ASA NEWS
ASSOCIATION OF SURGICAL ASSISTANTS
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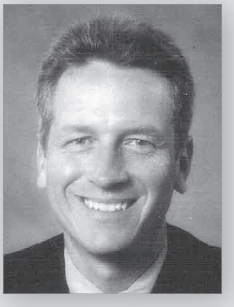
NEW DIRECTIONS FOR ASA

BILL BRESNIHAN, CFA, CSA, FAST, ASA PRESIDENT


Bill Bresnihan, CFA, CSA, FAST


Theresa Cooper, CFA, CSA


Kathy Duffy, CFA


Doug Hughes, CFA, CSA


Dennis Stover, CST, CSA


Valerie Thompson, CFA

First ASA Board of Directors Appointed

The first Board of Directors for the Association of Surgical Assistants was appointed on January 23, 2010, during a meeting of the ASA Advisory Committee. This transitional Board currently has three appointed officers and three appointed directors. The members of this Board include Bill Bresnihan, CFA, CSA, FAST, president; Dennis Stover, CST, CSA, vice president; Theresa Cooper, CFA, CSA, secretary/treasurer; Kathy Duffy, CFA, director; Doug Hughes, CFA, CSA, director; and Valerie Thompson, CFA, director.

What is ASA and Why Now?

The new member organization, under the ASA name, has membership open to the CFA, CSA, SA-C and other surgical assistants. We aim to promote the future of our profession for all surgical assistants. The CFA, CSA and SA-C are in competition with other providers of surgical assisting services, and the time has come to either thrive or perish! The ASA Board of Directors has chosen to make the profession thrive, and it takes dollars to do so. We must increase our national presence through legislative efforts to ensure our future! Lobbyists alone cost tens of thousands of dollars per year.

For years, the current ASA members have wanted to separate ASA

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from the AST. That also means that we must separate our finances from AST. AST has a $4 million annual budget, and we do not have one established yet, as we have no revenue. We must start somewhere and $200.00 is where we are at the moment.

Part of the difficulty in launching the new organization with only an $80 dues amount (such as AST's) gets down to the financial realities of trying to put together a meaningful organization of surgical assistants with very limited resources. For example, if we were able to attract 1,000 surgical assistants to join ASA for $80 that would work out to an annual dues revenue base of $80,000. In terms of being able to underwrite any kind of a state and federal government affairs program, not to mention other member benefits, would prove next to impossible. On the other hand, with a $200 membership fee, we can project a possible revenue base of $200,000, and that would enable us to provide a lot more for the ASA membership.

What ASA Members Will Receive

Below are some of the new benefits of membership:

1. Your membership will include surgical assistant professional liability insurance! (Many self-employed CFA, CSA and SA-C pay about $400 annually for coverage.)
2. Discounted CE offerings and other educational opportunities.
3. An ASA-branded credit card from Capital One, which will contribute to the ASA a very small percentage of all purchases made with it.
4. A quarterly newsletter for surgical assistants mailed to you.
5. A monthly E-News update on the activities of ASA.
6. Annual Meetings which will be separate from AST and will focus on issues related to surgical assistants.
7. Re-designed ASA web site with a members only portal where members can discuss issues and exchange detailed reimbursement and practice information.
8. Possible collaboration with national surgical assistant billing services.
9. Other benefits to be determined later.

Where ASA Stands Now—Time for Surgical Assistants to Become Involved

The establishment of the interim Board of Directors of the ASA is a part of the process leading up to May 2011, when the members of the organization (not the AST Board) will (1) formally adopt bylaws; (2) elect directors and officers; and (3) file the articles of incorporation following that meeting. Work will continue over the next year on the development of the bylaws (still subject to change). However, longer term, if the membership of the organization eventually determines these policies do not represent what the majority of members want or need, then the new Board of ASA will be able to re-visit the policies

Where Are the Bylaws?

The proposed Bylaws have been posted on the front page of the ASA website.

What's Next?

Join us in Texas at the ASA/AST National Conference. Our first business session is scheduled for Thursday, May 27, at 3 pm. We will be discussing bylaws, policies, elections and taking the beginning steps of this new organization. You will have an opportunity to be heard and your voice can affect the future of surgical assisting.

During the second business session on Saturday, May 29, a vote on the bylaws will occur and that will set the stage for the first formal open elections that will be held in San Francisco in 2011. For the first time ever, one organization is open to all surgical assistants to come and participate in the election process—even to become candidates.

