

Payment Policy: Assistant Surgeon

Reference Number: CC.PP.029

Product Types: ALL

Effective Date: 01/01/2014

Last Review Date: 04/1/2019

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Policy Overview

The American College of Surgeons (ACS) defines assistant surgeons as ***“individuals who are trained and able to participate in and actively assist the surgeon in completing the operation safely and expeditiously by helping to provide exposure, maintain hemostasis, and serve other technical functions.”*** The ACS goes on to clarify that Assistants at Surgery could be either another surgeon, a resident in a qualified surgical education program and at times, non-physician practitioners.

The ACS provides guidance for surgical procedures which typically require an Assistant Surgeon. Each surgical procedure is designated in one of three categories, 1) “Almost Always, 2) “Sometimes” and 3) Almost Never.” These designations are based on clinical guidelines established by the American College of Surgeons and other specialty society medical organizations. Each organization is asked to review codes for their specialty and determine if the surgery requires the use of a physician as an Assistant at Surgery. Participating specialty organizations include:

- American College of Surgeons
- American College of Ophthalmology
- American Academy of Orthopaedic Surgeons
- American Academy of Otolaryngology – Head and Neck Surgeons
- American Association of Neurological Surgeons
- American College of Colon and Rectal Surgeons
- American Pediatric Surgical Association
- American Society of Plastic Surgeons
- American Society of Transplant Surgeons
- American Urological Association
- Congress of Neurological Surgeons
- Society for Surgical Oncology
- Society for Vascular Surgery
- Society of American Gastrointestinal Endoscopic Surgeons
- The American College of Obstetricians and Gynecologists
- The Society of Thoracic Surgeons

The Centers for Medicare and Medicaid Services (CMS) also provides designations for surgical procedures billed with an Assistant Surgeon. However, CMS bases their Assistant Surgeon designations on statistical data; in other words, the frequency of which an Assistant Surgeon is billed for a particular surgery. Unlike the ACS guidance, CMS does not consider clinical circumstances as part of the determination as to whether or not a surgical procedure requires an

PAYMENT POLICY

Assistant Surgeon

Assistant Surgeon. The CMS designations can be found in the CMS Physician's Fee Schedule File.

The Health Plan uses the ACS guidance as the primary source for determining the appropriate use of assistant surgeon modifiers; however, CMS guidelines are used in certain situations identified below under the "Reimbursement" section.

The purpose of this policy is to define payment criteria for procedures which are appropriate to be billed with the assistant surgeon modifier to be used in making payment decisions and administering benefits.

Application

1. Professional Services

Policy Description

Modifiers **80, 81, 82** and **AS** represent surgical assistant services when appended to surgical procedure codes. The Primary Surgeon and the Assistant Surgeon must report the same procedure codes when using these modifiers.

The Health Plan utilizes the American College of Surgeons Assistant Surgeon designations as the primary source to determine if billing for an Assistant Surgeon is appropriate.

Reimbursement

The Health Plan's code editing software will evaluate claim lines and identify procedure codes that have been inappropriately submitted with an Assistant Surgeon modifier.

The ACS uses three categories to determine the appropriateness of Assistant Surgeon resources for any given surgical procedure:

Almost Always

These are surgical procedures that have been determined as always requiring an Assistant Surgeon in attendance. Assistant Surgeon modifiers billed with these procedures are allowed for reimbursement

Almost Never

These are surgical procedures that have been determined as almost never requiring an Assistant Surgeon in attendance. Assistant Surgeon modifiers billed with these procedures are *not* allowed for reimbursement.

Sometimes

When a surgical procedure is billed with a code that has a "sometimes" designation, the code editing software will compare the procedure code to the CMS designation for the same procedure. When the ACS assigns a designation of "sometimes," the code editing software will refer to the CMS assignment for the same procedure. The procedure code is evaluated as follows:

PAYMENT POLICY
Assistant Surgeon

ACS Designation	CMS Designation	Edit Outcome
“Sometimes”	“Always”	“Always or Never”
Reviewed by the code editing physician consultant team within the appropriate surgical specialty. Based on physician consultant consensus, the code is assigned a designation of “Sometimes” or “Never” and will be paid or denied accordingly.		

ACS Designation	CMS Designation	Edit Outcome
“Sometimes”	“Never”	“Never”
The code editing specialty physician consultant team uses the CMS designation for procedures that the ACS assigns as “sometimes” and CMS assigns as “never.” Since CMS bases appropriateness of an Assistant Surgeon on statistical data (versus a clinical review) of how often claims are submitted with an Assistant Surgeon modifier, the assumption is that the Assistant Surgeon modifiers are rarely submitted with these procedures and therefore medical necessity for an Assistant Surgeon is unwarranted. These claim lines are denied.		

Documentation Requirements

Not Applicable.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
10021-69990	Surgical Procedure Codes

Modifier	Descriptor
-80	Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).
-81	Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.
-82	Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).
-AS	Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Services for Assistant at Surgery.

ICD-10 Codes	Descriptor
NA	Not Applicable.

Definitions

- **Modifier 80: Assistant Surgeon**

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s). Modifier 80 is appended to the same service code as the primary surgeon and designates the surgeon as a surgical assistant on the procedure.

- **Modifier 81: Minimum Assistant Surgeon**

Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number. Modifier 81 should be appended to the procedure code representing the services performed by each physician who participated in the operative session. Typically, the Assistant at Surgery is not present for the entire procedure; rather, he or she assists with a specific part of the procedure only.

- **Modifier 82: Assistant Surgeon (when qualified resident surgeon not available)**

The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure number(s). Modifier 82 is limited to use in a teaching hospital to indicate that a qualified resident surgeon is unavailable. Typically in this environment, training programs allow qualified residents to function as the first assistant. However, when there is a qualified resident available or in facilities without a teaching program for specific specialties, Medicare covers assistant at surgery services when modifier 82 is appended to the basic services code.

- **Modifier AS: Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist Services for Assistant at Surgery**

HCPCS Level II modifier AS is used to report non-physician providers (NPP) or advance practice providers (APP) who assist in surgery.

Related Policies

Policy Name	Policy Number
NA	Not Applicable

Related Documents or Resources

1. <https://www.facs.org/~media/files/advocacy/pubs/pas%202013.ashx>
2. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html>

PAYMENT POLICY
Assistant Surgeon

References

1. *Current Procedural Terminology (CPT®)*, 2018
2. American College of Surgeons. (2013). *Physicians as Assistants at Surgery*. Retrieved from <https://www.facs.org/~media/files/advocacy/pubs/pas%202013.ashx>

Revision History	
11/14/2016	Initial Policy Draft Created
03/01/2018	Conducted review, updated policy
04/01/2019	Conducted review, updated policy

Important Reminder

For the purposes of this payment policy, “Health Plan” means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan’s affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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PAYMENT POLICY

Assistant Surgeon

herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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