CO-SURGEON, ASSISTANT SURGEON, TEAM SURGEON, AND ASSISTANT-AT-SURGERY GUIDELINES

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Description

Co-Surgeons are defined as two or more surgeons, where the skills of both surgeons are necessary to perform distinct parts of a specific operative procedure. Co-surgery is always performed during the same operative session.

An assistant surgeon is defined as a physician who actively assists the operating surgeon. An assistant may be necessary because of the complex nature of the procedure(s) or the patient's condition. The assistant surgeon is usually trained in the same specialty.

An assistant-at-surgery may be a physician assistant, nurse practitioner or nurse midwife acting under the direct supervision of a physician, where the physician acts as the surgeon and the assistant-at-surgery as an assistant.

Under some circumstances, highly complex procedures may require the services of a surgical team, consisting of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and complex equipment. A physician operating in this setting is referred to as a team surgeon.

Policy

The Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) identifies which procedures are eligible for co-surgeon, assistant surgeon, and team surgeon services and the rates at which they are reimbursable. Blue Cross Blue Shield North Carolina (Blue Cross NC) will reimburse co-surgeon, assistant surgeon, and team surgeon services according to the criteria outlined in this policy.

Reimbursement Guidelines

Co-Surgeons

Medicare reimburses for a co-surgeon if the procedure is identified as co-surgeon appropriate and a physician is performing the surgery. Reimbursement for each co-surgeon is based on the lesser of the actual charges or 62.5% of the Medicare Physician Fee Schedule (MPFS) amount. Multiple procedure guidelines may apply if additional procedures are performed. Each surgeon should document their distinct operative work in a separate operative report. Claims from both co-surgeons should report the same procedure code with modifier 62 appended.

Co-surgeon claims for procedures designated as co-surgeon allowed will be denied when both surgeons have the same specialty or subspecialty.

Assistant Surgeon

Medicare makes payment for an assistant at surgery if the procedure is identified as appropriate for an assistant and the person performing the service is a physician. An assistant surgeon must be appropriately board-certified or otherwise highly qualified as a skilled surgeon and licensed as a physician in the state where the services are provided. The assistant surgeon is also expected to comply with applicable statutes and regulations appropriate for the assistant surgeon role.

One assistant surgeon is allowed for a surgical procedure and may be of the same specialty or subspecialty or may be of a different specialty.

Blue Cross NC utilizes assistant surgeon indicators identified by industry standard coding software to determine if the procedure indicates the use of an assistant surgeon. Providers should bill using industry standard modifiers when reporting assistant surgery services are eligible for reimbursement.

Assistant surgeon reimbursement shall not exceed 16% of the MPFS amount.

Modifier 80 (assistant surgeon), 81 (minimum assistant surgeon), or 82 (when qualified resident surgeon not available) is used by physicians to bill for assistant at surgery services.

Modifier AS (PA, NP, or CNS services for assistant at surgery) indicates that a non-physician provider served as the assistant at surgery.

Modifiers 80, 81 and 82 should be used for a physician to report an assistant for surgery services. These modifiers are not intended to be used for non-physician reporting assistant for surgery services.

Physician Assistant/Nurse Practitioner/Nurse Midwife

Medicare makes payment for an assistant at surgery when the procedure is identified as appropriate for an assistant and the person performing the service is a physician, physician assistant (PA), nurse practitioner (NP) or a clinical nurse specialist (CNS). The PA, NP, or CNS must be appropriately certified or licensed in the state where the services are provided and be credentialed in the facility where the procedure is performed. Benefits are allowed when medical necessity and appropriateness of assistant surgeon services are met, and when the physician assistant/nurse practitioner/nurse midwife is under the direct supervision of a physician. Separate benefits will not be allowed for the hospital-employed physician assistant/nurse practitioner/nurse midwife. The physician assistant/nurse practitioner/nurse midwife benefit for a covered procedure is 13.6% of the maximum allowed for the procedure.

