession to perform the role.

There are three flaws in Medicare's policies for paying assistants-at-surgery that prevent the payment system from meeting the program's goals of making appropriate payment for medically necessary services by qualified providers. First, because Medicare pays for assistant-at-surgery services under both the hospital inpatient prospective payment system and the physician fee schedule, and hospital payments for surgical care are not adjusted when an assistant receives payment under the physician fee schedule, Medicare may be paying too much for some hospital surgical care. Second, paying a health professional under the physician fee schedule to be an assistant-at-surgery, instead of including this payment in an all-inclusive payment, gives neither the hospital nor surgeon an incentive to use an assistant only when one is medically necessary. Third, the distinctions between those health professionals eligible for payment as an assistant-at-surgery under the physician fee schedule and those who are not eligible are not based on surgical education or experience as an assistant. Criteria for determining who should be paid as assistants-at-surgery under the physician fee schedule do not exist. However, hospitals are responsible under health and safety rules to provide quality care for their patients.

Contents

Letter

	1
Results in Brief	3
Background	5
Various Health Professionals Provide Assistant-at-Surgery Services, and Hospital Employees Provide Most of These Services	9
Widely Accepted Professional Requirements for Assistants-at- Surgery Do Not Exist	13
While Medicare Payments for Assistant-at-Surgery Services Have Flaws, Paying Hospitals for All These Services Would Correct Them	18
Conclusions	22
Matter for Congressional Consideration	22
Agency Comments	22

Appendix I

Professional Associations, Schools, and Hospitals	25
--	----

Appendix II

Comments from the Centers for Medicare & Medicaid Services	27
---	----

Tables

Table 1: Physician Fee Schedule Payments for Health Professionals for Assistant-at-Surgery Services	8
Table 2: Health Professions Whose Members Can Assist at Surgery	10
Table 3: Education and State Licensure Requirements for Those Who May Assist at Surgery	14
Table 4: Surgical Education and Experience Requirements for Certification as an Assistant-at-Surgery	17

Figure

Figure 1: Percentage of Assistant-at-Surgery Services Paid under the Physician Fee Schedule for Physicians and Nonphysician Health Professionals, 1997-2002	13
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Abbreviations

ACS	American College of Surgeons
AHA	American Hospital Association
BBA	Balanced Budget Act of 1997
CMS	Centers for Medicare & Medicaid Services
CoP	condition of participation
CRNFA	Certified Registered Nurse First Assistant
GME	graduate medical education
HCFA	Health Care Financing Administration
PPS	prospective payment system

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Congressional Committees

Ensuring that Medicare beneficiaries receive care from qualified providers and that payments to providers are for the appropriate amount and only for medically necessary services are recognized goals of Medicare. Achieving these goals when paying for assistants-at-surgery,¹ who perform tasks as members of surgical teams under the direction of surgeons, poses a particular challenge because of the range of considerations affecting whether hospitals or surgeons decide an assistant is necessary for a given beneficiary's surgical procedure and the variation in education and experience of individuals who serve as assistants.

Medicare pays hospitals, physicians, and certain nonphysician health professionals for assistant-at-surgery services through the hospital inpatient prospective payment system (PPS) and the Medicare physician fee schedule. Medicare makes a single payment to hospitals for all the services, including assistant-at-surgery services, that a hospital provides to a beneficiary while an inpatient. The inpatient PPS pays predetermined fixed amounts for groups, or bundles, of services, designed to provide incentives to control spending by rewarding efficiency. Medicare also pays teaching hospitals under the inpatient PPS for providing graduate medical education (GME) to the residents employed by the hospital, some of whom assist at surgery.

Medicare also makes payments under the Medicare physician fee schedule for assistant-at-surgery services performed by physicians and members of certain nonphysician health professions whose members assist. These nonphysician health professionals—primarily physician assistants, nurse practitioners, and clinical nurse specialists—are allowed to bill Medicare under the physician fee schedule.² Congress has been asked to authorize

¹An assistant-at-surgery is sometimes referred to as a first assistant or second assistant.

²Members of a few other health professions, such as nurse midwives, can also be paid as assistants-at-surgery under the physician fee schedule. Assistant-at-surgery services performed by these professionals accounted for less than 1 percent of such Medicare-paid assistant services in 2002. When discussing payments for assistants-at-surgery under the physician fee schedule, this report focuses on physicians, physician assistants, nurse practitioners, and clinical nurse specialists.

Certified Registered Nurse First Assistants (CRNFA) and other nonphysician health professional groups whose members provide assistant-at-surgery services to bill Medicare under the physician fee schedule for these services.

In 2001, Congress directed us to report on the potential impact on the Medicare program of allowing physician fee schedule payments to CRNFAs for assistant-at-surgery services.³ Congress required that we give special consideration to quality of care, appropriate education requirements, and appropriate rates of Medicare payment for assistants-at-surgery. This report examines: (1) who serves as an assistant-at-surgery, (2) whether health professionals who perform the role must meet a uniform set of professional requirements, and (3) whether Medicare's payment policies for assistants-at-surgery are consistent with the goals of the program and, if not, whether there are alternatives that would help attain those goals.

To determine who serves as an assistant-at-surgery, we analyzed Medicare data for 1997 through 2002 from the Part B Extract and Summary System maintained by the Centers for Medicare & Medicaid Services (CMS),⁴ which oversees Medicare. These summary data are derived from the Medicare Physician/Supplier Procedure Summary Master Files, which contain procedure-specific billing data for all physician and supplier services provided to Medicare beneficiaries each year. CMS contractors edit these data, and data limitations are published annually. We used our analysis of these data to determine the number, variety, and location of surgical procedures for which physician and nonphysician health professional assistants-at-surgery sought Medicare payment under the physician fee schedule.⁵ We also analyzed these data by the categories in the American College of Surgeons' (ACS) study that classifies each

³Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, App. F, § 433, 114 Stat. 2763, 2763A-526.

⁴On July 1, 2001, the agency that administers the Medicare program was renamed from the Health Care Financing Administration (HCFA) to CMS. This report refers to the agency as HCFA when discussing actions taken before the name change and as CMS when discussing actions taken after the name change.

