

**Assistant at Surgery- Modifiers 80/81/82 and AS**
**Date of origin: May 28, 2026**
**Review dates: None yet recorded**
**DEFINITION**

An Assistant-at-Surgery (AAS) is a provider who provides active, hands-on intraoperative assistance to the primary surgeon during a surgical procedure

**FOR MEDICARE**

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD [in our Provider Manual](#).

**POLICY SPECIFIC INFORMATION**

For coding purposes, an Assistant-at-Surgery is an individual who provides active, intraoperative support to the primary surgeon, beyond incidental or ancillary assistance.

The operative report must explicitly document the medical necessity of the assistant's involvement and describe the specific services performed during the procedure.

Reimbursement for Assistant-at-Surgery services billed by the same or different physician or qualified health care professional is determined based on the modifier appended to the surgical CPT code

**Place of service**

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information [in our Provider Manual](#).

**Documentation requirements**

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

An assistant at surgery must provide substantive intraoperative services, not just routine or ancillary support. Because of this, the operative report must clearly describe the assistant's active participation. The procedures or services performed must support the appropriate use of modifiers 80, 81, 82, and AS. Documentation must demonstrate that the assistant surgeon actively participated in the procedure.

**Assistant Surgeon CMS Status Indicators (SI)**

SI	Description
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 at surgery may not be paid.
2	Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.
9	Assistant at Surgery concept does not apply.

**Modifiers**

<b>Modifier</b>	<b>Description</b>
80	Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).
81	Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.
82	Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery

## Resources

- American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- Association of Surgical Assistants (ASA). "Appropriate Use of Assistant at Surgery Modifiers and Payment Indicators – Clarification." *The Surgical Assistant*. Vol. 19, No. 3, Summer 2013. Page 3.

## DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies, and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis, and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry-standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste, and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal, or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align with these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by

state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available [in our Provider Manual](#).

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## CHANGE / REVIEW HISTORY

Date	Revisions made
May 2026	New Policy