CorroHealth

Assistant at Surgery

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Assistant at Surgery

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Assistant at Surgery

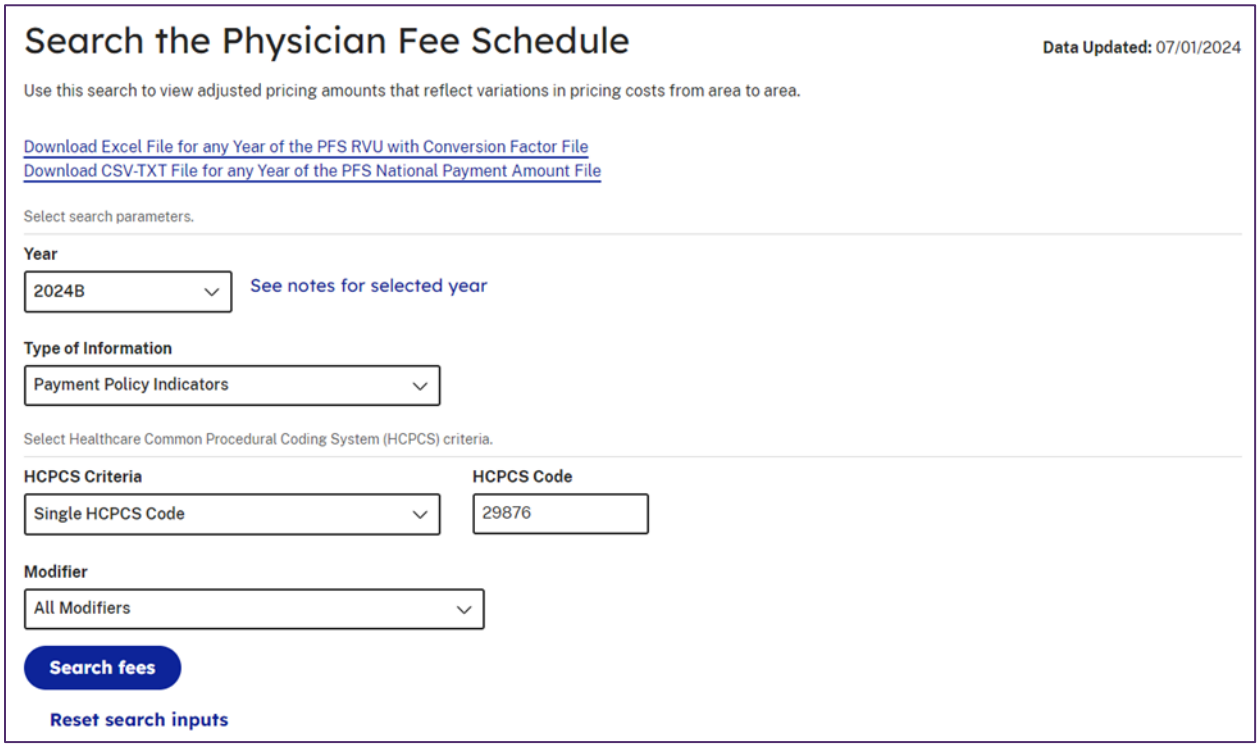
Introduction

Not all surgical procedures justify the use of an assistant. Simply having an extra pair of hands during surgery does not guarantee reimbursement from the payer. Like all medical services, the assistant's involvement must meet established criteria for medical necessity. Each payer has its own guidelines for determining when an assistant at surgery is appropriate. To avoid denied claims, providers are encouraged to obtain prior authorization before including a surgical assistant in the procedure.

Procedure Codes

CMS identifies which procedures qualify for additional payment for an assistant at surgery using the "Asst Surg" column in the Medicare Physician Fee Schedule (MPFS) Relative Value File. If a procedure is not approved for assistant reimbursement, providers cannot bill the patient for the assistant's services, even if an Advance Beneficiary Notice (ABN) is issued.

