

PRESENTATION

BY

THE GEORGIA SOCIETY OF GENERAL SURGEONS, INC.

TO

**THE STATE COMMISSION ON THE EFFICACY OF THE
CERTIFICATE OF NEED PROGRAM**

OCTOBER 24, 2005

INTRODUCTION

The Georgia Society of General Surgeons, Inc. ("GSGS") is a non-profit organization recently founded by general surgeons in the State of Georgia. As part of its mission, it advocates on a statewide basis for Georgia general surgeons, including representing their interests at various state and local governmental meetings. It also promotes the promulgation of sound healthcare rules that impact Georgia general surgeons. Our members are entirely made up of licensed Georgia physicians who have been certified by the American Board of Surgery as specialists in general surgery.

GSGS wants to thank the State Commission on the Efficacy of the Certificate of Need Program ("CON Commission") for the opportunity to make this presentation and submit this paper to you. It is our understanding that the CON Commission has the authority to make recommendations to change in the Certificate of Need ("CON") statute and the regulations promulgated by the Department of Community Health ("DCH"). We hope that this presentation will assist you in making those recommendations.

GSGS's Position on CON

Under CON law, a single specialty physician group is entitled to operate an ambulatory surgery center without obtaining a CON as long as the cost to build and equip

it is under a certain threshold (currently around 1.4 million dollars). To operate such a facility, the physician group must obtain a Letter of Non-Reviewability (“LNR”) from DCH stating that the facility is exempt from the CON law. One of the critical factors looked at by DCH when deciding whether to grant an LNR is whether the group is a single specialty.

The term “single specialty” is not defined in the CON statute. O.C.G.A. 31-6-2(14)(G)(iii). (Tab 1.) Instead, DCH provides example of those specialties in its ambulatory surgery rules. Rule 111-2-2-.40(2)(j). (Tab 2.) The examples include all of the specialties we are familiar with such as oral surgery, gastroenterology, ophthalmology, orthopedics, otolaryngology, plastic surgery, and urology. But, notwithstanding the fact that the entire medical community in Georgia and the rest of the country recognizes that general surgery is also a single specialty, DCH specifically defines it as a multi-specialty. As a result, Georgia general surgeons are precluded from obtaining an LNR to operate a single specialty surgery center. We think this result is grossly unfair and do not understand why this has not been corrected.

In sum, GSGS believes that the CON statutes should be modified to recognize that general surgery is a single specialty.

The Single-Specialty Exemption

In 1991, the CON statute was amended to create an exception for physicians and single specialty ASCs. Thus, as long as the physician group stays under the capital expenditure threshold and practices as a single specialty, its ASC is exempt from CON review. The 1991 statutory exemption for single-specialty centers does not expressly exclude general surgery. We believe that the General Assembly’s decision not to exclude

general surgery from the statutory exemption meant that it intended for the exemption to apply to all specialties, including general surgery. Unfortunately, DCH has not interpreted the statute that way. As a result, DCH has defined general surgery as a multi-specialty in the rules. (Tab 2.) Consequently, DCH routinely grants Letters of Non-Reviewability to single specialty surgery centers except for general surgery. In addition, because of court decision issued in a case brought by my practice against DCH, DCH has now stated that it cannot change the rule to include general surgery in the definition of single specialty but any such change must be made by the Georgia Legislature.

The reason general surgery has been excluded from the definition of single specialty is a mystery. Even prior to 1991, DCH allowed single specialty centers to operate ASCs by granting a "Limited Purpose" CON to physicians. Those Limited Purpose CONs were granted to all types of specialties except "general surgery". There is no rational explanation for the exclusion. In fact, we believe there was a misunderstanding in the 1980's regarding the term "general surgery." We suspect that the agency was trying to address general practitioners, or what used to be called "GPs". Those were doctors, usually in rural area, who did a little bit of everything. If they had to deliver a baby, they did. If somebody needed an infectious disease treated they did that too. It is possible that the agency was trying to prevent a doctor who was a GP from getting a Limited Purpose CON in "general surgery" and doing everything and anything in that center. Unfortunately, that misunderstanding has continued for over two decades. The result is that Board certified general surgeons have been precluded from opening surgery centers to practice only general surgery.

General Surgery Is a Single-Specialty Practice

Undisputedly, general surgery is a specialty and is recognized as such by the medical community, including physicians and hospitals. Even the Department of Community Health recognizes general surgery is a single specialty. Indeed, the annual hospital questionnaire prepared by DCH and filled out by every hospital in the state identifies general surgery as a single specialty. (Tab 3.)

Even the materials used by the Ambulatory Surgery Center Technical Advisory Committee in 1996 clearly state that general surgery is a specialty. The ASC Technical Advisory Committee referred to Healthcare Management Guidelines when formulating rules applicable to ASCs. Those rules were eventually adopted in 1998. In any event, those guidelines state that the “specialties of ophthalmology, gynecology, otolaryngology, orthopedics and general surgery have accounted for over 75 percent of the ambulatory surgery performed.” (Tab 4, emphasis added.) Likewise, the same TAC minutes from 1996 reference a chart reflecting operation room turnover time by specialty. Once again, it lists general surgery as a specialty. (Tab 5.) We do not believe that anybody can seriously contend that general surgery is not a specialty.

Certifications from the member boards of the American Board of Medical Specialties (“ABMS”) are a commonly accepted practice to define medical specialties. In fact, DCH has historically used Board certification to determine specialties. General surgeons are certified by the American Board of Surgery which is one of the ABMS's twenty-four member boards. (A complete list is attached at Tab 6.) Like other specialty boards, the American Board of Surgery prescribes numerous requirements for a physician to obtain a certification, including completion of a specialized residency. The definition

of general surgery used by the American Board of Surgery is attached as Tab 8. As you can see, it limits the practice to certain areas of the body, including the abdomen, breast, head and neck.

Also, the Georgia Department of Human Resources—which licenses surgery centers—recognizes that general surgery is a specialty. The Department's regulations provide that

[e]ach ambulatory surgical center, when applying for a permit shall designate the type(s) or classification(s) of services to be provided in or by the center. These classifications may include, but are not necessarily limited to the following: general surgery; eye, ear, nose, and throat; plastic surgery; oral and maxillofacial; obstetrical-gynecological; oncological; ophthalmological; and urological.

Ga. Comp. R. & Regs. r. 290-5-33-.04. (Tab 7.)

General Surgery Does Not Overlap Other Specialties Anymore than Other Specialties Overlap

One of the primary reasons we have heard for treating general surgery differently than other operations is that general surgery overlaps too much with other specialties and, therefore, is in effect a multi-specialty practice. No study has been done to justify this conclusion and appears to be based on DCH's confusion over the scope of services provided by general surgeons. In any event, it is simply incorrect.

Medical specialties are not defined simply by anatomical region, type of procedure, or disease treated. Some overlap exists between all medical specialties. The American Board of Medical Specialties acknowledges this in its statement on "Relationship Between Specialty Board Certification and Medical Licensure" (Adopted 1/28/77; Revised & reaffirmed 3/20/97). It reads in part: "The boundaries between specialties are often hazy and overlapping. State governments should not define such

boundaries lest transgressions be punishable under the law. The ABMS believes that practice restrictions should be determined only by the judgment of individual physicians, the medical staffs of hospitals, or the customs of the community in which the doctor practices."

The degree of procedural or anatomical overlap does not negate the existence of a specialty. Orthopedic Surgeons perform virtually every procedure performed by Podiatrists; yet everyone recognizes that each is a distinct and separate specialty. Likewise ENT's and plastic surgeons both do procedures in the area of the face, yet DCH and the medical community recognize them as single specialties. Even CPT codes are nothing more than descriptions of specific procedures performed by physicians. The entire code is theoretically available to all physicians, and is not "divided" among the various specialties. The American Medical Association, which owns copyright to CPT codes, makes no attempt to limit use of any code to any specialty.

The scope of a general surgery ASC will be limited to procedures historically done by general surgeons and that can be done safely in an office-based ASC. It will not provide services that are typically done by urologists, ophthalmologists, plastic surgeons, orthopedists, or any other specialty.

It is undisputed that the medical community knows that General Surgery is a distinct, well-defined specialty. This is because the types of procedures performed by General Surgeons are distinctly different than those performed by other specialists. There has never been to this day any analysis whatsoever to refute this fact.

No Adverse Impact from Allowing General Surgery ASCs

There have been allegations made that the impact of a single practice, single specialty general surgery ASC could be devastating to small community hospitals, which they claim rely heavily on general surgery as a source of revenue. This is an emotional argument with no factual basis. There are no studies known to exist that have demonstrated facilities of this type will financially harm any hospital facility. Generally, these very hospitals, which they claim to be concerned about, have no more than one or perhaps two General Surgery specialists on their medical staff. Economically, the capital investment required to establish a General Surgery ASC is limited to \$1.4 million. O.C. G.A. 31-6-2(14)(G)(iii). As a result, the type of procedures that can be done there will not replace the surgeries that must be done at the local hospital. Also, the caseload required to operate it profitably dictates that a minimum of 4 to 5 general surgeons utilize the facility. Accordingly, common sense and the economics of medicine dictate that these centers will not be desirable or profitable in this rural environment, and will thus pose no threat to these hospitals.

Further, the CON statute and DCH rules already exempt all other single specialties from the CON requirement and numerous single specialty surgery centers have been opened. These centers include the surgical specialties of orthopedics, plastics, oral, eye, ear nose and throat, and even podiatry. There is no evidence that the hospitals have lost any significant amount of income because of these centers. Moreover, there is no reason to believe that the patients treated by the physicians in their surgery centers would have used the hospital facilities. Likewise, there is no reason to believe that the

inclusion of general surgery to the list of exempt centers will have any significant impact on the hospitals.

Finally, the cost to the patient and the third party payors is generally less at outpatient surgery centers. Indeed, there has been a significant move by the medical community and the payors to encourage outpatient surgery at surgery centers in order to reduce costs. There is no reason that the procedures done by general surgeons should be excluded. In fact, it would make sense from all payors perspective, including the state merit system, to encourage the use of facilities that can provide quality services at reduced cost.

A Brief History of Ambulatory Surgery Centers

GSGS believes that the issue of general surgery has been impacted by the ever-increasing dispute between hospitals and physicians over the proliferation of physician owned single specialty centers. As a result, we want to briefly address why ambulatory surgery centers developed in the first place. Stated most simply, Ambulatory Surgery Centers (“ASCs”) are facilities where surgeries are performed that do not require hospital admission and an overnight hospital stay. Patients who elect to have surgery in an ASC arrive on the day of the procedure, have the surgery in an operating room, and recover under the care of the nursing staff, all without a hospital admission. Many procedures that thirty years ago were so invasive as to require an overnight or even multi-day stay in the hospital can now be provided on an outpatient basis in ASCs. As a result of new technology, minimally invasive surgical techniques, and improvements in anesthesia, patients can now be safely discharged within hours after surgery.

The first multi-specialty ASC opened in Arizona in 1970 after an anesthesiologist heard from his neighbors about how much they had to pay for relatively minor surgical procedures. That anesthesiologist set out to develop a new model of health care delivery that was safe and cost effective, which became the first surgery center. All ASCs have at least one dedicated operating room and related equipment to safely perform surgery and ensure quality patient care. According to data published by the Federated Ambulatory Surgery Association (FASA), the typical ASC has three operating rooms, with an average annual volume between 3,000 and 4,000 procedures. Most are locally owned small businesses. FASA data indicate that 61 % have 20 or fewer employees.

Although some surgery centers are owned by hospitals, physicians have some degree of ownership in most ASCs, with many being totally physician owned. Active physician participation in the ownership and management is believed to contribute significantly to the quality of services rendered by ASCs. Surgery Centers have very low rates of infection, complications and medical errors. Data from liability insurers show ASCs to have a low incidence of claims.

The industry is almost equally divided between those centers that provide services in only one specialty, called single-specialty ASCs, and those that provide services in many specialties. Today there are more than 3,300 ASC facilities providing services in all 50 states. More than 7,000,000 procedures were performed in 2002.

The Federal Government Has Encouraged Outpatient Surgery Centers

Since 1982, when Medicare agreed to pay for surgeries performed in ASCs, the program has saved a significant amount of money. ASCs that meet Medicare

certification criteria receive payments for those procedures that have been approved by Medicare. Today, more than 2,000 ASC procedures have been granted that approval.

The Office of Inspector General commented in their 1999 final rule regarding safe harbor provisions that "ASCs can significantly reduce costs for Federal health care programs, while simultaneously benefiting patients." Medicare has promoted the use of ASCs as cost-effective alternatives to higher cost settings, such as hospital inpatient surgery.

Physician Owned Surgery Centers Are Not Unregulated and Unsafe

During the course of GSCS's and its members' efforts to include the practice of general surgery in the Certificate of Need exemption, there have been allegations that physician practice owned ASCs are "unregulated", and implied that patient safety is a public concern. In reality, ASCs, including the single specialty ASCs operating in Georgia, are some of the most highly regulated health care providers in the country. To receive Medicare payments, the facility must be certified by Medicare. Medicare certification is based in part on a physical inspection of the premises either by a state surveyor or a private accrediting body. Medicare certification requires compliance with a comprehensive set of standards concerning surgery, staffing, medical equipment, provisions for transfer of a patient to a hospital in case of an emergency and all requirements of state law. Collectively, these requirements are called Conditions of Coverage. 42 C.F.R. 416.40 et. seq.

Like hospitals, ASCs are also regulated by the states, with 43 states (including Georgia) requiring ASCs to be licensed. In Georgia, the Department of Human Resources licenses ASCs. DHR Rule 290-5-33-.01 et. seq. Many state regulations mirror

the Medicare Conditions of Coverage. Both states and Medicare survey ASCs regularly to verify that the established standards are being met. Indeed, there have been numerous single specialty physician owned ASCs licensed in Georgia over the past decade and there has been no allegation that these ASCs are not safe for patients. Indeed, the proliferation of these centers has been encouraged by payors (Medicare and private insurers) and embraced by the general public.

In addition to state and federal inspections, ASCs increasingly seek accreditation from one or more of five bodies that accredit ambulatory surgery centers such as the Joint Commission and the Accreditation Association for Ambulatory Health Care. These accrediting bodies require that the facility maintain standards that go beyond the requirements of state regulation and the Medicare Conditions of Coverage. Surgery centers continue to seek this additional seal of approval so that patients visiting accredited ASCs can be assured that the centers provide the highest quality care.

Why ASCs are Good for Consumers

Consumers and healthcare payers both benefit from availability of ASCs. Patients benefit from access to high quality, yet convenient care provided at a significantly lower cost than offered by a hospital. Likewise, insurers, government, and industry benefit by substantially reducing outpatient surgery cost without sacrificing quality or patient safety.

Patient satisfaction is a hallmark of the ASC industry. Medicare beneficiaries prefer ASCs to hospitals for outpatient surgical and diagnostic procedures, according to a study by the U.S. Department of Health and Human Services Office of the Inspector General (OIG). The OIG surveyed 837 Medicare beneficiaries who had cataract

extraction with intraocular lens implant, upper gastrointestinal endoscopy, colonoscopy or bunionectomy procedures. The survey showed:

- Beneficiaries prefer outpatient surgery to in-hospital stays.
- 98 percent of beneficiaries said they were satisfied with ASCs, compared to 94 percent being satisfied with hospitals.
- Post-operative care was not a problem for most beneficiaries.

Reasons cited for a preference of ASCs over hospital outpatient departments included less paperwork, lower cost, and more convenient location and parking. Also cited was no waiting at the ASC, and more organized and friendlier staff compared to crowded and uncomfortable hospital settings.

Another survey conducted by Arthur Anderson showed that more than half of the ASCs that responded started more than 82% of their cases on time. Convenient and prompt scheduling of cases is important to consumer satisfaction, and enhances physician productivity as well. In fact, under Georgia law, physician owned ASCs are required to be located adjacent or in the same building as the physicians office. As a result, the physician has easier access to his patients and can control the management of the center.

ASCs Are Key to Health Care Cost Containment

The bottom-line is that ASCs provide value – multiple studies have demonstrated that the quality of care delivered at ASCs is equal to or better than that provided by hospitals, and ASCs deliver it a substantially lower cost. ASCs are able to accomplish this by maintaining lower overhead costs and by focusing on one thing: treating ambulatory patients efficiently.

On average, even over 20 years ago procedures at ambulatory surgery centers cost 47% less than those same procedures at hospitals. (Based on a 1977 study conducted by Blue Cross/Blue Shield of North Carolina.) This study showed that facility fees for

removal of tonsils, for example, costs an average of \$464 in an ASC, compared with \$998 if the procedure is performed in a hospital. Other examples include cataract surgery which costs an average \$835 in an ASC, compared with \$2,012 in a hospital; repair of inguinal hernia \$601 in a surgery center, compared to facility fees of \$1,271 if this were performed in a hospital. The same trend continues today.

Like all health care facilities, ASCs and their surgeons are subject to federal and state anti-kickback laws. As noted above, to encourage physician investment, the Inspector General of HHS established an ASC safe harbor saying "Our regulatory treatment of ASCs recognizes the Department's historical policy of promoting greater utilization of ASCs because of the substantial cost savings to Federal health care programs when procedures are performed in ASCs rather than in more costly hospital inpatient or outpatient facilities."

CONCLUSION

GSCS believes that Georgia Legislature intended to exempt all single specialty surgery centers from CON review in O.C.G.A. 31-6-14(G)(iii), not only those specialties selected by DCH. In light of the misunderstanding of the law, GSCS suggests that the appropriate action be taken by the Georgia Legislature to correct this problem. Moreover, an effort should be made by the Georgia Legislature to foster the creation of small businesses and to encourage the policy of quality health care at lower costs.

