mln BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

Items & Services Not Covered Under Medicare

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

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What's Changed?

- Added language on Medicare Advantage (MA) Plan patients (page 4)
- Added language on Railroad Retirement Board (RRB) coverage of hospital services from a Canadian hospital (page 7)

You'll find substantive content updates in dark red font.

This booklet outlines items and services Medicare doesn't cover as well as exceptions (items and services we may cover). This isn't an all-inclusive list.

For Medicare Advantage (MA) plan patients, check with the MA plan for information on eligibility, coverage, and payment. Each plan can have different patient out-of-pocket costs and specific rules for getting and billing for services. You must follow the plan's terms and conditions for payment.

Note: Any item or service provided directly or indirectly by an individual or entity excluded by the Office of Inspector General from all federal health care programs isn't covered.

Items & Services Not Covered Under Medicare

We don't cover these items and services categories:

- Medically unreasonable and unnecessary services and supplies
- Non-covered items and services
- Services and supplies denied as bundled or included in another service's basic allowance
- Items and services paid by other organizations or provided without charge

Medicare Benefit Policy Manual, Chapter 16 lists general Medicare coverage exclusions, and Medicare Benefit Policy Manual, Chapter 15 has more information on covered and noncovered medical and other health services.

Medically Unreasonable & Unnecessary Services & Supplies

We don't pay for medically unreasonable and unnecessary services and supplies to diagnose and treat a Medicare patient's condition. These include:

- Hospital-provided services that, based on the patient's condition, could have been provided in a lower-cost setting, like the patient's home or nursing home
- Hospital services exceeding Medicare length of stay limits
- Evaluation and management services exceeding those considered medically reasonable and necessary
- Excessive therapy or diagnostic procedures
- Unrelated screening tests, exams, and therapies where the patient has no symptoms or diagnoses, except certain screening tests, exams, and therapies
- Unnecessary services based on the patient's diagnosis, like transcendental meditation
- Items and services administered to the patient to cause or assist in death (assisted suicide)

Services must meet specific medical necessity requirements in the statute, regulations, manuals, and any medical necessity criteria defined by National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), if any apply. For every service you bill, you must indicate the specific sign, symptom, or patient complaint that makes the service reasonable and necessary.

Exceptions

We may cover these items and services:

- Medicare Preventive Services
  - Medicare Claims Processing Manual, Chapter 18 has more information on preventive and screening services
- Transitional Care Management
- Chronic Care Management
- Advance Care Planning

We may also cover items and services that ease pain or discomfort, even if their use may increase risk of death, if they're not provided for the specific purpose of causing death.

The Physician Fee Schedule Relative Value Files webpage shows coding and payment for items and services we may cover.

Non-covered Items & Services

Custodial Care

Medicare Fee-for-Service doesn't cover custodial care, like long-term care services and supports, in the patient's home or an institution.

Custodial care is personal care that:

- Doesn't require the continued attention of trained medical or paramedical personnel
- Helps an individual with activities of daily living, like:
  - Walking
  - Getting in and out of bed
  - Bathing
  - Dressing
  - Feeding
  - Using the toilet
  - Preparing a special diet
  - Supervising normally self-administered medication

Who Covers Custodial Care?

Long-term care includes non-medical care for people who have a chronic illness or disability.

Medicare and most health insurance plans don't cover long-term care.

Supplement insurance (Medigap) policies don't pay for custodial care.

Some patients may be eligible for custodial care through Medicaid.

Medicare Advantage (MA) plans may cover custodial care as part of supplemental home and community-based services.

Visit LongTermCare.gov and Eldercare Locator for more information or to find community services for older adults and their families.

Exceptions

- If Medicare Part A denies coverage for a hospital or skilled nursing facility (SNF) stay because it's considered custodial care, we may cover individual Medicare Part B services that are reasonable and necessary to treat the patient's illness or injury, like periodic patient visits by a physician
- Custodial care doesn't exclude payment for Part B claims for medically necessary ancillary services
- For patients who choose hospice care, the care is custodial only if it's not reasonable and necessary for managing the terminal illness or related conditions
- Some MA plans may cover some non-skilled supplemental benefits that:
  - Compensate for physical impairments
  - Reduce the impact of injuries or health conditions
  - Reduce avoidable emergency room use

Get more information about Medicare and hospice care, including covered and non-covered hospice services.