When a PA, NP, or CNS is the assistant at surgery, the amounts paid for serving as an assistant at surgery shall be the lesser of the actual charge or 85% of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery. Assistant surgeon reimbursement for this group shall not exceed 13.6% of the MPFS amount.

Team Surgeon

Highly complex procedures requiring multiple physicians of different specialties, and other highly skilled personnel and equipment may be considered for reimbursement as team surgery. Benefits are allowed for medically necessary procedures and allowance(s) will be determined on an individual consideration basis.

Procedures that are minor, non-surgical, or that are not of sufficient complexity to require multiple physicians of different specialties and other highly skilled personnel and equipment, do not satisfy the definition of team surgery, and will be denied if submitted with modifier 66 (Team Surgery).

Additional Information

Physicians will not be allowed additional benefits for the supervision of a physician assistant/nurse practitioner/nurse midwife.

Provider claims with a physician billing for both primary surgeon and assistant surgeon services for the same procedure are considered inappropriate and are not eligible for reimbursement.

Medicare does not recognize a registered nurse first assistant (RNFA) as a qualified Medicare provider therefore RN-First Assistants are not eligible for reimbursement as surgical assistants.

Rationale

Refer to Multiple Procedure and Bundling guidelines for procedures performed in addition to the primary procedure(s) during the same operative session.

When multiple procedures are performed and the secondary procedures are allowable according to the multiple procedure guidelines, as well as being eligible for assistant surgeon services, benefits for those services will be allowed and processed according to the multiple procedure guidelines.

When a surgeon is unexpectedly requested to render services during an ongoing operative session, claims will be reviewed according to the above criteria.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see the Blue Cross NC web site at www.bcbsnc.com.

Modifier 62

Procedures billed with modifier 62 will be denied when a claim for the same procedure code without modifier 62 has been previously submitted and processed for a different provider.

Procedures billed without modifier 62 will be denied when a claim for the same procedure code with modifier 62 has been previously submitted by a different provider.

Procedures identified by the Medicare Fee Schedule where co-surgeon restrictions may apply will be denied when billed with modifier 62.

Procedures identified by the Medicare Fee Schedule as non-surgical in nature or as not requiring co-surgeons will be denied if billed with modifier 62.

Procedures designated as co-surgeons not allowed that are billed with modifier 62 will be denied.

Modifier 66

Procedures billed with modifier 66 will be denied when a claim for the same procedure code without modifier 66 has been previously submitted and processed for a different provider.

Procedures billed without modifier 66 will be denied when a claim for the same procedure code with modifier 66 has been previously submitted by any provider.

Procedures where team surgery is not allowed, based on the Medicare Physician Fee Schedule (MPFS), will be denied if billed with modifier 66.

Medical and surgical services billed with modifier 66 in which the team surgery concept does not apply will be denied.

Claims for services provided by more than one surgeon should have each surgeon's provider identification number.

Claims and medical records for all providers in the operative session may be required.

CPT® Code / Modifier	Description
62	Two surgeons
66	Surgical team
80	Assistant surgeon
81	Minimum assistant surgeon
82	Assistant surgeon (when qualified resident surgeon not available)
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery

Related policy

Bundling Guidelines

Modifier Guidelines

References

Centers for Medicare and Medicaid Services, CMS Manual System

American Medical Association, Current Procedural Terminology (CPT®)

Medicare Provider Manual (Blue Book)
https://www.bluecrossnc.com/sites/default/files/document/attachment/providers/public/pdfs/Provider_Manual.pdf

History

BlueCross BlueShield of North Carolina

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Medicare Reimbursement Policy

6/1/2022	New policy developed. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022**. (eel)
12/31/2022	Routine Policy Review. Minor revisions only. (cjw)
9/29/2023	Clarified AS modifier instruction. No change to policy intent. (tlc)

Application

These reimbursement requirements apply to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services.

This policy relates only to the services or supplies described herein. Please refer to the Member's Evidence of Coverage (EOC) for availability of benefits. Member's benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing, and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.