

SURGICAL FIRST ASSISTANT RESOURCE GUIDE

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PREFACE

In the Association of Surgical Technologist Surgical *First Assistant Resource Guide*, a broad range of issues affecting the surgical first assistant (SFA) was presented. This guide focuses on related practice, reimbursement and business issues and endeavors to present information that will answer many of the basic questions regarding insurance reimbursement for non-physician SFA services.

There is no guaranteed step-by-step procedure, Current Procedural Technology coding, or modifier number that will automatically result in a favorably processed claim by the insurer every time. The policies of each insurance company may vary greatly in relationship to non-physician providers: some won't pay claims, some will, and among those that do, procedures and reimbursement levels may vary. Inconsistencies may even exist within the same company and its many offices around the country. One office of an insurance company may be very familiar with non-physician SFAs, and processing through those offices might be a relatively easy matter. Another office of the same company in a different part of the country may be totally unfamiliar with reimbursement for non-physician SFAs and may reject a claim simply because it has never seen a similar claim before. These offices may require you to provide much more follow-up information.

This guide will help you address some common questions and will serve as a valuable tool to educate and inform third-party payers about this rapidly evolving cost-savings practice. You also will find useful information on becoming credentialed by institutions as an SFA and obtaining professional malpractice insurance.

AST wishes to acknowledge the work of the following individuals who contributed to this guide: James Bell, CST/CFA; Bill Bresnihan, CST/CFA; Donna Henderson, CST/CFA; Dick Kellett, CST/CFA; Karyn Songer, CST/CFA; and Robin Szarmach, CST/CFA.

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I. Scope of Practice

Role Title

How employers determine titling or labeling the various OR roles may be a primary source of confusion not only for the insurance industry, hospital administrators, and the public, but for the practitioners themselves. Misnomers are known to occur in the use of the terms *surgeon's assistant*, *surgical assistant*, *first assistant*, or even *second scrub*.

Many believe the term *surgeon's assistant* should only be used in reference to a physician assistant (PA) either working in the employment of a surgeon or who works regularly in the operating room. Sometimes, this individual may be referred to as a surgical PA. Some in the PA profession might even argue that only those who have graduated from one of the PA programs providing more extensive surgical education should be titled as a surgeon's assistant.

Surgical assisting and first assisting deal specifically with the intraoperative assistant role and are terms more appropriately used interchangeably, although there are some important distinctions to be made. The broader of the two terms is surgical first assistant and generally encompasses tasks that are distinguished as (1) second assisting, such as holding retractors, suctioning and sponging the operative site, or applying dressings and (2) first assisting, such as providing aid in exposure, providing hemostasis (clamping or tying off bleeders), and suturing.

Some OR supervisors have inadvertently added to this confusion in nomenclature by resisting the use of the term CST *surgical assistant*. Because CSTs have been so closely associated with the previously described scrub role, the tendency is to think that the CST is working as *either* a CST (scrub role) *or* surgical assistant, incorrectly believing that an incongruity exists in the term or job title of CST surgical assistant.

In earlier documents developed by AST (such as the Job Description: CST Surgical Assistant), AST used the terms surgical assistant and first assistant interchangeably. Because of the need to distinguish between these terms, AST now primarily uses the term surgical first assistant (SFA). This identifies the role as one dealing with first assisting tasks (not just second assisting) and clarifies this role as referring to an individual working in the operating room for the benefit of the public and others unfamiliar with the operating room.

While a single surgical assistant on a case may be performing both second and first assisting tasks, more complex surgeries may require both a distinct first assistant and a second assistant (sometimes even a third assistant is used). However, it is the first assisting aspect of the SFA role that generally requires the skills of a more knowledgeable and experienced CST, and for which the profession has been focusing its efforts on such projects as the development of the certifying examination and a curriculum.

The Role of the CST in the Operating Room

By virtue of both their educational (didactic and clinical) background and practical experience, certified surgical technologists (CSTs) working in the operating room function primarily in one or in a combination of the following three roles: surgical technologist in the scrub role, ST-SR, (the role of all entry-level CSTs and the role most CSTs continue to perform), circulating surgical technologist (a role in which far fewer numbers of

CSTs work), and/or the CST/CFA, certified surgical technologist/certified first assistant, the role generally requiring higher levels of continuing education and/or experience).

A description of the profession in the scrub, circulating, and assisting roles is presented in the *AST Recommended Standards of Practice*. These roles are also described in the *Standards and Guidelines of an Accredited Educational Program in Surgical Technology*, which provides a detailed outline of requirements for accredited surgical technology educational programs. The description in *Standards and Guidelines* is consistent with the Recommended Standards of Practice and is also significant because it reflects the official positions of the AST, the American Medical Association (AMA), the American College of Surgeons (ACS), and the American Hospital Association (AHA) in regard to the profession.

The approximate 270 accredited surgical technology programs in the United States provide the baseline knowledge and clinical experience for CSTs to function in each of these roles. As is the case in almost all professions, more complex tasks, functions, or procedures will be performed by individuals in the field who have acquired more experience and/or the highest skill levels. Such is the case with those CSTs functioning in the role of the first assistant (more often labeled the surgical assistant).

The Role of the First Assistant

As defined by the American College of Surgeons, the first assistant provides aid in exposure, hemostasis, and other technical functions that will help the surgeon carry out a safe operation with optimal results for the patient. This role will vary considerably with the surgical operation, specialty area, and type of facility.

Clinical Skills Performed Under Direct Supervision of Surgeon

1. Positioning the patient.
 - A. The surgeon shall convey the exact position that will give the best exposure for the surgical procedure. The surgical assistant will carry out this order. Consideration will be given to the patient's comfort and safety.
 - B. Points of pressure shall be padded: elbows, heels, knees, eyes, face, and axillary region.
 - C. Circulation shall not be impaired. (A tourniquet may be required for some procedures.)
 - D. Nerve damage shall be guarded against.
 - E. The temperature of the patient should be discussed with the anesthesia personnel and methods employed to maintain the desired temperature range.
 - F. The surgical assistant shall be familiar with common positions as they relate to the surgical procedure and will be able to use the equipment necessary to provide the position. Competencies will include the following:
 - (1) Fracture tables
 - (2) Head stabilizers
 - (3) Body stabilizers
 - (4) C-arm extensions
 - (5) Any other equipment needed
 - G. Upon completion of the procedure, the patient shall be evaluated for any possible damage from positioning, which shall include assessment of the skin. The abnormal condition shall be reported to the surgeon and treatment and documentation shall be carried out.
2. Providing visualization of the operative site by the following:

- A. Appropriate placement and securing of retractors with or without padding.
 - B. Packing with sponges.
 - C. Digital manipulation of tissue.
 - D. Suctioning, irrigating, or sponging.
 - E. Manipulation of suture materials (e.g., loops, tags, running sutures).
 - F. Proper use of body mechanics to prevent obstruction of the surgeon's view.
3. Utilizing appropriate techniques to assist with hemostasis.
- A. Permanent
 - (1) Clamping and/or cauterizing vessels or tissue.
 - (2) Tying and/or ligating clamped vessels or tissue.
 - (3) Applying hemostatic clips.
 - (4) Placing local hemostatic agents.
 - B. Temporary
 - (1) Applying tourniquets and demonstrating awareness of the indications/contraindications for use with knowledge of side effects of extended use.
 - (2) Applying vessel loops.
 - (3) Applying noncrushing clamps.
 - (4) Applying direct digital pressure.
4. Participating in volume replacement or autotransfusion techniques as appropriate.
5. Utilizing appropriate techniques to assist with closure of body planes.
- A. Utilizing running or interrupted subcutaneous sutures with absorbable or nonabsorbable material.
 - B. Utilizing subcuticular closure technique with or without adhesive skin closure strips.
 - C. Closing skin with method indicated by surgeon (suture, staples, etc.).
 - E. Other.
6. Selecting and applying appropriate wound dressings, including the following:
- A. Liquid or spray occlusive materials.
 - B. Absorbent material affixed with tape or circumferential wrapping.
 - C. Immobilizing dressing (soft or rigid).
7. Providing assistance in securing drainage systems to tissue.

The role of the CST surgical first assistant is described in the *AST Recommended Standards of Practice*. The multi-leveled job description is based on the premise that a CST in the first assisting role is performing at the same skill level as that of any other non-physician health care professional serving in that role.

ASSOCIATION OF SURGICAL TECHNOLOGISTS (1997) RECOMMENDED STANDARDS OF PRACTICE – FIRST ASSISTANT

The standards for the First Assistant: Entry-level roles were developed to offer guidance to surgical technologists functioning as first assistants in a variety of specialty areas. These standards are intended to be applicable whether employment is private, group, by physician, or by hospital or other institution.

First Assistant: Entry Level

The standards for the first assistant: Entry-level role were developed to offer guidance to surgical technologists functioning as first assistants in a variety of specialty areas. These standards are intended to be applicable whether employment is private, group, by physician, or by hospital or other institution.

Competencies

1. Demonstrates the principles of safe positioning of the surgical patient
2. Provides visualization of the operative site during the operative procedures
3. Demonstrates the proper techniques to assist the surgeon in providing hemostasis
4. Demonstrates the appropriate techniques to assist with the closure of body planes
5. Expedites the operative procedure by anticipating the needs of the surgeon
6. Demonstrates advanced knowledge of normal and pathological anatomy and physiology
7. Demonstrates knowledge of emergency situations
8. Demonstrates superior organizational skills
9. Demonstrates a professional attitude

Recommended Education and Experience

Credentialed by the LCC-ST as a certified first assistant with routes to certification as follows:

- CST with current certification and 2 full years of first assisting experience during the last 4 years with a documented 350 surgical cases
- CST with current certification who has completed an approved first assistant program and can document 350 surgical cases

First Assistant: Generalist

The standards for the First Assistant: Generalist role were developed to offer guidance to surgical technologists functioning as first assistants in a variety of specialty areas. These standards are intended to be applicable whether employment is private, group, by physician, or by hospital or other institution.

Competencies

1. Demonstrates the principles of safe positioning of the surgical patient
2. Provides visualization of the operative site during the operative procedures
3. Demonstrates the proper techniques to assist the surgeon in providing hemostasis

4. Demonstrates the appropriate techniques to assist with the closure of body planes
5. Expedites the operative procedure by anticipating the needs of the surgeon
6. Demonstrates advanced knowledge of normal and pathological anatomy and physiology
7. Demonstrates knowledge of emergency situations
8. Demonstrates superior organizational skills
9. Demonstrates a professional attitude

Recommended Education and Experience

- Credentialed by the LCC-ST as a certified first assistant with currency through documentation of 100 continuing education credits, 30 of which must be in the advanced category, within a 6-year time-frame as defined in the *AST Guidelines for Continuing Education*.
- Documentation of ACLS credentials

First Assistant: Specialist

The standards for the First Assistant: Specialist role were developed to offer guidance to surgical technologists functioning as first assistants in a specialty area. These standards are intended to be applicable whether employment is private, group, by physician, or by hospital or institution.

