

Multidisciplinary letter

March 17, 2004

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Max Baucus
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Joe Barton
Chairman
Committee on Energy and Commerce
U.S House of Representatives
Washington, DC 20515

The Honorable John D. Dingell
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Bill Thomas
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Charles B. Rangel
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen and Ranking Members:

The undersigned organizations representing physicians and other non-physician professionals write to express our deep concern with the recent recommendation of the General Accounting Office (GAO) to revise Medicare payment policy regarding assistants-at-surgery. The recommendations included in this report reach far beyond the scope of the Congressional request and have serious implications for the quality and safety of surgical patient care.

The report's overall recommendation that Congress should consider consolidating all Medicare payments for assistants-at-surgery services under the hospital inpatient PPS is wholly inappropriate for the following reasons. First, the recommendation will lead to interference with a surgeon's professional judgment regarding medical necessity and patient safety. Second, there is no indication that current payment policies provide incentives for the improper use of assistants-at-surgery. Third, the report's recommendations raise serious concerns about creating new financial disincentives for hospitals to provide appropriately skilled assistants. Finally, expenditure data suggest that current policy has promoted efficient use of assistants with appropriate skill levels. Therefore, we strongly urge Congress to maintain current Medicare payment policies for assistant-at-surgery services.

First, the recommendation ignores the surgeon's professional judgment about the level of care required by his or her patient. In addition, the report fails to acknowledge that the various types of professionals who provide these services are not wholly interchangeable. There are significant differences in the training and experience among providers. Their services as assistants-at-surgery are not always limited just to providing a "second set of hands." At times, surgeons call upon assistants to utilize problem-solving skills that are only developed through medical and surgical training. As a result, the primary surgeon's decision about who is most appropriate to serve as an assistant at surgery may be based on factors such as the nature of a specific operation, the unique medical circumstances of an individual patient, the availability of appropriately trained physicians or non-physician staff, or ready access to other appropriately trained specialists elsewhere in the hospital. The arrangement proposed by GAO, however, would prevent the surgeon from seeking assistance from the most appropriate professional available and raises serious patient safety concerns.

Second, there is no indication that current payment policies provide incentives for the improper use of physicians or non-physicians as assistants at surgery. The report ignores the fact that current policies provide no incentive for physicians to choose one type of provider over another. The surgeon's payment remains the same, regardless of whether a surgical resident, a physician-employed or independently-employed physician assistant, or hospital staff provide these services. The only factor in this decision is a desire to provide safe, high-quality surgical care.

In addition, the report offers no assurances that current hospital payments are adequate to enable them to provide prompt access to the various types of professionals, including physicians, whose services may be needed—vague references to the hospital responsibilities under health and safety rules notwithstanding. Indeed, where the issue of financial incentives is concerned, GAO's recommendation actually acts contrary to its stated purpose by establishing entirely new financial incentives for hospitals to make available only the lowest cost—rather than most appropriate—type of provider.

Finally, current payment policies have not contributed to escalating Medicare program costs, nor are there any indications that assistants at surgery are being used unnecessarily. Each year, Medicare pays for more than 70 million surgical procedures, at a cost of \$10.5 billion in 2002. Of those procedures, an assistant-at-surgery was paid under the fee schedule in less than 2 percent of cases, resulting in \$158 million in Medicare Part B payments. Physicians assisted in many of these cases, but in many other circumstances non-physician professionals were used.

Since the enactment of the Balanced Budget Act of 1997 non-physician professionals have been eligible for reimbursement, and the percentage of assistant-at-surgery services paid to physicians under the fee schedule has declined. Conversely, the percentage of these services paid to non-physician professional has increased. Total Medicare payments for assistants-at-surgery services under physician fee schedule have actually declined by 46 percent since 1986. This amounted to a \$137 million cost-savings to Medicare in 2002 alone.

Congress has rejected proposals to bundle assistant-at-surgery payments with those for other services in the past because the detriments far outweigh any potential benefits. Given the significant patient safety implications, the absence of any data demonstrating inappropriate behavior under current polices, and the relatively small amount of Medicare spending involved, we urge you once again to preserve current Medicare payment policies for these important services.

Sincerely,

American Academy of Child and Adolescent Psychiatry
American Academy of Facial, Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Clinical Urologists
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Chest Physicians
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American College of Radiology Association
American College of Surgeons

American Gastroenterological Association
American Medical Association
American Medical Group Association
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Psychiatric Association
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of General Surgeons
American Society of Plastic Surgeons
American Society of Transplant Surgeons
American Urological Association
Association of American Medical Colleges
College of American Pathologists
Congress on Neurological Surgeons
Medical Group Management Association
NASPE-Heart Rhythm Society
National Association for Medical Direction of Respiratory Care
North American Spine Society
Society for Vascular Surgery
Society of American Gastrointestinal Endoscopic Surgeons
Society of Interventional Radiology
Society of Surgical Oncology
Society of Thoracic Surgeons