 <b>JOHNS HOPKINS</b> <small>HEALTH PLANS</small>	Johns Hopkins Health Plans <b>Provider Relations and Network Innovation          Reimbursement Policy</b>	<i>Policy Number</i>	RPC.018
		<i>Effective Date</i>	06/10/2024
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This document applies to the following Participating Organizations:

Advantage MD

EHP

Priority Partners

US Family Health Plan

**Keywords:** Assistant Surgeon, Modifier 80, Modifier 81, Modifier 82, Modifier AS

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## **I. ABOUT OUR REIMBURSEMENT POLICIES**

The most current version of the reimbursement policies can be found on [www.hopkinsmedicine.org](http://www.hopkinsmedicine.org).

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

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- Reject or deny the claim
- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

## **II. PURPOSE**

JHHP allows for reimbursement for one assistant surgeon when eligible procedures and services are billed with Modifiers 80, 81, 82 or AS, as applicable, when reported on UB-04 claim forms, CMS-1500 claim forms or their electronic equivalent. This policy is applicable for both participating and nonparticipating providers, who submit claims to JHHP.


## **III. POLICY STATEMENT**

This policy provides basic reimbursement guidance on the appropriate reporting of Assistant-at-Surgery services that are within the provider's scope of practice, under state and federal law. Each line of business possesses its own unique guidelines for benefit and payment purposes. As such, JHHP will align with regulatory, state and federal guidance to identify physician and non-physician services that are eligible as reimbursable or non-reimbursable, as applicable to the member's plan.

*Providers are responsible for reviewing the **"EXCEPTIONS & EXCLUSIONS"** Sections below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

## **IV. BILLING GUIDELINES AND PAYMENT METHODOLOGY**

- A. For assistant-at-surgery services performed by physicians, the reimbursement amount equals to 16 percent of the contracted rate, as applicable for the surgical payment.
- B. Procedures with an Assistant-at-Surgery Indicator of 1 or 9 should not be reported with Assistant-at-Surgery modifiers; if reported with one of these modifiers, the claim line will deny.
- C. Services rendered for Assistant-at-Surgery by non-physician providers—physician assistants (PA), nurse practitioners (NP) and clinical nurse specialists (CNS)—are reimbursed at 85% of 16% (13.6 percent) of the contracted rate.
- D. Procedures billed with the assistant-at-surgery physician modifiers -80, -81, -82, or the AS modifier for PA, NP, or CNS are subject to this Assistant-at-Surgery policy. Accordingly, JHHP will pay claims for procedures with these modifiers only if the services of an Assistant-at-Surgery are authorized.
  1. Providers may refer to the Medicare Physician Fee Schedule (MPFS) status indicators for Assistant-at-Surgery services to determine if the procedure is allowed with the assistance of a second surgeon.
- E. The appropriate modifier(s) for Assistant-at-Surgery services must be reported, and in the correct order, or the service will be denied.
  1. Assistant-at-Surgery payment adjustments are subject to other modifier payment adjustments.
- F. Assistant surgeons must bill the same procedure codes as the primary surgeon, with the exception of when the primary surgeon bills a global code. In that case, the assistant surgeon must bill the related surgery-only code, as global surgery rules do not apply to Assistant-at-Surgery services.
- G. When the member's plan benefits requires precertification/prior authorization for a certain procedure or service, the provider is responsible to verify coverage, obtain the authorization and bill accordingly.
  1. Prior authorization is not a guarantee of payment.
- H. All providers, whether physicians, PA, NP, or CNS must bill under their own National Provider Identifier (NPI) number, when submitting a claim for Assistant-at-Surgery services.

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- I. Supporting documentation must clearly establish medical necessity and provide adequate details of the assistant surgeon's role during the operative session. Documentation should include, but is not limited to, operative notes that indicate the reason for the surgical assist.
  1. Refer to the JHHP [resources and guidelines for all of our health plans](#) for additional information for Medical Record Standards Documentation.

## V. EXCEPTIONS & EXCLUSIONS

A. **PPMCO:** JHHP reimburses Assistant-at-Surgery services in accordance to the Maryland Medicaid Administration Professional Services Provider Manual. Modifiers. As such:

1. Does not recognize modifier 81 for payment purposes
2. Recognizes modifier AS, as informational only
3. Does not reimburse Assistant Surgeons when they report with modifiers -54 (surgical care only), and -55 (post-operative management only)
4. JHHP reimburses covered Assistant-at-Surgery services, appended with modifiers 80 and 82, 20% of the contracted rate for the surgical procedure.
5. JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Priority Partner members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service. Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.
  - Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.


