ENROUTE™
Transcarotid Neuroprotection System

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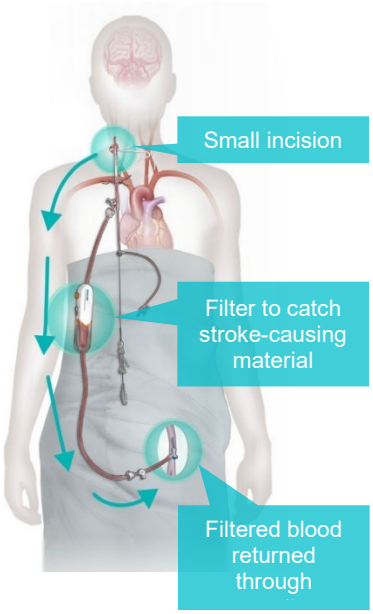
ENROUTE™ TCAR Coding Alert FAQ



Effective for dates of service on or after January 1, 2026, CPT code 37215 can be reported with **modifier 62 (co-surgeon)** when documentation supports that two surgeons were required to perform surgery on the same patient during the same operative session.[1,3]

Do both surgeons need to append the modifier 62 on their claim?

Modifier 62 must be on both claims, or one physician will be paid at 100% and the other physician's claim will deny. Both surgeons must also use the same CPT Code and Diagnosis Code.[5]

Do both surgeons need to provide clinical documentation?

Yes. When appending modifier 62 and the Medicare Physician Fee Schedule indicator is "1," documentation must be submitted to support the medical necessity of having two surgeons perform the procedure.[2,4-5]

- The medical record must justify why two surgeons were needed.
- Co-surgeon's name, NPI number and the reason for the need of the co-surgeon including the procedure or service performed.
- Each surgeon should document his own operative notes.
- Identify the other as a co-surgeon and reference the work performed by the co-surgeon along with the details of your own work.
- Have the same Procedure code with Modifier 62 appended and Diagnosis code.
- Co-surgeon submit his own claim with his own documentation.

Can claims be resubmitted since the code is retroactive to January 1, 2026, for dates of service on or after that date?[2]

Yes. Claims may be corrected and resubmitted if the required documentation supporting the use of modifier 62 (Co-Surgeon) is available and both surgeons bill the same CPT procedure code with modifier 62 appended and the same diagnosis code.

If the original claims were billed using an assistant-at-surgery modifier, both the primary surgeon's claim and the assistant surgeon's claim must be corrected. Each surgeon must resubmit the claim using modifier 62. When resubmitting the corrected claims, the supporting clinical documentation must also be resubmitted to demonstrate the medical necessity for two surgeons performing the procedure.

Both claims will need to be reprocessed to reflect co-surgeon billing. The payer will typically recoup the original payment and reprocess the claims so that each co-surgeon is reimbursed at 62.5% of the allowable fee schedule amount.

Example:

Original Payment (Assistant Surgeon)

- Primary surgeon: 100% allowable
- Assistant: ~16% allowable

Correct Payment (Co-Surgeons)

- Surgeon 1: 62.5%
- Surgeon 2: 62.5%

How can a denied 62 modifier claim due to missing documentation be corrected?

Submitting the additional documentation and making sure the documentation includes the requirements listed in question two.[4]

Can two physicians of the same specialty bill the Co-surgeon modifier 62?

Yes, two surgeons of the same or different specialties performing parts of the same procedure at the same time.[2]

Do both surgeons have to bill the same amount?

No, each surgeon can bill different amounts (billed charges) but need to bill the same CPT code 37215 with appended modifier 62 Co-surgeon.[5]

Do both surgeon split the payment 50/50?

No, both surgeons each get 62.5% of the allowable fee schedule.
Reimbursement is calculated at 62.5% of the allowable amount for CPT code 37215 for each surgeon. Additional documentation is required to support the use of modifier 62. For example, if the allowable amount for CPT 37215 is $1,000; each surgeon would be reimbursed $625 (62.5% of $1,000).[5]

Do the RVU's change for the CPT code when appending the Co-surgeon Modifier 62?

