

	<b>Reimbursement Policy Manual</b>		Policy #:	RPM035
<b>Policy Title:</b>	<b>Modifiers 62 &amp; 66 - Co-surgery (Two Surgeons) and Team Surgery (More Than Two Surgeons)</b>			
<b>Section:</b>	<b>Modifiers</b>	<b>Subsection:</b>	<b>Surgery</b>	
<b>Scope:</b>	This policy applies to the following Medical (including Pharmacy/Vision) plans:			
<b>Companies:</b>	<input checked="" type="checkbox"/> All Companies: Moda Partners, Inc. and its subsidiaries & affiliates <input type="checkbox"/> Moda Health Plan <input type="checkbox"/> Moda Assurance Company <input type="checkbox"/> Summit Health Plan <input type="checkbox"/> Eastern Oregon Coordinated Care Organization (EOCCO) <input type="checkbox"/> OHSU Health IDS			
<b>Types of Business:</b>	<input checked="" type="checkbox"/> All Types <input type="checkbox"/> Commercial Group <input type="checkbox"/> Commercial Individual <input type="checkbox"/> Commercial Marketplace/Exchange <input type="checkbox"/> Commercial Self-funded <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Short Term <input type="checkbox"/> Other: _____			
<b>States:</b>	<input checked="" type="checkbox"/> All States <input type="checkbox"/> Alaska <input type="checkbox"/> Idaho <input type="checkbox"/> Oregon <input type="checkbox"/> Texas <input type="checkbox"/> Washington			
<b>Claim forms:</b>	<input checked="" type="checkbox"/> CMS1500 <input type="checkbox"/> CMS1450/UB (or the electronic equivalent or successor forms)			
<b>Date:</b>	<input checked="" type="checkbox"/> All dates <input type="checkbox"/> Specific date(s): _____ <input type="checkbox"/> Date of Service; For Facilities: <input type="checkbox"/> n/a <input type="checkbox"/> Facility admission <input type="checkbox"/> Facility discharge <input type="checkbox"/> Date of processing			
<b>Provider Contract Status:</b>	<input checked="" type="checkbox"/> Contracted directly, any/all networks <input checked="" type="checkbox"/> Contracted with a secondary network <input checked="" type="checkbox"/> Out of Network			
Originally Effective:	1/1/2000	Initially Published:	9/20/2013	
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Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No				
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## Reimbursement Guidelines

### A. General

1. Surgical procedures will be reimbursed as either co-surgery, team surgery or as surgeon-assistant.
2. Except for co-surgery or team surgery, only one surgeon maybe be considered the primary surgeon.
3. Components of a procedure, separate procedures, or bilateral surgery may not be billed by more than a single primary surgeon. For example:
  - a. One surgeon may not bill a column 1 procedure code, and another bill a column 2 procedure code of a CCI procedure-to-procedure (PTP) edit.
  - b. Two surgeons may not each bill as the primary surgeon for the same or similar procedures on opposite bilateral sides or different body areas during the same surgical session. [This is considered co-surgery](#) and needs to be reported with modifier 62 appended.
4. 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%.
  - a. For example, two sequential eye surgeries by different eye surgeons, or two sequential orthopedic surgeries by different orthopedic surgeons.

- b. 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.
- c. If sequential surgery claims are identified:
  - i. The first surgeon's claim processed will be allowed the primary surgical procedure at 100%.
  - ii. The second surgeon's claim processed will be subject to multiple surgery reductions even to the first surgical procedure.
  - iii. Adjustments and refund requests will occur if overpayments are identified after the original processing.

**B. Two Surgeons / Co-surgeons – Modifier 62.**

1. The following situations are considered co-surgery:
  - a. Two surgeons of different specialties working together to perform a specific procedure with a single procedure code.
  - b. Two surgeons of the same or different specialties simultaneously performing parts of the procedure (e.g., heart transplant).
  - c. Two surgeons simultaneously performing the same or similar procedure(s) on different body parts (e.g., bilateral), which shortens the total anesthesia time required for one surgeon to perform the same set of procedures consecutively (e.g., bilateral knee replacements, burn/injury treatments to multiple body areas).

2. 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.

