The Surgical Assistant

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Inside:

THE ROAD TO RECOGNITION

Kathy Duffy, CSFA, CSA, ASA Secretary

The 2013 Florida legislative session ended in disappointment and frustration for the surgical assisting/surgical technology legislation (Senate Bill 360 by Senator Rene Garcia/House Bill 281 by Representative Matt Gaetz.)

For the third year in a row, the Florida House of Representatives failed to approve the bill. Florida's anti-regulatory climate forced us to amend the language of the bill early on, to remove the "mandatory insurance reimbursement for surgical assistants" portion of the bill, leaving us with the recognition portion intact. This was done during the first of eight committee reviews. Had this language not been amended, the bill would have died in the first committee. We moved forward with the amended bill, only to be disappointed again. Our bill was attached to another forward moving bill and last minute "behind the scenes" dealing by politicians dealt a deadly blow.

Our lobbyist, Pete Buigas, felt there was more than one way to get around the negative politicians and felt a business solution with insurance companies was a better answer to the reimbursement issues that independent practitioners encounter. Pete used his knowledge of the insurance industry and Florida insurance law to develop an idea that had never been approached: a network of surgical assistants.

—continued on page 3

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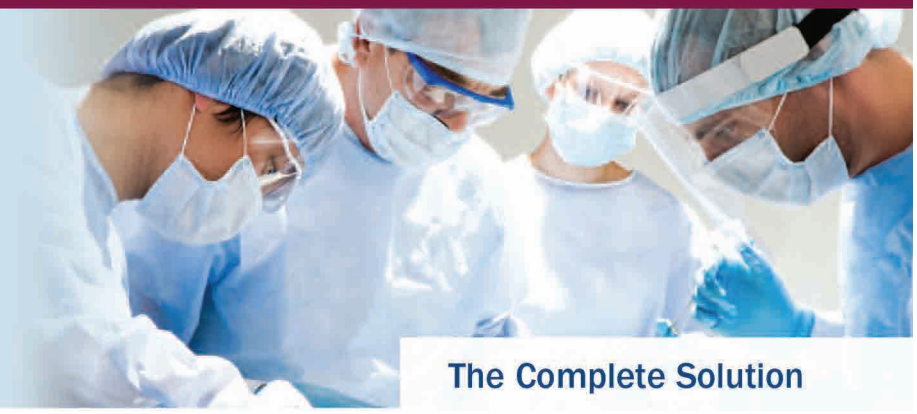

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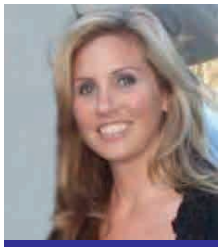
It's not uncommon for surgeons to belong to management companies. These companies represent multiple surgical practices on many levels, the most important being negotiating insurance contracts. It's obvious, the more players you have, the better your negotiating power. That being said, Pete had the vision for a surgical assisting network, that could approach and negotiate contracts with insurance companies for surgical assistants. His idea had never been tested. He brought his idea to the leadership of the ASA. With their blessing, he began to speak with CIGNA insurance. CIGNA has never recognized surgical assistants as practitioners (only a few were lucky enough to hold contracts) and as a result, were inundated with customer service complaints from their members all over the state in regards to being billed by out-of-network providers. CIGNA showed interest in Pete's vision but would only deal with a third party affiliation. Since There was no TPA for surgical assistants, Pete created National Provider Alliance, the first management company for surgical assistants. Through NPA, Pete was able to negotiate a contract with CIGNA, representing a major shift in CIGNAs payment policies by agreeing to reimburse surgical assistants. ASA has been charged with the verification of credentials of everyone in the network.


Pete Buigas


Melaney Cordell

The network is open to all CSFAs, CSAs and SA-Cs in the state of Florida. Sadly, the leadership of the NSAA did not support this initiative, but NPA still welcomes any Florida CSA who would like to join the network.

This ground breaking initiative has never been tested but we are confident that success will enable us to be able to launch this initiative in other states, and on a national level. ASA thanks Pete Buigas, Melaney Cordell and CIGNA insurance in Florida for their hard work and dedication to the establishment of surgical assistant professional as viable members of the surgical team.

