

2009 SURGICAL ASSISTANT SALARY SURVEY

More than 500 surgical assistant practitioners participated in the recent salary survey and a summary of results will be presented in this newsletter. It is critically important that this information be obtained and shared in order to establish benchmarks so this profession can advance and recognize both its successes and areas that require focus.

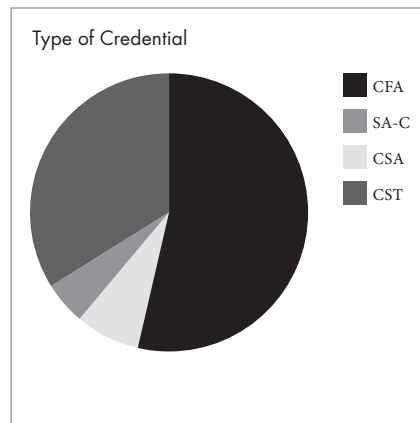
Six questions were posed in the survey:

- Which credential do you hold?
- How long have you been certified?
- What type of employer do you have?
- Which state do you work in?
- How long have you been working as a surgical assistant?
- What is your annual salary range?

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TYPE OF CREDENTIAL

When the survey results were compiled, the information was extrapolated from 504 responses. Since many practitioners hold dual credentials, the actual responses exceeded the number of participants.

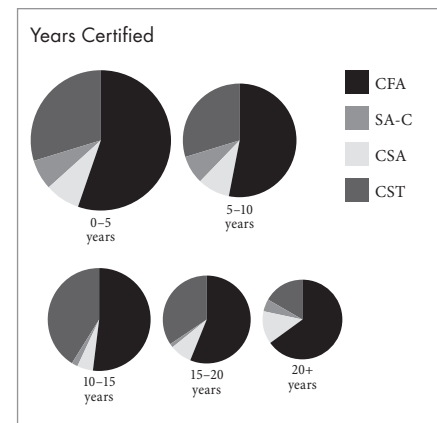


Results reflect a majority of CFAs participating, followed up by CSTs who are performing in the role of surgical assistants. The latter could also include individuals who are currently building up their case histories in order to qualify to take a certifying examination.

The lower number of CSAs and SA-Cs could be anticipated, since no direct method is currently available to contact them and invite their participation. Hopefully, more will be engaged in future surveys so the entire range of practitioners is accurately represented.

HOW LONG HAVE YOU BEEN CERTIFIED?

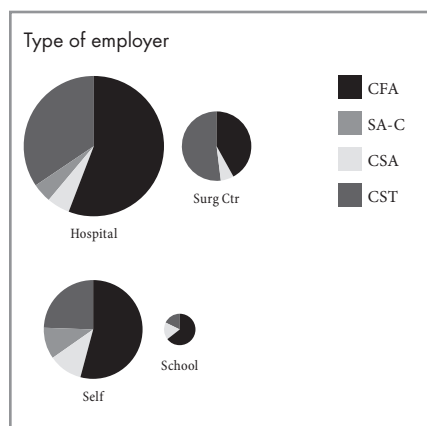
Nearly one-third of the CFA respondents have been certified less than five years and approximately another one-third have been certified between



five to 15 years. It is interesting to note that more than 25% have been certified at least 15 to 20+ years. More than half of the CSAs who responded have been certified less than 10 years. The majority of SA-C respondents have also been certified less than 10 years. In this instance, CSTs are included for representation—91 have been certified 10 years or less; 66 have been certified 10-20 years.

WHAT TYPE OF EMPLOYER DO YOU HAVE?

More than 50% of the CFAs work at hospitals; 28% are self employed; approximately 11% work at surgery centers, and the rest are working in education. The majority of CSAs and



SA-CS are working for hospitals or are self employed. More than half of the CST respondents work at hospitals, and the remainder is split between surgery centers and self employment.

