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Glenn M. Hackbarth, J.D., Chairman
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December 30, 2004

The Honorable Richard B. Cheney
President of the Senate
U.S. Capitol
Washington, DC 20515

Dear Mr. Vice President:

Section 643 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Medicare Payment Advisory Commission to report on the feasibility and advisability of paying certified registered nurse first assistants (CRNFAs) separately under Medicare for first assistant at surgery services. Our findings are as follows.

Currently, physicians and certain nonphysician practitioners specified in statute [physician assistants (PAs), clinical nurse specialists (CNSs), nurse practitioners (NPs), and certified nurse midwives (CNMs)] are paid separately by Medicare when they function as first assistants at surgery.¹ Physicians are paid 16 percent of the physician fee for surgery; PAs, CNSs, and NPs are paid 85 percent of 16 percent (or 13.6 percent) of the physician fee; CNMs are paid 65 percent. Other nonphysician practitioners (NPPs) who function as first assistants, such as CRNFAs, surgical technologists, and orthopedic physician assistants, are not eligible for separate payment from Medicare and instead are typically paid by the hospital or surgeon. A change in law would be required for them to become eligible.

Background

In 2002 Medicare paid \$158 million for first assistant at surgery services for providers who charged separately. Medicare paid physicians \$104 million and NPPs \$54 million. In total the \$158 million paid for these services was less than 2 percent of the amount Medicare paid to surgeons for surgical procedures in 2002, and almost 90 percent of the services were for hospital

¹ Residents are not allowed to charge separately because their cost is considered to be covered through general medical education payments to teaching hospitals. If a surgical resident is available, no one else is allowed to charge for first assisting services with some exceptions.

inpatients.² This estimate is not comprehensive, because the costs of providers who performed first assistant at surgery services but did not charge Medicare separately are subsumed in hospital and physician payments and cannot be separately estimated.

Most surgeries do not use separately billing first assistants. Of the 74 million surgical procedures Medicare paid for in 2002, only about 5 million were for procedures where Medicare permits billing for a first assistant.³ Of those surgeries deemed to “almost always” require a first assistant by the American College of Surgeons (ACS), 36 percent had a charge for a separately billable first assistant.⁴ The other 64 percent presumably used a first assistant paid for by a hospital or a physician, such as a resident, a CRNFA, or a surgical technologist.

Hospitals and physicians may be using CRNFAs and other first assistants who are not paid separately because they improve efficiency or because they improve quality. Physicians may prefer to use assistants whom they have trained and are accustomed to working with because they enable the physicians to operate more efficiently. Because the physician fee schedule pays a fixed amount per procedure, if physicians can complete an operation in less time than the average, it is to their advantage to do so. Similarly the hospital is paid a fixed amount for each discharge in a diagnosis related group. If the operating room is used for less time than the average, it is to the hospital's advantage. Because CRNFAs may attend to the patient pre- and post-operatively, it is possible that they are viewed as leading to efficiencies in those phases of care as well, for example, by decreasing length of stay. (See attachment for a discussion of the definition of CRNFA first assisting services.) Although Medicare does not currently pay directly for quality, physicians and hospitals are likely to prefer high- to low-quality outcomes. If CRNFAs are thought to improve quality by, for example, improving outcomes or increasing patient satisfaction, there would be incentive to use them for that reason as well.

CRNFAs are licensed as registered nurses (RNs) in all 50 states. They are certified by the Certification Board of Perioperative Nursing and are required to have:

- been certified in perioperative nursing (two years and 2,400 hours of perioperative practice),
- completed 2,000 hours of practice as an RN first assistant,
- completed a formal RNFA program with classroom and clinical internship, and
- earned a Bachelor's or Master's of science in nursing (a new requirement; 38 percent of current CRNFAs meet this requirement).

² General Accounting Office. 2004. *Medicare: Payment changes are needed for assistants-at-surgery*. Washington, DC: GAO, (GAO-04-97)

³ MedPAC analysis of 2002 Medicare claims.

⁴ GAO *ibid*.

The Association of periOperative Registered Nurses (AORN) reports there were 1,689 CRNFAs in January 2003, with 13 states having fewer than 10.⁵

The levels of education and training differ for the NPPs who currently can bill Medicare separately. CNSs and NPs have master's degrees in nursing and are licensed in all states either as RNs or as advanced practice nurses. They require 500 hours of clinical experience before certification. By contrast, PAs commonly have several years of health care experience before entering training, and training can be at the certificate, associate's, bachelor's, or master's level though most programs last two years. The National Commission on Certification of Physician Assistants certifies PAs, and they are licensed by all 50 states. Medicare does not impose any standards for NPPs; instead it relies on the certification programs or state licensing to set education and experience standards, hence no specific surgical experience is required by Medicare for NPPs functioning as first assistants at surgery.