Competencies

1. Demonstrates all competencies required for the First Assistant: Generalist
2. Demonstrates advanced knowledge in the anatomy and physiology related to their specialty area
3. Demonstrates advanced knowledge in the surgical pathology and related procedures related to their specialty area
4. Demonstrates advanced knowledge of patient-care techniques related to their specialty area

Recommended Education and Experience

1. CST/CFA with currency
2. Associate degree in surgical technology or a related science or health science field, or 8 years of professional experience in the role of the first assistant
3. Documentation of a minimum of 150 surgical cases within the defined specialty area

4. Documentation or demonstration of other advanced-level expertise related to the defined specialty area
5. Documentation of ACLS credentials
6. Documentation as a professional provider of education to other surgical technology students, CSTs, CST/CFAs, or other health care providers.

The Role of the Second Assistant

A distinction should be made between first and second assisting. According to the *Standards and Guidelines*, the second assisting surgical technologist assists the surgeon and/or first assistant during the operative procedure by carrying out technical tasks other than cutting, clamping, and suturing of tissue. This role is distinct from that of the first assistant and may, in some circumstances, be performed at the same time as the scrub role. Duties include but are not exclusive to the following:

- a. Holds refractors or instruments as directed by the surgeon.
- b. Sponges or suction operative site.
- c. Applies electrocautery to clamps on bleeders.
- d. Cuts suture material as directed by the surgeon.
- e. Connects drains to suction apparatus.
- f. Applies dressings to the closed wound.

The *Standards and Guidelines* state, “This role [second assistant] is distinct from that of the first assistant and may, in some circumstances, be performed at the same time as the scrub role.”

While some individuals may identify themselves as first assistants, they may be primarily engaged in tasks associated with the second assistant role and are to a lesser extent engaged in first assisting tasks such as clamping, cauterizing or tying bleeders, and suturing tissue.

II. Formal Education

A committee was appointed to develop a formal SFA curriculum as a postgraduate program for experienced operating room professionals. The first meeting of the group was held in March 1991. Committee members reviewed existing programs and developed an outline for student eligibility requirements, curriculum content and suggested program length, and faculty and clinical preceptor qualifications. A preliminary draft of this curriculum was approved by the Board for distribution at the pre-conference Instructors Workshop and at the SFA booth in the exhibit area at the 1991 conference.

During three more meetings, the committee worked on the development of a core curriculum document similar to the core curriculum for entry-level surgical technology programs. These meetings resulted in the publication of the *Core Curriculum for Surgical First Assisting* in February 1993.

Program accreditation similar to the accreditation process for entry-level surgical technology programs is not yet available. However, AST has initiated an approval system for formal educational programs in surgical first assisting. The goal of this approval system is to recognize those SFA programs that are operating substantially in compliance with the educational standards developed by AST for this emerging profession.

RECOMMENDATIONS FOR FORMAL SURGICAL FIRST ASSISTANT PROGRAM DEVELOPMENT

AST Approval System for Surgical First Assistant Programs

AST has initiated an approval system for formal educational programs in surgical first assisting. The goal of this approval system is to recognize those SFA programs that are operating substantially in compliance with the educational standards developed by AST for this emerging profession.

The SFA approval system has been modeled after the present accreditation policies and procedures used to evaluate surgical technology programs. The major difference will be that the SFA approval process will be based solely upon careful inspection and review of documentation provided by the applicant program and will not include an on-site evaluation as is done with surgical technology accreditation. The rationale for developing the SFA approval system in a similar fashion to the surgical technology accreditation is to allow for an easy transition to a formal accreditation process.

SFA programs applying for AST approval will be required to be in relative compliance with the established minimum criteria, known as the Standards of an Approved Educational Program in Surgical First Assisting. The Standards address areas such as curriculum, faculty credentials, clinical opportunities, student and program evaluation methodology, admissions processes, learning resources, and financial resources. A minimum of two reader/reviewers will be appointed to review the SFA program applications. The reader/reviewers will be selected on the basis of -their knowledge of the SFA's role, their education, and their ability to be impartial in their review of the program under consideration. Upon completion of their review, each reader/reviewer will submit evaluations addressing his or her assessment of if and how the program has met each standard and any comments he or she feels are relevant to the review. Applicant programs will then be given an opportunity to respond to the readers/reviewers' findings. The final step will involve further review of all documentation by the AST Board of Directors, at which time a determination will be made on the approval status of the applicant program.

AST's SFA program approval will be granted for a maximum of two years to programs that have been deemed in substantial compliance with the Standards. At the end of the approval period, a program wishing continued approval status will be required to submit a new application. Interested program faculty and institutional administrators can obtain applications and other related materials by contacting the Accreditation Review Committee at AST headquarters, 303-694-9262.

SURGICAL FIRST ASSISTANT CURRICULUM MODEL

The following is an outline of the S FA curriculum model contained in the *Core Curriculum for Surgical First Assisting*.

The curriculum developed by AST and the first assistant certifying examination developed by the LCC-ST are not directly related and were developed independently from each other. The curriculum was developed based upon what a special committee of AST recommends be taught in formal educational programs that prepare students for the first assisting role. The exam was developed based on a job analysis of the actual current practice of CSTs serving as first assistants. Therefore, subject areas covered in the curriculum and exam may be different. Eligibility requirements are also different. Eligibility requirements for programs are determined by individual institutions, and the eligibility requirements for the exam were developed by the LCC-ST.

Description of Role

As defined by the American College of Surgeons, the SFA provides aid in exposure, hemostasis, and other technical functions that will help the surgeon carry out a safe operation with optimal results for the patient. This role will vary considerably with the surgical operation, specialty area, and type of facility.

These activities only will be performed as delegated tasks under the direct and immediate supervision of the responsible surgeon. The responsibilities of this training do not include surgical maneuvers of a surgeon, that is, non-physician assistants are not being trained to independently perform any surgical operation, major or minor.

Clinical skills performed under direct supervision of the surgeon may include the following: positioning the patient, preparing the skin, providing visualization of the operative site, utilizing appropriate techniques to assist with hemostasis, participating in volume replacement or autotransfusion techniques as appropriate, utilizing appropriate techniques to assist with closure of body planes, selecting and applying appropriate wound dressings, and providing assistance in securing drainage systems to tissue. (For details please refer to the AST Job Description: CST Surgical Assistant.)

Admission Eligibility Requirements

1. CST, certified nurse-operating room (CNOR), or physician assistant-certified (PA-C), with certification currency.
2. Three years of current operating room scrub and/or assisting experience within the last five years.
3. Eight semester credits or 10 quarter credits in anatomy and physiology within the last five years.
4. Proof of liability insurance.
5. Current CPR/BLS certification.
6. Acceptable health and immunization records.
7. Computer literacy.

Proposed Curriculum Length

This is intended to be a postgraduate advanced level course for experienced operating room professionals who wish to become SFAs. Because the student population is likely to be concurrently employed in an operating room or surgical environment, sponsoring institutions are strongly encouraged to offer the curriculum courses on an evening and/or weekend schedule.

The total of approximately 265 to 280 clock hours of lecture and laboratory time, as indicated in the suggested curriculum, could be arranged in several ways:

1. Approximately six to 12 weeks of 40-hour-a-week class time
2. Thirty-three eight-hour Saturdays (two semesters)
3. Twenty-nine weeks of three 3-hour evenings per week
4. Twenty-nine weeks of one 3-hour evening and one 6-hour Saturday per week

Another combination may be used as best fits the sponsoring institution and the student population.

Curriculum Content

I. Preclinical Didactic Course Content

A. Surgical Anatomy (100-120 lecture and laboratory hours)

1. Cells and Tissue
2. Embryology
3. Introduction to Pathology
4. Skull and Brain
5. The Eye
6. Face, Neck and Throat
7. Shoulder, Axilla and Breast
8. Upper Limb
9. The Back
10. The Thorax
11. Abdominal Cavity and Retroperitoneum
12. Pelvis and Perineum
13. Inguinal and Femoral Regions
14. Lower Limb

B. Perioperative Microbiology (10 lecture hours)

C. Surgical Pharmacology (20 lecture hours)

D. Anesthesia Methods and Agents (10 lecture hours)

1. Preparation Before Surgery
2. Intraoperative Considerations
3. Postoperative Management

E. Bioscience (21-25 lecture hours)

1. Wound healing (1/2-1 hour)
2. Understanding diagnostic tests (8-10 hours)
3. Care and handling of surgical specimens (1/2 hour)
4. Management of the critically ill patient (6 hours)

5. Thermoregulatory devices (1/2 hour)
 6. Fluid, electrolyte, acid-base, and nutritional balances (5-6 hours)
 7. Skin assessment (1/2-1 hour)
- F. Role Definition and Interaction (6-8 lecture hours)
- G. Ethical, Moral, and Legal Responsibilities (10 lecture hours)
- H. Fundamentals (34-36 hours lecture and demonstration; laboratory practice required will depend on class size, faculty, and facilities. Note: Times listed below are estimates for lecture-demonstration only and do not include practice or return-demonstration time.)
1. Monitoring devices (EKG pads, oximeters, etc.) (2 hours)
 2. Review of bladder catheterization (1/2 hour)
 3. Positioning the surgical patient (2-3 hours)
 4. Application of pneumatic tourniquets (1/2 hour)
 5. Skin preparation (1/2 hour)
 6. Drapes and draping (1 hour)
 7. Operative instrumentation (2 hours)
 8. Visualization techniques (2 hours)
 9. Hemostasis (4 hours)
 10. Suturing techniques (4 hours)
 11. Surgical wound dressings (2 hours)
 12. Drainage systems (1/2 hour)
 13. Postoperative pain control methods (1/2 hour)
 14. Special equipment (7 hours)
 15. Endoscopic surgery (4-5 hours)
 16. Transportation of the critically ill patient (1 hour)
- I. Complications in Surgery (8-10 lecture hours)
- J. Computer Applications for the Surgical First Assistant (2 lecture hours)
- II. Clinical Preceptorship (approximately 100-125 cases)
- The purpose of the clinical preceptorship is to provide training in basic surgical skills for SFAs in the areas designated here, under the direct supervision of the qualified preceptor, to be accomplished within an appropriate time frame. Students must be performing in the role of the SFA on these cases, and a statement of proficiency is required upon completion of each designated area. (It is not mandatory for the new graduate to be clinically proficient in the more complicated surgical procedures such as cardiovascular surgery and neurosurgery.)
- A. General Surgery
1. Minimum of 20-25 major open cases
 2. Minimum of 10-15 minor cases
- B. Orthopedic Surgery
1. Minimum of 20-25 major cases
 2. Minimum of 10-15 minor cases
- C. Peripheral Vascular Surgery
1. Minimum of 10-15 cases
- D. Endoscopic Procedures
1. Minimum of 10 cases to include a variety of endoscopic experiences
- E. Electives
1. Minimum of 20 cases from two surgical specialty areas
 - a. Pediatric surgery
 - b. Neurosurgery

- c. Hand surgery
- d. Plastic surgery
- e. Obstetric and gynecologic surgery
- f. Thoracic surgery
- g. Genitourinary surgery
- h. Trauma surgery
- i. Transplant surgery
- j. Ear, nose, and throat surgery
- k. Ophthalmic surgery
- l. Cardiovascular surgery
- m. Oral surgery
- n. Procurement surgery
- o. Others

Instructional Staff

- 1. Administrative Personnel
The program must have adequate leadership and management.
- 2. Program Director/Coordinator or Equivalent
 - A. Responsibilities
In addition to other assigned responsibilities, the director/coordinator of the educational program shall be responsible for the organization, administration, continuous review, planning, development, and general effectiveness of the program. The director/coordinator shall be sufficiently free from service and other noneducational responsibilities to fulfill the educational and administrative responsibilities indicated.
 - B. Qualifications
The director/coordinator of the educational program shall be qualified in terms of academic preparation, teaching abilities, and knowledge of the surgical environment and shall meet the educational standards for faculty as required by the institution.

