

Origination: October 2025
Last Review: October 09, 2025
Next Review: October 09, 2027
Effective Date: January 01, 2026

Description

Provide a payment policy statement and guidelines that address the claims processing and payment for eligible services submitted with a -62 [Two Surgeons] modifier.

Policy & Guidelines

According to the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS), a modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. It may also provide more information about a service such as it was performed more than once, unusual events occurred, or it was performed by more than one provider and/or in more than one location.

Policy Statement

Effective with dates of service on or after January 1, 2026, Blue Cross and Blue Shield of Vermont (Blue Cross VT) may process payment for eligible services with procedure codes submitted with a modifier -62 utilizing the CMS methodology and guidelines.

For the purposes of claims processing and reimbursement of eligible surgical procedures within the context of this policy, Blue Cross VT utilizes the CMS National Physician Fee Schedule (NPFS) Relative Value File status indicators as defined below.

The following assigned numeric values cross reference to a status indicator for which two surgeons, of different specialties sharing equal work for one surgical procedure, may be paid.

Retrieved from: <https://www.cms.gov/status-indicators>

CMS NPFS Table -62 Column Status Indicator	Definition
"0"	Co-surgeons are NOT permitted for this procedure.
"1"	Co-surgeons allowed WITH supporting documentation required to establish the medical necessity of two surgeons for the procedure.
"2"	Co-surgeons permitted, and NO documentation required if the two-specialty requirement is met.
"9"	Concept does not apply.

Eligible

Blue Cross VT considers it appropriate to use modifier -62, when thoroughly documented and in accordance with the following guidelines:

- Procedures contained in the NPFS list of procedures as co-surgeons allowed (i.e., status indicator "2"). Blue Cross VT will reimburse both surgeons provided that the surgeons are of different specialties.
- The NPFS includes a list of procedures where co-surgeons payment restrictions may apply (i.e., status indicator "1"). These services may be reimbursed, upon review of supporting documentation that establishes medical necessity of two surgeons for the procedure.
- When guidelines within this policy are met, Blue Cross VT will reimburse modifier -62 as noted in [Addendum A](#). For additional information refer to the Provider Handbook located: <https://www.bluecrossvt.org/documents/provider-handbook>

Not Eligible

Examples of situations where a co-surgeon would not be eligible for payment include:

Professional Claims:

- Procedures included in the NPFS list as co-surgeons not permitted (Status indicator "0").
- Procedures designated on the NPFS list as co-surgeons are allowed (Status indicator "2"), but the two-specialty requirement is not satisfied.
- Procedures designated by the NPFS list as co-surgeons concept does not apply (i.e., status indicator "9").
- Status indicator "1" procedures after review of supporting documentation establishes

that two surgeons were not medically necessary.

Incongruently split billed procedures designated as co-surgeons allowed will be denied as follows:

- Previously processed claims without modifier -62
 - In the event that a provider bills a procedure with modifier -62 and a claim has already been processed for a different provider without modifier -62 appended to the procedure code, the second claim will be denied.
- Previously processed claims with modifier -62
 - When a claim is received without modifier -62 and there exists a previously processed claim for the same procedure code by a different provider with modifier -62, the procedure billed without the modifier -62 will be denied.

Facility Claims:

Method II Critical Access Hospitals (CAH)

According to CMS, co-surgeon services rendered by a physician or non-physician practitioner that has reassigned their billing rights to a Method II CAH are payable by CMS when the procedure is billed on type of bill 0850-085X with revenue code 0960-0989 and modifier -62.

- Procedures billed with modifier -62 when designated as co-surgeons not allowed (status indicator “0”) and the bill type is 0850-085X (CAH) and the revenue code is 0960-0989 (Professional fees).
- Procedures billed with modifier -62 when designated as co-surgeons payment restriction may apply (status indicator “1”) and the bill type is 0850-085X (CAH) and the revenue code is 0960-0989 (Professional fees).
- Procedures billed with modifier -62 when designated as co-surgeons concept does not apply (status indicator “9”) when the bill type is 0850-085X (CAH) and the revenue code is 0960-0989 (Professional fees).
- Cases and/or claim lines where one of the surgeons is not billing with the appropriate modifier for co-surgery:
 - Procedures designated as co-surgeons allowed when billed without modifier -62 and the same procedure has been billed with modifier -62 on the same claim and the bill type is 0850-085X (CAH) and the revenue code is 0960-0989 (Professional fees).
 - Procedures designated as co-surgeons allowed when billed with modifier -62 and the same procedure has been billed without modifier -62 on the same claim and the bill type is 0850-085X (CAH) and the revenue code is 0960-0989 (Professional fees).
 - Previously processed claims without modifier -62--In the event that a provider bills a procedure with modifier -62 and a claim has already been processed for a different provider without modifier -62 appended to the procedure code, the

second claim will be denied.

