

WHAT IS ABOUT TO CHANGE FOR THE ASA ARE YOU READY AND WILL YOU BE A PART OF IT?

Christina Jordan, CST, CFA

As if being in Las Vegas isn't going to be exciting enough, there are many new developing ideas and transitions that are about to take place related to surgical assisting. What is going on? Will these innovations affect me? Will I be happy with the potential changes? Want to be the first to know? If you answered yes to any of these questions then you need to be in Las Vegas for the ASA 11th Annual Meeting that precedes the AST Annual Conference. It isn't too late to register, so don't delay any longer. You don't want to get your information second hand; we all remember how the game of telephone plays out don't we?

The ASA Advisory Committee has been working hard to provide the most innovative speakers and hands-on demonstrations. If you have been paying attention, you will see the agenda this year is stronger than ever before. In addition to

the nationally recognized speakers, we have also organized a panel discussion. However, this year we're shaking things up in Looking to the Future—the Outlook for All of Us. We now have exciting information that will surely change the way you see your career and your professional surgical assisting organization. You will have the opportunity to ask direct questions and get first-hand answers. Do you have to be a CFA? Absolutely not. In Whether you are a CSA, SA-C, AS-C, performing surgical assisting responsibilities or currently a surgical assisting student, we want you to be a part of this discussion to bring your ideas and your experience to the table. If you only wish to attend the surgical assisting meeting and not conference, separate registration is available. This year for the first time, we are offering a special discount to surgical assisting students who want to attend.

Some of the topics will include defining a direction for a broader surgical assisting organization; possible member benefits, such as malpractice insurance; defining legislative priorities, and more. Are you curious yet? Have you started to develop questions that you need answers to? This is just a small sample of the information that will be talked about at the panel discussion.

Don't miss out on your opportunity to have your concerns heard and getting the information first hand.

Tell your students if you are instructors, tell your colleagues if they do not receive this newsletter, spread the word to all surgical assistants regardless of their credential, but most importantly register for the most exciting ASA Day yet.

We look forward to seeing you and sharing the exciting times that are about to come for the profession of surgical assisting.

CMS INFORMED CONSENT, O.R. STAFFING REGULATIONS ADDRESS SURGICAL ASSISTING IN THE OPERATING ROOM

Catherine Sparkman, AST director of government affairs

The Center for Medicare and Medicaid Services (CMS) recently modified its Conditions of Participation relating to informed consent and staffing. Several of the changes relate to, and affect, the role of nonphysician surgical assistants in the O.R. 42 C.F.R. §482.24(c)(2)(v) itemizes the minimum elements that a properly executed informed consent form must contain. They include identification of the hospital, the specific procedure or treatment, the practitioner performing the procedure, and the anticipated benefits, material risks and alternative therapies. The regulations continue with suggestions of what a “well designed consent form might include.” Among them is a “[s]tatement, if applicable, that qualified medical practitioners, who are not physicians who will perform important parts of the

surgery or administration of anesthesia will be performing only tasks that are within their scope of practice, as determined under state law and regulation, and for which they have been granted privileges by the hospital.”

Regulations governing surgical informed consent [42 C.F.R. §482.51(b)(2)] amplify the above rules. A “well designed” surgical informed consent process would include: (1) a description of the proposed surgery, including the anesthesia to be used; (2) the indications for the proposed surgery; (3) material risks and benefits for the patient related to the surgery and anesthesia; (4) treatment alternatives, including the attendant material risks and benefits; (5) the probable consequences of declining recommended or alternative therapies; (6) who will conduct the surgical

intervention and administer the anesthesia; (7) whether physicians other than the operating practitioner, will be performing important tasks related to the surgery, in accordance with the hospital’s policies; and (8) whether, as permitted by state law, qualified medical practitioners, who are not physicians will perform important parts of the surgery or administer the anesthesia, and if so, the types of tasks each type of practitioner will carry out; and that such practitioners will be performing only tasks within their scope of practice for which they have been granted privileges by the hospital. The *CMS Regulations and Interpretive Guidelines* defines “important surgical tasks” to include: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, implanting devices and placing invasive lines.”