3. Codes Eligible for Co-Surgeon modifier 62
  - a. For claims processed on or after July 1, 2018 (regardless of date of service):
    - i. Procedure codes with a co-surgeon indicator of "0" on the Medicare Physician Fee Schedule (MPFSDB) are not eligible to be performed as co-surgery and will be denied if submitted with modifier 62 appended. Exception: See [exception for burn/injury treatment surgery](#).
    - ii. Procedure codes with a co-surgeon indicator of "1" on the MPFSDB require submission of supporting documentation for review to establish medical necessity of two surgeons for the procedure. Exception: See [exception for burn/injury treatment surgery](#).
    - iii. Procedure codes with a co-surgeon indicator of "2" on the MPFSDB are considered eligible for modifier 62 (co-surgery) if the two surgeons are of different specialties.
      - 1) Two surgeons of the same specialty may also be appropriate in some instances, e.g., heart transplant or bilateral knee replacements.
      - 2) 33361-33369 cardiac transthoracic aortic valve replacement (TAVR) and implantation (TAVI).
        - a) CPT guidelines for procedure codes 33361-33369 state that TAVR/TAVI procedures require two physicians; all components must be reported with modifier 62.
        - b) Procedure codes 33361-33369 will be denied if submitted without modifier 62 appended.

iv. Procedure codes with a co-surgeon indicator of “9” on the MPFSDB are not eligible for modifier 62; the co-surgeon concept does not apply. These procedure codes will be denied if submitted with modifier 62 appended. Exception: See [exception for burn/injury treatment surgery](#).

v. Exception: the following specific surgical codes with co-surgery indicators of “0,” “1,” and “9” which are used in treating burns and other injuries will be allowed with modifier 62 (co-surgery) for all lines of business:

15002, 15003, 15004, 15005, 15271, 15272, 15273, 15274, 15275, 15276, 15277, 15278, 15852, 0479T, 0480T

Note: These procedure codes *may not* be billed by two different surgeons billing as primary surgeons for the same patient, same operative session, same date of service simply because the surgeons are working on treating different body areas; this [meets the definition of co-surgery](#), and the combined total procedures performed must be reported by both surgeons using modifier 62.

b. For claims processed prior to July 1, 2018:

All procedure codes submitted with modifier 62 are allowed if the claims agree on the co-surgeon roles, codes, and modifiers.

#### 4. Billing and Coding Requirements.

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.

#### 5. Billing discrepancies.

a. 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 # 1:

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

Surgeon B: 22600-62 (posterior cervical fusion)  
22614-62 (additional level)

b. If a claim is received with modifier 62 appended after another claim for that procedure has been processed and released as the primary surgeon (on a claim without modifier 62 appended), the subsequent claim with modifier 62 appended is denied.

Similarly, if a claim without modifier 62 appended is received after another claim for that procedure has been processed and released as co-surgery with modifier 62 appended. The subsequent claim(s) that do not agree with the first claims processed (modifier missing or added), will be denied.

i. The billing office for the denied claim needs to contact the billing office of the other surgeon to arrange submission of a corrected claim so that both surgeon’s claims agree about whether or not co-surgery modifier 62 applies.

Example # 2:

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)

- ii. If one surgeon reports as the primary surgeon, and a second surgeon reports as a co-surgeon for the same procedure codes and neither claim has been released, both claims will be pended and a non-clean-claim review is triggered. Review of medical records (operative report(s)) may be required. Corrected claim(s) will be required so that both surgeon’s claims agree about whether or not co-surgery modifier 62 applies.
6. Co-surgery Pricing Adjustments –
- a. CPT codes with modifier 62 appended will be reimbursed as follows:
    - i. For Commercial and Medicaid claims:
      - 1) 60% of the applicable fee schedule rate.
      - 2) 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.
      - 3) 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.
    - ii. For Medicare Advantage claims:
      - 1) For contracted providers, 60% of the applicable fee schedule rate.
      - 2) For out-of-network providers, 62.5% of the applicable fee schedule rate.
      - 3) 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.
      - 4) 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.
  - b. Applicable Fee Schedule Rate.  
The applicable fee schedule rate is determined by:
    - i. In-network, participating providers – Contracted fee schedule.
    - ii. 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.
  - c. Multiple Procedures
    - i. When co-surgery occurs, a maximum of one procedure code will be processed as a primary surgical procedure code.
    - ii. When a co-surgeon acts as a primary surgeon on a separate procedure code(s) not included in the co-surgery reimbursement (not billed by any surgeon with modifier 62 appended):
      - 1) Report the additional procedure code(s) without modifier 62 appended.
      - 2) Multiple surgery guidelines will be applied to the additional procedures even when the primary procedure is subject to co-surgery pricing adjustments.

Example # 3:

	<u>Code</u>	<u>Description</u>	<u>Reimbursement</u>
Surgeon A :	61548-62	(pituitary tumor	60%
(Neurosurgeon)		excision, transnasal)	(primary, co-surgery)

Example # 3:

	<u>Code</u>	<u>Description</u>	<u>Reimbursement</u>
	62272	(spinal puncture, therapeutic)	50% (secondary, no co-surgery adjustment)
Surgeon B: (ENT)	61548-62	(pituitary tumor excision, transnasal)	60% (primary, co-surgery)
	31287	(sphenoidotomy)	50% (secondary, no co-surgery adjustment)

- iii. When a team surgeon acts as an assistant surgeon on a separate procedure code not included in the team surgery reimbursement (not billed by any surgeon with modifier 66 appended), the appropriate assistant surgery modifier should be appended. Team surgery modifier 66 should not be appended.