- Previously processed claims with modifier -62 -- When a claim is received without modifier -62 and there exists a previously processed claim for the same procedure code by a different provider with modifier -62, the procedure billed without modifier -62 will be denied.

Reimbursable Services

Blue Cross VT will pay 62.5% of the allowed amount for services appropriately appended with modifier -62 refer to [Addendum A](#).

Provider Billing Guidelines and Documentation

Claims submitted with the -62 modifier related to procedures that have status indicator “1” within the NPFS require supporting documentation to establish the medical necessity of having two surgeons.

Required documentation elements:

- **Separate Operative Reports:** Each co-surgeon must provide a detailed summary via operative report of the surgical procedure(s) involving two surgeons performing the parts of the procedure simultaneously, and clearly defining the work performed for their individual portion of the surgery.
- **Co-surgeon Identification:** The operative report should clearly state the name of the co-surgeon involved.
- **Medical Necessity Statement:** A concise statement of medical necessity must be included to support the need of two surgeons.
- **Distinct Surgical Contributions:** Each operative report must provide a full account of the specific portion of the co-surgery procedure(s) performed by that surgeon.
- **Provider Signature:** The documentation must include the signature of at least one surgeon.

If the documentation provided does not clearly demonstrate the distinct part of the surgery each surgeon performed, additional information will not be requested. In this circumstance reimbursement for the procedure submitted with the -62 modifier will not be eligible for payment.

When reporting codes with more than one modifier, it is vital to sequence the modifiers: First, enter the functional modifier (pricing and or payment modifier) next, enter the informational modifier (or statistical modifier), which clarifies aspects of the procedure or service rendered. If multiple informational modifiers are reported those can be reported in any order, after the primary functional modifier has been entered.

Per the provider handbook the modifier sequencing have certain requirements or have specific payment rules:

1. Modifiers that are not listed as informational must be billed in the first position of the modifier field to process correctly.
2. If a modifier has an impact on pricing, the service line it is reported on must be billed at the full charge,* without any reductions. Our claims processing system uses the billed charge as part of the calculation for payment. If a reduction has already been made, it will further reduce the allowance for the service.

*We define “full charge” as the amount that would be billed if you were performing the complete service.

Benefit Determination Guidance

Payment for services is determined by the member’s benefits. It is important to verify the member’s benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member’s benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member’s benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member’s benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association’s Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (Blue Cross VT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member’s Blue Plan must honor. A member’s Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member’s Blue Plan cannot apply its local billing practices on claims rendered in another Plan’s service area. A member’s Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member’s benefits prior to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based

on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in-network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Related Policies

CPP_32 Claims Editing Payment Policy

Process to Submit Questions Related to Coding Denials (s)

Provider Handbook/Modifiers

Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

- 1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
- 2) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
- 3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy takes

precedence.

- 4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

References

American Medical Association. (2025). *CPT®: Current Procedural Terminology (Professional)*.

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.

Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files. Retrieved from: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment>[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment Value-Files](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment-Value-Files).

CMS.GOV. Status Indicators. Retrieved from: <https://www.cms.gov/status-indicators>

Policy Implementation/Update Information

This policy was originally implemented on 01/01/2026.

Date of Change	Effective Date	Overview of Change
10/09/2025	01/01/2026	New policy.

Approved by

Update Approved: 10/09/2025

Tom Weigel, MD

Tom Weigel, MD, Chief Medical Officer

Addendum A

Payment Table	
-62 Modifier	[Two Surgeons]
▪ When documentation is submitted for procedures in the NPFS that have status indicator “1” and the clinical review has confirmed the appropriate use of -62 modifier, the procedure will be reimbursed at 62.5% of the allowed amount. When documentation is NOT submitted, NO clinical review will be conducted. The claims will not be eligible payment. ▪ With a status indicator “2” and the co-surgeons are permitted, and NO additional documentation is required if the two-specialty requirement is met the procedure will be reimbursed at 62.5% of the allowed amount. ▪ With a status indicator “0” no payment will be made for co-surgeons. ▪ With a status indicator of “9” no payment will be made for co-surgeons.	

Table 1: -62 Modifier Decision Tree

