Highmark Reimbursement Policy Bulletin

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

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-004	VIEW HISTORY	
Subject:	Modifiers 52 and 53		
Effective Date:	August 1, 2016	**End Date:**	
Issue Date:	June 14, 2019	**Revised Date:**	July 1, 2019
Date Reviewed:	July 2019		
Source:	Reimbursement Policy		

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

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:

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.

Note: 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.

REIMBURSEMENT GUIDELINES:

The Plan will reimburse approved service lines reporting modifier 52 at 67% of the allowance.

The Plan will reimburse approved service lines reporting modifier 53 at 50% of the allowance.

POLICY UPDATE HISTORY INFORMATION:

8 / 2016	Implementation
7 / 2019	Added note for discontinued bilateral services

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Subject:	Modifiers 52 and 53		
Effective Date:	August 1, 2016	**End Date:**	
Issue Date:	December 1, 2017		
Source:	Reimbursement Policy		

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

Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreements supersede Reimbursement Policy direction and regional applicability.

PURPOSE:

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.

REIMBURSEMENT GUIDELINES:

The Plan will reimburse approved service lines reporting modifier 52 at 67% of the allowance.

The Plan will reimburse approved service lines reporting modifier 53 at 50% of the allowance.