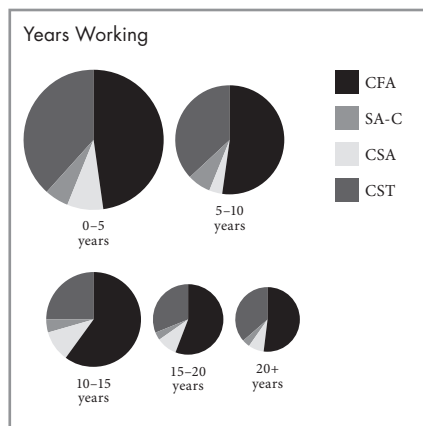
WHICH STATE DO YOU WORK IN?

Respondents from 44 states and Puerto Rico participated in the survey. Florida, Illinois, Indiana, Kentucky and Texas contributed significantly, but practitioners from many other states including Minnesota, Pennsylvania, Tennessee and Wisconsin participated in significant numbers. The broad range of

geographic areas demonstrates that surgical assistants are in demand across the country.

HOW LONG HAVE YOU BEEN WORKING AS A SURGICAL ASSISTANT?

More than 25% of the CFAs have been working less than five years; 45% have been employed five to 15 years; and the remainder has worked more than 15 years. Nearly 42% of the CSAs have been working less than 10 years; approximately 44% have worked 10 to 20 years, while the balance has worked over 20 years. Over half of the SA-Cs have worked less than 10 years; 28% have worked less than 20 years and three have worked more than 20 years. CSTs responded in numbers, 194 for this question, and 112 have worked less than 10 years; 54 have been employed less than 20 years, and 28 have been working over 20 years.

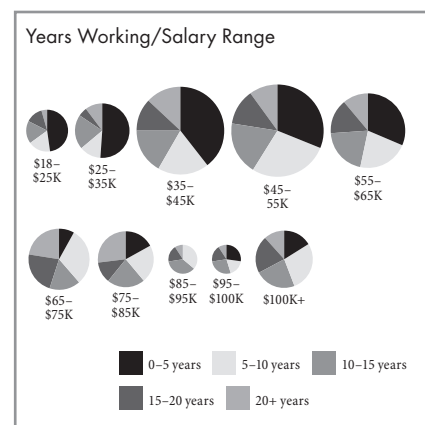


WHAT IS YOUR ANNUAL SALARY RANGE?

We started at \$18,000 and the top range exceeded \$100,000. Twenty-six respondents came in at the \$18K-\$25K level; 39 practitioners

reported \$25-\$35K; 108 reported \$35-\$45K; 127 reported \$45-\$55K; 85 reported \$55-\$65K; 59 reported \$65-\$75K; 43 reported \$75-\$85K; 13 reported \$85-\$95K; 12 reported \$96K-\$100K; and 56 reported earnings exceeding \$100K.

Overall, there are many indications that this profession is growing and represents a genuine career advancement for many surgical technologists. More than 500 practitioners responded and that high a



response rate indicates a willingness to be engaged. To grow this profession, the insights and talents of all surgical assistants, CFAs, CSAs, SA-Cs and CSTs who are performing surgical assistant responsibilities are needed.

We will be exploring refinements and other areas that should be defined in a future survey, including the number of hours allocated to performing as a surgical assistant or surgical technologist and the number of hours worked per week, use of overtime and other questions based on input received from surgical assistants. If you have suggestions, please email kludwig@ast.org.

To see all the data in the survey, visit www.surgicalassistant.org and click on the link on the opening page.

CONGRATULATIONS! YOU'RE A CFA!!

NOW WHAT?

PART 2

Kathy Duffy, CST, CFA

Editor's Note: For some valuable background information, please refer to the articles Congratulations! You're a CFA!, Part 1 and How to Apply for an NPI Number for Non-physician Surgical Assistants, both downloadable at www.surgicalassistant.org

FINDING EMPLOYMENT AS A SURGICAL ASSISTANT

Ahh, the toughest part is behind you! You passed the test and you are now a Certified First Assistant! What an awesome feeling! You have worked hard and studied until you thought your eyes would fall out! Now, on to the next chapter! This article is intended to share my experience in setting up an independent practice and to educate the potential of the surgical assistant credential.