Guideline

It is recognized that there are organizational differences and that the director/coordinator may not be an operating room professional; however, he/she should possess a working knowledge of the program's clinical activities.

- 3. Medical/Surgical Director
 - A. Responsibilities
The medical/surgical director shall provide continuous competent guidance for the clinically related program components and for clinical relationships with other educational programs. The medical/surgical director shall actively elicit the understanding and support of practicing surgeons.

B. Qualifications

The medical/surgical director shall be a licensed physician experienced in the type of health care services for which the student is being trained.

4. Faculty and/or Instructional Staff

A. Responsibilities

In each location where a student is assigned for didactic instruction or supervised laboratory practice, there must be a qualified individual designated to provide instruction, supervision, and evaluation of each student's progress in achieving program requirements.

Guideline

Instructors in didactic courses should be aware of the overall organization and objectives of the educational program and should be familiar with the outcome knowledge and skills expected of students in the clinical facilities.

A method should be established for providing adequate communication between the clinical affiliate sites and the sponsoring institution.

B. Qualifications

The instructors must be knowledgeable in course content and effective in teaching their assigned subjects.

Guideline

Instruction should be conducted by faculty who meet the educational and work experience requirements of post-secondary educational institutions. Programs should assure that all courses are taught by instructors having qualifications appropriate to the course being taught and that those instructors have current knowledge in that subject.

In securing qualified faculty, careful attention should be given to communication skills such as listening, interviewing, and counseling and a knowledge of behavioral sciences.

Instructors who have had no surgical first assisting experience may be qualified to provide didactic instruction in such subjects as anatomy, physiology, pathology, microbiology, and pharmacology. Programs should exercise care in selecting faculty for these subjects.

A faculty member who is teaching surgical first assisting didactic courses should be a certified surgical technologist (CST), certified nurse-operating room (CNOR), physician assistant-certified (PA-C), or physician/surgeon. The faculty member should have appropriate educational background and three years or more of current clinical experience as a surgical first assistant. Each instructor should be qualified to teach clinical skills and should be sufficiently free from non-educational

responsibilities to fulfill the instructional responsibilities required. In addition, the instructor should understand the teaching and evaluation methodologies being used in the total instructional process.

Current curricula vitae for the SFA faculty should be on file with the program.

C. Number

There shall be sufficient faculty to provide students with adequate attention, instruction, and supervised practice to acquire the knowledge and competencies needed for entry into the profession.

Guideline

The ratio of students to faculty will vary according to the learning objectives and teaching methods used in any given instructional period. Of principal concern is that the students receive not only the group and individualized instruction required to accomplish the defined learning objectives, but also that tutorial/individualized instructional opportunities should be available for students requiring assistance in attaining the stated objectives of the program.

Determination of faculty teaching loads should be consistent with institutional policy for other faculty.

5. Clinical Preceptors

A. Responsibilities

Clinical preceptors are responsible for understanding the content and the scope of the students' clinical preparation prior to the clinical practicum. Preceptors shall be responsible for providing clinical first assisting experience opportunities, evaluating student performance in an ongoing manner, informing the program director/coordinator about student performance that is less than satisfactory, and attesting to the level of student achievement during each rotation.

B. Qualifications

A clinical preceptor shall be a doctor of medicine or a doctor of osteopathy who has current surgical privileges at an appropriately accredited institution/health care facility. (An oral-maxillofacial surgeon who is a doctor of dental surgery may be utilized for a specialty rotation.)

The preceptor may utilize other health care professionals who are experienced in the provision of surgical patient care services.

III. NATIONAL FIRST ASSISTANT CST/CFA CERTIFICATION

A joint Board of Directors and Liaison Council on Certification for the Surgical Technologist (LCC-ST) Committee to study the feasibility of development of a certifying exam for surgical first assistants met in February 1991. This committee reported to the Board and LCC-ST at a pre-

conference meeting. On the basis of this report and further discussion and evaluation, the Board charged the LCC-ST to proceed with development of a certifying exam for SFAs. The first exam was offered in September 1992.

Development of the Exam

The national first assistant certifying examination was developed by the LCC-ST working in conjunction with The Psychological Corporation, an independent testing agency. Individuals participating in the development process were practicing first assistants, surgeons, subject matter experts, and instructors from across the country and representatives of the many different surgical specialties. The development consisted of several steps, the first of which was a job analysis, conducted by The Psychological Corporation in May 1991. A group of practicing SFAs met and identified the tasks that first assistants do in the performance of their jobs. These tasks were rated according to their frequency of performance and their criticality to the patient and/or surgical outcome.

The list of tasks that resulted from the job analysis was reviewed by two consultants, a practicing SFA and a surgical technology instructor. The consultants produced a list of knowledge areas and skills in which a first assistant must be proficient to perform the tasks listed in the job analysis. A group consisting of practicing SFAs and another surgical technology instructor reviewed the results, and the knowledge areas and skills were then ordered and grouped. The result was the content outline for the exam. This committee finalized the exam specifications, including assigning weights, or percentages, to each area or skill. Each area is represented on the exam according to these percentages.

After the content outline was developed, a third group of practicing SFA and educators wrote questions for the exam. These questions were then reviewed by The Psychological Corporation's editors to ensure compliance with standard question-writing techniques and format. The edited questions were viewed by several groups of practicing SFAs and educators as the next step in the developmental process. This review ensured that the content of the questions was accurate and relevant to the activities of first assistants and that each question had only one answer that was clearly and unequivocally correct.

The exam was constructed on the basis of the content outline, using the newly written, edited, and reviewed questions. The percentage assigned to each area on the content outline determined how many questions from that area appear on the exam. This test was reviewed by a group of six practicing SFAs and educators. The group reviewed the test to ensure that all the questions were relevant, did not duplicate each other, and properly represented the knowledge areas and skills on the content outline. Therefore, each question has been reviewed at least twice before it appears on the examination.

The passing score was recommended by a panel of practicing SFAs who used a method called the modified-Angoff approach. In this method, each judge considers each question individually and makes a judgment about a probability that a minimally competent candidate who has at least two years of experience as a first assistant or who has completed an AST-approved first assistant program would answer the question correctly. For the very easy questions, the predicted probability of these minimally competent candidates answering correctly is high. For difficult questions, the probability is low. The overall passing score was then computed as the average of the predicted

probabilities for all individual questions. This panel recommended the passing score to the LCC-ST, which set the passing score. The passing score (expressed in terms of a scaled score of 300) represents the minimum level of knowledge that must be demonstrated to pass the examination.

Exam Information

For further information about the examination, please contact the Liaison Council on Certification for the Surgical Technologist at 1-800-707-0057 or review the web site at www.lcc-st.org.

Current Eligibility Requirements

The current eligibility requirements established by LCC-ST® are:

1. Current certification as a CST/CFA®. Note: application for eligibility review and the verification of first assistant experience must be accomplished in time to test BEFORE the current CST/CFA® certification expires; OR
2. A Certified Surgical Technologist (CST®) with current certification and two years of first assistant experience during the last four years. The LCC-ST defines two years of first assistant experience as having done first assistant tasks, as specified on the “Supervisor’s Experience Verification Form,” on a minimum of 350 cases. Therefore, an applicant must have done first assistant tasks for at least two years during the last four years and on at least 350 cases to be eligible for this exam; OR
3. A Certified Surgical Technologist (CST®) with current certification who has completed a First Assistant Program approved by the Association of Surgical Technologists (AST), provided he/she meet the minimum documentation requirements established by the LCC-ST® for first assistant surgical case experience.

LCC-ST® retains sole authority to establish eligibility requirements and make all final decisions regarding eligibility.

First Assistant Certifying Exam Content Outline

The National First Assistant Certifying Examination is designed to test first assistants with at least two full years experience. The questions are based on the following outline (percentage of questions indicated in parentheses for each section) as it applies to various surgical areas. While the greatest emphasis will be on the intra-operative tasks performed by first assistants, questions covering pre-operative and post-operative tasks of first assistants will also be included. The examination will include questions from the surgical areas listed on the following pages. The greatest emphasis is on the general, gynecological and orthopedic surgical areas.

Surgical Areas:

1. General
2. Genitourinary
3. Gynecological/Obstetrics

4. Neurosurgery
5. Ophthalmology
6. Orthopedic
7. Otorhinolaryngology
8. Plastic and Reconstructive
9. Thoracic
10. Vascular
- I. Surgical Patient Care (15%)
 - A. Evaluation of Diagnostic Results
 1. Lab values
 2. Radiologic results
 3. Pathologic results
 4. History, Physical, Medications, Allergies
 - B. Patient Transfer Principles
 - C. Catheterization Techniques
 - D. Positioning and Draping Principles
 1. Surgical positions
 2. Equipment
 3. Safety
 - E. Surgical Hazards and Emergencies
 1. Patient emergency
 2. Universal precautions
 3. Environmental (e.g. fire, electrical, humidity)
 4. Equipment
 - F. Legal Aspects of Surgery (e.g. consents, limitations, negligence)
 - G. Patient Communication
 - H. Monitor OR Environment (Personnel and Physical)
- II. Usage of Surgical Equipment, Supplies and Medications (10%)
 - A. Surgical Equipment
 1. Electrosurgical units
 2. Tourniquets
 3. Endoscopes
 4. Microscopes
 5. Video equipment
 6. Power equipment
 7. Lasers
 8. Other, including specialty equipment
 - B. Supplies: Types and Usage
 1. Implantable devices
 2. Dressing materials
 3. Casting materials
 4. Draping (equipment)
 - C. Surgical Pharmacology
 1. Classification
 2. Action and use
- III. Surgical Anatomy and Physiology (20%)
 - A. Body Systems

1. Integumentary system
 2. Skeletal
 3. Muscular
 4. Nervous
 5. Sensory organs
 6. Endocrine
 7. Blood
 8. Cardiovascular
 9. Lymphatic
 10. Respiratory
 11. Digestive
 12. Urinary
 13. Reproductive
- B. Surgical Pathology
1. Fractures
 2. Trauma
 3. Malignancies
 4. Obesity
 5. Criticality
 6. Other conditions
- C. Tissue Assessment
- Wound Types
- a. Wound classification
 - b. Incisional
 - c. Traumatic
- Tissue Types
- a. Connective
 - b. Epithelial
 - c. Muscle
 - d. Nervous
- D. Surgical Principle of Wound Healing
1. Types
 2. Phases
 3. Influencing factors of wound healing
 - a. Condition of patient
 - b. Wound type
 - c. Operative technique
- IV. Surgical Skills (55%)
- A. Instrumentation
1. Types
 2. Usage
 3. Function
- B. Principles of Tissue Handling
1. Halsted principles
 2. Tissue manipulation methods (e.g. manual vs. mechanical)
 3. Traction/countertraction
 4. Types of dissection (e.g. sharp and blunt)

- C. Facilitation of Operative Exposure
 - 1. Methods of exposure
 - 2. Manual vs. mechanical
 - 3. Suction
 - 4. Sponges/packs
 - 5. Illumination
- D. Hemostasis
 - 1. Effects on hemodynamics
 - 2. Methods
 - a. Clamping
 - b. Ligation
 - c. Use of electro-surgical unit
 - d. Tamponade
 - e. Topical/pharmacologic
 - f. Ligaclips
 - 3. Blood and fluid replacement
- E. Suturing
 - 1. Suture material
 - 2. Stapling devices
 - 3. Suturing technique
 - 4. Suture instrumentation (e.g. needles)
 - 5. Knot tying
 - 6. Tension while following
 - 7. Suture cutting
- F. Insertion, Placement and Securing of Drains
 - 1. Purposes
 - 2. Types
 - 3. Functions
 - 4. Methods of securing

Certification Period and Recertification

By passing the exam, the CST first assistant may use the title certified surgical technologist/certified first assistant (CST/CFA) during the six-year period that the certification is valid. Once certified as a first assistant, the individual's CST certification period will be adjusted to coincide with the CFA certification period.