Items & Services Provided Outside the U.S.

We don't cover most items and services provided outside the U.S., including when the patient purchased the item in the U.S. or purchased the item from an American firm. We also won't pay for medical services sub-contracted to another provider or supplier outside the U.S.

We don't pay for provider professional services outside the U.S., except certain limited services. CMS recognizes these as U.S. jurisdictions for Part A and Part B services:

- All 50 states
- District of Columbia
- Commonwealth of Puerto Rico
- U.S. Virgin Islands
- Guam
- Commonwealth of Northern Mariana Islands
- American Samoa
- Territorial waters touching U.S. land (for services onboard a ship)

We consider a hospital outside the U.S. if it's not physically located in 1 of the jurisdictions listed above, even if it's owned or operated by the U.S. government.

Exceptions

We may cover these services:

- Emergency inpatient hospital services at a foreign hospital closer to, or more accessible from, the emergency site than the nearest U.S. hospital if 1 of these conditions also exists:
  - The patient was physically present in the U.S. at the time of the emergency
  - The patient was physically present in Canada when the emergency occurred and traveling by the most direct route without unreasonable delay between Alaska and another state
- Emergency or non-emergency inpatient services provided by a hospital outside the U.S. if the hospital is closer to, or substantially more accessible from, the patient's U.S. home than the nearest participating U.S. hospital that can treat the patient's medical condition
- Physician and ambulance services provided in connection with a patient's covered foreign inpatient hospital stay when:
  - The physician is legally authorized to practice in the country where they provide the services
  - The ambulance supplier meets Medicare's definition of an ambulance
- Services provided onboard a ship in a U.S. port or within 6 hours of when the ship arrived or departed
  - If services don't meet this requirement, we consider them provided outside U.S. territorial waters, even if the ship is of U.S. registry

The Railroad Retirement Board (RRB) pays Qualified Railroad Retirement Beneficiaries (QRRBs) for covered hospital services provided in Canadian and U.S. hospitals. If the QRRB files a payment claim for Part B services connected to a hospitalization in Canada, the RRB processes the Part B claim and decides whether:

- The inpatient services met all requirements
- The physician or ambulance services were provided in connection with the other required services

Items & Services Required Because of War

We don't cover items and services required because of war or an act of war that happen after the patient's current Medicare effective date.

Personal Comfort Items & Services

We don't cover personal comfort items because these items don't meaningfully contribute to treating a patient's illness, injury, or the functioning of a malformed body member. Some examples of personal comfort items include:

- Radios, TVs, phones, and air conditioners
- Beauty and barber services (with certain exceptions)

When a patient asks for a personal comfort item, tell them there's a specific charge for the item. You can't charge more than the customary amount for any current or future charges. You also can't require the patient to ask for noncovered items or services as a condition of admission or continued stay.

Exceptions

We may cover certain basic personal resident services under Part A in a SNF or general psychiatric hospital when the patient can't perform them for themselves, like shaves, haircuts, shampoos, or simple hair sets. More elaborate services, like professional manicures or hair styling, aren't covered.

We may consider these ordinary resident care and covered costs payable under Part A when they're:

- Provided by a long-stay institution
- Included in the flat rate charge
- Routinely provided without patient charge

Routine Services & Supplies

We don't cover these routine items and services

- Routine or annual physical checkups (with certain exceptions).
- Physical exams performed without a specific sign, symptom, or patient complaint. This includes exams required by third parties, like insurance companies, businesses, or government agencies.
- Eye exams for prescribing, fitting, or changing eyeglasses.
- Eye refractions provided by practitioners for any purpose.
- Eyeglasses or contact lenses.
- Hearing aids and hearing exams.
- Chiropractic services other than manual manipulation of the spine to correct a subluxation (if legal in the state where it's performed).
- Immunizations (with certain exceptions).

