Coding Policy

Assistant for Surgical Procedures

CODING POLICY NUMBER: 3

Effective Date: 1/1/2025

Last Review Date: 1/2025

Next Annual Review: 2026

SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies"). **The full Company portfolio of current coding policies is available online and can be [accessed here](#).**

POLICY APPLICATION

☒ Providence Health Plan Participating Providers   ☒ Non-Participating Practitioners

☒ Commercial   ☒ Medicaid/Oregon Health Plan   ☒ Medicare

POLICY STATEMENT

I. Surgical assistants are individuals who assist the surgeon in performance of a surgical procedure. An assistant is approved only for procedures identified with an assistant surgery indicator of "2" on the Medicare Physician Fee Schedule (MPFS).

II. Codes with assistant surgery indicator of "0" on the MPFS may be paid if medically necessary. Supporting documentation is required.

III. Second or third surgical assistants are approved on a case-by-case basis depending on the complexity of the procedure. Supporting documentation is required.

IV. Surgical assistants must be approved by the facility to assist at surgery and:

A. may be a physician.

       B.   may be a Registered Nurse who is certified as a first assistant (Registered Nurse First Assistant [RNFA] is approved for Commercial and Oregon Health Plan lines of business only. RNFA's are **not** approved for Medicare lines of business).

       C.   may be a Physician Assistant who is in the employ of a plan provider.

       D.   may be a Nurse Practitioner.

       E.   may be a Certified Nurse Midwife, but only as assistant for Cesarean section deliveries.

V.   Only providers who are credentialed with PHP may bill as surgical assistants. An assistant may not bill "incident to" under the surgeon's name. Charges for an assistant billed under the surgeon's name will be denied. See also Reimbursement Policy for "incident to" billing.

PROCEDURE

GENERAL

The assistant surgeon must report the same code reported by the surgeon with the addition of the appropriate modifier (80, 81, or AS). Reimbursement is based on the assistant surgeon's contract and is a percentage of the allowed amount for the surgery as listed below. **The surgeon of record is responsible for identifying the presence of the assistant surgeon or assistant at surgery and the work performed by the assistant.** The assistant's claim may be denied if the role of the assistant is not documented by the surgeon.

- A physician acting as an assistant is reimbursed at 16% of the maximum allowable for the procedure. Claims are to be billed with modifier -80 or -82. (Modifier -82 is used only at teaching facilities when no resident is available.)
- Except as defined below, a certified RNFA, PA, or CNM (CNM for Cesarean deliveries only) is reimbursed at 13.6% of the maximum allowable for the surgical procedure. Claims are to be billed with modifier -81 or -AS.
- An OHP provider contracted to be reimbursed at a percent of current Oregon Medicaid fee-for-service (FFS) maximum allowable rate is reimbursed at 16% of DMAP's full surgical rate for covered procedures.

CROSS REFERENCES

- Reimbursement Policy for "Incident To" Billing

REFERENCES

1. CMS / Medicare Rules and Regulations
2. Medicare Physician Fee Schedule

3. Oregon Health Plan Rules and Regulations
4. Providence Health Plan Clinical Coding Edits
5. National Correct Coding Initiative Edits

POLICY REVISION HISTORY

Date	Revision Summary
3/2023	Annual review (converted to new template 5/2023). Original policy effective date: 9/1990
1/2024	Annual review. Removed reference to Coding Policy 62.0 (retired in 2024) and referred to reimbursement policy for "incident to" billing which will replace CP 62.0.
1/2025	Annual review. No changes to policy.