Manual: Reimbursement Policy
Policy Title: Modifier 62 - Co-surgery (Two Surgeons)
Section: Modifiers
Subsection: None
Date of Origin: 1/1/2000              Policy Number: RPM035
Last Updated: 7/5/2017              Last Reviewed: 7/12/2017

IMPORTANT STATEMENT

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS’ National Correct Coding Initiative (CCI/NCCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.

Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.
**Reimbursement Guidelines**

The following situations are considered co-surgery:

- Two surgeons of different specialties working together to perform a specific procedure with a single procedure code.
- Two surgeons of the same or different specialties simultaneously performing parts of the procedure (e.g., heart transplant).
- Two surgeons simultaneously performing the same or similar procedure(s) on bilateral body parts, which shortens the total anesthesia time required for one surgeon to perform the same set of bilateral procedures consecutively (e.g., bilateral knee replacements).

The following situation is *not* considered co-surgery:

One or more surgeons of different specialties who each perform different, specific CPT codes which are not billed by the other surgeon, even if performed through the same incision. In this situation, each surgeon may be reimbursed for a primary procedure and multiple surgery discounts only apply to the procedures billed by each surgeon.

Two surgeons of the same specialty may not perform sequential procedures (a.k.a. “tag-team surgeries”), bill different, specific CPT codes not billed by the other surgeon, and both be reimbursed as primary surgeries at 100%.

For example, two sequential eye surgeries by different eye surgeons, or two sequential orthopedic surgeries by different orthopedic surgeons.

Both/all surgical procedures should be performed by a single surgeon with the second surgeon acting as the assistant or as a co-surgery session and submitted according to modifier 62 guidelines. If sequential surgery claims are identified, the first surgeon’s claim processed will be allowed the primary surgical procedure at 100%. The second surgeon’s claim processed will be subject to multiple surgery reductions even to the first surgical procedure. Adjustments and refund requests will occur if overpayments are identified after the original processing.

For the procedures performed as co-surgery, both co-surgeons are expected to bill the exact same combination of procedure codes with modifier 62 appended. Additional procedures performed in the same operative session may be reported as primary surgeon or assistant surgeon.

Any discrepancy in procedure codes reported with modifier 62 between the two co-surgeon’s claims causes both claims to require additional investigation and delay of processing.

**Example:**

Surgeon A:  
22554-62  (anterior cervical fusion)  
22585-62  (additional level)

Surgeon B:  
22600-62  (posterior cervical fusion)  
22614-62  (additional level)
If one surgeon reports as the primary surgeon, and a second surgeon reports as a co-surgeon for the same procedure codes, a non-clean-claim review is triggered which may require a corrected claim, additional records, claim adjustment and/ refund requests (if the primary surgeon claim has already been processed).

Example:

Surgeon A: 22554 (anterior cervical fusion, primary surgeon)
22585 (additional level, primary surgeon)

Surgeon B: 22554-62 (anterior cervical fusion, co-surgeon)
22585-62 (additional level, co-surgeon)

Pricing Adjustments – (Commercial & Medicare Advantage)
CPT codes with modifier 62 appended will be reimbursed as follows: 60% of the applicable fee schedule rate.

The co-surgery pricing adjustment will only be applied to procedure codes with modifier 62 appended, not to additional procedure codes billed as a primary or assistant surgeon without modifier 62 appended.

Please Note: Other pricing adjustments may also apply before the final allowable amount for each line item is determined. For example, bilateral adjustments, assistant surgeon adjustments, multiple surgery adjustments, related within global adjustments, etc..

Applicable Fee Schedule Rate
The applicable fee schedule rate is determined by:

- In-network, participating providers – Contracted fee schedule.
- Out-of-network, non-participating providers – Member plan language for Maximum Plan Allowable. Plans may use a percentage of Medicare’s allowable, or other sources.

Multiple Procedures
When co-surgery occurs, a maximum of one procedure code will be processed as a primary surgical procedure code.

If multiple procedure codes are performed, some as co-surgery with modifier 62 appended, and additional procedure codes during the same operative session are performed as primary and assistant surgeons, multiple surgery guidelines will be applied to the additional procedures even when the primary procedure is subject to co-surgery pricing adjustments.