Search the Physician Fee Schedule | CMS



Assistant at Surgery

Search Results

Showing 1-1 of 1

HCPCS Code	Modifier	Short Description	Proc Stat	PCTC	Global	MULT SURG	BILT SURG	ASST SURG	CO SURG	Team SURG
29876		Knee arthroscopy/surgery	A	0	090	3	1	1	0	0

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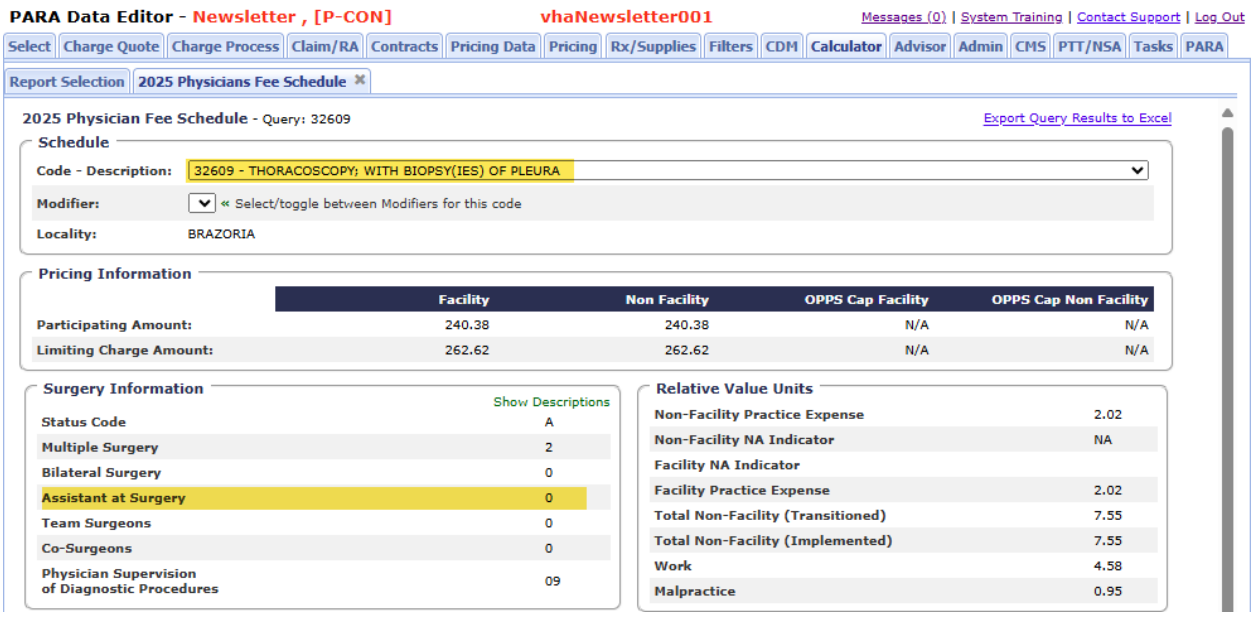
In the example above, the procedure code for assistant at surgery has an assigned indicator of "1", however, there are other indicators that you may see, as in the examples below:

- **Indicator 0** means payment restrictions apply and supporting documentation is required to establish medical necessity.
- **Indicator 1** indicates assistant-at-surgery services are not payable.
- **Indicator 2** means assistant-at-surgery services are payable without additional documentation.
- **Indicator 9** means the concept does not apply.

Example 1:



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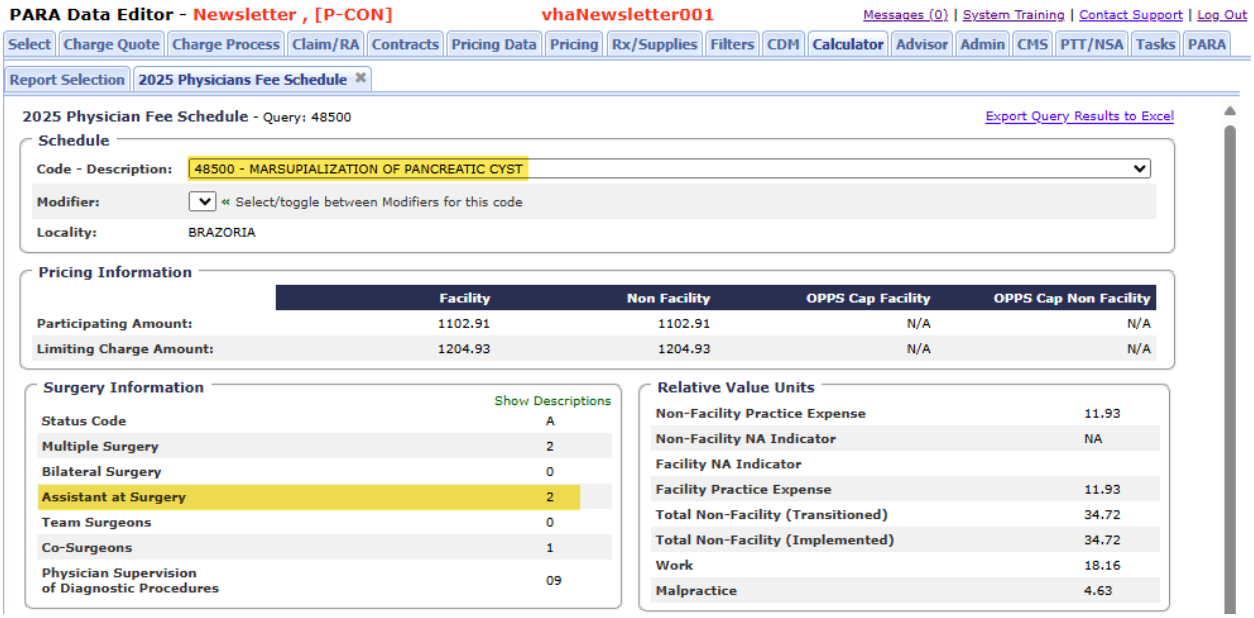