Currently, CST/CFA certification renewal can be accomplished only by:

1. Receipt of verification from two surgeons or surgical supervisors, both of which document that you have functioned as a first assistant on at least 350 cases and for at least to years during the six years of your certification period; AND
2. Meeting ONE of the following options:
 - A. Provide proof to LCC-ST of having completed 100 continuing education credits that meet the requirements of LCC-ST (currently AST Categories 1-3 with at least 30 in Category 3 and not more than 10 in Category 2) during the six-year period of your certification and pay the recertification processing fee; OR
 - B. Take and pass the CFA certifying examination before the expiration date of your certification.

Renewal of certification as a CST/CFA automatically renews CST certification. If desired, the CST/CFA may renew only the CST portion of the certification at the end of the six-year period by meeting the CST renewal requirements.

Revocation

LCC-ST has the right to revoke the certification of any individual based on the LCC-ST Denial/Revocation Policy. Such policy may be changed by LCC-ST at its sole discretion at any time. LCC-ST has and reserves the sole authority to make all final decisions regarding the eligibility for and granting, denial, maintenance, suspension, or revocation of certification.

(CST and CFA are federally registered certification marks owned by the Liaison Council on Certification for the Surgical Technologist.)

IV. CONTINUING EDUCATION

CST/CFA Continuing Education Credit Processing

To renew certification currency, CST/CFAs must earn a minimum of 100 credits within a six-year period: 30 credits must be earned in category III. For complete information, refer to the *AST Guidelines for Continuing Education*.

CONTINUING EDUCATION OPPORTUNITIES

AST has a number of educational opportunities available to SFAs at its national conference each year. AST chapters and regions also offer educational programs. For information on chapter and regional workshops, consult the “Upcoming Programs” section of the *Journal* or call the Education Department at AST headquarters.

V. Credentialing Process

Whether self-employed or physician-employed, an individual must proceed through a credentialing process to obtain privileges to practice as an SFA at each institution. Even if you are an employee of the institution, you should be credentialed at that institution to ensure that your first assisting role is recognized in writing by the facility.

During this process, a credentialing committee reviews your experience and educational preparation to determine if you possess the level of knowledge and skills required to practice as an SFA. You must submit documentation to the committee, including an application form, and you should be prepared to be interviewed and to pay a fee (see following sections). The committee has the authority to approve or deny practice privileges based on whether you meet the criteria for SFA practice that have been established at that institution. If the committee grants its approval, final approval may be granted by the head of the surgery department. This approval means that you have been granted practice privileges for defined SFA functions at that facility.

The institution may choose to place restrictions on the tasks that nonphysician SFAs can perform, or it may grant privileges extending to the full limit allowed by regulatory law in that state. In other words, the institution can be more restrictive in what it allows SFAs to do, but not more expansive, than applicable state regulations. If you are working for a surgeon or are self-employed, you may be granted privileges to work as an SFA only for those surgeons to whom you have contracted your services.

It is important that the hospital has guidelines in place that recognize the practice parameters of the SFA. Such guidelines delineate the tasks for which you have been granted privileges; you must be very careful not to perform tasks that you have not been given privileges to perform.

1. Ensure that the hospital bylaws reflect the role of the non-physician SFA practicing in the operating room. If the hospital bylaws do not acknowledge this type of provider as a valid member of the OR team and a lawsuit occurs, the SFA could be found in direct violation of the bylaws. This matter probably would be resolved, but it is best that the role of the SFA be reflected in the bylaws. The executive offices of hospitals maintain the bylaws, and you should ask to see the portion that pertains to SFAs in the operating room. If SFAs are not included in the description, you should follow the appropriate process to amend the bylaws. Although this can be a lengthy process, it is one that is to your benefit to pursue.

2. Ensure that a job description is in place. If you are performing a task that is not delineated in a job description, you may be held liable if a problem occurs. To the CST's job description, add a list of specific first assistant tasks or assist the hospital in writing a separate job description, using the *AST Recommended Standards of Practice*.
3. If you are an employee of the facility, verify the hospital's liability coverage. While you should carry your own insurance, it is important to learn the extent to which the hospital will support you if problems arise. This information can be obtained from the OR supervisor. If you are self-employed, you must have your own coverage.
4. Complete the credentialing process and ascertain that all pertinent credentialing information is contained in your file.

Credentialing Documentation Format

When seeking surgical first assisting privileges, you must be able to document your qualifications and credentials for review by the appropriate credentialing committee. In addition to documenting education, experience, and training, securing a physician sponsor is advantageous to any CST or CST/CFA seeking surgical first assisting privileges.

General and Personal Information

In addition to listing employment history, educational information, and references, the following general and personal information should be included in a resume:

1. Name
2. Office address and phone
3. Home address and phone
4. Date of birth, place of birth, and citizenship
5. Social security number and marital status
6. Sponsoring surgeon (employer)
7. Nature of affiliation (i.e., SFA specialty section)
8. Specialty area (orthopedics, cardiovascular, etc.)
9. Results of physical examination
10. Photograph

Certification

Include a copy of your certification showing the date issued, and have the name, address, and telephone number of the certifying body (i.e., Liaison Council on Certification for the Surgical Technologist).

It is recommended that you have been a CST for a minimum of 2 years and have CST/CFA status.

Health Status

Be able to document the date of your last complete physical examination and include a statement addressing your general health status; any drug or alcohol problems should be included. Many institutions now require tuberculosis testing and hepatitis B vaccination.

Professional Liability Insurance

Document your present liability insurance carrier and the amount of coverage. Include statements on general topics as whether you have been involved in a malpractice suit or have had any judgments or settlements issued against you.

Educational Data

Include the following information about your educational background:

1. High school or equivalency, including copy of diploma and date of completion.
2. Undergraduate college or university, including copies of degrees and dates of completion.
3. Training programs, including copies of certificates and dates of completion.
4. Copies (in chronological order) of all continuing education certificates, such as AST national conferences, regional meetings, hands-on workshops, medical courses, etc.

Professional Affiliations

List your local, regional, and national affiliations, including dates of membership and offices held.

Employment and Institutional Affiliations

In chronological order, list all employment since graduation, including dates of employment and the names and titles of supervisors or other contact persons. (Expect that all prior employers and references will be contacted).

References

Include at least two professional references (one must be from a physician) and personal character references that include mention of your ethical, professional, and personal character and any direct observations of your clinical skills.

Clinical Privileges

A written job description specifically defining your duties should be provided by the sponsoring physician/employer. An alternative is the delineation of privileges form. This form identifies the skills required for the privileges that you are requesting and that you believe you possess through your training and experience (e.g., first assist, prep and drape, suture, apply dressings).

Interviews

Expect to be interviewed by the various department chairpersons or section chiefs, usually from the Department of Surgery, Department of Medical Staff, and the section chief for the specific department where you applied (e.g., orthopedics, cardiovascular, plastic surgery).

Application Fees

Application fees vary by state and institution. Some institutions do not have a fee for allied health professionals, while others may charge between \$150 and \$300. This fee usually is not refundable.

Malpractice Insurance

Securing professional liability insurance is an important concern for all surgical technologists, in particular for individuals who are self-employed or privately employed SFAs. National Professional Group Risk Management Services, Inc. (NPG), the profession's liability insurance company, provides discounted liability insurance to AST members who are certified as CSTs and who are institutionally, privately, or self-employed.

NPG offers a separate policy to AST members that provides coverage for those employed as surgical SFAs. For more information, contact AST, or NPG at 1-800-253-5486. Further information is also available online at www.ast.org.

VI. OBTAINING REIMBURSEMENT AS AN SFA

Tips for Developing a Successful SFA Practice

How you develop your SFA practice is limited only by your creativity, hard work, and determination. There are a number of ways that you can structure your practice, including the following:

1. Contract with individual surgeons, surgeon groups, hospitals, or outpatient clinics to provide your services. Your contract could include provisions to be paid on a per-case basis or to work on a retainer. Retainer status means that you are paid to be available on certain days in the event that your services are required.
2. Establish contracts with insurance companies and other insurer groups that enable you to negotiate set rates as a provider.
3. If working for a surgeon, negotiate a base salary as well as commissions that are based on the surgeon's successful billing for your services.

It is important that you invest your time and energy in building good business relationships with surgeons and others using your services. They must feel confident about your skills, sense of personal responsibility, and professional ethics.

When developing a practice, consider what area of surgery you most enjoy and in which you are most skilled. You must keep in mind that you want to specialize in procedures that reimburse for first assistant services and are not performed primarily on Medicare patients. If aligning yourself with a particular surgeon, consider whether that surgeon's practices consist of a high number of Medicare cases, which do not reimburse for non-physician SFA services. If this occurs, make arrangements with the surgeon or facility to be paid on a per-case or hourly basis.

Be aware that you will probably not receive reimbursement for every case you provide services. You may determine that the time and expense involved in obtaining reimbursement may outweigh the actual amount of reimbursement or that pursuing reimbursement may adversely affect your business relationship with a particular surgeon or facility. There will be circumstances when you will knowingly provide services for a patient and not be reimbursed, such as a Medicare patient, to maintain a good relationship with a surgeon or facility.

Medicare Reimbursement

While many SFAs who are either self-employed or privately employed have established reimbursement through numerous private carriers, only physician assistants (PAs), or surgical PAs, have successfully amended federal legislation to allow a reduced level of reimbursement (in comparison to physician reimbursement) for PAs serving as "assistants at surgery" under the Medicare system. The legislation also provides for the reimbursement of nurse practitioners and advanced-degree (master's level) clinical nurse specialists working in narrowly defined rural settings (see "Legislative Issues").

