THE UNIVERSITY OF CHICAGO UChicago Medicine | Office of Corporate Compliance

Modifier 62 & 82, etc: Co-Surgery & Assistant at Surgery Modifiers

February 2022

Procedures involving the use of a co-surgeon or assistant-at-surgery lead to greater overall reimbursement and are often the subject of documentation reviews from payors. The use of a co-surgeon or assistant at surgery is permitted only for certain procedures. Medical records must demonstrate why a co-surgeon or assistant was needed during the surgery, and the specific involvement of the co-surgeon or assistant.

Caution: *Teaching Hospitals are expected to use a qualified resident surgeon to assist at surgery. When a qualified resident is not available, specific documentation is required. Note that frequent attestation that a resident is not available may be subject to review by the payor.*

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Requirements for Use

1. Ensure the procedure is **Eligible** for co- or assistant at surgery, otherwise it should not be billed by any clinicians as such
2. Ensure the case scenario fits **Usage Criteria**
3. Ensure **Documentation Criteria** is met and is clearly supported prior to completion of operative report and billing (see **Examples**)

	Co-Surgery ***Two physicians in different specialties working together as primary surgeons***	**Assistant at Surgery** ***A physician or NPP actively assists the primary surgeon performing a surgical procedure***
Modifiers	**Modifier 62:** Co-surgery Use when two surgeons were required due to their individual skillset **and** the complex nature of the procedure and/or patient condition, such as when: • Two surgeons of different specialties were required to **perform a specific task** associated with the same procedure ***or*** • Two Surgeons (may be same specialty) **perform parts of the procedure simultaneously** (i.e. heart transplant or bilateral knee replacements) *Do not use when surgeons of different specialties are performing a different procedure with different CPT codes (no modifier needed)* **Claim Instructions:** • **Who submits a claim?** Each provider submits a separate claim • **Who adds Modifier 62?** Each provider submits a claim with modifier 62 for the same procedure (CPT).	**Modifier 82:** No qualified resident surgeon available (teaching) **Modifier AS:** NPP assistant at surgery (PA, NP, CNS) **Modifier 80:** Assistant surgeon Use an **Assistant at Surgery modifier (82, 80, AS)** according to the below definitions, note that an assistant may be of the same specialty: • **Modifier 82** - a physician assists the primary surgeon when there is no qualified resident surgeon available (teaching hospital) • **Modifier 80** - A Physician actively assists the primary surgeon. See Modifier 82 for teaching setting • **AS** - Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist assists the primary surgeon (do not use when NPP is contributing only ancillary services/extra hand) *NPP must be authorized to provide such services under State law **Claim Instructions** • **Who submits a claim?** Both primary surgeon and assistant submit a claim with the same procedure (CPT). • **Who uses Modifier 82/AS/80?** Primary surgeon does NOT add a modifier. Only the assistant surgeon claim should contain a modifier 82, 80, or AS.
Documentation Criteria	**Who documents?** **Both surgeons** document a separate operative note for their portion of the procedure. **Modifier 62:** Co-surgeon **What to document?** Both surgeons: 1. Document your **co-surgeon's name** and **the reason the co-surgeon was needed** (medical necessity) 2. In the body of the operative report, **reference the work performed by the co-surgeon** along with the detail of your own work.	**Who documents?** Only the **primary surgeon** documents the operative report: **Modifier 82** no qualified resident available (teaching hospitals) **Modifier AS** NPP assistant (teaching and non-teaching hospitals) **Modifier 80** assistant surgeon (non-teaching hospital) **What to document?** Primary surgeon: 1. Documents the **assistant's name** and **the reason the assistant was needed** (medical necessity) • **For Modifier 82** document that **"no qualified resident was available"**. Best practice is to also document the reason the resident was unavailable, such as: • Resident involved in other activities; Complexity of surgery; Not enough residents in the program; Emergency, etc. • For surgeons with an across-the-board policy of Resident non-involvement see "Exception C" on page 3 for instructions 2. In the body of the operative report, **reference the work performed by the assistant** along with the detail of your work.