TAB 1

Ga. Code Ann., § 31-6-2

▽

WEST'S CODE OF GEORGIA ANNOTATED
TITLE 31. HEALTH
CHAPTER 6. STATE HEALTH PLANNING AND DEVELOPMENT
ARTICLE 1. GENERAL PROVISIONS
→ § 31-6-2. Definitions

As used in this chapter, the term:

- (1) "Ambulatory surgical or obstetrical facility" means a public or private facility, not a part of a hospital, which provides surgical or obstetrical treatment performed under general or regional anesthesia in an operating room environment to patients not requiring hospitalization.
- (2) "Application" means a written request for a certificate of need made to the department, containing such documentation and information as the department may require.
- (3) "Bed capacity" means space used exclusively for inpatient care, including space designed or remodeled for inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the Department of Human Resources, except that single beds in single rooms shall be counted even if the room contains inadequate square footage.
- (4) "Certificate of need" means an official determination by the department, evidenced by certification issued pursuant to an application, that the action proposed in the application satisfies and complies with the criteria contained in this chapter and rules promulgated pursuant hereto.
- (5) "Clinical health services" means diagnostic, treatment, or rehabilitative services provided in a health care facility, or parts of the physical plant where such services are located in a health care facility, and includes, but is not limited to, the following: radiology and diagnostic imaging, such as magnetic resonance imaging and positron emission tomography; radiation therapy; biliary lithotripsy; surgery; intensive care; coronary care; pediatrics; gynecology; obstetrics; general medical care; medical/surgical care; inpatient nursing care, whether intermediate, skilled, or extended care; cardiac catheterization; open-heart surgery; inpatient rehabilitation; and alcohol, drug abuse, and mental health services.
- (6) "Consumer" means a person who is not employed by any health care facility or provider and who has no financial or fiduciary interest in any health care facility or provider.
- (6.1) "Department" means the Department of Community Health established under Chapter 5A of this title.
- (7) "Develop," with reference to a project, means:
 - (A) Constructing, remodeling, installing, or proceeding with a project, or any part of a project, or a capital expenditure project, the cost estimate for which exceeds \$900,000.00; or
 - (B) The expenditure or commitment of funds exceeding \$500,000.00 for orders, purchases, leases, or acquisitions through other comparable arrangements of major medical equipment.

Notwithstanding subparagraphs (A) and (B) of this paragraph, the expenditure or commitment or incurring an obligation for the expenditure of funds to develop certificate of need applications, studies, reports, schematics, preliminary plans and

Ga. Code Ann., § 31-6-2

specifications, or working drawings or to acquire, develop, or prepare sites shall not be considered to be the developing of a project.

(7.1) "Diagnostic, treatment, or rehabilitation center" means any professional or business undertaking, whether for profit or not for profit, which offers or proposes to offer any clinical health service in a setting which is not part of a hospital.

(8) "Health care facility" means hospitals; other special care units, including but not limited to podiatric facilities; skilled nursing facilities; intermediate care facilities; personal care homes; ambulatory surgical or obstetrical facilities; health maintenance organizations; home health agencies; diagnostic, treatment, or rehabilitation centers, but only to the extent that subparagraph (G) or (H), or both subparagraphs (G) and (H), of paragraph (14) of this Code section are applicable thereto; and facilities which are devoted to the provision of treatment and rehabilitative care for periods continuing for 24 hours or longer for persons who have traumatic brain injury, as defined in Code Section 37-3-1.

(9) "Health maintenance organization" means a public or private organization organized under the laws of this state which:

(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physicians' services, hospitalization, laboratory, X-ray, emergency and preventive services, and out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of the basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis; and

(C) Provides physicians' services primarily:

(i) Directly through physicians who are either employees or partners of such organization; or

(ii) Through arrangements with individual physicians organized on a group practice or individual practice basis.

(10) "Health Strategies Council" or "council" means the body created by this chapter to advise the Department of Community Health and adopt the state health plan.

(11) "Home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which is primarily engaged in providing to individuals who are under a written plan of care of a physician, on a visiting basis in the places of residence used as such individuals' homes, part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse, and one or more of the following services:

(A) Physical therapy;

(B) Occupational therapy;

(C) Speech therapy;

(D) Medical social services under the direction of a physician; or

(E) Part-time or intermittent services of a home health aide.

(12) "Hospital" means an institution which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or

Ga. Code Ann., § 31-6-2

sick persons or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Such term includes public, private, psychiatric, rehabilitative, geriatric, osteopathic, and other specialty hospitals.

(13) "Intermediate care facility" means an institution which provides, on a regular basis, health related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide but who, because of their mental or physical condition, require health related care and services beyond the provision of room and board.

(14) "New institutional health service" means:

(A) The construction, development, or other establishment of a new health care facility,

(B) Any expenditure by or on behalf of a health care facility in excess of \$900,000.00 which, under generally accepted accounting principles consistently applied, is a capital expenditure, except expenditures for acquisition of an existing health care facility not owned or operated by or on behalf of a political subdivision of this state, or any combination of such political subdivisions, or by or on behalf of a hospital authority, as defined in Article 4 of Chapter 7 of this title or certificate of need owned by such facility in connection with its acquisition;

(C) Any increase in the bed capacity of a health care facility except as provided in Code Section 31-6-47;

(D) Clinical health services which are offered in or through a health care facility, which were not offered on a regular basis in or through such health care facility within the 12 month period prior to the time such services would be offered;

(E) Any conversion or upgrading of a facility such that it is converted from a type of facility not covered by this chapter to any of the types of health care facilities which are covered by this chapter;

(F) The purchase or lease by or on behalf of a health care facility of diagnostic or therapeutic equipment with a value in excess of \$500,000.00. The acquisition of one or more items of functionally related diagnostic or therapeutic equipment shall be considered as one project;

(G) Clinical health services which are offered in or through a diagnostic, treatment, or rehabilitation center which were not offered on a regular basis in or through that center within the 12 month period prior to the time such services would be offered, but only if the clinical health services are any of the following:

(i) Radiation therapy;

(ii) Biliary lithotripsy;

(iii) Surgery in an operating room environment, including but not limited to ambulatory surgery; provided, however, this provision shall not apply to surgery performed in the offices of an individual private physician or single group practice of private physicians if such surgery is performed in a facility that is owned, operated, and utilized by such physicians who also are of a single specialty and the capital expenditure associated with the construction, development, or other establishment of the clinical health service does not exceed the amount of \$1 million; and

(iv) Cardiac catheterization; or

(H) The purchase, lease, or other use by or on behalf of a diagnostic, treatment, or rehabilitation center of diagnostic or

therapeutic equipment with a value in excess of \$500,000.00. The acquisition of one or more items of functionally related diagnostic or therapeutic equipment shall be considered as one project.

The dollar amounts specified in subparagraphs (B), (F), and (H) of this paragraph, division (iii) of subparagraph (G) of this paragraph, and of paragraph (7) of this Code section shall be adjusted annually by an amount calculated by multiplying such dollar amounts (as adjusted for the preceding year) by the annual percentage of change in the composite construction index, or its successor or appropriate replacement index, if any, published by the Bureau of the Census of the Department of Commerce of the United States government for the preceding calendar year, commencing on July 1, 1991, and on each anniversary thereafter of publication of the index. The department shall immediately institute rule-making procedures to adopt such adjusted dollar amounts. In calculating the dollar amounts of a proposed project for purposes of subparagraphs (B), (F), and (H) of this paragraph, division (iii) of subparagraph (G) of this paragraph, and of paragraph (7) of this Code section, the costs of all items subject to review by this chapter and items not subject to review by this chapter associated with and simultaneously developed or proposed with the project shall be counted, except for the expenditure or commitment of or incurring an obligation for the expenditure of funds to develop certificate of need applications, studies, reports, schematics, preliminary plans and specifications or working drawings, or to acquire sites.

(15) "Nonclinical health services" means services or functions provided or performed by a health care facility, and the parts of the physical plant where they are located in a health care facility that are not diagnostic, therapeutic, or rehabilitative services to patients and are not clinical health services defined in this chapter.

(16) "Offer" means that the health care facility is open for the acceptance of patients or performance of services and has qualified personnel, equipment, and supplies necessary to provide specified clinical health services.

(16.1) "Operating room environment" means an environment which meets the minimum physical plant and operational standards specified on January 1, 1991, for ambulatory surgical treatment centers in Section 290-5-33-.10 of the rules of the Department of Human Resources.

(17) "Person" means any individual, trust or estate, partnership, corporation (including associations, joint-stock companies, and insurance companies), state, political subdivision, hospital authority, or instrumentality (including a municipal corporation) of a state as defined in the laws of this state.

(18) "Personal care home" means a residential facility having at least 25 beds and providing, for compensation, protective care and oversight of ambulatory, nonrelated persons who need a monitored environment but who do not have injuries or disabilities which require chronic or convalescent care, including medical, nursing, or intermediate care. Personal care homes include those facilities which monitor daily residents' functioning and location, have the capability for crisis intervention, and provide supervision in areas of nutrition, medication, and provision of transient medical care. Such term does not include:

(A) Old age residences which are devoted to independent living units with kitchen facilities in which residents have the option of preparing and serving some or all of their own meals; or

(B) Boarding facilities which do not provide personal care.

(19) Reserved.

(20) "Project" means a proposal to take an action for which a certificate of need is required under this chapter. A project or

proposed project may refer to the proposal from its earliest planning stages up through the point at which the new institutional health service is offered.

(21) "Review board" means the Health Planning Review Board created by this chapter.

(22) "Skilled nursing facility" means a public or private institution or a distinct part of an institution which is primarily engaged in providing inpatient skilled nursing care and related services for patients who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

(23) "State health plan" means a comprehensive program adopted by the Health Strategies Council, approved by the Governor, and implemented by the State of Georgia for the purpose of providing adequate health care services and facilities throughout the state.

Current through end of the 2005 Special Session

© 2005 Thomson/West

END OF DOCUMENT

TAB 2

111-2-2-.40 Specific Review Considerations for Ambulatory Surgery Services.

(1) **Applicability.** For Certificate of Need purposes, an Ambulatory Surgery Service is considered a new institutional health service if it is to be offered in an ambulatory surgery facility (ASF) or in a diagnostic, treatment, or rehabilitation center (DTRC).

(a) If the ambulatory surgery service is or will be provided as "part of a hospital", the hospital's provision of such service is not subject to Certificate of Need (CON) review under this rule. For purposes of this rule, the following are always considered to be "part of a hospital": a) is the service is located within a hospital; or, b) if the service is located in a building on the hospital's primary campus and that building, or relevant portion thereof, is included within the hospital's permit issued by the State's licensing agency, subject to determination by the Department. The Department also will make a determination of reviewability on a case-by-case basis in other situations involving hospitals.

(b) The entity that develops any ambulatory surgery service shall be the applicant.

(c) A limited purpose ambulatory surgery service will be issued a limited-purpose CON. A new CON will be required to become a multi-specialty service.

(d) These Rules do not apply to adult open-heart surgery, adult cardiac catheterization, pediatric cardiac catheterization, pediatric open-heart surgery, and obstetrical services because these services are covered under other CON Rules. If an ambulatory surgery service, which is part of a hospital, expands the number of ambulatory surgery operating rooms and the capital expenditure exceeds the CON threshold, the project will be reviewed under these Rules 111-2-2-.40. If an ambulatory surgery service, which is part of a hospital, involves a capital expenditure, which exceeds the CON threshold and does not increase the number of ambulatory surgery operating rooms, the project will be reviewed under the General Review Considerations (111-2-2-.09).

(2) Definitions.

(a) "Ambulatory surgery" means surgical procedures that include but are not limited to those recognized by the Centers for Medicare and Medicaid Services ("CMS"), the Department's Division of Medical Assistance ("DMA"), the State Health Benefit Plans, or by any successor entities, as reimbursable ambulatory surgery procedures. Ambulatory surgery is provided only to patients who are admitted to a facility which offers ambulatory surgery and which does not admit patients for treatment that normally requires stays that are overnight or exceed 24 hours and which does not provide accommodations for treatment of patients for periods of twenty-four hours or longer.

(b) "Ambulatory surgery facility" means a public or private facility, not part of a hospital, which provides surgical treatment performed under general or regional anesthesia in an operating room environment to patients not requiring hospitalization. In addition to operating rooms, an ambulatory surgery facility includes all components of pre and post-operative ambulatory surgery care.

(c) "Ambulatory surgery operating room" means an operating room located either in a hospital, in an ambulatory surgery facility, or in a DTRC facility that is equipped to perform surgery and is constructed to meet the specifications and standards of the Office of Regulatory Services of the Department of Human Resources.

(d) "Ambulatory surgery service" means the provision of ambulatory surgery including pre and post-operative care to patients not requiring hospitalization. An ambulatory surgery service may be provided within any of the following types of healthcare facilities: hospitals, ambulatory surgery facilities, or DTRCs.

(e) "Ambulatory surgery services patient" means a person who makes a single visit to an operating room during which one or more surgical procedures are performed.

(f) "Authorized ambulatory surgery service" means a Department sanctioned ambulatory surgery service, which is either existing or approved prior to the date on which the Department renders a decision on a proposed project. An existing ambulatory surgery service is an authorized service, which has become operational, and an approved ambulatory surgery service is an authorized service, which has not yet become operational, including any approvals under appeal.

(g) "Diagnostic, treatment, or rehabilitation center (DTRC) facility" means, for purposes of this rule, any professional or business undertaking, whether for profit or not-for-profit, which offers or proposes to offer an ambulatory surgery service in a setting that is not part of a hospital.

(h) "Limited purpose ambulatory surgery service" means an ambulatory surgery service providing surgery in only one of the specialty areas as defined in 111-2-2-.40(2)(j) and meets either of the definitions in numbers 2 or 7.

(i) "Most recent year" means the most current twelve-month period within a month of the date of completion of an application or within a month of the date of completion of the first application when applications are joined. If the Department has received an annual or ad hoc survey within six months of the date of completion of the application (or first application when applications are joined), the Department may consider the report period covered in such a survey as the most recent year.

(j) "Multi-specialty ambulatory surgery service" means an ambulatory surgery service offering general surgery; or, general surgery and surgery in one or more of, but not limited to, the following specialties; or, surgery in two or more of, but not limited, to the following specialties: dentistry/oral surgery, gastroenterology, obstetrics/gynecology, ophthalmology, orthopedics, otolaryngology, pain management/anesthesiology, plastic surgery, podiatry, pulmonary medicine, or urology.

(k) "Not requiring hospitalization" means patients who do not require an inpatient admission to an acute care general hospital prior to receiving ambulatory surgery services, who normally would not require a stay that is overnight or exceeds 24 hours, and who are not expected to require an inpatient admission after receiving such services.

(l) "Official inventory" means the inventory of all facilities authorized to perform ambulatory surgery services maintained by the Department based on responses to the

most recent Annual Hospital Questionnaire (AHQ) Surgical Services Addendum and Freestanding Ambulatory Surgery Center Survey and/or the most recent appropriate surveys and questionnaires.

(m) "Official state component plan" means the document related to ambulatory surgery services adopted by the State Health Strategies Council, approved by the Board of Community Health, and implemented by the State of Georgia for the purpose of providing adequate health care services and facilities throughout the state.

(n) "Operating room environment" means an environment, which meets the minimum physical plant and operation standards specified on January 1, 1991, for ambulatory surgical treatment centers in Rule 290-5-33-.10 of the Rules of the Department of Human Resources.

(o) "Planning Area" means fixed sub-state regions for reviewable services as defined in the State Health Component Plan for Ambulatory Surgery Services.

(3) Standards.

(a) The need for an ambulatory surgery service shall be determined through application of a numerical need method and an assessment of the aggregate utilization rate of existing services.

1. The numerical need for a ambulatory surgery service shall be determined by a demographic formula which includes the number of ambulatory surgery services cases in a planning area. The following need calculation applies to each planning area:

(i) determine the projected ambulatory surgery services patients for the horizon year by multiplying the planning area ambulatory surgery patients' rate by the total Resident population for the planning area for the horizon year;

(ii) determine the number of operating rooms needed by dividing the number of projected ambulatory surgery services patients (step i) by the capacity per operating room. Capacity per operating room per year is 1000 patients. (This is based on 250 operating room days per year (50 weeks x 5 days/weeks) x 5 patients per room per day x80% utilization.);

(iii) determine the existing and approved inventory of ambulatory surgery operating rooms by adding:

(I) The pro-rata portion of hospital shared inpatient/ambulatory surgery operating rooms devoted to ambulatory surgery services. This portion is determined as follows:

$$\frac{(\# \text{ ambulatory surgery patients} \times 90 \text{ min.})}{\{(ambulatory surgery patients \times 90 \text{ min.}) + (\text{inpatient patients} \times 145 \text{ min.})\}} \times \# \text{ shared rooms}$$

(II) # of hospital dedicated ambulatory surgery operating rooms; and

(III) # of freestanding ambulatory surgery operating rooms.

(iv) determine the projected net surplus or deficit for ambulatory surgery services by subtracting the total ambulatory surgery operating rooms needed (step iii) from the inventory of existing and approved ambulatory surgery services operating rooms in the planning area.

2. Prior to approval of a new or expanded ambulatory surgery service in any planning area, the aggregate utilization rate of all existing and approved ambulatory surgery service in that planning area shall equal or exceed 80 percent during the most recent year; and

3. A proposed multi-specialty ambulatory surgery service shall have a minimum of three operating rooms and a limited purpose ambulatory surgery service shall have a minimum of two operating rooms.

(b) The Department may allow an exception to the need standard referenced in (3)(a), in order to remedy an atypical barrier to ambulatory surgery services based on cost, quality, financial access, or geographic accessibility. An applicant seeking such an exception shall have the burden of proving to the Department that the cost, quality, financial access, or geographic accessibility of current services, or some combination thereof, result in a barrier to services that should typically be available to citizens in the planning area and/or the communities under review. In approving an applicant through the exception process, the Department shall document the bases for granting the exception and the barrier or barriers that the successful applicant would be expected to remedy.

(c) Each applicant shall have a hospital affiliation agreement and/or the medical director must have admitting privileges and other acceptable documented arrangements to insure the necessary backup for medical complications. The applicant must document the capability to transfer a patient immediately to a hospital with adequate emergency room services.

(d) An applicant shall submit written policies and procedures regarding discharge planning. These policies should include, where appropriate, designation of responsible personnel, participation by the patient, family, guardian or significant other, documentation of any follow-up services provided and evaluation of their effectiveness.

(e) An applicant shall provide evidence of a credentialing process that provides that surgical procedures will be performed only by licensed physicians who have been granted privileges to perform these procedures by the organization's governing body.

(f) An applicant shall assure that an anesthesiologist, a physician qualified to administer anesthesia, an oral surgeon, or a nurse anesthetist trained and currently certified in emergency resuscitation procedures is present on the premises at all times a surgical patient is present.

(g) An applicant shall submit evidence that qualified personnel will be available to insure a quality service to meet licensure, certification and/or accreditation requirements.

(h) An applicant shall submit a policy and plan for reviewing patient care, including a stated set of criteria for identifying those patients to be reviewed and a mechanism for evaluating the patient review process.

(i) An applicant shall submit written policies and procedures for utilization review consistent with state federal and accreditation standards. This review shall include review of the medical necessity for the service, quality of patient care, and rates of utilization.

(j) An applicant shall provide a written statement of its intent to comply with all appropriate licensure requirements and operational procedures required by the Office of Regulatory Services of the Georgia Department of Human Resources.

(k) An applicant for a new ambulatory surgery service shall provide a statement for the intent to meet, within 12 months of obtaining state licensure, the appropriate accreditation requirements of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for Accreditation of Ambulatory surgery Facilities, Inc. (ASF) and/or other appropriate accrediting agency.

(l) An applicant for an expanded ambulatory surgery service shall provide documentation that they fully meet the appropriate accreditation requirements of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (ASF) and/or other appropriate accrediting agency.

