Modifier Coding Alert

Modifier Madness: Look to 66 In 'Team' Situations

Remember, every surgical team member has to use modifier 66.

There are several modifiers in the CPT® book that leave coders wondering when, if ever, a coder would have cause to use them. The modifiers are on the books, however, and it's always good practice to know how to use even the most obscure-seeming modifier.

One of those lesser known modifiers is 66 (Team surgery). Impress your colleagues, and get ahead of the coding curve by taking a look at how to use modifier 66, which you might need if an unusual situation arises at your practice.

Modifier 66 Describes Team Surgeries

If more than two providers of different specialties perform work during the same surgery, often using complex surgical equipment, you've got yourself a team. When this happens, you'll append modifier 66 (Surgical team) to the surgical code(s).

Definition: "A surgical team is ... several surgeons of different specialties involved in one case," explains **Lynn M. Anderanin, CPC, CPPM, CPC-I, COSC,** senior director of coding education at Healthcare Information Services in Park Ridge, Ill.

Background: Under some circumstances, providers carry out highly complex procedures under the surgical team banner. Such circumstances may be identified by each participating individual with the addition of modifier 66 to the procedure code used for reporting services.

An example of when you might use modifier 66 is the separation of conjoined twins, Anderanin says.

"Depending on where they are conjoined, you may have a plastic [surgeon], cardiothoracic [surgeon], and neurosurgeon all involved in the complex surgery," she explains.

Warning : You'll need to make sure that the CPT® code is modifier 66-approved. According to Medicare contractor Palmetto GBA, you should "refer to the Medicare Physician Fee Schedule Database (MPFSDB) to determine if CPT® modifier 66 is applicable to a particular surgical CPT® code. Note that team surgeries are normally limited to organ transplants and re-transplants."

Prove Medical Necessity on 66 Claims

When you are coding for team surgery, the medical record must show medical necessity for having a team of surgeons working together, because team surgeries are paid for on a "by-report" basis.

Action: Your physician(s) must provide details in his documentation describing the procedure performed and stating that he was part of a team. Each provider reports the same procedure code(s) with modifier 66 attached. This tells the payer that the amount for the procedure should be divvied up between a team of providers instead of being paid to just one. This process is identical to the co-surgery requirements; it just involves a larger team.

And it's not just your physician's documentation that needs to be top-notch on team surgery claims. All of the providers' documentation must pass muster for the payer to accept a procedure code with modifier 66 appended.

Keep in mind, if your surgeon does something different than what is described in the code choice, she may be able to bill that particular procedure on her own. You would only need modifier 66 where a "team" was performing the same procedure.

Check Medicare 'TEAM SURG' Column Before Using 66

When coding for Medicare, you need to check the physician fee schedule before using modifier 66 □ as per Palmetto's advice.

Why? If you see a "0" or "9" in the" TEAM SURG" column, you should never apply modifier 66 to that code. The zero indicates that team surgeons are not permitted for the procedure, and the nine indicator means the concept does not apply. Medicare will never allow billing for a surgical team with any procedure that includes a "0" or "9" indicator in the fee schedule's "TEAM SURG" column.

If you find a "1" in the" TEAM SURG" column, Medicare may allow modifier 66 with supporting documentation that establishes medical necessity for the surgical team. If you find a "2" in the "TEAM SURG" column, Medicare will permit modifier 66 with that code.