Example:

<table>
<thead>
<tr>
<th>Surgeon A: (Neurosurgeon)</th>
<th>Code</th>
<th>Description</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>61548-62</td>
<td>(pituitary tumor excision, transnasal)</td>
<td>60% (primary, co-surgery)</td>
</tr>
<tr>
<td></td>
<td>62272</td>
<td>(spinal puncture, therapeutic)</td>
<td>50% (secondary, no co-surgery adjustment)</td>
</tr>
</tbody>
</table>
Example:

<table>
<thead>
<tr>
<th>Surgeon B: (ENT)</th>
<th>Code</th>
<th>Description</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>61548-62</td>
<td>(pituitary tumor excision, transnasal)</td>
<td>60% (primary, co-surgery)</td>
</tr>
<tr>
<td></td>
<td>31287</td>
<td>(sphenoidotomy)</td>
<td>50% (secondary, no co-surgery adjustment)</td>
</tr>
</tbody>
</table>

Background Information

Modifiers
Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance, but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.
Co-surgery (Two Surgeons)
Co-surgery is when the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session due to the complex nature of the procedure(s) and/or the patient’s condition. In these cases, the additional physicians are not acting as assistants-at-surgery, but rather as co-surgeons. Additional assistant surgeons may or may not be used.

If multiple procedures are performed, some procedures may be performed as co-surgery, and other additional procedures may each be performed by only one or the other surgeon as primary. The second surgeon may act as the assistant surgeon for these additional procedures.

Codes and Definitions
Modifier 62 Two Surgeons: When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added.

Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or 82 added, as appropriate.

Coding Guidelines
When co-surgery is performed, each co-surgeon should report the same CPT codes with modifier 62 appended for the procedures which were performed as a shared co-surgery. (AMA³, ⁴) (See also Modifier 62 definition from the CPT book Appendix A, above.)

“This modifier [-62] is used to report the services of two physicians related to a specific surgical procedure. If one surgeon, for example, performs the incision and exposes the area requiring surgery, and another surgeon then performs the surgery indicated in the code, both surgeons report the same procedure code with the -62 modifier appended. This indicates that only one total procedure listed in CPT was performed by these two surgeons. For example, CPT code 63064 Costovertebral approach with decompression of spinal cord or nerve root(s), (eg, herniated intervertebral disk), thoracic, single segment indicates that one procedure was performed. If one surgeon opens the area of the spine where the decompression will be performed, and another surgeon performs the decompression, then both surgeons would report 63064-62. Both physicians should document the level of involvement with this surgery in separate operative notes and include
a copy of these operative notes when the service is reported to the third party payor. If one surgeon does not use the -62 modifier, the third party payor may assume that the physician reporting the procedure without the modifier performed the entire procedure - despite the second physician reporting the procedure with the modifier -62.” (AMA³)

“We receive many questions concerning how to report surgeries performed by more than one physician. To help you understand the proper coding we present the following information.

The General Question
I am a general surgeon who sometimes performs surgeries with other surgeons (cosurgeries), such as orthopedic or neurosurgeons. I open the surgical site, the other surgeon does the definitive portion of the procedure, and then I close. What CPT codes should I report for my services? I have heard from some sources that I should bill for a thoracotomy and wound repair. But other sources have told me to report the same CPT codes as the other surgeon. Which is correct?

Here’s How to Code
For situations in which one surgeon performs the opening and closing of a surgery and another physician performs the definitive portion of the procedure, both physicians should report the same CPT codes, and appropriately append either modifier -62 or modifier -66.

Illustration
A patient’s surgery includes arthrodesis of two interspaces of the thoracic spine by anterior interbody technique, with anterior instrumentation of three vertebral segments. Physician "A" performs a thoracotomy at the start of the surgical session, and Physician "B" performs the arthrodesis and spinal instrumentation. Upon completion of the arthrodesis and spinal instrumentation, Physician A closes the operative site.

Coding the Illustration
(The physicians in the illustration would report the codes indicated below.)

<table>
<thead>
<tr>
<th>Physician A</th>
<th>Physician B</th>
</tr>
</thead>
<tbody>
<tr>
<td>22556-62</td>
<td>22556-62</td>
</tr>
<tr>
<td>22558-62</td>
<td>22558-62</td>
</tr>
<tr>
<td>22845-62</td>
<td>22845-62</td>
</tr>
</tbody>
</table>

When performing these cosurgeries, it is important to communicate with the other surgeon’s office to be certain that you submit the claims properly.” (AMA⁴)

Cross References
References & Resources


