



Reduced Services (Modifier 52)

Reimbursement Policy ID: RPC.0132.5400

Recent review date: 01/2026

Next review date: 11/2027

AmeriHealth Caritas District of Columbia reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas District of Columbia may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy provides guidelines for appropriate billing and reimbursement for reduced services for claims submitted using Modifier 52-Reduced services.

Exceptions

N/A

Reimbursement Guidelines

Modifier 52 is used to report that a procedure or service has been partially reduced at the physicians discretion. It indicates that part of a procedure or service was performed, but less than expected, and did not meet the full description as described in the Current Procedural Terminology (CPT) Manual.

It is inappropriate to use Modifier 52 to report terminated or discontinued procedures. See reimbursement policy Discontinued Procedures (Modifier 53, 73 & 74) RPC.0019.5400.

An elective cancellation of a procedure prior to anesthesia or sedation, and/or operating suite preparation should not be reported with Modifier 52.

AmeriHealth Caritas District of Columbia will reimburse procedure codes submitted with modifier 52 at a reduced rate of 50% of the allowable amount. Documentation in the medical record should indicate to what extent the services were provided.

Definitions

Modifier 52-Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

Edit Sources

- I. Current Procedural Terminology (CPT) and associated publications and services.
- II. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10).
- III. Healthcare Common Procedure Coding System (HCPCS).
- IV. Centers for Medicare and Medicaid Services (CMS).
- V. The National Correct Coding Initiative (NCCI).
- VI. Coding guidelines from Specialty Societies (e.g., American Society for Radiation Oncology (ASTRO), American Academy of Pediatrics (AAP), American Congress of Obstetricians and Gynecologists (ACOG), American Academy of Family Practitioners (AAFP), etc.).
- VII. Corresponding AmeriHealth Caritas District of Columbia Clinical Policies.
- VIII. AmeriHealth Caritas District of Columbia Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0019.5400 Discontinued Procedures (Modifier 53, 73 & 74)

Policy History

01/2026	Reimbursement Policy Committee Approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas District of Columbia from Policy History section

01/2023	<p>Template Revised</p> <ul style="list-style-type: none">• Revised preamble• Removal of Applicable Claim Types table• Coding section renamed to Reimbursement Guidelines• Added Associated Policies section
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