(m) An applicant shall provide documentation that charges are reasonable compared to other similar surgery services serving the same planning area.

(n) An applicant shall foster an environment that assures access to services to individual's unable to pay and regardless of payment source or circumstances by the following:

1. providing evidence of written administrative policies and directives related to the provision of services on a nondiscriminatory basis;
2. providing a written commitment that unreimbursed services for indigent and charity patients in the service will be offered at a standard which meets or exceeds three percent of annual gross revenues for the service after Medicare and Medicaid contractual adjustments and bad debt have been deducted; and
3. providing documentation of the demonstrated performance of the applicant, and any facility in Georgia owned or operated by the applicant or the applicant's parent organization, of providing services to individuals unable to pay based on the past record of service to Medicare, Medicaid, and indigent and charity patients, including the level of unreimbursed indigent and charity care.

(o) An applicant for an ambulatory surgery service shall document an agreement to provide Department requested information and statistical data related to the operation and provision of ambulatory surgery and to report that data to the Department in the time

frame and format requested by the Department. This information shall include, but not be limited to, any changes in number of ambulatory surgery operating rooms that may occur as a result of service expansion.

Authority O.C.G.A. Secs. 31-5A et seq., 31-6 et seq. **History.** Original Rule entitled "Specific Review Considerations for Ambulatory Surgery Services" adopted, F. Dec. 16, 2004; eff. Jan. 5, 2005.

TAB 3

Annual Hospital Questionnaire Part G
Phoebe Putney Memorial Hospital

HOSP616 2004 Dougherty

Facility UID: HOSP616
 Facility Name: Phoebe Putney Memorial Hospital
 Georgia Department of Community Health

Part G: Facility Workforce Information

Year: 2004

This information is being collected to support Georgia's healthcare workforce planning activities.
 Please provide information as of 12/31/2004.

1. BUDGETED STAFF

Please report the budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12/31/2004.
 Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12/31/2004.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians and Physician's Assistants	65.35	6.30	0.00
Physicians Assistants Only (not including Licensed Physicians)	14.80	6.00	0.00
Registered Nurses (RNs-Advanced Practice*)	660.67	151.02	70.49
Licensed Practical Nurses (LPNs)	149.92	28.72	27.99
Pharmacists	28.85	6.88	0.00
Other Health Services Professionals*	436.78	65.49	0.00
Administration and Support	188.45	52.10	0.00
All Other Hospital Personnel (not included above)	1,803.40	321.47	0.00

* Include Therapists, Technicians, Allied Health Professionals, and Assistants/Aides

2. FILLING VACANCIES

Using the drop-down menus, please select the average time needed during the past six months to fill each type of vacant position.

Type of Vacancy	Average Time Needed to Fill Vacancies
Physician's Assistants	31-60 Days
Registered Nurses (RNs-Advanced Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	31-60 Days
Pharmacists	More than 90 Days
Other Health Services Professionals	31-60 Days
All Other Hospital Personnel (not included above)	31-60 Days

3. RACE/ETHNICITY OF PHYSICIANS

Please report the number of physicians with admitting privileges by race.

	American Indian/Alaska Native	Asian	Black/African American	Hispanic or Latino	Hawaiian/Pacific Islander	White	Multi-Racial	Total Physicians
Physicians	0	36	35	1	0	188	0	260

Friday, October 21, 2005

2004 AHQ Survey Data
 Part G: 1 of 3

Part G: Facility Workforce Information (continued)

4. Please report the number of Active and Associate/Provisional Medical staff for the following specialty categories. Keep in mind that physicians may be counted in more than one specialty. Please indicate whether the specialty group(s) is hospital-based. Also, indicate how many of each medical specialty are enrolled as providers in Georgia Medicaid/PeachCare for Kids and/or the Public Employee Health Benefit Plans (PEHB-State Health Benefit Plan and/or Board of Regents Benefit Plan).

MEDICAL SPECIALTIES	Number of Medical Staff	Check the appropriate boxes below to indicate if any of these medical staff are hospital-based	# Enrolled as Providers in Medicaid/PeachCare and PEHB Plan	
			Medicaid	PEHB
a. General and Family Practice	19	<input checked="" type="checkbox"/>	19	19
b. General Internal Medicine	42	<input type="checkbox"/>	42	42
c. Pediatricians	22	<input type="checkbox"/>	22	22
d. Other Medical Specialties	47	<input type="checkbox"/>	47	47
SURGICAL SPECIALTIES				
e. Obstetrics	19	<input type="checkbox"/>	19	19
f. Non-OB Physicians Providing OB Services	2	<input type="checkbox"/>	2	2
g. Gynecology	20	<input type="checkbox"/>	20	20
h. Ophthalmology Surgery	5	<input type="checkbox"/>	5	5
i. Orthopedic Surgery	14	<input type="checkbox"/>	14	14
j. Plastic Surgery	2	<input type="checkbox"/>	2	2
k. General Surgery	11	<input type="checkbox"/>	11	11
l. Thoracic Surgery	5	<input checked="" type="checkbox"/>	3	3
m. Other Surgical Specialties	21	<input type="checkbox"/>	21	21
OTHER SPECIALTIES				
n. Anesthesiology	11	<input checked="" type="checkbox"/>	4	4
o. Dermatology	2	<input type="checkbox"/>	1	2
p. Emergency Medicine	13	<input checked="" type="checkbox"/>	13	13
q. Nuclear Medicine	2	<input checked="" type="checkbox"/>	2	2
r. Pathology	3	<input checked="" type="checkbox"/>	1	1
s. Psychiatry	2	<input type="checkbox"/>	2	2
t. Radiology	6	<input checked="" type="checkbox"/>	6	6
u. Other (specify)				
Radiation Oncology	2	<input checked="" type="checkbox"/>	2	0
Neonatal	3	<input checked="" type="checkbox"/>	3	3
ernatology/Oncology	9	<input checked="" type="checkbox"/>	9	9

5. **NON-PHYSICIANS:** Please report the number of professionals for the categories below. Exclude any hospital-based staff reported in Part G, Questions 1, 2, 3, and 4 above.

a. Number of Dentists (include oral surgeons) with Admitting Privileges	5
b. Number of Podiatrists Granted Clinical Privileges in the Hospital	4
c. Number of Certified Nurse Midwives with Clinical Privileges in the Hospital	6
d. Number of all Other Staff Affiliates with Clinical Privileges in the Hospital	70
e. Provide the Name of Professions Classified as "Other Staff Affiliates with Clinical Privileges" above.	Physician Assistants, Nurse Practitioners, Surgical Technologists, Orthopedic Techs, Ophthalmologic

Comments and Suggestions

Friday, October 21, 2005

2004 AHQ Survey Data
Part G: 2 of 3

HOSP616 Phoebe Putney Memorial Hospital

TAB 4

Dotty W. Roach, Director



State Health Planning Agency

4 EXECUTIVE PARK DRIVE, N.E. / ATLANTA, GEORGIA 3032
Suite 2100
(404) 679-482
GIST 238-482

**MINUTES OF THE MEETING
CAPACITY/UTILIZATION/ADVERSE IMPACT SUBCOMMITTEE OF THE
AMBULATORY SURGERY SERVICES
MODIFIED TECHNICAL ADVISORY COMMITTEE (TAC)**

**November 28, 1995
1:30 P.M. - 4:00 P.M.
4 Executive Park Drive
Suite 1200
Atlanta, Georgia 30329**

Joan Anderson, R.N., Chair

COMMITTEE MEMBERS PRESENT

Pamela Allen
Joan Anderson, R.N.
Peggy Cella
Carter Davis Jr., M.D.
Gayle Evans
Robyn Marchesseau, R.N.
Ted Walker

STAFF PRESENT

Jan Bequeath
Karen Decker
Marge Hayden
Pam Stephenson

COMMITTEE MEMBERS ABSENT

Elizabeth Brock
Lewis Williams, D.D.S.

GUESTS PRESENT

Armando Basarrate, Parker Hudson Rainer & Dobbs
Anne Duma, Dekalb Medical Center
Marti Dennison, Northside Hospital
Don Ferus, Dekalb Medical Center
Julia Hunter, Dekalb Medical Center
Everette Jenkins Strategic Health Concepts, Inc.
Allison K. Luke, Georgia Hospital Assoc.
Marie Mullin, Gwinnett Health System
John Munna, M.D., Atlanta
Andrea Price, Egleston Children's Hospital
Helen Sloat, Nelson Mullins Riley & Scarborough
Brain Toporek, Gerry Mills & Associates
Tony Zizzamia, St. Joseph Hospital Systems

Milliman & Robertson, Inc.

Healthcare Management Guidelines

Healthcare Management Guidelines™

Volume 3
Ambulatory Care Guidelines

by
Richard L. Doyle, M.D.
and
Alan P. Feren, M.D.

Use of these Guidelines in an automated system without the execution of
a licensing agreement is a violation of copyright.
It is also illegal under federal copyright law to reproduce, fax or input electronically
this publication or any portion of it without the expressed written permission
of Milliman & Robertson, Inc.

January, 1994 Edition
Second Printing

©Copyright 1995
Milliman & Robertson, Inc.

Healthcare Management Guidelines

Although ambulatory surgery can trace its roots of ancestry to 3000 BC, the first freestanding ASC was formally established in 1970. Growth and acceptance of this alternative setting for delivery did not occur until nearly five years later. From 1985 until present, the total number of freestanding ambulatory surgical centers has tripled, with current levels exceeding 1300 facilities. Growth has been due to physician and patient acceptance of the outpatient setting for the majority of procedures performed. This represents 50% of all procedures performed. Technological advances in both medicine and surgery will permit more of the Medicare patient population to utilize outpatient surgical facilities. Additionally, more services will be required by our aging employee benefit population, adding to the urgent need for cost-effective health care.

Historically, most ambulatory surgery has been performed in the hospital environment. Strong public marketing by the hospital as well as accessibility and convenience for the surgeon are contributing factors. Employee benefits directors, as well as third-party payors, have less concerns regarding appropriateness of care and quality assurance when outpatient surgery is performed in the hospital environment. The overall costs associated with this level of confidence have been unreasonably high. Hospitals tend to shift cost from the inpatient portion of the facility to the ambulatory portion of the facility in order to compensate for losses sustained as a result of low reimbursement from DRGs, HMO and PPO contracts, as well as Medicaid. As a result, the hospital-based ASC has become the most expensive of all of the outpatient surgical delivery settings. In numerous instances, contracted per diem rates for an overnight stay are actually less than the charges for the same procedure performed in an outpatient facility.

Freestanding surgical centers may be sponsored by hospitals, independent corporations or physicians. State licensure for these ASC's varies according to geographic location. During the past ten years, nationally accepted standards to validate quality assurance, quality of care, and peer review have been developed by accreditation agencies which include the Accreditation Association of Ambulatory Health Care (AAAHC), the Joint Commission on the Accreditation of Health Organizations (JCAHO), and Medicare. Additionally, the American Society of Plastic and Reconstructive Surgery, Inc. (ASPRS) accredits plastic surgery facilities which are generally physician-sponsored and single-specialty. The process of accreditation is voluntary and represents a facility's willingness to be accountable for the quality of care provided. It also signals the facility's commitment to continued quality improvement. An accreditation certificate (generally one to three years in duration requiring recertification on a continuing basis) represents the highest form of recognition achievable by a healthcare facility for the delivery of quality care.

The specialties of ophthalmology, gynecology, otolaryngology, orthopedics and general surgery have accounted for over 75 percent of the ambulatory surgery performed. Urology, upper and lower gastrointestinal endoscopy, and pain control have been added in this update. Managed care focus on the above specialties will therefore result in the greatest healthcare dollar savings.

The MEASUR Index provides a means to identify the appropriateness of the charges made by an ASC. The Index provides information on:

- i) the expected time a surgery patient will be in the operating room,
- ii) the expected time a surgery patient will be in the recovery room,
- iii) the reasonable cost for time spent in the operating room or the recovery room,
- iv) expected medical/surgical and anesthesia supplies required during the surgery and on-site recovery (on an item-by-item basis), and
- v) the reasonable charge for those supplies (on an item-by-item basis).

CPT Codes, descriptions and two digit numeric modifiers only are copyright 1993 American Medical Association. All Rights Reserved.

TAB 5

Profile of OR Turnover Time by Type of Ambulatory Surgery Facility

Specialty	Ambulatory Surgery Center					Hospital Based Ambulatory Surgery						
	Number	Percent	Time Range	Minutes	Weighted Average	Number	Percent	Time Range	Minutes	Weighted Average		
General Surgery	90	19.4%	31	37	6	7	967	23.6%	47	58	11	14
Gynecology	37	8.0%	29	30	2	2	588	14.4%	45	52	6	7
Neurosurgery	7	1.5%	21	26	0	0	138	3.4%	52	68	2	2
Ophthalmology	88	19.0%	34	37	6	7	320	7.8%	34	42	3	3
Oral Surgery	3	0.6%	39	44	0	0	30	0.7%	44	55	0	0
Orthopedics	88	19.0%	38	45	7	9	848	20.7%	53	60	11	12
Otolaryngology	82	17.7%	32	38	6	7	308	7.5%	38	42	3	3
Plastic Surgery	32	6.9%	33	37	2	3	131	3.2%	45	57	1	2
Podiatry	14	3.0%	29	35	1	1	38	0.9%	40	46	0	0
Urology												
Major	18	3.9%	27	35	1	1	108	2.6%	49	61	1	2
Cysto	4	0.9%	30	31	0	0	264	6.5%	38	45	2	3
Vascular/Thoracic												
Open heart							196	4.8%	82	105	4	5
Non open heart							157	3.8%	62	74	2	3
Total	463	100.0%			33	38	4,093	100.0%			48	57

Source: OR Manager, January 1994

	Amb Surg Ctr	Hospital Based
Potential Cases		
Average Case Time	38	57
Setup/Clean Up Time	20	20
Available Min. 250 days 8 hrs	120,000	120,000
Maximum capacity	2,075	1,551
Desired occupancy	75.0%	75.0%
Cases potential	1,556	1,163

TAB 6



American Board of Medical Specialties®



Member Boards and Associate Members

About ABMS

Ask ABMS

Who's Certified

Member Boards

Approved Certificates

General Requirements

Approval of New Boards

Conferences

Publications

Links

Member Boards American Board of...

Allergy & Immunology 510 Walnut Street Suite 1701 Philadelphia, PA 19106-3699 (215) 592-9466	Anesthesiology 4101 Lake Boone Trail Suite 510 Raleigh, NC 27607-7506 (919) 861-2570	Colon & Rectal Surgery 20600 Eureka Road Suite 600 Taylor, MI 48180 (734) 282-9400
Dermatology Henry Ford Health System 1 Ford Place Detroit, MI 48202-3450 (313) 874-1088	Emergency Medicine 3000 Coolidge Road East Lansing, MI 48823-6319 (517) 332-4800	Family Medicine 2228 Young Drive Lexington, KY 40505-4294 (859) 269-5626
Internal Medicine 510 Walnut Street, Suite 1700 Philadelphia, PA 19106-3699 (215) 446-3500	Medical Genetics 9650 Rockville Pike Bethesda, MD 20814-3998 (301) 634-7315	Neurological Surgery Suite 2138 6550 Fannin Street Houston, TX 77030-2701 (713) 441-6015
Nuclear Medicine 4555 Forest Park Blvd., Suite 119 St. Louis, MO 63108 (310) 825-6787	Obstetrics & Gynecology 2915 Vine Street, Suite 300 Dallas, TX 75204 (214) 871-1619	Ophthalmology 111 Presidential Blvd, Suite 241 Bala Cynwyd, PA 19004-1075 (810) 664-1175
Orthopaedic Surgery 400 Silver Cedar Court Chapel Hill, NC 27514 (919) 929-7103	Otolaryngology 5615 Kirby Drive, #600 Houston, TX 77005 (713) 850-0399	Pathology P.O. Box 25915 Tampa, FL 33622-5915 (813) 286-2444
Pediatrics 111 Silver Cedar Court Chapel Hill, NC 27514-1651 (919) 929-0461	Physical Medicine & Rehabilitation 3015 Allegro Park Lane SW Rochester, MN 55902-4139 (507) 282-1776	Plastic Surgery Seven Penn Center, Suite 400 1635 Market Street Philadelphia, PA 19103-2204 (215) 587-9322
Preventive Medicine 330 South Wells Street, Suite 1018 Chicago, IL 60606-7106 (312) 939-2276	Psychiatry & Neurology 500 Lake Cook Road, Suite 335 Dearfield, IL 60015-5249 (847) 945-7900	Radiology 5441 East Williams Blvd., Suite 200 Tucson, AZ 85711 (520) 790-2900
SURGERY 1617 John F. Kennedy Blvd., Suite 860 Philadelphia, PA 19103-1847 (215) 568-4000	Thoracic Surgery 633 N. St. Clair St., Suite 2320 Chicago, IL 60611 (312) 202-5900	Urology 2216 Ivy Road, Suite 210 Charlottesville, VA 22903 (434) 979-0059

ABMS Associate Members

Accreditation Council for Graduate Medical Education 515 North State Street, Suite 2000 Chicago, IL 60610-4322 (312) 755-5000	Accreditation Council for Continuing Medical Education 515 N. State Street Suite 7340 Chicago, IL 60610 (312) 755-7401	American Hospital Association One North Franklin Chicago, IL 60606-3421 (312) 422-3000
American Medical Association 515 N. State St. Chicago, IL 60610 (312) 464-5000	Association of American Medical Colleges 2450 N Street, N.W. Washington, D.C. 20037-1126 (202) 828-0400	Council of Medical Specialty Societies 51 Sherwood Terrace, Suite M Lake Bluff, IL 60044-2232 (847) 295-3456
Educational Commission for Foreign Medical Graduates 3624 Market Street Philadelphia, PA 19104-2685 (215) 386-5900	Federation of State Medical Boards 400 Fuller Wisner Road, Suite 300 Eufless, TX 76039-3855 (817) 571-2949	National Board of Medical Examiners 3750 Market Street Philadelphia, PA 19104-3190 (215) 590-9500

TAB 7

290-5-33-.04 Classifications of Services. Amended.

Each ambulatory surgical center, when applying for a permit shall designate the type(s) or classification(s) of services to be provided in or by the center. These classifications may include, but are not necessarily limited to the following: general surgery; eye, ear, nose, and throat; plastic surgery; oral and maxillofacial; obstetrical-gynecological; oncological; ophthalmological; and urological. Provided, however, that any facility providing labor and delivery services must meet the requirements of Rules and Regulations for Hospitals, Maternity and Obstetrical and Newborn Services, Chapter 290-5-6, Rules 290-5-6-.16 and 290-5-6-.17, dated May 10, 1977, or as later revised. The permit for a single ambulatory surgical treatment center may cover one or more types of services. Each ambulatory surgical treatment center shall provide only those services listed on the face of its permit.