My facility did not employ CFAs, RNFAs or PAs. I was able to work as an assistant on my day off and weekends only. During the week, if there were cases that needed an assistant and there was enough staff, my manager would allow me to assist, providing I clocked out. There could be no overlap between on the clock as a tech and in the case as an assistant.

I attempted to make it work to my advantage, but my schedule did not allow me to commit to assisting a surgeon in another

hospital until the day before the surgery because of my employer's O.R. schedule. This wasn't fair to the surgeon trying to schedule an assistant. The surgical coordinators working in the surgeon's offices needed immediate answers and could not properly schedule surgeries with a missing component... like an assistant. Ultimately, they would find someone else to assist. For a couple of years, this went on, until I recognized too many missed opportunities.

When one of the local, well-known assistants whom I backed up, passed away, I wanted to move up and become the surgeon's regular assistant. I waited an appropriate amount of time before approaching her. Well, someone beat me to the punch and cleared their schedule for her. Strike one. Then another, well-loved surgeon who worked with many surgeons as an assistant became ill and retired. I didn't wait. I jumped in with a thoracic/vascular surgeon, and I have been working

with him exclusively and other surgeons as needed.

FIGURING OUT BILLING

So, now, you have your certification, business name, NPI number, EIN number, physician sponsors and credentials, and you are ready to rock and roll. Hmmmm, what should you do about billing? Should you ask your surgeons if you can use their staff to bill for you? If so, what's involved and should you pay them a fee? Should you hire a billing company? Should you do your own billing? I think it's important

What should you do about billing?

Should you ask your surgeons if you can use their staff? Should you pay them a fee? Should you hire a billing company? Should you do your own billing?

for anyone who is self employed and outsources his/her billing service to understand the process of how you are paid. It's confusing, to say the least, but maybe this will aid in understanding the process:

In the beginning, I chose to hire a billing company. The company was referred by another surgical assistant and was highly recommended. The fee was very, very reasonable—way below the standard 6% and 10% for initial billing and additional charges as denials need to be resubmitted. The routine was pretty standard: Do a case, get

1500
HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete Item 9 a-d	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____		14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (accident) OR PREGNANCY (LMP) MM DD YY	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 2. _____ 3. _____ 4. _____		22. MEDICARD RESUBMISSION CODE ORIGINAL REF. NO. _____	
23. PRIOR AUTHORIZATION NUMBER _____		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Physical Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF LIMITS H. ICD-9-CM I. ID. QUAL J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ _____	
29. AMOUNT PAID \$ _____		30. BALANCE DUE \$ _____	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____		32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____	
33. BILLING PROVIDER INFO & PH # ()			

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

make sense of the billing process when trying to decide which way to go.

The 1500 Claim Form is the only form used to submit claims. I googled "1500 claim form" and found a few sites that offered software to process billing claims. The 1500 Form is used by everyone... there is no difference for the surgeon, assistant, or anesthesiologist. The difference is the modifier code. After investigating my options, I chose to download a program that gave me the form only. Software for electronic submissions is expensive, so I opted for a "fill and print" software package. It was \$149 and allowed me to fill in the information and print the completed form. If I had questions regarding what information the form needed, an online instruction manual was available. The disadvantage is that the submissions were mailed, not electronically submitted, so it took a little longer to be paid or denied.

The Face Sheet is the document included in the patient's chart that includes all their financial information: Name, Address, SS#, Insurance, PCP, Phone numbers. All of this information is confidential and governed by HIPAA. This information must be protected from public view. Most likely, the information will be kept somewhere in your home. Be sure it is not visible to anyone, who would have access to where you keep your records. The Face Sheet is what is used when filling out the 1500 Form. I won't go into detail about how to fill out the 1500 Form. Instructions for filling out the 1500 Form are included with the software

a Face Sheet from the chart. Fax the Face Sheet with any other pertinent information to the billing office, and they do the rest. In order to establish myself as a client, I needed to supply a copy of my W-9 tax information, proof of malpractice insurance and my business information. The billing office would call (or send a fax) to the surgeon's office requesting CPT Codes and Diagnosis Codes. This information was filled in on the interactive 1500 Claim Form. It was electronically submitted to the clearinghouse,

which in turn, would distribute the claims to the proper insurance company. The claim was processed and either denied or paid. It was a simple enough process, but I found that "very, very reasonable" translates to a lot of missed claims. When the billing company closed its doors, I decided to do my own billing and received guidance through the basics of the CMS website, filling in the 1500 Claim Form and deciphering denial codes.