We need your support and encourage all surgical assistants to step forward and create your futures. (See highlights of the the ASA Meeting agenda on page 8. Register online at www.ast.org. Click the conference logo.)

If you wish to receive this newsletter and are not currently a member of ASA, please send your mailing and email information to kludwig@ast.org.

MALPRACTICE INSURANCE FOR THE NONPHYSICIAN SURGICAL ASSISTANT

DOUGLAS J HUGHES, CFA, CSA, BAS

The medical world of today is far more advanced and complex. With the advent of new practices, techniques and treatments has come a greater legal responsibility to the patient. It is more important than ever for health care providers at all levels to protect themselves, their families, and their assets from financial disputes that may arise out of malpractice claims, whether alleged or the result of health care provider error, omission, or negligence. Legal and financial protection for health care professionals, such as physicians, nurses, surgical technologists, and non-physician surgical assistants is obtained in the form of personal liability/malpractice insurance.

Personal liability or malpractice insurance protects health care workers by providing them with legal and financial security in the event they are named in a lawsuit. Even in cases where the lawsuit is proven frivolous, thousands of dollars may be spent in defense of the provider. Liability insurance protects the interests of the insured and provides him or her with an attorney, coverage of all reasonable costs incurred in defense of the practitioner, reimbursement for lost wages, reimbursement for fees incurred from licensing disputes, court costs and settlement payments in addition to liability limits. If no insurance is carried by the health care provider named in the lawsuit, the legal costs incurred will be paid by that individual and can be financially and emotionally devastating.

While many health care providers are covered under an insurance program through their employer, these policies protect the interests of the company or facility, over those of the individual employee. Employer-provided liability coverage may not carry limits high enough to cover all of the defense costs and therefore may not protect the employee in the event of a lawsuit. Also, companies may in turn sue their employees to recover money lost in a suit, if the employee was deemed to be at fault. It is necessary for individuals to obtain additional coverage through personal liability/malpractice insurance to truly protect their interests and assets above those of the company they work for. Additionally, personal coverage protects medical personnel outside of the workplace such as volunteers, or in the event that a suit is filed and a provider no longer works for the company covered.

There are many companies that offer professional liability/malpractice insurance. The Association of Surgical Assistants recommends coverage through CM&F Group, Inc. and, beginning June 1, will provide this coverage to active members at no additional charge. The basic insurance package offered to ASA members through CM&F provides $1,000,000 in coverage per incident and $6,000,000 total per year (aggregate annual certificate). The average surgical first assistant in the US can generally expect to pay between $100 and $500 for this amount of coverage depending on whether they are hospital or self-employed, their state of practice, and the company from which the policy is purchased. The coverage available through CM&F Inc. offers substantial peace of mind and a wealth of security as a benefit of joining the Association of Surgical Assistants.

Personal liability/malpractice insurance is essential in today's complicated health care system. It is necessary for health care providers to protect their assets, families, and futures from claims made against them, even alleged claims. Insurance coverage above and beyond that which may be provided through -an employer provides individuals with an advocate and added security, so that they may be protected in the event that a malpractice lawsuit is filed against them. Therefore, it is imperative that practicing surgical assistants not leave their careers and futures to chance by neglecting coverage under a personal liability/malpractice insurance policy.

CYTOREDUCTIVE SURGERY, PSEUDOMYXOMA PERITONEI, AND HIPEC

TOM LESCARBEAU, CST, CFA

Cytoreductive surgery (CS) is a practice that has been around for sometime. Many surgical oncology procedures being performed use the basic principles of CS. The goal is to remove as much of the diseased tissue as possible, while preserving normal function of the targeted organ system. This formerly considered palliative treatment regimen has evolved over recent years with promising results. When CS is performed extensively in the abdomen, it poses a cascade of potential difficulties for the surgical assistant. A multi-specialty background is absolutely imperative. The surgical assistant must have experience with procedures involving gynecologic, gastrointestinal, endocrinology, and even thoracic cases when dealing with the disease described here.

