	Reimbursement Policy

Subject: Modifier 66: Surgical Teams

Effective Date: **08/07/20**	Committee Approval Obtained: **08/07/20**	Section: **Coding**

*****The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.healthybluela.com.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Healthy Blue if the service is covered by a member's Healthy Louisiana benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

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

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Healthy Blue reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Healthy Blue strives to minimize these variations.

Healthy Blue reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Healthy Blue allows reimbursement of procedures eligible for surgical teams when billed with Modifier 66 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Modifier 66 reimburses at the lower of billed charges or 80% of the fee on file or contracted/negotiated rate. Each physician participating in the surgical team must bill the applicable procedure code(s) for their individual services with Modifier 66. If any or all physicians participating in the surgery fail to use the

	modifier appropriately, claims may be denied or pended for duplicate or suspected duplicate services, respectively. Multiple procedure rules and fee reductions apply if the surgical team performs multiple procedures unless surgeons of different specialties are each performing a different procedure. Assistant surgery rules and fee reductions apply if any member of the surgical team acts as an assistant performing additional procedure(s) during the same surgical session. **Note:** Assistant surgeon rules do not apply to procedures appropriately billed with Modifier 66. Healthy Blue performs a prepayment review to support the use of Modifier 66. Providers must submit documentation with claims billed with the modifier. Claims submitted without documentation will be denied.
History	• Biennial review approved and effective **08/07/20**: Updated definitions, background, related policy, and reference sections. • Biennial review approved and effective **10/03/18**: Assistant surgeon language expanded • Effective **09/01/17**: Policy template updated • Biennial review approved **10/03/16**: Policy template updated • Biennial review approved **10/13/14**: Reimbursement percentage language added • Review approved **07/01/13**: Disclaimer updated • Biennial review approved and effective **05/21/12**: Policy template updated • Biennial review approved **05/17/10**: Language added regarding documentation requirements; policy template updated • Review approved **11/10/08**: Policy template updated • Initial policy approval effective **07/10/06**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contracts • AMA CPT Professional Edition 2020
Definitions	• **Modifier 66:** under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the *surgical team* concept; such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure number used for reporting services

	• **General Reimbursement Policy Definitions**
Related Policies	• Assistant at Surgery (Modifiers 80/81/82/AS) • Claims Requiring Additional Documentation • Duplicate or Subsequent Services on the Same Date of Service • Modifier 62: Co-Surgeons • Modifier Usage • Multiple and Bilateral Surgery: Professional and Facility Reimbursement • Scope of Practice
Related Materials	• None