FLORIDA CSFAs, CSAs AND SA-Cs

Get reimbursed for your professional expertise and services through Cigna. ASA is offering all credentialed surgical assistant members the opportunity to join a reimbursement network and benefit from a streamlined reimbursement process through a partnership with the National Provider Alliance.

Download the information from the front page of the ASA website, www.surgicalassistant.org.

Keep your current billing agency or use NPA at no additional charge.

Questions — contact Melaney Cordell at the National Provider Alliance, melaney@nationalprovideralliance.com.

TEXAS CSFAs, CSAs AND SA-Cs

The National Provider Alliance in partnership with ASA are now actively exploring reimbursement for surgical assistants with major insurance companies in Texas.

Recently, we announced that the National Provider Alliance together with Cigna will offer reimbursement to all CSFAs, CSAs and SA-Cs who are members of ASA in Florida. We would like to repeat our success in Texas — even unlicensed credentialed surgical assistants who are members of ASA.

To get this effort rolling, we need to demonstrate to the insurance entities that a critical mass of surgical assistants is eager to join this reimbursement network and that statewide coverage is available.

With your preliminary information, NPA will be able to begin discussions with the intention of negotiating the optimal reimbursement rate with major health plan(s).

This is a historic opportunity for Texas surgical assistants and represents the next step in our efforts to obtain reimbursement for surgical assistants nationally.

If you did not receive the packet by email, or if you have questions, please contact Melaney Cordell at NPA, melaney@nationalprovideralliance.com.

POSITIVE RISK IMPACT

THROUGH STANDARDS OF PRACTICE

S Benn Psalms, SA-C

Risk is a reality that we encounter daily. The true definition and implied meaning of "risk" has lost meaning through overuse and intellectual neglect. I find this to be especially true for practitioners in the healthcare setting. We have heard the term "risk" from the first day of training and continue to use it in our own individual practices. Risk of contamination, risk of infection, risk of bleeding and risk of death are just a few common and familiar phrases that we hear or use almost on a daily basis. However, what does the term "risk" actually imply? For me, the word meant "the chance of something happening, usually bad or undesirable." After all, who wants to get infected and die, right? A hasty look in the dictionary provided the definition,"exposure to the chance of injury or loss; a hazard or dangerous chance." This seemed to be pretty close to my own personal definition. At this point, I was feeling pretty intellectual.

Suddenly, something about the definition I read and accessed in my own mind began to bother me. At first, I could not put my finger on it. Suddenly, the word "chance" jumped off the page. Chance. The implied randomness of the word irritated me. Was the morbidity and mortality of my patients left to a simple role of some cosmic dice? Could my own decisions during the case sway an outcome in either direction? What about all of my training and experience over the past 23 years, including all those five-minute scrubs, double gloving and strikethrough prevention measures. I required a better definition of that word; a definition that would remove or reduce the implied variableness of chance. After substantial research, I found a combined definition that would satisfy, to a great extent, my obsessive compulsive disorder — a consequence of my chosen profession. Risk can be defined as the probability or threat of quantifiable damage, injury, liability, loss or any other negative occurrence that is caused by external or internal vulnerabilities, and may be *avoided through preemptive action.*

So, can risk be avoided? Not totally, but it can be minimized. Members of any profession are responsible for ensuring safe and effective practice. This is accomplished through the creation and implementation of standards of practice which define the professional competencies required for accepted and safe practice and are essential for continued improvement of the specific vocation. These practices help to protect the public health, safety and welfare and to provide ongoing competencies. Standards of practice in the surgical assistant arena also educate the general public and healthcare community by providing them information specifically regarding the scope of practice and role of a surgical assistant in the operating room. As a surgical assistant, standards of practice and the resulting scope of practice act not only as guides, but serve as the criteria by which we will all be measured.

Risk avoidance is especially important to the non-hospital employed, or independent, surgical assistant. In the event of injury, of self or others, while performing any duty not specifically addressed in the scope of practice as outlined by that facility during the credentialing process,[1] the independent surgical assistant is not

covered by the facility's insurance policy. Furthermore, if the surgical assistant causes, or by any action does not prevent, injury, while performing any action outside of their facility-defined scope, he/she may be consider liable.