⁵Of the assistant-at-surgery services paid under the physician fee schedule in 2002, almost 90 percent were for hospital inpatients, about 10 percent were for surgeries on hospital outpatients, and about 1 percent for surgeries in ambulatory surgical centers. Less than one-half of 1 percent of services allowed under the physician fee schedule for assistant-at-surgery services occurred in a nonfacility setting, such as a physician's office.

surgical procedure by the likelihood that it will require an assistant-at-surgery.⁶ We could not determine the number of assistants-at-surgery who were paid under the inpatient PPS because CMS does not collect those data. We interviewed staff from CMS; representatives of nine large academic teaching hospitals distributed across the country; and representatives of state licensing boards, assistant-at-surgery education programs, and associations of hospitals, physicians, nurses, and other health professions, including those whose members assist at surgery (see app. I). We used these interviews to determine whether nonphysician health professionals who perform the role of assistant-at-surgery must meet a uniform set of professional requirements. In making this determination, we also reviewed literature about the licensure and certification of health professionals who serve as assistants-at-surgery and Medicare laws and regulations affecting assistants.

We conducted our work from July 2001 through December 2003 in accordance with generally accepted government auditing standards.

Results in Brief

Members of a wide range of health professions serve as assistants-at-surgery, including physicians, residents in training for licensure or board certification in a physician specialty, several different kinds of nurses, and members of several other health professions. Hospitals employ residents, international medical graduates,⁷ and all the types of nonphysician health professionals who perform the role. Hospital employees likely serve as assistants-at-surgery for a majority of the procedures for which the ACS says an assistant is “almost always” necessary. Since 1997, the number of assistant-at-surgery services performed by physicians and paid under the Medicare physician fee schedule has declined, while the number of such services performed by nonphysician health professionals eligible to receive payment under the physician fee schedule has increased.

⁶American College of Surgeons (ACS), *Physicians as Assistants at Surgery: 2002 Study, 4th edition* (Chicago, Ill.: 2002). ACS members and members of 14 other surgical specialty organizations reviewed procedures applicable to their specialties and determined how often each surgical procedure requires the use of a physician as an assistant-at-surgery.

⁷International medical graduates are physicians who have graduated from a medical school outside the United States, Puerto Rico, or Canada. For purposes of this report, international medical graduates do not include individuals who are in U.S. residency programs or who are physicians licensed in the United States, but may include some who are certified as surgical assistants.

There is no widely accepted set of uniform requirements for experience and education that the health professionals who serve as assistants-at-surgery are required to meet. The health professions whose members provide assistant-at-surgery services have varying educational requirements. No state licenses all the health professionals who serve as assistants-at-surgery, and the health professional licenses that states do issue typically attest to the completion of broad-based health care education, rather than education or experience as an assistant. Furthermore, the certification programs developed by the various nonphysician health professional groups whose members assist at surgery differ. We found that there was insufficient information about the quality of care provided by assistants-at-surgery generally, or by a specific type of health professional, to assess the adequacy of the requirements for members of a particular profession to perform the role.

There are three flaws in Medicare's policies for paying assistants-at-surgery that prevent the payment system from meeting the program's goals of making appropriate payment for medically necessary services by qualified providers. First, because Medicare pays for assistant-at-surgery services through both the hospital inpatient PPS and the physician fee schedule, and hospital payments for surgical care are not adjusted when an assistant receives payment under the physician fee schedule, Medicare may be paying too much for some hospital surgical care. Second, paying a health professional under the Medicare physician fee schedule to be an assistant-at-surgery, instead of including this payment in an all-inclusive payment, gives neither the hospital nor surgeon an incentive to use an assistant only when one is medically necessary. Third, the distinctions between those health professionals eligible for payment as an assistant-at-surgery under the physician fee schedule and those who are not eligible are not based on surgical education or experience as an assistant. Criteria for determining who should be paid as assistants-at-surgery under the physician fee schedule do not exist. However, hospitals are responsible under health and safety rules to provide quality care for their patients.

To help address these flaws and meet Medicare's goals, we suggest that Congress may wish to consider consolidating all Medicare payments for assistant-at-surgery services under the hospital inpatient prospective payment system. We received comments on a draft of this report from CMS, which agreed that payment policy for assistants-at-surgery could be improved. CMS also discussed several details related to implementing payment policy changes.

Background

Assistants-at-surgery, who serve as members of surgical teams, perform tasks under the direction of surgeons and aid them in conducting operations. These tasks may include making initial incisions (“opening”), exposing the surgical site (“retracting”), stemming blood flow (“hemostasis”), surgically removing veins and arteries to be used as bypass grafts (“harvesting”), reconnecting tissue (“suturing”), and completing the operation and reconnecting external tissue (“closing”). Some of these tasks, like retraction, are relatively simple, while others, such as harvesting, are more complex. An assistant-at-surgery may perform one or more simple or complex tasks during an operation.

Tasks performed by others on the surgical team differ from those performed by assistants-at-surgery. Scrub staff work within the sterile field—the area within the operating room that is kept free from harmful microorganisms—passing instruments, sponges, and other items directly to the surgeon and assistant-at-surgery who work within the sterile field. Circulators work outside the sterile field, responding to the needs of team members within the sterile field. Anesthesiologists, or anesthetists, who administer and monitor anesthesia, painkillers, and other drugs, are also present during an operation.

Need for Assistants-at-Surgery Depends on Complexity of Operation, Condition of Patient

Decisions by a hospital or surgeon to use an assistant-at-surgery depend on the complexity of the operation and medical condition of the patient. Physician associations, such as the ACS and the American Society of General Surgeons, maintain that the surgeon should be responsible for determining if an assistant-at-surgery is needed, although some hospitals require the use of an assistant for certain surgical procedures. Hospitals that employ assistants-at-surgery may assign them to a procedure without consulting the surgeon performing the procedure.

Since 1994, the ACS, with other surgical specialty organizations, has conducted studies to determine which surgical procedures require physicians as assistants-at-surgery. These studies classify surgical procedures as “almost always,” “sometimes,” or “almost never” requiring

an assistant-at-surgery. The 2002 study classifies approximately 5,000 surgical procedures, about 1,750 of which are designated as “almost always” requiring a physician to serve as an assistant-at-surgery.⁸

A small number of surgical procedures have accounted for the majority of the assistant-at-surgery services paid for under the Medicare physician fee schedule: In 2002, 100 procedures accounted for almost 75 percent of the assistant-at-surgery services that Medicare paid under the physician fee schedule. ACS designated 81 of these procedures as “almost always” requiring a physician as an assistant-at-surgery, and the remaining 19 procedures were designated as “sometimes” requiring a physician as an assistant.

Medicare Pays for Assistants-at-Surgery as Part of PPS Payments to Hospitals and under the Physician Fee Schedule

Medicare pays for medically necessary services, including those performed by assistants-at-surgery, for eligible elderly and disabled patients provided by health professionals and institutions meeting certain requirements. Part A, or Hospital Insurance, pays for inpatient hospital care, care provided by certain other health care facilities, and some home health care. Part B, or Supplementary Medical Insurance, includes payment for the services and items provided by physicians, certain other nonphysician health professionals, suppliers, outpatient hospital departments, and home health care agencies.