B. **USFHP:** JHHP aligns with TRICARE billing and reimbursement methodologies. Please consult the authoritative guidance found in the TRICARE Manuals to obtain specific information on policy, benefits, and coverage for Assistant-At-Surgery services, not addressed in this policy.

1. In accordance with [TRICARE Reimbursement Manual- Chap 1 Sect 17](#) Assistant Surgeon guidance applies to CPT codes 10040-69990, 92982, 92984, 92995, 92996, 92998.
2. JHHP will not reimburse Assistant Surgeons when they report with modifier 58, 78, or 79 in conjunction with modifier AS, 80, 81 or 82 for the same procedure code, on the same date of service.
3. Per TRICARE guidance, no payment may be made for an assistant surgeon when co-surgeon services are reimbursed.

## VI. CODES, TERMS and DEFINITIONS

### Definition of Terms


<b>Term</b>	<b>Definition</b>
Assistant-At-Surgery	An Assistant-at-Surgery is a provider who actively assists the physician in charge of a case in performing a surgical procedure. A physician, nurse practitioner, physician assistant or clinical nurse specialist who is authorized to provide such services under state law can serve as an Assistant-at-Surgery.

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Scope of Practice	Scope of practice refers to those activities that a person licensed to practice as a health professional is permitted to perform, which is increasingly determined by statutes enacted by state legislatures and by rules adopted by the appropriate licensing entity.
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Assistant-At-Surgery Modifiers: Applies for surgical procedures where the complexity of the surgery necessitates the need for additional, skilled operative assistance. Providers are to report the appropriate modifier to denote whether the service meets the requirements for payment.

<b>Modifier</b>	<b>Definition</b>
<b>AS</b>	Physician assistant, nurse practitioner, or clinical nurse specialist services for Assistant-at-Surgery.  Use the modifier "AS" for Assistant-at-Surgery services provided by a physician's assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).
<b>80</b>	Assistant Surgeon: Surgical assistant services may be identified by adding the modifier 80 to the usual procedure number(s).  Use the "80" modifier when the Assistant-at-Surgery service was provided by a physician.
<b>81</b>	Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.  This modifier pertains to physician's services only. Minimal surgical assistance may be identified by adding the modifier 81 to the usual procedure code and describes an assistant surgeon providing minimal assistance to the primary surgeon.

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<b>82</b>	<p>Assistant Surgeon (when qualified resident surgeon <b>not</b> available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).</p> <p>Use the "82" modifier when a qualified resident surgeon is not available in a teaching facility:</p> <ul style="list-style-type: none"> <li>The unavailability of a qualified resident surgeon is a prerequisite for use of this modifier and the service must have been performed in a teaching facility.</li> <li>The circumstance explaining that a resident surgeon was not available must be documented in the medical record. This modifier is not intended for use by non-physician providers.</li> </ul>
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MPFS Status Indicators (SI)

<b>SI</b>	<b>Definition</b>
<b>0</b>	Use the modifier "AS" for Assistant-at-Surgery services provided by a physician's assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).
<b>1</b>	Statutory payment restriction for assistants at surgery applies to this procedure. Assistant-at-Surgery may not be paid.
<b>2</b>	Payment restrictions for assistants at surgery does not apply to this procedure. Assistant-at-Surgery may be paid.
<b>9</b>	Concept does not apply.


## VII. REFERENCES

This policy has been developed through consideration of the following:

- [COMAR- Maryland Department of Health- Maryland Medicaid Administration](#)
  - CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
  - [CMS MLN9013344-How to Use the PFS Look-Up Tool Booklet](#)
  - [CMS Medicare Physician Fee Schedule \(MPFS\)](#)
  - [Medicare Claims Processing Manual CH. 1 - General Billing Requirements](#)
  - [Medicare Claims Processing Manual CH. 12- Physicians/Nonphysician Practitioners](#)
  - [National Provider Identifier Standard \(NPI\) website](#)
  - [TRICARE Reimbursement Manual](#)

## VIII. APPROVALS

Date	Review/Revision	Reason for Modification	Approved By
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3/27/2024	Revision	Updated policy formatting  Updated "About" section, "Exceptions and Exclusions" section, general policy guidance and language.  Updated and included key definitions, terms, codes, and reference sections.	Reimbursement Policy Committee (RPC)
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