Payment Policy: Co-Surgeon/Team Surgeon – Modifiers 62/66 (Commercial)

POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
R20210032	1/01/2021	RPC (Reimbursement Policy Committee)

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY:

ConnectiCare has policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. ConnectiCare will inform you of new policies or changes in policies through updates to the Provider Manual and/or provider news. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in ConnectiCare's policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by ConnectiCare due to programming or other constraints; however, ConnectiCare strives to minimize these variations.

ConnectiCare follows coding edits that are based on industry sources, including, but not limited to; CPT guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. ConnectiCare uses industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how ConnectiCare handles specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, ConnectiCare may deny the claim and/or recoup claim payment.

Overview

ConnectiCare has based this reimbursement policy on the guidelines established by the Centers of Medicare and Medicaid Services (CMS) regarding reimbursement of surgical procedures requiring either a co-surgeon (2 surgeons of different specialties) or team surgeon (more than 2 surgeons of different specialties).

The intent of this policy is to serve as a general reference guide for the appropriate use of modifiers 62 or 66 when appended to procedures submitted on professional claims for physicians or other qualified health care professionals.

Note: Guidelines for Assistant-at-Surgery (Modifiers 80/81/82 and AS) are covered in a separate policy. Please visit our website to view/download our complete policy https://www.connecticare.com/providers/our-policies/reimbursement-policies

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Policy:

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of 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.

The Co-Surgeon and Team Surgeon Eligible Lists are developed based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File status indicators. All codes in the NPFS with status code indicators "1" or "2" for "Co-Surgeons" or "Team Surgeon" are considered eligible by ConnectiCare when indicated by the appropriate modifier (62 or 66). *Procedure codes with status code indicator of "0" or "9" submitted with modifier 62 or 66 will be denied.*

Applicable Modifiers:

Modifier	Description
62	**Co-Surgeon/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 modifier 82 added, as appropriate.*
66	**Surgical Team (3 or more surgeons):** 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.

CMS Relative Value Status Indicators (SI):

SI	Description
0	Co-surgeon or Team Surgeon not permitted for this procedure.
1	Co-surgeons /Team Surgeons could be paid. Supporting documentation is required to establish medical necessity of two or more surgeons for the procedure.
2	• Co-surgeons permitted. No documentation is required if two specialty requirements are met *(modifier 62)* • Team surgeons permitted; pay by report *(modifier 66)*
9	Co-surgeon / Team Surgeon concept does not apply.

Reimbursement Guidelines:

ConnectiCare allows additional reimbursement for an eligible procedure or service reported (CMS Relative Value Status Indicator 1 or 2) with modifiers 62 or 66 appended when the criteria below are met.

Modifier 62 (Co-Surgeon)

For procedures performed as "co-surgery", same operative session for the same member and same date of service, 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.

- Only codes in the CMS NPFS with status code indicators "1" or "2" for "Co-Surgeons" are considered eligible when submitted with modifier 62 appended
- If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier 62. Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements.
- Except for co-surgery or team surgery, only one surgeon may be considered the primary surgeon.
- Components of a procedure, separate procedures, or bilateral surgery may not be billed by more than a single primary 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
- Multiple procedure reductions apply to Co-Surgeon claim submissions when one or more physicians are billing multiple CPT codes that are eligible for reductions.
- ConnectiCare follows CMS guidelines and does *not* reimburse for Assistant Surgeon services, as indicated by modifiers 80, 81, 82, or AS, for procedures where reimbursement has been provided for eligible Co-Surgeon services, using

the same surgical procedure code, during the same encounter reported with Co-Surgeon modifier 66.

- If a co-surgeon acts as an assistant surgeon in the performance of additional procedure(s) during the same surgical session, the procedures are reimbursable services (if eligible per the Assistant Surgeon Eligible List) when indicated by separate procedure code(s) with modifier 80 or modifier 82 appended, as appropriate.

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.

Billing Requirements - Modifier 62 (Co-Surgeon):

- For 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**.**
- Documentation of the medical necessity for two surgeons is required for certain services identified in the Medicare Fee Schedule Data Base (MFSDB).
- 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.
- 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.
    - 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 co-surgery modifier 62 applies.

Modifier 66 (Team-Surgeon)

- For procedures performed as "team-surgery" (more than 2 surgeons of different specialties), same operative session for the same member and same date of service, each surgeon is expected to bill the exact same combination of procedure codes with modifier 66 appended.
- Only codes in the CMS NPFS with status code indicators "1" or "2" for "Team-Surgeons" are considered eligible when submitted with modifier 66 appended

- If a team of surgeons (more than 2 surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier 66.
- 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%.
- Multiple surgery guidelines will be applied to the additional procedures even when the primary procedure is subject to team surgery pricing adjustments.
- ConnectiCare follows CMS guidelines and does not reimburse for Assistant Surgeon services, as indicated by modifiers 80, 81, 82, or AS, for procedures where reimbursement has been provided for eligible Team-Surgeon services, using the same surgical procedure code, during the same encounter reported with Team Surgery modifier 66.
- If 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.

  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.

Billing Requirements - Modifier 66 (Team-Surgeon):

- For the procedures performed as team surgery, all surgeons are expected to bill the exact same combination of procedure codes with modifier 66 appended. 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
  - All claims from all surgeons must agree on whether team surgery (modifier 66) was performed. Any discrepancy in procedure codes reported with modifier 66 will require additional investigation and delay of processing and/or denials.
- Documentation must support the medical necessity of "team" surgery
- 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 will be denied.
- 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.

- The billing office for the denied claim(s) needs to contact the billing office of the other surgeon(s) to arrange submission of a corrected claim so that all surgeons' claims agree about whether team surgery modifier 66 applies.

References

1. Medicare Claims Processing Manual," Section 40.8, Claims for Co-surgeons and Team Surgeons, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf on the Centers for Medicare & Medicaid Services (CMS)
2. Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files at https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/rvu21a
3. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

Revision history

DATE	REVISION
4/2021	• New Policy