No, Modifier 62 does not change the RVU's assigned to the CPT code itself. The RVU values remain same, but payment is split at 62.5% of the fee schedule between the two surgeons.[2]

Do commercial payors recognize and reimburse for the Co-surgeon modifier 62?

Yes, most payers recognize and reimburse the co-surgeon modifier (62) when billed with CPT code 37215. However, you should confirm each payer's specific coverage policy and requirements for appending modifier 62 to this code before submitting your claim.

When will this code be implemented for Medicare?

CMS has published a Transmittal notifying the Medicare Administrator Contractors (MAC's) to have the code implemented into their systems by April 6th. Link to CMS Manual Transmittal 13673

Can the Assistant Surgery Modifier still be used with CPT Code 37215?

Yes, the Assistant at Surgery Modifier 80's can be appended to CPT code 37215 if there is documentation supporting medical necessity for the assistant. It must clearly document the assistant's role during the operative session. An Assistant may be of the same specialty.

Does Modifier 62 impact the RVU's assigned to the CPT code?

No, Modifier 62 does not change the RVU's assigned to the CPT code. **Payment** derived from those RVU's is split between the co-surgeons (typically 62.5% each).

Bottom Line:

- RVU's = unchanged
- Payment = (~62.5% each surgeon)
- wRVU credit = organization contracting

Reimbursement Support

For reimbursement assistance, please contact Boston Scientific PI HEMA team:

- Email: VT.Reimbursement@bsci.com
- Website: **Peripheral Vascular - Reimbursement - Boston Scientific**

References

1. https://www.cms.gov/files/document/r13673cp.pdf
2. https://www.wpsgha.com/guides-resources/view/112
3. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
4. https://www.aapc.com/blog/33013-4-simple-rules-for-co-surgeon-documentation/?msockid=3dfcfa547df063510c0fef1a7c7662e6
5. https://medicare.fcso.com/coding/modifier-62-fact-sheet

ENROUTE Transcarotid Stent System
USE/INDICATIONS FOR USE The ENROUTE® Transcarotid Stent System used in conjunction with the ENROUTE Transcarotid Neuroprotection System (NPS) is indicated for the treatment of patients at high risk and standard risk for adverse events from carotid endarterectomy, who require carotid revascularization and meet the criteria outlined below: High Risk | Standard Risk With neurological symptoms: ≥ 50% stenosis of the common or internal carotid artery by ultrasound or angiogram | ≥ 70% stenosis of the common or internal carotid artery by ultrasound or ≥ 50% stenosis of the common or internal carotid artery by angiogram Without neurological symptoms: ≥ 80% stenosis of the common or internal carotid artery by ultrasound or angiogram | ≥ 70% stenosis of the common or internal carotid artery by ultrasound or ≥ 60% stenosis of the common or internal carotid artery by angiogram Reference vessel diameter: Must be within 4.0 mm – 9.0 mm at the target lesion Carotid bifurcation location: Minimum 5 cm above the clavicle to allow for placement of the ENROUTE Transcarotid NPS

ENROUTE Transcarotid Neuroprotection System
INTENDED USE/INDICATIONS FOR USE The ENROUTE Transcarotid Neuroprotection System (ENROUTE Transcarotid NPS) is intended to provide transcarotid vascular access, introduction of diagnostic agents and therapeutic devices, and embolic protection during carotid artery angioplasty and stenting procedures for patients diagnosed with carotid artery stenosis and who have appropriate anatomy described below: • Adequate femoral venous access • Common carotid artery reference diameter of at least 6 mm • Carotid bifurcation is a minimum of 5 cm above the clavicle as measured by duplex Doppler ultrasound (DUS) or computerized axial tomography (CT) angiography or magnetic resonance (MR) angiography.

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