

Commercial Reimbursement Policy

Subject: **Modifiers 80, 81, 82, and AS: Assistant at Surgery - Professional**

Policy Number: **C-08006**

Policy Section: **Coding**

Last Approval Date: **12/02/2025**

Effective Date: **09/27/2023**

Policy

The health plan allows reimbursement for an assistant surgeon when eligible procedures are billed with modifiers 80, 81, 82, or AS unless provider, state, or federal contracts and/or requirements indicate otherwise. Eligible procedures are identified using the Centers for Medicare and Medicaid Services (CMS) Medicare Physician Fee Schedule (MPFS) Assistant Surgery payment indicators and applied using the guidelines as indicated below.

Reimbursable:

- Codes identified with MPFS Assistant Surgery payment indicator '2'.
- Only one assistant surgeon per covered surgical procedure.

Nonreimbursable:

- Codes identified with MPFS Assistant Surgery payment indicators '0', '1', and '9'.
- Procedures requiring assistance for positioning and retraction for maintaining visualization.
- Applicable assistant surgeon modifier billed inappropriately.

Procedures reported with an assistant surgeon modifier are subject to multiple surgery reimbursement rules.

The assistant at surgery should not report procedure codes different from the procedure codes reported by the primary surgeon, EXCEPT if the primary surgeon bills an OB global code; then the assistant at surgery would bill the specific surgery code with the appropriate modifier.

Related Coding

Modifier	Description	Comments
80	Physician providing assistance in surgery	16% of the allowance
81	Physician providing minimum assistance in surgery	16% of the allowance
82	Physician providing assistance in surgery when qualified resident not available	16% of the allowance
AS	Non-physician providing assistance in surgery	16% of the allowance under the applicable physician extender fee schedule. If there is no applicable physician extender fee schedule, the Assistant

		Surgeon services will be eligible for reimbursement under the applicable physician fee schedule at 14% of the allowance for the primary procedure.
--	--	--

Definitions

Assistant Surgeon	An assistant at surgery is a physician or non-physician practitioner who actively assists the physician in charge of the case in performing a surgical procedure.
Payment Indicator	Medicare Physician Fee Schedule (MPFS) Assistant Surgeon payment indicator: 0- Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity. 1- Statutory payment restriction for assistants at surgery applies to this procedure. Assistant surgeon may not be paid. 2- Payment restriction for assistants at surgery does not apply to this procedure. Assistant surgeon may be paid. Assistant surgeon concept does not apply.
General Reimbursement Policy Definitions	

Related Policies and Materials

Claims Requiring Additional Documentation – Professional and Facility
Modifier Usage - Professional
Modifiers 50 and 51: Multiple and Bilateral Surgery - Professional

References and Research Materials

This policy has been developed through consideration of the following: • CMS • MPFS Indicator list • Optum EncoderPro 2025

Policy History

12/02/2025	Review approved: no changes
09/27/2023	Review approved and effective: updated policy name from Assistant at Surgery (Modifiers 80, 81, 82, AS); replaced CMS alignment from 'reimbursement' to the 'identification'
09/24/2021	Review approved 09/24/2021 and effective 03/01/2022: policy language updated to follow CMS MPFS Assistant Surgery Indicators, removed reference to ACS reimbursement guidelines. Updated Definitions and Related Policies sections. Removed and retired Assistant Surgery Coding list.

06/01/2019	Review approved: updated template; added definitions section and related coding table
05/03/2018	Review approved: Coding table updated; added codes 15733, 19294, 20939, 31241, 31253, 31257, 31259, 31298, 32994, 36465, 36466, 36482, 36483, 38222, 55874, 0479T, 0483T, 0484T, C9738, C9748, G0516, G0517, G0518 to deny effective DOS 01/01/2018. Added code C9749 to deny effective DOS 04/01/2018
07/11/2017	Review approved: added new code effective 07/01/2017 0474T to the assistant surgeon not allowed list
03/07/2017	Review approved: added and deleted codes to “nevers” list, updated ‘methodology’ section with minor language changes
11/01/2016	Review approved: deleted codes 0347T and 0356T; updated policy to match list.
08/02/2016	Review approved; added codes effective 07/01/2016, 0437T, 0438T, 044T, 0441T, 0442T, 0445T, update policy to match list.
07/18/2016	Review approved: updated “nevers” coding chart to include codes that were left off when copied over to new sheet for 2016.
02/05/2015	Review approved: coding updates to the “nevers” list, minor revisions to 1 st paragraph, description section; updated ‘nevers’ coding chart; added 61645 to CMS ‘sometimes’
01/06/2015	Review approved: updated coding table, and policy to match list
08/05/2014	Review approved; revisions to Coding Grid: 0347T, 0356T eff 07/01/14, and policy to match list
11/05/2013	Review approved: minor language and punctuation updates, added physician fee schedule language; embedded “Nevers” excel list in policy
08/06/2013	Review approved: revised ‘Never’ coding table; removed 29838, C9724-C9725, C9732
02/05/2013	Review approved: revised ‘Never’ coding table; embedded coding table into policy: 2013AssistSurgNEVERSCoding_01012013
01/07/2013	Review approved; revised ‘Never’ coding table; Changes to “Nevers” coding based on 2014 coding update
11/06/2012	Review approved; revised language for modifier AS, added provider degrees in policy section, and any other provider language
08/07/2012	Review approved: added codes 0302T, 0303T, 0304T, 0307T, 0308T
01/10/2012	Review approved: updated ‘never’ codes
02/01/2011	Review approved: updated coding table to include new 2011 “Never” codes.
08/20/2010	Review approved: a bracketed statement was added to the Policy Section #2. If a state mandate would allow a 2 nd assist surg under certain circumstances, then the terms of that language needs to be inserted.
01/05/2010	Review approved: Header and Footer updated and Policy History added; Coding table removed, Excel file embedded in policy; the Reference Information Section was renamed “Methodology for Determining Assistant

	Surgeon Edit Designations: Policy language clarified to conform to current standard policy language
03/18/2009	Review approved; Rationale section was removed; coding grid was updated to include the new 2009 never codes; minor language changes to policy section
08/05/2008	Review approved: added statement: Only one assistant surgeon per covered procedure will be reimbursed
05/09/2008	Initial policy approval and effective

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

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

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving, and we reserve the right to review and update these policies periodically.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Anthem Blue Cross and Blue Shield.

©2008-2026 Anthem Blue Cross Blue Shield. All Rights Reserved.