	Reimbursement Policy

Subject: Modifier 62: Co-Surgeons		
Effective Date: **08/07/20**	Committee Approval Obtained: **08/07/20**	Section: **Coding**

*****The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.amerigroup.com/IA**.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Iowa, Inc. 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 CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup allows reimbursement of procedures eligible for co-surgeons when billed with Modifier 62 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement to each surgeon is based on 62.5% 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. 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.
History	• Biennial review approved and effective **08/07/20**: Updated Definitions and Reference Sections • Biennial review approved **10/03/18**: Assistant surgeon language expanded • Biennial review approved **10/03/16** and effective **12/15/17**: Same specialty language removed • Initial policy approval **08/04/15** and effective **04/01/16**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup contract • AMA CPT Professional Edition 2020
Definitions	• **Modifier 62:** when two 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 • **General Reimbursement Policy Definitions**

Related Policies	• Assistant at Surgery (Modifiers 80/81/82/AS) • Duplicate or Subsequent Services on the Same Date of Service • Modifier Usage • Multiple and Bilateral Surgery: Professional and Facility Reimbursement • Modifier 66: Surgical Teams
Related Materials	• None