Exceptions

We may cover these items and services:

- Physician services (or services incident to a physician's service) to diagnose and treat an eye disease, like glaucoma or cataracts
- 1 pair of eyeglasses or contact lenses after each cataract surgery with insertion of an intraocular lens
- Shots directly related to treating an injury or direct exposure to a disease or condition, like anti-rabies treatment or immune globulin
- Shots specifically covered by statute, like seasonal flu virus, pneumococcal, or hepatitis B
- Reasonable supply of antigens (no more than a 12-month supply) prepared for a patient by a Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) after examining the patient and determining a treatment plan and dosage regimen
- Cochlear implants and auditory brainstem implants that replace cochlear structures or auditory nerve function and deliver electrical energy to auditory nerve fibers and other neural tissue through implanted electrode arrays
- Osseointegrated implants that replace the middle ear function and deliver mechanical energy to the cochlea through a mechanical transducer as prosthetic devices if hearing aids are medically inappropriate or patient can't use them due to:
  - Congenital malformations
  - Chronic disease
  - Severe sensorineural hearing loss
  - Surgery

Cosmetic Surgery

We don't cover cosmetic surgery or related expenses. Cosmetic surgery includes any procedure to improve the patient's appearance.

Exceptions

We may cover prompt (as soon as medically feasible) repair of an accidental injury or improvement of the functioning of a malformed body member, like:

- Surgery for treating severe burns
- Surgery for repairing the face after a serious auto accident
- Surgery for therapeutic purposes that coincidentally serves some cosmetic purpose

Items & Services Provided by Patient's Immediate Relatives & Members of the Patient's Household

We don't pay for items and services provided by the patient's immediate relatives and members of the patient's household since these items and services are usually provided at no cost because of their relationship. A patient's immediate relatives include:

- Husband or wife
- Natural or adoptive parent, child, or sibling
- Stepparent, stepchild, stepbrother, or stepsister
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law
- Grandparent or grandchild
- Grandparent's or grandchild's spouse

If the step- or in-law marriage relationship ends through divorce or death, the prohibited relationship continues to exist.

Members of the patient's household include those who share a common residence as part of a single-family unit:

- Individuals related by blood, marriage, or adoption
- Domestic employees
- Other individuals living together as part of a single-family unit (not roomers or boarders)

We also don't pay for these items and services:

- Services provided incident to a physician's professional service when the physician furnishes, orders, or supervises the services to their immediate relatives or to members of their household
- A prohibited patient relationship to the physician or supplier that provides the services exists and an unrelated individual, partnership, or professional corporation submits the charges for those services

A professional corporation means a corporation that's completely owned by 1 or more physicians and practices medicine, osteopathy, dentistry, podiatry, optometry, or chiropractic, or is owned by other health care professionals as authorized by state law.

Any incorporated physician or group of physicians is a professional corporation. We don't pay for items and services by non-physician suppliers that aren't incorporated, even when the supplier is owned by:

- A sole proprietor who has an excluded relationship to the patient
- A partnership when even 1 partner is related

This payment restriction doesn't apply to a corporation (other than a professional corporation), regardless of the patient's relationship to corporate stockholders, officers, or directors, or the individual who provided the service.

Dental Services

We don't cover items and services for the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth, like preparing the mouth for dentures or removing diseased teeth in an infected jaw. Structures directly supporting the teeth are the periodontium which includes:

- Gingivae
- Dentogingival junction
- Periodontal membrane
- Cementum
- Alveolar bone (alveolar process and tooth sockets)

