HIGHMARK.

Reimbursement Policy

Title: Modifiers 52, 53, 54, 55, and 56

Policy Number: RP-004

Version Number: 2026.07.27

Medicare Advantage:	PA, WV, DE, NY	Version Effective:	July 27, 2026
Commercial:	PA, WV, DE, NY	Originally Effective:	August 1, 2016
Claim Type:	CMS 1500	History Versions:	Click Here → History

Disclosure: *The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan and ensure you are reimbursed based on the codes that correctly describe the health care services provided. Reimbursement Policies do not provide guidance on whether a service is a covered benefit under the members' contract. Benefit determinations are based in all cases on the applicable benefit plan contract language and applicable medical policies. Should there be any conflicts between Reimbursement Policy and the member's benefit plan, the member's benefit plan will prevail. Additionally, health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement Policy is not intended to impact care decisions or medical practice. This Reimbursement Policy is intended to serve as a guide as to how the plan pays for covered services, however, other factors may influence payment and, in some cases, may supersede this policy. The provider should consult their network provider agreement for further details of their contractual obligations. The policy is applicable to designated markets either entirely, or partially, as indicated within the policy. Policy designation of claim type is based on how the provider is contracted with the Plan.*

Description:

This policy provides direction on how the Plan will reimburse modifiers 52, 53, 54, 55, and 56.

Reimbursement Guidelines:

Commercial

For claims processed on or after November 1, 2021, reimbursement is as follows:

- Modifier 52 - The Plan will reimburse claim lines at 50% of the approved allowance.
- Modifier 53 - The Plan will reimburse claim lines at 50% of the approved allowance.
- Modifier 54 - The Plan will reimburse claim lines at 70% of the approved allowance.
- Modifier 55 - The Plan will reimburse claim lines at 20% of the approved allowance.
- Modifier 56 - The Plan will reimburse claim lines at 10% of the approved allowance.

Medicare Advantage

Prior to March 30, 2026, only the **New York** region is reimbursed as follows:

- Modifier 52 - The Plan will reimburse claim lines at 50% of the approved allowance.
- Modifier 53 - The Plan will reimburse claim lines at 50% of the approved allowance.

For claims processed on or after March 30, 2026, the reimbursement below applies **to all regions**:

- Modifier 52 - The Plan will reimburse claim lines at 50% of the approved allowance.
- Modifier 53 - The Plan will reimburse claim lines at 50% of the approved allowance

Coding:

Modifier 50 may not be submitted in combination with modifiers 52, 53, or 73 on the same line item for discontinued bilateral services. If the procedure is discontinued, only a unilateral procedure may be reported as discontinued.

Definitions:

Modifier	Description	Definition
52	Reduced Services	Used to indicate that a service or procedure was partially reduced or eliminated at the discretion of the physician or other QHP.
53	Discontinued Procedure	Appended to a surgical or diagnostic procedure code to indicate that the physician or other QHP terminated the procedure due to extenuating circumstances or conditions that threatened the patient's well-being.
54	Surgical Care Only	Used to indicate that a provider performed only the surgical procedure and not the preoperative or postoperative care that is normally included in the surgery package.
55	Postoperative Management Only	Used when one physician or other QHP performs the surgical procedure, and another provider takes over all or part of the postoperative care.

56	Preoperative Management Only	Used by a physician or other qualified health care professional who performs preoperative care but does not provide the intraoperative (surgical) or postoperative services.

References: N/A

Related Plan Policies: N/A

Policy Update History:

3 / 2026	Added Medicare Advantage applicable to the policy for the PA, WV, DE regions
7 / 2026	Merged RP-005 direction into policy with new template

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSIONS

Bulletin Number:	RP-004		
Subject:	Modifiers 52 and 53		
Effective Date:	August 1, 2016	**End Date:**	
Issue Date:	March 30, 2026	**Revised Date:**	March 2026
Date Reviewed:	December 2025		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan.

REIMBURSEMENT GUIDELINES:

Modifier 52: Reduced Services

Modifier 52 is used to report a service or procedure that is performed at a reduced level from what is specified by the code descriptor. When a physician does not complete a procedure in its entirety or elects to partially reduce or discontinue the procedure for reasons other than the patient's well-being being threatened, the procedure must be billed by appending modifier 52. Please refer to CPT coding guidelines for more specific information on the reporting of modifier 52.

Modifier 53: Discontinued Procedure

In certain instances, a physician may decide to terminate a procedure due to extenuating circumstances, such as if the well-being of the patient is threatened, making it necessary to indicate that the surgical or diagnostic procedure was started but discontinued. This circumstance must be reported by appending modifier 53 to the code reported by the physician for the discontinued procedure. Please refer to CPT coding guidelines for more specific information on the reporting of modifier 53.

