healthfirst
Health Insurance for New Yorkers

Provider Alert

Coding Instructions for Co-Surgeons and Team Surgeons

Healthfirst follows the Centers for Medicare & Medicaid Services (CMS) guidance for the use of co-surgeon (-62) and team surgeon (-66) modifiers with claim submissions.

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 procedures and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at-surgery.

The following guidance applies when billing for surgical procedures that require the use of two surgeons or a team of surgeons:

Co-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 the modifier "-62" (two surgeons). Co-surgery also refers to surgical procedures involving two surgeons performing parts of the procedure simultaneously, such as during a heart transplant or bilateral knee replacements.

CMS Co-Surgeon Payment Indicator:

1 = Co-surgeons could be paid. Supporting documentation is required to establish medical necessity of two surgeons for the procedure.

2 = Co-surgeons permitted. Documentation is not required if two specialty requirements are met.

Team Surgeons (Modifier 66)

- If a team of surgeons (more than two surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with the modifier "-66" (surgical team). All claims for team surgeons must contain sufficient information to allow pricing "by report".

CMS Team Surgeon Payment Indicator:

1 = Team surgeons could be paid. Supporting documentation is required to establish medical necessity of a team; "by report".

2 = Team surgeons permitted; "by report".

Multiple-Procedure Rules

If surgeons of different specialties each performs a different procedure (with specific CPT codes), neither co-surgery nor multiple-surgery 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.

Required Documentation for Dispute for Non-Payment

CMS/Medicare Physician Fee Schedule (MPFS) indicates which procedures require medical records to determine coverage of co-surgeons or team surgeons. It also ensures that the roles are consistent with the use of the modifier rather than an assistant surgeon or other role. To support coverage of co-surgeons and team surgeons:

- each surgeon involved in the case must bill using the same procedure code (CPT/HCPCS) and apply the appropriate modifier (i.e., 62 or 66)
- each surgeon must submit an operative report with details regarding their separate, independent contribution to the overall procedure.

For example, if an otolaryngologist and neurosurgeon were acting as co-surgeons for the trans-nasal removal of a pituitary adenoma, the otolaryngologist operative report would include details regarding the initial trans-nasal surgical approach to access the tumor, and the neurosurgeon operative report would include the details of the removal of the tumor. If two neurosurgeons were performing spinal decompression procedures simultaneously on different sides, then each operative report would indicate the side that was treated by the specific surgeon. As per CMS, the medical necessity of two surgeons must also be supported in the medical records.

For more information, refer to the CMS and Medicare Claims Processing Manual, Chapter 12, Section 40.8.

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/globallsurgery-icn907166.pdf

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

If you have any questions, please call Provider Services at **1-888-801-1660**, Monday to Friday, 8:30am–5:30pm.