# Frequency

Reimbursement Policy ID: RPC.0025.2400

Recent review date: 02/2024

Next review date: 11/2025

*Select Health of South Carolina 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. Select Health of South Carolina 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.*

## Policy Overview

This policy describes limitations on reimbursement to providers contracted with Select Health of South Carolina, 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. Per SCDHHS contract and Bright Futures Periodicity Schedule, well-child (preventative) visits 99381-99385 and 99391-99395 for ages 0-21 are not subject to frequency limits.

Select Health of South Carolina follows, the Centers for Medicare and Medicaid (CMS), and medical practice standards with regard to frequency limits of services and supplies. Only medically necessary services and/or supplies are reimbursable.

4.1. General Core Benefits and Services Requirements
Core Benefits shall be available to each Medicaid Managed Care Member within the CONTRACTOR's Service Area. The CONTRACTOR shall provide Core Benefits and services to Medicaid Managed Care Members, pursuant to the provisions of this contract.

The CONTRACTOR shall:
4.1.2. Furnish Core Benefits and services in accordance with Medical Necessity and in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries and for beneficiaries under the age of 21 up to the limits as specified in the Medicaid FFS Program as defined in the State Plan, administrative rule and Department Policy, Procedure manuals and all applicable federal and state statues, rule, and regulations.
4.1.5. Ensure that services are covered in accordance with 42 CFR 438.210, as follows:
4.1.5.2. May not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the Medicaid Managed Care Member.

## Exceptions

N/A

## Reimbursement Guidelines

Select Health of South Carolina utilizes edits to prevent payment for services and supplies exceeding the frequency limit as indicated in the SCDHHS Fee Schedule under the available benefit coverage:

- Claims or claim lines exceeding the frequency limit under outlined in the SCDHHS Fee Schedule benefit coverage of a service or supply will be denied. A Medicaid Bulletin, Bureau Change Impact Cover sheet, or any other SCDHHS communication may supersede the fee schedule.

- 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.

Select Health of South Carolina utilizes other edits for maximum units of service; see RPC.0023.2400.

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)
IV. MCO Contract 2021 Amendment VI, https://www.scdhhs.gov/sites/default/files/documents/1.1.24%20MCO%20CONTRACT%20FINAL.pdf
V. SCDHHS Fee Schedule

## Attachments

N/A

## Associated Policies

RPC.0023.2400: Maximum Units

## Policy History

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| 04/2024 | Revised preamble |
| 02/2024 | Reimbursement Policy Committee approval |
| 12/2023 | Annual review<br>• Update Edit Sources |
| 08/2023 | Removal of policy implemented by Select Health of South Carolina from Policy History section |
| 01/2023 | Template revised<br>• Revised preamble<br>• Removal of Applicable Claim Types table<br>• Coding section renamed to Reimbursement Guidelines<br>• Added Associated Policies section |