Medicare makes payments to hospitals under part A through the hospital inpatient PPS⁹ for assistants-at-surgery.¹⁰ A fixed payment is made for all the inpatient hospital services, including assistant-at-surgery services, that a hospital provides to a beneficiary with a given diagnosis or receiving a particular type of surgery. Payments under the hospital inpatient PPS reflect the average bundle of services that beneficiaries with a particular

⁸Approximately 1,550 surgical procedures are designated as “sometimes” requiring a physician as an assistant-at-surgery. In addition to procedures designated as “almost always” or “sometimes” requiring a physician to serve as an assistant-at-surgery, the remaining procedures are designated as “almost never” requiring a physician to serve as an assistant.

⁹42 U.S.C. § 1395ww (2000).

¹⁰The bundle of services for which hospital inpatient payments are made generally does not include physician services provided by physicians, physician assistants, nurse practitioners, and clinical nurse specialists. 42 U.S.C. § 1395x(b)(4), (s)(2)(K) (2000).

diagnosis receive as inpatients in similar hospitals. The hospital's payment for a bundle of services is the same regardless of whether an assistant-at-surgery is used or who provides the assistant-at-surgery services.

Prospective payment systems, such as the hospital inpatient PPS, are designed to promote efficiency: because the payment for a particular bundle of services is almost always the same, regardless of the services a particular patient receives, hospitals are discouraged from providing unnecessary services.¹¹ Providing additional services would not increase their payments. Consequently, PPS payments to the hospital are sometimes less and sometimes more than the cost of providing care.

Payments are also made under the hospital inpatient PPS to teaching hospitals for providing GME to the residents employed by the hospital.¹² In 2001, about 20 percent of the approximately 5,800 U.S. hospitals were considered teaching hospitals. In 2003, surgical residents comprised about 20 percent of all residents at these hospitals.¹³ There were about 7,500 residents in general surgery and about 13,000 more surgical residents training for specialties, such as orthopedics, all of whom were required to serve as assistants-at-surgery as part of their training. In addition to these surgical residents, some nonsurgical residents have surgical rotations during which they serve as assistants-at-surgery.

Medicare makes part B payments to assistants-at-surgery under the physician fee schedule¹⁴ when assistant services are performed by a physician or by a nonphysician health professional authorized to receive such payment. In 2002, these payments totaled about \$158 million, less than 2 percent of the \$10.5 billion Medicare paid to surgeons for surgical

¹¹Additional payments are made for cases in which inpatient hospital care has been extraordinarily costly. About 7 percent of inpatient hospital PPS payments in fiscal year 2002 were for these cases.

¹²Teaching hospitals are paid an amount for each resident that covers the costs associated with providing services. 42 U.S.C. § 1395ww(h) (2000).

¹³For purposes of this report, surgical residencies are defined as those in colon and rectal surgery, neurological surgery, obstetrics and gynecology, ophthalmology, orthopedic surgery, adult reconstructive orthopedics, foot and ankle orthopedics, hand surgery, musculoskeletal oncology, orthopedic sports medicine, orthopedic surgery of the spine, orthopedic trauma, pediatric orthopedics, otolaryngology, neurotology, pediatric otolaryngology, plastic surgery, craniofacial surgery, general surgery, pediatric surgery, surgical critical care, urology, pediatric urology, vascular surgery, and thoracic surgery.

¹⁴42 U.S.C. § 1395w-4(a) (2000).

procedures that year. Medicare also makes global payments to surgeons under the physician fee schedule that cover the surgery and some pre- and postoperative services that the surgeons and their employees perform. Assistant-at-surgery services are not included in this bundle of services. Generally, the amount Medicare pays under the physician fee schedule is based on the resources needed to perform a service: the physician’s time and skill, practice expenses that include the costs of staff, equipment, and supplies, and the cost of liability insurance. While a surgeon’s global fee for a surgical procedure is set to reflect the resources required to perform the service, payments under the physician fee schedule for assistant-at-surgery services are not; they are calculated as a fixed percentage of the surgeon’s global fee. The percentage varies depending on the profession of the assistant-at-surgery. The Medicare physician fee schedule pays physicians more than nonphysician health professionals for assistant-at-surgery services (see table 1).

Table 1: Physician Fee Schedule Payments for Health Professionals for Assistant-at-Surgery Services

Health profession	Payment
Physician	16.0% of surgeon’s payment
Clinical nurse specialist	13.6% of surgeon’s payment
Nurse practitioner	13.6% of surgeon’s payment
Physician assistant	13.6% of surgeon’s payment

Source: 42 C.F.R. §§ 405.502(a)(9), 414.52, 414.56 (2002).

Medicare sets requirements that various health care institutions, suppliers, and professionals must meet to be paid by the program. Institutions, such as hospitals, must meet conditions of participation (CoP)—health and safety rules used to ensure quality of care. Until 1986, HCFA specified some requirements for assistant-at-surgery services in its hospital CoP. Hospitals were required to have physicians serve as assistants-at-surgery for procedures “with unusual hazard to life,” while “nurses, aides, or technicians having sufficient training to properly and adequately assist” could assist at “lesser operations.”¹⁵ In a broad revision of the hospital CoP in 1986, the agency eliminated these requirements: it said the purpose of the revisions to the surgical services section, which had included the assistant-at-surgery requirements, was to “delete the overly prescriptive

¹⁵20 C.F.R. § 405.1031(a) (1967), redesignated as 42 C.F.R. § 405.1031(a) in 1977.

details” about the operation of surgical services.¹⁶ CMS retains requirements for other surgical team members, including scrub and circulating staff.¹⁷

CMS also establishes regulatory requirements for the health professions eligible to receive payment under the Medicare physician fee schedule. Members of that profession can be paid for providing covered services, including assistant-at-surgery services.¹⁸ Although CMS’s rules include the minimum requirements that these professionals must meet to receive payment for services, there are no specific requirements to receive assistant-at-surgery payments in Medicare regulations. General requirements include education, licensure, and certification; no surgical education or experience is mandated. For example, physician assistants must graduate from an accredited physician assistant education program, pass the National Commission on Certification of Physician Assistants certification examination, and be licensed to practice as a physician assistant, but do not have to have experience as an assistant-at-surgery.

