moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM013
Policy Title:	Modifiers 80, 81, 82, & AS - Assistant At Surgery		
Section:	Modifiers	Subsection:	Surgery

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	12/31/1999	Initially Published:	3/4/2014
Last Updated:	8/9/2023	Last Reviewed:	8/9/2023
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		8/9/2023	

Reimbursement Guidelines

A. General

1. Moda Health makes determinations regarding whether assistant at surgery services are reimbursable on a code-by-code basis. When multiple procedure codes are billed for a surgical session and only some of the codes are eligible for assistant surgeon reimbursement, only the eligible codes will be reimbursed.

2. The assistant surgeon must report the same codes as the surgeon. An exception to this is when the OB/GYN surgeon bills a cesarean global maternity care code. In that case, the assistant at surgery must bill the cesarean delivery only code.

3. Non-physician assistant at surgery services are to be submitted with modifier -AS appended, not modifier -81.

4. The same clinical edits apply to the assistant surgeon as the primary surgeon.

B. Provider Types Eligible for Reimbursement for Assistant at Surgery Services

Moda Health considers the following provider types eligible for reimbursement for assistant at surgery services:

1. MD (Medical Doctor)
2. DO (Doctor of Osteopathic Medicine)
3. PA (Physician's Assistant)
4. NP (Nurse Practitioner)
5. RNFA (Registered Nurse First Assistant)

C. Provider Types Not Eligible for Reimbursement for Assistant at Surgery Services

1. The following provider types are not eligible for reimbursement of assistant at surgery service. Moda Health does not credential these provider types, and they are not eligible providers under our member plan language.
   a. Certified First Assistant (CFA)
   b. Certified Surgical First Assistant (CSFA)
   c. Certified Surgical Assistant (CSA)

   These provider types are also not recognized by Medicare as eligible to bill or be reimbursed for assistant at surgery services. (ASA[5])

2. Claims for services of CFAs, CSAs, or CSFAs, will be printed and returned to the billing office.

3. Contracted participating providers and groups are expected to not submit claims for assistant at surgery services performed by CFAs, CSAs, or CSFAs. Members may not be balance-billed for CFA services.

D. Assistant Surgeon Fee Adjustments

1. Procedure codes eligible for assistant at surgery reimbursement:
   a. Reported by physician providers with modifier -80 or -82 appended will be reimbursed at:
      i. Commercial: 20% of the established fee for the primary surgery.
      ii. Medicare Advantage: 16% of the established fee for the primary surgery.
      iii. Medicaid: 16% of the established fee for the primary surgery.

   b. Reported by physician providers with modifier -81 appended will be reimbursed at:
      i. Commercial: 20% of the established fee for the primary surgery.
      ii. Medicare Advantage: 16% of the established fee for the primary surgery.
      iii. Medicaid: 16% of the established fee for the primary surgery.

   c. Reported by a non-physician provider (NPP) with modifier -AS appended will be reimbursed at the following rates:
      - Commercial: 10% of the established fee for the primary surgery.

- Medicare Advantage: 13.6% of the established fee for the primary surgery.
- Medicaid: 16% of the established fee for the primary surgery.

2. ***Please Note:*** Other pricing adjustments may also apply before the final allowable amount for each line item is determined. For example, multiple surgery fee reductions, bilateral adjustments, related within global adjustments, co-surgery adjustments, etc.

E. Procedure Codes Eligible for Assistant Surgeon Reimbursement

1. Procedure codes with a CMS assistant surgeon indicator of "2" are eligible for assistant surgeon reimbursement.
   a. One assistant surgeon is allowed per procedure code/surgery.
   b. A second assistant surgeon will be considered only on a written appeal when documentation of medical necessity for the second assistant surgeon is submitted.

2. Procedure codes with a CMS assistant surgeon indicator of "0" are not eligible for assistant surgeon reimbursement upon initial adjudication of the claim. However, the claim may be reviewed for reimbursement upon written appeal when documentation has been submitted that supports the medical necessity for the assistant surgeon. Per CMS guidelines, these procedures normally do not require an assistant surgeon, but an assistant surgeon may be medically necessary in some instances.

3. Procedure codes with a CMS assistant surgeon indicator of "1" or "9" are not eligible for assistant surgeon reimbursement. CMS guidelines indicate assistant surgeons cannot be paid on these procedures. No criteria or guidelines for approval upon appeal have been established for procedure codes with an indicator of "1" or "9".

4. In the absence of a CMS assistant at surgery indicator for a particular procedure code, Moda Health may establish an assistant at surgery designation.

F. Reconsiderations of Assistant Surgeon denials

Assistant surgeon denials will be reconsidered upon written appeal. Appropriate supporting documentation must be included, such as:

1. Copies of CMS assistant surgeon indicator setting showing an indicator of "0" or "1" for the relevant date of service.
2. Medical necessity for second assistant surgeon or procedure codes with a CMS assistant surgeon indicator of "0".
3. Other relevant coding guidelines.
4. Copy of the operative report and any other relevant medical record documentation.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
APC	=	Ambulatory Payment Class
ASA	=	Association of Surgical Assistants
CCI	=	Correct Coding Initiative (see “NCCI”)
CFA	=	Certified First Assistant
CMS	=	Centers for Medicare and Medicaid Services
CNS	=	Clinical Nurse Specialist
CPT	=	Current Procedural Terminology
CSA	=	Certified Surgical Assistant
CSFA	=	Certified Surgical First Assistant
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka “CCI”)
NP	=	Nurse Practitioner
NPP	=	Non-physician Provider
PA	=	Physician Assistant
RNFA	=	Registered Nurse First Assistant
RPM	=	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)
UB	=	Uniform Bill

Modifier Definitions:

Modifier	Modifier Description & Definition
Modifier 80	**Assistant Surgeon:** Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).
Modifier 81	**Minimum Assistant Surgeon:** Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.
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 code number(s).
Modifier AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery.