It is illegal for SFAs to gain reimbursement through Medicare Part B at this time. If any SFA presently bills or in the past has billed Medicare for first assisting, this individual has done so illegally. The only way whereby an individual can gain reimbursement is through billing as a physician, physician assistant, nurse practitioner, or clinical specialist. The penalties for illegal billing are very stringent. Individual states have been devising their own laws to deal with this illegal practice and can require guilty individuals to pay back all money illegally gained as well as serve prison time.

Worker's Compensation

Worker's Compensation policies vary among states, and you must check with your state office regarding its policies.

Reimbursement from Private Insurers

AST believes that institutions sometimes include an assisting fee in their bundled charges to the insurance company when assisting services are provided by an SFA employee of the facility or by an independent SFA contracted by the facility. It is potentially illegal for an SFA employed by an institution to bill insurance companies separately. Independent SFAs may contract their services to surgeons and/or facilities and are reimbursed by the surgeon, facility, insurance company, or the patient. Reimbursement, as stated previously, may be made directly to the SFA provider or indirectly through the surgeon, facility, or patient.

For physician-employed SFAs, it is reasonable to expect that fees for services performed by the SFA are billed within the framework of the physician's billing procedures, which are conducted by the physician's staff; consequently, this method is likely to be the most convenient and economical for the SFA. The SFA's earnings might be separately tracked and disbursed to the SFA after a fee for billing administration has been assessed by the physician. The SFA may elect to work for a fixed salary and the physician/employer retains any excess income. Conversely, if the SFA's annual reimbursement does not cover the expense to the physician of employing the SFA, the physician would be expected to absorb the difference.

Filing a Claim with an Insurance Company

Prior to filing a claim, it is important to establish a working relationship with the company you will be billing. The three main insurance plan types are indemnity (fee for service), preferred provider organization (PPO), and health maintenance organization (HMO) (see "Glossary" for description). If you are frequently providing services to PPO and HMO patients, you should consider contracting directly with those groups.

Obtaining a Provider Number

Obtaining a provider number is not required by all companies. The company may assign you your own provider number or may advise you to use your Social Security number or tax ID number. To obtain a provider number, fill out an application requesting to be designated as a provider. Contact the provider relations department of the insurance company to be sent an application.

Using the physician's provider number to obtain reimbursement is considered fraudulent by all insurance companies. However, check with each individual company because there may be circumstances in which the company may accept a single bill under the physician's provider number.

Getting Consent for Your Services

Prior to assisting on a procedure, make sure that the surgeon has informed the patient that a first assistant will be used. The patient's consent can be obtained either on the surgical consent form or a separate form designated for this purpose (see sample form in Appendix 1).

Knowing How to Code for Your Services

In order to code, you must have access to copies of the most recent editions of the CPT and ICD-9 (International Classification of Diseases-9th Revision) coding books. These books are available from a number of publishers, including the American Medical Association, and are revised yearly.

When coding a procedure that you have assisted, check with the surgeon to find out what codes the surgeon is using and use the identical code. Also, be aware that many insurance companies maintain their own bank of codes, including those that do not qualify for reimbursement.

Determining a Modifier Code

Select the CPT modifier code that most accurately reflects the services you provided. Again, it is important to work with the insurance company you are billing. There are no established modifier codes for non-physician providers that all insurance companies use; some companies have even created their own special modifier codes. Contact the insurance companies to find out what codes they accept.

Deciding What Amount to Bill

The amount to bill can be based on a percentage of the surgeon's fee. Deciding what amount to charge is your decision. AST does not endorse any particular percentage and does not advise SFAs on what amount to bill. Some SFAs charge the same percentage for all procedures or vary the rate according to the procedure being performed or the insurer being billed.

When deciding what amount to bill, consider how your billing rate may affect your marketability. One of the advantages for non-physician SFAs in today's market is their ability to provide cost-effective services. Charging the same percentage as an MD first assistant could diminish this advantage.

Procedure for Filing a Claim

The following is the procedure to file a claim.

1. Obtain the necessary patient information. Much of this information can be found on the hospital's patient admission form (also called a face sheet). Develop a patient information

form that can accommodate the following data: patient's name, address, telephone number, date of birth, and social security number; insurance company's name, address, and telephone number; insured's name, social security number, and date of birth; insured's employer, address, and telephone number; insured's ID number and group number; patient's relationship to insured; and the name of the hospital where surgery was performed.

2. The following additional information is needed: date of service (actual date surgery was performed), physician's name, name of assistants on the case, the diagnosis established prior to surgery, any and all procedures performed, the scheduled starting time (or time the SFA arrived if after scheduled time), the actual starting time and ending time, and the assistant assignment (i.e., the SFA was first assistant). (It should be noted that second and third assisting services are not reimbursable.)
3. Assign an account number for the patient and enter the patient information into an automated or manual tracking system.
4. Determine the proper CPT and ICD-9 codes to be used. Most companies require that you use the same CPT and ICD-9 codes that the surgeon uses.
5. Use the CPT modifier code that most accurately reflects the services that you provided.
6. Use the appropriate provider number, tax ID number, or Social Security Number.
7. Collect all the information and the charges and fill out the HCFA 1500 form (see sample form in Appendix 1). Submit this form to the insurance company along with a copy of the operative report, which you can obtain either from the hospital or from the surgeon's office. Ensure that the operative report mentions that you first assisted on the case. A letter is also sent to the patient informing the patient of the charges and whether the insurance company has been billed (see sample letter in Appendix 1).
8. If no response is received from the insurance company within 35 days, contact the company and request a confirmation of when payment can be expected. Make note of the name of the individual with whom you spoke and the dates of this and any future contact made with the company; this record is placed in the patient's file.
9. If the insurance company denies the claim, contact the physician to obtain a letter of necessity (see sample letter in Appendix 1) to submit to the company. Include a letter of appeal (see sample letter in Appendix 1) as a cover letter (see the following section).
10. If no response is received from the insurance company in 60 to 90 days, send a new claim with a note stating that this is a claim resubmission.
11. Determine what aging schedule to apply to the account and whether you want to bill the patient (see "Billing the Patient").

How to Appeal or Dispute a Claim

A payment denial results when an individual or insurance company refuses to make payment on a claim. Reasons for this include the company's rejection of a particular procedure code or the failure to acknowledge nonphysician SFAs. The insurance company should be contacted to verify the type and extent of the patient's coverage. The patient or other responsible party may be contacted to facilitate the reimbursement process by serving as liaison between the SFA and the insurance company. However, such assistance may be difficult to arrange since the patient may not fully understand the services that were provided during surgery.

Claims submitted to an insurance carrier usually generate a response within 45 to 60 days. Upon receiving a claim denial, the SFA must submit a written appeal within a given period of time, generally 10 to 20 days.

Ideally, a written appeal includes the following items:

1. A letter of appeal requesting payment reconsideration.
2. A copy of the original claim.
3. A letter of necessity from the surgeon.
4. A copy of the operative record, including an explanation of the procedure and any applicable drawings.

When the insurer receives this information, it will review the information and notify you of its decision within 30 days.

Billing the Patient

The subject of fee collection for SFA services is one of the most difficult and sensitive issues faced by the SFA. It must be emphasized that the collection method you employ can profoundly affect how you are viewed by your clients (such as surgeons) and your peers. Misuse of this business tool can adversely affect the livelihood of the SFA. You may choose to accept only the reimbursement given by the insurance company, or you may choose to bill the patient. If billing the patient, strongly consider working with the patient to negotiate what amount the patient is willing to pay and on what timetable before resorting to a collection agency.

Handling Delinquent Accounts

Account age is considered in increments of 30, 60, 90, or 120 days. Monthly statements can be sent informing the patient that the account has not been paid, although telephone contact can be much more effective than sending statements. Patients who demonstrate a conscientious effort to make payments, however small an amount, are allowed to continue to do so without harassment.

Accounts that carry a delinquency of greater than 120 days, and on which several contacts by telephone and mail have been made eliciting no response, may be referred to a collection agency if you choose to do so. At this point, the initial collection notices are sent to patients, which are followed by a final notice that clearly outlines what steps will be taken to collect the debt, such as referring the account to either a professional collection agency or an attorney or filing a claim in small claims court.

Prior to referring the account to an external agent, review the account in detail to ensure that your chronological record of attempted collection efforts is complete and well documented. Any correspondence that occurred during the ongoing attempt to notify the claimant of payment due must be documented and preserved.

It is extremely important to keep the surgeons' offices advised of any patient accounts that have been turned over to a collection agency or resulted in litigation.

Hiring a Collection Agency

The pursuit of delinquent accounts may anger your referring surgeons; therefore, the ramifications of this activity must be carefully weighed before proceeding. Only those accounts bearing evidence of having a strong chance for full collection should be referred to an agency; the remaining accounts are written off as a loss.

You can use a collection agency or hire an individual to provide an "in-house" collection service. Prior to hiring an individual collector, his/her integrity must be ascertained; an oversight in this area can prove time-consuming and costly. In the case of a collection agency, make sure that you carefully check the agency's insurance policy to verify that the agency and its employees are insured against theft and dishonesty.

Most states have review boards or commissions that monitor the activities of its collection agencies and serve as valuable sources of information. The SFA can contact the state government for assistance in this area.

Securing a Billing Service

The results of effective billing practices are the lifeline of the SFA's business; therefore, the careful selection of a billing service is of the utmost importance.

Finding a Billing Service

Preferred sources for information on billing services include physicians, especially surgeons, individual surgical assistants, or members of related groups, such as anesthesiologists. These professionals can be asked what service they utilize, whether their experience with the service has been satisfactory, and why this is true. Other questions may include how long they have used a particular service, the reasons for terminating a relationship with a service, and whether they have had any negative experiences with other services.

Listings for billing services can be found in the telephone book under "billing services" or "medical management." Ads can also be found in professional journals such as *The Surgical Technologist*.

Interviewing a Prospective Billing Service

Any verbal assurances made by the billing service representative during the initial interview must be verified as existing in written form as well, either in the company's guidelines or bylaws.

Request that the company provides you with at least two references (current clients of the service). A clearly outlined working relationship between you and the service would include your own stipulations, for example, that the service must notify you of pending delinquent accounts or its intent to send accounts to collections and that any plan by the service to instigate an aggressive action toward an account is authorized by you in advance. Such matters can negatively impact your business if not thoroughly discussed and agreed upon at the beginning of the relationship.

The following are important points to be addressed during the interview:

1. Examine what features of the service favorably set it apart from others. One such feature is the ability to access instantly a file on a given account at any time to determine its exact status as a result of a telephone inquiry by you.
2. Ascertain the degree to which the service takes an interest in learning the particular aspects of the SFA's business. The importance of such interest cannot be overemphasized: billing methods employed for nonphysician assistants are specialized, and unless the company has a history of serving SFA clients, the billing statistics it provides as proof of performance may only be applicable to its physician clients.
3. Determine if the service is available upon demand, that is, whether you can expect immediate response in the event that problems or questions arise. The existence of this important feature will have direct bearing on your selection of a particular service over another.
4. Determine the kind of attitude the service holds towards insurance companies, patient relations, and collections; ultimately, this perspective can affect your standing with surgeons and others within your professional network. It is imperative that you cultivate a non-aggressive approach in regard to the collection methods employed by the chosen service; otherwise, a decline in the number of surgeon requests for your services may become evident.
5. Discover the average length of time that the service requires to achieve recovery on accounts; the national average is 120 days.
6. Determine the service's level of success in appealing and resubmitting claims. This information can be verified with the client references whose names were provided during the initial interview. The prospective billing service is required to explain in detail all procedures and guidelines governing the appeals process and, if possible, provide you with literature outlining this process.
7. Determine the service's procedure for disputing claims. You must be continually apprised of the status of appealed claims. Significant decisions on the handling of such claims must have your prior approval.
8. Examine the written agreement for its clarity of content. A description of how the company communicates with its clients and a specific listing of services provided the SFA are required.

