 <p><b>JOHNS HOPKINS</b> MEDICINE</p> <p>JOHNS HOPKINS HEALTHCARE</p>	<p><b>JOHNS HOPKINS HEALTHCARE</b></p>	<p>Policy Number: <b>RPC.018</b>  Effective Date: 08/01/2020  Revision Date: 6/01/2022</p>
	<p>Subject: Assistant at Surgery  Department: Provider Relations  Lines of Business: EHP, PPMCO, USFHP, AdvantageMD</p>	<p>Page 1 of 4</p>

**ACTION**

- New Policy
- Repealed Policy Date: \_\_\_\_\_
- Superseded Policy Number: \_\_\_\_\_

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


These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member’s Johns Hopkins HealthCare (JHHC) 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 must be billed with ICD-10 codes, CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current Reimbursement Policies are not followed, Johns Hopkins HealthCare (JHHC) may:

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

JHHC reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state or commercial client contracts, or state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHC strives to minimize these variations.

JHHC reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy on [www.jhhc.com](http://www.jhhc.com).

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### **POLICY:**

Johns Hopkins Healthcare LLC allows reimbursement for one assistant surgeon when eligible procedures are billed with Modifiers 80, 81, 82 or AS as applicable. If an applicable modifier is not billed appropriately, the procedure may be denied.

### **SCOPE:**

This payment policy applies to procedures, reported with modifiers 80, 81, 82, or AS on UB-04 claim forms, CMS-1500 claim forms or their electronic equivalent.

### **DEFINITIONS:**

**Assistant-at-Surgery** - An "assistant at surgery" is a physician who actively assists the physician in charge of a case in performing a surgical procedure. The "assistant at surgery" provides more than just ancillary services.


**Assistant-at-Surgery modifiers** - apply for surgical procedures where the complexity of the surgery necessitates the need for additional, skilled operative assistance:

- **Modifier 80** – used when the assistant surgeon services were provided by an MD, DO, or DPM
- **Modifier 81** – used to identify minimal assistant surgeon services (assistance provided for a small, selective portion of the procedure)
- **Modifier 82** – used when the assistant surgeon services were provided by an MD, DO, or DPM and no qualified resident was available
- **Modifier AS** – used when the assistant surgeon services were provided by a Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, or Registered Nurse First Assistant

### **PROVIDER BILLING GUIDELINES:**

Billing expectations and reimbursement for Assistant-at-Surgery modifiers is based on the procedure code's assistant-at-surgery indicator found in the CMS Physician Fee Schedule:

1. *Assistant-at-Surgery Indicator 0*: additional documentation must be submitted to support medical necessity

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2. *Assistant-at-Surgery Indicator 1 & 9*: the procedure should not be reported with Assistant-at-Surgery modifiers; if reported with one of these modifiers, the claim line will deny for incorrect coding
3. *Assistant-at-Surgery Indicator 2*: the procedure should be reported with an Assistant-at-Surgery modifier
  - a. Maryland Medicaid does not recognize modifier 81; modifiers AS, 80 and 82 will be paid at 20% of the contracted rate
  - b. MA, EHP, & USFHP align with CMS; modifier 80, 81, and 82 will be paid at 16% of the contracted rate; modifier AS will be paid at 85% of 16% of the contracted rate (13.6%)

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.

Assistant-at-Surgery payment adjustments are subject to other modifier payment adjustments.

JHHC does not base reimbursement upon medical documentation review, but medical documentation must be available upon request to support the use of the modifier.

Documentation should include, but is not limited to, operative notes that indicate the reason for the surgical assist.

### **EXCLUSIONS**

N/A

### **EXEMPTIONS**


N/A

### **REFERENCES:**

CMS Medicare Claims Processing Manual, [Pub. 100-04, Chap. 12, Sect. 20.4.3](#)

Novitas Solutions, Jurisdiction JL, [Assistant at surgery modifier fact sheet](#)

TRICARE Policy Manual 6010.60-M, April 1, 2015, [Chap. 4, Sect. 4.1 - Assistant Surgeons](#)

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TRICARE Reimbursement Manual 6010.61-M, April 1, 2015, [Chap. 1, Sect. 17 - Assistant Surgeons](#)

State Medicaid Professional Services [Provider Manual, Chap. 3, Sect. C \(vi\) – Assistant Surgeons](#)

### **APPROVALS**

Reimbursement Policy Committee      Date: 5/24/2022

Review/Revision Dates: 6/15/2020, 5/24/2022