Nevada | Anthem Blue Cross and Blue Shield Healthcare Solutions | Medicaid Managed Care

Reimbursement Policy
Modifiers 80, 81, 82, and AS: Assistant at Surgery

Policy Number: **G-06005**
Policy Section: **Coding**
Last Approval Date: **12/18/2025**
Effective Date: **12/18/2025**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://anthem.com/nv/provider**.

Policy

The health plan allows reimbursement for one assistant surgeon when eligible procedures are billed with modifiers 80, 81, 82, or AS, unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

If an applicable modifier is not billed appropriately, the procedure may be denied. When multiple procedures are performed where only some of the procedures are eligible for assistant at surgery reimbursement, only assistant at surgery services for the eligible procedures will be considered for reimbursement. The same multiple-procedure fee reductions and clinical edits apply to both the assistant at surgery and the primary surgeon.

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 80 — Denotes an assistant at surgery providing full assistance to the primary surgeon.
  - Modifier 80 reimbursement: 20%
- Modifier 81 — Denotes an assistant at surgery providing minimal assistance to the primary surgeon.
  - Modifier 81 reimbursement: 20%

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- Modifier 82 — Denotes an assistant at surgery when a qualified resident surgeon is not available to assist the primary surgeon.
  - Modifier 82 reimbursement: 20%
- Modifier AS — Denotes an assistant at surgery who is a non-physician (physician assistant, nurse practitioner, or clinical nurse specialist).
  - Modifier AS reimbursement: 20%

Definitions

- Modifier 80 - Denotes an assistant at surgery providing full assistance to the primary surgeon
- Modifier 81 - Denotes an assistant at surgery providing minimal assistance to the primary surgeon
- Modifier 82 - Denotes an assistant at surgery when a qualified resident surgeon is not available to assist the primary surgeon
- Modifier AS - Denotes an assistant at surgery who is a non-physician (physician assistant, nurse practitioner, or clinical nurse specialist
- **General Reimbursement Policy Definitions**

Related Policies and Materials

- Code and Clinical Editing Guidelines
- Exhibit A: Market Assistant at Surgery Reimbursement
- Modifier Usage

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2025
- State contract
- State Medicaid

Policy History

- **12/18/2025 -** Review approved and effective: no changes
- **12/19/2023 -** Review approved and effective: updated policy title from Assistants at Surgery (Modifiers 80, 81, 82, and AS)
- **09/1/42020 -** Review approved and effective
- **04/03/2017 -** Review approved
- **11/04/2015 -** Review approved: updated policy language
- **07/01/2013 -** Review approved and effective: updated policy template
- **06/06/2011 -** Review approved 06/06/2011 and effective 12/07/2011: updated policy language; updated Background and Definitions sections and policy template
- **06/01/2009 -** Review approved: updated Background section/policy template
- **02/01/2009 -** Initial 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 Procedural 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.

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