A major risk for both the patient and the surgical team for this course of care is the handling of radioactive chemotherapeutic agents. One of the latest adjunct therapies used in conjunction with cytoreductive surgery is heated-intraperitoneal chemotherapy, or HIPEC. As we know from traditional surgical oncology and hematology, tumors can be excised or treated with systemic chemotherapy; radioactive drugs are infused over a period of time to target and destroy abnormal cells. Consequently, many normal cells are also destroyed in adjacent organ systems. This highly effective treatment regimen has many undesirable side effects including hair loss, nausea and vomiting. Many other side effects can be attributed to the systemic circulation of the drugs throughout the body. Each drug's potency is measured not only by the efficacy but the amount of time the drug remains in the body, or half-life.

HIPEC is different, because the drugs are heated and used topically to treat tumors that occur on the surface of organs and tissues. It is designed to treat specific tumors that are not embedded within deep tissues and are not accessible via traditional systemic circulation of chemotherapeutic drugs. The lack of traditional attachment of the cells is the primary reason for topical administration.

Pseudomyxoma peritonei, or PMP, is one of these types of cancers where cytoreductive surgery and HIPEC are indicated. PMP is a rare form of cancer with atypical presentation. The origin of the disease has been reported on several abdominal locations. The appendix is common, where rupture of the serosal layer causes mucin to be released. The mucinous material appears as a jelly-like substance and spreads throughout the abdominopelvic cavity, thereby being referred to as jelly belly. The disease slowly progresses and disseminates to any number of abdominopelvic organs.

"The term pseudomyxoma peritonei is literally interpreted as 'false mucinous tumor of the peritoneum.' It is most commonly applied to a slowly progressive disease process characterized by extensive mucus accumulation within the abdomen and pelvis. Such a broad definition allows both mucinous adenomas of the appendix and mucus-producing gastrointestinal adenocarcinomas to be included together under this term."[1]

The dissemination of the disease is a compelling factor that intrigues those that study it. The slow progression can be attributed to the inability of the abnormal cells to

attach and invade in the usual cancer-like fashion, thereby rendering the classification, in some cases, as benign and others as malignant. However, there seems to be common sites where the jelly-like material is found. These areas in the abdominopelvic region of occurrences include the right lower quadrant, appendiceal base, ascending colon, right subphrenic area, bilateral gutters, anterior gastric surface, omentum, mesentery, bilateral adenexa and perimetrium, culde-sac of Douglas, and retrovescicle space. In any event, removal of the abnormal tissue is indicated.

Treating PMP can be broken down into two distinct phases subsequent to diagnosis: (1) initial debulking of affected tissues and organs, or cytoreduction, and (2) infusion HIPEC. The primary procedural consideration is complete or partial peritonectomy during the debulking phase. The goal is initially to stay within the preperitoneal space during dissection, then removing the affected peritoneal tissue for pathological examination. This may involve the subdiaphragmatic regions bilaterally as well as the gutters. This poses a unique challenge for the team, and exposure can be difficult. Additional debulking may include any combination of interventions, such as a hysterectomy, salpingoophorectomy, cholecystectomy, partial colectomy, and small bowel resection. Surface debulking of the visceral peritoneum can also be extensive. Care to prevent enteric injury and vascular integrity is key.

The peritoneal cavity is then infused with chemotherapeutic agents that are heated to a temperature not conducive to cellular survival. The agents fill the abdominal cavity to ensure that all surfaces are exposed to the agent. The first cases reported used perfusion catheters and equipment used for cardiothoracic bypass procedures. This technique has given rise to manufacture of procedure-specific equipment by several companies. Four catheters are placed in the abdomen (inflow and outflow), and the abdomen is temporarily closed. Although there are varying reports as to the type of medication used for this process, Mitomycin C is commonly used. The drug is brought up to 42-45 degrees Celsius and continuously circulated within the abdominal cavity. This process continues for 90 minutes. The drug is then removed; hemostasis is achieved; a full count is performed; and the wound is closed in the usual fashion.

Perioperative handling of the medication has specific protocols that are similar to those of an oncology unit and must be followed. A common postoperative complication reported is pleural effusion. Chest tubes are placed as a precautionary measure to combat respiratory complications. The key to a good prognosis is early detection. Using CS and HIPEC has been reported as favorable in several studies. Patient selection continues to be paramount.

An understanding to the presentation of the disease and its behaviors provide the reader with facts that can prepare the surgical team members for critical surgical care. Due to the rare occurrences of disease where HIPEC is indicated, studies are somewhat fragmented and spread out over long periods of time. The research was pioneered in the US by Paul Sugarbaker, MD, FACS, FRCS, in Washington, DC, and has also been studied in France, Germany, Taiwan, UK, Japan, Denmark, Italy, the Netherlands, Belgium and Canada. This emerging treatment will also be described and published in an upcoming issue of *The Surgical Technologist*.