Greek, right? Yes, but maybe the following information will help you

CPT codes are used for billing. Codes are usually assigned by the surgeons after the surgery (unless it's an elective surgery, then codes don't change too much). Each code (and there are thousands) represents a procedure. Some surgeries require multiple CPT codes.

The Diagnosis Code is also used for billing. Each CPT Code corresponds to a Diagnosis Code.

The NPI number is the National Provider Identifier. The surgeon's NPI number and your NPI number must be submitted on the 1500 Form.

The surgeon's office will provide you with the CPT/Diagnosis Codes and NPI Number for billing. Since Medicare is the driving force in reimbursements policies, most insurance companies use Medicare tables as a guide. To be sure that you will be paid for your services, you will need to do a Payment Policy Indicator search on the Center for Medicare and Medicaid Services (CMS) website, <http://www.cms.hhs.gov/PfsLookup/>. Follow the directions and search on payment policy indicators. Enter the CPT Code and choose the "all modifier" option. It will give you payment policies for the CPT Code entered. Most insurance companies use this for payment policies. Under "Asst Surg," 0 indicates no payment for an assistant; 1 indicates maybe an assistant will be paid, and 2 indicates an assistant will be paid.

Another important factor to be considered is your fee. The Physicians Fee Schedule, available on the same page, is a PDF file that can also be downloaded. It lists the CPT codes and the corresponding Medicare payment amount for

the surgeon. Before you can download this PDF file, you need to know your locality. Each area of the country has specific payment indicators so location number is key to downloading the proper PDF file. The site for Florida and the Virgin Islands is http://medicare.fcso.com/Fee_resources/137945. It may take a bit of investigating and googling to find the correct Medicare website for your area. Locality number is determined by county. Once you determine your locality, then you should be able to locate the Physician's Fee Schedule PDF file on that same website. Be sure to select "Part B" Physicians Fee Schedule for your locality. There is also an option to select one CPT Code and query in that manner, rather than downloading the file. Even though surgical assistants are not paid by Medicare, many patients have elected to use other companies as their Medicare provider: Humana, Secure Horizons, Evercare, etc. These Medicare providers will pay the Medicare rate, but the advantage is that YOU will get paid

You can bill for any amount, but insurance companies will pay what they pay, regardless of what your fee is. The general rule of thumb is that you will receive 10%-16% of what the surgeon is paid, not what the surgeon bills. Throw into that mix whether you are a network provider for the insurance company that you are billing. It's a personal choice to become a network provider. I was advised not to be a network provider for any insurance company. That decision should be based on how many denials you get because you're not a network provider. It's an application process that may or may not

be approved for something as little as having too many network providers in the geographic area. As a network provider, you are guaranteed payment of a preset amount per CPT Code, providing it's a code that will pay for the assistant. The amount billed for your services is arranged with your billing provider, which has the experience of knowing what the market will bear in terms of what you can bill versus what you will be paid.

If you are seriously considering an independent practice, I would advise you to check the CPT Code payment policy indicator, and

Keep in mind the benefits of being a hospital employee—no malpractice insurance, taxes deducted, vacation and sick pay.

how much the surgeon will get paid from the physician fee schedule. Then you can calculate how much you will get paid. Typically it's between 10% and 16%. Once you have an amount, divide it by the case's length of time (incision to closure), to determine a per hour rate. Compare it with your hourly wage and see if it is worthwhile. Keep in mind the benefits of being a hospital employee—not needing malpractice insurance, taxes deducted from your pay and other benefits, including vacation and sick pay, should play a key role in the decision-making process.



