New Jersey | Medicaid

Reimbursement Policy
Modifier 62

Policy Number: **G-06027**
Policy Section: **Coding**
Last Approval Date: **03/26/2026**
Effective Date: **03/26/2026**

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Policy

The health plan allows reimbursement of procedures eligible for co-surgeons when billed with modifier 62 unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Reimbursement to each surgeon is based on 62.5% of the applicable fee schedule or contracted/negotiated rate. Co-surgeons must be from different specialties and perform surgical services during the same operative session.

Each surgeon must bill the same procedure code(s) with modifier 62. If one or both surgeons fail to use the modifier appropriately, it is possible that one surgeon may receive 100% of the applicable fee schedule or negotiated/contracted rate, and the other surgeon's claim may be denied or pended due to a duplicate or suspected duplicate service, respectively.

Assistant surgeon and/or multiple procedures rules and fee reductions apply if:

- A co-surgeon acts as an assistant in performing *additional procedure(s)* during the same surgical session.
  Note**:** Assistant surgeon rules do not apply to procedures appropriately billed with modifier 62.
- Multiple procedures are performed.

Related Coding

Standard correct coding applies.

Definitions

- **Modifier 62:** When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her 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. 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 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.
- **General Reimbursement Policy Definitions**

Related Policies and Materials

- Duplicate or Subsequent Services on the Same Date of Service
- Modifier Usage
- Modifiers 50 and 51: Multiple and Bilateral Surgery
- Modifier 66
- Modifiers 80, 81, 82, and AS: Assistant at Surgery

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2026
- State contract
- State Medicaid

Policy History

- **03/26/2026 -** Review approved and effective: no changes
- **03/26/2023 -** Review approved and effective: policy template updated
- **08/07/2020 -** Review approved: updated Definitions and Reference Sections; removed language that prepayment review is required
- **10/03/2018 -** Review approved and effective: Assistant surgeon language expanded
- **10/03/2016 -** Review approved 10/03/2016 and effective 12/15/2017: Same specialty language removed

- **10/13/2014** - Review approved and effective: Background section and policy template updated
- **05/20/2013** - Review approved: Disclaimer updated 04/23/2013
- **04/09/2012** - Review approved and effective: Background section and policy template updated
- **05/17/2010** - Review approved and effective: Background section and definitions updated; policy template updated
- **11/10/2008** - Review approved and effective: Background section/policy template updated
- **06/06/2006** - Initial approval 06/06/2006 and effective 10/01/2006

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies

when necessary. When there is an update, we will publish the most current policy to the website.

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