REFERENCES

1. Sugarbaker Oncology Associates. www.surgicaloncology.com. Accessed February 9, 2010.

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MEDICARE ASC PAYMENTS: 2010 AND 2011

BY KATHY BRYANT

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ASC payment rates are now set for the 3,482 procedures that Medicare will reimburse ASCs for providing in 2010. These rates were determined using the methodology that the Centers for Medicare and Medicaid Services (CMS) first used for the 2008 payment rates. In 2010, despite receiving an inflation update for the first time in six years, ASCs will see continuing declines in the payment rates for their highest-volume procedures and increased disparity between payment rates for ASCs and hospital outpatient departments (HOPDs).

HIGHEST-VOLUME PROCEDURES

For the third straight year, the Medicare payment rates for the highest-volume procedures have declined. For example, since the inception of the new payment system, the payment rate for CPT 43239, upper GI endoscopy with biopsy, has decreased 17 percent from $446 to $369.45. The chart shows the 2010 decreases in payment rates for the highest-volume procedures in ASCs.

INFLATION UPDATE

In calculating the 2010 rates, CMS included a 1.2-percent inflation update. Although higher than the 0.6 percent CMS used in calculating the proposed rates, the difference does not result from a change in policy. Rather, the inflation adjustment is based upon the consumer price index for urban consumers (CPI-U), and between the time the proposed rule was prepared and the final rule issued, the CPI-U changed. While ASCs appreciate that after publishing the proposed rule, CMS reevaluated this issue and adjusted the rates to reflect more recent CPI-U data, the fact that CMS continues to use the CPI-U, rather than the more accurate market basket measure it uses to set hospital inflation updates, is disappointing.

Since discussions of modifying the ASC Medicare payment system in the '90s, the ASC Association has advocated for using the same inflation measure for ASCs as is used for HOPDs. This measure would more accurately reflect the increases in ASC costs than the CPI-U. Furthermore, the Medicare Payment Advisory Committee (MedPAC) is providing some support by questioning whether the CPI-U measure is the right one. But, for the time being, the CPI-U continues to be the ASC inflation measure.

GROWING DISPARITY BETWEEN ASCS AND HOPDS

ASC payment rates will drop to 59.7 percent of the HOPD rates in 2010, a decrease of 31 percent since 2003. Even since the adoption of the new payment system in 2008, ASC rates have dropped from 62.7 percent to 59.7 percent of the HOPD rates. With the adoption of the new

CPT Code	Description	2010 Payment Rate	% Change
66984	Cataract surg. w/iol, 1 stage	$962.44	-.2%
43239	Upper GI endoscopy, biopsy	$369.45	-6%
45380	Colonoscopy and biopsy	$380.23	-5%
45378	Diagnostic colonoscopy	$380.23	-5%
66821	After cataract laser surgery	$234.03	-5%
45385	Lesion removal colonoscopy	$380.23	-5%
62311	Inject spine l/s (cd)	$295.98	-4%
64483	Inj. foramen epidural l/s	$295.98	-4%

payment system in 2008, there is a relationship between ASC and HOPD payment rates, but two big discrepancies remain.

As noted above, the inflation update for each system is determined independently. In 2010, the updates used for ASCs and HOPDs differ by about a percentage point. Additionally, in the first two years of the new payment system, the ASC payment rates were not updated for inflation while the HOPD rates were updated by 3.3 percent in 2008 and 3.6 percent in 2009. Using a more appropriate inflation update for ASCs would help to address this growing disparity.

Another reason for the growing difference in rates is that CMS is using different relative weights for ASCs and HOPDs. Using the new relative weights for HOPDs (including an adjustment to achieve budget neutrality), CMS further adjusts the relative weights before using them to calculate ASC payments. In 2009, CMS reduced the HOPD relative weights by 2.49 percent to obtain the ASC relative weights, and in 2010, the reduction was 4.33 percent.

Again, the ASC Association has objected to this secondary rescaling since its inception. In addition, the American Medical Association, the American Academy of Ophthalmology, the American Association of Orthopaedic Surgeons, the American Gastroenterological Association, the American Society for Gastrointestinal Endoscopy, the American Society for Therapeutic Radiology and Oncology, the Catholic Health Association, the American Society of Cataract and Refractive Surgeons, and the ASC Advocacy Committee and the Outpatient Ophthalmic Surgery Society have also opposed this secondary rescaling system.

