Payment Policy: Assistant Surgeon

Reference Number: CC.PP.029
Product Types: ALL
Effective Date: 01/01/2014
Last Review Date: 12/01/2022

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

The American College of Surgeons (ACS) defines assistant surgeons as *"a trained individual who is able to participate in and actively assist the surgeon in completing the operation safely and expeditiously by helping to provide exposure, maintain hemostasis, and serve other technical functions."* The ACS goes on to clarify that Assistants at Surgery could be either a qualified surgeon, a resident in an approved surgical education program and at times, non-physician practitioners.

The ACS provides guidance for surgical procedures which typically require an Assistant Surgeon. Each surgical procedure is designated in one of three categories, 1) Almost Always, 2) Sometimes and 3) Almost Never. These designations are based on clinical guidelines established by the American College of Surgeons and other specialty society medical organizations. Each organization reviews codes for their specialty and determines if the surgery requires the use of a physician as an Assistant at Surgery. Participating specialty organizations include:

- American College of Surgeons
- American College of Ophthalmology
- American Academy of Orthopaedic Surgeons
- American Academy of Otolaryngology – Head and Neck Surgeons
- American Association of Neurological Surgeons
- American College of Colon and Rectal Surgeons
- American Pediatric Surgical Association
- American Society of Plastic Surgeons
- American Society of Transplant Surgeons
- American Urological Association
- Congress of Neurological Surgeons
- Society for Surgical Oncology
- Society for Vascular Surgery
- Society of American Gastrointestinal Endoscopic Surgeons
- The American College of Obstetricians and Gynecologists
- The Society of Thoracic Surgeons

The Centers for Medicare and Medicaid Services (CMS) also provides designations for surgical procedures billed with an Assistant Surgeon. However, CMS bases their designations on statistical data; in other words, the frequency with which an Assistant Surgeon is billed for a particular surgery. Unlike ACS, CMS does not consider clinical circumstance in the determination as to whether a procedure requires an Assistant Surgeon. CMS designations can be found in the CMS Physician's Fee Schedule.

The purpose of this policy is to define payment criteria for procedures which are appropriate to be billed with the assistant surgeon modifier to be used in making payment decisions and administering benefits.

Application

1. Professional Services

Policy Description

Modifiers 80, 81, 82 and AS represent surgical assistant services. The Primary Surgeon and the Assistant Surgeon must report the same procedure codes when using these modifiers.

The Health Plan uses ACS guidance as the primary source for determining appropriate use of assistant surgeon modifiers; however, CMS guidelines are used in certain situations identified below under "Reimbursement".

Reimbursement

The Health Plan's code editing software evaluates claim lines and identifies procedure codes that have been inappropriately submitted with an Assistant Surgeon modifier.

The ACS uses three categories to determine the appropriateness of Assistant Surgeon resources for any surgical procedure:

Almost Always

These procedures have been determined as almost always requiring an Assistant Surgeon. Assistant Surgeon modifiers billed with these procedures are allowed for reimbursement.

Almost Never

These procedures that have been determined as almost never requiring an Assistant Surgeon. Assistant Surgeon modifiers billed with these procedures are not allowed for reimbursement.

Sometimes

When a procedure with a "sometimes" designation is billed, the code editing software compares the CMS and ACS designations for the code. The procedure code is evaluated as follows:

<table>
<tr><th>ACS Designation</th><th>CMS Designation</th><th>Edit Outcome</th></tr>
<tr><td>"Sometimes"</td><td>"Always"</td><td>"Always or Never"</td></tr>
<tr><td colspan="3">Reviewed by a physician consultant team within the appropriate surgical specialty. Based on physician consultant consensus, the code is assigned a designation of "Sometimes" or "Never" and will be paid or denied accordingly.</td></tr>
</table>

ACS Designation	CMS Designation	Edit Outcome
"Sometimes"	"Never"	"Never"

The specialty physician consultant team uses the CMS designation for codes that ACS assigns as "sometimes" and CMS assigns as "never." Since CMS bases their designation on statistical data (vs clinical review), the assumption is that Assistant Surgeon modifiers are rarely submitted with these procedures and therefore medical necessity for an Assistant Surgeon is unwarranted. These claim lines are denied.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

References

1. *Current Procedural Terminology (CPT®)*, 2022
2. American College of Surgeons. (2020). *Physicians as Assistants at Surgery. Retrieved from* https://www.facs.org/media/fw5l0hmd/2020-physicians-as-assistants-at-surgery-consensus.pdf
3. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

Revision History	
11/14/2016	Initial Policy Draft Created
03/01/2018	Conducted review, updated policy
04/01/2019	Conducted review, updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/12/2021	Annual Review completed; no policy changes required
12/01/2022	Annual review completed; code tables removed as this information can be found within resources listed under References

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage,

certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

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