A recent example was on the ASA Facebook comment section regarding an independent surgical assistant not assisting in case turnover by helping clean the room. Cleaning the room is an example of a task that would not customarily be included in the lists of tasks of the independent surgical assistant. If an employee was injured (toes crushed while the bed was being moved, eyes splashed with disinfectant, etc) by the independent surgical assistant, risk management would possibly deny culpability of medical care since the independent surgical assistant was not within the scope (not capability) the facility had approved when he/she caused or contributed to the injury. According to most states' laws, the types of injuries compensable under workers' compensation are those which can be connected in some way to an "employment requirement or condition." Employers in most states are required to carry workers' compensation insurance, but only workers properly classified as "employees" are covered (as opposed to independent contractors, under which surgical assistants are often classified). An independent surgical assistant runs the risk of having to file a personal medical claim for a personal injury or be financially responsible for the medical treatment or care of other individuals injured as a result of his/her actions outside of the documented scope of practice.

Also worth mentioning is the potential loss of individual earnings due to cancellation of currently scheduled cases, or the inability to schedule new cases, secondary to personal injury.

This risk can be easily diminished, if not avoided completely, by the preemptive action of staying within the official scope of practice of a surgical assistant at that facility. The surgical assistant could contribute to the flow of the workday by performing other duties, such as reviewing the next patient's history, developing a list of any allergies to medication or latex or speaking with the surgeon directly about the next case in order to anticipate instrumentation needs.

There is a slight risk when staying within the prescribed tasks. Some members of the surgical team may view a surgical assistant's behavior as lazy or selfish. It may possibly affect whether a surgeon uses you; however, professional performance as an assistant should easily put that to rest.

These facts are simple and straightforward; the causal connection is clear, and the evidence is well documented: Surgical assistant job descriptions are established to reduce risk and to define our role in the operating room. As independent surgical assistants, it is our collective responsibility to not only adhere to the organization's policies, but also realize how our decisions affect our vocation as a whole.

Benn Psalms has been working as an independent surgical assistant for five years in Tucson, Arizona, and a CST for 17 years. He is involved in medical research and has co-authored 18 articles. Benn is a member of ASA and AST.

[1] *Editor's Note: Throughout this article "scope of practice" does not refer to statutory scope of practice as defined by state law. Facilities determine the tasks a surgical assistant contractor may or may not perform based on their interpretation of state law.*

OBTAINING PRO
UNDER M

How the NPs

Surgical assistants and registered nurse first assistants have been assiduously and arduously seeking a way to be added to the list of nonphysician providers (NPPs) reimbursed under Medicare Part B. Both professions offer trained and skilled professionals to surgical patients and the surgeons who serve them, though Medicare declines to add these practitioners to the list of NPPs who qualify for reimbursement. It was a hard-fought battle for those currently reimbursed, and success came through unlikely channels.

The nurse practitioner profession (and to some extent the physician assistant profession) arose out of a need to meet a rising demand for primary care services, especially in rural areas. Studies documented the value of nurse practitioner services, and the utilization of these practitioners grew despite opposition from physicians and other nurses. Initially, compensation was provided by means of a salary or patients-per-month agreements. Nurse practitioners working in medically underserved rural areas took advantage of this reimbursement available under the Rural Health Clinic Act of 1977 (signed by President Carter). The Act's goals were to encourage utilization of NPs and PAs by providing reimbursement for services provided to Medicare and Medicaid patients, even in the absence of a full-time physician; and to create a cost-based reimbursement mechanism for services when provided in clinics located in underserved rural areas. The law followed an earlier effort to include services of licensed nurse practitioners under Medicare and Medicaid, and mandated that a 50% of services in funded rural health clinics be provided by nurse practitioners, certified nurse-midwives, and physician assistants. Later, the Omnibus Reconciliation Act of 1989 provided limited reimbursement for nurse practitioners collaborating with physicians in rural areas and mandated a study of nonphysician providers and Medicare reimbursement. The continuing shortage of

