Weill Cornell Medicine	Policy Title	Documenting, Coding and Billing of Co-Surgery Cases
	Document Number	2007.002
	Department	Clinical Compliance
	Effective Date	October 1, 2006
	Last Updated	May 4, 2023
	Clinical Compliance Committee Review Date	

Purpose:
The purpose of this policy is to establish a workflow that supports coordination of procedure documentation, procedure coding and timely claim submission for co-surgery cases.

Scope:
This policy is applicable to surgeons billing procedures with a co-surgeon indicator of "1" or "2" as listed in the Medicare Physician Fee Schedule when the service is performed by co-surgeons and both surgeons will seek reimbursement for their portion of the same service. This policy is also applicable to coders and billing staff who support co-surgeons.

Overview:
Medicare and other third-party payers will provide reimbursement for co-surgery when two surgeons share work and responsibility in performing a specific surgical procedure. The total resulting reimbursement (from most payers) will be 125% of the usual allowed amount, divided equally between the co-surgeons. To ensure that each co-surgeon is properly reimbursed, each co-surgeon is required to document and coordinate their coding and billing of the service(s) in accordance with co-surgery rules.

Definitions:
Co-surgeon – two or more surgeons, where the skills of both surgeons are necessary to perform distinct parts of a specific operative procedure, during the same operative session.

Modifier 62 – a code that is appended to a CPT procedure code by each co-surgeon to notify the payer that two surgeons of the same or different specialties worked together as primary surgeons performing distinct components of a surgical procedure.

Co-surgeon Indicators -- The Centers for Medicare & Medicaid Services (CMS) Co-Surgeon Indicators are listed in the CMS National Physician Fee Schedule Relative Value File for each CPT code and identify which services are eligible for co-surgery billing as well as whether claim adjudication requires documentation review. Values which are currently in the CMS file are listed below:

0 - Co-surgeon not permitted for this procedure.
1 - Co-surgeons may be paid; supporting documentation required to establish medical necessity.
2 - Co-surgeons permitted; no documentation is required if two specialty requirements are met.
9 - Co-surgeon concept does not apply.

Policy:

Documentation Requirements --Each co-surgeon must dictate and complete an operative report in which they indicate that the case was performed as a co-surgery and list the name of the co-surgeon involved. Each co-surgeon operative report should include a concise statement of medical necessity supporting the need for two surgeons. Each co-surgeon's operative report must provide a full written account that describes the details of the portion of the co-surgery procedure(s) they personally performed. Any other procedures personally performed (not as co-surgery) should also be detailed in the operative report of the performing surgeon.

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Pre-Billing Monitoring/Billing Coordination – Co-surgery cases require pre-billing monitoring and coordination by a billing, coding, or compliance staff member from each co-surgeon's Department.

The pre-billing review performed in each co-surgeon's department involves reviewing the operative notes and billing codes for both surgeons.

The purpose of the pre-billing review is to verify the following, based on Medicare rules:

- Each co-surgeon has an operative note in the medical record.
- Each operative note lists the other surgeon as a co-surgeon.
- Each operative note has a clinical indication that describes the medical necessity for two surgeons.
- Each operative includes a description of the distinct personal surgical work performed by the surgeon who is authoring the note.
- Review the codes being billed by each surgeon:
    - Review the Medicare Physician Fee Schedule to confirm which codes qualify for co-surgery (must have a co-surgery indicator of "1" or "2").
    - Identify the eligible co-surgery code(s) for the shared procedure(s) and verify that modifier -62 is appended.
    - Identify any additional procedure the surgeon personally performed that will not require the co-surgery modifier if performed independently.
- Both co-surgeons will link the same diagnosis to the common procedure code(s).
- Query either provider for documentation deficiencies or coding clarification prior to releasing the charges/insurance claim to the provider.

The final coordination step is to prepare to send the supporting documentation for/with the claim if the Co-surgery indicator was "1" for any of the shared procedures as required to support medical necessity.

Most payers follow Medicare guidelines, however, it may be necessary to research payer specific guidelines for billing a co-surgery case if the patient is not covered by Medicare insurance.

Contacts:
Direct any questions about this policy to the Clinical Compliance and Privacy Office:
- Telephone: (646) 962-6930
- Email: Compliance@med.cornell.edu

Reports of Non-Compliance:
Reports of Non-Compliance should be made to the Clinical Compliance and Privacy Office:
- Telephone: (646) 962-6930
- Email: Compliance@med.cornell.edu

Policy Review:
The Compliance Department will review and update this Policy, when necessary, in the normal course of its review of the Organization's Compliance Program.

Policy Revision History:
Original Policy Date – October 1, 2006
Review and Update – May 4, 2023
References:

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56 Fed. Reg. 59502, 59516 (Nov. 25, 1991) - Department of Health and Human Services Health Care Financing Administration 42 CFR Parts 405,413, and 415 Medicare Program; Fee Schedule for Physicians' Services (established the Medicare Part B payment policy for the co-surgery modifier under the physician fee schedule.
https://www.govinfo.gov/content/pkg/FR-1991-11-25/pdf/FR-1991-11-25.pdf

CMS, Medicare Claims Processing Manual, Pub. No. 100-04, chapter 12, § 40.8
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf

Department of Health and Human Services, Office of Inspector General, Report A-01-20-0053, November 2022 -- Medicare Improperly Paid Physicians for Co-Surgery
https://oig.hhs.gov/oas/reports/region1/12000503.asp

Medicaid Version 2022-1
March 16, 2022
Page 32-33
https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician_Manual_Policy_Guidelines.pdf

Billing When Two Surgeons Are Involved Physician Manual Policy Guidelines Version 2022-1 October 15, 2015 Page 33 of 45 When two surgeons (usually of different skills) work together as primary surgeons performing distinct part(s) of a single reportable procedure, add modifier –62 to the procedure code number. One surgeon should file one claim line representing the procedure performed by the two surgeons. The billing surgeon will apportion the total payment in relation to the responsibility and work done.

New York State
Medicaid Program
Physician – Procedure Codes – Section 5 – Surgery (page 4 & page 6)
https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician_Procedure_Codes_Sect5__2015-2.pdf

MMIS SURGERY MODIFIERS: Note: NCCI associated modifiers are recognized for NCCI code pairs/related edits. For additional information please refer to the CMS website: http://www.cms.hhs.gov/NationalCorrectCodInitEd/ -50 Bilateral Procedure (Surgical): Unless otherwise identified in the listings, bilateral surgical procedures requiring a separate incision that are performed at the same operative session, should be identified by the appropriate five digit code describing the first procedure. To indicate a bilateral surgical procedure was done add modifier -50 to the procedure number. (Reimbursement will not exceed 150% of the maximum Fee Schedule amount. One claim line is to be billed representing the bilateral procedure. Amount billed should reflect total amount due.)

Commented [SMP1]: I found this for Medicaid which seems to indicate that one physician bills and apportion the total payment. I would like to ask for data on how NYS Medicaid has paid co-surgery cases from CBO.

In the second publication sited – I did find where individual CPT codes could be billed with modifier 62 by each co-surgeon. These were mostly spine procedures.

Let's discuss.