



ASSISTANT SURGEONS

Policy # 23

Implementation Date: 1/1/03

Review Date:

Revision Date: 3/1/06, 4/1/14

Disclaimer:

1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Advantage (Medicare/CMS), and Select Health Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

An assistant surgeon is defined as a practitioner who actively assists the operating surgeon in the performance of a surgical procedure. An assistant surgeon must be practicing within their Scope of Practice guidelines as defined by State Law. An assistant surgeon performs medical functions under the direct supervision of the operating physician.

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Select Health **allows payment for assistant surgeons when medically necessary and appropriate according to CMS (Centers for Medicare and Medicaid Services)**. Services that CMS has designated with an indicator of "0" (Payment restriction for an assistant-at-surgery applies to this procedure unless supporting documentation is submitted to establish the medical necessity) will be reviewed on appeal for appropriateness and medical necessity. For procedures with a payment restriction, the documentation must be in the operative report and indicate the reason an assistant surgeon was necessary, including the duties and/or functions performed. These services must require skills and expertise over and above what would be expected from a facility-provided scrub technician (i.e., assisting in proper patient positioning, pre-operative skin preparation, draping, knowledge of specialized surgical instruments and equipment, retraction, and post-operative dressing applications). Select Health will not pay an assistant surgeon if the documentation indicates they are being used for the above-listed duties or to perform any of the services specifically identified as inclusive in the global surgical procedure for the primary surgeon.

Except for limited situations, the codes submitted by assistant surgeons should match the primary surgeon's codes. There are exceptions, the most common being for obstetric care, where the primary surgeon bills 59510 (Routine obstetric care including antepartum care, cesarean delivery, and postpartum care) and assistant surgeon bills 59514 (Cesarean delivery only) with the appropriate modifier.

Non-physician practitioners must be credentialed with Select Health to receive reimbursement for assistant surgeon services. Physician Assistants and Nurse Practitioners that are credentialed as assistants will be reimbursed if the AS modifier is appended to correct CPT codes.

SELECT HEALTH ADVANTAGE (MEDICARE/CMS)

Select Health Advantage **will follow the commercial plan policy.**

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care **will follow the commercial plan policy.**

Applicable Codes

Modifiers	Descriptions
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available)
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery

Sources

1. OPTUM, EncoderPro. (2013, January 1). CPT - Modifiers. Retrieved April 14, 2014.
2. Current Procedural Terminology (2014). American Medical Association, Professional Edition
3. Physicians/Nonphysician Practitioners Chapter 12 (Rev. 2914, March 25, 2014) Medicare Claims Processing Manual Retrieved August 27, 2014, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf>

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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