Amerigroup An Anthem Company	**Reimbursement Policy**	
Subject: Modifier 62: Co-Surgeons		
Effective Date: **10/03/18**	Committee Approval Obtained: **10/03/18**	Section: **Coding**

*****The most current version of the 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. Under Quick Tools, select Reimbursement Policies > Medicare. *****

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 Medicare Advantage 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 participating providers and facilities; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

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

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

Amerigroup Medicare Advantage 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 Medicare Advantage strives to minimize these variations.

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

Policy	Amerigroup Medicare Advantage 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 percent 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. However, Amerigroup Medicare Advantage does not consider surgeons performing different procedures during the same surgical session as co-surgeons, and Modifier 62 is not required. Each surgeon must bill the same procedure code(s) with Modifier 62, when applicable. If one or both surgeons fail to use the modifier appropriately, it is possible that one surgeon may receive 100 percent 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 10/03/18: Assistant surgeon language expanded; different procedures co-surgeon language added • Biennial review approved 10/03/16 and effective 09/15/17: Same specialty language removed • Initial review approved and effective 01/01/15
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contract
Definitions	• **Modifier 62:** used to indicate two surgeons, usually from different specialties, where the participation of both surgeons is necessary in performing a specific operative procedure; two surgeons may be necessary due to the complex nature of the procedure(s) or the member's condition • **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 66: Surgical Teams • Modifier Usage

	• Multiple and Bilateral Surgery: Professional and Facility Reimbursement
Related Materials	• None