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COMPLETING THE NPI APPLICATION

On the ASA discussion board, many postings have focused on inquiries related to the NPI application and how to correctly fill out the questions regarding the taxonomy code in Step 8. The following information has been provided to assist practitioners complete the required responses.

This information is not intended for certain audiences, such as RNFAs, CRNFAs,NPs, midwives or physician assistants. These providers have been assigned other taxonomy codes.

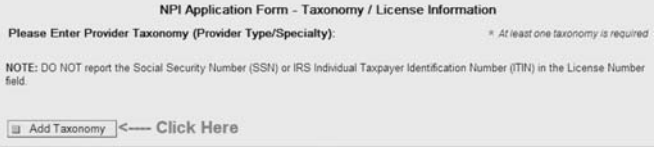
It is important to remember that your responses to the online NPI application cannot be saved if you need to research missing information for a question. Be sure you have the following data before you begin the application.

For Individual Providers	For Organizations
Provider Name	Organization Name
SSN** (or ITIN if applicable)	Employer Identification Number (EIN)***
Date of Birth (Provider)	Name of Organization's Authorized Official
State of Birth (if country of birth is US)	Phone Number of Organization's Authorized Official
Provider Gender	Organization Mailing Address
Mailing Address	Practice Location Address and Phone Number
Practice Location Address and Phone Number	Taxonomy (provider type)
Taxonomy (provider type)	Contact Person Name
State License Information*	Contact Person Phone Number and Email
Contact Person Name	
Contact Person Number and Email	

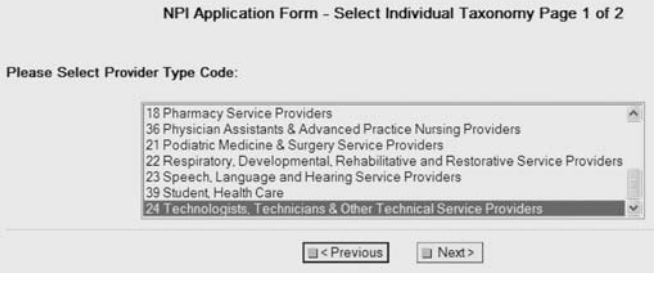
*Required for certain provider types only **Only provide this information in the SSN or ITIN field
***Do not report SSN or ITIN information in the EIN field

In Step 7: This does not apply to nonphysician surgical assistants. Click next to continue to the following screen.

In Step 8: Practitioners need to provide the taxonomy code or type of provider. At least one taxonomy is required to be added. Click on the button that shows *Add Taxonomy.* (Remember, do not report your Social Security Number or IRS Individual Taxpayer Identification Number (ITIN) in the License Number field.).



In Step 9: You will see a list of different types of service providers. Choose provide type code No. 24, *"Technologists, Technicians & Other Technical Service Providers."* Click next



In Step 10: In this screen, scroll down to where you see the following: *"246ZC0007X—Surgical Technologist, Other—Certified First Assistant."* Click on this response and continue to next screen.

(Note: if you are an LSA in Texas, an RSA in Illinois or a KYCSA in Kentucky, then you must complete the fields for License Number and State where issued.)

This information has been provided by Luis Aragon, LSA, RSA. Please visit *www.surgicalassistant.org* to download a complete pdf.

A NEW TWIST ON DISTAL BICEPS TENODESIS

CHERYL SHANK, CST, CFA

Distal biceps tendon rupture, an uncommon injury in the past, has received more attention recently. As a growing middle-aged population seeks to remain healthy and active, increased loads on the upper extremities, whether vocationally or recreationally, have resulted in greater numbers of this injury being reported.

What was once considered a weightlifter's injury, and a disfiguring one at that, might now be an injury that your grandparents sustain in their karate class, playing rugby, or mountain biking.

Related Anatomy and Pathology

The distal biceps tendon attaches to the radial tuberosity at the elbow. This muscle provides strength with flexion, as well as supination. A single traumatic event involving flexion against resistance at the elbow can cause a sudden tearing, or popping sensation, resulting in an immediate loss of strength. Left untreated, the patient can expect a 35% to 40% decrease in flexion strength, a 50% loss of supination strength, as well as a cosmetic "Popeye" deformity.

