COMPLIANCE TIP

TO: Compliance Alert Distribution List

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SUBJECT: Billing Medicare for Co-Surgeries

DATE: March 21, 2018

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure and/or the patient’s condition. The operating surgeons share responsibility for the surgical procedure, with each serving as a primary surgeon during some portion of the procedure. The global surgery package rules are applicable to each of the physicians participating in a co-surgery.

In general, co-surgery is billed in the following situations when the skill of two surgeons is required:

- two surgeons (each in a different specialty) are required to perform a specific procedure;
- two surgeons of the same or different specialties simultaneously performing parts of the procedure (e.g., heart transplant); or
- two surgeons (usually in same specialty but may be different specialties) simultaneously performing the same procedure on bilateral body parts (e.g., bilateral knee replacements).

If surgeons of different specialties are each performing a different procedure (with a different CPT code) during the same operative session, co-surgery rules do not apply (even if the procedures are performed through the same incision).
Example:

Procedure performed – Costovertebral approach with decompression of spinal cord or nerve root(s), (e.g., herniated intervertebral disk), thoracic; single segment

<table>
<thead>
<tr>
<th>Surgeon</th>
<th>PortionPerformed</th>
<th>Code</th>
<th>Modifier</th>
<th>Medicare Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>opens the area of the spine where the decompression will be performed and closes after decompression completed</td>
<td>63064</td>
<td>62</td>
<td>62.5% (primary procedure, co-surgery reduction)</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>performs the decompression</td>
<td>63064</td>
<td>62</td>
<td>62.5% (primary procedure, co-surgery reduction)</td>
</tr>
</tbody>
</table>

Any discrepancy in procedure codes reported with modifier -62 between the two co-surgeons may prompt additional investigation and ultimately delay claim processing. Also, if one surgeon does not append the -62 modifier, the payer may assume that the physician reporting the procedure without the modifier performed the entire procedure - despite the second physician reporting the procedure with the modifier -62. This could lead to both underpayments and overpayments.

Documentation

If using a single operative report, the documentation must distinguish the portion(s) of the procedure performed by each co-surgeon. Each co-surgeon must sign the report. Each co-surgeon appends the -62 modifier to the procedure code for the shared procedure. As a best practice, both surgeons should be listed on the report as co-surgeons.

If using separate operative reports, each surgeon documents the portion of the service he or she performed. Each co-surgeon must sign their own report. Each co-surgeon appends the -62 modifier to the procedure code for the shared procedure. Separate reports are preferred as each surgeon is responsible for his or her own documentation.

Payment for Co-surgeries

Payers may not allow co-surgery for every surgery. Medicare has specific indicators that alert providers about payment restrictions. These payment policy indicators, which are listed below, may be applied to payers that follow Medicare co-surgery guidelines.

Medicare Physician Fee Schedule Payment Policy Indicators for Co-surgery

0 = Co-surgeons not permitted for this procedure.
1 = Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure.
2 = Co-surgeons permitted; no documentation required if two specialty requirements are met.
9 = Concept does not apply.
Medicare reimburses each co-surgeon at 62.5% of the global surgery fee schedule amount for the procedure billed with the -62 modifier.

**Multiple Procedure by Co-Surgeons**

When multiple procedure codes are performed during the same operative session as the co-surgery, multiple surgery guidelines will be applied. The procedure with the highest allowed amount, which may or may not be the procedure with the -62 modifier appended, will pay at 100%. Multiple surgery rules will be applied to the other procedures. If the procedure with the -62 modifier appended does not have the highest allowed amount, multiple surgery reductions and the co-surgery reduction will be applied.

**Example:**

<table>
<thead>
<tr>
<th>Surgeon</th>
<th>Code</th>
<th>Modifier</th>
<th>Basic Allowance</th>
<th>Description</th>
<th>Medicare Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgeon</td>
<td>61548</td>
<td>62</td>
<td>$1,727.24</td>
<td>pituitary tumor excision, transnasal</td>
<td>62.5% (primary procedure, co-surgery reduction)</td>
</tr>
<tr>
<td>Neurosurgeon</td>
<td>62272</td>
<td>51</td>
<td>$89.17</td>
<td>spinal puncture, therapeutic</td>
<td>50% (secondary procedure for NEUROSX, multiple surgery reduction, no co-surgery adjustment)</td>
</tr>
<tr>
<td>Otolaryngologist</td>
<td>61548</td>
<td>62</td>
<td>$1,727.24</td>
<td>pituitary tumor excision, transnasal</td>
<td>62.5% (primary procedure, co-surgery reduction)</td>
</tr>
<tr>
<td>Otolaryngologist</td>
<td>31287</td>
<td>51</td>
<td>$211.45</td>
<td>sphenoidotomy</td>
<td>50% (secondary procedure for OTO, multiple surgery reduction, no co-surgery adjustment)</td>
</tr>
</tbody>
</table>
Co-surgery with Add-on Codes

If add-on procedures are performed during the same surgical session, the add-on code must be reported with modifier -62 as well.

Both surgeons must report both components of the related service (the primary/"parent" code and the add-on code) with modifier -62 appended.

Example:

<table>
<thead>
<tr>
<th>Surgeon</th>
<th>Portion Performed</th>
<th>Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgeon</td>
<td>performs the decompression on the initial segment</td>
<td>63064</td>
<td>62</td>
<td>Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc), thoracic, single segment</td>
</tr>
<tr>
<td>Neurosurgeon</td>
<td>performs the decompression on the additional segment(s)</td>
<td>+ 63066</td>
<td>62</td>
<td>each additional segment</td>
</tr>
<tr>
<td>Orthopedist</td>
<td>opens the area of the spine where the decompression will be performed and closes after decompression completed</td>
<td>63064</td>
<td>62</td>
<td>Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc), thoracic, single segment</td>
</tr>
<tr>
<td>Orthopedist</td>
<td>N/A</td>
<td>+ 63066</td>
<td>62</td>
<td>each additional segment</td>
</tr>
</tbody>
</table>

Diagnoses for Co-surgery Cases

The co-surgeons should link the same diagnosis code to the common procedure code (i.e., the one billed with the -62 modifier). The diagnosis code for secondary procedures (those not performed as co-surgery) should be documented by the performing surgeon and linked only to the secondary procedure code the individual operating surgeon performed.
Best Practices

It is important that each surgeon’s billing team communicates with one another to be certain that the claim is coded and submitted properly. This communication could reasonably start at the time of scheduling. Both surgeons may need to obtain prior authorization for the surgery and problems may be reduced if both surgeons are requesting prior authorization on the same procedure and diagnosis codes and it is clearly conveyed to the payer that this is a co-surgery.

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