ASANEWS

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MEDPAC DISCUSSION OF CRNFA AT SEPTEMBER MEETING

On September 9-10, 2004, the Medicare Payment Advisory Commission (MedPAC) held a public meeting with open comment periods at the Ronald Reagan Building and International Trade Center in Washington, DC. At the meeting, analyst David Glass presented a mandated report on the Certified Registered Nurse First Assistance study.

As required by the Medicare Modernization Act (MMA), MedPAC was mandated to conduct a study on the feasibility and advisability of providing for payment under part B for surgical first assisting services furnished by a certified registered nurse first assistant (CRNFA) to Medicare beneficiaries. This study was discussed in an the Spring 2004 newsletter, after the GAO released the results of their study in January. A draft copy of the study, prepared by Glass and other members of the MedPAC staff, was shared with the commissioners at the meeting, but was not available to the public. The report on the study, along with recommendations for legislation or administrative actions, is due by January 1, 2005.

As reported, CRNFAs and other nonphysician surgical assistants including surgical technologists, Certified First Assistants, and/or Certified Surgical Assistants cannot bill Medicare separately for first assistant surgical services. Only physician assistants, certified nurse midwives, clinical nurses, and nurse practitioners can bill separately for such services, though physician assistants account for much of the bulk of the first assisting performed by nonphysician practitioners, who are paid separately.

During his presentation, Glass suggested that the optimal solution would be to combine the global surgical professional fee and hospital payment. Further, surgeons and hospitals would determine who should assist and get paid, as well as divide the payment to reflect who supplies assistants. In this process, ASA has voiced the concern that the GAO report was flawed and it over-reported 70,000 hospital employed surgical technologists incorrectly as surgical assistants. This flaw in the report may have falsely led GAO, and now MedPAC, to believe that there are far more hospital employed surgical assistants than actually exist. Our data show that, to the contrary, most surgical assistants are self-employed. AST, ASA, and several other groups representing nonphysician surgical assistants have therefore sought direct Medicare reimbursement.

Following remarks by Glass, members of the commission offered their comments. Several commissioners, including Ralph Muller, Glenn Hackbarth and Mary Wakefield, noted that the preferred conclusion may be too big a response to too small a problem and that "CMS

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has bigger fish to fry." Hackbarth and Wakefield further noted that they did not foresee CMS adopting the preferred solution any time soon. Rather, they believe, in the short term, another alternative should be sought. Commissioner Autry DeBusk agreed with Hackbarth and Wakefield and added that the country is in need of CRNFAs, because they have the education, license, and experience needed to assist during surgery. All comments were taken into consideration and the commission will revisit the issue at their October meeting.

The commission then heard public comments from Marlene Creighton, a CRNFA from Buffalo, and Sharon McElrath, of the American Medical Association (AMA). Creighton stressed that nurses and RNs are a cost-effective entity that Medicare is not taking advantage of. McElrath reminded the commission that the same proposal came up two years ago and was turned down due to overwhelming influence from the American College of Surgeons and the AMA. McElrath further cautioned against stirring up consternation when many are already facing cuts in Medicare payments.

A transcript of the September meeting is available online at MedPAC's web site: *www.medpac.gov/public_meetings/transcripts/0904_allcombined_transc.pdf*. Pages 126-148 describe the commission's discussion of the study, and pages 148-152 show public comments on the study. ASA has been and will be represented at any further public hearings by organization leadership and by our Washington lobby firm, Capitol Associates.

ASA FORUM 2005

For the last three years, the Association of Surgical Assistants has held its annual forum in Washington, DC, in late September or early October. In the interest of positioning ourselves for a better lobby period with the 2004 election pending, this year's ASA Forum has been moved forward to April 8-10, 2005. We believe the April date will be ideal for a powerful lobby day, and one that will be enhanced by combining the ASA forum with the AST State Assembly Leader's Forum, which will be held in the same hotel at the same time. Both groups will attend the lobby day and work on the same issues, and the increased numbers will be powerful.

Our ASA Forums in the past have focused on "The Business of Surgical Assisting," and have proven to be not only a great resource for surgical assistants just starting out, but also for the experienced assistant looking for more or better information. The forum itself is a networking opportunity not to be missed, and anyone who has participated in a lobby day on Capitol Hill will tell you it's a very informative and exciting experience.

This year, the forum will be held at the Jurys Hotel in the heart of the capital. This hotel overlooks Dupont Circle, a tree-lined urban park at the edge of the downtown business district, near Embassy Row, just seven blocks from the White House.