CMS Assistant Surgeon Indicators are published on the Medicare Physician Fee Schedule Database (MPFSDB). Current values in use are:

Value	Assistant Surgeon Indicator Definition
0	Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.
1	Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.
2	Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.
9	Assistant at Surgery concept does not apply.

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

Modifier 80 Assistant Surgeon –

During certain operations, one physician assists another physician in performing a procedure. The physician who assists the operating surgeon would report the same surgical procedure as the operating surgeon. The assistant surgeon generally is present during the entire operation or a substantial portion of the operation to provide assistance to the operating physician.

This modifier is not intended for use by non-physicians assisting at surgery (e.g., Nurse Practitioners, Physician Assistants, Registered Nurse First Assistants, etc.).

Modifier 81 Minimum Assistant Surgeon –

At times the operating physician plans to perform a surgical procedure alone. When a minor problem is encountered during the operation that requires the service of an assistant surgeon for a relatively short period of time, this is considered a minimum assistant surgeon. (*AMA*[2, 3])

This modifier is not intended for use by non-physicians assisting at surgery (e.g., Nurse Practitioners, Physician Assistants, Registered Nurse First Assistants, etc.).

Modifier 82 Assistant Surgeon (when qualified resident surgeon not available) –

In certain programs or facilities (e.g., in teaching hospitals), the physician who generally acts as the assistant surgeon is a qualified resident surgeon. There may be times when a qualified resident surgeon is not available to assist the operating surgeon, so a physician assists the operating surgeon in this instance.

This modifier is not intended for use by non-physicians assisting at surgery (e.g., Nurse Practitioners, Physician Assistants, Registered Nurse First Assistants, etc.).

Modifier AS – Non-physician Assisting at Surgery

Medicare has established the -AS modifier to report Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) services for assistant-at-surgery, non-team member. Therefore, for Medicare reporting purposes and as directed by a commercial third-party payor, to indicate PA, NP, or CNS services for assistant-at-surgery, HCPCS modifier -AS would be appended to the usual procedure number instead of one of the CPT modifiers.

"Although the intent of the assistant surgeon modifiers [-80, -81, -82] is to report physician services, the results of our survey indicate that many users report the modifiers for a variety of non-physician surgical assistant services. The most common misinterpretation of the assistant surgeon modifiers is to report PA or NP assistant surgical services.

Although, from a CPT perspective, this is not the intended use of the assistant surgeon modifiers, some third-party payors consider this an acceptable means of reporting non-physician assistants during surgery. Many have established their own guidelines for reporting assistant surgeon services.

Since each third-party payor may establish reporting guidelines that vary from coding guidelines, a clear understanding of CPT coding guidelines, as well as third-party payor reporting guidelines is essential." (*AMA*[2])

"Medicare Policy:
There is no Medicare provider category for RNFAs, no separately billable RNFA services, and no separate reimbursement for RNFA services. Medicare cannot reimburse a surgical assistant's services if the assistant is an unlicensed practitioner and does not qualify to be a Medicare provider.

Such services are reimbursed as part of the Diagnostic Related Group (DRG), if inpatient, and part of the Ambulatory Payment Class (APC), if outpatient.

The services of RNFAs must not be filed to Medicare Part B as payable services and/or billed to beneficiaries or their secondary insurance. To do so, such providers will be at risk of sanctions for inappropriate billing, which could constitute Medicare fraud." (Noridian[4], CMS[6])

"Assistant at surgery services rendered by a surgical technician, a first surgical assistant, scrub nurse, or any person bearing a title other than physician, PA, NP, CNS or nurse midwife are not payable by Medicare Part B and is not billable to the patient. Billing the services of a non-covered assistant at surgery under the surgeon's performing provider number is an inappropriate application of the "incident to" guidelines and any services billed in this manner represents an overpayment to the provider and must be refunded to the Program." (ASA[5])

Cross References

A. "Robotic Assisted Surgery." Moda Health Reimbursement Policy Manual, RPM006.

B. "Valid Modifier to Procedure Code Combinations." Moda Health Reimbursement Policy Manual, RPM019.

C. "Maternity Care." Moda Health Reimbursement Policy Manual, RPM020.

D. "Modifier 51 - Multiple Procedure Fee Reductions." Moda Health Reimbursement Policy Manual, RPM022.

E. "Add-on Codes." Moda Health Reimbursement Policy Manual, RPM025.

References & Resources

1. American Medical Association. "Modifiers Used with Surgical Procedures", CPT Assistant, Fall 1992, page 15.

2. American Medical Association. "A Closer Look at the Use of Surgical Modifiers" *CPT Assistant,* March 1996: 8.

3. Grider, Deborah J. *Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage*. Chicago: AMA Press, 2004.

4. "Surgical Assistant Services – Revised." Noridian Medicare B News, August 5, 2009.

5. Association of Surgical Assistants (ASA). "Appropriate Use of Assistant At Surgery Modifiers And Payment Indicators – Clarification." *The Surgical Assistant.* Vol. 19 No. 3, Summer 2013. Page 3.

6. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 100.1.7.B.

Background Information

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider

- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g., T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
8/9/2023	Annual review. Section A.2: minor rephrasing, no content changes.

Date	Summary of Update
12/14/2022	Format/Update Scope, States: Idaho added. Cross References: Hyperlinks added.
6/8/2022	Formatting & clarification/Update: Change to new header. Changed Subsection field from “None” to “Surgery.” Acronym table: 1 entry added. References & Resources: Item # 6 added. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
3/4/2014	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
12/31/1999	Original Effective Date (with or without formal documentation). Policy based on…