Reimbursement Policy	
Subject: **Modifier 66**	
Policy Number: **G-06039**	Policy Section: **Coding**
Last Approval Date: **03/15/2023**	Effective Date: **08/07/2020**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://providers.anthem.com/ny**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Anthem Medicare Advantage covered the service for the 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, Anthem Medicare Advantage 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem Medicare Advantage strives 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

Anthem Medicare Advantage 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.

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.

Anthem Medicare Advantage performs a prepayment review to support the use of Modifier 66. Providers must submit documentation with claims billed with Modifier 66. Claims submitted without documentation will be denied.

Related Coding
Standard correct coding applies

Policy History	
03/15/2023	Review approved: Policy template updated
08/07/2020	Review approved and effective: updated Definitions, Background, Related Policy, and Reference sections.
10/03/2018	Review approved and effective: Assistant surgeon language expanded
10/03/2016	Review approved: Policy template updated
01/01/2015	Initial approval and effective

References and Research Materials
This policy has been developed through consideration of the following: • CMS • State contract • Optum EncoderPro 2023

Definitions	
Modifier 66	Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified healthcare 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
Assistant at Surgery (Modifiers 80/81/82/AS)
Claims Requiring Additional Documentation
Duplicate or Subsequent Services on the Same Date of Service
Modifier Usage
Modifier 62
Multiple and Bilateral Surgery: Professional and Facility Reimbursement
Scope of Practice