9. Analyze the service's fees. Billing service fees (billed monthly) are usually based on a percentage of total collections and can range from 8% to 15%. Selecting a billing service requires careful research with an eye for economy; however, it should be remembered that a less expensive service may not be able to provide the desired level of quality in its performance. Make sure that you have been fully informed of all fees that may be assessed.
10. Other items that should be discussed are (a) the service's length of time in business, (b) accessibility (computerized, availability of CPT/ICD-9 specialists, fax service, and toll-free 800 telephone number), (c) assistance with obtaining a federal tax ID number, and (d) payment disbursement methods (e.g., insurance checks forwarded to the SFA).

Percentage of Receivables Assessed by Service

An initial billing can represent 7% to 10%.

Standard Monthly Statements Issued by Service

The billing service should provide the following reports:

1. Accounts receivable report.
2. Monthly aging reports for all open accounts: production report reflecting charges, adjustments, and payments received.
3. Specialty reports that illustrate production graphs and provide referral sources.

Billing Service Expectations of the SFA

The billing service will expect the following from you:

1. Be an independent contractor.
2. Act solely as an SFA.

3. Obtain appropriate malpractice *insurance coverage* required by law in your geographical area.
4. Obtain a federal tax ID number (the billing office may obtain this for the SFA).
5. Provide the following items for each account: (a) face sheet, (b) operative report, (c) copy of insurance card, (d) copy of surgeon's charge sheet with CPT codes, and (e) statement listing your fees for services.

Reimbursement Questions and Answers

In the Government and Public Affairs office at AST, we receive many of telephone calls each month with questions regarding the reimbursement of CST/CFA and other SFAs for their services in the operating room. Reimbursement is a complex area, which varies as the SFA moves from insurance company to insurance company and geographic area to geographic area. Key to successful reimbursement in the long run for every SFA is a gradual building of relationships with physicians, hospitals, and insurance companies involved. The following are some of the more typical questions and answers we deal with on a daily basis.

Medicare (and to a large extent Medicaid)

Can I be reimbursed by Medicare or Medicaid for my services as an SFA?

- SFAs do not qualify for reimbursement as first assistants through Medicare at this time.
- For Medicare cases – many non-physician SFAs take these cases in the interest of maintaining a good relationship with the surgeon, who provides them with other cases, and write them off. Law prevents independents from billing Medicare patients for services not covered by Medicare.

Are RNs and PAs reimbursed by Medicare or Medicaid for their services?

- The only non-physicians eligible at this time for reimbursement as first assistant are Physician Assistants (PA), Nurse Practitioners (NP) and other narrowly defined advance practice nurses (APN). RN, CNOR, RNFA and CRNFA do not meet this criteria.

Does Medicare/Medicaid reimburse directly to the PA or NP?

- Medicare rules require that reimbursement be made to the employing physician/surgeon, not directly to the PA or NP

Private Insurer Reimbursement

Does XYZ Insurance Company provide reimbursement for non-physician SFAs?

- Policies vary widely from company to company – some reimburse non-physician SFAs and others do not. These policies also vary within companies from one geographic location to another, so that XYZ may provide reimbursement in Georgia, but not in Nevada.

What regions are best for reimbursement?

- In areas where non-physician SFAs have been traditionally utilized, it is more common for insurance companies to reimburse. This is also due in part to the fact that independent first assisting companies in these areas have expended considerable time building the business of and support for reimbursement in these areas. AST does not have data available at this time that would map out these areas.

How much should I charge?

- Because AST does not function as a union or bargaining unit, it is impossible for us to answer that question with a number. Some companies have fixed amounts that they will reimburse for physicians providing first assisting services. Many non-physician SFAs take the approach that the insurer is “incented” to accept the claim if you can demonstrate that they are being billed a lower rate than the physician would charge (1/2, 2/3, etc., of what the company would pay the physician). Others maintain that they are entitled to the same reimbursement as the physician first assistant.

What are other reimbursement options?

- Some free-lance or independent non-physician SFAs work on contract for the hospital at a negotiated hourly or per-case rate. This leaves the job of dealing with the insurers to the hospital itself.
- Others work on contract to the surgeon for a negotiated rate and leave the reimbursement negotiations with insurance companies up to the physician.
- Again – the independent non-physician SFA establishes strong relationships with surgeons and insurers, and files claims for services provided. Most independents realize that there will be a certain percentage of write-offs that they will have to withstand when an insurance company will not reimburse in order to maintain relationship with hospital/physician.
- When other routes have failed – some turn to the patient, who may have signed a form prior to surgery acknowledging responsibility for assisting fees not covered by insurance.

- Still fewer turn to the surgeon for payment – this may not be the best strategy in terms of long-term relationship with the surgeon.

***Note: It should always be made perfectly clear when dealing with hospitals or insurance companies that you are a non-physician surgical first assistant.**

What is AST doing?

Why doesn't AST work with all the insurance companies to get them to pay us?

- AST, on the advice of both legal counsel and many SFAs, has agreed that this may not be an effective tactic for AST to take. This is a fragile environment that may be best addressed by the interaction of the various market forces (insurers, hospitals, surgeons, independent practitioners, etc.).

Why doesn't AST initiate legislation requiring companies to pay an SFA for their services?

- While the various nursing groups have seen some success in using this tactic, it has been part of a broader nursing effort to pass legislation that will require reimbursement for a broad range of nursing services that include, but are not limited to surgical first assisting. AST has developed a model reimbursement bill of this type, which is available to members. It has been AST's position that seeking regulation of the profession in the form of licensure or registration (requiring certification as a condition of employment) is our highest priority, and a key building block to move ahead on the reimbursement front.

VII. LEGISLATIVE ISSUES

Status of First Assisting

The issues surrounding non-physician SFAs are complicated. Non-physician SFAs, whether a registered nurse (RN), PA, CST, or CST/CFA, are not specifically addressed in either HCFA's Conditions of Participation regulations or in the Joint Commission for Accreditation of Healthcare Organizations' (JCAHO) standards for accreditation. Specific legislation at the state level for all nonphysician SFAs is generally vague if it exists at all. Rather, the question of who may serve as an SFA appears to be addressed primarily at the institutional level with wide variances throughout the nation.

Generally speaking, CSTs acting as surgical first assistants are doing so under the delegatory authority of physicians, specific provisions for which vary slightly from state to state. The basis for CSTs serving as surgical first assistants is usually found in state medical practice acts or as rendered through the states' attorneys general offices. The underlying principle is that physicians/surgeons may delegate to nonphysicians those tasks normally carried out by another physician when performed under the direct supervision and in the physical presence of the physician, and the physician and/or employer has made a reasonable determination that the person to whom the tasks are to be delegated has the appropriate skills and knowledge to safely perform those tasks. This principle supports the discretion of the physician in determining who will assist and to what extent during the conduct of his/her case, as long as state laws or hospital policies are not violated.

AST has reviewed the medical practice acts and nurse practice acts, or their equivalents, in all states and concludes that when a CST is working in an operating room during a surgical procedure, the CST is working under the physician's delegatory authority. Certain states have issued opinion letters that may limit the practice of first assisting to an extent. Prior to entering the profession, it is recommended that the prospective surgical first assistant contact AST Headquarters at 303-694-9130 for advice on his/her particular state.

ACS Statement on First Assisting

It may also be helpful to review the official position statement of the American College of Surgeons (ACS) regarding the qualifications of the surgical first assistant in the operating room (American College of Surgeons *Statements on Principles*, revised 2/94). ACS states, "The first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The first assistant provides aid in exposure, homeostasis, and other technical functions which will help the surgeon carry out a safe operation with optimal results for the patient. This role will vary considerably with the surgical operation, specialty area, and type of hospital."

ACS supports the concept that "ideally, the first assistant to the surgeon at the operating table should be a qualified surgeon or resident in a surgical educational program approved by the appropriate residency review committee and accredited under the Accreditation Council for Graduate Medical Education." But while supporting this concept, ACS recognizes that "Attainment

of this ideal in all hospitals is recognized as being impracticable. In some circumstances it is necessary to utilize appropriately trained non-physicians to serve as first assistants to qualified surgeons. . .Traditionally, the first assistant's role in such institutions has been filled by a variety of individuals from diverse backgrounds. It is the surgeon's responsibility to designate an individual who is most appropriate for this purpose in keeping with the bylaws of the medical staff of the hospital.”

ACS addresses the other nonphysician first assistants in the operating room, including that, "...surgical technologists may function as first assistants in the absence of more qualified individuals. "

Medicare Reimbursement

The Omnibus Budget Reconciliation Act of 1986 authorized payments for physician assistants who serve as assistants at surgery if state law allows them to assist; these payments are limited to 65% of the amount paid to MD first assistants. The Reconciliation Act of 1990 reduced Medicare payment for physicians who serve as assistants at surgery from 20% to 16% of the primary surgeon's global fee. This act also authorized payments for nurse practitioners and clinical nurse specialists who serve as assistants at surgery in rural areas only, and only if allowed by state law. If an assistant at surgery is employed at a hospital and provides assisting services, Medicare payment for these services is reflected in the DRG per-case amount that is paid for hospital services under Medicare Part A.

At this time, the Health Care Financing Administration (HCFA) has not developed a definition of an assistant at surgery. In February 1991, a statement defining a qualified assistant at surgery was cooperatively drafted by the American Academy of Physician Assistants (AAPA), Association of Operating Room Nurses (AORN), and AST. The statement was submitted to the Physician Payment Review Commission (PPRC) for its consideration while it was studying Medicare reimbursement of assistants at surgery. The PPRC had been asked by Congress to study a number of issues relating to assistants at surgery, including the necessity and appropriateness of using assistants, the appropriateness of payment, and the level of payment.

Representatives from AAPA, AORN, and AST drafted the statement with the intent to maintain consistency in reimbursement policies by providing reimbursement to nonphysicians for providing the same services that are customarily reimbursable to physicians.

The definition of a qualified assistant contained in the statement is consistent with the AST House-approved *Recommended Standards of Practice*. The forms of the education or training referred to in the statement include a formal education program, continuing education, preceptorship, or any combination of these methods. It is recommended that successful completion of the Certified Surgical Technologist/Certified First Assistant examination administered by the Liaison Council on Certification for the Surgical Technologist be required as a prerequisite for employment as a first assistant.

Before making its recommendation, the PPRC considered three options: (1) a return to the reimbursement policies in force before the 1986 Omnibus Budget Reconciliation Act, which would not only eliminate the possibility of reimbursement for CSTs and RNs, but withdraw reimbursement to PAs; (2) maintenance of the status quo, which would leave reimbursement intact

for PAs but exclude CSTs and RNs; or (3) open reimbursement to all qualified nonphysicians (CSTs, RNs, and PAs) on the basis of “equal pay for equal work.”

