Massachusetts | Commercial

Commercial Reimbursement Policy

Subject: **Modifier 66 – Professional**	
Policy Number: **C-21006**	Policy Section: **Coding**
Last Approval Date: **11/17/2023**	Effective Date: **11/17/2023**

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 Wellpoint member's 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 Current Procedure 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, Wellpoint may:

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

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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.

Policy

Wellpoint allows reimbursement of procedures eligible for surgical teams when billed with modifier 66 unless provider, state, or federal contracts and/or requirements indicate otherwise. Eligible procedures are identified using the Centers for Medicare and Medicaid Services (CMS) Medicare Physician Fee

Schedule (MPFS) Team Surgery payment indicators and applied using the guidelines as indicated below.

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.

Reimbursable:

- Codes identified with MPFS Team Surgery payment indicator '1' and '2'.

Non-reimbursable:

- Codes identified with MPFS Team Surgery payment indicators '0' and '9'.

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

- A member of the surgical team 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 66.

- Multiple procedures are performed by the surgical team

Note: Multiple procedures rules do not apply when surgeons of different specialties are each performing a different procedure.

Related Coding
Standard correct coding applies

Policy History

11/17/2023	Review approved and effective: removed *Team Surgeon Services* from policy title; added clarifying language to indicators
09/24/2021	Initial policy approved 09/24/2021 and effective 11/01/2022: Co-Surgeon/Team Surgeon Services policy (C-08001) was retired and split into two new policies: Modifier 62: Co-Surgeon Services (C-21005) effective 3/1/2022 and Modifier 66: Surgical Teams (C-21006) effective 11/1/2022.

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2023

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 and Materials

Modifiers 80, 81, 82, and AS: Assistant at Surgery - Professional
Modifier 62 - Professional
Modifier Rules - Professional
Modifiers 50 and 51: Multiple and Bilateral Surgery - Professional
Scope of License - Professional

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.