The following step-by-step video tutorial shows how this information can be obtained by using the Calculator tab of the PDE: Calculator - Professional Fee on Vimeo.

Documentation

Medical necessity must be clearly documented whenever an assistant at surgery is used. Even if a payer does not request supporting documentation upfront, a claim should not be submitted unless the provider can produce a detailed operative note that justifies the assistant's involvement.

The primary surgeon is responsible for dictating exactly what the assistant did during the procedure. Merely naming the assistant in the operative report is not enough. The documentation must clearly demonstrate that the assistant's role was essential to the surgery and not limited to ancillary or routine tasks. This ensures the payer understands that the assistant was medically necessary and not simply present for support.

Modifiers

Once you've confirmed that the payer allows reimbursement for an assistant at surgery and that medical necessity requirements are met, the next step is to apply the correct modifier. Modifiers help describe the specific circumstances under which the assistant was involved. The available modifiers for assistant at surgery scenarios include:

- **"80"** = Modifier 80 is used when assistant at surgery services are provided by a medical doctor. For instance, in a spinal fusion procedure, the assistant may be medically necessary to help hold the vertebrae in place and assist with harvesting and placing the bone graft. In this scenario, the primary surgeon would report CPT® code 22610, while the assistant surgeon would report 22610 with modifier 80. When a physician performs the assistant role, Medicare reimburses 16% of the applicable surgical fee schedule amount.
- **"81"** = Modifier 81 indicates minimal assistance during surgery by another physician. Some payers allow this modifier when a second physician is involved in only a small, selective portion of the procedure, such as opening or closing. However, Medicare generally does not recognize modifier 81 for payment, and CMS does not include it in the Medicare Physician Fee Schedule Relative Value File. Because of this, providers should not use modifier 81 to report assistant services performed by a non-physician practitioner (NPP). While CMS does not accept modifier AS, some payers may accept modifier 81 instead.
- **"82"** = Modifier 82 is reserved for use in teaching hospital settings when a qualified resident is not available to assist during surgery. Medicare has specific rules for using this modifier. It will not reimburse assistant services in a teaching hospital that has a training program related to the surgical specialty unless one of the following conditions is met: a qualified resident is unavailable; exceptional circumstances justify the assistant's involvement even if a resident is available; or the primary surgeon has a consistent policy of not involving residents in any phase of patient care. For example, if a lung hernia requires immediate repair and the residents on call are assisting in another procedure, a second thoracic surgeon may assist the primary surgeon. In this case, the primary surgeon would report CPT code 32800, and the assistant surgeon would report 32800 with modifier 82. It is essential that the assistant surgeon clearly documents in the operative report why a resident was not involved in the procedure. This scenario is outlined in Chapter 12 of the Medicare Claims Processing Manual.

100.1.7 - Assistants at Surgery in Teaching Hospitals
(Rev. 811, Issued: 01-13-06, Effective: 01-01-06, Implementation: 02-13-06)
A. General

A/B MACs (B) do not pay for the services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service unless the requirements of one of subsections

C, D, or E are met. Each teaching hospital has a different situation concerning numbers of residents, qualifications of residents, duties of residents, and types of surgeries performed.

Contact those affected by these instructions to learn the circumstances in individual teaching hospitals. There may be some teaching hospitals in which A/B MACs (B) can apply a presumption about the availability of a qualified resident in a training program related to the medical specialty required for the surgical procedures, but there are other teaching hospitals in which there are often no qualified residents available. This may be due to their involvement in other activities, complexity of the surgery, numbers of residents in the program, or other valid reasons. A/B MACs (B) process assistant at surgery claims for services furnished in teaching hospitals on the basis of the following certification by the assistant, or through the use of modifier 82 which indicates that a qualified resident surgeon was not available.

