Using modifier 62, co-surgeons

When two surgeons work together as primary surgeons performing distinct parts of a procedure, each surgeon should report the co-surgery once using the same procedure code and report his/her distinct operative work by adding modifier 62 and any associated add-on code(s) for that procedure.

Per the AMA CPT rules for modifier 62, two surgeons may only be co-surgeons on one primary procedure and any associated add-on codes or additional procedures if the two surgeons continue to act as co-surgeons performing distinct separate parts of the same procedure.

- If additional procedure(s), including add-on procedures, are performed during the same surgical session, separate codes may also be reported with modifier 62 added.
- Per the AMA rules, you cannot append modifier 62 to the instrumentation or grafting codes.
- If a co-surgeon acts as an assistant in performing additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with the modifier 80 or modifier 82 added.
- Do not report an 80 modifier with a 62 modifier when two surgeons are working together on co-surgery. It is implied within the description of the 62 modifier that each surgeon will be "assisting" with the procedure.
- Append the 62 modifier to add-on codes the same way you would with any other co-surgery service.
- Communicate with the staff of the other surgeon billing co-surgery so claims are submitted in the same time frame.

Documentation requirements for modifier 62

Additional reimbursement will be considered only when the documentation submitted clearly states the medical necessity of the co-surgery.

- Each surgeon must document the separate procedures they are performing, or portions of procedures in individual op reports.
• If multiple procedures are performed not all will necessarily meet the standard for co-surgery.

• Billing must include the supporting documentation for use of modifier 62 versus modifier 80.

• Modifier -62 (Two surgeons) indicates that the individual skills of two surgeons are required during the same surgical procedure. In such cases, each surgeon codes independently of the other, with modifier -62 appended to the applicable CPT procedure code(s).

• Section 15044 of the Medicare Carriers Manual (MCM) further specifies that co-surgeons share responsibility for a surgical procedure, each serving as a primary surgeon during some portion of the surgery. Both must be surgeons, and are frequently but not necessarily of different specialties. The MCM further specifies that co-surgeons share pre- and postoperative responsibility for the patient.

• For instance, a neurosurgeon and otolaryngologist may work side-by-side during the “approach” portion of a skull base surgery (e.g., 61590, Infratemporal pre-auricular approach to middle cranial fossa [para-pharyngeal space, infratemporal and midline skull base, nasopharynx], with or without disarticulation of the mandible, including parotidectomy, craniotomy, decompression and/or mobilization of the facial nerve and/or petrous carotid artery). In this case, each surgeon reports 61590-62.

When can we bill as co-surgeons?

Although two heads are generally better than one, neither CPT nor CMS allows billing for co-surgeons in every situation. According to the Physician Fee Schedule, surgical procedures fall into one of four categories with respect to co-surgeons:

• 1. Procedure for which modifier -62 is allowed but supporting documentation is required to establish medical necessity for two surgeons, regardless of specialty: This category includes some craniectomies (e.g, 61526 and 61530), craniotomy 61533-61543 and most skull base surgery approach codes (61580, 61582-61598). The documentation should show what special circumstances or skills required the surgeons to share responsibility for the patient. For example, the extraordinary duration of some skull base surgeries may require that two surgeons work in shifts, allowing each to scrub out while the other continues the procedure. Or they may work simultaneously but perform distinct components of a procedure. These procedures are identified with a “1″ in column U (labeled “co-surg”) of the Physician Fee Schedule.
• 2. Procedures for which modifier -62 is allowed as long as each surgeon is of a different specialty: Two neurosurgeons working together cannot report modifier -62 for these codes. Examples of such procedures include laminotomy/laminectomy codes 63001-63048 and diskectomy 63075-63078. These procedures are identified with a “2″ in column U of the fee schedule.

• 3. Procedures for which modifier -62 is never allowed: Such procedures are identified by a “0″ in column U of the fee schedule and include endovascular therapy (61624-61626) and stereotactic procedures 61790-61795, among others.

• 4. Procedures for which the concept of co-surgeons does not apply and for which modifier -62 is therefore inappropriate: These procedures are noted by a “9″ in column U. Examples include supplemental “V” and “S” codes not normally used in neurosurgery.

Providing the Evidence to Get Paid

Co-surgeons must work in synchronicity in both the operating room and when coding: Each surgeon must dictate his or her own operative report and identify the other surgeon as a co-surgeon. And, each surgeon must submit his or her own CMS-1500 claim form with the required documentation, using his or her own personal identification number (PIN). If two physicians have the same tax ID numbers [because they are from the same practice, for instance], they will be considered one person from a payer standpoint and won’t be able to use modifier -62.

Co-surgeons will not necessarily file identical claims. For example, although a neurosurgeon and otolaryngologist may work together during an approach, the neurosurgeon will likely perform the definitive portion of skull base surgery alone. In this case, each surgeon reports 61590-62, but the neurosurgeon will also report the definitive procedure (e.g., 61606, Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; intradural, including dural repair, with or without graft) appended with modifier -51 (Multiple procedures).

Two Surgeons Won’t Always Mean Modifier -62

Just because two surgeons operate on the same patient during the same operative session does not mean that modifier -62 is appropriate. The MCM section 4828 notes, “If surgeons of different specialties are each performing a different procedure (with
specific CPT-4 codes [e.g., "sequential" surgery]), 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.”

For example, if the otolaryngologist performs approach 61590 without the neurosurgeon’s help, and the neurosurgeon performs the definitive procedure 61606 without the otolaryngologist’s help, each surgeon should report his or her portion of the surgery independently, with no modifiers appended. If the neurosurgeon performs additional procedures (e.g., 62272*, Spinal puncture, therapeutic, for drainage of cerebrospinal fluid [by needle or catheter] for regulation of cerebrospinal fluid pressure), the multiple-procedures rules apply.

In a second example, the neurosurgeon performs a decompressive lumbar laminectomy L3-S1 with foraminotomies and lateral recess decompression, which is followed by lateral mass fusion with use of morselized autograft by an orthopedic surgeon. In this case, each surgeon performs a distinct procedure as appropriate to his or her specialty, without aid from the other surgeon. Therefore, both the neurosurgeon and orthopedic surgeon should report his or her portion separately even though all procedures were performed using the same incision and closure.

The neurosurgeon reports 63047 (Laminectomy, facetectomy and foraminotomy [unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis], single vertebral segment; lumbar) for the decompression at the first level and 63048 for each additional segment. The orthopedic surgeon reports the fusion and bone grafts independently, using 22612 (Arthrodesis, posterior or posterolateral technique, single level; lumbar [with or without lateral transverse technique]) and 20937 (Autograft for spine surgery only [includes harvesting the graft]; morselized [through separate skin or fascial incision]).