Authority Ga. L. 1964, pp. 499, 507, 522, 565, 611, 612, 613; Ga. L. 1964, p. 338, as amended; Ga. L. 1966, pp. 310, 311, 312; Ga. L. 1972, pp. 1069, 1070, 1071, 1072; Ga. L. 1973, p. 635 et seq.; Ga. L. 1978, pp. 1757, 1758; Ga. L. 1978, p. 941 et seq.; and Ga. L. 1979, p. 1109 et seq. **Administrative History.** Original Rule entitled "Required Developmental Progress" was filed on January 23, 1976; effective February 12, 1976. **Amended:** Rule repealed. Filed October 31, 1979; effective November 20, 1979. **Amended:** Rule entitled "Classifications of Services" adopted. Filed January 22, 1980; effective March 1, 1980, as specified by the Agency.

TAB 8

SPECIALTY OF SURGERY (General Surgery) DEFINED
SPECIALTY OF SURGERY (General Surgery) DEFINED
SPECIALTY OF SURGERY (General Surgery) DEFINED
SPECIALTY OF SURGERY (General Surgery) DEFINED

SPECIALTY OF SURGERY (General Surgery) DEFINED
SPECIALTY OF SURGERY (General Surgery) DEFINED

The American Board of Surgery, Inc. interprets the term "General Surgery" in a comprehensive but specific manner; as a discipline having a central core of knowledge embracing anatomy, physiology, metabolism, immunology, nutrition, pathology, wound healing, shock and resuscitation, intensive care and neoplasia, which are common to all surgical specialties.

A General Surgeon is one who has specialized knowledge and skill enabling comprehensive and continued care of the surgical patient relating to the diagnosis, preoperative, operative, and postoperative management, including the management of complications, in the following areas of primary responsibility:

- ALIMENTARY TRACT
- ABDOMEN AND ITS CONTENTS
- BREAST, SKIN AND SOFT TISSUE
- HEAD AND NECK, including trauma, vascular, endocrine, congenital and oncologic disorders - particularly tumors of the skin, salivary glands, thyroid, parathyroid, and the oral cavity.
- VASCULAR SYSTEM, excluding the intracranial vessels and the heart.
- ENDOCRINE SYSTEM, including thyroid, parathyroid, adrenal and endocrine pancreas.
- SURGICAL ONCOLOGY, including coordinated multimodality management of the cancer patient by screening, surveillance, surgical adjunctive therapy, rehabilitation, and follow-up.
- COMPREHENSIVE MANAGEMENT OF TRAUMA, including musculoskeletal, hand and head injuries. The responsibility for all phases of care of the injured patient is an essential component of general surgery.
- COMPLETE CARE OF CRITICALLY ILL PATIENTS with underlying surgical conditions, in the Emergency Room, Intensive Care Unit and Trauma/Burn Units.

Additionally, the General Surgeon is expected to have significant preoperative, operative and postoperative experience in pediatric, plastic, general thoracic and transplant surgery. Also, the Surgeon must have understanding of the management of the

more common problems in cardiac, gynecologic, neurologic, orthopedic, and urologic surgery, and of the administration of anesthetic agents.

The General Surgeon must be capable of employing endoscopic techniques, particularly proctosigmoidoscopy, colonoscopy, esophagogastroduodenoscopy laparoscopy, and operative choledochoscopy, and must have experience in other relevant diagnostic and therapeutic techniques including laryngoscopy, bronchoscope, and fine needle aspiration. The General Surgeon should have the opportunity to become familiar with evolving diagnostic and therapeutic methods, such as laser applications, investigations and manipulations of the distal common bile duct (including sphincterotomy), stereotactic breast biopsy, physiologic testing and evaluation of the gastrointestinal tract, non-invasive diagnostic evaluation of the vascular system and invasive vascular interventional techniques. Surgeons should also have the opportunity to become familiar with ultrasonography of the head and neck, breast, abdomen (including laparoscopic intra-abdominal), and endorectal ultrasound.

Source: *The American Board of Surgery, Inc., Booklet of Information, July 1997 - June 1998, p.10-11.*

HAND OUT MATERIALS

Provided to the
State Commission on the Efficacy of the CON Program

By
Chris Smith, MD, President,
Georgia Society of General Surgeons, Inc.

(October 24, 2005)



South Georgia Physicians Association, L.L.C.

1921 Palmyra Road • Albany, Georgia 31701
(229) 432-7003 • Fax (229) 432-9536 • Toll Free (877) 892-6410
www.sgpallc.com

June 11, 2003

Mr. Clyde Reese
General Counsel
Georgia Department of Community Health
2 Peachtree St., NW
40th Floor
Atlanta, GA 30303

Re: Albany Surgical, P.C.

Dear Mr. Reese:

It is my understanding that you will be reviewing the appeal of Albany Surgical, P.C. to allow them to establish an Ambulatory Surgery Center (ASC) in Albany, Georgia.

I have worked in health care in Albany, Georgia for the past 12 years. I currently serve as Executive Director of South Georgia Physicians Association, L.L.C. (SGPA), which represents over 230 physicians. Due to my position, I work directly with local physicians, employers, insurers and networks.

Allow me to share a small capsule of Albany healthcare and why it is important that Albany Surgical, P.C. be awarded an ASC.

Although Albany is a two-hospital community, there is not enough competition to effectively control the rising cost of healthcare to employers.

I recently met with a local employer whose healthcare cost is nearly \$14,000 per employee per year. In fact, their healthcare costs now exceed payroll. As a result, their plant is facing serious economic concerns over their continued viability. If the plant is forced to close or relocate, nearly 1,000 people will lose their jobs. Unfortunately, this predicament is becoming the standard instead of the exception.

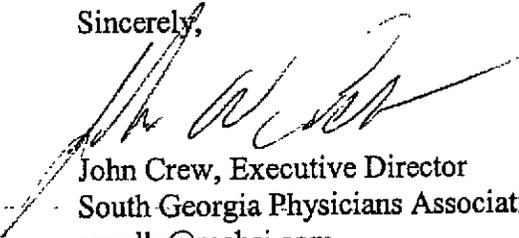
The payor mix in Albany is not unlike other communities. Approximately 50% of the population is Medicare or Medicaid, another 15% is self-pay or indigent, and the balance is commercially insured. Due to the expected Medicare and Medicaid cuts, Albany hospitals are attempting to modify their managed care relationships to shift costs to the commercial employers. Prior to this development, employers had already been forced to cut back on benefits and raise their employee premiums. With a current healthcare cost of nearly \$14,000 per employee per year, I know one company that will not survive the additional costs.

Georgia is in a financial crisis. The reductions in the various state programs during the past legislative session were astounding. The fact that the State could not give its teachers a raise is atrocious. The reason I mention this is the Department of Community Health is using a PPO network that does not allow ancillary facilities to participate. Albany currently has an Endoscopy Center that is not allowed to be a provider for the State Health Plan. Our State employees must use the local hospitals, when the same procedures could be done for less than half the cost to the State at the Endoscopy Center. Clearly, the state is a poor steward of its own healthcare cost by limiting access to lower cost provider services. Are we going to prevent industries, the backbone of Georgia, from accessing more affordable healthcare?

For years, the hospitals have proclaimed that ASC or other ancillary facilities would cause financial devastation to local hospitals and that the state would then have to subsidize the hospitals. I agree the state is going to subsidize healthcare but not as a result of an ASC operating in Albany, Georgia. 19% of Georgians are not insured and that number is increasing. The subsidies will result from the growing population of Albany uninsured as hospitals keep lower cost healthcare services out of Albany and force employers to pay exorbitant healthcare prices or discontinue their healthcare coverage. Over the last three to five years, the profits of both Albany hospitals have been substantial despite wasting money on exorbitant administrative salaries and unnecessary building projects.

I encourage you to approve the ASC for Albany Surgical, P.C. Albany employers must have access to affordable healthcare. Do not allow the political process to continue diminishing the availability of affordable healthcare in Albany.

Sincerely,



John Crew, Executive Director
South Georgia Physicians Association, LLC
sgpallc@mchsi.com

Cc: The Honorable Sonny Perdue, Governor

ALBANY SURGICAL, P.C.

401 FOURTH AVENUE
P.O. BOX 1686
ALBANY, GEORGIA 31702-1686

TELEPHONE 229-434-4200
1-800-537-6107

JOSEPH J. BURNETTE, M.D.
A. CULLEN RICHARDSON, III, M.D., F.A.C.S.
V. JOHN BAGNATO, M.D., F.A.C.S.

O. GREY RAWLS, JR., M.D., F.A.C.S. (RETIRED)
CHRISTOPHER C. SMITH, M.D., F.A.C.S.
J. PRICE CORR, JR., M.D., F.A.C.S.

SPECIALISTS IN GENERAL SURGERY

August 09, 2003

William G. Baker, M.D., Chairman
Ambulatory Surgical Services – Technical Advisory Committee
Department of Community Health,
Division of Health Planning
34th Floor
2 Peachtree Street, N. W.
Atlanta, Georgia 30303

Dear Dr. Baker:

Thank you Dr. Baker, for allowing me to address the T.A.C. Committee. My name is Dr. Christopher C. Smith. I am a general surgeon who has practiced general surgery in Albany Georgia for the last 20 years. I am in a six-member general surgery group named Albany Surgical.

We completed an outpatient surgery center, but prior to our obtaining a letter of non-review ability, the State Health Care Planning Agency declared general surgeons as not eligible for the single specialty exemption. We were stunned to find out that the State of Georgia did not consider general surgeons a specialty. This has become a 12-year venture in bureaucracy that has become the most frustrating event in my life. We discussed our situation with our colleagues and with other physicians and have been met with laughter and disbelief that the state of Georgia would not consider general surgeons as specialist. You see, I spent 13 years of post high school education in becoming a general surgeon, and my partners and I are very proud of our board certifications. The more that we looked into this, the more confused we were about why the state did not consider us specialist. We attempted to clarify this matter and obtained letters from the American Board of Medical Specialists, the American Board of Surgery, The American College of Surgeons and from the Medical Association of Georgia (who stated they consider this a bedrock issue). There were letters from the American Society of General Surgery who clearly stated that general surgeons were a well-defined, very narrow, single specialty. The State Health Care Planning Commission ignored all of this.

In attempting to get the specific objections from Clyde Reese, we were stunned to find out that he stated, even in front of this committee on its first meeting, that general surgeons "operated on too many parts of the body". This is very interesting because orthopedic surgeons operate on the entire body. Plastic surgeons operate on the entire body. Neurosurgeons deal with the problems of nerves of the entire body. Should they be disqualified? Mr. Reese also stated that there was too much overlap between general surgeons and other specialist. This, too, perplexed us because there is a 100% overlap between orthopedics and podiatry, yet both have the exemption. Plastic surgeons and ENTs have a huge amount of overlap, yet both have the exemption. General surgeons are the only specialty that deals with many areas of the body which includes the thyroid, parathyroid, stomach, small bowel, hernias, breast cancer, esophageal reflux, just to name a few.

Mr. Reese also stated that general surgeons were not a specialty because we were generalists and that a general surgeon could obtain extra training to become a sub-specialist in pediatric surgery, colorectal surgery or surgical oncology. Mr. Reese was very misinformed as orthopedic surgeons can also receive sub-specialty training to be spinal surgeons or hand surgeons and become sub-specialist.

Albany Surgical has been dealing with this frustrating position of the state and wondering by what logic they could have decided that we were not specialists when in the face of all evidence, we obviously are a well-described, well-recognized specialty by all medical authorities. We chose to finally, out of frustration, sue the state over this matter. We feel like we have been arbitrarily singled out by the state and are not being treated as the other specialties. In our lawsuit, the Community Hospital Association lawyers did 99% of the speaking against our SurgiCenter.

It became obvious that it was their issue rather than the states. Their strategy was brilliant, because suddenly we became super-specialists. The community hospital lawyers stated that "general surgeons have an unfair economic advantage over all other surgical specialists, and, therefore, the state in its wisdom decided to restrict their access to SurgiCenters". This is fascinating as general surgeons are the lowest paid of all surgical specialties.

The community hospital lawyers repeatedly state that general surgeons owning SurgiCenters will destabilize rural hospitals. Rural hospitals rarely have more than one or two general surgeons, which because of expense of the centers and the number of general surgeons required to operate a center (4 or 5) this is not a reasonable issue. General surgery SurgiCenters will be only located in the urban or suburban areas and are absolutely no threat to rural hospitals.

Under discovery we were also surprised to find that the state asked no expert opinion as to general surgeons being specialist. There was no testimony or even any discussion as to this matter in any committee meeting prior to this decision. The State Board of Medical Examiners, The Medical College of Georgia, The Medical Association of Georgia or any other state medical authority was not asked its opinion.

It became obvious that the reason general surgeons were not specialists is that Albany Surgical made the mistake of building the first general surgery SurgiCenter in the state of Georgia and not promptly obtaining a letter of non-reviewability. I am asking this committee to right what was obviously a bureaucratic wrong and recognize general surgery as a single specialty and give general surgery the rights of all other specialists.

Thank you for allowing me to address this committee.

Sincerely,

A handwritten signature in black ink, appearing to read "Chris C. Smith". The signature is written in a cursive, somewhat stylized font.

Christopher C. Smith, M.D., F.A.C.S.

CC: The Honorable Sonny Purdue

CC/trr

The Georgia Society of Anesthesiologists, Inc.

1231 COLLIER ROAD, N.W.
SUITE J
ATLANTA, GEORGIA 30318
404-249-9178 PHONE
404-249-8831 FAX

November 24, 2003

John Bagnato, M.D.
Albany Surgical, P.C.
401 Fourth Avenue
P.O. Box 1686
Albany, GA 31702-1686

Dear Dr. Bagnato

Thank you for your letter of 22 September 2003. The Georgia Society of Anesthesiologists (GSA) appreciates your inquiry and welcomes the opportunity to respond. I am currently Vice-President of the society, and Dr. Bannister has asked me to address the issues which you mentioned in your correspondence, as well as those raised by Dr. Moree in his letter to Dr. Baker. In my practice with Georgia Perioperative Consultants of Atlanta, I am involved in anesthetic coverage of a tertiary hospital (Piedmont), a community hospital (Fayette), a hospital based outpatient surgery center (Peachtree Orthopaedic Surgery Center), and two free-standing outpatient surgical centers where plastic surgery and hand cases are performed. I also recently addressed the annual meeting of the Georgia Society of Ambulatory Surgery Centers regarding anesthetic and safety concerns in the out of hospital setting.

Both the American Society of Anesthesiologists (ASA) and the GSA support the concept of outpatient surgery, provided that patient safety remains the top priority in all venues. A number of GSA members, in fact, practice exclusively in the out of hospital setting. As Dr. Moree noted, an alarming number of adverse events have occurred in Georgia at free-standing surgicenters. Interestingly, Physician Anesthesiologists were not involved in patient care at many of the centers where these unfortunate mishaps occurred.

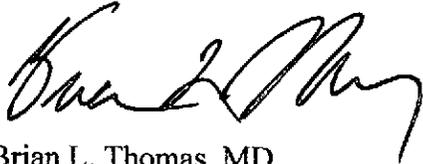
Both societies strongly feel that involvement of Physician Anesthesiologists is essential to the safe practice of outpatient surgery. The practice of employing Certified Registered Nurse Anesthetists (CRNAs) without Medical Direction by a Physician Anesthesiologist is not, and never will be supported by either society. Early involvement of Anesthesiologists in the planning and construction phases should help to ensure that appropriate equipment is available to deal with the inevitable emergencies. Many Anesthesiologists have experience in formulating policies and procedures for this care setting, ensuring compliance with the myriad of state and federal regulations germane to surgery in the out of hospital setting. Procedures for transportation to a hospital facility should complications arise and backup Physician coverage policies are especially critical.

There is extensive information on the ASA website www.asahq.org which you might find helpful as you devise a plan for this facility. I would direct you in particular to the ASA statements on Recommended Scope of Practice of Nurse Anesthetists and Anesthesiologist Assistants at www.asahq.org/clinicalinfo.htm, Guidelines for Ambulatory Anesthesia and Surgery as well as the guidelines for Office Based Surgery, which can be found at www.asahq.org/publicationsAndServices/systoc.htm.

The executive committee of the GSA does believe that surgery in the out of hospital setting can be practiced safely, provided that patient care excellence is ensured by collaboration between Surgeons and Anesthesiologists throughout all phases of the process.

Please feel free to contact me if we can provide additional information.

Best regards,



Brian L. Thomas, MD
Vice-President
Georgia Society of Anesthesiologists
Chairman-Elect
Department of Anesthesiology
Piedmont Hospital, Atlanta

ALBANY SURGICAL, P.C.

401 FOURTH AVENUE
P.O. BOX 1686
ALBANY, GEORGIA 31702-1686

O. GREY RAWLS, JR., M.D., F.A.C.S. (RETIRED)
CHRISTOPHER C. SMITH, M.D., F.A.C.S.
J. PRICE CORR, JR., M.D., F.A.C.S.

TELEPHONE 229-434-4200
1-800-537-6107

JOSEPH J. BURNETTE, M.D.
A. CULLEN RICHARDSON, III, M.D., F.A.C.S.
V. JOHN BAGNATO, M.D., F.A.C.S.
B. SCOTT DAVIDSON, M.D., F.A.C.S., F.S.S.O.

SPECIALISTS IN GENERAL SURGERY / SURGICAL ONCOLOGY

December 3, 2003

Mr. Richard Green, Director
Division of Health Planning
2 Peachtree Street, N.W.
34th Floor
Atlanta, GA 30303-3159

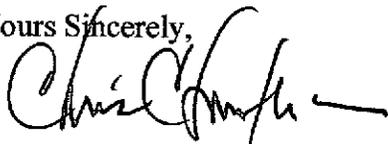
Dear Mr. Green:

Deborah Weingard suggested that I write you a note to help explain the situation with general surgery being not recognized as a specialty by the State of Georgia For C.O.N. purposes. As you may be aware, Governor Perdue, at the MAG House of Delegates this summer called this a "ridiculously absurd" situation. Dr. Donald Palmisano, the president of the A.M.A, also addressed this issue in his speech to the House of Delegates.

As I am sure you are aware, the overwhelming majority of opposition to general surgeons having the same rights as other specialist stems from the efforts of the Alliance of Community Hospitals. In Albany Surgical's lawsuit against the state on this matter, all of the legal work was done by the alliance lawyers. In the discovery portion of our law suit, we were stunned to find out that the State Health Care Planning Agency had no expert witnesses, no testimonies prior to their interpretation that general surgeons were not specialist. In the past, Mr. Reese was quoted in saying that general surgeons "operated on too many parts of the body" and that general surgeons "overlap too much with other specialties". With your familiarity with the medical profession, I am sure that your realize that this is a gross misunderstanding.