CMS Regulations and Interpretive Guidelines relating to surgical privileges also address surgical assistants. 42 C.F.R. §482.51(a)(4) requires surgical privileges in a hospital be delineated for all practitioners. Interpretive guidelines require that the hospital must specify the surgical privileges for each practitioner that performs surgical tasks. These practitioners include nonphysician assistants at surgery. When a practitioner performs certain surgical procedures under supervision, the specific tasks/procedures and the degree of supervision (to include whether or not the supervising practitioner is physically present in the same O.R., in line of sight of the practitioner being supervised) be delineated by that

practitioner's surgical privileges and included on the surgical roster.

If the hospital utilizes non-MD/DO surgical assistants, the hospital must establish criteria, qualifications and a credentialing process to grant specific privileges to individual practitioners based on each individual practitioner's compliance with the privileging/credentialing criteria and in accordance with federal and state laws and regulations, which would include surgical services tasks conducted by these practitioners, while under the supervision of an MD/DO.

When practitioners whose scope of practice for conducting surgical procedures requires the direct supervision of an MD/DO surgeon, the term "supervision" would mean the supervising MD/DO surgeon is present in the same room, working with the same patient.

In summary, "Surgery and all surgical procedures must be conducted by a practitioner, who meets the medical staff criteria and procedures for the privileges granted, who has been granted specific surgical privileges by the governing body in accordance with those criteria, and who is working within the scope of those granted and documented privileges."

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Editor's note: For surgical assistants performing any important surgical tasks identified by CMS, verify that your hospital has issued the proper credential for you to practice as a first assistant at surgery. Also, the patient medical records should list you as the surgical assistant (or first assistant at surgery) and not as "second scrub."

INFORMED CONSENT PROCESS

A well-designed information consent process would include discussion of the following elements:

(Example is excerpted from Interpretive Guidelines §482.51(b)(2))

- Description of the proposed surgery, including the anesthesia to be used
- Indications for the proposed surgery
- Material risks and benefits for the patient related to the surgery and anesthesia, including the likelihood of each, based on the available clinical evidence, as informed by the responsible practitioner's clinical judgment. Material risks could include risks with a high degree of likelihood but a low degree of severity, as well as those with a very low degree of likelihood but high degree of severity
- Treatment alternatives, including the attendant material risks and benefits
- Probable consequences of declining recommended or alternative therapies
- Who will conduct the surgical intervention and administer the anesthesia
- Whether physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks related to the surgery, in accordance with the hospital's policies. Important surgical tasks include: opening and closing, dissecting tissue, harvesting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, implanting devices and placing invasive lines

A well-designed informed consent form might also include the following additional information:

(Example is excerpted from Interpretive Guidelines §482.24(c)(2)(v))

- Name of the practitioner who conducted the informed consent discussion with the patient or the patient's representative
- Date, time and signature of the person witnessing the patient or the patient's legal representative signing the consent form
- Indication or listing of the material risks of the procedure or treatment that were discussed with the patient or the patient's representative
- Statement, if applicable, that physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks related to the surgery, in accordance with the hospital's policies and, in the case of residents, based on their skill set and under the supervision of the responsible practitioner
- Statement, if applicable, that qualified medical practitioners who are not physicians who will perform important parts of the surgery or administration of anesthesia will be performing only tasks that are within their scope of practice, as determined under state law and regulation, and for which they have been granted privileges by the hospital

MANAGING MODIFIERS FOR SURGICAL ASSISTANT SERVICES

Jennifer Bever, MS, FACHE

Orthopaedic practices commonly question how to correctly code and bill for surgical assistant services for both physicians and nonphysician providers (NPPs). Although commercial rules for reporting surgical assistant services can and do vary markedly, the Medicare rules apply across the country and are quite clear. In addition, Current Procedural Terminology® (CPT) clearly defines relevant modifiers and their use.

The March/April 2007 issue of AAOS Now addressed the use of modifier AS for surgical assistant services provided by NPPs. This issue will examine the use of other modifiers for surgical assistant services.