Commercial Reimbursement

For claims processed on or after November 1, 2021, reimbursement is as follows:

Modifier 52 - The Plan will reimburse claim lines at 50% of the approved allowance.

Modifier 53 - The Plan will reimburse claim lines at 50% of the approved allowance.

Medicare Advantage Reimbursement

Prior to March 30, 2026, only the *New York* region is reimbursed as follows:

Modifier 52 - The Plan will reimburse claim lines at 50% of the approved allowance.

Modifier 53 - The Plan will reimburse claim lines at 50% of the approved allowance.

For claims processed on or after March 30, 2026, the reimbursement below applies to *all* regions:

Modifier 52 - The Plan will reimburse claim lines at 50% of the approved allowance.

Modifier 53 - The Plan will reimburse claim lines at 50% of the approved allowance.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

Modifier 50 may not be submitted in combination with modifiers 52, 53, or 73 on the same line item for discontinued bilateral services. If the procedure is discontinued, only a unilateral procedure may be reported as discontinued.

POLICY UPDATE HISTORY INFORMATION:

8 / 2016	Implementation
7 / 2019	Added note for discontinued bilateral services
11 / 2021	Added NY region applicable to the policy and changed modifier 52 reduction
9 / 2022	Added Medicare Advantage applicable to the policy for the NY region
3 / 2026	Added Medicare Advantage applicable to the policy for the PA, WV, DE regions

IMPORTANT INFORMATION

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Reimbursement Policies do not provide guidance on whether a service is a covered benefit under the member's contract. Benefit determinations are based in all cases on the applicable benefit plan contract language and applicable medical policies. Should there be any conflicts between Reimbursement Policy and the member's benefit plan, the member's benefit plan will prevail. Additionally, health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement Policy is not intended to impact care decisions or medical practice. This Reimbursement Policy is intended to serve as a guide as to how the plan pays for covered services, however, other factors may influence payment and, in some cases, may supersede this policy. The provider should consult their network provider agreement for further details of their contractual obligations.

Highmark Reimbursement Policy Bulletin

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HISTORY VERSION

Bulletin Number:	RP-004		
Subject:	Modifiers 52 and 53		
Effective Date:	August 1, 2016	**End Date:**	
Issue Date:	September 1, 2022	**Revised Date:**	September 2022
Date Reviewed:	August 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☒
Applicable Claim Type	**UB**	☐	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

The purpose of this policy is to provide the Plan's reimbursement direction for modifier 52 and modifier 53.

REIMBURSEMENT GUIDELINES:

Modifier 52: Reduced Services

Modifier 52 is used to report a service or procedure that is performed at a reduced level from what is specified by the code descriptor. When a physician does not complete a procedure in its entirety or elects to partially reduce or discontinue the procedure for reasons other than the patient's well-being being threatened, the procedure must be billed by appending modifier 52. Please refer to CPT coding guidelines for more specific information on the reporting of modifier 52.

Modifier 53: Discontinued Procedure

In certain instances, a physician may decide to terminate a procedure due to extenuating circumstances, such as if the well-being of the patient is threatened, making it necessary to indicate that the surgical or diagnostic procedure was started but discontinued. This circumstance must be reported by appending modifier 53 to the code reported by the physician for the discontinued procedure. Please refer to CPT coding guidelines for more specific information on the reporting of modifier 53.

Commercial Modifier Reimbursement

For claims processed on or after November 1, 2021, modifiers 52 and 53 are reimbursed as follows:

Modifier 52 - The Plan will reimburse claim lines at 50% of the approved allowance.

Modifier 53 - The Plan will reimburse claim lines at 50% of the approved allowance.

For claims processed before November 1, 2021, see previous versions of this policy by clicking the HISTORY VERSION link at the top of this policy.

Medicare Advantage Modifier Reimbursement

Modifier 52 - The Plan will reimburse claim lines at 50% of the approved allowance.

Modifier 53 - The Plan will reimburse claim lines at 50% of the approved allowance.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

Modifier 50 may not be submitted in combination with modifiers 52, 53, or 73 on the same line item for discontinued bilateral services. If the procedure is discontinued, only a unilateral procedure may be reported as discontinued.

POLICY UPDATE HISTORY INFORMATION:

8 / 2016	Implementation
7 / 2019	Added note for discontinued bilateral services
11 / 2021	Added NY region applicable to the policy. Changed modifier 52 reduction.
9 / 2022	Added Medicare Advantage Applicable to the policy