BILLING CONSIDERATIONS FOR HOSPITAL EMPLOYED FIRST ASSISTANTS

Tom VanRoekel, CFA

Editor's Note: For some valuable background information, please refer to the ASA Newsletter Summer 2009, available at <http://surgicalassistant.org>.

While being an independent surgical assistant can be lucrative, for many surgical assistants it is not a viable option. A family's dependence upon a hospital employer's health insurance benefits; low demand for surgical assistants; security of a steady paycheck, or simply personal preference, are all reasons why some practitioners do not become independent. Whatever the reasons for working at a hospital, a surgical assistant should know that as a hospital employee, it is still possible to collect some of the reimbursement monies for the services you provide in the operating room. This article will discuss some of the main points to consider, and explain a few of the possible

agreement proposals you can bring to the table when negotiating with your employer.

Before even mentioning billing to your hospital, there is a fair amount of research that needs to be done. First and foremost, it is critically important to perform due diligence and thoroughly understand the billing process. Scrubbing in to assist on a case without knowing the procedure or anatomy is foolish. The same reasoning applies to this situation, and there are many surgical assistants, who would be willing to share their advice and experience on the subject, all you need to do is ask.

The second item to consider ahead of time is the worth of the

billing. The payor mix for your hospital will help you determine the value of billing. The payor mix is a breakdown of the sources that the hospital receives reimbursement from, eg Medicare, Blue Cross, Humana, etc. Finding out the payor mix for your particular institution, and more specifically the payor mix for the types of cases that you assist in, is going to be a key indicator of whether or not billing will be a viable option for you. The payor mix can vary greatly among different specialties in surgery and also different geographic locations. It is also very important to note that Medicare will only reimburse other physicians, residents, Physician Assistants (PA), Nurse Practitioners

(NP), and Clinical Nurse Specialists (CNS) for surgical first assistant services, and that not all health insurance companies will allow payment for surgical first assistants either.

Hypothetically, if you assist primarily in vascular surgery cases, and the payor mix for your institution shows that 75% of the cases in which you typically assist are Medicare cases, then there is no reason to bill. In this situation, you would not be reimbursed for 75% of the cases (remember, Medicare doesn't pay). There's no guarantee that you will be paid by the insurance company in the other 25% of the cases either. Unfortunately, this situation is the sad truth for many surgical assistants. Now, if the opposite were true and only 25% of your cases were Medicare cases, then billing may be an option worth considering, since the other 75% might be cases that are billable.

Keeping these considerations in mind and assuming you are familiar with the medical billing process and have determined a reasonably good payor mix at your facility, it is time to start developing some billing/payment scenarios to present to the hospital administration. One word of caution when talking with the hospital administration, it is very likely that the vice president, chief executive officer, or other administrative personnel may not be familiar with a Certified First Assistant, Certified Surgical Assistant or Surgical Assistant Certified or have any idea of what a practitioner's duties are in the operating room. Before initiating a billing discussion, it is worthwhile to consider providing a brief overview of the surgical assistant's

responsibilities in the surgical procedure. (*Download a surgical assistant job description at www.ast.org*). If you have a good relationship with your immediate manager, it might also be a good idea to obtain a recommendation and have him or her present to support your proposal.

The following billing and payment scenarios are examples of reasonable agreements that could be reached between a hospital and a surgical assistant. Note that all three of these options result in a win-win situation for both parties, and, most importantly, do not add any increased cost to the patient.

OPTION 1:

This option has the most potential for financial gain for the surgical assistant, and is also the most complicated. In this scenario, the surgical assistant would remain an employee of the hospital, retaining all regular benefits and wages. Before beginning a case that is billable, the surgical assistant must "clock out," meaning that the practitioner must be off the clock and not receive hourly compensation from the hospital. That is the financial incentive for the hospital in this type of agreement. When you clock out for a case that means that the hospital is getting your services for free. Now you ask, why would I want to work for free? Well, technically you are working for free. However, instead of collecting an hourly wage for assisting in that case, you will be collecting the reimbursement dollars from the insurance company at a later date. You're still getting paid for the case, but in a different way. The reason why the surgical assistant must clock out is that

it is prohibited to bill insurance and receive an hourly wage at the same time. This practice is referred to as double dipping and can result in some serious consequences. When the case is over, you can clock back in and assume your normal duties as a hospital employee.