Members of our group would very much like to meet with you if you should desire. I have enclosed copies of several letters to Dr. Baker on the Technical Advisory Committee for your consideration.

Yours Sincerely,



Christopher C. Smith, M.D., F.A.C.S.



American College of Surgeons

633 N Saint Clair St
Chicago, IL 60611-3211

Voice: 312/202-5000
Fax: 312/202-5001

e-mail: postmaster@facs.org
ACS Web site: <http://www.facs.org>

Officers

President

Claude H. Organ, Jr., MD, FACS
Oakland, CA

President-Elect

Edward R. Laws, MD, FACS
Charlottesville, VA

First Vice-President

Anna M. Ledgerwood, MD, FACS
Detroit, MI

Second Vice-President

Murray F. Brennan, MD, FACS
New York, NY

First Vice-President-Elect

Andrew L. Warshaw, MD, FACS
Boston, MA

Second Vice-President-Elect

Henry L. Laws, MD, FACS
Birmingham, AL

Secretary

John O. Gage, MD, FACS,
Pensacola, FL

Treasurer

John L. Cameron, MD, FACS
Baltimore, MD

Executive Director

Thomas R. Russell, MD, FACS
Chicago, IL

Comptroller

Gay L. Vincent, CPA
Chicago, IL

Board of Regents

Chair

Edward M. Copeland III, MD, FACS
Gainesville, FL

Vice-Chair

Gerald B. Healy, MD, FACS
Boston, MA

H. Randolph Bailey, MD, FACS
Houston, TX

Barbara L. Bass, MD, FACS
Baltimore, MD

L. D. Britt, MD, FACS
Norfolk, VA

Bruce D. Browner, MD, FACS
Farmington, CT

Martin B. Camins, MD, FACS
New York, NY

William H. Coles, MD, FACS
Chapel Hill, NC

A. Brent Eastman, MD, FACS
San Diego, CA

Richard J. Finlay, MD, FACS
Vancouver, BC

Josel E. Fischer, MD, FACS
Boston, MA

Alden H. Harken, MD, FACS
Oakland, CA

Charles D. Mabry, MD, FACS
Pine Bluff, AR

Jack W. McAninch, MD, FACS
San Francisco, CA

Mary H. McGrath, MD, FACS
San Francisco, CA

Robin S. McLeod, MD, FACS
Toronto, ON

Claude H. Organ, Jr., MD, FACS
Oakland, CA

Carlos A. Pellegrini, MD, FACS
Seattle, WA

Karl C. Podratz, MD, FACS
Rochester, MN

John T. Preskitt, MD, FACS
Dallas, TX

J. David Richardson, MD, FACS
Louisville, KY

Thomas V. Whalen, MD, FACS
New Brunswick, NJ

Board of Governors

Chair

Courtney M. Townsend, Jr., MD, FACS
Galveston, TX

Vice-Chair

Rene Lafreniere, MD, FACS
Calgary, AB

Secretary

Julie A. Freischlag, MD, FACS
Lincoln, MD

January 29, 2004

Richard Greene, Director
Division of Health Planning
Georgia Department of Community Health
2 Peachtree Street, NW
40th Floor
Atlanta, GA 30303

Dear Mr. Greene:

Over the past few years, the American College of Surgeons (ACS) has been concerned with an issue in Georgia relating to the Certificate of Need (CON) law and how the specialty of general surgery is defined. During the court case of Albany Surgical, P.C. vs Department of Community Health (DCH), the College submitted an amicus curiae brief challenging the department's definition of General Surgery as a multi-specialty for purposes of Georgia CON requirements. At this time, the College wishes to provide further comment on this issue as recent revisions to the rules issued by Georgia's DCH for CONs governing ambulatory surgical centers (ASCs) do not yet reflect the correct view of general surgery as a single specialty. This mis-conception will inappropriately and unfairly deny general surgeons eligibility for the benefits afforded by the single specialty exemption in the CON law.

It is universally recognized by academic and private healthcare institutions that general surgery is a distinct single medical specialty, just as unique and focused as any other single medical specialty. Although the term "general" is in the title of general surgery, it does not imply that surgeons in this specialty area: practice multi-specialties; are primary care physicians; perform every type of surgical procedure; or have no specialty status. Just the opposite is true.

Individuals entering careers and training programs in general surgery must have an MD/DO degree before moving on to specialize in this area. They apply to general surgery residency programs, and if accepted, undergo a minimum of five years of training in the specialty. This training is geared to educate the residents in the essential components of general surgery, including surgery of the head and neck, breast, skin and soft tissues, alimentary tract, abdomen, vascular system, and the endocrine system. It also includes the comprehensive management of trauma, burns, emergency surgery and surgical critical care.

FOUNDED BY SURGEONS OF THE UNITED STATES AND CANADA, 1913

The American College of Surgeons Is an Equal Opportunity/Affirmative Action Employer



Richard Greene
January 29, 2004
Page 2

Most general surgeons in this country have the above special training and expertise tested when they receive certification through the American Board of Surgery. This certification process parallels those of other medical specialties that also have defined areas of practice. In fact, hospitals consider general surgery as a single specialty for purposes of their physician recruitment, credentialing and granting of privileges for surgical procedures. Healthcare insurers also consider general surgery a single specialty practice as evidenced by reimbursement for specific types of procedures provided by the specialty.

Ambulatory surgery centers are facilities where high-quality surgical care is provided in a cost-effective and safe manner. As technology has improved, many surgical procedures, once limited to hospitals, have now been safely and appropriately moved into the ambulatory setting. Thus, the College believes that the department must carefully weigh their decisions in this area that would reduce patient access to specialized surgical care in these types of facilities. Therefore, we suggest the following revisions to guidelines governing CONs for ambulatory surgery centers:

1. **Applicability 1 (Facilities Considered as Part of a Hospital)** – This guideline expands the scope of which hospital ASCs do not need to obtain certificates of need to include ambulatory surgical services on premises outside the hospital's campus if the services are "integrated with other hospital services and systems, and the services are billed through the hospital's Medicare or Medicaid provider number and/or license number issued by the Department of Human Resources." While the College does not object to this guideline, we believe the regulations should also be expanded to exempt from CON requirements physician-owned ASCs offering general surgery services. In addition, providers wishing to expand or replace their facilities should be required to only include the costs associated with the new or upgraded surgical suites, not the cost of the entire project, when calculating the capital threshold under the CON requirements.
2. **Definition 10 (Multi-Specialty Ambulatory Surgery Service)** – Because general surgery is a single specialty, the words "general surgery or" should be stricken from this definition. To maintain this definition as currently written discriminates against the specialty and restricts patient access to high-quality, cost-effective surgical care.

Finally, the College takes issue with the process that surrounded development of these guidelines, particularly the composition of the Technical Advisory Committee (TAC). We are deeply troubled that membership on the TAC disproportionately favored the interests of the hospital community – effectively limiting the consideration of issues central to surgeons and their patients.



Richard Greene
January 29, 2004
Page 3

We urge the department to remove general surgery from the definition of a multi-specialty ambulatory surgery service. General surgery is clearly a single specialty, and physician-owned ambulatory surgical centers offering general surgery should be exempted from the CON process in the same way that other single specialty ambulatory surgical centers are exempt. Maintaining the status quo discriminates against those in the specialty who wish to provide high-quality ambulatory surgical care in their own ambulatory surgical center, and unnecessarily restricts patient access to quality surgical care.

Sincerely,

A handwritten signature in cursive script that reads "Tom Russell".

Thomas R. Russell, MD, FACS
Executive Director

TRR:jhs

cc: Neal Childers, JD
DCH General Counsel

Office of the Governor:

John K. Watson
Chief of Staff

Trey Childress
Policy Director

Harold Melton, Esq.
Executive Council

The American College of Surgeons is a voluntary, educational and scientific organization devoted to the ethical and competent practice of surgery, and to enhancing the quality of care provided to surgical patients. For over 90 years, the College has disseminated medical and surgical information to the profession and to the general public, and it has been deeply involved in establishing standards of practice. With over 64,000 members, nearly half of which are general surgeons, the ACS is the largest surgical association in the world.

American Medical Association

Physicians dedicated to the health of America



Donald J. Palmisano, MD, JD 515 North State Street
President Chicago, Illinois 60610

312 464-4016
312 464-5543 Fax
donald_palmisano@ama-assn.org

May 13, 2004

The Honorable Sonny Perdue
Office of the Governor
Georgia State Capital
203 State Capitol
Atlanta, GA 30334

Dear Governor Perdue:

I am writing on behalf of the American Medical Association (AMA), which represents approximately 250,000 physicians in Georgia and across the country, requesting that the Georgia Department of Community Health, Division of Public Planning (the Division) reconsider the application of Georgia's Certificate of Need (CON) requirement as it applies to general surgeons.

The AMA urges reconsideration in part because there is little evidence to suggest that CON programs are effective in restraining health care costs or in limiting capital investment. Due to this lack of evidence, it is AMA policy to oppose the extension of certificate of need requirements to physicians' offices.

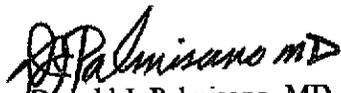
The AMA understands that although Georgia has a CON requirement, that requirement has specific exceptions. One exception is for surgery that is performed in the offices of a single group practice of private physicians if such surgery is performed in a facility that is owned, operated, and utilized by such physicians who are of a single specialty. The most obvious interpretation of this "single specialty" requirement is that general surgeons, as board certified specialists, would fall under this CON exemption. The Division, unfortunately, has not adopted this interpretation. Instead, it currently holds that general surgery is not a "single specialty" for purposes of the CON exemption. Because of this interpretation, general surgeons seeking to perform in-office surgery through an ambulatory surgical center must obtain CON approval before becoming operational. Consistent with its policy, the AMA opposes the Division's interpretation, because it extends CON to physician's offices without evidentiary justification.

The AMA also requests consideration due to the nature of the CON process itself. This process is time consuming and expensive, and it is extremely difficult to obtain CON approval. Application of CON requirements to private initiatives like general surgery Ambulatory Surgery Centers consequently has a chilling effect on market innovations and competition. This chilling effect is very unfortunate in today's health care financing climate, where innovation and competition are essential to controlling the rising costs that threaten the stability of our health care system.

The Honorable Sonny Perdue
May 13, 2004
Page 2

Thank you for your time and consideration as the AMA respectfully asks you to reconsider the Division's position.

Sincerely,


Donald J. Palmisano, MD, JD

cc: Tim Burgess, Commissioner, Georgia Department of Community Health
Christopher C. Smith, MD, FACS ✓

American Medical Association

Physicians dedicated to the health of America



Search our site

[HOME](#)

[JOIN / RENEW](#)

[CONTACT US](#)

[SITEMAP](#)

[privacy statement](#)

[web guidelines](#)

[AMA Home](#) > [PolicyFinder](#)

Results List

- ▶ [Search Tips](#)
- ▶ [About AMA Policy](#)
- ▶ [Download Policy Finder](#)
- ▶ [Principles of Medical Ethics](#)
- ▶ [AMA Strategic Plan and Vision](#)
- ▶ [AMA History](#)

H-205.999 Cost Effectiveness of State Certificate of Need Programs.

Our AMA believes that there is little evidence to suggest that **Certificate** of Need programs are effective in restraining health care costs or in limiting capital investment. In the absence of such evidence, the AMA reaffirms current policy opposing the extension of **certificate** of need to private physicians' offices. (CMS Rep. D, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

◀ [prev / next Results](#) ▶

[Back to results list](#)

◀ [prev / next Policy number](#) ▶

[Search Tips](#) | [New Search](#) | [Refine Search](#)



American College of Surgeons

633 N Saint Clair St
Chicago, IL 60611-3211

Voice: 312/202-5000
Fax: 312/202-5001

e-mail: postmaster@facs.org
ACS Web site: <http://www.facs.org>

Officers

President

Edward R. Laws, MD, FACS
Charlottesville, VA

President-Elect

Kathryn D. Anderson, MD, FACS
San Marino, CA

First Vice-President

Andrew L. Warshaw, MD, FACS
Boston, MA

Second Vice-President

Henry L. Laws, MD, FACS
Birmingham, AL

First Vice-President-Elect

J. Patrick O'Leary, MD, FACS
New Orleans, LA

Second Vice-President-Elect

William F. Sasser, MD, FACS
St. Louis, MO

Secretary

John O. Gage, MD, FACS
Pensacola, FL

Treasurer

John L. Cameron, MD, FACS
Baltimore, MD

Executive Director

Thomas R. Russell, MD, FACS
Chicago, IL

Comptroller

Gay L. Vincent, CPA
Chicago, IL

Board of Regents

Chair

Edward M. Copeland III, MD, FACS
Gainesville, FL

Vice-Chair

Gerald B. Healy, MD, FACS
Boston, MA

H. Randolph Bailey, MD, FACS
Houston, TX

Barbara L. Bass, MD, FACS
Baltimore, MD

L. D. Britt, MD, FACS
Norfolk, VA

Bruce D. Browner, MD, FACS
Farmington, CT

Martin B. Camins, MD, FACS
New York, NY

A. Brent Eastman, MD, FACS
La Jolla, CA

Richard J. Finley, MD, FACS
Vancouver, BC

Joseph E. Fischer, MD, FACS
Boston, MA

Barrett George Haik, MD, FACS
Memphis, TN

Alden H. Harken, MD, FACS
Oakland, CA

Edward R. Laws, MD, FACS
Charlottesville, VA

Charles D. Mabry, MD, FACS
Pine Bluff, AR

Jack W. McAninch, MD, FACS
San Francisco, CA

Mary H. McGrath, MD, FACS
San Francisco, CA

Robin S. McLeod, MD, FACS
Toronto, ON

Carlos A. Pellegrini, MD, FACS
Seattle, WA

Karl C. Podratz, MD, FACS
Rochester, MN

John T. Preskitt, MD, FACS
Dallas, TX

J. David Richardson, MD, FACS
Louisville, KY

Thomas V. Whalen, MD, FACS
New Brunswick, NJ

Board of Governors

Chair

Courtney M. Townsend, Jr., MD, FACS
Galveston, TX

Vice-Chair

Mary Margaret Kemeny, MD, FACS
Jamaica, NY

Secretary

Julie A. Freischlag, MD, FACS
Baltimore, MD

February 22, 2005

The Honorable Jeff Anderson
Chair, Board of Community Health
10 Glenlake Parkway, NE
Suite 1000
Atlanta, GA 30328-7249

Dear Mr. Anderson:

Over the past few years, the American College of Surgeons (ACS) has been concerned with an issue in Georgia relating to the Certificate of Need (CON) law and how the specialty of general surgery is defined. During the court case of Albany Surgical, P.C. vs Department of Community Health (DCH), the College submitted an amicus curiae brief challenging the department's definition of General Surgery as a multi-specialty for purposes of Georgia CON requirements. At this time, the College wishes to provide further comment on this issue as rules relating to CONs governing ambulatory surgical centers (ASCs) do not yet reflect the correct view of general surgery as a single specialty. This mis-conception inappropriately and unfairly denies general surgeons eligibility for the benefits afforded by the single specialty exemption in the CON law.

It is universally recognized by academic and private healthcare institutions that general surgery is a distinct single medical specialty, just as unique and focused as any other single medical specialty. Although the term "general" is in the title of general surgery, it does not imply that surgeons in this specialty area: practice multi-specialties; are primary care physicians; perform every type of surgical procedure; or have no specialty status. Just the opposite is true.

Individuals entering careers and training programs in general surgery must have an MD/DO degree before moving on to specialize in this area. They apply to general surgery residency programs, and if accepted, undergo a minimum of five years of training in the specialty. This training is geared to educate the residents in the essential components of general surgery, including surgery of the head and neck, breast, skin and soft tissues, alimentary tract, abdomen, vascular system, and the endocrine system. It also includes the comprehensive management of trauma, burns, emergency surgery and surgical critical care.



Honorable Jeff Anderson
March 22, 2005
Page 2

Most general surgeons in this country have the above special training and expertise tested when they receive certification through the American Board of Surgery. This certification process parallels those of other medical specialties that also have defined areas of practice. In fact, hospitals consider general surgery as a single specialty for purposes of their physician recruitment, credentialing and granting of privileges for surgical procedures. Healthcare insurers also consider general surgery a single specialty practice as evidenced by reimbursement for specific types of procedures provided by the specialty.

Ambulatory surgery centers are facilities where high-quality surgical care is provided in a cost-effective and safe manner. As technology has improved, many surgical procedures, once limited to hospitals, have now been safely and appropriately moved into the ambulatory setting. Thus, the College believes that the current rules unfairly reduce patient access to specialized surgical care in these types of facilities.

We urge the Board of Community Health to adopt the position that general surgery should be removed from the definition of a multi-specialty ambulatory surgery service in the CON rules, and to direct the Department of Community Health to take whatever actions are necessary to revise the CON rules to reflect this position. General surgery is clearly a single specialty, and physician-owned ambulatory surgical centers offering general surgery should be exempted from the CON process in the same way that other single specialty ambulatory surgical centers are exempt. Maintaining the status quo unfairly discriminates against those in the specialty who wish to provide high-quality ambulatory surgical care in their own ambulatory surgical center, and unnecessarily restricts patient access to quality surgical care.

Sincerely,

Thomas R. Russell, MD, FACS
Executive Director

TRR:jhs

The American College of Surgeons is a voluntary, educational and scientific organization devoted to the ethical and competent practice of surgery, and to enhancing the quality of care provided to surgical patients. For over 90 years, the College has disseminated medical and surgical information to the profession and to the general public, and it has been deeply involved in establishing standards of practice. With over 66,000 members, nearly half of which are general surgeons, the ACS is the largest surgical association in the world.