Various Health Professionals Provide Assistant-at-Surgery Services, and Hospital Employees Provide Most of These Services

Members of a wide range of health professions serve as assistants-at-surgery. Hospitals employ residents, international medical graduates, and all the types of nonphysician health professionals who perform the role. Hospital employees likely serve as assistants-at-surgery for a majority of the procedures for which the ACS says an assistant is “almost always” necessary. The number of assistant-at-surgery services performed by physicians and paid for under the physician fee schedule has declined, while the number of such services performed by nonphysician health professionals eligible to receive payment under the physician fee schedule has increased.

¹⁶ Medicare and Medicaid Programs; Conditions of Participation for Hospitals, 51 *Fed. Reg.* 22010, 22027, 22042 (1986) (codified at 42 C.F.R. part 482).

¹⁷ 42 C.F.R. § 482.51(a)(2), (3) (2002).

¹⁸ 42 C.F.R. §§ 410.20(b), 410.74(c), 410.75(b), 410.76(b) (2002), rules for physicians, physician assistants, nurse practitioners, and clinical nurse specialists, respectively. Medicare may pay for any medically necessary service that an eligible health professional may perform under state law.

Members of a Variety of Health Professions Serve as Assistants-at-Surgery

Physicians, residents in training for licensure or board certification in a physician specialty, several different kinds of nurses, and members of several other health professions serve as assistants-at-surgery (see table 2). Surgical associations state that surgeons or residents are preferred as assistants-at-surgery, but surgeons are often not available to assist at surgery.

Table 2: Health Professions Whose Members Can Assist at Surgery

Health profession	Total number of members ^a
Physician	
Physician (postresidency)	850,000
Resident	100,000
Nurse	
Registered nurse, including those in surgical specialties, such as orthopedics or plastic surgical nurses	3.1 million ^b
Licensed practical/vocational nurse	900,000
Nurse practitioner	130,000 ^c
Clinical nurse specialist	69,000 ^c
Certified registered nurse first assistant	1,700
Other health professions	
Surgical technologist	71,000
Physician assistant	46,000
Ophthalmic assistant/technician/medical technologist	30,000-40,000
Surgical assistant	5,000-6,000
Orthopedic technologist	3,000
Orthopedic physician assistant	2,500
International medical graduate	Unknown

Source: Health professional associations.

^aNumbers are the most recent data available, typically for 2000.

^bIncludes nurse practitioners, clinical nurse specialists, and CRNFAs. The table also includes separate counts for each of these groups.

^cThe numbers for nurse practitioners and clinical nurse specialists include some nurses who have qualified as both.

Hospitals Employ the Full Range of Health Professions Whose Members Serve as Assistants-at-Surgery

Hospitals employ the gamut of health professionals who serve as assistants-at-surgery to perform the role. Some hospitals tend to hire assistants-at-surgery from a particular health profession, sometimes offering training courses in assistant services for that profession, to ensure that the hospital has a sufficient number of assistants. To encourage surgeons to use their operating rooms, hospitals may (1) employ assistants-at-surgery, eliminating the need for the surgeons to hire their own assistants, or (2) arrange for health professionals in independent practice to serve as assistants.

While teaching hospitals use residents as assistants-at-surgery, these hospitals may also hire nonphysician health professionals to perform the role. In a recent survey of neurosurgery residency program directors, nearly all cited the need to hire nonphysician health professional staff, such as physician assistants, in response to the weekly 80-hour work limit for residents.¹⁹ Teaching hospitals with other surgical specialty programs may also need to hire nonphysician health professionals as assistants-at-surgery because of the limit on resident hours.

Hospital Employees Likely Perform More than Half of All Assistant-at-Surgery Services

Because hospitals are not required to keep records on the use of assistants-at-surgery to receive Medicare payment under the inpatient PPS, the number and cost of such services provided by all hospital employees are unknown. Still, hospital employees likely serve as assistants-at-surgery for the majority of the surgeries performed on Medicare patients. In 2002, Medicare made payments under the physician fee schedule to assistants-at-surgery about 36 percent of the time that the program made payments to surgeons for the surgical procedures that ACS designated in its most recent study as “almost always” requiring an assistant-at-surgery.²⁰ Since the remaining 64 percent of those surgical procedures were likely to have had assistants-at-surgery, hospital employees would likely have performed this role. In its final regulation revising the physician fee schedule for 2000,

¹⁹Dongwoo John Chang, M.D., and Susan Bell, R.N., “Restricted: The Impact of Residents’ 80-Hour Workweek on Neurosurgical Resident Training and Patient Care,” *American Association of Neurological Surgeons Bulletin: The Socioeconomic and Professional Quarterly for AANS Members*, 12:2:7-10 (2003).

²⁰In 2002, about 75 percent of these Medicare-paid services for assistants-at-surgery were for surgical procedures determined by ACS as “almost always” requiring a physician as an assistant, about 24 percent for procedures ACS determined to “sometimes” require an assistant, and the remaining payments were for procedures determined as “almost never” requiring an assistant or for surgical procedures with no designation.

HCFA relied upon the results of the American Hospital Association's (AHA) National Hospital Panel Survey that found that only 11 percent of responding hospitals said it was a regular practice for physicians to bring their own staff to the hospital to serve as assistants-at-surgery or to perform other functions.²¹ A representative of the AHA told us that most assistants-at-surgery, including residents and nonphysician staff, are hospital employees.

Nonphysicians Are Performing an Increased Share of Assistant-at-Surgery Services Paid under the Physician Fee Schedule

The percentage of assistant-at-surgery services paid to physicians under the physician fee schedule has declined, and the percentage of these services paid to nonphysician health professionals has increased, particularly since enactment of the Balanced Budget Act of 1997 (BBA). The act raised the amount paid for assistant-at-surgery services to these nonphysician health professionals under the physician fee schedule, extended billing by clinical nurse specialists and nurse practitioners to urban areas (such billing had been limited to rural areas), and allowed physician assistants to contract with surgeons to be an assistant without having to be employees of the surgeon.²² The number of assistant-at-surgery services paid for under the physician fee schedule and provided by nonphysician health professionals increased more than 200 percent from 1997 through 2002, while the number of services provided by physicians serving as assistants declined about 23 percent.²³ During this period, the percentage of Medicare-paid assistant-at-surgery services performed by nonphysician health professionals increased by 25 percentage points (see fig. 1).