OVIDER STATUS EDICARE:

and PAs Did It

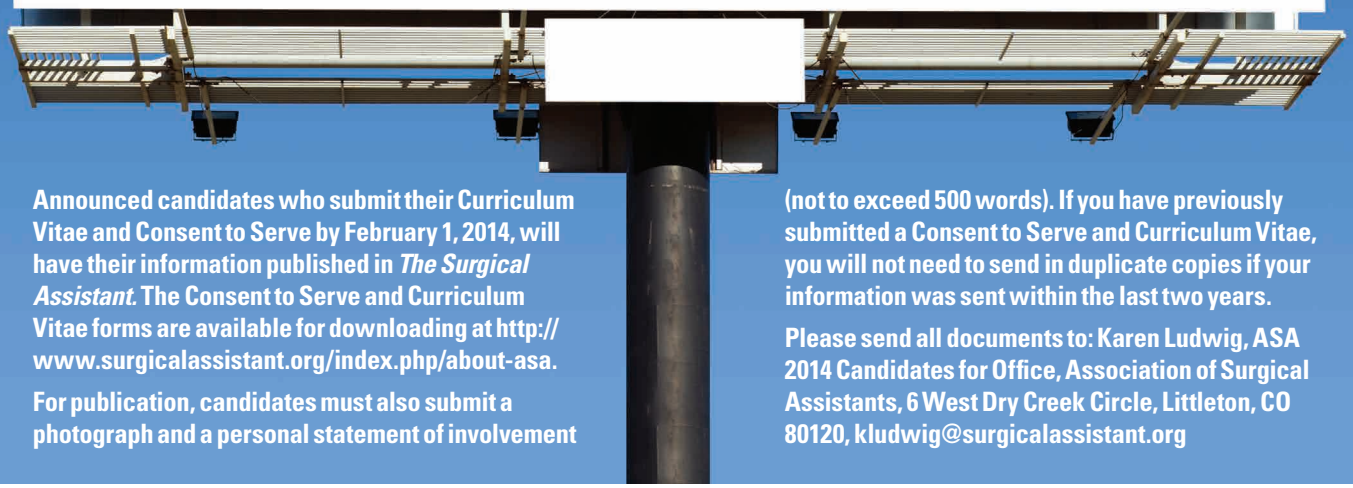
Cathy Sparkman, ASA Director of Government Affairs

primary healthcare providers impelled the nurse practitioner initiative forward. The initial effort, filed in 1991, increased Medicare reimbursement of nurse practitioners, clinical nurse specialists, and certified nurse-midwives to increase the delivery of health services in underserved areas. However, the bill stalled in committee. In was revived as the Primary Care Health Practitioner Incentive Act of 1997 and was passed and signed by President Clinton as the Balanced Budget Act of 1997. Prior to January 1, 1999, nonphysician services were reimbursed by Medicare Part B only in certain geographical areas and healthcare settings. Nurse practitioner and clinical nurse specialist services were covered when provided in collaboration with a physician in nursing facilities in urban areas and in all settings in rural areas. NPs and CNSs could also bill Medicare directly for services provided in rural areas. Physician assistant services were covered when provided under the supervision of a physician in hospitals and nursing facilities, as an assistant to surgery, in physician offices and patient homes in rural areas, and in a rural area designated as a health professional shortage. The Act removed restrictions on settings. Effective January 1998, payment was allowed for nonphysician practitioner services in all geographic areas and healthcare settings permitted under state licensing laws, but only if no facility or other provider charges were paid in connection with the service. NPs and CNSs were allowed to bill directly in all settings (both rural and urban). Services of a PA were required to be billed through an employer.

What began as a response to the shortage of primary care and other clinical care practitioners in rural and medically underserved areas grew into an across-the-board, all-setting reimbursement scheme for the NPPs identified in Medicare Part B. Although assistant-at-surgery services have long been provided by other nonphysician practitioners such as RNFAs and surgical assistants, Medicare has been reluctant to open up the nonphysician provider definitions to include those medical professionals that arguably have the more specific, focused and robust training and expertise in the surgical arena. Efforts at inclusion of additional practitioners may take a back seat during the roll-out of the Affordable Care Act in the next few years; yet the goal to add the most highly skilled practitioners to the NPP echelon is still a valuable and valid one. The early reimbursement of NPs and PAs as primary care providers in rural and medically underserved areas both encouraged and advanced their professions and raised the quality of medical care. Reimbursement of surgical assistants would achieve the same goals.

