MEDICAID REIMBURSEMENT POLICY

Co-Surgeon and Team Surgeons

Active

Section: Surgery/Interventional Procedure
Policy Number: 003
Effective Date: 04/01/24

Description

This policy addresses reimbursement for surgical procedures when two or more surgeons are required to perform surgery on the same patient during the same operative session.

Policy Statement

This policy identifies the procedures that are eligible for co-surgeon and team surgeon reimbursement and the associated documentation requirements.

In some cases, the complex nature of a procedure and/or the patient's condition may require the skills of two or more surgeons during the same operative session. If two surgeons are required, each surgeon bills for the procedure with modifier "62" (two surgeons). If a team of more than 2 surgeons is necessary, each surgeon bills for the procedure with modifier "66" (surgical team).

Co-Surgery (Modifier 62)
When two surgeons, usually of different specialties, work together as primary surgeons to perform a specific task associated with the same surgical procedure or to perform parts of a procedure simultaneously (e.g., heart transplant or bilateral knee replacements), each surgeon submits the same procedure code(s) with modifier 62, for the same date of service.
Blue Cross and Blue Shield of Minnesota (Blue Cross) determines which procedures are co-surgeon eligible and whether supporting documentation is necessary based upon the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Co-surgeons indicators:

0= Co-surgeons not permitted for this procedure.
1= Co-surgeons could be paid. Supporting documentation is required to establish the medical necessity of two surgeons for the procedure. Each surgeon's specific role in the procedure must be clearly documented and medical records must be submitted as an attachment with the claim.
2= Co-surgeons permitted.
9= Concept does not apply.

Blue Cross will reimburse eligible co-surgeon services at 62.5% of the allowable amount to each surgeon.

Simultaneous Bilateral Procedures
When the same procedure is performed at the same time on opposite sides by co-surgeons, each surgeon should report the procedure with modifiers 50 and 62.

Team Surgery (Modifier 66)
When more than two surgeons of the same or different specialties perform a specific task associated with the same surgical procedure, each surgeon should submit the same procedure code with modifier 66, for the same date of service.

Blue Cross determines when procedures are team surgeon eligible and whether supporting documentation is necessary based upon the CMS NPFS Team Surgery indicators:

0 = Team surgeons not permitted for this procedure.
1 = Team surgeons could be paid. Supporting documentation is required to establish medical necessity of a team; paid by report. Each surgeon's specific role in the procedure must be clearly documented. Blue Cross requires each surgeon to submit documentation with the claim.
2 = Team surgeons permitted; pay by report. Each surgeon must submit documentation with the claim.
9 = Concept does not apply.

Each team surgeon's documentation must describe their specific involvement in the procedure. Blue Cross will review and make reimbursement decisions on a case-by-case basis. Reimbursement will be 62.5 percent of the global surgery fee schedule amount for allowable team surgery services.

Global Surgical Package
The global surgical package applies to each of the surgeons participating in a co or team surgery. Refer to *Medicaid Surgery/Interventional Procedure - 007 Global Surgical Package Reimbursement Policy.*

Multiple Procedure Reductions
Co-surgeon and/or team surgeon claims submitted with multiple procedure codes are subject to multiple procedure reductions if applicable. Refer to *Medicaid Surgery/Interventional Procedure – 005 Multiple Surgical Reduction Reimbursement Policy*

Documentation Submission
Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage
Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are

subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	50	62	66
ICD-10 Diagnosis:	N/A		
ICD-10 Procedure:	N/A		
CPT/HCPCS:	N/A		
Revenue Codes:	N/A		

Resources

Current Procedural Terminology (CPT®)
Medicare Physician Fee Schedule (MPFS) Relative Value File
Medicare Claims Processing Manual Chapter 12, Section 40.8
National Government Services

Policy History

09/26/2023	Initial Committee Approval
03/26/2024	Annual Policy Review