UnitedHealthcare® Medicare Advantage
Reimbursement Policy
CMS 1500
Policy Number 2024R9010A

Co-Surgeon/Team Surgeon Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Medicare Advantage enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents**. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.

Application

This reimbursement policy applies to all Medicare Advantage Products and for services reported using the 1500 Health Insurance Claim Form (a/k/a CMS 1500) or its electronic equivalent or its successor form. This policy applies to all network physicians and other qualified health care professionals.

Policy

Overview

The Co-Surgeon and Team Surgeon Policy identifies which procedures are eligible for Co-Surgeon and Team Surgeon services as identified by the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS).
A Co-Surgeon is identified by appending modifier 62 to the surgical code.

A Team Surgeon is identified by appending modifier 66 to the surgical code.

Reimbursement Guidelines

Co-Surgeon Services

Modifier 62 identifies a Co-Surgeon involved in the care of a patient at surgery. Each Co-Surgeon should submit the same *Current Procedural Terminology* (CPT®) code with modifier 62 for the same date of service.

For services included on the Co-Surgeon Eligible List (see below), UnitedHealthcare Medicare Advantage will reimburse Co-Surgeon services at 63% of the Allowable Amount to each surgeon, subject to additional multiple procedure reductions if applicable (see Multiple Procedure Reduction section, below).

The Allowable Amount is determined independently for each surgeon and is calculated from the Allowable Amount that would be given to that surgeon performing the surgery without a Co-Surgeon. The reimbursable percentage amount (63%) of allowable is based on the rate adopted by CMS, which allows 62.5% of allowable to each Co-Surgeon.

Team Surgeon Services

Modifier 66 identifies Team Surgeons involved in the care of a patient during surgery. Each Team Surgeon should submit the same CPT code with modifier 66 for the same date of service.

Each Team Surgeon is required to submit written medical documentation describing the specific surgeon's involvement in the total procedure. For services included on the Team Surgeon Eligible List (see below), UnitedHealthcare Medicare Advantage will review each submission with its appropriate medical documentation and will make reimbursement decisions on a case-by-case basis.

Co-Surgeon and Team Surgeon Eligible Services

The Co-Surgeon and Team Surgeon eligible services are based on the CMS NPFS status indicators.

Under the NPFS Co-Surgeon Data Element there are two indicators that indicate services for which the two surgeons, each in a different specialty may be paid. The indicators are:

- 1=Co-Surgeons could be paid, though supporting documentation is required to establish the medical necessity of two surgeons for the procedure
- 2=Co-Surgeons permitted and no documentation required if the two-specialty requirement is met

All codes in the NPFS with status code indicators "1" or "2" for "Co-Surgeons" are considered by UnitedHealthcare Medicare Advantage to be eligible for Co-Surgeon services as indicated by the Co-Surgeon modifier 62.

Under the NPFS Team Surgeons Data Element there are two indicators that indicate services for which the Team Surgeons may be paid. The indicators are:

- 1=Team Surgeons could be paid, though supporting documentation required to establish medical necessity of a team; pay by report
- 2=Team Surgeons permitted; pay by report

All codes in the NPFS with the status code indicators "1" or "2" for "Team Surgeons" are considered by UnitedHealthcare Medicare Advantage to be eligible for Team Surgeon services as indicated by the Team Surgeon modifier 66.

Multiple Procedure Reductions

Multiple procedure reductions apply to Co-Surgeon and Team Surgeon claim submissions when one or more physicians are billing multiple CPT codes that are eligible for reductions.

