Co-Surgeon / Team Surgeon

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

This reimbursement policy pertains to services reported using the 1500 Health Insurance Claim Form (CMS-1500), its electronic equivalent, or any successor form. It applies across all products and includes both network and non-network physicians, as well as other qualified healthcare professionals. This encompasses, but is not limited to, non-network authorized individuals and healthcare professionals operating under percent of charge contracts. The Co-Surgeon and Team Surgeon Policy outlines the procedures eligible for Co-Surgeon and Team Surgeon services, as specified in the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS). To designate a Co-Surgeon, modifier 62 should be appended to the surgical code, while a Team Surgeon should be identified by appending modifier 66 to the surgical code.

Reimbursement Guidelines

Co-Surgeon Services

Modifier 62 is used to identify a Co-Surgeon involved in patient care during surgery. Each Co-Surgeon should bill the same Current Procedural Terminology (CPT®) code with modifier 62 for the same service date. Molina Healthcare reimburses Co-Surgeon services at 63% of the Allowable Amount for each surgeon, as determined independently for each surgeon. The reimbursable percentage (63%) is based on the Centers for Medicare and Medicaid Services (CMS) rate, which allows 62.5% to each Co-Surgeon. Additional multiple procedure reductions may apply (see Multiple Procedure Reduction section below).

Team Surgeon Services

Modifier 66 is used to identify Team Surgeons involved in patient care during surgery. Each Team Surgeon should bill the same CPT code with modifier 66 for the same service date. Team Surgeons must provide written medical documentation describing their specific involvement in the procedure. Reimbursement decisions for services on the Team Surgeon Eligible List (see below) will be made on a case-by-case basis after reviewing the submitted medical documentation.

Co-Surgeon and Team Surgeon Eligible Lists

These lists are based on CMS National Physician Fee Schedule (NPFS) Relative Value File status indicators. Molina Healthcare considers codes with status indicators "1" or "2" for "Co-Surgeons" eligible for Co-Surgeon services using modifier 62, and codes with status indicators "1" or "2" for "Team Surgeons" eligible for Team Surgeon services using modifier 66. Payment indicators for HCPCS codes G0412 - G0415 are applied when settling CPT codes 27215-27218.

Multiple Procedure Reduction

Multiple procedure reductions apply when multiple physicians bill eligible CPT codes. Molina Healthcare follows CMS guidelines and does not reimburse for Assistant Surgeon services (modifiers 80, 81, 82, or AS) when eligible Co-Surgeon services for the same surgical procedure code are provided during the same encounter. Procedures performed by a Co-Surgeon acting as an Assistant Surgeon are reimbursable when indicated by separate procedure code(s) with modifier 80 or 82, as appropriate.

Simultaneous Bilateral Services

Surgeons performing the same procedure on opposite sides should report simultaneous bilateral procedures with modifiers 50 and 62. Assistant Surgeon services are not reimbursed except for simultaneous bilateral submissions as described in the "Assistant Surgeon and Co-Surgeon Services" section in this policy.

Medical Necessity of Services

Modifiers identifying assistant surgeon, co-surgeon, and team surgeries are subject to pre- and/or post-payment audits for medical necessity. Medical necessity criteria include the ACS Physicians as Assistants at Surgery eligibility list, CMS NPFS, and patient health status. Charges for services not meeting medical necessity criteria will be denied.

Supplemental Information

Definitions

Term	Definition
CMS	Center for Medicare and Medicaid
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 The allowable amount is determined as the amount billed, 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 (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)

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Published	08/16/2023	New Policy
Revised Date	12/12/2024	Updated Templated

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed*