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Welcome to Medicare Learning Network Podcasts at the Centers for Medicare and Medicaid Services, or "CMS." These podcasts are developed and produced by the Medicare Learning Network® within CMS, and they provide official information for healthcare professionals.

If you submit claims to Medicare Administrative Contractors, or MACs, for services to beneficiaries then you will benefit from this podcast. This podcast is intended for physicians.

This podcast, based on MLN Matters® Article SE1322, provides clarification on existing policy regarding significant payments errors because of failing to apply properly the co-surgeon modifier, when two or more surgeons of different specialties participate in one operative session and each separately submit claims to Medicare.

First, we will discuss when two or more surgeons with different specialties submit claims for the same operative session for the same beneficiary and same date of service. In these instances, you must use the co-surgeon modifier.

Second, let's discuss what happens when two different providers bill the same CPT code, same patient and same date of service and one of the providers bills with modifier 62. In these instances, the other provider must also bill with modifier 62. However, when the co-surgeons are of different specialties and are working at the same time, only modifier 62 may be used.

Next, we will discuss the Medicare Claims Processing Manual, and what guidance is provided in Section 40.8, "Claims for Co-Surgeons and Team Surgeons."

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. In these cases, if you are an additional physician you are not acting as assistant-at-surgery.

If two surgeons, each in a different specialty, are required to perform a specific procedure, each surgeon bills for the procedure with a modifier 62, meaning two surgeons. Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure at the same time, for example, a heart transplant.

Next, let's discuss billing instructions. The following three billing procedures apply when billing for

a surgical procedure or procedures that require the use of two surgeons or a team of surgeons.

One (1) - Modifier 62: If two surgeons, each in a different specialty, are required to perform a specific procedure, each surgeon bills for the procedure with modifier 62. Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure at the same time. Documentation of the medical necessity for two surgeons is required for certain services identified in the Medicare Fee Schedule Data Base, or MFSDB.

Two (2) - Modifier 66: If you are a team of surgeons, that is, more than two surgeons of different specialties, required to perform a specific procedure, each surgeon bills for the procedure with a modifier 66. To establish that a team was medically necessary, you need to sufficiently document field 25 of the MFSDB, which identifies certain services submitted with a 66 modifier. All claims for team surgeons must contain sufficient information to allow pricing by report.

Three (3) - Different procedures requiring no modifier: If you are surgeons of different specialties and are each performing a different procedure, with different CPT codes, neither co-surgery nor multiple surgeon rules apply, even if the procedures you perform are through the same incision. If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services.

Now, we will discuss payments. For co-surgeons (modifier 62), the fee schedule amount related to the payment for each co-surgeon is 62.5 percent of the global surgery fee schedule amount. Team surgery (modifier 66) is paid for on a "By Report" basis.

Next, let's discuss two case examples from the Recovery Auditor Review. The first example is a provider bills for CPT code 61548, excision of a pituitary tumor, and bills with modifier 62, for a patient on date of service March 8, 2012. A different provider bills for the same service for the same patient on the same date of service because they were the co-surgeon. However, the co-surgeon did not bill with modifier 62. The second surgeon was overpaid for failing to properly apply modifier 62.

In the last example, a provider bills for CPT code 49652, Laparoscopy, surgical repair, ventral, umbilical, spigelian or epigastric hernia, and bills with modifier 62, for a patient on July 2, 2011. A different provider bills for the same service for the same patient on the same date of service because they were the co-surgeon. However, the co-surgeon did not bill with modifier 62. The second surgeon was overpaid for failing to properly apply modifier 62.

In both of these examples, you should add the appropriate modifier to the claim line when you are the co-surgeon, operating on the same beneficiary, on the same date of service.

There are some additional resources to guide you in your use of modifier 62. The specific sites at which they can be found can be located on page three of SE1322.

To download the MLN Matters® Article SE1322, go to the CMS website at www.cms.gov and click on “Outreach and Education” at the top of the page. From that page, scroll down to the Medicare Learning Network section and click on the MLN Matters® Articles link. Follow the links to “2013 MLN Matters® Articles” and search for SE article number “SE1322.”

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