



Highmark Blue Cross Blue Shield (Highmark BCBS) partners with Wellpoint companies to administer certain services to Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), and Child Health Plus (CHPlus) members. Please note, this information is specific to the MMC, HARP, and CHPlus programs only.

<b>Reimbursement Policy</b>	
Subject: <b>Modifiers 80, 81, 82, and AS: Assistant at Surgery</b>	
Policy Number: <b>G-06005</b>	Policy Section: <b>Coding</b>
Last Approval Date: <b>12/19/2023</b>	Effective Date: <b>12/19/2023</b>

\*\*\*\* Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to [providerpublic.mybcbswny.com](https://providerpublic.mybcbswny.com). \*\*\*\*

### Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Highmark BCBS covered the service for the member's 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 Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

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

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or

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Wellpoint Partnership Plan, LLC provides management services for Highmark Blue Cross Blue Shield's managed Medicaid. Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.

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requirements. Highmark BCBS strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

### Policy

Highmark BCBS allows reimbursement for one assistant surgeon when eligible procedures are billed with Modifiers 80, 81, 82 or AS as applicable unless otherwise noted by physician, state, federal, or CMS contracts and/or requirements. If an applicable modifier is not billed appropriately, the procedure may be denied.

When multiple procedures are done and 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 the assistant at surgery and the primary surgeon.

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.

Related Coding		
Modifier Code	Description	Comments
80	Denotes an assistant at surgery providing full assistance to the primary surgeon	Reimbursement is based on 20% of the allowable fee for the primary surgeon.
81	Denotes an assistant at surgery providing minimal assistance to the primary surgeon	Reimbursement is based on 16% of the allowable fee for the primary surgeon.
82	Denotes an assistant at surgery when a qualified resident surgeon is not available to assist the primary surgeon	Reimbursement is based on 20% of the allowable fee for the primary surgeon.
AS	Denotes an assistant at surgery who is a non-physician (physician assistant, nurse practitioner or clinical nurse specialist)	Reimbursement is based on 20% of the allowable fee for the primary surgeon.

Policy History	
12/19/2023	Review approved and effective: updated policy title from Assistants at Surgery (Modifiers 80, 81, 82, and AS)
04/03/2017	Review approved: policy template updated
11/04/2015	Initial approval 11/04/2015 and effective 01/01/2017

<b>References and Research Materials</b>
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This policy has been developed through consideration of the following:
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| <ul style="list-style-type: none"><li>• CMS</li><li>• Optum EncoderPro 2023</li><li>• State contract</li><li>• State Medicaid</li></ul> |
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<b>Definitions</b>
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General Reimbursement Policy Definitions
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<b>Related Policies and Materials</b>
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Code and Clinical Editing Guidelines
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Modifier Usage
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