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Modifier Coding Alert

Cooperative Surgery: Include Modifier 62 When Physicians 'Share' a CPT® Code

The documentation details will point you to the right modifier.

When physicians work together to perform surgery on the same patient during the same encounter, the modifier you choose will make your claim sink or swim.

Warning: The encounter must meet specific guidelines for 62, or you're probably better off choosing another modifier and you do have several modifier options when physicians work together to perform the same procedure. Check out what the experts have to say about filing successful modifier 62 claims.

Tip 1: Sort Out the Best Modifier

Start by ensuring modifier 62 is actually the modifier that best explains the surgical scenario you are coding. Here are the most common modifiers used in multi-provider situations:

- Modifier 62: Append this to each surgeon's procedure when the physicians perform distinct, separate portions of the same procedure (a single CPT® code). Also referred to as co-surgery, modifier 62 applies when the skill of two surgeons (usually of different skills) is required in the management of a specific surgical procedure.
- Choose between modifier 80 (Assistant surgeon), modifier 81 (Minimum assistant surgeon), and modifier 82 (Assistant surgeon [when qualified resident surgeon not available]) when one surgeon assists another with multiple portions of the case rather than completing his work independently. What to look for? Make sure your physician indicates in his documentation that he's working with an assistant surgeon, what the assistant surgeon did, and why he or she was used during the case.
- Attach modifier AS (Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery) when you report a non-physician practitioner's (NPP's) involvement to Medicare.

Tip 2: Focus On Co-Surgery Definition

When two surgeons (such as a cardiologist and general surgeon) cooperate to perform a surgery within the same body cavity and with a single goal, each of them applies his own expertise to achieve that single goal. At the same time, they assist and complement each other.

To bill for co-surgery, both surgeons must bill using the same CPT® code(s) and append modifier 62. In other words, you should append modifier 62 when two surgeons work together to complete a procedure described by a single CPT® procedure code, says **Laureen Jandroep, CPC, COC, CPC-I, CPPM,** founder/CEO Certification Coaching Organization, LLC in Oceanville, N.J.

"Think of the physicians sharing a CPT® code not a patient," she adds. "If they are sharing a patient/op session but can represent their work with their own CPT® code then they don't need modifier 62."

According to the American Medical Association (AMA), "each surgeon should report his/her distinct operative work by adding the modifier 62 to the single definitive procedure code." In short, modifier 62 applies for only one primary procedure and its related add-on codes for each surgeon.

Treat each physician's portion as a separate procedure that you'll typically see in a separate operative note. The sum of these two op notes equals the one code both physicians are submitting.

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Tip 3: Identify Your Code's Co-Surgery Indicator

You should be careful to know when modifier 62 applies to the code you wish to report. Medicare won't pay for co-surgeries with just any code in the practice, so don't bother appending the modifier where it doesn't fit.

Check your Medicare physician fee schedule database to confirm that the procedure you wish to report qualifies for modifier 62. Otherwise, your surgeons cannot code and bill as co-surgeons for that procedure. To be eligible for payment, make sure that your procedure codes have either a Medicare co-surgery indicator of "1" or "2," Jandroep says. The coverage dictates a pricing of 125 percent of the allowable, which is a 50-50 split between each surgeon (or 62.5 percent for each surgeon).

If you find a code carries a co-surgery indicator of "1," you must supply documentation to establish medical necessity for two surgeons. Only when you establish medical necessity clearly will a payer consider additional reimbursement. You should present which circumstances in the procedure requires special skills or expertise by two surgeons sharing a responsibility.

A "2" in the co-surgery column indicator means that you may append modifier 62 as long as each of the operating surgeons is of a different specialty or of the same specialty but with different expertise.

Medicare will not allow modifier 62 for a procedure with a "0" indicator, which means that you are not allowed to bill for co-surgeons.

Finally: You may find cases when you find a "9" in the co-surgery column. If so, Medicare will not consider modifier 62 applicable to this code, so don't bill with the modifier.

Important: Just because you looked up the co-surgery indicator once, doesn't mean you can always count on that. Always double-check the indicator, because Medicare sometimes changes a codes status.

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