In April 1991 in its annual report to Congress, the PPRC recommended no changes in the current policy regarding payment for nonphysician surgical assistants.

The PPRC stated that,

While the Commission is troubled by further extensions of fee-for-service payment under Medicare Part B, it is also concerned with the inconsistent treatment of physician assistants and other nonphysician practitioners under current law. Although the Commission considered recommending the elimination of fee-for-service payment for surgical assistance by PAs, it concluded that this option might disrupt current practice arrangements and, therefore, must be further explored.

Therefore, at this time, it is illegal for non-physician SFAs to bill Medicare for their services under any circumstances.

Researching Your State Regulations

The following sources are available for those wishing to access rules, regulations, or statutes that could affect the duties performed by SFAs.

State Statutes

State statutes can be found in any public library. Always check the supplements for recent changes. These statutes may be easily found online at www.ast.org under the heading “Government Affairs.” This web site provides easy access to individual state web sites. Medical Practice Acts are generally found under the “Professions and Occupations Code” of each state.

Hospital licensing data can be found in the directory for statutes.

Regulations

The regulation of hospital licenses is enforced by the Department of Health and Human Services (HHS). HHS documents may include a section on hospital staffing. Information on contacting the Department of Health and Human Services is listed under the federal government section in the telephone directory.

Medical practice is regulated by the Board of Medical Examiners. The state Board of Medical Examiners, listed in the telephone directory under state government, can be contacted for further information. Again, one may also wish to utilize the AST web service at www.ast.org for further information.

For more information, or if problems exist, the best place to obtain an opinion or gather additional data is through the Attorney General's office, which is listed in the phone directory under state government.

AST OFFICIAL STATEMENTS ON FIRST ASSISTING

Position Statement on First Assisting Adopted by the House of Delegates, 1988

As defined by the American College of Surgeons, the first assistant provides aid in exposure, hemostasis, and other technical functions that will help the surgeon carry out a safe operation with optimal results for the patient. This role will vary considerably with the surgical operation, specialty area, and type of facility.

The Association of Surgical Technologists, Inc., recognizes the first assistant and scrub technologist roles are differentiated by education. First assistants must be educated in the use of surgical instruments on tissues versus the handling of instruments.

Certified surgical technologists with additional specialized education or training may function as first/surgical assistants to the surgeon at the operating table in those situations or facilities where more completely trained assistants are not available.

Practice privileges of those acting as first/surgical assistants should be based upon verified credentials reviewed and approved by the appropriate credentialing committee.

Footnote: The second assistant retracts and suctions.

Position Statement on Reimbursement Adopted by the House of Delegates, 1991

The Association of Surgical Technologists' House of Delegates supports the principle that when a CST provides the same service that is customarily reimbursable to another health care professional, the CST also should be eligible for that reimbursement.

SFA Reimbursement Resolution Adopted by the Board of Directors, 1993

Whereas, The CST and CST/CFA provides first assisting services;

Whereas, The Liaison Council on Certification for the Surgical Technologist provides certifying examinations;

Whereas, The non-physician first assistant receives reimbursement by some third parties;

Whereas, the CST and CST/CFA recognize their limitations and abilities; therefore, be it

Resolved, That the CST and CST/CFA receive reasonable and ethical fees for their services.

VIII. SETTING UP AN SFA BUSINESS

To set up your own business, you must be willing to invest a significant amount of time in educating yourself regarding how to run a business successfully and on legal and other requirements. It is paramount to recognize the vital importance of knowledgeable legal and accounting advisors. Obtaining advice from these professionals is a sound investment. There are a number of decisions you will have to make in structuring your business that can not be easily changed. Taking the extra time to set up the new corporation properly will enhance its stability for years to come. The following will give you a brief overview of some aspects to consider when setting up your business.

When setting up your business, you must make certain decisions regarding incorporating (i.e., S-corporation or C-corporation), being on a cash or accrual basis, registering the corporation, obtaining a tax identification number, and establishing relationships with legal and accounting advisors.

To register the corporation, contact the department of your state's government that oversees corporations. Most states require submission of articles of incorporation under the corporation's name. Articles of incorporation are one to two pages in length and outline the rules by which the corporation will function. The articles also name the officers and in some cases incorporate a company seal. There is usually a one-time filing fee, followed by a biannual renewal fee.

Additional information can be obtained through the state department that controls trade names. A trade name is a subgroup functioning under the corporate group, which allows a totally different function to exist under the same corporate name, i.e., the SFA may decide that his/her surgical assisting company will also sell medical supplies or provide billing and wants to obtain a trade name.

Registering the corporation name or trade name can be accomplished by contacting the state Department of Revenue. This is true regardless of whether the SFA has a sole proprietorship or a corporation. An affidavit must be filled out and registered with the state. Upon completion of the appropriate paperwork, a registration number is assigned. This allows for a prospective customer to check that the SFA is in fact whom he/she states. A minimal fee is usually associated with registering a company.

Obtaining a tax identification number may be accomplished by ordering the appropriate forms from the Internal Revenue Service. Upon receipt of the completed forms, the IRS will assign a tax identification number. The corporation uses this number to pay any federal or state taxes. Hospitals and insurance companies will use this number as a means to track their accounts payable disbursements.

Tax Withholdings

If you are self-employed, you are expected to pay the following taxes.

1. State income tax: A percentage required by each state based on estimated earnings and reported quarterly.
2. Federal income tax: Estimated reports and payments made quarterly based on earnings.
3. In addition to federal and state income taxes, self-employed SFAs are required to pay social security taxes. Consult your financial advisor for details.

FUTA (federal unemployment tax) and SUTA (state unemployment tax) are not applicable.

Organizing the Office

To manage effectively the continually increasing volume and complexity of information that an SFA must track, your office must be adequately equipped and organized. Listed here are several items that you should consider having in place prior to offering your services.

1. File cabinets, with room for expansion.
2. Availability of a copying machine. Easy access to or ownership of a copier is absolutely necessary.
3. A billing address other than the home address. An alternate address, such as a post office box, allows the SFA to maintain privacy.
4. A daily record of all surgeries performed, mileage traveled, future surgery dates, etc. This can take the form of a small book or log or as data stored in a computer.
5. A spreadsheet or patient account ledger, in either paper or computer form, including all data pertaining to each patient's account. The patient's name, account number, date of surgery, procedure performed, fees charged and to whom, account balance, name of hospital where services were provided, etc., are examples of necessary information.
6. Availability of a fax machine. Although not required, a fax machine is quite useful in allowing immediate communication with other parties without the delays associated with the postal service. The fax machine allows efficient communication with the offices of surgeons, insurance companies, and others.
7. A computer. The use of computers in the SFA's business is highly recommended and while it is true that initial costs are significant, the time saved through their use renders them cost-effective. The ability to rapidly produce billing statements, statistical information, addressed envelopes, letters, and other information is a valuable asset.

Accounts Receivable

The financial success of the SFA, as with any other business, depends largely upon the effective management of accounts receivable.

Utilizing either a computerized or manual system for records management in a home-based office requires the SFA to maintain a constant vigilance over accounts receivable. It is only through a practice of careful monitoring that the SFA can obtain a clear picture of the status of his/her business. As the client base and profits increase, the danger in losing control over accounts receivable becomes very real and failure to observe and act upon such trends can be detrimental to the financial success of the SFA.

Data and statistics generated as a result of the SFA's accounting practices are useful in allowing sound decisions to be made concerning the current and future direction of the business. For example, collected data can reflect that certain surgical procedures do not result in frequent or sufficient reimbursement for the SFA, thereby leading to an analysis of whether to continue providing that particular service.

Manual Tracking

Manual tracking is a system that is best employed in the early stages of a business, when patient numbers are low and the total volume of paperwork is still manageable. This system is inexpensive and effective; yet, its inherent flaw is the extensive time required not only to maintain it but also to analyze and manipulate the data produced.

Common to both the manual and computerized methods of managing accounts receivable is the need for an organized filing system consisting of at least two separate and complete alphabetical files, one each for accounts paid and unpaid. A separate manila folder designated for each patient contains the hospital face sheet, patient account number, copy of the submitted bill, and any pertinent data. This folder is filed alphabetically under the patient's last name in the appropriate paid or unpaid file.

A master patient account ledger is needed in order to monitor accounts receivable as a whole. This ledger contains, at a minimum, each patient's name, date of service, surgeon, hospital, insurance carrier, charges, and account balances. In its entirety, the ledger provides an overall picture of the SFA's business; additionally, the ledger generates statistics, such as which physicians utilize the SFA's services most often or which insurance companies pay in a routine manner.

In a manual system, an account ledger card is assigned for each patient and is placed in the "tickler" file upon completion and mailing of a claim. The tickler file is constructed to allow filing space by days of the year. Upon creation of a new patient account and the mailing of the accompanying claim form, the patient's tickler ledger card is placed in the tickler file space that corresponds to the number of days from the current date that the SFA plans to review the account and proceed with the appropriate action.

For example, if John Doe's bill was sent on January 1, this date would be entered on his account ledger card, which is placed in the tickler file in the space representing the 45th day beyond the date of the mailing of his bill (in this case, February 15). On February 15, John Doe's account would be examined as a result of the daily review of the tickler file and the appropriate action would be taken on his account. A description of any action taken would be recorded on the account ledger card and on the aging schedule. The card would then be placed in the tickler file in the space designated as that for subsequent review and action (typically in 30 days) or, in this case, March 15. This process is repeated until either payment is made in full or the account is referred to a collection agency or resolved in some other manner.

The patient ledger cards are contained in this tickler file system until each account is paid, after which the tickler card and the entire patient's file, including a copy of the check, is placed alphabetically in the paid file.

The aging schedule, which can be included as part of the master patient account ledger or maintained as a separate document, allows the SFA to ascertain the status of unpaid accounts and provides statistical data and trends for easy review.

Computerized Tracking

The employment of a computer system in the SFA's business is indispensable because it can reduce the hours of work ordinarily demanded of a manual system into minutes. The tasks composing patient accounts receivable management, such as maintaining the patient account ledger, printing claim forms, overseeing the aging of accounts, generating statistics, and word processing, become simplified and expedited. Depending on the needs of the business and the preferences of the SFA, the use of a computer may be limited to the performance of a few simple tasks or it may become the nucleus of the practice. Modern computer technology,

when used to its full potential, can eliminate the need for a file cabinet containing patient files. It can alert the SFA to the existence of delinquent accounts, decrease postal fees through electronic mail communications (indeed, some insurers already have implemented electronic claims filing), schedule surgical cases, send and receive faxes, and balance the SFA's business checkbook. As demonstrated, the uses to which a computer can be applied to serve the SFA are virtually limitless.

Computerized accounts receivable is now the standard in most physicians' offices. Once a surgical procedure is performed, the physician submits the appropriate code number for the procedure to the biller/insurance coordinator who enters this information into the office computer. A HCFA form is produced by the computer and sent to the patient's insurance company. After the insurance company completes its reimbursement, the remaining portion of the bill may be sent to the patient, if applicable.