American College of Surgeons

633 N Saint Clair St
Chicago, IL 60611-3211

Voice: 312/202-5000
Fax: 312/202-5001

e-mail: postmaster@facs.org
ACS Web site: <http://www.facs.org>

Officers

President

Edward R. Laws, MD, FACS
Charlottesville, VA

President-Elect

Kathryn D. Anderson, MD, FACS
San Marino, CA

First Vice-President

Andrew L. Warsaw, MD, FACS
Boston, MA

Second Vice-President

Henry L. Laws, MD, FACS
Birmingham, AL

First Vice-President-Elect

J. Patrick O'Leary, MD, FACS
New Orleans, LA

Second Vice-President-Elect

William F. Sasser, MD, FACS
St. Louis, MO

Secretary

John O. Gage, MD, FACS
Pensacola, FL

Treasurer

John L. Cameron, MD, FACS
Baltimore, MD

Executive Director

Thomas R. Russell, MD, FACS
Chicago, IL

Comptroller

Gay L. Vincent, CPA
Chicago, IL

Board of Regents

Chair

Edward M. Copeland III, MD, FACS
Gainesville, FL

Vice-Chair

Gerald B. Healy, MD, FACS
Boston, MA

H. Randolph Bailey, MD, FACS
Houston, TX

Barbara L. Bass, MD, FACS
Baltimore, MD

L. D. Britt, MD, FACS
Norfolk, VA

Bruce D. Browner, MD, FACS
Farmington, CT

Martin B. Camins, MD, FACS
New York, NY

A. Brent Eastman, MD, FACS
La Jolla, CA

Richard J. Finley, MD, FACS
Vancouver, BC

Josef E. Fischer, MD, FACS
Boston, MA

Barrett George Haik, MD, FACS
Memphis, TN

Alden H. Harken, MD, FACS
Oakland, CA

Edward R. Laws, MD, FACS
Charlottesville, VA

Charles D. Mabry, MD, FACS
Pine Bluff, AR

Jack W. McAninch, MD, FACS
San Francisco, CA

Mary H. McGrath, MD, FACS
San Francisco, CA

Robin S. McLeod, MD, FACS
Toronto, ON

Carlos A. Pellegrini, MD, FACS
Seattle, WA

Karl C. Podratz, MD, FACS
Rochester, MN

John T. Preskitt, MD, FACS
Dallas, TX

J. David Richardson, MD, FACS
Louisville, KY

Thomas V. Whalan, MD, FACS
New Brunswick, NJ

Board of Governors

Chair

Courtney M. Townsend, Jr., MD, FACS
Galveston, TX

Vice-Chair

Mary Margaret Kemeny, MD, FACS
Jamaica, NY

Secretary

Julie Freischlag, MD, FACS
Baltimore, MD

February 22, 2005

The Honorable Sonny Perdue
Office of the Governor
Georgia State Capitol
Atlanta, GA 30334

Dear Governor Purdue:

Over the past few years, the American College of Surgeons (ACS) has been concerned with an issue in Georgia relating to the Certificate of Need (CON) law and how the specialty of general surgery is defined. During the court case of Albany Surgical, P.C. vs Department of Community Health (DCH), the College submitted an amicus curiae brief challenging the department's definition of General Surgery as a multi-specialty for purposes of Georgia CON requirements. At this time, the College wishes to provide further comment on this issue as rules relating to CONs governing ambulatory surgical centers (ASCs) do not yet reflect the correct view of general surgery as a single specialty. This mis-conception inappropriately and unfairly denies general surgeons eligibility for the benefits afforded by the single specialty exemption in the CON law.

It is universally recognized by academic and private healthcare institutions that general surgery is a distinct single medical specialty, just as unique and focused as any other single medical specialty. Although the term "general" is in the title of general surgery, it does not imply that surgeons in this specialty area: practice multi-specialties; are primary care physicians; perform every type of surgical procedure; or have no specialty status. Just the opposite is true.

Individuals entering careers and training programs in general surgery must have an MD/DO degree before moving on to specialize in this area. They apply to general surgery residency programs, and if accepted, undergo a minimum of five years of training in the specialty. This training is geared to educate the residents in the essential components of general surgery, including surgery of the head and neck, breast, skin and soft tissues, alimentary tract, abdomen, vascular system, and the endocrine system. It also includes the comprehensive management of trauma, burns, emergency surgery and surgical critical care.



Honorable Sonny Perdue
March 22, 2005
Page 2

Most general surgeons in this country have the above special training and expertise tested when they receive certification through the American Board of Surgery. This certification process parallels those of other medical specialties that also have defined areas of practice. In fact, hospitals consider general surgery as a single specialty for purposes of their physician recruitment, credentialing and granting of privileges for surgical procedures. Healthcare insurers also consider general surgery a single specialty practice as evidenced by reimbursement for specific types of procedures provided by the specialty.

Ambulatory surgery centers are facilities where high-quality surgical care is provided in a cost-effective and safe manner. As technology has improved, many surgical procedures, once limited to hospitals, have now been safely and appropriately moved into the ambulatory setting. Thus, the College believes that the current rules unfairly reduce patient access to specialized surgical care in these types of facilities.

We urge you and your office to work with the Board of Community Health to adopt the position that general surgery should be removed from the definition of a multi-specialty ambulatory surgery service in the CON rules. We also ask that you direct the Department of Community Health to take whatever actions are necessary to revise the CON rules to reflect this position. General surgery is clearly a single specialty, and physician-owned ambulatory surgical centers offering general surgery should be exempted from the CON process in the same way that other single specialty ambulatory surgical centers are exempt. Maintaining the status quo unfairly discriminates against those in the specialty who wish to provide high-quality ambulatory surgical care in their own ambulatory surgical center, and unnecessarily restricts patient access to quality surgical care. It also reinforces an anti-competitive and anti-small business policy that we suspect Georgia does not want to maintain.

Sincerely,

A handwritten signature in black ink, appearing to read "T. R. Russell".

Thomas R. Russell, MD, FACS
Executive Director

TRR:jhs

The American College of Surgeons is a voluntary, educational and scientific organization devoted to the ethical and competent practice of surgery, and to enhancing the quality of care provided to surgical patients. For over 90 years, the College has disseminated medical and surgical information to the profession and to the general public, and it has been deeply involved in establishing standards of practice. With over 66,000 members, nearly half of which are general surgeons, the ACS is the largest surgical association in the world.



The American Board of Surgery

1617 John F. Kennedy Boulevard, Suite 860, Philadelphia, Pennsylvania 19103-1847
(215) 568-4000 FAX: (215) 563-5718 Internet: <http://www.absurgery.org>

The American Board
of Surgery, Inc.

Incorporated 1937

March 30, 2005

Honorable Thurbert E. Baker
Office of the Attorney General of Georgia
40 Capitol Square, SW
Atlanta, Georgia 30334

OFFICERS:

BARBARA L. BASS, M.D.
Chairman

JEFFREY L. PONSKY, M.D.
Vice-Chairman

FRANK R. LEWIS, JR., M.D.
Secretary-Treasurer

Dear Attorney General Baker:

Dr. John Bagnato has asked me to write you to clarify the issue of whether "general surgery" is a single specialty or multi-specialty in the eyes of the medical world. The answer is that it is a single specialty, although it covers a wide spectrum of activity. Let me elaborate on the basis for this opinion.

The nature of a medical specialty must be codified, and its scope, training requirements, and certification requirements must be rather stringently defined in order to determine when a physician has been appropriately trained in a given area. This is done by a group of 24 medical specialty boards in the United States, and these boards issue primary certificates in each specialty area for medical diplomates who meet their requirements. Each of these boards may also issue subspecialty certificates after appropriate additional training to the holders of primary certificates.

The activities of these 24 boards are overseen and regulated by the American Board of Medical Specialties, an umbrella organization headquartered in Chicago, which has a set of Bylaws governing the whole process and prescribing the procedures and requirements for the establishment of new boards or certificates, or the modification of those already in place. All of these requirements are well-defined and relatively rigorous. This system has been in place since 1934 and is well accepted by the medical establishment and all hospitals. The term "board certification" stems from the operation of this system, and has come to be synonymous with a level of quality in medical practice which is often required before privileges are granted to a physician at a hospital.

If one wishes to answer the question of what a medical specialty is, the best definition then is that it is a discipline defined by a primary certificate and a medical specialty board approved by the ABMS. Similarly, subspecialties are best defined as those defined by a subspecialty certificate from a medical specialty board. Thus, "surgery" or "general surgery" (which are synonymous terms in this context) is a single specialty. The requirements for training and certification in surgery are determined by only one board - the American Board of Surgery, which has awarded a primary certificate in surgery since 1937. This system continues to the present time, and there are no plans to modify it, other

DIRECTORS:

Stanley W. Ashley, M.D.
Barbara L. Bass, M.D.
Richard H. Bell, Jr., M.D.
William G. Cloffi, M.D.
E. Christopher Elhson, M.D.
David V. Feliciano, M.D.
James W. Fleshman, Jr., M.D.
Timothy C. Flynn, M.D.
Richard L. Gamelli, M.D.
Keith E. Georgeson, M.D.
James C. Hebert, M.D.
David N. Herndon, M.D.
Irving L. Kron, M.D.
Frank R. Lewis, Jr., M.D.
Keith D. Lillmoen, M.D.
Jeffrey B. Matthews, M.D.
Michael S. Nussbaum, M.D.
Theodore N. Pappas, M.D.
Carlos A. Pellegrini, M.D.
Jeffrey L. Ponsky, M.D.
Russell G. Postier, M.D.
Robert S. Rhodes, M.D.
John J. Ricotta, M.D.
Michael G. Sarr, M.D.
William P. Schechter, M.D.
James A. Schulak, M.D.
Marshall Z. Schwartz, M.D.
Steven C. Stain, M.D.
Thomas R. Stevenson, M.D.
Jon S. Thompson, M.D.
Jonathan B. Towne, M.D.
Courtney M. Townsend, Jr.,
Marshall M. Urist, M.D.
Ronald J. Weigel, M.D.

EXECUTIVE STAFF:

Frank R. Lewis, Jr., M.D.
Executive Director
Robert S. Rhodes, M.D.
Associate Executive Director of Evaluation
Thomas W. Biester
Director of Psychometrics Data Analysis
Jessica A. Schreder
Operations Manager
James F. Fiore
Information Technology M
Christine D. Shiffer
Communications Manager

MEMBER BOARD OF
THE AMERICAN BOARD
OF MEDICAL SPECIALTY



than to change the specific training and testing requirements in response to changing technology.

If you have questions about this, I will be glad to respond and provide additional information if needed. However, I believe this information responds to Dr. Bagnato's request and should clarify the nature of the specialty as defined by the medical establishment.

Sincerely,

A handwritten signature in cursive script that reads "Frank R. Lewis" followed by a small flourish.

Frank Lewis, M.D.
Executive Director
American Board of Surgery

CC: John Bagnato, M.D.
Hon. Jeff Anderson

American Medical Association

Physicians dedicated to the health of America



Wes Cleveland, JD
Director
Advocacy Resource Center

515 North State Street
Chicago, Illinois 60610

312 464-4503
312 464-4961 Fax
wes_cleveland@ama-assn.org

April 15, 2005

Mr. Tim Burgess
Commissioner
Georgia Department of Community Health
2 Peachtree St., NW
Atlanta, GA 30303

Dear Mr. Burgess:

I am writing this letter to urge you to re-examine the Georgia Department of Community Health's (the Department's) interpretation of "general specialty" for purposes of Georgia's certificate of need process.

Georgia's certificate of need (CON) regulations state that if surgery is performed in a facility that is owned, operated, and utilized by physicians who are of a single specialty, that facility is not subject to CON (so long as the facility does not exceed certain spending limits). My understanding is that the Department's definition of "single specialty" does not include general surgery. Consequently, Ambulatory Surgical Centers (ASC) providing general surgery are subject to Georgia's CON regulations.

In an effort to encourage you to re-examine the Department's interpretation of "single specialty," it may be useful for you to know that the American Medical Association (AMA) clearly identifies general surgery as a medical specialty. For the AMA, general surgery is every bit a medical specialty as OB-GYN, orthopedics, pediatrics, neurosurgery, gastroenterology, etc.

The AMA strongly believes that the Department should reconsider its interpretation of "single specialty." This call for re-examination is necessary, not only because the interpretation fails to grasp the nature of general surgery. Re-examination would also constitute good public policy. ASCs can provide very high quality care often less expensively than alternative surgical sites. Recognition of general surgery as a specialty for Georgia's CON purposes would greatly benefit the residents of Georgia by making the benefits of ASCs more available to the public.

Sincerely,

A handwritten signature in black ink, appearing to read "Wes Cleveland".

Wes Cleveland, JD

cc: John C. Nelson, MD, MPH
John Bagnato, MD

American Medical Association

Physicians dedicated to the health of America



Wes Cleveland, JD
Director
Advocacy Resource Center

515 North State Street
Chicago, Illinois 60610

312 464-4503
312 464-4961 Fax
wes_cleveland@ama-assn.org

April 15, 2005

The Honorable Jeff Anderson
Chair, Board of Community Health
10 Glenlake Parkway, NE, Suite 1000
Atlanta, GA 30328-7249

Dear Chairman Anderson:

I am writing this letter to urge you to re-examine the Georgia Department of Community Health's (the Department's) interpretation of "general specialty" for purposes of Georgia's certificate of need process.

Georgia's certificate of need (CON) regulations state that if surgery is performed in a facility that is owned, operated, and utilized by physicians who are of a single specialty, that facility is not subject to CON (so long as the facility does not exceed certain spending limits). My understanding is that the Department's definition of "single specialty" does not include general surgery. Consequently, Ambulatory Surgical Centers (ASC) providing general surgery are subject to Georgia's CON regulations.

In an effort to encourage you to re-examine the Department's interpretation of "single specialty," it may be useful for you to know that the American Medical Association (AMA) clearly identifies general surgery as a medical specialty. For the AMA, general surgery is every bit a medical specialty as OB-GYN, orthopedics, pediatrics, neurosurgery, gastroenterology, etc.

The AMA strongly believes that the Department should reconsider its interpretation of "single specialty." This call for re-examination is necessary, not only because the interpretation fails to grasp the nature of general surgery. Re-examination would also constitute good public policy. ASCs can provide very high quality care often less expensively than alternative surgical sites. Recognition of general surgery as a specialty for Georgia's CON purposes would greatly benefit the residents of Georgia by making the benefits of ASCs more available to the public.

Sincerely,

A handwritten signature in black ink, appearing to read "Wes Cleveland".

Wes Cleveland, JD

cc: John C. Nelson, MD, MPH
John Bagnato, MD

MERCER UNIVERSITY

SCHOOL OF MEDICINE
Department of Surgery

ACADEMIC OFFICE

877 Hemlock Street, 5th Floor
Macon, Georgia 31201
(478) 633-1367
(478) 633-5153 (Fax)

Martin L. Dalton, Jr., MD, FACS
Milford B. Hatcher Professor & Chair
Program Director, Surgery Residency

Will C. Sealy, MD, FACS
Chairman Emeritus
(1912-2001)

Bruce J. Innes, MD, FACS
Professor
Clerkship Director

Julie J. James, R.N.
Nurse Educator/Clerkship Coordinator

Sheryl E. Nipper
Administrative Coordinator

Tony G. Blash
Education Coordinator

TRAUMA SERVICE

877 Hemlock Street, 5th Floor
Macon, Georgia 31201
(478) 633-1199
(478) 633-6195 (Fax)

Dennis W. Ashley, MD, FACS
Professor
Chief, Trauma Services

Charles G. Burton, MD, FACS
Associate Professor

Debra M. Kitchens, RN, CEN
Trauma Program Manager

CLINICAL OFFICE

801 Spring Street
Macon, Georgia 31201
(478) 633-1458
(478) 633-5025 (Fax)

Macram M. Ayoub, MD, FACS
Professor

Wm. Kim Thompson, Jr., MD, FACS
Associate Professor

Angela D. Stout, R.N.
Clinical Coordinator

RESEARCH LAB

Walter H. Newman, PhD
Professor & Director

Zhongbiao Wang, M.D., Ph.D.
Associate Director
(478) 301-2092
(478) 301-2913 (Fax)

Joseph M. VanDeWater, MD, FACS
Professor & Clinical Research Director
(478) 633-6197, 6196
(478) 633-2357 (Fax)

April 18, 2005

The Honorable Jeff Anderson
Chair, Board of Community Health
10 Glen Lake Parkway, N.E.
Suite 1000
Atlanta, Georgia 30328-7249

Dear Chairman Anderson:

As the Director of the Mercer University School of Medicine General Surgery Residency at the Medical Center of Central Georgia, I am deeply concerned over the ruling regarding general surgery not being a specialty. This strikes me as untimely and unusual in that the American Board of Surgery who certifies general surgeons was established in 1937.

I bring this to your attention because I have recently learned that DCH approved a pilot project, C-PORT, which suspends the CON law by allowing hospitals to provide a new service without a Certificate of Need. This goes well beyond a rule change as it constitutes a subversion of the law. It has occurred to me and my fellow general surgeons that if the DCH can suspend the law, why can they not change the law so that general surgery would be certified as a surgical specialty. This inconsistent application of the CON rules is overtly hypocritical and potentially harming to our patients as well as the 711 practicing general surgeons in the state of Georgia.

I hope that you will use your influence to right this terrible wrong that has been done to the general surgeons of Georgia. I look forward to hearing from you.

Sincerely yours,



Martin L. Dalton, M.D.
Professor and Chairman

MLD/mcw

c: John Bagnato, M.D.



AMERICAN SOCIETY OF GENERAL SURGEONS

4200 Commercial Way, Glenview, Illinois 60025 • Phone: 800-998-8322 • (847) 391-9770
Fax: (847) 391-9711 • Email: asgs-info@theasgs.org • Internet: <http://www.theasgs.org>

August 22, 2003

OFFICERS

President

Carlos A. Silva, MD, FACS
Washington, D. C.

President Elect

Jay A. Gregory, MD, FACS
Muskogee, Oklahoma

Immediate Past President

Robert D. Christensen, MD, FACS
Minneapolis, Minnesota

Past President

Peter A. Duhamel, MD, FACS
Rochester Hills, Michigan

Secretary Treasurer

J. Barry McKernan, MD, FACS
Woodstock, Georgia

BOARD OF TRUSTEES

John H. Armstrong, MD, FACS
San Antonio, Texas

Howard L. Beaton, MD, FACS
New York, New York

Philip F. Caushaj, MD, FACS
Pittsburgh, Pennsylvania

Joseph F. de Natale, MD, FACS
Pittsfield, Maine

Charles Drueck, III, MD, FACS
Chicago, Illinois

Michael E. Fenoglio, MD, FACS
Denver, Colorado

W. Peter Geis, MD, FACS
New Brunswick, New Jersey

Philip Z. Israel, MD, FACS
Marietta, Georgia

Robert R. Moss, MD, FACS
Santa Maria, California

Guy R. Nicastrì, MD, FACS
Derby, Connecticut

Ann L. Peick, MD, FACS
St. Louis, Missouri

Robert W. Sewell, MD, FACS
Bedford, Texas

David Vanderpool, MD, FACS
Governor, American College of Surgeons

Scott R. Karlan, MD, FACS
Delegate to AMA

Los Angeles, California

C. David Richards, MD, FACS
Alternate Delegate to AMA

Salt Lake City, Utah

EXECUTIVE DIRECTOR

L. Jack Carow, III

ASSOCIATE DIRECTOR

Ellen M. Rose

William G. Baker, Jr., M.D., Chair
Ambulatory Surgical Services
Technical Advisory Committee Health Strategies Council
34th Floor
2 Peachtree Street, N.W.
Atlanta, Georgia 30303 - 3142

Re: Draft Guidelines for Freestanding Ambulatory Surgery Centers

Dear Dr. Baker:

I am writing on behalf of the American Society of General Surgeons (ASGS) which is a national, not-for-profit association representing the interests of over 3000 practicing General Surgeon specialists in the United States. It has been brought to ASGS's attention by General Surgeons practicing in Georgia that the Georgia Department of Community Health (DCH) does not recognize General Surgeons as specialists for purposes of operating a single specialty surgery center. DCH's position is inconsistent with the undisputed fact that the practicing medical community nationwide recognizes the practice of General Surgery as a specialty.