Some types of NPPs are not licensed in all states. In previous reports to the Congress, the Commission did not recommend changing policy by extending separate billing status to either orthopedic physician assistants or certified surgical technologists, because they were not licensed in most states and their payment was considered covered as part of the prospective payment to the facility.⁶

The Government Accountability Office (GAO) recently reported on this issue of paying CRNFAs for assistant at surgery services from the physician fee schedule.⁷ GAO concluded that the current system for paying for assistant-at-surgery services is flawed and suggested that the Congress consider bundling all assistant-at-surgery payments into the hospital inpatient PPS. CMS has stated that care should be taken not to disrupt existing assistant-at-surgery relationships that surgeons have established and is therefore not planning changes to assistant-at-surgery policies.⁸

⁵ Communication from Association of periOperative Registered Nurses. August 10, 2004.

⁶ Medicare Payment Advisory Commission. 2002. *Medicare coverage of non-physician practitioners, and Medicare Payment to Advanced Practice Nurses and Physician Assistants*. Washington, DC: MedPAC.

⁷ GAO *ibid*.

⁸ Kuhn, Herb B., Director, Centers for Medicare Management of the Centers for Medicare & Medicaid Services. Letter to Stephen C. Crane, Executive Vice President/Chief Executive Officer, American Academy of Physician Assistants, May 27, 2004.

Effect of Paying CRNFAs separately

If Medicare adds CRNFAs to the list of NPPs eligible for payment under the fee schedule, there are several possible outcomes for Medicare payment. To the extent that CRNFAs substitute for other directly billable NPPs such as PAs, there would be no change in Medicare payment. If they substitute for physicians, there would be some savings because NPPs are paid less than physicians. By contrast, if they substituted for residents or if they were paid by Medicare for their current first assisting services, there would be additional cost. Similarly, beneficiary cost sharing will increase in the last two cases (see Table 1). It is possible that if the pool of chargeable first assistants increased, more operations would use first assistants.⁹ There is no evidence to predict what would happen to the quality of outcomes.

Table 1. Impact of allowing direct payment of CRNFAs by Medicare

Policy	Who assists?	Medicare payment change	Beneficiary copayment change
Current: Physician or hospital pays CRNFA, no Medicare direct payment	CRNFA	none	none
New: CRNFA directly bills Medicare, gets paid 13.6% of the physician fee schedule payment	CRNFA replaces PA, CNS, or NP as first assistant	none	none
	CRNFA replaces physician	(13.6% – 16%) or – 2.4%	– 2.4%
	CRNFA replaces resident	+ 13.6%	+ 13.6%
	CRNFA was doing previously with no separate payment	+ 13.6%	+ 13.6%

Note: CRNFA (certified registered nurse first assistant), PA (physician assistant), CNS (clinical nurse specialist), NP (nurse practitioner).

⁹ The ACS classified about 5,000 surgical procedures: 1,750 were classified as almost always requiring an assistant at surgery, 1,550 as sometimes, and 1,700 as almost never. Presumably those almost always requiring an assistant already have assistants and only those sometimes requiring an assistant would increase.

Given the small number of CRNFAs, any change in program cost would be relatively small in the short run. However, if the CRNFA certification became more valuable, as it would if they could directly bill Medicare, the number seeking certification might increase. In addition, an important principle is that Medicare should not pay twice for the same service. To the extent that the facility payment already covers the cost of a first assistant at surgery, any additional payment for directly billable first assistants can be thought of as duplicative.¹⁰

Conclusion

An ideal payment system would recognize the complicated reality that different surgeons have different preferences for whom they use to assist them, and that the arrangements between hospitals and surgeons differ according to circumstance. For example, some surgeons routinely bring their own assistants with them to the hospital. Those assistants may be physician assistants, surgical technologists, or others—some eligible for separate payment and some not. In some cases physicians pay the NPP, and in some cases the hospital reimburses the physician for the NPP's time. In some hospitals, for some surgeries, hospital employees, including CRNFAs, are more commonly used. These differing arrangements reflect the capabilities of the hospital staff at different hospitals and the kinds of technologies being used.

One conceptual idea that could recognize this complicated reality would be to combine the payments for the surgeon's professional fee and the hospital service and let the hospital and surgeon decide when it is clinically appropriate to use an assistant at surgery, what assistant to use, and how to divide the combined payment. The Congress would not have to decide who is eligible for payment, decide payment levels, or consider new providers as technology changes. Rather, hospitals and surgeons could make the decision of whom to use according to their differing circumstances. Combining payments is an approach that has been used with some success in the past, for example in the Medicare participating heart bypass center demonstration, and serves as a useful reference point in considering future payment system changes.

Combining payments could also give Medicare another mechanism to pay for quality. That is, the quality of a surgery and its related pre- and post-surgical care could be measured as a whole; and the hospital and the surgeon would be jointly accountable. Combining hospital and physician payments would make it possible for Medicare to reward good quality outcomes directly, and leave it to the participants in the care to divide the reward among themselves. For example, if the physicians and the hospitals determined that using particular first assistants led to better outcomes, then they could use and pay for those first assistants and they would be rewarded for better quality.