- **"AS"** = The AS modifier indicates that the assistant at surgery services were provided by a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS). Modifier "AS" is discussed in Chapter 12 of the Medicare Claims Processing Manual.

110.2 - Limitations for Assistant-at-Surgery Services Furnished by Physician Assistants
(Rev. 2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

Medicare law at section 1833(a)(1)(O) of the Social Security Act authorizes payment for services that a PA furnishes as an assistant-at-surgery. Specifically, when a PA actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services, the PA's services are eligible for payment as assistant-at-surgery services. For additional policy requirements concerning assistant-at-surgery services furnished by physicians and nonphysician practitioners, see chapter 12, section 20.4.3 of the Medicare Claims Processing Manual, pub. 100-04.

The A/B MAC (B) shall pay covered PA assistant-at-surgery services at 80 percent of the lesser of the actual charge or 85 percent of what a physician is paid under the Medicare Physician Fee Schedule. Since physicians are paid at 16 percent of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that

PAs receive for assistant-at-surgery services is 13.6 percent of the amount paid to physicians.

The AS modifier must be reported on the claim form when billing PA assistant-at-surgery services.

Modifiers in a Critical Access Hospital

A Method II Critical Access Hospital (CAH) must report both the 8X modifier and modifier AS when assistant at surgery services are provided by a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS). Chapter 4 of the Medicare Claims Processing Manual, provides additional information on the use of modifiers in a Method II CAH.

250.9 - Coding Assistant at Surgery Services Rendered in a Method II CAH (Rev. 1620; Issued: 10-24-08; Effective: 01-01-08; Implementation: 04-06-09)

An assistant at surgery is a physician or non-physician practitioner who actively assists the physician in charge of the case in performing a surgical procedure.

Medicare makes payment for an assistant at surgery when the procedure is authorized for an assistant and the person performing the service is a physician, physician assistant (PA), nurse practitioner (NP) or a clinical nurse specialist (CNS).

Assistant at surgery services rendered by a physician or non-physician practitioner that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedure is billed on type of bill 85X with revenue code (RC) 96X, 97X or 98X and an appropriate assistant at surgery modifier.

Under authority of 42 CFR 414.40, CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. This includes the use of payment modifiers for assistant at surgery services.

Modifier 80 (assistant surgeon), 81 (minimum assistant surgeon), or 82 (when qualified resident surgeon not available) is used to bill for assistant at surgery services. When billed without modifier AS (PA, NP or CNS services for assistant at surgery) the use of these modifiers indicate that a physician served as an assistant at surgery.

Modifier AS is billed to indicate that a PA, NP or CNS served as the assistant at surgery. Modifier 80, 81 or 82 must also be billed when modifier AS is billed. Claims submitted with modifier AS and without modifier 80, 81 or 82 are returned to the provider (RTPd).

Reimbursement for Assistant at Surgery Services

When an assistant at surgery is a medical doctor (MD or DO), they are reimbursed at 16% of the allowable amount for the primary surgeon's procedure. If the assistant is a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS), the reimbursement is 85% of that 16% amount. The below excerpt from Chapter 12 of the Medicare Claims Processing Manual contains additional information on reimbursement for an assistant at surgery:

20.4.3 - Assistant-at Surgery-Services (Rev. 2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13)

For assistant-at-surgery services performed by physicians, the fee schedule amount equals 16 percent of the amount otherwise applicable for the surgical payment.

A/B MACs (B) may not pay assistants-at-surgery for surgical procedures in which a physician is used as an assistant-at-surgery in fewer than five percent of the cases for that procedure nationally. This is determined through manual reviews.

Procedures billed with the assistant-at-surgery physician modifiers 80, 81, 82, or the AS modifier for physician assistants, nurse practitioners and clinical nurse specialists, are subject to the assistant-at-surgery policy. Accordingly, pay claims for procedures with these modifiers only if the services of an assistant-at-surgery are authorized.

Medicare's policies on billing patients in excess of the Medicare allowed amount apply to assistant-at-surgery services. Physicians who knowingly and willfully violate this prohibition and bill a beneficiary for an assistant-at-surgery service for these procedures may be subject to the penalties contained under §1842(j)(2) of the Social Security Act (the Act.) Penalties vary based on the frequency and seriousness of the violation. Go to Social Security Act Title XVIII (ssa.gov) and select the relevant section.

