PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Payment Policy

cmi_051718

Title	**Modifier 52 – Reduced Services**		
Number	**CP.PP.224.v3.0**		
Last Approval Date	08/12/24	**Original Effective Date**	05/17/00
Cross Reference	• *Physical Medicine and Rehabilitation Services* • *Maternity Services* • *Modifier 22 – Increased Procedural Services*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define when the Plan recognizes services appended with Modifier 52 that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products. Medicare Advantage products are not subject to this policy.
Policy	The Plan recognizes Modifier 52 appended to a service to indicate that the scope of a service or procedure was partially reduced, that services performed were significantly less than usually required or the procedure was eliminated at the physician's discretion. Modifier 52 is not valid when submitted with any **time-based codes**, including but not limited to anesthesia, psychotherapy, critical care, or physical medicine time-based codes. Modifier 52 must not be billed in conjunction with the following: • A procedure code appended with Modifier 22-*Increased Procedural Services*. • An E&M office visit code or Preventive Medicine Exam code • Unlisted procedure codes • Codes whose descriptions include "Unilateral or Bilateral" • A more descriptive code that describes the lessor or reduced service performed The Plan does not recognize the use of modifier 52 on **maternity delivery codes** to represent labor management when a mother is transferred to another provider for the actual delivery of the baby. Documentation in the member's medical record must indicate and explain the circumstances surrounding the reduced service by identifying what services were performed and which services were not performed for the procedure code being modified. Reimbursement for procedures appended with Modifier 52 will be 75% of the provider's applicable Fee Schedule allowed amount.

Codes/Coding Guidelines	For purposes of this policy, the codes associated with maternity deliveries include the following: • **59400** – Routine obstetric care including antepartum care, vaginal delivery (w/wo episiotomy and/or forceps) and postpartum care • **59409** – Vaginal delivery only (w/wo episiotomy and/or forceps) • **59410** – Vaginal delivery only (w/wo episiotomy and/or forceps) including postpartum care • **59510** – Routine obstetric care including antepartum care, cesarean delivery, and postpartum care • **59514** – Cesarean delivery only • **59515** – Cesarean delivery only; including postpartum care • **59610** – Routine obstetric care including antepartum care, vaginal delivery (w/wo episiotomy and/or forceps) and postpartum care after previous cesarean delivery • **59612 –**Vaginal delivery only after previous cesarean delivery (w/wo episiotomy and/or forceps) • **59614 –** Vaginal delivery only after previous cesarean delivery (w/wo episiotomy and/or forceps); including postpartum care • **59618** – Routine obstetric care including antepartum care, cesarean delivery and postpartum care following attempted vaginal delivery after previous cesarean delivery • **59620** –Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery • **59622** - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care
Violations of Policy	Violations of this policy by any party that enters a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined at Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	This policy does not apply to any provider reimbursed using an ASC APC payment methodology.
Laws, Regulations & Standards	None
References	• American Medical Association's Current Procedural Terminology (AMA/CPT), Professional Edition codebook • Centers for Medicare and Medicaid Services (CMS)
Policy Owner Review	Payment Integrity Oversight Committee
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.
Annual Review Dates	08/12/24; 02/05/24; 03/13/23; 04/08/22; 04/16/21; 04/30/20; 05/24/19; 06/05/18; 08/11/17; 09/14/16; 03/14/16; 07/13/15; 07/14/14; 07/16/13; 07/16/11; 08/04/11; 01/27/11; 02/12/10; 03/24/09; 06/16/08; 05/13/07; 04/11/06; 02/28/06; 08/29/05; 07/30/04

This policy was published on August 15, 2024

Version History	06/05/18	Added new section Codes/Coding Guidelines and moved the codes mentioned in the Policy section to the new codes section
	05/24/19	Clarified instructions on billing “timed based codes”
	04/30/20	Added a cross reference to “Maternity Services” Payment Policy
	04/16/21	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P electronic claim forms.
	04/08/22	In the Policy section, expanded on examples where the appending of modifier 52 is not appropriate
	03/13/23	In the Policy section, removed the examples for how to determine units on time-based codes.
	02/05/24	Annual review; no changes
	08/12/24	Annual review; no changes