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prepared by the Division of Advocacy and Health Policy

GAO issues report on assistants at surgery

The General Accounting Office (GAO) issued a controversial report in January entitled *Medicare: Payment Changes Are Needed for Assistants-at-Surgery* (GAO-04-97). Written in response to a directive from Congress to look at the potential effects of allowing Medicare fee schedule payments for certified registered nurse first assistants, the report concludes that Congress may want to consider consolidating all Medicare payments for assistant at surgery services into the hospital inpatient prospective payment system. This would include assistant at surgery services by all provider types—both physician and nonphysician—without regard to employment status.

Because Medicare's Part A hospital payments are intended to cover assistant at surgery services that are provided by hospital employees, and those payments are not reduced when a Part B payment to an assistant at surgery is made under the physician fee schedule, GAO believes that the program may be paying too much for some hospital surgical care. The College and other surgical and nonsurgical specialty organizations have already begun educating Congress about the very serious implications of such a radical policy change. To view the full report, visit <http://www.gao.gov/new.items/d0497.pdf>. The College's comments on the report may be viewed on the Web at: www.gao.gov (select the "GAO Reports" option and follow the instructions to access GAO-04-97).

Scope of practice legislation introduced

The American College of Surgeons recently joined a coalition of physician organizations to support the Veterans Eye Treatment Safety (VETS) Act, H.R. 3473. This bill would prohibit nonphysicians from performing eye surgery within the Department of Veterans Affairs (VA) health care system. The legislation comes in response to a decision at the Robert J. Dole Veterans Affairs Medical Center in Wichita, KS, to allow an Oklahoma-licensed optometrist to perform laser procedures. The College believes the VA decision sets a dangerous precedent and poses a serious threat to patient safety.

Surgeons are encouraged to write their legislators and urge them to cosponsor the VETS Act by visiting the College's Legislative Action Center at http://capwiz.com/facs/mail/oneclick_compose/?alertid=4521361.

National provider identifier established

The Centers for Medicare & Medicaid Services (CMS) published a final rule on January 23, establishing an individual national provider identifier (NPI) for each health care provider, including physicians, to use in filing and processing claims. As mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the NPI will replace current identifiers issued by the various payors. All physicians who electronically transmit claims or related transactions, such as verification of a patient's enrollment in a health plan, must obtain a single NPI and use that 10-digit number for all transactions with all payors. The NPI is expected to significantly reduce administrative costs for both providers and payors.

New rules for reporting hospital quality data

The NPI will contain no embedded information about the person it identifies. A CMS contractor, known as the “enumerator,” will process applications for NPIs during a two-year enrollment period beginning May 23, 2005. Surgeons need not take any action now to receive an identifier; additional information about NPI implementation, including the details of the application process, will be available in the future.

The regulation may be viewed in its entirety at <http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2004/pdf/04-1149.pdf>.

On January 28, CMS released the guidelines that hospitals must use to report information to the agency’s quality improvement organization’s data warehouse. Under provisions of the Medicare Prescription Drug, Improvement, and Modernization Act (MPDIMA), hospitals are required to submit data on all patients for a total of 10 quality measures that relate to three serious medical conditions—acute myocardial infarction, heart failure, and pneumonia. A number of hospitals began voluntarily transmitting this data in October 2003, but the MPDIMA provides an added incentive for submitting the data—a full market basket payment update in fiscal year 2005. Hospitals that do not provide the data will receive a payment update of 0.4 percentage points below the market basket.

To qualify for higher payments, hospitals must begin submitting data by July 1, 2004. For more information go to <http://www.cms.gov/media/press/release.asp?Counter=955>.

IOM reviews the future of emergency care

The Institute of Medicine (IOM) has established an ad hoc committee to report on the future of emergency care in the U.S. This 18-member group, which includes C. William Schwab, MD, FACS, from the University of Pennsylvania Medical Center, met for the first time February 2-4 to begin looking at safety net issues resulting in emergency department crowding, prehospital emergency medical services, patient flow, information technology, finance, rural emergency care, and emergency preparedness. The IOM has asked the College to provide data and background information that may be useful to the committee, as well as assistance identifying other experts and resources that might help to inform the committee’s deliberations. Those surgeons interested in following the progress of the committee may do so at <http://www.iom.edu/project.asp?id=16107>

College provides state news stories online

ACS Cross Country, a monthly newsletter produced by the College’s Division of Advocacy and Health Policy, digests state issues affecting surgeons at the local level. Check <http://www.facs.org/ahp/crosscountry.html> monthly to learn more about current ACS activities and grassroots initiatives that are planned or are under way throughout the country.