Keystone First
Family of Health Plans

Assistant Surgeon

Reimbursement Policy ID: RPC.0004.0100

Recent review date: 01/2024

Next review date: 10/2025

Keystone Fist reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Keystone First may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This Assistant Surgeon policy identifies procedures that are eligible for reimbursement as Assistant Surgeon services, as identified by the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) and the state of Pennsylvania.

Exceptions

N/A

Reimbursement Guidelines

Keystone First utilizes the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value File (NPFS) payment policy indicators.

All codes in the NPFS with the payment indicator of "2" for "Assistant Surgeon" are considered reimbursable for assistant surgeon services as indicated by assistant surgeon modifiers [80, 81,or 82].

Assistant surgeons submit procedure code(s) with an appropriate modifier appended [80,81,or 82] to represent their services. Only one assistant surgeon will be reimbursed for each eligible procedure.
Procedure code(s) must be identical to those billed by the primary surgeon, with the addition of the Assistant Surgeon modifiers 80, 81, or 82.

Keystone First will reimburse Assistant Surgeon services at [20%] of the allowable charges.

Definitions

Modifier 80 – Assistant Surgeon
Surgical assistant services may be identified by adding modifier 80 to the usual procedure code(s). Modifier 80 is appended to the same service as the primary surgeon and designates the surgeon as the surgical assistant on the service.

Modifier 81 – Minimum Assistant Surgeon
Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure code(s). Modifier 81 is used to indicate the Assistant at Surgery is not present for the entire procedure; rather, he or she assists with a specific part of the procedure only.

Modifier 82 – Assistant Surgeon (teaching hospital, no resident available)
The unavailability of a qualified resident surgeon is a prerequisite for use of Modifier 82. Use of this modifier is limited to a teaching hospital setting. When appended to the procedure code(s), modifier 82 represents the services performed by the assistant surgeon in the absence of a resident.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS), www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.
V. The National Correct Coding Initiative (NCCI)
VI. Corresponding Keystone First Clinical Policies.
VII. Applicable Keystone First manual reference.
VIII. Commonwealth of Pennsylvania Medicaid Program guidance.
IX. Commonwealth of Pennsylvania Medicaid Program fee schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
11/2024	Updated to biennial policy • No major changes
04/2024	Revised preamble
01/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by Keystone First from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section