It is important to understand that there will be some cases when your claim for payment will be denied by the insurance company, and you will not get paid. That's just the way it goes. Financially, the biggest advantage of this arrangement is that the surgical assistant collects

The payor mix is a breakdown of the sources that the hospital receives reimbursement from, eg Medicare, Blue Cross, Humana, etc.

all of the reimbursement money for assisting in the case. This option really offers the best of both worlds for the surgical assistant, who is able to retain the full-time benefits as an employee, and also receive a supplemental income by billing for services.

There are certain responsibilities that certainly can't be overlooked. First, the moment you "clock out" for a case, you are operating as an independent contractor and are no longer covered by the hospital's malpractice insurance, workers' compensation, or disability insurance. It is mandatory to have your own professional liability insurance.

Secondly, you will need to either submit the insurance claims yourself, or employ a billing company

It would also be wise to explore the advantages of incorporating as limited liability corporation (LLC) or subchapter-S corporation. Unless you are legally protected and, for some reason become involved in a lawsuit, all of your personal assets can be jeopardized. Another issue is taxes. When paid directly by insurance companies, no taxes are deducted. Billing independently

One word of caution when talking with the hospital administration, it is very likely that the vice president, chief executive officer, or other administrative personnel may not be familiar with a CFA, CSA or SA-C, or have any idea of what a practitioner's duties are in the O.R.

requires that such income is reported to the IRS, and the appropriate taxes paid. Overall, this situation is very similar to running your own independent assisting business, only you are able to maintain your status as a full-time hospital employee at the same time.

OPTION 2:

It is possible that your hospital might view the first option as a conflict of interest and suggest sharing your reimbursement earnings. Since

the hospital allows you to operate in its facility, this is not an unreasonable request. If you are billing yourself or employ a billing company, a 60/40 split of the reimbursement dollars might be appropriate (60% to the surgical assistant). A simpler option would be to utilize the hospital billing department for submitting the insurance claim along with the surgeon's claim. Since the hospital would be providing the billing service, the surgical assistant may end up with a 40/60 split (40% to the surgical assistant) to cover the costs incurred by the billing department. Does this qualify as double dipping? Since the hospital will be receiving the reimbursement money, there is no worry about double dipping. The hospital can identify your reimbursement share as bonus pay and simply add it to your paycheck. The additional income would be taxed as regular pay. This option brings in extra revenue for both the surgical assistant and the institution, so the end result is a financial win-win situation for both parties.

OPTION 3:

If you have been assisting for a while and good records are available, it may be possible to determine approximately how much yearly revenue can be generated by the hospital billing for your surgical assistant services. Research the O.R. records and calculate approximately how many billable cases you assisted during the last year or two. As an example, if you assisted on enough cases last year to generate \$15,000 in reimbursement and the caseload is staying relatively consistent, it would be fair to say that your surgical assistant services would probably

generate a similar dollar amount in the coming year. With that established, the only thing left to negotiate is what percentage the hospital receives and what percentage is allocated to you. Using the example of \$15,000 per year, a 50/50 split would result in an extra \$7,500 per year for both you and the hospital, or an extra \$625 per month. The extra compensation can be added to your paycheck as bonus pay and taxed as regular income.

These options are just a few examples of reasonable agreements that a surgical assistant could reach with a hospital employer. Realize that different institutions operate in different ways, and whether or not billing would work for you depends on your individual situation. If you choose to pursue a billing agreement with your employer, make sure any agreement you reach is verified in writing. Verbal agreements are easy, but if a conflict arises, there is no documentation to support your claims. Good luck!

Under Medicare Part B, surgical assisting services (at various percentages of the surgeon's fee) are reimbursed to other physicians, residents, Physician Assistants (PA), Nurse Practitioners (NP), and Clinical Nurse Specialists (CNS). Under Medicare Part A, a portion of the hospital's DRG is attributable to surgical assisting services in some surgeries (depending on acuity), but that amount is paid directly to the hospital and may not be assigned to any hospital employee.