Assistant Surgeon and Co-Surgeon Services During the Same Encounter
UnitedHealthcare Medicare Advantage follows CMS guidelines and does not reimburse for Assistant Surgeon services, as indicated by modifiers 80, 81, 82, or AS, for procedures where reimbursement has been provided for eligible Co-Surgeon services, using the same surgical procedure code, during the same encounter. If a Co-Surgeon acts as an Assistant Surgeon in the performance of additional procedure(s) during the same surgical session, the procedures are reimbursable services (if eligible per the NPFS Assistant Surgeon Eligibility indicator) when indicated by separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.
Simultaneous Bilateral Services
Simultaneous bilateral services are those procedures in which each surgeon performs the same procedure on opposite sides. Each surgeon should report the simultaneous bilateral procedures with modifiers 50 and 62. Assistant Surgeon services will not be reimbursed services in addition to the simultaneous bilateral submission as described in the "Assistant Surgeon and Co-Surgeon Services" section in this policy.

Definitions	
Allowable Amount	Defined as the dollar amount eligible for reimbursement to the physician or other qualified health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of an Allowable Amount, whichever is applicable. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.
Assistant Surgeon	A Physician or other qualified health care professional who is assisting the physician performing a surgical procedure
Co-Surgeons	Several Physicians (usually with different specialties) working together as primary surgeons performing distinct part(s) of a procedure. Claims submitted by Co-Surgeons are identified with modifier 62.
Team Surgeons	Three or more Physicians surgeons (with different or same specialties) working together during an operative session in the management of a specific surgical procedure. Claims submitted by Team Surgeons are identified with modifier 66.
Physician	A Doctor of Medicine (MD) or Doctor of Osteopathy (DO)

Questions and Answers	
1	**Q:** Why does UnitedHealthcare Medicare Advantage not allow reimbursement for non-physicians performing Co-Surgeon services? **A:** CMS claims processing manual guidelines for co-surgery refers to surgical procedures involving two different surgeons, usually of different specialties.
2	**Q:** Can a surgeon bill the 62 modifier or bill separately for the closure of a surgical incision? **A:** Closure of a surgical incision is included in the global surgical package. Separate codes for closure are generally not allowed. The CPT code descriptor may define more specifically the closure services included in a given procedure. For example: Spinal arthrodesis, posterior or posterolateral technique (CPT Code 22612). The code description indicates: “The periosteum, ligaments and paravertebral muscles are sutured to secure the bone grafting. The skin and subcutaneous tissues are closed in layers with sutures.” If a different surgeon performs the closure of the surgical site, the services would correctly be billed by both surgeons appending the co-surgeon modifier (62) to the primary CPT Code. In this example, CPT Code 22612-62 could be billed by an orthopedic spine surgeon and a plastic surgeon.

3	**Q:** Can two surgeons of the same specialty bill the 62 modifier for a procedure? **A:** In certain circumstances, co-surgeons may be of the same or different specialties. To be considered for reimbursement, documentation is required supporting the co-surgeons working as the primary surgeon performing a distinct part or parts of the same procedure.
4	**Q:** Can two surgeons use the 62 modifier for exposure of the operative field? **A:** Yes. To be considered for reimbursement, documentation is required supporting the co-surgeons working as the primary surgeon performing a distinct part or parts of the same procedure. For example: When an anterior approach to the spine is performed by a vascular surgeon followed by an anterior fusion performed by an orthopedic spine surgeon, the services would correctly be billed by both surgeons appending the co-surgeon modifier (62) to the primary CPT Code.

Codes

CPT code section
National Physician Fee Schedule Relative Value File

Modifier Codes

Code						
50	62	66	80	81	82	AS

Resources

www.cms.gov

American Medical Association, *Current Procedural Terminology (*CPT®)

Centers for Medicare and Medicaid Services: PFS Relative Value Files

CMS MLN Global Surgery Booklet

The Medicare Learning Network (MLN): MLN Matters SE1322

History

6/1/2024	Policy Version Change Application Section: Updated History Section: Entries Prior to 6/1/2022 archived
6/1/2023	Policy Version Change Policy Logo Updated
6/1/2022	Annual Review Policy Version Change Application Section: Updated Definition Section: Updated Q & A Section: Added Questions 2-4 Resource Section: Updated History Section: Entries Prior to 1/1/2020 archived
8/13/2014	New Policy