Frequency

Reimbursement Policy ID: RPC.0025.72AC

Recent review date: 08/2026

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. The health plan 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, and 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 describes limitations on reimbursement to providers contracted with the health plan, based on frequency limitations for benefit coverage of services and supplies. Many services and supplies have a frequency limit for coverage under the member's benefit. For example, many preventive and screening services are limited to once per year.

The health plan follows, Pennsylvania Medicaid, the Centers for Medicare and Medicaid (CMS), and medical practice standards regarding frequency limits of services and supplies. Only medically necessary services and/or supplies are reimbursable.

Exceptions

N/A

Reimbursement Guidelines

The health plan utilizes edits to prevent payment for services and supplies exceeding the frequency limit under the available benefit coverage:

- Claims or claim lines exceeding the frequency limit under benefit coverage of a service or supply will be denied.
- If authorization was granted as an exception to the normal frequency limit, the authorization number must also be reported on the claim for the service or supply to be considered for payment.
- Appropriate diagnosis code(s) and/or modifier(s) on the claim indicate the circumstance(s) for which a service or supply provided is medically necessary.

Providers must submit clean claims for accurate reimbursement of services and/or supplies.

The health plan utilizes other edits for maximum units of service; see RPC.0023.72AC.

Refer to CPT/HCPCS manuals for complete descriptions of procedure codes and their modifiers.

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. Healthcare Common Procedure Coding System (HCPCS)
III. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

Attachments

N/A

Associated Policies

RPC.0023.72AC Maximum Units

Policy History

09/2026	• Removed the next review date • Replaced the plan name with “the health plan”
08/2026	Reimbursement Policy Committee Approval
07/2026	Annual review • No major changes
09/2025	Reimbursement Policy Committee approval
08/2025	Annual review • No major changes
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble

04/2024	Revised preamble
04/2024	Reimbursement Policy Committee approval