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Examples of Documentation (Best Practice)	**Each surgeon documents a separate operative note and refers to the other surgeon:** ***Remember to detail the work of the other co-surgeon in the body of the report.*** **Vascular & Plastic:** Surgeon 1: The plastic surgeon Dr. Green is required to reshape bone flaps and replace various bone plates in a cosmetically pleasing fashion that allows for optimal decompression of the brain. Surgeon 2: The complexity and high risk of a major blood vessel complication from this procedure requires that a Vascular surgeon, Dr. White be in attendance. **Transplant:** Surgeon 1: The presence of co-surgeon was required secondary to the complexity of living donor liver transplant with extensive surgical history and microsurgical components including 2 donor bile ducts. Dr. Surgeon 2 performed role of cosurgeon for the liver transplant by performing half of the vascular anastomoses and I performed half as well as the microsurgical arterial and biliary anastomoses. I was present and scrubbed for all portions of the procedure. Surgeon 2: Co-surgeon was required secondary to the complexity of living donor liver transplant with extensive surgical history and microsurgical components including 2 donor bile ducts. I served as the co-surgeon for this case due to its technical complexity and performed 1/2 of the vascular anastomoses. **Hepatic & Endocrine:** Surgeon 1: Dr. Purple was consulted intraoperatively and became co-surgeon due to the complexity of the operation and the need for both an experienced endocrine surgeon and an experienced hepatic surgeon to allow for safe mobilization of the right lobe of the liver and resection of the right adrenal pheochromocytoma. Surgeon 2: A co-surgeon was required for this operation because of the extensive adhesions of the pheochromocytoma to the retroperitoneum and to the vena cava. Because of these adhesions, an experienced hepatic surgeon, Dr. Orange, M.D., was necessary to allow for safe mobilization of the right lobe of the liver and resection of the right adrenal pheochromocytoma. In addition, Dr. Orange was required because of his knowledge of pheochromocytoma, the intraoperative management and the extensive experience in surgical management and resection of pheochromocytoma.	**Only Primary Surgeon documents/dictates the operative report:** ***Remember to detail the work of the assistant surgeon in the body of the report (they do not document their own report).*** **No qualified resident, Modifier 82 (no qualified resident):** No qualified resident was available that was skilled enough to assist with the complexity of this Narnia procedure. The skilled assistance of Dr. Brown was necessary for the successful completion of this case. She was essential for the proper positioning, manipulation of instruments, proper exposure, manipulation of tissue, and wound closure. **No qualified resident, Modifier 82 (no qualified resident):** General Surgeon assisted with a complex portal vein resection/ reconstruction, CHA repair with autologous vein patch arteriorrhaphy. There was no suitable/qualified resident available for this portion of the case. **No qualified resident, Modifier 82 (no qualified resident):** Dr. Transplant Surgeon assisted me (Surgical Oncologist) with the hepaticojejunostomy since the hepatic duct only measured about 3 mm in greatest diameter and therefore required the expertise of an individual who is a transplant surgeon and with significant experience with hepaticojejunostomy, therefore was no qualified resident. **No qualified resident, Modifier 82 (no qualified resident):** This case was of highest complexity given the emergent nature of the case, the mechanism of injury, the injuries identified, and the procedure performed. No qualified resident was available, so Trauma Surgeon #2 was needed to scrub on this case. **Assistant Surgeon (physician), Modifier 80:** Cardiac Surgeon #2 was necessary for completing this complex operation safely by helping to provide exposure, maintain hemostasis and assisting in repair of valves, and performing the difficult coronary grafts. **APN Assist at Surgery, Modifier AS:** APN brown then assisted with the stapled end-to-end anastomosis and flexible sigmoidoscopy.
Payment Information (Medicare payment, private payors may vary, but often closely follow)	• Each co-surgeon is paid 62.5% of the global surgery fee schedule amount, both co-surgeons must be of different specialties (typically) Payment is based on eligibility for co-assist and outcome of any requested documentation review.	• Primary surgeon is paid 100% of the fee schedule • Assistant surgeon paid 16% of the fee schedule amount • PA, NP, and CNS assistants are paid 13.6% of the amount paid to physicians Payment is based on eligibility for assistant at surgery, national rate of assistant use (see Limitations), and outcome of any requested documentation review.
Limitations/ Special Rules	• When surgeons of different specialties are each performing a different procedure (with specific CPT codes), neither co-surgery nor multiple surgery rules apply (even if the procedures are performed through the same incision). • Do not use when surgeons of different specialties are performing a different procedure that is appropriate to report separately with a different CPT code (no modifier needed in these scenarios)	• A/B MACs (B) investigate situations in which it is ***always*** certified that there are no qualified residents available, and undertake recovery if warranted. • A/B MACs may not pay assistants-at-surgery for surgical procedures in which a physician is used as an assistant at surgery in fewer than five percent of the cases for that procedure nationally. This is determined through manual reviews. • Medicare's policies on billing patients in excess of the Medicare-allowed amount apply to assistant at surgery services.

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Eligibility (Payment Indicators from Physician Fee Schedule)	ASST SURG column: • "2" Indicator = Co-surgeons permitted. No documentation is required (to be submitted) if the two specialty requirements are met. (Both surgeons add CPT modifier 62 to the surgical procedure) • "1" Indicator = Co-surgeons could be paid. Supporting documentation is required to establish medical necessity of two surgeons for this procedure. • "0" indicator = Co-surgeons not permitted for this procedure.	ASST SURG column: • "2" Indicator = Assistants at surgery may be paid. • "1" Indicator = Assistants at surgery may not be paid. Statutory restriction. • "0" Indicator = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

Exceptions for Assistant-at-Surgery (Modifier 82) in Teaching Hospitals

Medicare does not pay for assistants at surgery when there are qualified resident surgeons in a GME-approved surgical residency program related to the medical specialty required for the surgical procedure.

One of the below criteria must be met to use Modifier 82 for a surgical case:

A. **No Qualified residents available:** Per CMS "...there are other teaching hospitals in which there are often no qualified residents available. This may be due to their involvement in other activities, complexity of the surgery, numbers of residents in the program, or other valid reasons.

B. **Exceptional Circumstances** - emergency, life threatening situations which require immediate treatment such as multiple traumatic injuries. CMS recognizes that other exceptional circumstances may exist that require a physician to assist at surgery, even though a qualified resident is available.

C. **Physicians Who Do Not Involve Residents in Care (across-the-board policy)**- Attending surgeon ***who has no involvement in the hospitals GME program*** and has an "across the board" policy of never involving residents in the pre-operative, operative, or postoperative care of their patients. **NOTE:** The attending must file a statement at each teaching hospital they elect to follow this policy, it must be submitted annually and available to submit to Medicare in the event of claims audits.

References:

-MLN Matters SE1322
-NGS Job Aid: Co-Surgery/Team Surgery/Assistant Surgery Modifiers
-Medicare Claims Processing Manual Chapter 12 Section 20.4.3, 40.8, 110.2, 120.1
-Medicare Claims Processing Manual Chapter 12 Section 100.1.7 Assistant at Surgery in Teaching Hospitals
-NGS: Assistants at Surgery Teaching Hospitals