As I understand it, DCH routinely grants Letters of Non-Reviewability (LNRs) to every other type of specialty group. The LNR allows a single group of physicians who practice in a single specialty to operate a surgery center without obtaining a Certificate of Need (CON). The Technical Advisory Committee (TAC) is currently considering Draft Guidelines for Ambulatory Surgery Centers which effectively define the specialties that DCH recognizes as single specialties. Moreover, the Draft Guidelines state that specialists are identified by "board certification or certification in the specialty." (See Definitions, ¶ 16.) The specialty of General Surgery is omitted from that list and, in fact, is included in the definition of multi-specialty.

There is no rationale provided in the Draft Guidelines for the distinction made between General Surgery and every other type of single specialty. Indeed, there is no rationale for making such a distinction in light of the fact that General Surgery itself is a nationally recognized specialty with its own specialty certifying board, the American Board of Surgery (ABS), Philadelphia, Pennsylvania.

Page 2
August 22, 2003
William Baker, Jr., M.D

Moreover, the American Board of Surgery is a member of the American Board of Medical Specialties (ABMS) which currently sanctions twenty-four certifying boards. ABMS certifying boards certify physicians in a specific area of practice as specialists. Like other specialty boards, the American Board of Surgery proscribes numerous requirements for a physician to obtain certification in General Surgery, including completion of a General Surgery residency program recognized by the Accreditation Council for Graduate Medical Education (ACGME). The parent-sponsors of the ACGME are the American Medical Association, American Hospital Association, American Association of Medical Colleges, American Board of Medical Specialties, and the Council of Medical Specialty Societies.

The TAC Draft Guidelines state in a footnote that the rules do not address "single specialty, physician-owned surgical facilities" because they are exempt under O.C.G.A. § 31-6-2(14)(g)(ii). Although the rules themselves do not specifically regulate exempt surgical facilities, the rules clearly dictate which specialists are entitled to a LNR.

It is understood by the practicing medical community that the specialty of General Surgery is defined in scope and does not include the practice of orthopedics, neurology, urology, oral surgery, obstetrics/ gynecology, ophthalmology, and pain management/anesthesiology. Moreover, the scope of General Surgery does not overlap other specialties in any greater degree than other specialties may overlap General Surgery. Appended are ASGS policy statements, "The Specialty of General Surgery and the Definition of a General Surgeon" and "Scope of Practice and Credentialing."

We respectfully request that TAC modify the Draft Guidelines to include the specialty of General Surgery in the list of single specialties.

Very truly yours,



Carlos A. Silva, M.D., F.A.C.S.
President
American Society of General Surgeons



Jay Gregory, M.D., F.A.C.S.
President Elect
American Society of General Surgeons

cc: Commissioner Tim Burgess; Georgia Department of Community Health
The Honorable Sonny Perdue, Governor, State of Georgia
ASGS Board of Trustees



AMERICAN SOCIETY OF GENERAL SURGEONS
4200 Commercial Way, Glenview, Illinois 60025 • Phone: 800-998-8322 • (847) 391-9770
Fax: (847) 391-9711 • Email: asgs-info@theasgs.org • Internet: <http://www.theasgs.org>

The Specialty of General Surgery and the Definition of a General Surgeon

The General Surgeon is....

A specialist specifically trained and qualified to provide surgical care of the whole patient. General Surgeon has expertise in the evaluation and comprehensive treatment of patients with injuries and illnesses involving a wide range of systems and anatomical regions.

The General Surgeon, by training, interest and professional ethics, is dedicated to the total care of the surgical patient and to coordination of the whole episode of care, consulting with other specialists when appropriate.

The General Surgeon's areas of major responsibility include comprehensive surgical care of:

- The alimentary tract
- The abdomen and its contents, including the pelvis
- The breast
- The skin, soft tissue and musculoskeletal system
- The chest
- The head and neck
- The vascular system
- The endocrine system
- Oncology
- Trauma
- Critically ill patients.

The General Surgeon coordinates the patient's surgical care with emphasis on quality, access, and cost-effectiveness.

ASGS Board of Trustees
Approved 4/29/95



AMERICAN SOCIETY OF GENERAL SURGEONS

4200 Commercial Way, Glenview, Illinois 60025 • Phone: 800-998-8322 • (847) 391-9770

Fax: (847) 391-9711 • Email: asgs-info@theasgs.org • Internet: <http://www.theasgs.org>

STATEMENT ON SCOPE OF PRACTICE AND CREDENTIALING

General Surgery is a comprehensive discipline that encompasses knowledge and experience common to all surgical specialties. The General Surgeon has primary responsibility and expertise in the areas of the abdomen and its entire contents, breast, head and neck, vascular system, endocrine system, oncology, trauma and critical care. The General Surgeon has the experience and training to manage common problems in plastic, thoracic, pediatric, gynecologic, urologic, neurologic and orthopaedic surgery. The General Surgeon has the training, competence and qualifications to perform a wide range of diagnostic and therapeutic procedures, including endoscopy. Education, training and documented experience are the paramount factors in determining the qualification of an individual surgeon to perform specific procedures. When qualified General Surgeons apply their skills and qualifications to the treatment of surgical problems, they best serve patients' interests.

Credentialing criteria for General Surgeons that grant privileges for a surgical procedure or that restrict their scope of practice should reflect training, quality of practice and experience rather than economic considerations. The ASGS advocates the granting of privileges for a surgical procedure based on a surgeon's experience, education and training. Disagreements over credentialing necessitate independent review by unbiased non economically motivated outside consultants. The ASGS can assist in reviewing surgeons' qualifications. It is important for practicing surgeons to evaluate and determine appropriate applications for new technology related to their surgical practice.

For reasons of both economics and quality of patient care, it is of paramount importance that new technology, equipment and procedures be presented promptly to practicing General Surgeons for their evaluation and application to their surgical practices. As major providers of surgical care in this country, General Surgeons are the patients' major advocates regarding surgical care.

**Approved by ASGS Board of Trustees
December 9, 1996**



American College of Surgeons

633 N Saint Clair St
Chicago, IL 60611-3211

Voice: 312/202-5000
Fax: 312/202-5001

e-mail: postmaster@facs.org
ACS Web site: <http://www.facs.org>

Officers

President

Claude H. Organ, Jr., MD, FACS
Oakland, CA

President-Elect

Edward R. Laws, MD, FACS
Charlottesville, VA

First Vice-President

Anna M. Ledgerwood, MD, FACS
Detroit, MI

Second Vice-President

Murray F. Brennan, MD, FACS
New York, NY

First Vice-President-Elect

Andrew L. Warshaw, MD, FACS
Boston, MA

Second Vice-President-Elect

Henry L. Laws, MD, FACS
Birmingham, AL

Secretary

John O. Gage, MD, FACS,
Pensacola, FL

Treasurer

John L. Cameron, MD, FACS
Baltimore, MD

Executive Director

Thomas R. Russell, MD, FACS
Chicago, IL

Comptroller

Gay L. Vincent, CPA
Chicago, IL

Board of Regents

Chair

Edward M. Copeland III, MD, FACS
Gainesville, FL

Vice-Chair

Gerard B. Healy, MD, FACS
Boston, MA

H. Randolph Bailey, MD, FACS
Houston, TX

Barbara L. Bass, MD, FACS
Baltimore, MD

L. D. Britt, MD, FACS
Norfolk, VA

Bruce D. Browner, MD, FACS
Farmington, CT

Martin B. Camins, MD, FACS
New York, NY

William H. Coles, MD, FACS
Chapel Hill, NC

A. Brent Eastman, MD, FACS
San Diego, CA

Richard J. Finley, MD, FACS
Vancouver, BC

Josef E. Fischer, MD, FACS
Boston, MA

Alden H. Harken, MD, FACS
Oakland, CA

Charles D. Mabry, MD, FACS
Pine Bluff, AR

Jack W. McAninch, MD, FACS
San Francisco, CA

Mary H. McGrath, MD, FACS
San Francisco, CA

Robin S. McLeod, MD, FACS
Toronto, ON

Claude H. Organ, Jr., MD, FACS
Oakland, CA

Carlos A. Pellegrini, MD, FACS
Seattle, WA

Karl C. Podratz, MD, FACS
Rochester, MN

John T. Preskitt, MD, FACS
Dallas, TX

J. David Richardson, MD, FACS
Louisville, KY

Thomas V. Whalen, MD, FACS
New Brunswick, NJ

Board of Governors

Chair

Courtney M. Townsend, Jr., MD, FACS
Galveston, TX

Vice-Chair

Rene Lafreniere, MD, FACS
Calgary, AB

Secretary

Julie A. Freischlag, MD, FACS
Baltimore, MD

January 29, 2004

Richard Greene, Director
Division of Health Planning
Georgia Department of Community Health
2 Peachtree Street, NW
40th Floor
Atlanta, GA 30303

Dear Mr. Greene:

Over the past few years, the American College of Surgeons (ACS) has been concerned with an issue in Georgia relating to the Certificate of Need (CON) law and how the specialty of general surgery is defined. During the court case of Albany Surgical, P.C. vs Department of Community Health (DCH), the College submitted an amicus curiae brief challenging the department's definition of General Surgery as a multi-specialty for purposes of Georgia CON requirements. At this time, the College wishes to provide further comment on this issue as recent revisions to the rules issued by Georgia's DCH for CONs governing ambulatory surgical centers (ASCs) do not yet reflect the correct view of general surgery as a single specialty. This mis-conception will inappropriately and unfairly deny general surgeons eligibility for the benefits afforded by the single specialty exemption in the CON law.

It is universally recognized by academic and private healthcare institutions that general surgery is a distinct single medical specialty, just as unique and focused as any other single medical specialty. Although the term "general" is in the title of general surgery, it does not imply that surgeons in this specialty area: practice multi-specialties; are primary care physicians; perform every type of surgical procedure; or have no specialty status. Just the opposite is true.

Individuals entering careers and training programs in general surgery must have an MD/DO degree before moving on to specialize in this area. They apply to general surgery residency programs, and if accepted, undergo a minimum of five years of training in the specialty. This training is geared to educate the residents in the essential components of general surgery, including surgery of the head and neck, breast, skin and soft tissues, alimentary tract, abdomen, vascular system, and the endocrine system. It also includes the comprehensive management of trauma, burns, emergency surgery and surgical critical care.



Richard Greene
January 29, 2004
Page 2

Most general surgeons in this country have the above special training and expertise tested when they receive certification through the American Board of Surgery. This certification process parallels those of other medical specialties that also have defined areas of practice. In fact, hospitals consider general surgery as a single specialty for purposes of their physician recruitment, credentialing and granting of privileges for surgical procedures. Healthcare insurers also consider general surgery a single specialty practice as evidenced by reimbursement for specific types of procedures provided by the specialty.

Ambulatory surgery centers are facilities where high-quality surgical care is provided in a cost-effective and safe manner. As technology has improved, many surgical procedures, once limited to hospitals, have now been safely and appropriately moved into the ambulatory setting. Thus, the College believes that the department must carefully weigh their decisions in this area that would reduce patient access to specialized surgical care in these types of facilities. Therefore, we suggest the following revisions to guidelines governing CONs for ambulatory surgery centers:

1. **Applicability 1 (Facilities Considered as Part of a Hospital)** – This guideline expands the scope of which hospital ASCs do not need to obtain certificates of need to include ambulatory surgical services on premises outside the hospital's campus if the services are "integrated with other hospital services and systems, and the services are billed through the hospital's Medicare or Medicaid provider number and/or license number issued by the Department of Human Resources." While the College does not object to this guideline, we believe the regulations should also be expanded to exempt from CON requirements physician-owned ASCs offering general surgery services. In addition, providers wishing to expand or replace their facilities should be required to only include the costs associated with the new or upgraded surgical suites, not the cost of the entire project, when calculating the capital threshold under the CON requirements.
2. **Definition 10 (Multi-Specialty Ambulatory Surgery Service)** – Because general surgery is a single specialty, the words "general surgery or" should be stricken from this definition. To maintain this definition as currently written discriminates against the specialty and restricts patient access to high-quality, cost-effective surgical care.

Finally, the College takes issue with the process that surrounded development of these guidelines, particularly the composition of the Technical Advisory Committee (TAC). We are deeply troubled that membership on the TAC disproportionately favored the interests of the hospital community – effectively limiting the consideration of issues central to surgeons and their patients.



Richard Greene
January 29, 2004
Page 3

We urge the department to remove general surgery from the definition of a multi-specialty ambulatory surgery service. General surgery is clearly a single specialty, and physician-owned ambulatory surgical centers offering general surgery should be exempted from the CON process in the same way that other single specialty ambulatory surgical centers are exempt. Maintaining the status quo discriminates against those in the specialty who wish to provide high-quality ambulatory surgical care in their own ambulatory surgical center, and unnecessarily restricts patient access to quality surgical care.

Sincerely,

A handwritten signature in cursive script that reads "Tom Russell".

Thomas R. Russell, MD, FACS
Executive Director

TRR:jhs

cc: Neal Childers, JD
DCH General Counsel

Office of the Governor:

John K. Watson
Chief of Staff

Trey Childress
Policy Director

Harold Melton, Esq.
Executive Council

The American College of Surgeons is a voluntary, educational and scientific organization devoted to the ethical and competent practice of surgery, and to enhancing the quality of care provided to surgical patients. For over 90 years, the College has disseminated medical and surgical information to the profession and to the general public, and it has been deeply involved in establishing standards of practice. With over 64,000 members, nearly half of which are general surgeons, the ACS is the largest surgical association in the world.



Georgia Board for Physician Workforce

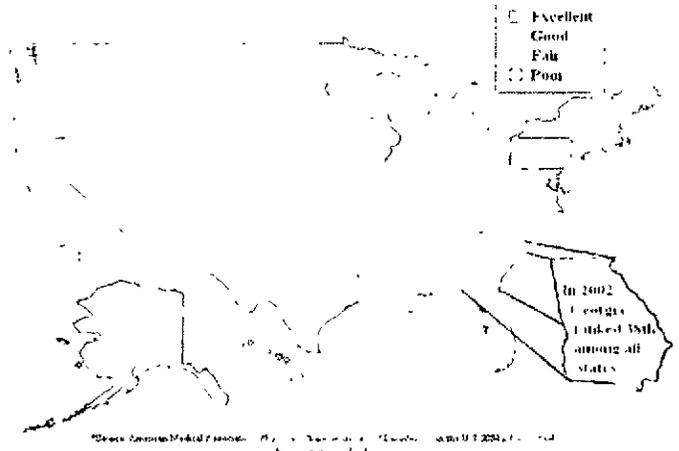
Fact Sheet on Georgia's Physician Marketplace

February 2005

Current Trends in the Physician Workforce

- o Georgia ranks 9th in population, but 38th in physician supply (down from 35th two years ago). The U.S. Census Bureau currently ranks Georgia as the 6th fastest growing state.
- o The rate at which new, practicing physicians are added to Georgia's workforce has declined 55% over the last 10 years (from a high of 1,682 in 1992-1994 to a low of 748 for 2000-2002).
- o Increasing demand for physician services, a stagnant physician supply, and changes in practice patterns are among the indicators of a developing physician shortage in Georgia.
- o Georgia relies heavily on physician migration from other states and on international medical graduates to meet workforce needs. Market forces are now reducing Georgia's attractiveness as a place in which to practice medicine. Increasing competition from other states, declining reimbursement for physician services, and rising medical liability insurance costs, are influencing whether doctors elect to practice medicine in Georgia.

Distribution of Physicians, U.S. 2002*
per 100,000 population

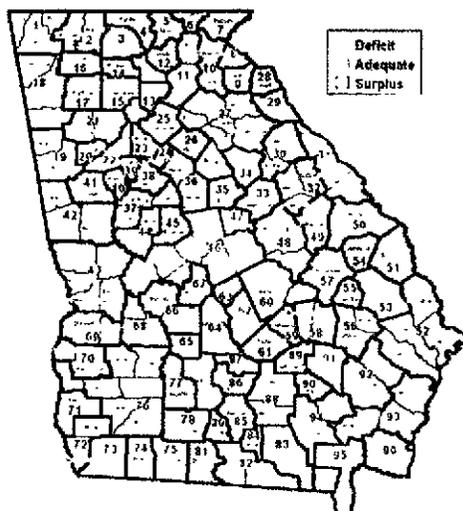


Wax and Distribution of Physicians

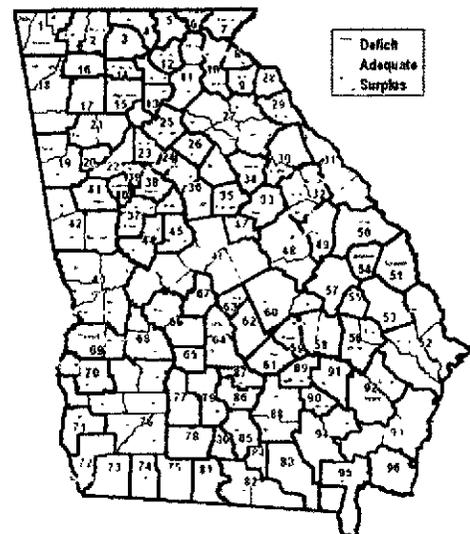
Between 2000 and 2002, 152 new OB/GYNs were licensed and practicing in Georgia. Yet, data currently gathered by the OB/GYN society indicates as many as 165 OB/GYNs have left or will leave practice in the near future. This drop, if realized, would overcome the gains made in 2002 for this specialty and result in a real drop in the rate of OB/GYNs to population in Georgia.

There are fewer General Surgeons, per capita, today than there were 10 years ago. In 1992, there were 8.63 General Surgeons per 100,000. In 2002 there was a slight reduction in the number of these physicians, with only 8.48 General Surgeons per 100,000.

OBSTETRICS & GYNECOLOGY
Physician Distribution - 2002
Deficit, Adequate, and Surplus PCSAs*



GENERAL SURGERY
Physician Distribution - 2002
Deficit, Adequate, and Surplus PCSAs*



Medical Marketplace Challenges to Building Physician Capacity

Medical Liability Costs and Availability

Current Situation

- **Malpractice insurance premiums** for Georgia physicians continue to increase at extreme rates. Respondents to a GBPW follow-up survey reported increases of 25-50% on average in 2003. This is in addition to the 20% increase reported in 2002.
- **Availability of insurance** is a growing concern due to the limited number of insurance companies writing liability policies for physicians in Georgia. MAG Mutual, the principle provider of coverage in Georgia, reported that of the 20 insurers in the state in 2001 (who had \$1 million or more in premiums), only three remain who accepted new physicians in 2003.
- The **specialties most affected** are OB/GYN, General Surgery, Radiology, Neurology, and Emergency Medicine.
- If trends continue, **further challenges will emerge** impacting important primary care specialties, including OB/GYN and General Surgery. The results could see an increasing rate of erosion in the physician to population ratio of General Surgeons and a decline in the capacity of the OB/GYN workforce in the state.