With the multitude of advantages in computer use comes an entirely new set of problems, the first of which is the purchase price. A complete system including a printer and appropriate software is expensive, and the time and effort necessary to learn to use the particular software applicable to the SFA's practice can be daunting.

Significant progress in recent years has rendered computers more user friendly. Many programs feature built-in "help" programs to assist the learner, and most software manufacturers sponsor an assistance service via telephone for the benefit of computer users.

It is inevitable that the SFA will consider the value of a computer to the success of his/her business. A willingness to learn the basics of computer operation and seek the advice of friends who are knowledgeable about computers, in addition to purchasing instructional magazines or books, is necessary. The greater the SFA's understanding of and ability to utilize the power inherent in a computerized system, the more immediate a benefit to his/her business is realized.

IX. CONCLUSION

The profession of surgical technology will be facing many issues in the coming years. While it would be an overstatement to say that surgical first assisting will be the most important issue that the profession will confront in this decade, it does represent a critical juncture for the future of the profession and AST. Its importance is most obvious in terms of how recognition of the role of the CST broadens career opportunities for the profession.

To address surgical first assisting properly, AST is carrying out a coordinated effort to review opportunities for continuing education as well as the role that the formal surgical technology programs might play. There also are legislative, professional malpractice liability, credentialing, and third-party reimbursement issues that are being monitored with appropriate action being taken. The Board of Directors continues to monitor the issue on the basis of its potential impact on the entire membership to determine the extent to which AST can commit resources to a project that when viewed in its overall context (legal costs, volunteer and staff time, priority over other issues) may take considerable resources. The "what" of the issue--expanding professional career opportunities--is obviously important. But the "how" of the issue--building a consensus in the membership, coordinating our resources to address the educational, legal, and legislative questions--is just as important because it will in many ways speak to this Association's ability to tackle a complex issue and successfully deal with it.

AST believes that recognition of the role of the surgical technologist in surgical first assisting will be beneficial to the entire membership. As in the case of circulating, and perhaps more so, it will potentially increase career opportunities for all surgical technologists and at the same time answer charges that they cannot be utilized flexibly in a variety of roles. Unlike circulating, which many may view as a lateral move, first assisting is more widely viewed as providing an "upward" opportunity.

Surgical technologists--including the nonmember SFAs who came from among the AST membership yet no longer think of themselves as "techs"--must unite together and find the best solutions for the benefit of everyone who works or hopes to work in the future as a SFA.

The review of educational, legal, liability, and reimbursement issues contained in this publication underscores the need to adhere to high educational and credentialing standards that will best serve the interests of the profession and the public.

APPENDIX 1: SAMPLE LETTERS AND FORMS

Sample Consent Form

ABC Medical Services, Inc.
Anywhere, USA 00000
(000) 123-4567

CONSENT FORM

I, _____, have been informed by my physician,
_____ MD/DO, that at the time of my surgery a
surgical assistant from ABC Medical Services, Inc., will be present.

The surgical assistant will be present to assist on a _____ procedure
to be performed on the date of _____.

I understand that I am responsible for any fees not covered by my insurance company.

Signed: _____

Witness: _____

Date: _____

INSERT HCFA 1500 FORM

Sample Billing Letter to the Patient

**ABC Medical Services, Inc.
Anywhere, USA 00000
(000) 123-4567**

Dear _____,

ABC Medical Services, Inc., is a corporation that provides surgical first assisting services.

You recently had a surgical procedure performed at _____ hospital on the date of _____.

At the request of your surgeon, _____, MD/DO, ABC Medical Services, Inc., sent _____, a surgical first assistant, to assist on your surgery.

Your insurance company has been billed for our services. You will be responsible for any fees not covered by your insurance company. We will be happy to answer any questions you may have.

We hope that you are on the road to a speedy recovery.

Sincerely,

ABC Medical Services, Inc.

Sample Letter of Necessity

Office (000) 123-4567

Fax (000) 765-4321

*Mark T. Whelan, M.D.
2000 West Main Street
Dayton Beach, Florida 32122*

April 10, 2000

Surgical Assistants Services
PO Box 3000
Daytona Beach, FL 32120

RE: Mahnborg, Eric

To Whom It May Concern:

Eric Malmborg underwent ACL reconstruction of his right knee, as well as a partial lateral meniscectomy, on 11-1-1999. This required the assistance of surgical assistant services. I believe that it was medically necessary for an assistant to be present during this type of reconstruction of the knee.

If you have any further questions, please do not hesitate to contact me.

Sincerely,

Mark T. Whelan, M.D.

MTW/lrs

Sample Letter of Appeal

January 15, 2000

(Name, Title)
(Department)
Blue Cross Blue Shield of Tennessee
801 Pine Street
Chattanooga, TN 37402

RE: Claim #535590303
Harold Gordon Smith
Our File No. 153

Dear Mr/Ms (Name):

Cherilynn Andrews, CST/CFA, is a professional, non-physician surgical assistant. She is considered to be an "allied health professional." This individual responds at the surgeon/hospital's request to perform surgical first assistant duties.

The Certified Surgical Technologist/Certified First Assistant (CST/CFA) credential is recognized nationally by the American College of Surgeons (ACS) and the National Commission for Certifying Agencies (NCCA), as well as the medical staff offices of the institutions in which the CST/CFA practices.

According to the American College of Surgeons, the function of the CST/CFA is to provide aid in exposure and hemostasis, in addition to other technical functions that, under the surgeon's direct supervision, assist the surgeon in performing a safe operation with optimal results for the patient. Such variables as the type of surgical procedure, the specialty area, and the particular facility can affect the CST/CFA's role in surgery.

Surgical First Assistants (SFAs) are recognized as allied health professionals in the facilities in which they provide service. Each facility's Medical Staff Office and/or Credentialing Committee verifies the SFA's credentials and approves the assistant's privileges in the surgery departments; in some instances, this office may require that the SFA enlist the auspices of a physician sponsor.

As a general rule, MD assistants charge between 20 % and 30 % of the surgeon's fee for their services. By comparison, the CST/CFA charges approximately 12 % to 15 % of the surgeon's

(Name, Title)
Blue Cross Blue Shield of Tennessee
January 15, 1996

Page Two

fee. The lower fee charged by the SFA is one factor that renders this allied health care professional an attractive alternative in light of the every-rising costs of health care delivery.

Insurance companies are always in search of measures to reduce costs. The use of a non-physician surgical assistant represents a per-procedure savings of approximately 40% to 60% over that amount normally charged by a physician serving as first assistant.

SFAs provide services on a per-case basis, and these procedures can occur in elective or emergency cases. In the latter case, it often is impossible to identify payors or determine insurance coverage in advance of providing health care services.

Our position emphasizes, in the following points, the value of using---and thus providing reimbursement to---non-MD providers in the delivery of quality health care services: (1) they are cost-effective; (2) the facility ensures verification of the SFA's credentials; (3) the surgeon chooses to use this individual in place of an MD assistant; and (4) the surgical patient receives safe, high-quality services. We feel strongly that in providing these advantages over the use of physician assistants, the SFA is entitled to reimbursement from Blue Cross Blue Shield, thereby precluding the patient's receiving a bill for the first assistant's services.

Based on these facts, we wish to appeal the enclosed claim and request reconsideration of payment for the services rendered by the first assistant in this case. Enclosed is proof of Cherilynn Andrews' national certification as a SFA, as well as the operative report for the surgery in question. Please advise if further information is needed.

Sincerely,

Carol Myers
Office Manager

Enclosures

GLOSSARY

Aging schedule. A record of patient accounts reflecting payment dues dates, for example, 30, 60, or 90 days.

C-corporation. A separate legal entity that protects the personal assets of the shareholders (owners). In a C-corporation, taxes on earnings are paid by the corporation. Generally, any remaining income is paid to the shareholders and may be taxed a second time as dividend income.

CPT code. As defined in the *Physicians' Current Procedural Terminology*, CPT is "a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients, and third parties." CPT codes are used when filling out a HCFA 1500 form

Health maintenance organization (HMO): One of the most restrictive forms of health insurance coverage that usually does not provide coverage for medical services received outside of the HMO. HMO members generally pay a small copayment, usually \$10 to \$20, for all available services in the HMO. Types of HMOs include a "closed" clinic that employs its own health care providers or an "open" HMO in which the HMO contracts with health care providers to provide services at a fixed rate. HMO participants must have all care, other than emergency care, directed by a "primary care" physician.

An HMO attempts to control the costs of medical care by limiting the amount and type of treatment that an individual receives to that which is approved or recommended by the primary care physician or other HMO specialists. The HMO generally negotiates, through capitation payments, reduced rates from providers in exchange for an increased volume of patients.

HCFA 1500 form. The Uniform Health Insurance Claim Form, which is the standard form that health care professionals use to submit claims.

ICD-9 code. As defined in the ICD-9, "ICD-9 is an acronym for *International Classification of Diseases, 9th Revision, Clinical Modification*... a statistical classification system that arranges diseases and injuries into groups according to established criteria." This code also is required on the HCFA 1500 form.

Indemnity plan (fee for service). A plan in which the insured person generally is able to choose any qualified health care provider regardless of any network or physician group the provider belongs to. After a deductible has been met, the plan pays a percentage, usually 70% or 80%, of the eligible charge. Generally, the coverage (coinsurance) increases to 100 % after out-of-pocket expenditures of usually \$1,000 to \$5,000 have been paid by the insured. Eligible

charges are determined by the insurance company in its schedule of "reasonable and customary charges," and any amounts billed by provider that exceed this are disallowed.

Letter of necessity. A written statement from the attending surgeon attesting that an assistant was medically necessary. This document often is required when a claim has been denied because the insurer believes an assistant was not medically necessary.

Master patient account ledger. Either a computerized or manual listing of all outstanding patient accounts.

Modifier code. A number used after the CPT procedure code to indicate that a service or procedure has been altered by some circumstance, such as the use of an assistant or other procedure variables. These codes are found in the CPT code book.

Patient ledger cards. Card system used in a manual filing system in which cards listing individual patient accounts are created and placed in a "tickler file."

Preferred provider organization (PPO). A plan that incorporates some of the provisions of the indemnity plan, inasmuch as participants can choose any qualified medical care provider, but pay lower copayments or deductibles when they use providers within the designated PPO network.

The PPO generally consists of a network of health care providers that have contracted with an insurance company or employer to provide certain medical services at discounted rates in return for a guaranteed volume of patients. The PPO may or may not incorporate a yearly deductible, and participants pay a copayment at the time of service, usually \$10 to \$20 for office visits and other services.

Provider number. A number issued to a provider by an insurance company that is used in reference to the provider's account information.

S-corporation. A separate legal entity that protects the personal assets of the shareholders (owners). Generally, in an S-corporation, profits and losses flow through the corporation, without paying corporate taxes, to the shareholders who pay taxes on the income. Any losses that flow through the corporation are deductible by the shareholders in the year that the losses occur.

Tax ID number. A number issued by the IRS for tax reporting purposes. Some insurance companies may allow its use as a provider number. This is not the same as a personal Social Security number. It is also referred to as an employer identification number (EIN) and belongs to the company.

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