This year's forum will feature the addition of a clinical track on Saturday, a great opportunity to earn those much-needed CEUs. More information on the hotel location is available online at *www.jurys-washingtondc-hotels.com/jurys_washingtondc*, and information on the meeting itself will be available soon at *www.surgicalassistant.org*.

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In the course of our work with members at ASA, we have become aware of many instances in which the "legality" of surgical assisting by nonphysician assistants has been called into question. This article will be the first in a series that will demonstrate the support for the profession that has been shown by respected medical associations and societies, and that has been codified in state law.

Generally speaking, CST/CFAs acting as first assistants are doing so under the broad delegatory authority of physicians, specific provisions for which vary slightly from state to state. The basis for CST/

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Our AMA: (1) affirms that only licensed physicians [...] education, training, experience and demon[...] competence should perform surgical procedures;

(2) recognizes that the responsible surgeon m[...] performance of part of a given operation to su[...] provided the surgeon is an active participant throug[...] part of the operation. Given the nature of the su[...] role and the potential of risk to the public, it is app[...] that qualified personnel accomplish this function;

(3) policy related to surgical assistants, con[...] American College of Surgeons' Statements on Pri[...] The surgical assistant is limited to performing spe[...] defined in the medical staff bylaws, rules and re[...] generally include the following tasks: aid in main[...] exposure in the operating field, cutting suture ma[...] and ligating bleeding vessels, and, in selected in[...] performing designated parts of a procedure. (b) [...] responsibility to designate the individual most ap[...]

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CFAs serving as first assistants is usually found in state medical practice acts or as rendered through the states' attorneys' general offices. The underlying principle is that "physicians/surgeons may delegate to non-physicians, those tasks normally carried out by another physician when performed under the direct supervision and in the physical presence of the physician and the physician and/or employer has made a reasonable determination that the person to whom those tasks are to be delegated has the appropriate skills and knowledge to safely perform those tasks." This principle supports the discretion of the physician in determining who will assist and to what extent, throughout the conduct of his or her case. It also emphasizes the need for all individuals who function as first assistants to be credentialed by the institution in which those specific services will be provided.

The American Medical Association has affirmed these principles with a statement within the "Policies of the AMA House of Delegates," which they refer to as "cornerstones of the AMA in the sense that they define what the association stands for as an organization." The AMA goes on to state the importance of proper hospital credentialing for any individual that practices as a surgical assistant. (See sidebar for the text of the statement.)

AST and ASA have been fortunate to have the support of groups like the American Medical Association and the American College of Surgeons for many years. The importance of the direct physician to surgical assistant delegatory relationship cannot be underestimated, and we have been fortunate that these two groups have consistently affirmed the principles we believe help us provide safe, high quality patient care in the operating room.

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purpose within the bylaws of the medical staff. The first assistant to the surgeon during a surgical operation should be a credentialed health care professional, preferably a physician, who is capable of participating in the operation, actively assisting the surgeon. (c) Practice privileges of individuals acting as surgical assistants should be based upon verified credentials and the supervising physician's capability and competence to supervise such an assistant. Such privileges should be reviewed and approved by the institution's medical staff credentialing committee and should be within the defined limits of state law. Specifically, surgical assistants must make formal application to the institution's medical staff to function as a surgical assistant under a surgeon's supervision. During the credentialing and privileging of surgical assistants, the medical staff will review and make decisions on the individual's qualifications, experience, credentials, licensure, liability coverage and current competence. (d) If a complex surgical procedure requires that the assistant have the skills of a surgeon, the surgical assistant must be a licensed surgeon fully qualified in the specialty area. If a complication requires the skills of a specialty surgeon, or the surgical first assistant is expected to take over the surgery, the surgical first assistant must be a licensed surgeon fully qualified in the specialty area. (e) Ideally, the first assistant to the surgeon at the operating table should be a qualified surgeon or resident in an education program that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) and/or the American Osteopathic Association (AOA). Other appropriately credentialed physicians who are experienced in assisting the responsible surgeon may participate when a trained surgeon or a resident in an accredited program is not available. The AMA recognizes that attainment of this ideal in all surgical care settings may not be practicable. In some circumstances, it is necessary to utilize appropriately trained and credentialed unlicensed physicians and non-physicians to serve as first assistants to qualified surgeons. (BOT Rep. 32, A-99; Reaffirmed: Res. 240, 708, and Reaffirmation A-00)

Source: *www.ama-assn.org/apps/pf_new/pf_online?f_n= browse&doc=policyfiles/HnE/H-475.986.HTM* (accessed 09-28-04).