# Part B Insider (Multispecialty) Coding Alert

## PART B REVENUE BOOSTER: Make Co-Surgery Denials a Thing of the Past

**4 tips break down what documentation both physicians should have.**

When two physicians perform services on the same patient during the same surgical session, you have to be extra vigilant about whether to apply modifier 62 and what documentation your physician provides, or you could face a denial that's complicated to appeal.

**Don't miss:** Tackle these two scenarios -- one where the physicians assist each other and one where the physicians perform distinct parts of the procedure -- and discover when you should apply modifier 62.

**Scenario 1: Both MDs Perform Same Procedure**

Suppose a urologist and an ob-gyn perform a bladder suspension and a hysterectomy at the same surgical session.

**Solution:** Both physicians should report 58267 (Vaginal hysterectomy, for uterus 250 grams or less...) or 58293 (Vaginal hysterectomy, for uterus greater than 250 grams...).

You should report this claim as two surgeons (modifier 62). In other words, "each surgeon is going to code the main procedure with modifier 62," says **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P,** charge capture manager for the University of Washington Physicians in Seattle.

**Reason:** If one specialist performs one part, or component, of a procedure, and another specialist is performing another part of the procedure, payers will consider them co-surgeons. This means the physicians should each report the same CPT code with modifier 62, says **Veronica Antonelli, CPC,** coding and compliance coordinator for Women's Care Florida/PBS. Using modifier 62, each surgeon will receive 62.5 percent of the allotted fee for the service.

**Scenario 2: Each MD Performs Distinct Services**

But what if the services performed by the two specialists aren't represented in a single code?

"If two surgeons are working on performing two distinct procedures during the same surgical session, you can't use modifier 62 and call the surgery a co-surgery because the physicians won't be reporting the same code," Antonelli says. In this case, "each physician should report the code for the service he provided, without a modifier."

**Example:** A patient undergoes a vaginal hysterectomy and a sling procedure. In this case, each surgeon should report a separate code(s) to represent his individual service(s).

The urologist would report 57288 (Sling operation for stress incontinence...), and the gynecologist would report either 58260 (Vaginal hysterectomy, for uterus 250 grams or less) or 58262 (... with removal of tube[s], and/or ovary[s]). Modifier 62 no longer applies because the surgeons report two separate codes.

**Upside:** When two separate codes are used, each physician should receive the full fee allotted for the service he reports.

**4 Tips to Remember When Using Modifier 62**

When two surgeons work together to perform one procedure, each physician's individual documentation requirements can get jumbled. Keep a few tips in mind for your modifier 62 claims.

**Tip 1:** Each physician should identify the other as a co-surgeon. Make sure the other physician is billing with modifier 62.
**Tip 2:** Each physician should document her own operative notes. When surgeons are acting as "co-surgeons," it is implied that they are each performing a distinct part of the procedure which means they can't share the same documentation.
**Tip 3:** Each physician must link the same diagnosis code to the common procedure code.
**Tip 4:** Each physician must submit his own claim with his own documentation. Plus, some physicians submit a letter to the carrier detailing the reason for two surgeons.