If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSIL may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSIL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Co-Surgeon/Team Surgeon Modifiers

Policy Number: CPCP009

Version: 1.0

Clinical Payment and Coding Policy Committee Approval Date: Sept. 16, 2020

Plan Effective Date: Sept. 16, 2020

This policy was created to serve as a general reference guide to coding and payment for the utilization of a co-surgeon or a team of surgeons. Health care providers (facilities, physicians and other health care professionals) are expected to exercise independent medical judgement in providing care to patients. This policy is not intended to impact care decisions or medical practice. This policy does not address all situations that may occur and in certain circumstances these situations may override the criteria within this policy.

Modifications to this policy may be made at any time. Any updates will result in an updated publication of this policy.

Description:

This policy provides coding details for surgical procedures that utilize two or more surgeons or other qualified health care professionals for the same surgical patient. Co-Surgeons or team surgeons are used when multiple surgeons or qualified health care professionals with different skills and/or specialties are required or when conducting surgery simultaneously minimizes anesthesia time or complications.

In certain situations, two surgeons with different individual skills are required to perform surgery on the same patient during the same operation on the same day. Often these surgeons have different specialties which requires them to perform their own unique portion of the surgery. This may be due to the complexity of the surgery and/or the patient's condition. In this scenario, the surgeons are acting as co-surgeons and each surgeon should bill the procedure with a modifier 62 appended.

Team surgery occurs when more than two physicians, usually of different specialties, and/or other qualified health care professionals, including assistant surgeons, nurse practitioners, and physician assistants are required to perform highly complicated procedures on the same patient, on the same day. Team surgery is identified by appending modifier 66 to the procedure.

Reimbursement Information:

This policy applies to co-surgeon services that are billed using the CMS 1500 Health Insurance Claim Form. This policy applies to all products, in network and out of network physicians and other qualified health care professionals.

Co-Surgery

In cases of co-surgery, each surgeon must append modifier 62 to services billed and the CPT code on both surgeon's claims should match. Both surgeons are required to submit separate operative reports that explicitly state what services each surgeon performed during the surgery, reflecting the complexity of the case.

The following criteria must be met for Co-Surgery claims to be eligible for reimbursement:

- Compliance with CMS guidelines which state that HCPCS/CPT codes appearing in the National Physician Fee Schedule (NPFS) with a relative value file co-surgery status indicator of "1" or "2" are eligible for co-surgeon reimbursement with modifier 62.
- Services rendered by both surgeons must be determined to be medically necessary.
- The procedure requires two surgeons with different specialties performing a specific procedure, or two surgeons performing a specific procedure simultaneously.
- The Co-Surgery services are submitted with an appropriate surgical CPT code by both surgeons with modifier 62 listed in the first position.
- NOTE: Physicians cannot bill as assistants for the procedure in which they acted as co-surgeons.

When two surgeons are operating on two completely different anatomic portions of the patient on the same date and time, it is not considered co-surgery. In these instances, each surgeon is considered the primary provider for the surgery they are conducting and modifier 62 should not be applied.

Modifier 62 should not be billed for procedures when one of the surgeons is acting as an assistant surgeon. If a co-surgeon acts as an assistant during another procedure during the same surgical session, as indicated by a separate procedure code, they may bill as an assistant for that separate procedure. Multiple surgery reductions may apply.

Team Surgery

For team surgery, each team surgeon should use the same CPT code on their individual claim form and append modifier 66 in the primary modifier position. Each team surgeon may be asked to submit an operative report that states what services each surgeon performed during the surgery.

For team surgery claims to be eligible for reimbursement, the following criteria must be met:

- Compliance with CMS guidelines which state that CPT codes appearing in the National Physician Fee Schedule (NPFS) with a relative value file team surgery status indicator of "1" or "2" are eligible for reimbursement with the appropriate modifier.
- Services rendered by a team must be determined to be medically necessary.
- Teams must be composed of more than two surgeons of different specialties.
- The team surgery services must be submitted with an appropriate surgical Current Procedural Terminology (CPT) code and modifier 66 is listed in the first position.

References:

Centers for Medicare and Medicaid Services (CMS). Physician Fee Schedule Relative Value Files. https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/pfs-relative-value-files.html

Policy Update History:

Approval Date	Description
10/11/2017	New policy
12/06/2017	Revisions from legal
09/28/2018	Annual review
08/16/2019	Annual review
09/16/2020	Annual review, Disclaimer update