Co-Surgeon and Team Surgeon Payment Policy

Applicability

This Policy applies to the following Fallon Health products:
☒ Fallon Medicare Plus
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ Summit ElderCare (PACE)
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

Policy

The purpose of this policy is to describe reimbursement for surgical procedures performed by co-surgeons and team surgeons.

Definitions

Co-surgeon: Co-surgeons are defined as two surgeons, where the skills of both surgeons are necessary to perform distinct parts of a specific operative procedure. Surgeons are typically from different specialties, collaborate and each perform distinct parts of same procedure. Each surgeon is considered a primary surgeon for their portion of work. Individual skills of two surgeons may be required to perform surgery on same patient during same operative session because of complex nature of procedure(s) and/or patient's condition and the additional physician is not acting as an assistant at surgery.

Surgical Team: When more than two surgeons, of the same or different specialties, work together to perform highly complex surgical procedures (e.g., transplant, major trauma), where each surgeon has a distinct operative role. The surgical team concept only applies to surgical procedures designated on the Medicare Physician Fee Schedule as eligible for team surgery billing.

Reimbursement

The Plan reimburses qualifying claims for co-surgeons (modifier 62) at 62.5% of the allowed amount for Fallon Medicare Plus, NaviCare, Summit ElderCare, Fallon Health Weinberg PACE and Community Care, and at 57.5% of the allowed amount for MassHealth ACO.

The Plan reimburses qualifying claims for team surgeons (modifier 66) at 62.5% of the allowed amount for Fallon Medicare Plus, NaviCare, Summit ElderCare, Fallon Health Weinberg PACE and Community Care, and at 57.5% of the allowed amount for MassHealth ACO.

The Plan follows the Medicare Physician Fee Schedule (MPFS) payment policy indicators to determine if co-surgeons and team surgeons are allowed.

Medicare Physician Fee Schedule (MPFS) Co-Surgeon (CO SURG) Indicators
The Medicare Physician Fee Schedule (MPFS) Co-Surgeon (CO SURG) indicators are used to determine if co-surgeon services are allowed for a procedure code:
0 = Co-surgeons not permitted for this procedure.
1 = Co-surgeons could be paid, though supporting documentation is 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.

Medicare Physician Fee Schedule (MPFS) Team Surgeon (Team SURG) Indicators
The Medicare Physician Fee Schedule (MPFS) Team Surgeon (Team SURG) indicators are used to determine if team surgeon services are allowed for a procedure code:
0 = Team surgeons not permitted for this procedure.
1 = Team surgeons could be paid, though supporting documentation is required to establish the medical necessity of two surgeons for the procedure.
2 = Team surgeons permitted.
9 = Concept does not apply.

Use the following link to go to the Medicare Physician Fee Schedule Look-up Tool: https://www.cms.gov/medicare/physician-fee-schedule/search. In the "Type of Information" box, select Payment Policy Indicators; then enter the procedure code in the "HCPCS Code" box and click "Search Fees." Under Search Results, look for CO SURG or Team SURG to find the indicator.

If the CO SURG/Team SURG Indicator is 1, surgeons must submit documentation to establish medical necessity for co-surgeon or team surgeon.

The Plan will reimburse a procedure either as co-surgery, team surgery or as assistant surgeon.

Referral/notification/prior authorization requirements

Many surgical procedures require prior authorization. Please refer to the Procedure Code Look-up Tool on the Plan website for prior authorization requirements. The Procedure Code Look-up Tool is available at: http://www.fchp.org/providertools/ProcedureCodeLookup/.

Services provided by non-contracted providers require prior authorization, even when the service itself doesn't require prior authorization. This requirement applies to co-surgeons and team surgeons.

Each PACE plan member s assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as approved by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be approved by the interdisciplinary team.

Billing/coding guidelines

Modifiers are required when billing for a surgical procedure(s) that requires use of two surgeons or a team of surgeons.

Always review the Medicare Physician Fee Schedule payment policy indicators prior to submitting claims for co-surgeons and team surgeons.

Modifier 62 (Co-Surgeons)

- Two surgeons (each in a different specialty) work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report their distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacement.
- Each surgeon should report the co-surgery once using the same procedure code.
- If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62.
- If one of the surgeons performs multiple procedures, the multiple procedure payment reduction rules apply to that surgeon's services.

Modifier 66 (Team Surgery)

- A team of 3 or more surgeons is required to perform a specific procedure, each surgeon bills for the procedure with a modifier 66.
- Each surgeon should report the team surgery once using the same procedure code.
- Modifier 66 should not be used for two or less surgeons.
- If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 66.
- If one of the surgeons performs multiple procedures, the multiple procedure payment reduction rules apply to that surgeon's services.

If surgeons of different specialties are each performing a different procedure (with different CPT codes), neither co-surgery nor multiple surgeon rules apply (even if the procedures are performed through the same incision).

Only physicians (MD/DO) may submit claims for co-surgeon (modifier 62) or team surgeon (modifier 66).

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	03/01/2026
Connection date & details:	January 2026 – Policy origination

The criteria listed above apply to Fallon Health Plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.