MEDICARE REIMBURSEMENT FOR SURGICAL ASSISTANTS

Catherine Sparkman, AST director of government affairs

Allied health personnel assisting at surgery face a number of obstacles in seeking and receiving reimbursement for their services in the operating room. Medicare reimbursement presents confusing and sometimes contradictory payment methodologies, with end results bringing both bad and good news. The good news: hospitals do receive reimbursement for surgical assisting services in cases where the necessity of a surgical assistant is determined. The bad news: only a few medical practitioners are eligible to receive direct reimbursement for surgical assisting services, and the fact that a hospital receives reimbursement does not mean that those funds are earmarked for, or paid directly to, the surgical assistant.

The Basics

Medicare, initiated under the Lyndon Johnson Administration, is the ultimate “public option”—in today’s parlance—for eligible beneficiaries. This health insurance program is operated and funded by the Federal government and

is administered by the Centers for Medicare and Medicaid Services (CXMS), formerly the Health Care Financing Administration (HCFA). The reimbursement program is divided into two discrete schemes: Medicare Part A, the hospital insurance plan, pays for hospital inpatient services, and Medicare Part B reimburses hospital outpatient costs and medical services performed by physicians and certain non-physician providers (NPPs). The two programs are fiscally independent from one

another, and reimbursement from each program is governed by separate payment systems. Hospitals are reimbursed through the inpatient prospective payment system (IPPS) and the outpatient prospective payment system (OPPS) calculations. Physician and NPPs are reimbursed through Medicare Part B according to the physician fee schedule adopted by CMS. The hospital payment schedules are adjusted according to several factors, including standard payment amounts, indirect costs of medical education, or patient outlier cases.

Medicare Part A and the DRG Codes

Medicare Part A reimbursement to hospitals takes into account both capital costs (building) and operating expenses (which include services, medical and pharmaceutical supplies, nurses and other medical staffing), cost of recovery in the hospital, and other factors including hospital type, primary and secondary diagnoses, and patient demographics (age, gender, complications, discharge status). This

Editor’s Note: This information represents only a small portion of the relevant aspects related to the discussion regarding reimbursement.

In May, at the Association of Surgical Assistants Annual Meeting, two presentations will be held that are scheduled for Saturday morning, May 29, beginning at 8 am.

The first two-hour presentation will focus on legislation and reimbursement, featuring Catherine Sparkman, AST director of government affairs.

The second two-hour presentation will examine reimbursement and billing. A panel including representatives from recognized billing companies and practitioners who self bill will lead these discussions.

After both presentations, time has been allotted for questions and answers with attendees.

In Dallas, surgical assistants will have face-to-face opportunities to hear from experts and swap professional experiences with colleagues.

combination of factors results in a “DRG weight.” There are over 500 DRG (diagnosis-related group) codes governing the spectrum of hospital services to eligible beneficiaries. For surgical services, the American College of Surgeons collaborates with CMS to determine the equipment and personnel needed for specific surgical procedures. Hence a complex or intensive surgical procedure requiring more personnel, supplies and equipment will be weighted higher (and reimbursed at a higher level) than a less

Medicare Part B: Physicians, NPPs and the Fee Schedule

Although Medicare Part B was originally designed to reimburse only physicians, over time other practitioners were added to the mix of providers eligible for payment. Currently, Medicare Part B will reimburse services of nurse practitioners, clinical nurse specialists, physician assistants, nurse midwives and nurse anesthetists as “non physician providers (NPPs). CMS reimburses these nonphysician practitioners on a percentage

cardiothoracic surgeons, registered nurse first assistants and surgical assistants, have met with administrative and political resistance. The Medicare Payment Authorization Commission (MedPAC) has consistently refused to add more Medicare Part B fee-for-service practitioners. In the past, expansion of the list of NPPs was calculated to address physician shortages and not to entertain arguments of reduction in cost of care. For example, nurse practitioners were included as NPPs to address short-



complicated procedure. Although there is no longer a “line item” breakout of various costs of a surgical procedure under the weighted DRG system, the additional personnel costs are accounted for. Consequently, a hospital will be compensated through the DRG system for supplying assistants at surgery, where such personnel have been determined to be warranted. However, there is no mechanism under Medicare Part A to assign those personnel costs directly to those performing the services.

of the physician fee schedule. For example, if the physician fee schedule provides that a physician or surgical resident assisting at surgery receives a certain amount (usually calculated as a percentage of the surgeon’s fee) for serving as the assistant, eligible NPPs will be reimbursed at a percentage of that physician’s fee for performing the same assisting services.