**C. Team of Surgeons (more than two surgeons of different specialties) – Modifier 66.**

1. Definition of Team Surgery

If a team of surgeons (more than 2 surgeons of different specialties) is required to perform a specific procedure, the procedure is considered a team surgery. Each surgeon bills for the procedure code with modifier 66 appended.

2. Tag-team surgeries not allowed.

Two or more 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%.

- a. For example, two sequential eye surgeries by different eye surgeons, or two sequential orthopedic surgeries by different orthopedic surgeons.
- b. 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.
- c. If sequential surgery claims are identified:
  - i. The first surgeon’s claim processed will be allowed the primary surgical procedure at 100%.
  - ii. The second surgeon’s claim processed will be subject to multiple surgery reductions even to the first surgical procedure.
  - iii. Adjustments and refund requests will occur if overpayments are identified after the original processing.

3. Codes Eligible for Team Surgeon modifier 66.

- a. Procedure codes with a team surgeon indicator of “0” on the Medicare Physician Fee Schedule (MPFSDB) are not eligible to be performed as team surgery and will be denied if submitted with modifier 66 appended.
- b. Procedure codes with a team surgeon indicator of “1” on the MPFSDB require submission of supporting documentation for review to establish medical necessity of a team of surgeons for the procedure.
- c. Procedure codes with a team surgeon indicator of “2” on the MPFSDB are considered eligible for modifier 66 (team surgery) if the surgeons are of different specialties.

- d. Procedure codes with a team surgeon indicator of “9” on the MPFSDB are not eligible for modifier 66; the team surgery concept does not apply. These procedure codes will be denied if submitted with modifier 66 appended.
4. Billing and Coding Requirements.
- a. For the procedures performed as team surgery, all surgeons are expected to bill the exact same combination of procedure codes with modifier 66 appended.
  - b. Any additional procedures specific to each surgeon’s specialty which are also performed in the same operative session may be reported as primary surgeon or assistant surgeon. Multiple surgery guidelines will be applied to the additional procedures even when the primary procedure is subject to team surgery pricing adjustments.
5. Billing discrepancies.
- a. All claims from all surgeons must agree on whether or not team surgery (modifier 66) was performed. Discrepancies will cause claim delays or denials.
  - b. If a claim is received with modifier 66 appended after another claim for that procedure has been processed and released as the primary surgeon (on a claim without modifier 66 appended), the subsequent claim(s) with modifier 66 appended is/are denied.
- Similarly, if a claim without modifier 66 appended is received after another claim for that procedure has been processed and released as team surgery with modifier 66 appended. The subsequent claim(s) that do not agree with the first claims processed (modifier missing or added), will be denied.
- i. The billing office for the denied claim(s) needs to contact the billing office of the other surgeon to arrange submission of a corrected claim so that all surgeons’ claims agree about whether or not team surgery modifier 66 applies.
  - ii. If none of the claims have been released, all claims will be pended and a non-clean-claim review is triggered. Review of medical records (operative report(s)) may be required. Corrected claim(s) will be required so that all surgeons’ claims agree about whether or not team surgery modifier 66 applies.
6. Team Surgery Pricing Adjustments.
- a. When an eligible procedure is reported with team surgery modifier 66, the total reimbursement for the team of surgeons will be 150% of the applicable fee schedule rate for the procedure code.
    - i. The total team surgery allowance will be divided equally among the team of surgeons.
      - 1) For team surgery with three surgeons, each surgeon will be reimbursed at 50% of the fee schedule amount.
      - 2) For team surgery with four surgeons, each surgeon will be reimbursed at 37.5% of the fee schedule amount.
      - 3) No additional assistant surgeon claims will be allowed for the procedure codes reported with team surgery modifier 66.
    - ii. If there is more than one procedure performed, multiple procedure reduction rules apply.
  - b. Applicable Fee Schedule Rate.

The applicable fee schedule rate is determined by:

    - i. In-network, participating providers – Contracted fee schedule.
    - ii. 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.

- c. Multiple Procedures
  - i. When co-surgery occurs, a maximum of one procedure code will be processed as a primary surgical procedure code.
  - ii. When a team surgeon acts as a primary surgeon on a separate procedure code(s) not included in the team surgery reimbursement (not billed by any surgeon with modifier 66 appended):
    - 1) The additional procedure code(s) should be reported without team surgeon modifier 66 appended.
    - 2) Multiple surgery guidelines will be applied to the additional procedure(s) even when the primary procedure is subject to team surgery (modifier 66) pricing adjustments.
  - iii. When a team surgeon acts as an assistant surgeon on a separate procedure code not included in the team surgery reimbursement (not billed by any surgeon with modifier 66 appended), the appropriate assistant surgery modifier should be appended. Team surgery modifier 66 should not be appended.

