DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Co-Surgery Not Billed with Modifier 62

Provider Types Affected

This MLN Matters® Special Edition is intended for physicians submitting claims to Medicare contractors (carriers and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.

What You Need to Know

Recovery Auditors have identified significant payment errors because of failure to appropriately apply the co-surgeon modifier, used when two or more surgeons of different specialties contribute to one operative session and each separately submit claims to Medicare.

When two or more surgeons with different specialties submit claims for the same operative session for the same beneficiary and same date of service, all providers must use the co-surgeon modifier. When two different providers bill the same CPT code, same patient and same date of service and one of the providers bills with modifier 62, the other provider must also bill with modifier 62. Note, however, that modifier 62 may only be used when the co-surgeons are of different specialties and are working simultaneously.

Background

The" 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) website, provides the following guidance:

Section 40.8. Claims for Co-Surgeons and Team Surgeons

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.

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 (Two Surgeons). Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant.

Billing Instructions

The following billing procedures apply when billing for a surgical procedure or procedures that required the use of two surgeons or a team of surgeons:

- Modifier 62 - 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. Documentation of the medical necessity for two surgeons is required for certain services identified in the Medicare Fee Schedule Data Base (MFSDB).
- Modifier 66 - 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." Field 25 of the MFSDB identifies certain services submitted with a "-66" modifier which must be sufficiently documented to establish that a team was medically necessary. All claims for team surgeons must contain sufficient information to allow pricing "by report."
- Different procedures require no modifier - If surgeons of different specialties are each performing a different procedure (with different CPT codes), neither co-surgery nor multiple surgeon rules apply (even if the procedures are performed through the same incision). If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services.

Payments

For co-surgeons (modifier 62), the fee schedule amount applicable to the payment for each co-surgeon is 62.5 percent of the global surgery fee schedule amount. Team surgery (modifier 66) is paid for on a "By Report" basis.

Case Examples from the Recovery Auditor Review

- A provider bills for CPT Code 61548, Hypophysectomy or excision of pituitary tumor, and bills with modifier 62, for a patient on date of service March 8, 2012. A different provider bills for the same service for the same patient on the same date of service because he/she was the co-surgeon, yet did not bill with the modifier 62. The second surgeon was overpaid for failing to properly apply modifier 62.
- A provider bills for CPT Code 49652, Laparoscopy, Surgical repair, ventral, umbilical, spigelian or epigastric hernia, and bills with modifier 62, for a patient on July 2, 2011. A different provider bills for the same service for the same patient on the same date of service because he/she was the co-surgeon, yet did not bill with modifier 62. The second surgeon was overpaid for failing to properly apply modifier 62.

In both of these examples, providers should append the appropriate modifier to the claim line when they are the co-surgeon, operating on the same beneficiary, on same date of surgery.

Additional Information

You may wish to review the "Medicare Claims Processing Manual," Chapter 12, Section 40.8)Claims for Co-Surgeons and Team Surgeons), which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf on the CMS website.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.