Certified Registered Nurse First Assistants (CRNFAs)

Certified Registered Nurse First Assistants (CRNFAs) are experienced registered nurses who have completed advanced training to function as surgical first assistants. Their certification, typically obtained through programs like the one offered by the National Assistant at Surgery Certification (NASC), validates their expertise in perioperative care and surgical assistance. CRNFAs play a vital role in the operating room, contributing to improved surgical outcomes through their specialized skills and clinical judgment.

Despite their qualifications, billing for CRNFA services remains complex and varies significantly across payers and states. Medicare does not reimburse CRNFA services, as CRNFAs are not recognized as licensed providers under Medicare's assistant at surgery guidelines. Unlike physician assistants (PAs), nurse practitioners (NPs), or clinical nurse specialists (CNSs), CRNFAs do not have independent billing privileges under Medicare. As a result, their services must often be reported through the supervising surgeon's provider number, which can create confusion and potential compliance issues.

Some private insurers may reimburse CRNFA services, but requirements differ. These payers may accept modifiers such as 81 or AS, depending on the insurer's policies. However, because CRNFAs lack a universal provider identification number, billing often requires coordination with the payer to determine acceptable reporting methods. To ensure proper reimbursement, healthcare facilities employing CRNFAs must stay informed about payer-specific guidelines, modifier usage, and documentation standards.

Co-Surgeons

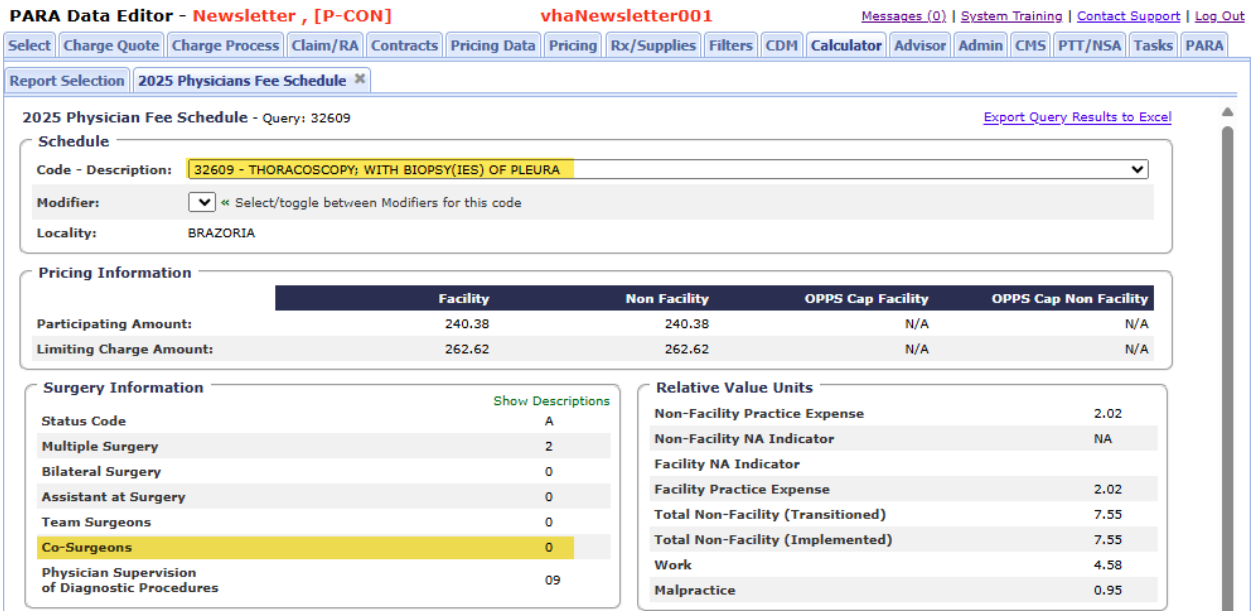
In certain complex surgical procedures, two surgeons may work together as co-surgeons, each performing distinct and critical components of the operation. This arrangement is different from assistant at surgery services, where one provider supports the primary surgeon. Co-surgery is typically reported when both surgeons are of different specialties and their combined expertise is medically necessary for the procedure.