## Codes, Terms, and Definitions

### Acronyms & Abbreviations Defined

Acronym or Abbreviation	Definition
AMA	American Medical Association
ASO	Administrative Services Only
CCI	Correct Coding Initiative (see "NCCI")
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DRG	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
MPFS MPFSD MPFSDB	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MS DRG	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	National Correct Coding Initiative (aka "CCI")
PTP	Procedure To Procedure (a type of NCCI edit)
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	Relative Value Unit
TAVI	Transthoracic Aortic Valve Implantation
TAVR	Transthoracic Aortic Valve Replacement
UB	Uniform Bill

**Procedure codes for burn treatments or other injuries eligible for co-surgery modifier 62 exception:**

<b>Code</b>	<b>Code Description</b>
15002	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children
15003	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)
15004	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children
15005	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15852	Dressing change (for other than burns) under anesthesia (other than local)

Code	Code Description
0479T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm <sup>2</sup> or part thereof, or 1% of body surface area of infants and children
0480T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm <sup>2</sup> , or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)

Modifier Definitions:

Modifier	Modifier Description & Definition
Modifier 62	<p><b>Two Surgeons:</b> 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.</p> <p><b>Note:</b> 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.</p>
Modifier 66	<p><b>Surgical Team:</b> Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the “surgical team” concept. Such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure number used for reporting services.</p>

Status Indicators:

Co-Surgeons (Modifier 62)

The Medicare Physician Fee Schedule (MPFSDB) Co-Surgeons (Modifier 62) (CO- SURG) indicator designates services for which two surgeons, each in a different specialty, may be paid. The co-surgeons Indicators currently in use are:

Indicator	Indicator Definition
0	Co-surgeons not permitted for this procedure
1	Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure.
2	Co-surgeons permitted; no documentation required if two specialty requirements are met.
9	Concept does not apply.

## Team surgeons (Modifier 66)

The Medicare Physician Fee Schedule (MPFSDB) Team surgeons (Modifier 66) (TEAM SURG) Indicator designates services for which team surgeons may be paid. The team surgeons indicators currently in use are:

Indicator	Indicator Definition
0	Team surgeons not permitted for this procedure.
1	Team surgeons could be paid; supporting documentation required to establish medical necessity of a team; pay by report.
2	Team surgeons permitted; pay by report.
9	Concept does not apply.

### Coding Guidelines & Sources – (Key quotes, not all-inclusive)

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.<sup>3,4</sup> (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.”<sup>3</sup>

“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.)

Physician A	Physician B
22556-62	22556-62
22558-62	22558-62
22845-62	22845-62

When performing these cosurgeries, it is important to communicate with the other surgeon's office to be certain that you submit the claims properly." <sup>4</sup>

## Cross References

["Modifier 51 – Multiple Procedure Fee Reductions."](#) Moda Health Reimbursement Policy Manual, RPM022.

## References & Resources

1. American Medical Association. "Appendix A – Modifiers." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.
2. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 40.8.
3. American Medical Association. "Modifiers Used with Surgical Procedures", *CPT Assistant*, Fall 1992, pages 15-22.
4. American Medical Association. "Coding Tip: Reporting Cosurgeries", *CPT Assistant*, July 1996, page 7.
5. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 23 – Fee Schedule Administration and Coding Requirements, Addendum – MPFSDB Record Layouts, 2018 File Layout, Field 21.

## 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.

#### Team Surgery (More than Two Surgeons)

Team surgery is when the individual skills of more than two surgeons of different specialties 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 team surgeons.

### **IMPORTANT STATEMENT**

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member’s medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to 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] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member’s medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member’s medical benefit plan, the member’s medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider’s agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

\*\*\*\*\* The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to [https://www.modahealth.com/medical/policies\\_reimburse.shtml](https://www.modahealth.com/medical/policies_reimburse.shtml) \*\*\*\*\*

### Policy History

Date	Summary of Update
8/14/2024	Formatting updates. No policy changes.
10/11/2023	Added exception allowing specific burn treatment procedures as co-surgery (more generous than CMS); subject to 28 TAC. Clarified bilateral co-surgery. Formatting updates.
7/13/2022	Added Medicare Advantage modifier 62 out-of-network pricing adjustment. Acronyms added. Formatting updates.
9/20/2013	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2000	Original Effective Date (with or without formal documentation). Policy based on CMS policy on Co-surgery modifier 62 and Team surgery modifier 66 & AMA guidelines.