	Reimbursement Policy	
Subject: Assistant at Surgery (Modifiers 80/81/82/AS)		
Effective Date: **10/15/17**	Committee Approval Obtained: **06/05/17**	Section: **Coding**

*****The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com/ia.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Amerigroup Iowa, Inc. if the service is covered by a member's Amerigroup benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup allows reimbursement for one assistant surgeon when eligible procedures are billed with Modifiers 80, 81, 82 or AS, as applicable unless otherwise noted by provider, state, federal or CMS contracts and/or requirements. Amerigroup uses code-editing software to process claims billed for assistant at surgery. If an applicable modifier is not billed appropriately, the procedure may be denied. Assistant surgeon services are eligible for reimbursement as follows: • Modifier 80: 16 percent • Modifier 81: 16 percent

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- Modifier 82: 16 percent
- Modifier AS: 65 percent of the Modifier 80 amount

When multiple procedures are performed where only some of the procedures are eligible for assistant at surgery reimbursement, only assistant at surgery services for the eligible procedures will be considered for reimbursement. The same multiple-procedure fee reductions and clinical edits apply to both the assistant at surgery and the primary surgeon. For multiple surgical assists for the same member in the same operating session, payment will be made with the following multiple surgery methodology:

- 100 percent of the payable amount for the primary procedure
- 50 percent for the secondary procedure
- 50 percent for third through fifth procedures with the sixth and additional procedures only if determined to be medically necessary through clinical review

The assistant at surgery should not report procedure codes different from the procedure codes reported by the primary surgeon **except** if the primary surgeon bills a global code; then, the assistant at surgery would bill the specific surgery code with the appropriate modifier.

Note: Amerigroup allows surgeons to bill for assistant surgeon services by appending Modifier AS.
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<tr><td>History</td><td>

- Biennial review approved **04/03/17** and effective **10/15/17**: Policy language updated
- Review approved **06/05/17** and effective **06/05/17**: Policy language updated
- Initial review approved **08/04/15** and effective **04/01/16**
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<tr><td>References and Research Materials</td><td>

This policy has been developed through consideration of the following:

- CMS
- State Medicaid
- State contract
- Optum Learning: Understanding Modifiers, 2016 Edition
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<tr><td>Definitions</td><td>

- **Modifier 80:** Denotes an assistant at surgery providing full assistance to the primary surgeon
- **Modifier 81**: Denotes an assistant at surgery providing minimal assistance to the primary surgeon
- **Modifier 82**: Denotes an assistant at surgery when a qualified resident surgeon is not available to assist the primary surgeon
- **Modifier AS:** Denotes an assistant at surgery who is a nonphysician (physician assistant, nurse practitioner or clinical nurse specialist)
- **General Reimbursement Policy Definitions**
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Related Policies	• Code and Clinical Editing Guidelines • Modifier Usage
Related Materials	• None