Outpatient Facility Coding Alert

Modifiers: Enhance Your Assistant Surgeon Modifier Reporting With This Guide

Plus, know how to report PA, NP, and CNS-assisted surgeries.

Coding some operative reports can be challenging on their own, but adding in an assistant surgeon to the mix adds an extra degree of difficulty. That's in part because you've got to consider a handful of different assistant surgeon modifiers.

Rely on these helpful points and expert advice to code your assistant surgery claims with the highest degree of confidence.

Understand Rationale for an Assistant on the Case

The primary surgeon may use an assistant surgeon for several reasons, such as a particularly complex procedure or patient condition. The assistant surgeon works under the direct supervision of the principal surgeon.

Sometimes the surgeon you code for might act as the primary surgeon on the case; sometimes he might act as the assistant surgeon, and that will impact your coding. The primary surgeon should bill the procedure without a modifier, while the assistant surgeon must append the appropriate modifier to the same procedure code.

Definition: According to Medicare guidelines, "an assistant at surgery must actively assist when a physician performs a Medicare-covered surgical procedure. This necessarily entails that the assistant be involved in the actual performance of the procedure, not simply in other, ancillary services."

Medicare guidelines continue: "Since an assistant would, thus, be occupied during the surgical procedure, the assistant would not be available to perform (and thus, could not bill for) another surgical procedure during the same time period."

Check Out the Choices

CPT® provides the following three assistant-surgeon modifiers:

- 80 (Assistant Surgeon)
- 81 (Minimum Assistant Surgeon)
- 82 (Assistant Surgeon when qualified resident surgeon is not available).

The distinction between modifiers 80 and 81 is whether the assistant surgeon participates during the entire procedure, or just a portion of it. Most practices find that modifier 80 cases are the most common scenario.

Reserve modifier 82 for cases in a teaching hospital when a qualified resident is not available, so an assistant surgeon participates in the entire procedure. Medicare defines "qualified resident not available" to mean the following circumstances:

- A resident was unavailable because he was working on another activity.
- The surgery was complex, and the resident did not have the necessary skills to assist.
- There were not enough available residents in the residency program.
- The patient's condition was emergent or life-threatening and required immediate treatment.

Add Modifier AS for Certain Cases

Medicare will only pay for a surgical assistant when the procedure performed is authorized for an assistant, and the

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person performing the service is a physician, physician assistant (PA), nurse practitioner (NP), or a clinical nurse specialist (CNS).

When a PA, NP, or a CNS assists at surgery, attach modifier AS (Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery) to the surgical code along with modifier 80.

Without modifier AS, modifiers 80, 81, and 82 indicate that a physician was the surgical assistant. Claims you submit that include modifier AS without modifier 80, 81, or 82 will be returned to you.

Caution: Many commercial insurers follow Medicare's rules, but not all do. Be sure to query each of your payers to find out their policies on billing for surgical assistants. They may want only the modifier AS, or they may not recognize it at all.

Check Fee Schedule for Pro-Fee Billing Guidelines

Before billing for an assistant at surgery under the Medicare Physician Fee Schedule (MPFS), double-check the ASST SURG column to verify that the procedure(s) allows an assistant.

Payers will not reimburse you for assistants at surgery in all cases, regardless of the modifier(s) you attach to the claim. For Medicare, assistant at surgery services are eligible for reimbursement only when national claims data indicates the procedure would require an assistant in at least 5 percent of the claims based on a national average, according to Medicare guidelines.

Remember these designations in the ASST SURG column:

- "0" indicates that Medicare will allow payment (upon satisfactory review) for an assistant at surgery if you submit supporting documentation to establish medical necessity.
- "1" tells you that an assistant at surgery will never be paid. You should never apply modifiers 80 or AS to these codes.
- "2" means that Medicare will routinely pay for the procedure in conjunction with an assistant surgeon. Append modifier 80 and/or AS to these codes to indicate that an assistant surgeon was involved with the case.
- "9" indicates that the assisted surgery concept does not apply. You should never attach modifiers 80 or AS to these codes. Many of the N status or noncovered codes carry a 9 in the assistant at surgery column.

Caution: "Many carriers create their own rules that determine which practitioners can bill as assistant surgeons," says **Barbara J. Cobuzzi, MBA, CPC, COC, CPC-P, CPC-I, CENTC, CPCO, AAPC Fellow**, vice president at Stark Coding & Consulting LLC, in Shrewsbury, New Jersey.

Document the Details

Each physician must document his own part of the procedure when more than one provider is involved, says **Melanie Witt, RN, MA,** an independent coding consultant in Guadalupita, N.M.

"Medicare requires the primary surgeon to list the assistant surgeon in the operative report, and make some notation within the procedure description regarding how the assistant was involved," explains **Terri Brame Joy, MBA, CPC, COC, CGSC, CPC-I**, director of operations with Encounter Telehealth in Omaha, Nebraska.

Bottom line: Be aware that payment is much less for an assistant surgeon than for a co-surgeon. For an assistant surgeon, Medicare allows 16 percent of the total allowed amount, and commercial payers vary from 16 to 50 percent of the primary allowed amount. Coding experts advise against billing the full global fee for the assistant's fee because this may confuse the carrier as to who was the surgeon and who was the assistant, and often one surgeon remains unpaid. For assistant at surgery services performed by a PA, NP, or a CNS, Medicare further reduces reimbursement to 85 percent of the 16 percent.

For more information, refer to page 12 of this helpful Fact Sheet from CMS:

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https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.pdf and this one from Novitas: Assistant at Surgery Modifier Fact Sheet.

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