Assistant Surgeon Payment Policy

Policy

The Plan allows payment for an assistant surgeon when medical necessity and appropriateness criteria are met. The Plan uses Medicare and other nationally recognized guidelines to determine medical necessity and appropriateness of assistant surgeon services. Cases may be reviewed on an individual consideration basis. The Plan does not reimburse for assistant surgeons at teaching hospitals unless there is no qualified resident available.

Definitions

Assistant surgeon/assistant at surgery: A physician or other qualified healthcare provider who actively assists the principal surgeon in the performance of a surgical procedure. An assistant surgeon may be necessary due to the complex nature of the procedures(s) or the patient's condition. The assistant surgeon performs medical functions under the direct supervision of the principal surgeon. The operative report should clearly document the assistant surgeon's role during the operative session.

Primary attending surgeon: Considered the surgical attending of record or the principal surgeon involved in a specific operation. In addition to his or her technical and clinical responsibilities, the primary surgeon is responsible for the orchestration and progress of a procedure.

Reimbursement

Modifier 80, 81 or 82 is reported by a physician (MD/DO) for assistant surgeon services. When modifier 80, 81 or 82 is reported, reimbursement for a covered procedure is the lesser of 16% of the contracted rate of the principal surgeon or 16% of billed charges; specific contract terms may apply.

Modifier AS is reported by a physician assistant (PA), nurse practitioner (NP) and clinical nurse specialist (CNS) for assistant at surgery services. When modifier AS is reported, reimbursement for a covered procedure is 85% of the amount allowed for an assistant surgeon.

Separate reimbursement will not be allowed for the hospital-employed assistant surgeons or assistants at surgery.

Beginning 11/1/2009, claims processed with multiple procedures billed by an assistant surgeon are reimbursed at 50% of the assistant surgeon rate for the 2nd procedure and beyond. This applies to all surgery assists (physician, PA, NP, CNS). This is in addition to the reduction to 16% for assistant surgery.

Assistant surgeon services will not be reimbursed if the procedure does not allow for assistant surgeon services (see Medicare Physician Fee Schedule (MPFS) Assistant at Surgery (ASST SURG) Indicators under Billing/coding guidelines below). The member cannot be held liable. The Plan will not reimburse separately for a Registered Nurse First Assistant (RNFA) assisting a physician during surgery as per Medicare guidelines.

Referral/notification/prior authorization requirements

Fallon Health Weinberg and Navicare® models of care are based on patient care coordination; therefore, we encourage referring providers to contact the member's designated navigator if there are questions or concerns prior to prescribing tests, supplying equipment, or providing any other additional appointments or services that may not routinely be authorized or may require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

Billing/coding guidelines

Payment is allowed for assistant surgeons only when medical necessity and appropriateness of assistant surgeons are met. The Plan follows Medicare and other nationally recognized guidelines to determine medical necessity and appropriateness of assistant surgeon services. If medical necessity and appropriateness criteria are not met, the assistant surgeon claim will be denied even if the code(s) billed by the assistant surgeon and the surgeon match exactly.

Medicare Physician Fee Schedule (MPFS) Assistant at Surgery (ASST SURG) Indicators

The Medicare Physician Fee Schedule (MPFS) assistant at surgery (ASST SURG) indicators are used to determine if assistant surgeon services are allowed for a procedure code:

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. Assistants at surgery may not be paid.
2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistants at surgery may be paid.
9 = Concept does not apply.

Use the following link to go to the Medicare Physician Fee Schedule Look-up Tool: https://www.cms.gov/medicare/physician-fee-schedule/search. In the “Type of Information” box, select Payment Policy Indicators; then enter the procedure code in the “HCPCS Code” box and click “Search Fees.” Under Search Results, look for ASST SURG.

Procedure codes with MPFS ASST SURG indicators of 1 and 9 submitted with assistant surgeon modifier 80, 81, 82 or AS are not eligible for reimbursement.

Procedure codes with MPFS ASST SURG indicator of 0 submitted with assistant surgeon modifier 80, 81, 82 or AS are not eligible for reimbursement upon initial adjudication of the claim. The appeals process must be followed in order to submit documentation establishing medical necessity - this should include the operative report.

When conditions of medical necessity and appropriateness are met, and the code(s) billed by the assistant surgeon and the surgeon match exactly, both claims will be paid.

When conditions of medical necessity and appropriateness are met, but the code(s) billed do not match exactly, these claims will be processed as follows:

1) If the code(s) billed by the assistant surgeon represent anatomically correct area(s), similar level of complexity, and reasonable billed amount(s) to the code(s) billed by the surgeon, they will be processed as acceptable codes.
2) If the code(s) billed by the assistant surgeon **do not** represent anatomically correct areas, similar level of complexity, or reasonable billed amount(s) to the code(s) billed by the surgeon, the claim will be denied.

The appropriate modifier should be used and documented for reimbursement:

- 51 Multiple Procedures
- 80 Assistant Surgeon
- 81 Minimum Assistant Surgeon
- 82 Assistant Surgeon (when qualified resident surgeon not available)
    - The Plan does not reimburse for assistant surgeons at teaching hospitals unless there is no qualified resident available.

- AS Physician Assistant/Nurse Practitioner or Clinical Nurse Specialist services for assistant at surgery.

Only one assistant surgeon is allowed per eligible procedure. A second assistant surgeon will be considered only upon written appeal when documentation of medical necessity for the second assistant surgeon is submitted.

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	04/18/02
Previous revision date(s):	05/09/07 07/01/09 – moved to new policy template and corrected typographical errors in the Reimbursement section. 11/01/2009 – added description of additional 50% reduction for multiple procedures. 01/01/2011 - clarify language to state consistently that the Plan uses Medicare and other nationally recognized guidelines to determine medical necessity and appropriateness of assistant surgeon services. 07/01/2015 - updated to new Plan template. 11/01/2015 – Updated billing/coding guidelines. 05/01/2016 - Annual review.
Connection date & details:	March 2017 – Annual review January 2018 – Added Definitions January 2019 – Annual review, no updates. January 2020 – Updated referral/notification/prior authorization section. April 2022 – Medicare Physician Fee Schedule assistant at surgery (ASST SURG) indicators added under Billing/coding guidelines.

The criteria listed above apply to Fallon Health Plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.