	Reimbursement Policy	
Subject: Modifier 66: Surgical Teams		
Effective Date: **10/03/18**	Committee Approval Obtained: **10/03/18**	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://mediproviders.anthem.com/nv**.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem). 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, Anthem may:

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

Anthem 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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, Anthem strives to minimize these variations.

Anthem 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	Anthem 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.

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ANV-RP-0110-19 May 2019

<table>
<tr><td></td><td>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 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.</td></tr>
<tr><td>History</td><td>• Biennial review approved and effective 10/03/18: Assistant surgeon language expanded
• Effective 02/01/18: Policy template updated
• Biennial review approved 10/03/16: Policy template updated
• Biennial review approved 10/13/14: Policy template updated
• 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; Background and Related Policies/Procedures sections and definitions updated; Policy template updated
• Initial approval and effective date: 02/01/09</td></tr>
<tr><td>References and Research Materials</td><td>This policy has been developed through consideration of the following:
• CMS
• State Medicaid
• State contracts</td></tr>
<tr><td>Definitions</td><td>• Modifier 66: used in circumstances where highly complex procedures or the nature of the member’s condition require the services of a surgical team; a surgical team consists of:
    o More than two physicians from different specialties performing different procedures (identified by different procedure codes)
    o Other highly skilled, specially trained personnel
    o Various types of complex equipment

The surgical team concept is performed during the same operative session. Surgical teams may be appropriate for procedures, including but not limited to, organ transplants, surgeries on multiple organ systems, amputation, coronary artery bypass, surgery of the skull base to remove tumors or certain vertebral body resections.</td></tr>
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	• **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 Usage • Modifier 62: Co-Surgeons • Multiple and Bilateral Surgery: Professional and Facility Reimbursement
Related Materials	• None