Massachusetts | Commercial

| Commercial Reimbursement Policy | |
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| Subject: **Modifier 62 – Professional** | |
| Policy Number: **C-21005** | Policy Section: **Coding** |
| Last Approval Date: **11/17/2023** | Effective Date: **11/17/2023** |

## 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 Wellpoint member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure 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, Wellpoint 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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.

## Policy

Wellpoint allows reimbursement of procedures eligible for co-surgeons when billed with modifier 62 unless provider, state, or federal contracts and/or requirements indicate otherwise. Eligible procedures are identified using the Centers for Medicare & Medicaid Services (CMS) Medicare Physician Fee Schedule (MPFS) Co-Surgery payment indicators and applied using the guidelines as indicated below.

Reimbursement to each surgeon is based on 63% of the applicable fee schedule or contracted/negotiated rate. Co-surgeons must be from different specialties and performing surgical services during the same operative session.

Each surgeon must bill the same procedure code(s) with Modifier 62. If one or both surgeons fail to use the modifier appropriately, it is possible that one surgeon may receive 100% of the applicable fee schedule or negotiated/contracted rate, and the other surgeon's claim may be denied or pended due to a duplicate or suspected duplicate service, respectively. It is not considered co-surgery when two surgeons perform separate procedures during the same operative session.

**Reimbursable:**

- Codes identified with MPFS Co-Surgery payment indicator '2'.

**Non-reimbursable:**

- Codes identified with MPFS Co-Surgery payment indicators '0', '1', and '9'.

Assistant surgeon and/or multiple procedures rules and fee reductions apply if:

- A co-surgeon acts as an assistant in performing ***additional procedure(s)*** during the same surgical session

**Note:** Assistant surgeon rules do not apply to procedures appropriately billed with Modifier 62.

- Multiple procedures are performed

## Related Coding

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| Standard correct coding applies |

## Policy History

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| 11/17/2023 | Review approved and effective: removed *Co-Surgeon Services* from policy title |
| 09/24/2021 | Initial policy approved 09/24/2021; effective 03/01/2022; Co-Surgeon/Team Surgeon Services policy (C-08001) was retired and split into two new policies: Modifier 62: Co-Surgeon Services (C-21005) and Modifier 66: Surgical Teams (C-21006). Co-Surgeon/Team Surgeon Services (C-08001) effective 03/10/2008 |

## References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2023

## Definitions

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| Modifier 62 | 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- |



 

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| | 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. |
| General Reimbursement Policy Definitions | |

## Related Policies and Materials

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| Modifiers 80, 81, 82 and AS: Assistant at Surgery - Professional |
| Modifier 66 - Professional |
| Modifier Rules - Professional |
| Modifiers 50 and 51: Multiple and Bilateral Surgery - Professional |
| Scope of License - Professional |

## Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.