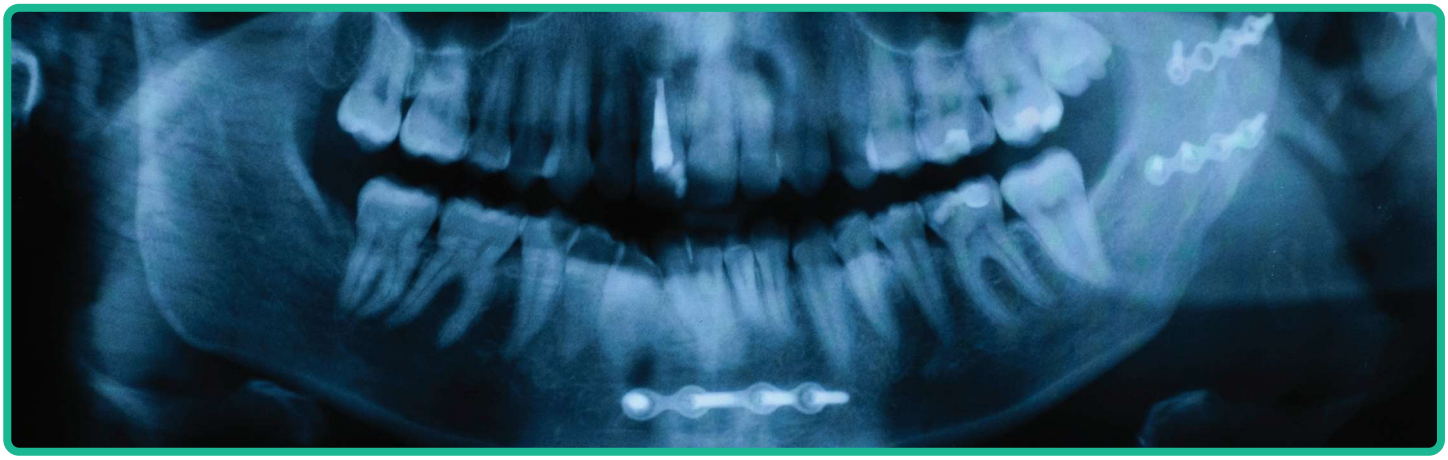
Regardless of whether we cover inpatient hospital services, we don't cover physician medical services connected to noncovered dental services.

See section 70 of Medicare Benefit Policy Manual, Chapter 1 and section 150 of Medicare Benefit Policy Manual, Chapter 15 for more information.

Exceptions

We may cover some dental services, like:

- X-ray taken when treating a fractured jaw or facial bone
- Tooth extraction to prepare the jaw for neoplastic disease radiation treatments
- Inpatient oral or dental exam as part of a comprehensive workup before renal transplant surgery or performed in a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC) before heart valve replacement
- If a dentist performs an otherwise noncovered procedure or service as incident to and an integral part of their covered procedure or service, we cover the total service (for example, wiring teeth when treating a jaw fracture)



Inpatient Hospital or SNF Services Not Delivered Directly or Under Arrangement

We don't normally cover non-physician services for Part A or Part B hospital inpatients unless those services are provided either:

- Directly from the hospital or SNF
- Under an arrangement the hospital or SNF makes with an outside source

Visit the SNF Consolidated Billing webpage for more information about billing SNF bundled services as part of the prospective payment system.

Exceptions

We may cover these items and services if they're medically necessary, even though they're not provided directly or under an arrangement:

- Physician services to hospital inpatients and SNF residents except for therapy in SNFs (the SNF must provide these services to Part A and Part B inpatients directly or under arrangement)
- Physician assistant services
- Nurse practitioner services
- Clinical nurse specialist services
- Certified nurse-midwife services
- Qualified clinical psychologist services
- Certified registered nurse anesthetist services

For SNF Part A inpatients, we may cover these services if provided by another authorized provider or supplier:

- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies (including related necessary ambulance services)
- Ambulance transportation related to dialysis services
- Epoetin Alfa (EPO) for certain dialysis patients
- Hospice care related to the patient's terminal condition
- Radioisotope services
- Some customized prosthetic devices
- Some chemotherapy and chemotherapy administration services

- The following categories of exceptionally intensive outpatient services, which we've determined are beyond the scope of SNF care plans and require the intensity of a hospital (including a Critical Access Hospital [CAH]) setting to provide them safely and effectively:
  - Cardiac catheterization
  - Computerized axial tomography scans
  - Magnetic resonance imaging
  - Ambulatory surgery using an operating room or comparable setting
  - Radiation therapy services
  - Angiography
  - Certain lymphatic and venous procedures
  - Emergency services

  This exception doesn't apply when the patient gets these services in an Ambulatory Surgical Center (ASC). Coverage includes transportation from the SNF to the hospital and back when the patient's medical condition requires an ambulance.

Medicare Benefit Policy Manual, Chapter 1 has more information on covered and noncovered inpatient hospital services.