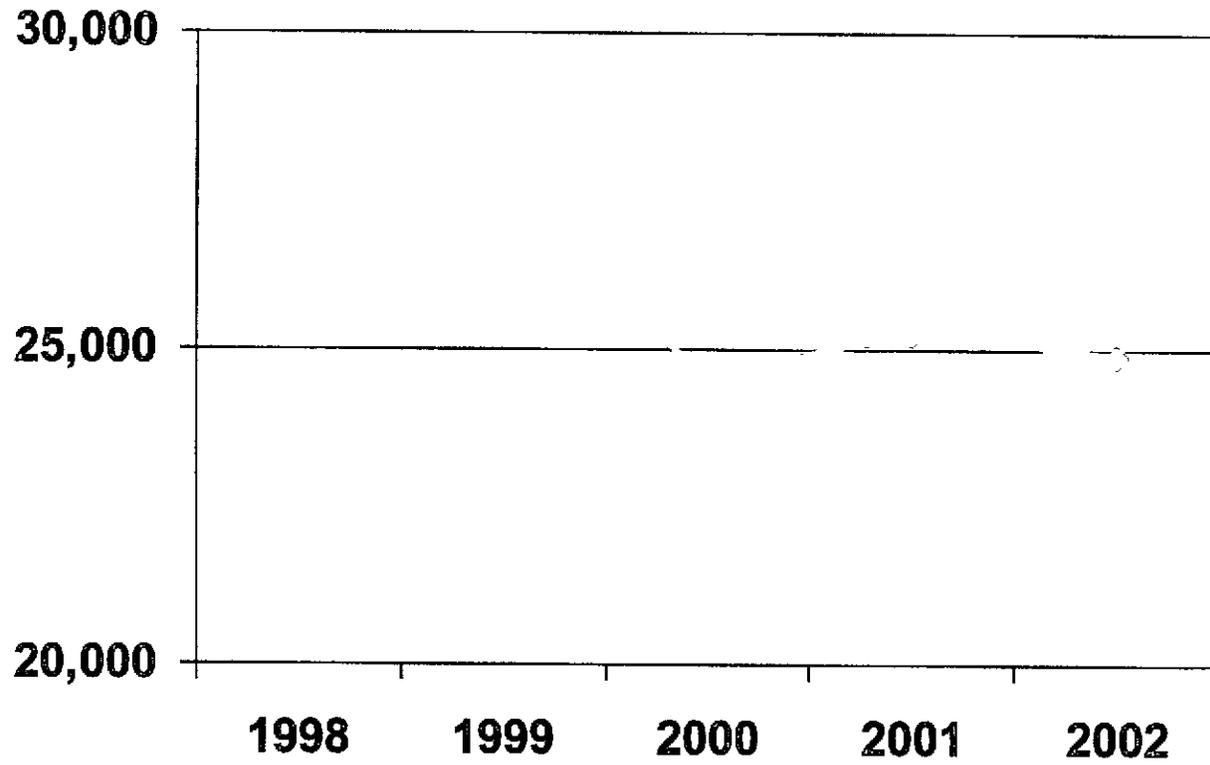
Physician Response

- **Stop high-risk procedures** – Nearly 14% of all physicians responding to the GBPW follow-up survey stopped performing high-risk procedures in 2003. The rate was highest among General Surgeons (27.5%), OB/GYN's (25%), Orthopedic Surgeons (22%), and Radiologists (19%). In 2002, 17.8% of the respondents had stopped providing high-risk services. The primary services impacted are obstetrical services, mammography, surgical care, and trauma.
- **Retire early or leave clinical practice** – 7% of all physicians responding to the survey indicated they plan to leave clinical practice as a result of the malpractice insurance crisis in Georgia. An additional 4% of respondents indicated plans to retire. The rates were highest among: OB/GYN's (13% plan to leave clinical practice and 12% plan to retire); and General Surgeons (13% plan to leave clinical practice and 7% plan to retire).
- **Georgia physicians may move to states that have lower insurance costs** – 3.3% of physicians responding to the survey indicated they are considering or already have plans to move out-of-state. Nine percent of Anesthesiologists, 7% of Emergency Medicine physicians, 7% of General Surgeons, and nearly 6% of responding OB/GYN's fall into this category.

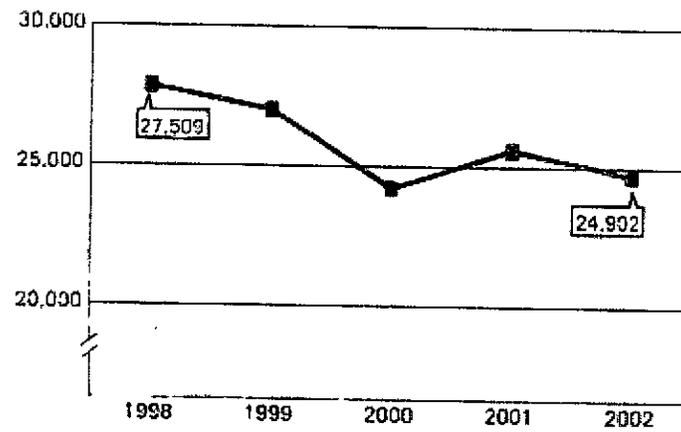
Decreasing Reimbursement for Physician Services

- In the late 1990s, a series of changes to Medicare reimbursement for physician services took place. These changes included tying Medicaid reimbursement rates to the Medicare fee schedule, and instituting reductions in reimbursement rates that resulted in a nationwide reduction in physician reimbursement. These changes have meant a decrease in payments of \$62 million, in constant dollars, since 1996, the last year Georgia Medicaid paid 100 percent of the Medicare fee schedule.
- In FY 2004, the Department of Community Health reduced the state's reimbursement rate for physicians, resulting in a net loss of \$44 million in state and federal funds.
- Recent studies have shown that Medicaid reimbursement rates do not cover physicians' costs and that it is becoming increasingly difficult for doctors to continue serving Medicaid patients by spreading the uncovered costs over their remaining patient base.
- Data reported through the physician license renewal process indicates an increasing number of physicians are limiting the number of Medicaid patients in their practice. After peaking in 1996, physicians now report the lowest percentage of accepting Medicaid in a decade. Further, it is understood that physicians will weigh the risks and rewards of the medical marketplace and as reimbursements decline and costs rise, physicians may choose to limit or cease practice.

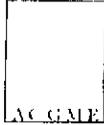
Number of US General Surgeons Down Since 1998



Number of U.S. General Surgeons Down Since 1998



Source: American Medical Association



Resident Physician Population by Specialty and State

ACGME Accredited Programs ¹

Academic Year 2003-2004

Specialty / Subspecialty	Endnotes	Total Programs	Total Approved Positions	Count of Residents on Duty
Alabama				
Allergy and immunology	2	1	4	1
Anesthesiology	4	1	54	51
Critical care medicine	5	1	0	0
Pain medicine	6	1	0	1
Pediatric anesthesiology	7	1	0	0
Dermatology	9	1	7	8
Dermatopathology	10	1	2	2
Emergency medicine	11	1	24	12
Family practice	12	8	164	153
Sports medicine		2	4	4
Internal medicine	13	5	257	225
Cardiovascular disease		2	18	16
Clinical cardiac electrophysiology		1	1	1
Endocrinology, diabetes, and metabolism		1	3	2
Gastroenterology		2	15	14
Geriatric medicine		1	3	1
Hematology and oncology		1	12	12
Infectious disease		2	8	7
Interventional cardiology		1	3	2
Nephrology		1	14	10
Pulmonary disease		1	2	1
Pulmonary disease and critical care medicine		1	12	9
Rheumatology		1	6	5
Medical genetics	14	1	2	1
Molecular genetic pathology		1	2	0
Neurological surgery	15	1	10	9
Neurology	16	2	21	20
Child neurology		1	3	3
Clinical neurophysiology		1	4	3
Nuclear medicine	17	1	0	4
Obstetrics and gynecology	18	2	44	43

Specialty / Subspecialty	Endnotes	Total Programs	Total Approved Positions	Count of Residents on Duty
Child and adolescent psychiatry		3	24	20
Forensic psychiatry		1	4	3
Geriatric psychiatry		3	9	6
Radiation oncology	29	2	15	13
Radiology-diagnostic	30	6	154	146
Neuroradiology		2	7	7
Pediatric radiology		2	2	1
Vascular and interventional radiology		5	19	10
Surgery-general	31	7	210	188
Hand surgery		1	2	2
Surgical critical care		2	7	7
Vascular surgery		2	3	3
Thoracic surgery	32	2	7	7
Urology	33	4	32	32
Transitional year	34	1	8	8
Total		242	3,121	2,852
Combined Programs				
Internal Medicine/Pediatrics (non-accredited)		3		37
Psychiatry/Neurology (non-accredited)		1		1
Total		4		38
State Total		246	3,121	2,890

Georgia				
Allergy and immunology	2	1	4	4
Anesthesiology	4	2	75	77
Critical care medicine	5	1	0	0
Pain medicine	6	2	3	5
Pediatric anesthesiology	7	1	0	3
Colon and rectal surgery	8	1	2	1
Dermatology	9	2	24	24
Dermatopathology	10	1	1	1
Emergency medicine	11	2	81	78
Medical toxicology		1	4	4
Family practice	12	12	249	238
Sports medicine		1	1	1
Internal medicine	13	7	395	368
Cardiovascular disease		2	36	33

Specialty / Subspecialty	Endnotes	Total Programs	Total Approved Positions	Count of Residents on Duty
Clinical cardiac electrophysiology		1	3	3
Endocrinology, diabetes, and metabolism		2	6	7
Gastroenterology		2	19	18
Geriatric medicine		1	7	4
Hematology and oncology		2	21	17
Infectious disease		2	11	9
Interventional cardiology		1	5	5
Nephrology		2	18	18
Pulmonary disease and critical care medicine		2	24	16
Rheumatology		2	9	6
Medical genetics	14	1	2	0
Molecular genetic pathology		1	1	1
Neurological surgery	15	2	18	17
Neurology	16	2	30	30
Child neurology		2	6	2
Clinical neurophysiology		2	10	9
Pain medicine		1	1	1
Vascular neurology		1	2	0
Nuclear medicine	17	1	0	6
Obstetrics and gynecology	18	6	101	100
Ophthalmology	19	2	27	24
Orthopaedic surgery	20	4	65	64
Pediatric orthopaedics		1	2	2
Otolaryngology	21	2	18	16
Pathology-anatomic and clinical	22	2	54	44
Blood banking/transfusion medicine		2	3	0
Cytopathology		1	2	1
Forensic pathology		1	2	1
Hematology		1	2	1
Medical microbiology		1	1	1
Neuropathology	23	1	2	0
Pediatrics	24	5	126	125
Neonatal-perinatal medicine		2	8	8
Pediatric cardiology		2	12	7
Pediatric critical care medicine		2	6	4
Pediatric emergency medicine		1	6	7
Pediatric endocrinology		1	1	0
Pediatric gastroenterology		1	2	2
Pediatric hematology/oncology		1	4	6

Specialty / Subspecialty	Endnotes	Total Programs	Total Approved Positions	Count of Residents on Duty
Pediatric infectious diseases		1	3	1
Physical medicine and rehabilitation	25	1	16	16
Pain medicine		1	5	5
Plastic surgery	26	2	13	13
Preventive medicine	27	4	29	19
Psychiatry	28	3	90	80
Addiction psychiatry		1	2	2
Child and adolescent psychiatry		2	22	13
Forensic psychiatry		1	2	3
Genatrc psychiatry		1	2	2
Radiation oncology	29	1	10	11
Radiology-diagnostic	30	3	84	75
Abdominal radiology		1	5	4
Neuroradiology		2	8	5
Nuclear radiology		1	2	0
Pediatric radiology		1	2	0
Vascular and interventional radiology		1	5	2
Surgery-general	31	7	197	159
Pediatric surgery		1	2	1
Surgical critical care		1	2	1
Vascular surgery		2	6	3
Thoracic surgery	32	2	9	9
Urology	33	2	16	16
Pediatric urology		1	1	1
Transitional year	34	3	32	28
Total		151	2,077	1,888
State Total		151	2,077	1,888

Hawaii				
Family practice	12	3	54	34
Sports medicine		1	1	1
Internal medicine	13	2	102	81
Geriatric medicine		1	12	10
Obstetrics and gynecology	18	2	44	41
Orthopaedic surgery	20	2	25	25
Pediatric orthopaedics		1	1	1
Otolaryngology	21	1	6	6

Endnotes

- 1 This table includes specialty and subspecialty programs accredited by ACGME. For programs in some specialties and subspecialties, ACGME approves for accreditation purposes the maximum number of residents per year and/or per program based upon established written criteria that include the adequacy of resources for resident education such as quality and volume of patients and related clinical material available for education, faculty-resident ratio, institutional funding, and the quality of faculty teaching. In all specialties and subspecialties as to which ACGME approves the maximum number of residents per program, ACGME may approve temporary increases, either for a particular residency year or in the aggregate within a program. ACGME accredits the core specialty programs that form the combined program. An approved resident in combined training is listed as a fraction in each program that constitutes the combined specialty program. For example, a resident in an internal medicine/pediatrics combined program is listed as .5 in internal medicine and .5 in pediatrics in the core approved numbers; however, the core filled numbers do not include residents in combined training. A second chart with a list of combined specialties and the total number of residents in combined training follows this chart. While an RRC approves an increase in complement in total, it will take a 5 year program 5 years to reach capacity because the approval is for one new first year resident for each of the 5 years following approval.
- 2 ACGME does not approve the maximum number of residents for residency programs in the specialties and subspecialties of allergy and immunology, family practice, nuclear medicine, and pediatrics, and in the subspecialties of anesthesiology-critical care and pediatric anesthesiology residency programs. Instead, each program establishes the number of resident positions and informs ACGME. The "approved positions" shown in this chart are the number of resident positions established and offered by individual programs, as reported to ACGME.
- 3 See Endnote 2 – ACGME does not approve the maximum number per program. This specialty will be no longer accredited as of June 30, 2005.
- 4 In residency year 2001-2002, ACGME began phasing in approval for the maximum number of residents in the aggregate for programs in anesthesiology and anesthesiology-pain management.
- 5 See Endnote 2 – ACGME does not approve the maximum number per program.
- 6 See Endnote 4.
- 7 See Endnote 2 – ACGME does not approve the maximum number per program.
- 8 ACGME approves the maximum number of residents both per year and in the aggregate for residency programs in the specialties of emergency medicine, colon and rectal surgery, and obstetrics-gynecology, and in the specialties and subspecialties of neurological surgery, ophthalmology, otolaryngology, orthopaedic surgery, plastic surgery, physical medicine and rehabilitation, general surgery, thoracic surgery, urology, and in the subspecialty of neuropathology.
- 9 ACGME approves the maximum number of residents per program, in the aggregate, and not per year, for residency programs in the specialty and subspecialties of internal medicine, neurology, psychiatry, medical genetics, dermatology, pathology (except neuropathology), radiation oncology, preventive medicine, diagnostic radiology, and transitional year.
- 10 See Endnote 9 – ACGME approves the maximum number per program in the aggregate, and not per year.
- 11 See Endnote 8 for specialty of emergency medicine and all its subspecialties – ACGME approves the maximum per program in the aggregate and per year.
- 12 See Endnote 2 for specialty of family practice and all its subspecialties – ACGME does not approve the maximum number per program.
- 13 See Endnote 9 for specialty of internal medicine and all its subspecialties – ACGME approves the maximum number per program in the aggregate, and not per year.
- 14 See Endnote 9 for specialty of medical genetics and its subspecialty – ACGME approves the maximum number per program in the aggregate, and not per year.
- 15 See Endnote 8 for specialty of neurological surgery – ACGME approves the maximum per program in the aggregate and per year.
- 16 See Endnote 9 for specialty of neurology and all its subspecialties – ACGME approves the maximum number per program in the aggregate, and not per year.

- 17 See Endnote 2 for specialty of nuclear medicine – ACGME does not approve the maximum number per program in the aggregate.
- 18 See Endnote 8 for specialty of obstetrics and gynecology – ACGME approves the maximum per program in the aggregate and per year.
- 19 See Endnote 8 for specialty of ophthalmology– ACGME approves the maximum per program in the aggregate and per year
- 20 See Endnote 8 for specialty of orthopaedic surgery and all its subspecialties – ACGME approves the maximum per program in the aggregate and per year.
- 21 See Endnote 8 for specialty of otolaryngology and all its subspecialties – ACGME approves the maximum per program in the aggregate and per year.
- 22 See Endnote 9 for specialty of pathology-anatomic and clinical and all its subspecialties except neuropathology – ACGME approves the maximum number per program in the aggregate, and not per year.
- 23 See Endnote 8 for subspecialty of neuropathology – ACGME approves the maximum per program in the aggregate and per year.
- 24 See Endnote 2 for specialty of pediatrics and all its subspecialties – ACGME does not approve the maximum number per program.
- 25 See Endnote 8 for specialty of physical medicine and rehabilitation and all its subspecialties – ACGME approves the maximum per program in the aggregate and per year.
- 26 See Endnote 8 for specialty of plastic surgery and all its subspecialties – ACGME approves the maximum per program in the aggregate and per year.
- 27 See Endnote 9 for specialty of preventive medicine and all its subspecialties – ACGME approves the maximum number per program in the aggregate, and not per year.
- 28 See Endnote 9 for specialty of psychiatry and all its subspecialties – ACGME approves the maximum number per program in the aggregate, and not per year.
- 29 See Endnote 9 for specialty of radiation oncology– ACGME approves the maximum number per program in the aggregate, and not per year.
- 30 See Endnote 9 for specialty of radiology-diagnostic and all its subspecialties – ACGME approves the maximum number per program in the aggregate, and not per year.
- 31 See Endnote 8 for specialty of general surgery and all its subspecialties – ACGME approves the maximum per program in the aggregate and per year.
- 32 See Endnote 8 for specialty of thoracic surgery – ACGME approves the maximum per program in the aggregate and per year.
- 33 See Endnote 8 for specialty of urology and its subspecialty – ACGME approves the maximum per program in the aggregate and per year.
- 34 See Endnote 9 for transitional year– ACGME approves the maximum number per program in the aggregate, and not per year.