If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of Texas may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Co-Surgeon/Team Surgeon Policy- Professional Provider

Policy Number: CPCP009

Version: 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: April 7, 2025

Plan Effective Date: April 18, 2025

Description

This policy provides coding details for surgical procedures utilizing two or more surgeons or other qualified health care professionals/QHPs for the same surgical patient. Co-Surgeons or team surgeons are used when multiple surgeons or QHPs with different skills and/or specialties are required or when conducting surgery simultaneously minimizes anesthesia time or complications.

Health care providers (facilities, physicians, and other qualified health care professionals are expected to exercise independent medical judgement in providing care to patients. This policy is not intended to impact care decisions or medical practice. This policy does not address all situations that may occur and in certain circumstances these situations may override the criteria within this policy.

This policy is not applicable to services billed on the UB-04 Claim Form.

Terms

Co-Surgeon Services- Two surgeons with different individual skills working together as primary surgeons to perform distinct parts of a surgical procedure on the same patient during the same operation on the same day. Often, these surgeons have different specialties which require them to serve as the primary surgeon for their unique portion of the surgery. This may be due to the complexity of the surgery and/or the patient's condition. In this scenario, the surgeons are acting as co-surgeons, and each surgeon should bill the procedure code with a modifier **62** appended.

Team Surgeon Services- Team surgery occurs when more than two physicians, usually of different specialties, and/or other QHPs, including assistant surgeons, nurse practitioners, and physician assistants, are required to perform highly complicated procedures on the same patient, on the same day. Team surgery is identified by appending modifier **66** to the procedure code.

Reimbursement Information

The plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement.

Applicable Modifiers

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
62	Two surgeons	Append modifier if two surgeons with different specialties are required to perform a specific procedure on the same patient during an operative session, both acting as primary surgeons. If co-surgeon acts as an assistant in the performance of an additional procedure, other than those reported with modifier 62, during the same surgical session, those services must be reported using different procedure codes with modifier 80 or 82, as appropriate. • Both surgeons should append modifier 62 on the submitted claim. • The procedure code and diagnosis code should be the same on the submitted claim.
66	Surgical team	Append modifier when more than two surgeons of different specialties are working together under the "surgical team" concept. • Should be submitted with supporting documentation that includes each surgeon's description of their performance during the procedure. • Both surgeons should submit this modifier on only those services where they are acting as primary surgeons.

For more information on when to append appropriate modifiers for assistant surgeon's services, providers should refer to **CPCP023 Modifier Reference Policy.**

Co-Surgery- Modifier 62

In cases of co-surgeon services, each surgeon must submit claims utilizing the same CPT code accurately reflecting the surgical procedure and append modifier **62**. Both surgeons are required to submit separate operative reports that explicitly state what services each surgeon performed during the surgery, reflecting the complexity of the case.

The following criteria must be met for Co-Surgery claims to be eligible for reimbursement:

- Compliance with CMS guidelines which state that HCPCS/CPT codes appearing in the National Physician Fee Schedule (NPFS) with a relative value file co-surgery status indicator of "1" or "2" are eligible for co-surgeon reimbursement with modifier **62**.
- Services rendered by both surgeons must be determined to be necessary.
- The procedure requires two surgeons with different specialties performing a specific procedure, or two surgeons performing a specific procedure simultaneously.
- The co-surgery services are submitted with an appropriate surgical CPT code by both surgeons with modifier **62** listed in the first position.
- Physicians cannot bill as assistants for the procedure in which they acted as co-surgeons.

Inappropriate usage of modifier 62

- When two surgeons are operating on two completely different anatomic portions of the patient on the same date and time, it is not considered co-surgery. In these instances, each surgeon is considered the primary provider for the surgery they are conducting and modifier **62** should **not** be applied.
- Modifier **62** should **not** be billed for procedures when one of the surgeons is acting as an assistant surgeon. If a co-surgeon acts as an assistant during another procedure during the same surgical session, as indicated by a separate procedure code, they may bill as an assistant for that separate procedure. Multiple surgery reductions may apply.

Team Surgery- Modifier 66

When appropriate for team surgery, each team surgeon should use the same CPT code on their individual claim form and append modifier **66** in the primary modifier position. Each team surgeon may be asked to submit an operative report that states what services each surgeon performed during the surgery.

For team surgery claims to be eligible for reimbursement, the following criteria must be met:

- Compliance with CMS guidelines which state that CPT codes appearing in the National Physician Fee Schedule (NPFS) with a relative value file team surgery status indicator of "1" or "2" are eligible for reimbursement with the appropriate modifier.
- Services rendered by a team must be determined to be necessary.
- Teams must be composed of more than two surgeons of different specialties.
- The team surgery services must be submitted with an appropriate surgical CPT code and modifier **66** listed in the first position.

Additional Resources

Clinical Payment and Coding Policy

CPCP023 Modifier Reference Policy

References

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Physician Fee Schedule Relative Value Files.

Policy Update History

Approval Date	Description
12/06/2017	New policy
09/28/2018	Annual review
08/16/2019	Annual review
09/16/2020	Annual review, Disclaimer update
10/05/2021	Annual review
10/27/2022	Annual review
09/05/2023	Annual review
01/12/2024	Annual review
04/07/2024	Annual review; Grammatical updates; Updated *References*.