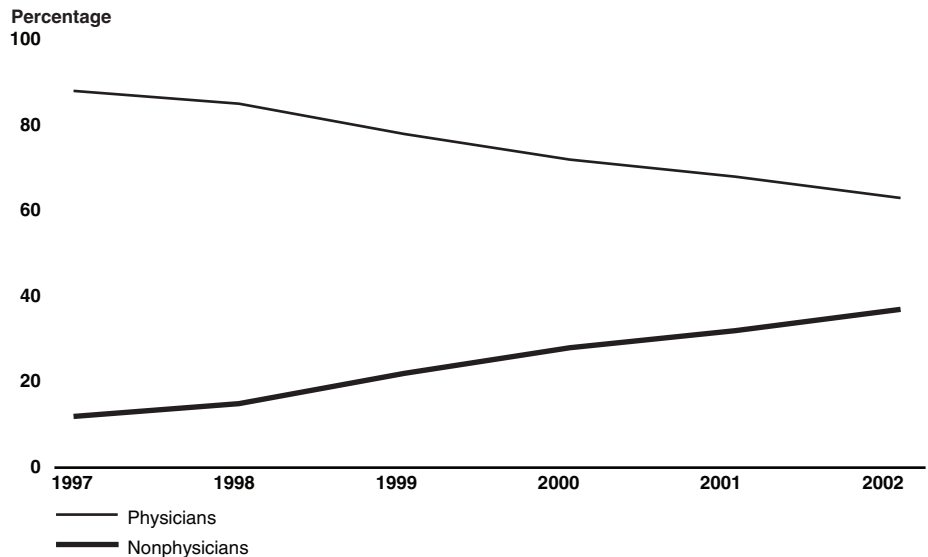
The amount paid to nonphysicians for these services has also increased. Prior to 1987, nonphysicians could not be paid as assistants-at-surgery. In 1997, nonphysicians were paid only \$16 million for assistant-at-surgery services; in 2002, they were paid about \$54 million. In comparison, physicians were paid \$295 million for assistant-at-surgery services in 1986; \$166 million in 1997; and \$104 million in 2002.

²¹Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2000, 64 *Fed. Reg.* 59401 (1999).

²²Pub.L.No. 105-33, §§ 4511-4512, 111 Stat. 251, 442-443. These provisions apply to services performed after 1997.

²³In 1997, Medicare paid 1,246,817 assistant-at-surgery services, 1,100,919 of which were provided by physicians. In 2002, Medicare paid 1,356,244 assistant-at-surgery services, 848,314 of which were provided by physicians.

Figure 1: Percentage of Assistant-at-Surgery Services Paid under the Physician Fee Schedule for Physicians and Nonphysician Health Professionals, 1997-2002



Source: GAO.

Widely Accepted Professional Requirements for Assistants-at-Surgery Do Not Exist

There is no widely accepted set of standards for the education and experience required to serve as an assistant-at-surgery. The health care professions whose members provide assistant-at-surgery services have varying educational requirements. No state licenses all the types of health professionals who serve as assistants-at-surgery. And the licenses they issue typically attest to the completion of broad-based health care education, making them of limited value in determining which health professionals have the education and experience to serve as an assistant-at-surgery. Furthermore, the certification programs developed by the various nonphysician health professional groups whose members assist at surgery differ. We found that there was insufficient information about the quality of care provided by assistants-at-surgery—either generally or by members of specific health professions—to assess the adequacy of the requirements for a particular profession.

Health Professions Whose Members Assist at Surgery Have Varying Educational Requirements

The health professions whose members serve as assistants-at-surgery have varying educational requirements (see table 3). For example, a licensed practical nurse typically completes a 1-year educational program, while a clinical nurse specialist must have a master's of science degree in nursing. In some cases, experience can substitute for education: orthopedic physician assistants may have associate degrees or certificates from military or nondegree programs or 5 years of experience working for an orthopedic surgeon.

Table 3: Education and State Licensure Requirements for Those Who May Assist at Surgery

Health profession	General education requirements	Licensure requirements in all states
Physician		
Physician (postresidency)	Doctor of medicine or osteopathy	Yes
Resident	Doctor of medicine or osteopathy	Yes ^a
Nurse		
Registered nurse, including those in surgical specialties, such as orthopedics and plastic surgical nurses	Associate's or bachelor's degree in nursing or nondegree hospital diploma	Yes
Licensed practical/vocational nurse	1-year program	Yes
Nurse practitioner	Master's of science in nursing or nondegree certificate	Yes ^b
Clinical nurse specialist	Master's of science in nursing	Yes ^b
Certified registered nurse first assistant	Bachelor's degree and certification program	Yes
Other health professions		
Surgical technologist	Associate's degree, military or nondegree certificate	No ^c
Physician assistant	Associate's or bachelor's degree or nondegree certificate	Yes
Ophthalmic assistant/technician/medical technologist	Certificate programs or work experience	No
Surgical assistant	Bachelor's degree or nondegree certificate ^d	No ^e
Orthopedic technologist	1-year certificate program, 2 years of experience, or combination	No
Orthopedic physician assistant	Associate's degree, military or nondegree certificate, or 5 years of experience	No ^f
International medical graduate	Non-U.S. degree in medicine	No

Source: Health professional associations.

^aResidents typically become licensed during their residency training.

^bSome states require an additional license as an advanced practice nurse.

^cOnly two states have laws that regulate this profession: Texas established a licensure program in 2001 for “licensed surgical assistants,” and beginning July 1, 2004, surgical technologists are required to meet registration requirements to practice in Illinois (2003 Ill. Laws 93-0280, adding 225 Ill. Stat. 130/1 – 130/170).

^dSome international medical graduates who have not obtained a residency or qualified for a license choose to become certified as surgical assistants.

^eOnly two states have laws that regulate this profession: Texas established a licensure program in 2001 for “licensed surgical assistants,” and beginning July 1, 2004, surgical assistants are required to meet registration requirements to practice in Illinois (2003 Ill. Laws 93-0280, adding 225 Ill. Stat. 130/1 – 130/170).

^fLicensure is required in Tennessee (Tenn. Code Ann. § 63-19-202 (2003)) and New York (N.Y. Educ. §§ 6540 – 6548 (2001)). In California, some orthopedic physician assistants who were licensed as physician assistants have been grandfathered in as physician assistants.

State Licenses Typically Do Not Require Education and Experience as Assistants-at-Surgery

While state licenses for health professionals, including those eligible for payment as assistants-at-surgery under the physician fee schedule, typically have “scopes of practice” that include assistant-at-surgery services, education and experience as an assistant are not necessarily required to obtain a license: the licenses for these health professions attest to the completion of broad-based health care education, which may not include courses in surgery.

No state licenses all the health professions whose members assist at surgery in its jurisdiction. For example, orthopedic physician assistants and surgical assistants are licensed in only a few states. Only one state, Texas, has a specific assistant-at-surgery license. Members of different health professions may qualify for this license, which requires surgical education and experience.²⁴ Nevertheless, a license is not required to serve as an assistant-at-surgery in Texas.