Modifier 80—Assistant Surgeon

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s). This modifier is intended for use by physicians acting as assistant surgeons in conjunction with other physicians. Although primary surgeons do not need to affix a modifier, assistant surgeons must affix modifier 80 on bills for the surgical codes. For example, if Dr. Primary bills 27447, Dr. Assistant should bill 27447-80.

Modifier 81—Minimum Assistant Surgeon

Although not widely used, modifier 81 added to the usual procedure number(s) indicates minimum surgical assistant services. This modifier is appropriate in those instances in which the assistant surgeon assists with part of a surgical

procedure, but is not present for the entire procedure. There are no written guidelines on what constitutes a “minimum” presence to report the service; the physician’s discretion determines when reporting services with modifier 81 is appropriate.

Commercial insurance companies may direct practices to use modifier 81 to designate assistant-at-surgery services performed by NPPs such as physician assistants, nurse practitioners, and clinical nurse specialists. Practices are strongly encouraged to obtain such directives in writing and retain that information on file, because the use of modifier 81 for NPP services is not in keeping with the definition per CPT. In fact, if an audit is conducted, practices that use modifier 81 to signify NPP-assisted services at the verbal directive of the payor

may be required to return those payments unless they have written proof of the directive from the plan.

Modifier 82—Assistant Surgeon (when qualified resident not available)

The unavailability of a qualified resident is a prerequisite for use of modifier 82 appended to the usual procedure code number(s). Because Medicare reimburses academic institutions for resident services, practices in those settings will have to justify claims for assistant surgeon services.

Medicare will reimburse for assistant surgeon services—even in a setting with residents—if there is no qualified resident available. This may mean that no residents are available (a distinct possibility because of the 80-hour work restrictions) or that the residents available do not have sufficient training to properly assist with the procedure.

When submitting Medicare claims with modifier 82, the practice/department must have a signed attestation on file confirming that no qualified residents were available. This attestation would be needed during an audit of practice records, so it should be filed in the patient’s medical record or scanned into the electronic medical record.

Occasionally, commercial plans will attempt to deny assistant surgeon services, citing the availability of residents. But unlike Medicare, these commercial plans do not pay into graduate medical education funds. Thus, these attempts to circumvent payment for medically necessary assistant surgeon services are unacceptable. Although this issue is perhaps best managed

during contract negotiations, the plans may have claim adjudication systems with automatic edits, based on place of service, which are difficult to adjust. If such denials occur, the practice may need to use modifier 82 and note that a signed attestation is on file to bypass system edits.

Surgical Assistant Procedure Coverage

Not all surgical services are eligible for surgical assistant payment. For each surgical CPT code, Medicare publishes the assistant payment status: payable, not payable, or possibly payable based on submitted documentation.

For example, total hip arthroplasty (27130) has a Medicare assistant payment status of “2—Assistant surgery may be paid.” In contrast, carpal tunnel release (64721) has a Medicare assistant payment status of “1—Assistant surgery may not be paid.” Although many of these status codes may seem intuitive, orthopaedic surgeons are often surprised to learn that several knee arthroscopy codes—including meniscectomy (29881)—are rated as “0—Payment restrictions for assistants at surgery apply to this procedure unless supporting documentation is submitted to establish medical necessity.”

If the CPT code has a “0” status indicator, the operative note will need to clearly state why the assistant was required and the extent of the work performed by the assistant to support payment. The primary surgeon is responsible for including this enhanced documentation in the operative note. Without such information, billing personnel will find appeal efforts difficult.

Commercial payers may follow Medicare’s surgical assistant payment guidelines or may create their own. Practices should ask their top commercial payers how surgical assistant payment status is determined. In some instances, payers use the American College of Surgeons surgical assistant survey (available at www.facs.org/ahp) to determine payment.

Billing staff must have access to assistant payment status lists when they review related denials to ensure proper action and appeal efforts.

No appeal is needed if ineligible codes were billed for assistant services, but an “assistant surgery coded in error” adjustment is appropriate.

Commercial claims for assistant services that are payable per the Medicare guidelines should be appealed unless the plan has clarified their own assistant payment guidelines.