2014 ASA CALL FOR CANDIDATES

In Denver, May 28–30, elections will be held for ASA Secretary and three Board positions. Each office is for a two-year term, 2014 through 2016.



Announced candidates who submit their Curriculum Vitae and Consent to Serve by February 1, 2014, will have their information published in *The Surgical Assistant.* The Consent to Serve and Curriculum Vitae forms are available for downloading at http://www.surgicalassistant.org/index.php/about-asa.

For publication, candidates must also submit a photograph and a personal statement of involvement (not to exceed 500 words). If you have previously submitted a Consent to Serve and Curriculum Vitae, you will not need to send in duplicate copies if your information was sent within the last two years.

Please send all documents to: Karen Ludwig, ASA 2014 Candidates for Office, Association of Surgical Assistants, 6 West Dry Creek Circle, Littleton, CO 80120, kludwig@surgicalassistant.org

HOW TO RUN FROM THE FLOOR

If you miss declaring your candidacy by February 1, for one of the ASA offices in the 2014 elections in Denver, there is another option. Interested ASA dues-paying active members can also become a candidate during the first Business Session that occurs on Wednesday, May 28. This candidate process is also called running from the floor.

Elections will be held for the office of secretary, plus three Board of Director positions. To be eligible, candidates must be an active member and, if elected, shall maintain that active status. A completed Curriculum Vitae and Consent to Serve forms must be submitted. (These are available on the ASA website, www.surgicalassistant.org. Click on About ASA and scroll down to the links posted under Interested in Serving?)

Interested practitioners must present their forms to the ASA Credentials Committee Booth for their review and approval before the first business session. The Credentials Committee Booth will be open on Tuesday, May 27, in the main registration area. Times will be posted and an announcement will be included in a later issue of The Surgical Assistant.

ASA Business Session 1 will be held on Friday, May 28. The declared candidates will be introduced and then any eligible candidate can place their name in nomination for one of the open positions to run from the floor. Each nomination must be seconded before a candidate is considered eligible to be placed on the ballot.

After the nominations from the floor are closed, the ASA Candidates Forum will occur. Each candidate for an officer position will be able to present a five-minute speech related to their positions and their priorities for the organization. Each candidate for a Board of Director office will have three minutes to share their priorities and views for the future of the organization.

Once the candidates have completed their presentations, ASA active members will be able to directly ask candidates relevant questions. Responses will be timed and rotated in order to allow as many as possible to participate.

We hope to see many active ASA members participate in Denver.

PROPOSED BYLAWS CHANGES

ARTICLE V Nominations and Elections

Section 1. Nominations

A. At least ninety days prior to the national meeting, the Credentials Committee shall present a list of candidates for each office to be filled at the ~~national conference~~ annual meeting accompanied by a curriculum vitae and a written consent of the nominees to serve if elected. All nominees who meet the qualifications for office shall be placed on that list after their credentials have been verified by the Credentials Committee.

~~B. Nominations may be made from the floor provided written consent of the nominees has been obtained in advance and their credentials have been verified by the Credentials Committee.~~

~~C.~~ B. A member holding an elective position may not be nominated for another position for which the term would begin before expiration of the term of the current position unless the member resigns from her/his current elective position.

~~D.~~ C. A member employed at national headquarters shall not be nominated for a national elected position.

Section 2. Elections

A. Elections shall be ~~by ballot at the national conference, the date and hours to be determined by the ASA~~ by electronic ballot available on the ASA website thirty days prior to the start of the ASA annual meeting or by live ballot at the annual meeting. Online voting will be closed by midnight the day before the final day of the ASA annual meeting ASA will determine the date and hours of voting at the annual meeting.

ARTICLE VI

Section 2. Eligibility of Officers

A. A candidate shall have been an active member for one year immediately preceding nomination and, if elected, shall maintain that active status. A majority of the Board of Directors shall hold the Certified Surgical First Assistant (CSFA) credential.

ARTICLE VII Meetings

Section 1. ASA shall meet annually and that meeting shall be known as the ~~national conference~~ annual meeting, the date and place of which shall be determined by the Board.

Section 2. The voting body of the ~~national conference~~ annual meeting shall be the active members. Voting by members shall be in person or online and each ~~delegate~~ active member will be entitled to one vote.

