Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Modifier 62: Co-Surgeons		
Effective Date: **12/15/17**	Committee Approval Obtained: **10/03/16**	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 > Medicaid/Medicare. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

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 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 our 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 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. 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 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. • Multiple procedures are performed.
Exemptions	• Amerigroup in Florida, in compliance with Florida's Agency for Health Care Administration (AHCA) Medicaid Services Coverage and Limitations handbook, reimburses procedures eligible for co-surgeons appended with Modifier 62 at 60 percent to each provider.
History	• Effective 02/01/18: Policy template updated • Effective 09/15/17: Louisiana exemption removed • Effective12/15/17: Biennial review approved 10/03/16; Tennessee exemption removed • Effective 06/01/16: Tennessee exemption added • Effective 12/31/15: Exited Maryland Medicare • Effective 12/31/15: Exited Florida Medicare • Effective 07/13/15: Maryland exemption removed • Biennial review approved 10/13/14: Background section and policy template updated; Nevada exemption updated; Maryland exemption added • Effective 07/01/13: Exited Ohio • Review approved 05/20/13 and effective 10/01/06: Disclaimer updated 04/23/13 • Biennial review approved 04/09/12: Background section and policy template updated; added Louisiana and Nevada exemption • Biennial review approved 05/17/10: Background section and definitions updated; policy template updated • Review approved 11/10/08: Background section/policy template updated • Initial committee approval: 06/06/06 with effective date of 10/01/06

References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup state contracts • Optum Learning: Understanding Modifiers, 2014 Edition
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. • **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