To determine whether co-surgery is reimbursable, providers must consult the Co-Surgery Indicator in the Medicare Physician Fee Schedule Database (MPFSDB). The following indicators help clarify whether a procedure qualifies for co-surgeon billing:

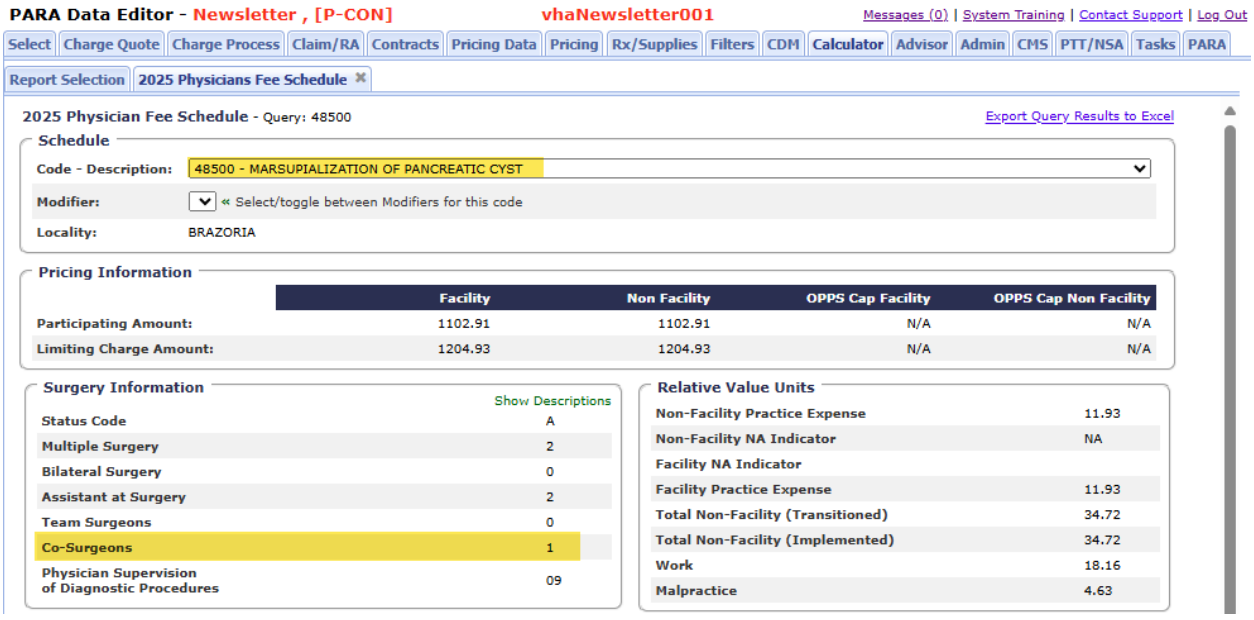
- **Indicator 0** means co-surgery is not payable.
- **Indicator 1** allows payment if medical necessity is documented.
- **Indicator 2** permits co-surgery without documentation if two specialty requirements are met.
- **Indicator 9** means the concept does not apply.

Assistant at Surgery

Example 1:



Example 2:



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When reporting co-surgery, each surgeon must report the procedure code with **modifier 62**, which indicates that two surgeons performed the procedure together. Accurate

documentation is essential, and each operative report should clearly describe the distinct roles and responsibilities of both surgeons. It's important to note that Certified Registered Nurse First Assistants (CRNFAs) are not eligible to bill as co-surgeons, as co-surgery requires two licensed physicians.

References

- Search the Physician Fee Schedule | CMS
- Chapter 4 of the Medicare Claims Processing Manual
- Chapter 12 of the Medicare Claims Processing Manual
- Status Indicators | CMS
- Assistant at Surgery Modifiers Fact Sheet
- AS - JE Part B - Noridian
- Jurisdiction M Part B - Assistant Surgery, Co-Surgery and Team Surgery: Modifier Required
- 2A318-Assistant at Surgery Services Billed Without Correct Payment Modifiers: Incorrect Coding | CMS
- 0222-Non-Physician Billed Without Correct Assistant at Surgery Modifier: Incorrect Coding | CMS
- Billing for RNFA Surgical Assist
- CRNFA - National Assistant at Surgery Certification
- Coding Surgical Teams Correctly - AAPC Knowledge Center
- Medicare Co-Surgery Billing for Part B Providers
- Modifier 62 Fact Sheet
- Medicare Improperly Paid Physicians for Co-Surgery and Assistant-at-Surgery Services That Were Billed Without the Appropriate Payment Modifiers, A-01-20-00503
- Calculator - Professional Fee on Vimeo