Section 3. Business Meetings

A. There shall be a minimum of one business meeting at each ~~national conference~~ annual meeting.

D. Special Meetings

1. During the ~~national conference~~ annual meeting, special meetings of the membership may be called by the President or upon written request of five members of the Board of Directors or by one-third of the total number of active members of the ASA in attendance.

2. Between ~~conferences~~ annual meetings special meetings of the membership may be called by two-thirds of the Board of Directors or by two-thirds of the active members credentialed for the previous conference. Thirty days' written notice of the time, place, and business to be considered at the special meeting shall be given to all members.

ARTICLE IX Committees

Section 1. Standing Committees

A. The standing committees shall be Bylaws, Education, and ~~Legislative~~ Nomination and Leadership and shall be appointed by the President with the approval of the Board of Directors.

Section 3. Eligibility of Committee Members

A. Members of the Bylaws, Education, and ~~Legislative~~ Nomination and Leadership Committees shall have active membership status in ASA.

Reimbursement Issues for the Surgical Assistant

Paul Beale, CSFA, ASA Director

How many times are surgical assistants requested to assist on a Medicare, Medicaid, Tricare Kaiser uninsured, self-pay, or Medicare supplemental plans? The list is endless. Often at the end, the realization hits that there is no compensation for your time and expertise. Keeping things in perspective, surgical assistants are providing a service of optimal care to the patient and serving as a qualified second set of hands and eyes to the surgeon across the table.

For more than 25 years, surgical assistants in the Metro Denver area have received compensation from area hospitals at a rate of $30.00/hr or $0.50 per minute without any cost of living adjustment. On many occasions, surgical assistants have approached hospital administration, requesting an increase in the rate of reimbursement but to no avail.

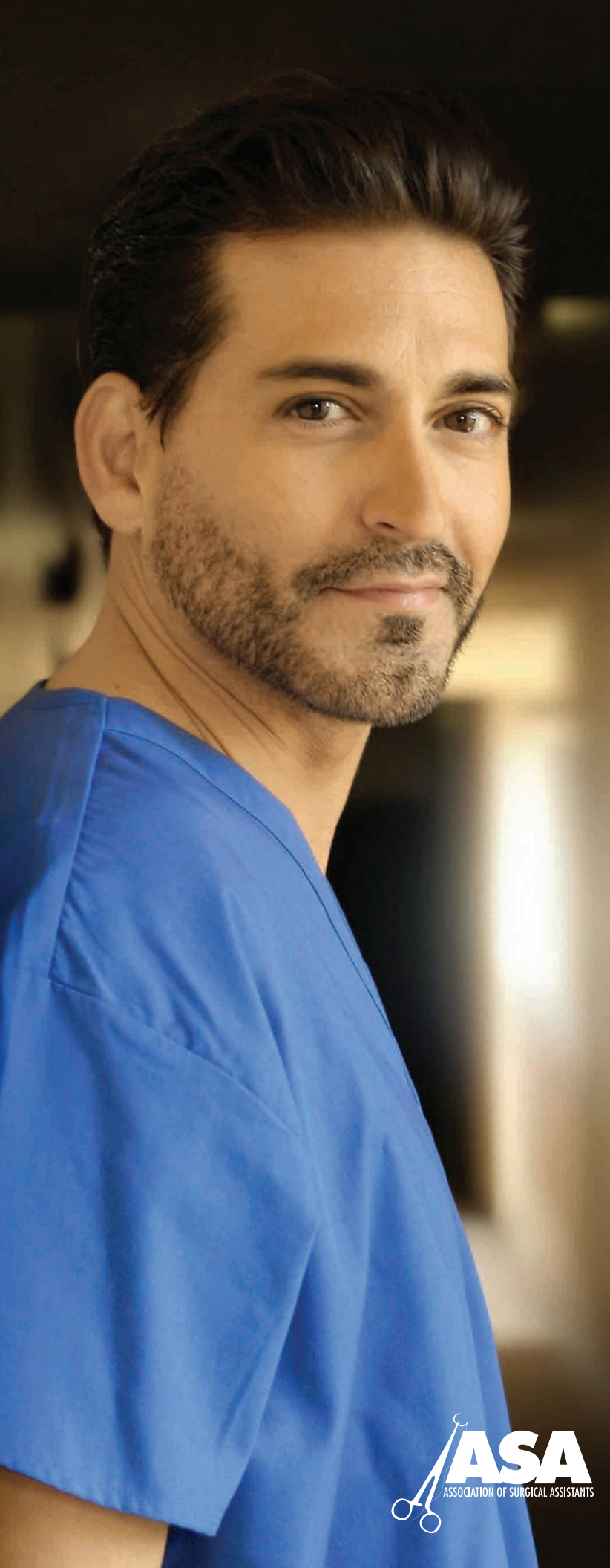
This past summer, a group of surgical assistants approached one area hospital, informing the management that surgical assistants would not be available to assist on many of these cases in the future. The OR management was having a difficult time trying to cover these cases and subsequently informed administration of the ensuing and potential problem.

