AmeriHealth Caritas Next
A product of AmeriHealth Caritas Louisiana, Inc.

Co-Surgeon

Reimbursement Policy ID: RPC.0005.LAEX

Recent review date: 03/2026

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AmeriHealth Caritas Next reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas Next may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This Co-Surgeon policy identifies the guidelines for reimbursement of Co-Surgeon services, as identified by the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS).

Exceptions

Reimbursement for Co-Surgery services furnished by a non-physician practitioner (NPP) is not reimbursable. The CMS claims processing manual guidelines for Co-Surgery refers to surgical procedures involving two different surgeons, usually of different specialties.

Reimbursement Guidelines

Modifier 62 identifies a Co-Surgeon involved in the care of a patient performing distinct parts of a procedure. To qualify for reimbursement, each Co-Surgeon must submit the same Current Procedural Terminology (CPT) code with modifier 62, for the same date of service. For services included on the CMS NPFS Co-Surgeon eligible list, AmeriHealth Caritas Next will reimburse Co-Surgeon services at 62.5% of the Allowable Amount to each surgeon, subject to additional multiple procedure reductions if applicable. The Allowable Amount is determined based on the rate adopted by the Centers for Medicare and Medicaid Services (CMS), which allows 62.5% of allowable to each Co-Surgeon.

All codes in the CMS NPFS with status code indicators "1" or "2" for "Co-Surgeons" are considered by AmeriHealth Caritas Next to be eligible for Co-Surgeon reimbursement if billed with the Co-Surgeon modifier 62. For each Co-Surgeon to be reimbursed for the procedure, each Co-Surgeon must report the same CPT code(s) with the 62 modifiers on procedures that required the skill of two surgeons.

Multiple procedure reductions apply to Co-Surgeon claim submissions when one or more physicians are billing multiple CPT codes that are eligible for reductions.

Critical Access Hospitals may bill a Method II CAH claim for co-surgeons with modifier 62. Method II billing is an optional Medicare payment method for Critical Access Hospitals (CAHs) that allows them to bill for both outpatient facility and professional services on the same UB-04 form by reassigning practitioners' billing rights to the hospital. Co-surgeon services rendered by a physician that has reassigned their billing rights to a Method II CAH are payable by Medicaid/Medicare when the procedure is authorized for co-surgeons and is billed on type of bill 85X with revenue code (RC) 96X, 97X or 98X and the 62 modifier.

Definitions

Modifier 62
Two surgeons of the same or different specialties who work together as primary surgeons performing distinct part(s) of a surgical procedure.

Multiple procedure reduction
Multiple Procedures performed by the same physician or other qualified health care professional on the same date of service during the same patient encounter may be subject to multiple procedure reduction for secondary and subsequent procedures.

Nonphysician practitioner (NPP)
A nonphysician practitioner is a healthcare provider who is not a physician but who practices in collaboration with or under the supervision of a physician. Nonphysician practitioners may also be known as mid-level practitioners or physician extenders [e.g., Physician Assistants (PA), Nurse Practitioners (NP), and Clinical Nurse Specialists (CNS)].

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. Centers for Medicare and Medicaid Services (CMS).

III. CMS Fee Schedule(s)

Attachments

N/A

Associated Policies

N/A

Policy History

03/2026	Reimbursement Policy Committee Approval
12/2025	CAH reimbursement information added
09/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas Next from Policy History section
01/2023	Template revised • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added