Medicare Benefit Policy Manual, Chapter 8 has more information on covered and noncovered SNF services.

Foot Care Services & Supportive Devices

We don't normally cover these foot care services and devices:

- Flat foot treatment
- Routine foot care, including:
  - Cutting or removing corns and calluses
  - Trimming, cutting, clipping, or debriding nails
  - Other hygienic and preventive maintenance foot care, like cleaning and soaking the feet, using skin creams to maintain ambulatory or bedridden patient skin tone, and other services without localized illness, injury, or symptoms
- Orthopedic shoes and other supportive foot devices

Exceptions

We may cover these devices and services:

- Orthopedic shoes integral to a leg brace
- Therapeutic shoes provided to diabetic patients
- Services necessary and integral to a covered service, like diagnosis and treatment of ulcers, wounds, or infections
- Foot warts (including plantar warts) treatment
- Mycotic nails treatment:
  - For an ambulatory patient, the physician attending the patient's mycotic condition must document:
    - Clinical evidence of toenail mycosis
    - Patient has marked ambulation limitation, pain, or secondary infection from thickening and dystrophy of the infected toenail plate
  - For a non-ambulatory patient, the physician attending the patient's mycotic condition must document:
    - Clinical evidence of toenail mycosis
    - Patient suffers from pain or secondary infection resulting from thickening and dystrophy of the infected toenail plate
- Foot care required because of metabolic, neurologic, or peripheral systemic diseases (this isn't an all-inclusive list):
  - Diabetes mellitus*
  - Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
  - Buerger's disease (thromboangiitis obliterans)
  - Chronic thrombophlebitis*
  - Peripheral neuropathies involving the feet associated with:
    - Malnutrition and vitamin deficiency:*
      - Malnutrition (general, pellagra)
      - Alcoholism
      - Malabsorption (celiac disease, tropical sprue)
      - Pernicious anemia
    - Carcinoma*
    - Diabetes mellitus*
    - Drugs and toxins*
    - Multiple sclerosis*

- Uremia (chronic renal disease)*
- Traumatic injury
- Leprosy or neurosyphilis
- Hereditary disorders:
  - Hereditary sensory radicular neuropathy
  - Angiokeratoma corporis diffusum (Fabry's)
  - Amyloid neuropathy

*We cover routine procedures for this condition when the patient is under the active care of an MD or DO who documented the condition.

Investigational Devices

We may cover Category B devices if considered medically reasonable and necessary and they meet all other Medicare coverage requirements.

Services Related to & Required as a Result of Noncovered Services

We don't pay medical and hospital services related to, and required as a result of, non-covered services, like:

- Cosmetic surgery
- Noncovered organ transplants
- Noncovered artificial organ implant
- Follow-up care or treatment related to complications during a hospital stay for a noncovered service

Exceptions

We may cover unrelated services when a patient is hospitalized for a noncovered service and needs services not related to the noncovered service. For example, if a patient breaks a leg while in the hospital for a noncovered service, we may cover the services to treat the broken leg since it's unrelated to the noncovered service.

We may cover reasonable and necessary medical or hospital services after a patient is discharged from a hospital stay for noncovered services and then needs services to treat a condition or complication that resulted from the noncovered services, like:

- Repairing complications after sex reassignment or cosmetic surgery
- Treating a noncovered surgical site infection

We don't pay for subsequent services normally incorporated into a global fee.

Services & Supplies Denied as Bundled or Included in Another Service's Basic Allowance

We don't pay for services and supplies denied as bundled or included in another service's basic allowance, like:

- Fragmented services included in the initial service's basic allowance
- Indirect prolonged care
- Physician standby services
- Case management services, like patient phone calls
- Supplies included in the procedure's basic allowance

Items & Services Paid by Other Organizations or Provided Without Charge

Services Paid Under the Medicare Secondary Payer Program

We don't pay for items and services paid (or expected to be paid) by:

- Auto insurance
- No-fault insurance
- Liability insurance
- Workers' compensation (WC) or U.S. or state plan

Exceptions

We may pay if the primary payer denied the claim and issued documentation indicating it was denied in these situations:

- Group Health Plan denies service payment because:
  - The patient isn't covered by the health plan
  - The patient exhausted particular service plan benefits
  - The plan doesn't cover the services
  - A deductible applies
  - The patient isn't entitled to benefits
- Benefits exhausted, so no-fault or liability insurer denies payment
- WC Plan denies payment, like when it isn't required to make payment
- Federal Black Lung Program doesn't pay the bill

In liability, no-fault, or WC situations, we may make conditional payments for covered services to prevent patient financial hardship when:

- Prompt claim payment isn't expected
- A properly submitted claim was denied in whole or in part
- The patient's physical or mental incapacity prohibits submitting a proper claim with the primary insurer

When we make a conditional payment, the insurer, patient, or both, must pay us if the primary insurer makes any later payments.

Review the Medicare Secondary Payer booklet for more information on who pays first, second, and third.

Items & Services Authorized or Paid by a Government Entity

We normally don't pay for these items and services authorized or paid for by a federal, state, or local government entity:

- Those provided by a government or non-government provider or other individual at public expense authorized by a federal agency, like the Veterans Administration (VA).
- Those provided by a federal provider or agency. We may pay federal hospitals, like other non-participating hospitals, for emergency inpatient and outpatient hospital services.
- Those a federal, state, or local government entity directly or indirectly pays for or provides without expecting payment from any source and without regard to the individual's ability to pay.
- Those that a non-government provider or supplier provides and either of these apply:
  - A government program other than Medicare pays the charges.
  - The provider or supplier intends to get payment from another government program (unless the payment by the other program is limited to Medicare deductible and coinsurance).

Items & Services the Patient, Another Individual, or an Organization Has No Legal Obligation to Pay for or Provide

We don't pay when the patient, another individual, or an organization has no legal obligation to pay for or provide the items or services, like:

- X-rays or shots provided to a patient without regard to their ability to pay and without expecting payment from any source.
- A volunteer ambulance transport company. If an ambulance company asks for but doesn't require a donation from a patient to help offset the service cost, there's no legal obligation for the patient or any other individual to pay for the service.
- A device or item provided at no cost to the service provider.

When a provider or supplier provides items or services at no cost to patients because they're unable to pay, this payment exclusion doesn't apply if they bill their patients who **are** able to pay.

Defective Equipment or Medical Devices Covered Under Warranty

We don't pay for defective medical equipment or medical devices under warranty if either of these apply:

- They're replaced at no cost by the warrantor
- The patient could get an acceptable replacement at no cost under the warranty but they bought the replacement instead

Exceptions

When a hospital or other provider replaces defective equipment or medical devices under warranty, we may cover them in situations like these:

- When a replacement from another manufacturer is substituted because the warranty-offered replacement is unacceptable to the patient or their physician
- If the warrantor supplied defective equipment or medical devices and they impose a charge or a pro rata payment, we may make a partial payment

We limit payment to the warranty amount the hospital or other provider would've paid if they could have purchased an acceptable replacement at reduced price under a warranty, but either of these applies instead:

- They paid full price to the original manufacturer
- A different manufacturer or other source purchased a new replacement

Advance Beneficiary Notices

You must issue an Advance Beneficiary Notice of Non-coverage (ABN) to a patient before providing items or services we usually cover but may not cover in specific situations, like if an item or service isn't medically necessary for the patient. The ABN helps patients decide whether to get an item or service and informs them about their financial liability. We may hold you financially liable if you're required to issue an ABN but you don't issue it to the patient.

You don't need to notify a patient before you provide items or services we never cover or aren't a Medicare benefit. But, we recommend you issue a voluntary ABN or similar notice as a courtesy to inform the patient about their financial liability.

The Advance Beneficiary Notice of Non-coverage Tutorial shows you how to correctly complete an ABN form, and the Medicare Advance Written Notices of Non-coverage booklet explains the ABN notice types, uses, and timing.

Resources

- Medicare Benefit Policy Manual, Chapter 6
- Medicare Claims Processing Manual
- Medicare National Coverage Determinations Manual
- Medicare Secondary Payer Manual
- Section 20.2 of Medicare Claims Processing Manual, Chapter 30

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