History

Over the years, several techniques have been developed to treat this injury, but with only marginal success, and the patient is at risk for many complications. Earlier operations tended to be nonanatomic, attaching the biceps to the lacertus fibrosis, or the brachialis muscle, to avoid the deeper dissections associated with anatomic repair. In 1961, Boyd and Anderson described a technique using two approaches. The anterior approach provided access to retrieve the tendon and pass it between the radius and ulna. A second incision was made posteriorly to attach the tendon to the radial tuberosity by pronating the forearm. These approaches avoided the dangers of deep dissection in the antecubital fossa but required the dissection of the muscles off of the lateral olecranon. Reattachment was marginal, utilizing a bone trough with sutures passed through drill holes. Variations included this two-approach operation with muscle-splitting techniques and suture anchors.

Current Strategies

Although reasonable results can be obtained with these repairs, most surgeons now prefer the approach of anatomic reattachment. The differences in techniques, centering on the number of incisions, site of reattachment, and fixation devices, have given way to a single-incision technique due to the development of bioabsorbable suture anchors and interference screws.

Approach

One approach utilizes a single-incision technique, which makes a 4 cm incision that is 4 cm distal to the flexion crease of the elbow, over the medial border of the radius. The incision is carried down sharply to the muscular interval of the pronator teres and the brachioradialis, avoiding injury to the lateral antebrachial cutaneous nerve. The muscular interval is then developed bluntly to the radial tuberosity. At this point, the bone is exposed in preparation for reattachment of the tendon. Exposure can be assisted with US Army retractors, as well as short, blunt Hohmann retractors. After adequate exposure has been made, the ruptured tendon is retrieved.

Retrieval

The ruptured distal biceps tendon can usually be palpated just proximal and medial to the flexion crease of the elbow. Utilizing the original 4 cm incision, the surgeon digitally tunnels subcutaneously to the tendon stump and retrieves the tendon. If necessary, a second incision directly over the tendon can be made to aid the retrieval. During my experience with this procedure and approx-

imately 30 patient cases, this second incision has only been needed one time. Once the tendon has been retrieved, it is sized and sutured in a Krackow whipstitch fashion for a distance of 12-13 mm, using a #2 Fiberwire® loop. The size of the tendon is verified against the size of the tunnel to ensure that the latter can accommodate it. Then, the size of the tendon is again checked to ensure that it will accommodate the size of the interference screw. If necessary, the tendon will be resized

Fixation

With the tendon prepared, we now return to the exposed radial tuberosity and prepare the bony socket, utilizing the Arthrex Bio-Tenodesis Screw System.[4] The forearm is flexed and supinated to aid exposure. A 2.4 mm-guide pin is inserted with a power drill into the tuberosity. The socket drill is then placed over the pin and drilled to a depth of 2 mm longer than the selected screw to be used. The screw is placed on the tenodesis driver, and one limb of the tendon suture is passed through the driver. To perform the tenodesis, the tip of the driver is placed into the bony socket, advancing the tendon with it. The screw is then deployed and will advance to secure the tendon. The driver is removed, and the suture limb protruding from the cannulated screw, can now be tied to the remaining limb as a second source of fixation.

Closure/Rehabilitation

The subcutaneous tissue and skin are closed, and the patient is placed in a posterior splint with the elbow at 90 degree flexion, and the forearm is supinated. After the wound is determined stable, active assisted motion in a neutral position is allowed for the first six weeks. At this point, range of motion and strengthening exercises may begin, depending upon the patient's level of tolerance. The patient is usually discharged to work and full activities can be resumed in three to six months.