¹⁰ This concern is not new, it was raised by the Congress in the original legislation allowing PAs to bill for first assistant services. That legislation, the Omnibus Budget Reconciliation Act of 1986, contained a provision (later repealed) that offset any additional payments by decreasing payments to hospitals.

However, combining payments would also require a number of difficult issues to be resolved, such as anti-kickback concerns, quality measures, current first assistant payments, and issues of equity between teaching and non-teaching hospitals arising from use and payment of residents. Resolving all of these issues would be complex and require a large investment in CMS staff resources. As a solution to the limited problem posed by first assistant at surgery payments, or even the broader issue of separately payable NPPs, an effort of this scope would not be warranted. Nonetheless, combining payments would be consistent with the direction of the Commission to focus on payment for quality and to consider ways to improve care coordination; the implications of integrating Medicare payment systems should be worked through over the longer term.

Law and regulation do not include criteria for determining which NPPs should qualify for separate payment. In the absence of explicit criteria, the Commission in the past has not recommended the inclusion of additional groups to the list of separately payable NPPs because of concerns about licensure and duplicate payments. CRNFAs would not automatically disqualify from consideration on the basis of licensure, as did other groups the Commission has looked at (CRNFAs are licensed as RNs in all states, as are some other NPPs) and they are similar to some of the groups allowed to bill separately in education and experience. But the Commission still has concerns, including duplicate payments. If the Congress chooses to add CRNFAs to the list of NPPs eligible for separate payment under Medicare Part B for assistant at surgery services, any additional payments should be offset from existing payments so that the effect of this change would be budget neutral.

Sincerely,

Glenn M. Hackbarth, J.D.
Chairman

Identical letter sent to the Honorable J. Dennis Hastert

Enclosures

Attachment: Definition of first assistant at surgery services

There may be some conflict between what is normally referred to as first assistant at surgery services and what the Congress specified in section 643 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Up until now, first assistant at surgery services have been defined as those provided in the operating room or during a procedure. The American College of Surgeons definition of a first assistant is:

The first assistant during a surgical operation should be a trained individual who is able to participate in and actively assist the surgeon in completing the operation safely and expeditiously by helping to provide exposure, maintain hemostasis, and serve other technical functions. The qualifications of the person in this role may vary with the nature of the operation, the surgical specialty, and the type of hospital or ambulatory surgical facility. *

This appears to be similar to the definition the Government Accountability Office (GAO) uses.

However, in section 643 of the MMA, Surgical first assisting services are defined as:

The term “surgical first assisting services” means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care (as determined by the Secretary) furnished by a certified registered nurse first assistant (as defined in paragraph (2)) which the certified registered nurse first assistant is legally authorized to perform by the State in which the services are performed.

This appears to be a broader definition in that it includes services outside the operating room including preoperative and postoperative care. Although perhaps more consistent with the global surgical payment to the surgeon, which includes preoperative and postoperative care for a stated period that depends on the procedure, it is significantly broader than what is normally thought of as first assisting services. These additional services are not included in other directly billable NPP services and presumably would require additional payment, if it was thought that the current 13.6 percent was appropriate for NPP first assistants. The approach of combining payments would remove the problem of defining what first assistants do, because whether clinical staff assisted only in the OR, or pre and post operatively as well, would be decided by the surgeons and hospitals and not need definition by CMS. In the interim, if the Congress chooses to pay CRNFAs separately, the definition of what first assisting services are should be clarified.

* ACS website. http://www.facs.org/fellows_info/statements/stonprin.html#anchor129977, accessed 21 September 2004.

Attachment: Mandate for Report

SEC. 643. MEDPAC STUDY OF COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS.

(a) **STUDY.**—The Medicare Payment Advisory Commission (in this section referred to as the “Commission”) shall conduct a study on the feasibility and advisability of providing for payment under part B of title XVIII of the Social Security Act for surgical first assisting services furnished by a certified registered nurse first assistant to medicare beneficiaries.

(b) **REPORT.**—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

(c) **DEFINITIONS.**—In this section:

(1) **SURGICAL FIRST ASSISTING SERVICES.**—The term “surgical first assisting services” means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care (as determined by the Secretary) furnished by a certified registered nurse first assistant (as defined in paragraph (2)) which the certified registered nurse first assistant is legally authorized to perform by the State in which the services are performed.

(2) **CERTIFIED REGISTERED NURSE FIRST ASSISTANT.**—The term “certified registered nurse first assistant” means an individual who—

(A) is a registered nurse and is licensed to practice nursing in the State in which the surgical first assisting services are performed;

(B) has completed a minimum of 2,000 hours of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

(C) is certified as a registered nurse first assistant by an organization recognized by the Secretary.