ASC LIST

One advantage of the new ASC payment system is the regular update of the ASC list. In 2010, there will be a net increase of 79 procedures on the ASC list. In addition to adding newly created codes to the ASC list, CMS added 26 procedures that it had previously excluded. Although Medicare beneficiaries' access to ASCs is limited because CMS still excludes many procedures from the ASC list that ASCs regularly provide safely to other patients, having the list updated annually helps.

WHAT CAN WE EXPECT IN 2011?

The transition to the new Medicare payment system will be complete in 2011. In making the final transition, it's expected that payment rates will continue to move in the same direction they have gone since 2008. Once this transition is complete, the changes in payment rates from year to year will be much smaller. On the other hand, unless changes

are made in either the way the inflation rate is calculated or CMS agrees to use the same relative weights in ASCs and HOPDs, the discrepancy between ASC and HOPD payments will continue to grow. ASCs can expect quality-reporting requirements for

ASCs to go into effect in 2011. Since Congress gave CMS the authority to require ASCs to report quality data and reduce Medicare payments for ASCs that don't report, the ASC Association has been working to assure that requirements will be appropriate and reported information will be accurate and useful to consumers. To prepare for reporting,

ASCs can participate in the ASC Association's Outcomes Monitoring Project. This project includes financial, operational and clinical indicators for ASCs, including six developed by the ASC Quality Collaboration and endorsed by the National Quality Forum. Participating in the project allows ASCs to gain experience reporting this information and comparing their results to other ASCs before public reporting is required. For information regarding the project, go to www.ascassociation.org/outcomes.

Changes in ASC payments may also occur as a result of health care reform. The legislation passed by the US House of Representatives on Nov. 7, 2009 includes a provision that would reduce the ASC annual inflation update beginning in 2010 by a "productivity index." MedPAC argues that providers are encouraged to be more productive if annual payment updates are less than inflation. The discount off the inflation update is called a productivity index, which in 2010 is 1.3 percent. MedPAC recommended that Congress reduce annual updates for Medicare providers, including ASCs, by a productivity index.

Additionally, the healthcare reform legislation adopted by the House incorporated that recommendation. In fact, if the recommendation is adopted for 2010, ASCs will see a negative update,

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since the ASC inflation update is only 1.2 percent. The ASC Advocacy Committee and US Representative Kendrick Meek (D-FL) are actively opposing this 2010 adjustment. Although the current Senate version of health care reform legislation also includes a productivity adjustment, it wouldn't be instituted until 2011.

What's clear is that in 2010 and beyond, ASCs need to be active with the ASC Association and their members of Congress to ensure that legislators and regulators understand the impact that Medicare policies have on Medicare beneficiaries' access to healthcare. As government continues to consider health care reform, it needs to understand that if the goal is to provide high-quality, cost-effective care, ASCs are the answer.

Note: More information regarding the 2010 Medicare payment rates and policies, including all payment rates, is available at www.ascassociation.org/Medicare2010.

Kathy Bryant is President of the ASC Association. For more information about the ASC Association, please call 703.836.8808 or visit www.ascassociation.org.

Editor's Note: Although the current health care reform bills did not pass, these ideas are still under discussion and it's valuable information for surgical assistants to have and express their opinions regarding health care legislation to their respective legislators.

ASA 2010 MEETING HIGHLIGHTS
May 27–29, Gaylord Texan, Grapevine, Texas

May 27	
10 am–12:50 pm	Breast Cancer on the Edge
1–3 pm	Exhibits
3–4 pm	ASA Business Meeting (Discussion of bylaws and structure of new organization)
4–4:50 pm	Choice of six presentations
5–6 pm	The Congressman Will See You Now
	Opening Night Party
May 28	
9–11 am	Management of Brain Tumors
11 am–2 pm	Exhibits
2–6 pm	Choice of 32 education presentations
May 29	
8–10 am	Surgical Assistant Legislation and Public Policy Panel
10 am–Noon	Surgical Assistant Billing and Reimbursement Panel
2-4 pm	Robotically-assisted Pediatric Surgery
4-5 pm	ASA Business Meeting II
For a complete agenda and/or to register, visit www.ast.org/conference	