Action Steps

1. Review available modifiers for surgical assistant services and outline which modifiers are appropriate to report services performed in the practice.
2. Ensure that NPP assistant services billed to Medicare are submitted under the NPP’s name and number, with the modifier AS, and that services are eligible for assistant payment.
3. Inquire about relevant state legislation governing payment for assistant-at-surgery services by clinical personnel such as nurses or technicians.
4. Inquire what modifier is required to signal NPP (or additional clinician if allowed)

assistant services for top commercial plans; also find out how the plans determine assistant payment status (Medicare or other list).

5. Review explanation of benefit statements containing surgical assistant denials to understand payment issues the practice is experiencing.

For additional information on this subject, consider the following resources:

- Wiskerchen S: Billing basics for physician assistants and nurse practitioners. *J Med Pract Manage* 2004;19:175-178.
- Bever J: Podcast: Avoiding common billing pitfalls: Non-physician providers. SoundPractice.net (Visit: <http://www.soundpractice.net> to download).
- AAOS/KZA 2007 Reimbursement Course: Before and Beyond the Codes: How to Improve Your Business. Visit <http://www.karenzupko.com> for information and registration.

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HOW TO ORGANIZE A STATE ASSOCIATION

Margaret Vaughn, Illinois Surgical Assistant Association lobbyist

There are many benefits to having a state association. I am the current executive director and founded the organization in 1997 as a way for surgical assistants to have a voice at the state level. Because of this state association, Illinois was successful in becoming the first state in the nation to pass a Registered Surgical Assistant and Registered Surgical Technologist Title Protection Act. This law allows nationally certified surgical assistants and surgical technologists to obtain a license from the Illinois Department of Professional Regulation and has turned the market around in a positive way for insurance reimbursements in Illinois.

In order to motivate people to form a state association, they have to understand the many benefits.

Strength in unity at the state level

While it is imperative that surgical assistants belong to the national associations, it is the state legislature in the state capitol (not Congress in Washington, DC) that can help you with reimbursement and licensing issues. For example, the state senator from Peoria, Illinois, is not going to care about a few surgical assistants from Chicago, but if the same issue is being presented by the Illinois Surgical Assistant Association—suddenly it is perceived as pertaining to the whole state and is just not a “local problem” in someone else’s district.

Professionalism in the field.

Just as doctors, nurses, and architects in the state belong to their respective state associations, surgical assistants need to have a state presence in order to be perceived as legitimate players among other professions.

Fundraising capabilities

If viewed as a legitimate organization, a state association facilitates soliciting donations from surgical equipment companies and surgical assistants by offering them membership in the state association at corporate rates or as a regular member fees rather than just donating money.

Enhanced networking opportunities

Because of the emergency nature of the work and practice setting, it is often difficult to meet other surgical assistants outside of the employer environment. Having a state association provides an opportunity to network with colleagues and build relationships that could turn into career opportunities. While national conferences also provide networking opportunities because of the geographic distances between the attendees, the job leads may not be as practical.

Remaining updated about industry trends

A state association keeps members abreast of, and helps address issues, which are unique to your state such as insurance reimbursement, hiring practices, etc.

Now that you can see the benefits, you may be more motivated to form a state association. Here are some guidelines.

1. Keep overhead/time commitments down.

These days, everyone is busy and in your state members may have to travel a great distance to get together. A lot can be accomplished by taking advantage of free conference calling. You can find links to free conference calling by just looking on the Internet. For surgical assistants, Sunday nights have been a good time for conference calls.

2. Give them a title and get them involved.

In the beginning, the state association will probably start out with a small group of people willing to get this initiative off the ground—that’s all that is required, but you have to make them feel needed. Nothing adds prestige like a title. You don’t have to have formal elections in the beginning—just ask who wants volunteer to serve in what position (president, vice president, secretary, treasurer, and if there are people left over, appoint them Board members (or CE Chair, Legislative Chair, etc). Most states require three officers when filing articles of incorporation. Don’t think you need an attorney to incorporate. You can print off the forms online and mail them in, or if one of your assistants lives

in the state capitol, the forms can be delivered in person. It is a lot less complicated than it seems. Once the organization is off the ground and your membership has grown, formal elections can be held in the following year.