Nonphysician Health Professions’ Certification Programs for Assistants-at-Surgery Vary

Certification programs for assistants-at-surgery generally require completion of a certain level of education or experience and passage of an examination. Each certification program created by a group of nonphysician health professionals for its members who serve as assistants-at-surgery has different requirements (see table 4). Certification programs for some nonphysician health professions not eligible for

²⁴Effective September 2001, Texas established a license category for “licensed surgical assistants.” (Texas Acts 2001 Tex. Gen. Laws ch. 1014, adding Tex. Occupations Code Ann., ch. 206.) Licensure requirements include 2,000 hours of experience, completion of a surgical training program with courses in specified areas such as anatomy and aseptic technique, an associate’s degree, and certification by a national organization recognized by the Texas State Board of Medical Examiners.

payment under the physician fee schedule are for a wide range of surgical services; others are specific to a particular type of surgery. For example, a CRNFA, in addition to being licensed as a registered nurse and earning a bachelor's degree in nursing,²⁵ must obtain certification as an operating room nurse, complete an approved program, have 2,000 hours of experience as an assistant-at-surgery, and pass an examination. For a surgical technologist to receive certification as an assistant-at-surgery, he/she must have a surgical technologist certification, complete an approved program or have 2 years of experience as an assistant, and pass the examination.

Certifications for those who are eligible for payment under the physician fee schedule as an assistant-at-surgery are typically for a broad range of services and are not specifically surgery-related. For example, the American Nurses Credentialing Center awards certifications to nurse practitioners for acute, adult, family, gerontological, pediatric, adult psychiatric and mental health, and family psychiatric and mental health care.

²⁵As of January 1, 2000, only registered nurses who have a bachelor's degree in nursing can be newly certified as CRNFAs. In 2002, less than 20 percent of CRNFAs had such a degree.

Table 4: Surgical Education and Experience Requirements for Certification as an Assistant-at-Surgery

Health profession	Surgical education requirements for certification	Surgical experience requirements for certification
Nurse		
Registered nurse, surgery-related certification ^a	Requirements vary by certification program, but surgical education is not required for certain surgical-related certifications	Requirements vary by certification program, but surgical experience is not required for certain surgical-related certifications
Certified registered nurse first assistant	Two to three surgical classes	2,400 hours of operating room experience in the scrub or circulating role and 2,000 hours as assistant-at-surgery
Other health professions		
Surgical assistant ^b	Completion of an approved surgical assistant education program or an international medical education program, unless surgical experience is substituted	2 to 3 years of surgical assistant experience, depending on certification program
Orthopedic physician assistant ^c	Three permissible educational paths for certification: completion of an orthopedic physician assistant program that includes surgical education; a primary care physician assistant program that may have minimal surgical education; and a nurse practitioner program that may or may not include surgical education, unless surgical experience is substituted	5 years of experience that includes surgical assisting
Surgical technologist ^d	Completion of an approved surgical education program that includes instruction and supervised surgical experience, unless surgical experience is substituted	2 years of surgical experience
Orthopedic technologist ^e	Completion of an approved surgical education program that includes an operating room rotation, unless surgical experience is substituted	1 year of surgical experience
Ophthalmic assistant/technician/medical technologist ^f	Completion of an approved education program that includes instruction and supervised surgical experience, unless surgical experience is substituted	18 months of surgical experience

Source: Health professional associations.

^aA variety of surgery-related certifications are available to registered nurses. Some of these are for surgical specialties, such as orthopedic nurse certified (ONC) or certified plastic surgical nursing (CPSN). While the ONC requires 1,000 hours of experience as an orthopedic nurse and the CPSN requires 2 years' experience of plastic surgical nursing, both of which may include operating room experience, neither program requires operating room experience.

^bCertified Surgical Assistant (CSA), Surgical Assistant-Certified (SA-C).

^cOrthopedic Physician's Assistant, Certified (OPA-C).

^dCertified Surgical Assistant/Certified First Assistant (CST/CFA).

^eOrthopedic Technologist-Surgery Certified (OT-SC).

^fCertified Ophthalmic Assistant (COA), Technician (COT), or Medical Technologist (COMT)-Ophthalmic Surgical Assisting.

No National Consensus on Requirements for Assistants-at-Surgery Exists

While some national physician and accreditation organizations say assistants-at-surgery should have to meet some requirements, there is no consensus about what those requirements should be. For example, ACS has stated that when surgeons or residents are unavailable to serve as assistants-at-surgery, nonphysician health professionals should be allowed to perform the role if they meet the “national standards” for their health profession or have “additional specialized training.” Similarly, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a private organization that accredits health care organizations, including hospitals, requires hospitals to credential their staff (i.e., establish requirements, such as licensure, certification, and experience for physicians and certain nonphysician health professionals) and ensure that those requirements are used when personnel decisions are made. But JCAHO does not suggest the type or length of education or experience to be used in credentialing hospital staff who serve as assistants-at-surgery.

Literature on Assistants-at-Surgery Is Insufficient to Evaluate Quality of Care

We found little evidence about the quality of care provided by assistants-at-surgery. Our February 2003 search of relevant literature maintained by the National Library of Medicine found only six articles dealing with the quality of care provided by assistants-at-surgery. None of the articles compares the quality of assistant-at-surgery services provided by one nonphysician health profession with that provided by another nonphysician health profession or physicians, and only one deals specifically with the influence of assistants on surgical outcomes.

While Medicare Payments for Assistant-at-Surgery Services Have Flaws, Paying Hospitals for All These Services Would Correct Them

There are three flaws in Medicare’s policies for paying assistants-at-surgery that prevent the payment system from meeting the program’s goals of making appropriate payment for medically necessary services by qualified providers. First, because Medicare pays for assistant-at-surgery services under both the hospital inpatient PPS and the physician fee schedule, and hospital payments for surgical care are not adjusted when an assistant receives payment under the physician fee schedule, Medicare may be paying too much for some hospital surgical care. Second, paying a health professional under the Medicare physician fee schedule to be an assistant-at-surgery, instead of including this payment in an all-inclusive payment, gives neither the hospital nor the surgeon an incentive to use an assistant only when one is medically necessary. Third, the distinctions between those health professionals eligible for payment as an assistant-at-surgery under the physician fee schedule and those who are not eligible

are not based on surgical education or experience as an assistant. Criteria for determining who should be paid as assistants-at-surgery under the physician fee schedule do not exist. However, hospitals are responsible under health and safety rules to provide quality care for their patients.

