Reimbursement Policy	
Subject: **Modifier 62**	
Policy Number: **G-06027**	Policy Section: **Coding**
Last Approval Date: **03/15/2023**	Effective Date: **01/01/2021**

**** Visit our provider website for the most current version of our reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://medicareprovider.healthybluemo.com**. ****

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Healthy Blue Medicare Advantage benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes, and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Healthy Blue Medicare Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Healthy Blue Medicare Advantage strives to minimize these variations.

Healthy Blue Medicare Advantage reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to our provider website.

MOHB-CR-RP-025463-23-CPN23634 June 2023

Policy

Healthy Blue Medicare Advantage allows reimbursement of procedures eligible for co-surgeons when billed with Modifier 62 unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Reimbursement to each surgeon is based on 62.5% of the applicable fee schedule or contracted/negotiated rate. Co-surgeons must be from different specialties and performing surgical services during the same operative session. However, Healthy Blue Medicare Advantage does not consider surgeons performing different procedures during the same surgical session as co-surgeons, and Modifier 62 is not required.

Each surgeon must bill the same procedure code(s) with Modifier 62, when applicable. If one or both surgeons fail to use the modifier appropriately, it is possible that one surgeon may receive 100% of the applicable fee schedule or negotiated/contracted rate, and the other surgeon's claim may be denied or pended due to a duplicate or suspected duplicate service, respectively.

Assistant surgeon and/or multiple procedures rules and fee reductions apply if:

- A co-surgeon acts as an assistant in performing additional procedure(s) during the same surgical session.

Note: Assistant surgeon rules do not apply to procedures appropriately billed with Modifier 62.

- Multiple procedures are performed.

Related Coding

Standard correct coding applies

Policy History

03/15/2023	Review approved: Policy template updated
01/01/2023	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract
- Healthy Blue Medicare Advantage contract(s)
- Optum EncoderPro 2023

Definitions

Modifier 62	When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding Modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure{s}) are performed during the same surgical session, separate code(s) may also be reported with Modifier 62 added.

	Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the Modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with Modifier 80 or Modifier 82 added, as appropriate
General Reimbursement Policy Definitions	

Related Policies and Materials

Assistant at Surgery (Modifiers 80/81/82/AS)
Duplicate or Subsequent Services on the Same Date of Service
Modifier Usage
Multiple and Bilateral Surgery: Professional and Facility Reimbursement
Modifier 66