3. Be Inclusive.

It is totally unproductive to fight against members of your own profession. A state association is not an educational certifying body; it is more a political arm—and there is strength in numbers.



Julio Rodriguez-Florida, RSA; Ronnell L Showell, RSA; John Gennaro, Synthes; Constance F Czarnecki, CST,CFA, RSA; and William Price, RSA.

Open membership to any nationally certified surgical assistant. We have different membership categories and rates. For example, Independent Self-Employed Surgical Assistant Rate—\$150; Hospital Employed SA Rate—\$100; CT & Student Rate—\$25. We also have a Corporate Partner Rate of \$250 for surgical equipment

companies that includes a set of mailing labels for our association and free advertisement on our website and in newsletters. It might be valuable to consider an associate member rate for doctors and other supporters. Work with the national certifying organizations to get the list of their members in your state. The national organizations can either email you the membership list for your state, or if you send or email the material, they will distribute it for you.

4. Continuing Education Workshops.

Because continuing education is required, it is a great motivator to get people to meetings. If you would like to have a regular association meeting, provide continuing education speakers before or after the meeting to provide an incentive for people to attend. When we first got started, we were renting spaces at

hotels and conference centers. Then we found we could do it less expensively by holding meetings at hospitals and giving attendees meal vouchers for the hospital cafeteria for lunch (We provide continental breakfast and snacks). Attendees love this because they can get whatever they want to eat and we don't have to worry about vegetarian or special diet requests, plus it is more affordable than having it catered or served in a conference center or hotel. Outside of the cost of mailing and postage to advertise the workshop, our only cost is \$135 to feed breakfast and lunch to the attendees and the rest is profit.

5. Communicate

Even if they don't participate in events, your members need to hear from you throughout the year or they may not renew. We have two to three continuing education workshops a year. We have a group email list for everyone, and we also send out workshop flyers and membership applications through regular mail. When you mail out the continuing education flyers, make sure you include an update about the profession or association. Keep them informed throughout the year.

6. Have Fun.

Once a year, the Illinois Surgical Assistant Association organizes a holiday party for members and their families. This year we were at a bowling alley. It helps to build camaraderie, gives members a better chance to get acquainted in a relaxed setting and people really appreciate the fact they can bring their kids.



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AMERICAN CENTER FOR EXCELLENCE IN SURGICAL ASSISTING

The origins of this program can be traced back to the founder's training as a surgical technologist in the navy and his opportunity in 1989 to work in a surgical assisting agency in Denver, Colorado as a self-employed surgical assistant. At that time, no formal training for surgical assisting was available and most practicing assistants acquired their skills on the job.

The agency provided an opportunity for training that resembled an apprenticeship, because it last for one year and only one individual could participate. But that experience subsequently sparked the idea that a formal assisting training program could benefit many surgical technologists who were seeking to advance their skills and possibly earn more income. In addition, this training could provide graduates with high-level skills and result in a competitive edge.

Last year the program enrolled just 43 new students. Low enrollment figures have been attributed to a challenging economy and the need for CAAHEP accreditation. After recently receiving the CAAHEP accreditation, interest has grown and current projections estimate enrollment figures will reach between 100 and 120 annually.

Up to now, the main point of contact has been marketing to operating room personnel around the country but future efforts will involve a much more active relationship with surgical technologists and surgical technology students.

Most of the students enrolling in the program want a career advancement with increased income at the hospital where they are currently employed. Some are looking to have more responsibilities than handing instruments and are seeking more new challenges and

the chance to work more closely with their surgeons.

Some students had already been asked to assist by their employers or surgeons. Many students have the ultimate goal of starting their own freelance surgical assisting business or agency.

Presently, graduates have not required any type of jobs program. Most of the students have been enrolled by their employers or with their support, but the program is currently investigating establishing a jobs program in the near future.

The greatest challenge facing the profession at this time is lack of status and recognition in the industry. Many accredited surgical assistant programs are now available, convenient and affordable enough for working O.R. professionals. Dan Bump, CST, CFA, is the program director. The website is www.acesatraining.com.