COMPLIANCE TIPS

TEST YOUR KNOWLEDGE OF MEDICARE'S POLICY ON ASSISTANT-AT-SURGERY

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On occasion, a medical department utilizes Physician Assistants to assist in surgical cases. The medical department does have a resident training program relating to the specialty required for the surgery and a qualified resident is not available to assist in the case. The surgical case is performed in a teaching setting and is assigned a payment policy indicator of "02" for assistant-at-surgery. The patient is a Medicare patient.

1) Is this a billable service to Medicare?
2) Assuming the answer to question #1 is yes, which modifier would be submitted with the surgical procedure code for the assistant-at-surgery charge?

The answer will be published in the next issue of *The Connector*. If you cannot wait until then, you may find the answer published on the Compliance Website under Compliance Tips – Medicare Policy on Assistant at Surgery.

http://www.hscj.ufl.edu/college-of-medicine/compliance/Edu.aspx#tips

ANSWER

1) Yes, this is a billable service. The "02" payment policy indicator means that Medicare allows assistant-at-surgery for this procedure.

2) The correct modifier to submit when the assistant-at-surgery service is provided by a Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist is the "AS" modifier. The fact that a nonphysician practitioner is performing the assist does not negate the other teaching setting requirements; that is, if a qualified resident is available to assist, then an assistant-at-surgery charge should not be submitted to Medicare Part B. The "-82" modifier would not be appropriate to support the charge for a nonphysician practitioner as an assistant-at-surgery in a teaching hospital. The medical record documentation must support that a qualified resident was not available. In the event of a government audit, the medical department submitting the assistant-at-surgery charge should be able to support why a qualified resident was not available for the particular case.

Definition

For billing purposes, an assistant-at-surgery is a physician or qualified nonphysician practitioner who actively assists the primary surgeon in the performance of a surgical case.

Medicare does not reimburse Registered Nurse First Assistants (RNFAs) for assistant-at-surgery but will reimburse Advanced Registered Nurse Practitioners (ARNP), Clinical Nurse Specialists (CNS), and

Physician Assistants (PA) if the service is within their state scope of practice, protocol, and hospital-granted privileges.

General Payment Policy

Medicare does not pay for an assistant-at-surgery for all surgical procedures. In fact, Medicare will not pay for assistant-at-surgery on procedures where it has determined the need is required in fewer than 5 percent of surgical cases nationally. In order to determine whether Medicare will reimburse for an assistant-at-surgery charge at all, check the payment policy indicator assigned to the surgical procedure code. +++ Medicare allows 16% of the usual surgical allowance for an assistant-at-surgery service.

Payment Policy Indicators

0 = Payment restrictions for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

This means that Medicare MAY pay for an assistant-at-surgery if the medical record documentation supports the medical necessity for the assistant.

1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant-at-surgery may not be paid.

If this service is billed, it will not be paid. The patient cannot be charged for this service. It would not be appropriate to ask the patient to sign an Advanced Beneficiary Notice (ABN) to shift financial responsibility from the provider to the patient. If a denial is received, it is highly unlikely that the denial will be overturned on appeal, regardless of the level of appeal.

2 = Payment restrictions for assistants at surgery does not apply to this procedure. Assistant-at-surgery may be paid.

Medicare allows assistant-at-surgery for this procedure code.

Assistant-at-Surgery in Teaching Settings

Medicare will only pay for assistant-at-surgery in a teaching setting (even if the payment policy indicator is "01" or "02") when:

- furnished by a physician who is primarily engaged in the field of surgery, and the primary surgeon does not use interns, residents, or fellows in ACGME-approved fellowship programs at all in the surgical procedures that the surgeon performs (including preoperative and postoperative care);
- there is not a resident training program relating to the specialty required for the surgery;
- a resident in a training program relating to the specialty required for the surgery is unavailable; or
- the service is required as a result of an exceptional medical circumstance.

Medicare Part A reimburses the hospital for the services of residents and billing Medicare Part B for an assistant-at-surgery charge in a teaching setting when a qualified resident is available could be considered double-dipping.

The Office of Physician Billing Compliance requires the surgeon to document whether or not a resident was involved in the case and whether or not a qualified resident was available. In order to bill, it is ultimately the surgical department's responsibility to support that a qualified resident was unavailable when the department has a resident training program relating to the specialty required for the surgery.

Remember, fellows in non-ACGME-approved fellowship programs, who have their own license to practice in this state and who are enrolled in Medicare, may bill the assistant-at-surgery charge under their own provider number if the hospital affords them the privilege to do so. However, this does not negate the other teaching setting requirements; that is, if a qualified resident is available to assist, then an assistant-at-surgery charge should not be submitted to Medicare.

Assistant-at-Surgery Modifiers

The following modifiers are submitted with the surgical procedure code for which the assistant-at-surgery was involved.

- 80 Modifier – use when the assistant-at-surgery service was provided by a medical doctor (MD or DO but not a resident, or a fellow classified as a resident under the UFCOM – Jacksonville Teaching Physician Billing Policy). This modifier would not be used on this campus as UF Health – Jacksonville is a teaching setting. ***
- 81 Modifier – use to identify minimum surgical assistant services. At times the operating physician plans to perform a surgical procedure alone. When a minor problem is encountered during the operation that requires the service of an assistant surgeon for a relatively short period of time, this is considered a minimum assistant surgeon. This modifier is not intended for use by nonphysician practitioners assisting at surgery (e.g. ARNP, CNS, and PA). This modifier would not be used on this campus as UF Health – Jacksonville is a teaching setting. ***
- 82 Modifier - use when the assistant-at-surgery service was provided by an MD or DO and a qualified resident was not available. Documentation must specifically state that a qualified resident was not available. In the event of a government audit, the medical department submitting the assistant-at-surgery charge should be able to support why a qualified resident was not available for the particular case. This modifier is not intended for use by nonphysician practitioners assisting at surgery (e.g. ARNP, CNS, and PA).

- AS Modifier – report only when assistant-at-surgery services are provided by an ARNP, CNS, or PA. Medicare further reduces the assistant-at-surgery allowance by 15% when provided by an ARNP, CNS, or PA. The fact that a nonphysician practitioner is performing the assist does not negate the other teaching setting requirements; that is, if a qualified resident is available to assist, then an assistant-at-surgery charge should not be submitted to Medicare Part B. The "-82" modifier would not be appropriate to support the charge for a nonphysician practitioner as an assistant-at-surgery in a teaching hospital. The medical record documentation must support that a qualified resident was not available. In the event of a government audit, the medical department submitting the assistant-at-surgery charge should be able to support why a qualified resident was not available for the particular case.

+++ Payment policy indicators may be checked via the Medicare Physician Fee Schedule Search Tool at https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

The payment policy indicator definitions may be found in the Medicare Claims Processing Manual 100-04, Chapter 23, Section 100.5.
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf

*** Keep in mind that for teaching physician billing purposes, a "teaching setting" means any provider, hospital-based provider, or non-provider setting in which Medicare payment for resident services is made under the Part A direct GME payment. As such, if a surgical procedure is performed outside of the UF Health – Jacksonville main campus, it may still be considered a "teaching setting" and the rules pertaining to assistant-at-surgery in a teaching setting would apply.