REFERENCES

1. Schneider JA. Hand and Upper Extremity Injuries in Outdoor Activities. *http://www.orthoped.com/upper_extremity_injuries_schneider.asp.* Accessed March 26, 2008.
2. Leslie BM, Ranger H. Reattachment of the Ruptured Distal Biceps Tendon Biceps Using a Modified Anterior Approach. 2000. *http://www.nwoa.com/swf/pdf/reattachment_of_the_ruptured_distal_biceps.pdf.* Accessed March 26, 2008.
3. Operative Techniques in Sports Medicine. 2003. Vol 11(1): 36-41.
4. Arthrex Bio-Tenodesis Screw System, Arthrex Inc. Naples FL 2007 *http://www.arthrex.com/myarthrex/brochures/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=4909.* Accessed march 26, 2008.

Fiberwire is a registered trademark of Arthex, Inc.

NEEDED— ARC-ST SITE VISITORS FOR SURGICAL ASSISTANT PROGRAMS

The Accreditation Review Committee on Education in Surgical Technology (ARC-ST) is looking for site visitors for surgical assistant programs. ARC-ST is working toward growing surgical assistant education and with growth comes the need for individuals who are qualified to serve in the capacity of a site visitor.

Surgical assistant programs that desire to become CAAHEP accredited undergo a one- to two- day site visit by site visitors who assess the program's compliance with the *CAAHEP Standards & Guidelines for an Accredited Program in Surgical Assisting* as well as how well the program is meeting its overall educational goals and objectives in providing quality surgical assistant education. The site visitor's responsibilities include "verifying and clarifying" the information that has been provided by the program in the self-study report.

Qualifications for becoming a surgical assistant program site visitor include being knowledgeable of the profession of surgical assisting as well as the educational process. The individual must have the CFA or CSA credential, and have completed the ARC-ST site visitor's training workshop. Additionally, the individual must complete the application process, which includes submitting the following documents to ARC-ST: Site Visitor Questionnaire, Consent to Serve, Curriculum Vitae, official educational transcripts, and copies of credentials, including certification(s), and licensures. The first three documents are available on the ARC-ST web site, *www.arcst.org.* If you have questions and are interested in being a site visitor, please contact Elaine McFarlane, Accreditation Coordinator at the ARC-ST at (303) 694-9262.

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TULSA TECHNOLOGY CENTER

Mildred Hill, CST, RNFA, MEd, surgical first assistant instructor, has been actively involved in the medical field for 32 years and has worked as a Certified Nurse Assistant, L&D tech, 12 years as a CST and later as an RNFA. She obtained her MA in education in 2004 and is presently assisting with instruction in the surgical technology program and the surgical first assistant online course at the Health Careers Center in the Lemley Complex in Tulsa.

The surgical assisting program began when former surgical technology students were seeking to advance their careers and contacted the school for resources for surgical assistant training. After discovering how few programs existed, the process moved forward with information gathered from the *Surgical Assistant Core Curriculum* and a review of the *CAAHEP Standards and Guidelines for an Accredited Program in Surgical Assisting.*

We decided to develop it as an online opportunity because we anticipate strong growth for this career option and wanted to reach students throughout the US. In addition, men and women who have joined the military can benefit from the online learning and avoid deferring their education.

Because the Tulsa Tech surgical technology has existed for many years, the addition of a surgical assisting program evolved naturally both for our students and our patients who will benefit from well trained professionals offering safe, quality patient care.

To get the word out about our new program, we initially mailed application forms and multiple program advertisements to health care facilities, both local and out of state. In addition, we will also be exhibiting at the AST National Conference in Orlando. Of course, building an online program will take time, but we are directing our efforts to students all over the country and we plan to stress that this credential will enhance their roles in the surgical arena and provide a career advancement opportunity.

Some of our students are enrolling because of the encouragement they received from their surgeons. Most of the students are eager to advance their skill, knowledge and experience in the operating room, as well as elevate their presence as a surgical team member by continuing to provide safe patient care.

One free standing surgery health care facility sponsored a student's enrollment in the surgical assisting program and one of the rural hospitals that employs surgical assistants offered positions to some of our new graduates. Recently, the surgical assisting program received a request from an out-of-state facility to enroll some of their students in our online course.

Through Tulsa Technology Center's WBE (work based experience) database portal, we receive weekly updates on new employers adding jobs for current students and graduates of various allied health care fields. We are confident that our graduates will be able to find employment in this specialty.