Medicare Payments for Assistants-at-Surgery Are Flawed

Medicare's policy of paying hospitals for the services associated with inpatient surgical care that may include assistant-at-surgery services and also paying physicians and certain nonphysician health professionals for those services is flawed. When Medicare pays under the hospital inpatient PPS and under the physician fee schedule for assistant-at-surgery services delivered to a particular patient, Medicare may pay too much for the assistant services because the hospital is not paid less when the assistant receives payment under the physician fee schedule. In addition, a hospital that uses an assistant-at-surgery who is eligible for payment under the physician fee schedule has a financial advantage in the form of lower labor costs over a hospital that uses assistants who cannot be paid under the physician fee schedule.

Given the discretion that hospitals and surgeons have in determining when and how an assistant-at-surgery is used, it is especially important that Medicare's payment policy create incentives to help ensure that assistant services are provided for Medicare patients only when medically necessary.²⁶ Allowing physician fee schedule payments to certain assistants-at-surgery, however, creates an incentive for hospitals to use them, rather than those who cannot be paid under the fee schedule. Because neither the hospital nor the surgeon incurs a cost when an assistant-at-surgery is paid under the physician fee schedule, neither has a financial incentive to use an assistant only when one is necessary. The lack of this incentive is of concern because assistant-at-surgery services receive little review to determine the medical necessity of the services. A 2001 report by the Department of Health and Human Services Office of Inspector General²⁷ found that most contractors used by Medicare to pay for part B services do not have any mechanism to ensure that assistant-at-surgery requests for payment for nonphysician health professionals are

²⁶No Medicare payment may be made for any expenses incurred for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury...." 42 U.S.C. § 1395y(a)(1)(A) (2000).

²⁷Department of Health and Human Services, Office of Inspector General, *Medicare Coverage of Non-Physician Practitioner Services*, OEI-02-00-00290, June 2001.

reviewed for medical necessity before they are paid. Medicare routinely requires submission of documentation of medical necessity for medical review for only 1 percent of assistant-at-surgery services paid under the physician fee schedule.

Because the requirements for those authorized to be paid as assistants-at-surgery under the Medicare physician fee schedule do not include assistant-at-surgery education or experience, payments can be made to assistants with no such education or experience. For example, about 23 percent of physician assistants work in surgical specialties. Other physician assistants working in nonsurgical specialties, however, may be paid as assistants-at-surgery under the Medicare physician fee schedule, and their only surgical experience may be a 6-week surgical rotation. On the other hand, nonphysician health professionals, such as surgical technologists, CRNFAs, and orthopedic physician assistants, all of whom have certification programs requiring education and experience as an assistant-at-surgery, cannot be paid by Medicare for their services under the physician fee schedule.

One way to address a concern associated with the physician fee schedule payments for assistants-at-surgery is to expand the number of nonphysician health professions eligible for payment. But this would not ensure that only those with the appropriate education and experience serve as assistants-at-surgery unless CMS also sets standards for all those who serve as assistants. There is no consensus, however, on what such standards should include.

Bundling Payments for Assistant-at-Surgery Services into Hospital Payments Would Be Preferable to Bundling into Surgeons' Fees

Bundling all payments for assistants-at-surgery into either the inpatient hospital PPS or the surgeon's global fee would address the flaws of the current payment system. The possibility of paying too much for assistant-at-surgery services would be eliminated because Medicare would make only one payment—to either the hospital or the surgeon—for the service. The hospital or surgeon would have a financial incentive to use the most appropriate assistant-at-surgery—and to use one only when necessary—because the payment would be the same regardless of whether an assistant was used. The lack of a relationship between the nonphysician health professionals eligible for assistant-at-surgery payments under the physician fee schedule and their education and experience would be moot because payments would no longer be made to individuals performing the

role; payments would be made, as part of a larger payment for a bundle of services, to hospitals or surgeons, who would have the responsibility to determine the education and experience that an assistant-at-surgery needs and when an assistant is needed.

Folding payments for assistant-at-surgery services into inpatient PPS payments has some advantages that would not accrue if payments were folded into the surgeon's global fee. Hospitals would continue to have incentives to use assistants-at-surgery when they are necessary, and to use the most appropriate assistant. Hospitals are already responsible—under the hospital CoP—for ensuring the health and safety of their patients and that necessary services are provided, including assistant-at-surgery services. Most hospitals already have credentialing processes for their employees. Also, since hospitals likely employ most assistants-at-surgery, limiting payments for assistant services to those made under the inpatient PPS would disrupt the employment relationships for far fewer assistants than would be the case if payment was made to surgeons.

There is precedent for Congress approving legislation that no longer allows a service to be paid for separately under part B, but instead requires that the service be included in a bundle of services under part A. In 1997, Congress passed legislation that requires virtually all kinds of services or items furnished to beneficiaries residing in skilled nursing facilities (SNF) that had been paid for separately under part B, instead be included in a bundle of services paid for under part A.²⁸ Prior to implementation of the provision, SNFs could permit a nonphysician health professional or supplier to seek payment under part B for ancillary services or items furnished directly to SNF residents, as long as the SNF did not include the service or item in its part A bill. The legislation, however, prevents this “unbundling” by including in Medicare SNF PPS payments ancillary services or items a SNF resident may require that previously had been paid under part B.

Bundling assistant-at-surgery services into the package of services covered by the surgeon's global payment based on the Medicare physician fee schedule has significant drawbacks. First, because the amount paid under the inpatient hospital PPS for assistants-at-surgery is unknown, the total amount to be added to the physician fee schedule for providing assistants is unknown. Second, a payment amount for assistant-at-surgery services

²⁸BBA, § 4432, 111 Stat. 414.

would have to be determined for each surgical procedure. Since data are not collected on how often each surgeon uses assistants-at-surgery for each surgical procedure, the bundled payment would presumably include an allotment for the expected average cost of assistants for all surgeons performing the procedure. Using this approach, surgeons with an unusually high number of procedures requiring assistants would be paid too little, while those with an unusually low number of procedures requiring assistants would be paid too much. In addition, a surgeon would have a financial incentive to use an assistant-at-surgery less frequently for surgical procedures for which ACS says that an assistant may be needed, even when the condition of the beneficiary indicates that an assistant would be desirable. Because there is a difference in costs to a surgeon depending on whether an assistant-at-surgery is used, a surgeon's bundled payment amount could be adjusted when an assistant is used. Doing so, however, would provide no financial incentive for surgeons to use an assistant-at-surgery only when one is medically necessary.

