



Assistant surgeons' fees should be paid for almost all bunionectomy procedures

All of the following bunionectomy procedures qualify for payment of an assistant surgeon's fee: a cheilectomy procedure (28289), a Keller, McBride or Mayo procedure (28292), an implant arthroplasty procedure (28293), a tendon transplant (Joplin) procedure (28294), a metatarsal osteotomy procedure (28296), a Lapidus procedure (28297), a phalanx osteotomy procedure (28298), and a double osteotomy procedure (28299). The only bunionectomy procedure that does not qualify for an assistant surgeon is a Silver bunionectomy (28290). Who says all of the above bunionectomy procedures qualify for payment of an assistant surgeon? Medicare says so.

The Centers for Medicare and Medicaid Services (CMS), the unquestionable authority in setting payment standards for medical services, continuously investigates which surgical procedures reasonably require the services of an assistant surgeon. CMS has concluded, year after year, that the above procedure codes automatically qualify for payment of an assistant surgeon. In fact, an assistant surgeon for these procedures has been found so indisputably necessary that Medicare and Medicaid pay nation-wide for an assistant surgeon for procedure codes: 28289, 28292, 28294, 28296, 28297, 28298 and 28299 - without forcing the providers to prove necessity on a case-by-case basis. This statement is verified by the AMA publication: [Medicare RBRVS: The 2003 Physician's Guide](#), which lists all of the surgical CPT codes and indicates whether there is a restriction on payment of an assistant surgeon's fee for each procedure code.

The fact that Medicare pays for an assistant surgeon for a particular procedure code is incredibly strong evidence in favor of payment of an assistant surgeon's fee by the private insurance companies for that code. And yet, the private insurance companies continue to deny payment of assistant surgeons' fees for these bunionectomy procedures. How and why does this happen?

The "why" is easy. The for-profit insurance companies will do anything this side of legal to plump up their bottom line of profitability. The "how" is a little trickier, but here is the answer. The for-profit insurance companies purposely misinterpret a document published by the American College of Surgeons (ACS) in order to deny payment of assistant surgeons' fees. The most recent copy of this ACS document is titled: [Physicians as Assistants at Surgery: 2002 Study](#). This document is available at the American College of Surgeons website: www.facs.org.

In a nutshell, this ACS publication lists every surgical CPT code and has three vertical columns to the right of the vertically listed CPT codes. The first column has space for an X when an assistant surgeon is "almost always" used, the next column has space for an X when an assistant surgeon is "sometimes" used, and the third column has space for an X when an assistant surgeon is "almost never" used.

Unless there is an X next to a surgical procedure code in the first column indicating an assistant surgeon is "almost always" used for that surgical procedure code, the for-profit insurance companies refuse to pay an assistant surgeon's fee. The outrageousness of this conduct is best understood by looking at this entire ACS document in context. The very first page of text in the ACS Physicians as Assistants at Surgery: 2002 Study articulates the rule for insurance coverage of assistant surgeons' fees: "The decision to request that a physician assist at surgery remains the responsibility of the primary surgeon and, when necessary, should be a payable service." This ACS document stresses that the primary surgeon's decision must override the generic list of categories ("almost always," "sometimes," and "almost never") in the 158-page list of surgical procedures. The very first page of the Study goes so surprisingly far as to print the following statement in bold with additional capitalization of the word "NOT", directing that "...an indication that a physician would "almost never" be needed to assist at surgery for some procedures does NOT imply that a physician is never needed." This exact statement is then repeated another 158 times, on every page of the general list.

The ACS reiterated this position in a 2002 policy paper (1), addressing the effect of legislation on Medicare payment for assistant surgeon services, stating "The college believes that Medicare and all third-party payers should provide full reimbursement for services that, according to the professional judgment of the primary surgeon, are deemed to be medically necessary." The ACS could not be clearer that the general surgical categorizations must defer to the determination by the primary surgeon, no matter what the table suggests. The test for coverage remains whether the primary surgeon has decided that the assistant surgeon's services were medically necessary. This is unquestionably the national standard any insurance company must use in its payment determination.

In addition, the American Academy of Orthopedic Surgeons (AAOS) in a published position paper (2) titled: Reimbursement of the First Assistant at Surgery in Orthopaedics states, "The ultimate decision as to the need for a surgical assistant must remain with the operating surgeon. To do otherwise would jeopardize the quality of care."

Finally, the California Code of Regulations, Title 18, Section 1300.71 was passed into law because of the bad behavior of the insurance companies in California regarding claims settlement practices. This code section may be summarized to include the above cited authorities as follows: "The payment policies and rules of an insurance company shall be consistent with the standards accepted by nationally recognized medical societies and organizations (ACS), federal regulatory bodies (CMS), and major credentialing organizations (AAOS) in regard to reimbursement for assistant surgeons."

Therefore, the stated policy of the American College of Surgeons, the payment rules promulgated by the Centers for Medicare and Medicaid Services, the policy statement of the American Academy of Orthopedic Surgeons, and the applicable California statute regarding payment of assistant surgeons' fees overwhelmingly support payment of assistant surgeons fees for almost all bunionectomy procedures. We should fight for payment of every assistant surgeon's fee on all but Silver bunionectomy procedures.

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The documents described above can be found at:

Letter drafted by and distributed for American College of Surgeons, April 22, 2002
http://www.aans.org/legislative/aans/reimbursement/2002-04-02_MedPAC.pdf

American Association of Orthopaedic Surgeons Position Statement: Reimbursement of the First Assistant at Surgery in Orthopaedics- Document Number 1120 (Revised August 1988)
<http://www.aaos.org/wordhtml/papers/position/1120.htm>

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