Efforts to expand the list of eligible NPPs who can be reimbursed for surgical assisting services, including initiatives by

ages in rural health care. Physician assistants were added as NPPs to accommodate physician extenders for the delivery of general medical care. No expansion of the list of eligible NPPs has related to the operating room directly; however, once identified as an NPP, these practitioners are eligible to receive reimbursement for surgical services. MedPAC has yet to recommend including additional NPPs based on cost savings in the O.R.

CHAIR'S COLUMN

Bill Bresnihan, CST, CFA, CSA, FAST

I am delighted to introduce the members of the 2010 ASA Advisory Committee, who are working to advance the interests of all surgical assistants, regardless of their credential. Theresa Cooper, CST, CFA, CSA, is a surgical assistant in Lynchburg, Virginia; Kathy Duffy, CST, CFA, is an independent surgical assistant in Boca Raton, Florida; Dennis Stover, CST, CSA, is the president and program director of Meridian Institute of Surgical Assisting, in Joelton, Tennessee; Valerie Thompson, CST, CFA, works as a surgical assistant in Louisville, Kentucky, and I work as an independent surgical assistant in Sunrise, Florida. Our group brings a variety of experiences to this committee, and it is our firm intention to propel this professional organization on a fast-forward pace.

In February 2009, at a meeting of the ASA Advisory Committee, the framework for a renewed and restructured ASA was created. In April 2009, at the AST Board of Directors meeting, the BOD gave approval of the ASA Advisory Committee's plan to restructure the ASA into a new and separate membership organization for all surgical assistants, regardless of their credential and AST involvement. The goal is to create a new member organization, which represents all surgical assistants and to solidify their collective voices to positively effect legislative, professional and regulatory issues.

The renewed ASA would offer its membership discounts on malpractice insurance, referrals to preferred surgical billing corporations, separate educational sessions at the national conference, discounted continuing education opportunities, reduced membership for surgical assistant students and other benefits, which have yet to be determined.

A meeting of the ASA Advisory Committee in January 2010 is currently planned to further refine the details of this broadened organization that is advocating for all surgical assistants.

The 2010 ASA Annual Meeting will run concurrently with the AST conference. For the first time, the ASA will have its own business sessions at the same times as the AST business sessions. During the first ASA business session, we will discuss the development of the new

ASA and related issues. In addition to all the clinical topics presented during conference, there will be targeted surgical assistant topics offered, such as surgical assistant business creation, billing, reimbursement, legislative updates, career options and the future of the profession.

I strongly encourage all practicing or aspiring surgical assistants to participate in the future development of the ASA. Make your plans now to join us in Dallas for the 2010 ASA Meeting. I welcome all of your comments and contributions so please direct any comments, concerns or inquiries to kludwig@ast.org.

CONTRIBUTING EDITORS WANTED

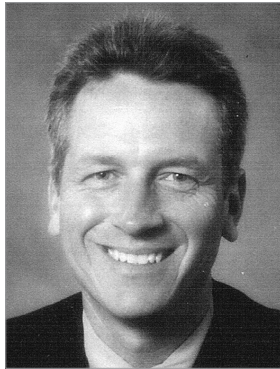


This newsletter is expanding and we are seeking additional voices and views that can be published and shared with the surgical assistant community.

If you have suggestions and are interested in writing articles of interest that are targeted to all surgical assistants, please email kludwig@ast.org.



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ASSOCIATION OF SURGICAL ASSISTANTS
**2010 ASA
ADVISORY
COMMITTEE**



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