Conclusions

Decisions to use an assistant-at-surgery should not be influenced by payment; they should be based on medical necessity. The majority of assistants-at-surgery are likely employed by hospitals, where the inpatient hospital PPS pays for their services. If Congress were to consolidate Medicare physician fee schedule payments for assistant-at-surgery services into the inpatient hospital PPS, this would give hospitals an incentive to use assistants only when they are necessary. Meanwhile, the hospital CoP would continue to give hospitals an incentive to assure that the most appropriate assistants-at-surgery are used as part of their responsibility to provide quality care for their patients. Paying for assistants under the physician fee schedule provides no such incentive.

Matter for Congressional Consideration

We suggest that Congress may wish to consider consolidating all Medicare payments for assistant-at-surgery services under the hospital inpatient prospective payment system.

Agency Comments

We received comments on a draft of this report from CMS, which agreed that payment policy for assistants-at-surgery could be improved. CMS noted that it would be helpful to describe the ongoing review process that CMS uses to assign relative values to physician fee schedule services. However, as we state in this report assistants-at-surgery are not paid on the basis of the resources they use to perform their work, but are instead

paid a percentage of the amount paid the surgeon. CMS also discussed several details related to implementing payment changes for assistants-at-surgery. Addressing these points was beyond the scope of this report. CMS's comments appear in appendix II. In addition, we obtained oral comments on a draft of this report from representatives of the American Medical Association, the American College of Surgeons, the American Society of General Surgeons, the American Association of Orthopaedic Surgeons, the Society of Thoracic Surgeons, the American Academy of Nurse Practitioners, the American Academy of Physician Assistants, the Association of periOperative Registered Nurses, and the American Hospital Association. We have modified the report, as appropriate, in response to their comments.

We are sending copies of this report to the Acting Administrator of CMS, appropriate congressional committees, and other interested parties. We will also make copies available to others upon request. This report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please call me at (202) 512-7101. Lianne Bradley and Michael Rose were major contributors to this report.

A handwritten signature in black ink that reads "Marjorie Kanof". The signature is written in a cursive, flowing style.

Marjorie Kanof
Director, Health Care—Clinical Health Care Issues

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Ranking Minority Member
Committee on Ways and Means
House of Representatives

Appendix I: Professional Associations, Schools, and Hospitals

To obtain information about assistants-at-surgery and their services we contacted subject matter experts. We interviewed representatives of:

American Academy of Nurse Practitioners
American Academy of Physician Assistants
American Association of Orthopaedic Surgeons
American Board of Surgical Assistants
American College of Surgeons
American Hospital Association
American Medical Association
American Nurses Association
American Nurses Credentialing Center
American Society of General Surgeons
American Society of Plastic Surgical Nurses
Anne Arundel Community College, Department of Nursing
Association of periOperative Registered Nurses
Association of Surgical Technologists
BJC HealthCare
Centers for Medicare & Medicaid Services
Certification Board Perioperative Nursing
Commission on Accreditation of Allied Health Education Programs
Duke University Hospital
Educational Commission for Foreign Medical Graduates
Ft. Sam Houston, Academy of Health Sciences, U.S. Army
Inova Fairfax Hospital
Johns Hopkins University, School of Medicine
Joint Commission on Allied Health Personnel in Ophthalmology
Massachusetts General Hospital
Mayo Clinic
Medical Group Management Association
Montgomery College Surgical Technology Program
National Association of Clinical Nurse Specialists
National Association of Orthopaedic Nurses
National Board for Certification of Orthopaedic Technologists
National Commission for Certifying Agencies/National Organization for Competency Assurance
National Rural Health Association
National Surgical Assistant Association
Naval School of Health Sciences
New York State Board for Medicine
Office of the Surgeon General of the Air Force
Office of the Chief, Medical Corps, U.S. Navy
Stanford University Hospital

**Appendix I: Professional Associations,
Schools, and Hospitals**

Texas State Board of Medical Examiners
The American Society of Orthopaedic Physician's Assistants
The Cleveland Clinic
The Society of Thoracic Surgeons
University of California at Los Angeles School of Nursing
University of Maryland School of Nursing
University of Michigan Hospital
University of Washington Medical Center

Appendix II: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

DEC 22 2001

Administrator
Washington, DC 20201

TO: Marjorie Kanof
Director, Health Care—Clinical Health Care Issues
General Accounting Office

FROM: Dennis G. Smith *Dennis G. Smith*
Acting Administrator
Centers for Medicare & Medicaid Services

SUBJECT: General Accounting Office Draft Report: "Medicare: Payment Changes Are Needed For Assistants-at-Surgery," (GAO-04-97)

Thank you for the opportunity to comment on the General Accounting Office's (GAO) draft report entitled, *Medicare: Payment Changes are Needed for Assistants-at-Surgery*.

In this report, GAO examines: (1) who serves as an assistant-at-surgery; (2) whether health professionals who perform the role must meet a uniform set of professional requirements; and (3) whether Medicare's payment policies for assistants-at-surgery are consistent with the goals of the program and, if not, whether there are alternatives that would help attain those goals.

The GAO suggests that the Congress may wish to consider consolidating all Medicare payment for assistant-at-surgery services under the hospital inpatient prospective payment system (IPPS).

The CMS has the following comments:

- The CMS agrees that payment policy in this area could be improved. However, many of the policy changes envisioned, such as changing IPPS rates, would require Congressional action.
- We understand GAO's concerns regarding the qualifications of assistants-at-surgery. In the report, GAO may want to balance this concern with the importance of a surgeon's medical judgment and practice preferences. For example, in some cases, shifting payment for these services to IPPS rates may be disruptive to surgeons that have built up relationships with their assistant-at-surgery staff. If a physician insists on using his or her own staff, it is not clear how this assistant-at-surgery would be reimbursed or whether the hospital would even permit the assistant to perform services. GAO may want to address this issue in their report.
- It might be helpful if GAO further explained how the construction of the IPPS rates and physician fee schedule (PFS) rates creates the potential for duplicate payment.

Page 2 — Marjorie Kanof

- In GAO's discussion on why assistant-at-surgery cases should not be bundled into the PFS payment rates, it cites several drawbacks. It may be helpful to describe the ongoing review process CMS uses to assign relative values to PFS services, since this process addresses several of the concerns GAO raised in this section.
- The GAO may want to consider the effect of the Sustainable Growth Rate (SGR) system in their analysis of this issue. If Congress were to move assistant-at-surgery expenses into the bundled PPS rates or into the PFS rates, the SGR could play a role in determining total actual savings to the Government.
- It is important to note that total PFS payments, including assistant-at-surgery payments under the PFS, grow at a predetermined amount based on a formula set in law. Whether or not these payments are made under the PFS, the total amount of money spent under the PFS remains the same.
- Any changes to the IPPS rates would require Congressional action.

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