After negotiations, the end result was a revised contract increasing the reimbursement rate to $100.00 per hour with a two-hour minimum surgery. This was the opportunity the surgical assistant community needed to begin dialogue and negotiations with the three major hospital corporations: HealthCare of America (HCA), Centura and Exempla. At the time of this article, letters have been drafted and sent to local hospital administrations and division administrators by our supporting surgeons. The surgical assistants have also drafted a letter outlining our request for the same revised contract and are penning our signatures, thereby exhibiting the cohesiveness of the surgical assistants.

Listed below are some steps that surgical assistants in other areas may employ in approaching the administration at local hospitals:

1. Set up a meeting with the Chief Executive Officer (CEO), Chief Operating Officer(COO), Chief Financial Officer (CFO) or their designated representative. Keep in close contact with those who can facilitate a positive response benefiting the surgical assistants
2. Be knowledgeable of the prevailing rates for the surgical assistants in your geographical area, such as hourly reimbursements from surgeons' offices and other providers and hospitals in your area
3. Communicate with the surgeons whom you assist and request letters of support for your reimbursement goal. Many times they are unaware that surgical assistants will not be reimbursed for these types of cases.
4. Be persistent and tenacious in your endeavor, reasonable with your requests, setting a timeline for responses to correspondence from the facilities. Do not accept the negative responses; the work and knowledge of surgical assistants merit compensation.
5. Network with other surgical assistants in your area and develop a cohesive group. Remember there is strength in numbers!

Webster's Dictionary defines perseverance as: "The quality that allows someone to continue trying to do something even though it is difficult. It is the continued effort to do or achieve something despite difficulties, failure, or opposition". In our endeavor to achieve recognition of our profession and compensation. we must be steadfast in pursuing this definition



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- ☑ Provides legislative representation that advocates for the practicing surgical assistant
- ☑ Provides major financial support for legislative efforts in Virginia and Florida
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- ☑ Sponsors advanced-level hands-on workshops, including robotics, cadaver labs, endovein harvesting, and learning-at-sea cruises
- ☑ Offers discounts to take the CSFA examination
- ☑ Publishes information that's relevant in the quarterly *The Surgical Assistant*
- ☑ Sponsors an annual meeting that features nationally recognized surgeon speakers
- ☑ Hosts open Facebook site for surgical assistants
- ☑ Hosts an open Discussion Board
- ☑ Host an open online Jobs Board
- ☑ Offers ASA dues-paying members free opportunities to post Positions Wanted

Join ASA to advance your career in surgical assisting and advance our profession.

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ASA
ASSOCIATION OF SURGICAL ASSISTANTS

AST Association of Surgical Technologists
ASA Association of Surgical Assistants

6 West Dry Creek Circle, Suite 200
Littleton, CO 80120

Paying Our Way

From 2011 to 2014, AST provided its standard range of membership benefits (journal, CE processing, event and product discounts, etc.) to the members of ASA at virtually no cost to ASA. The ASA leadership is grateful to AST for providing this support in the start-up years.

Now that we are approaching the three-year anniversary of ASA, the ASA Board agreed with the AST Board that it's important that we allocate $50 of ASA dues to AST to support a wide range of services that ASA is not yet able to provide independently.

Consequently, the ASA Board has voted to increase ASA membership dues for active and associate members by $25. Beginning January 1, 2014, ASA dues will be $175. Student dues will remain at the present level.