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 too 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.
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.” 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 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
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.

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.