



ITEMS AND SERVICES NOT COVERED UNDER MEDICARE



Target Audience: Medicare Fee-For-Service Providers

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INTRODUCTION

This booklet provides information on the four categories of items and services Medicare does not cover and exceptions (items and services Medicare may cover). This material is not an all-inclusive list of all items and services Medicare may or may not cover.

Please note: Any item or service furnished directly or indirectly by an individual or entity excluded by the Office of Inspector General from participating in all Federal health care programs, is a noncovered item or service pursuant to [Section 1862\(e\) of the Social Security Act](#).

When we use “you” in this booklet, we are referring to Medicare providers and suppliers.

CATEGORIES OF ITEMS AND SERVICES NOT COVERED UNDER MEDICARE

Learn about these four categories of items and services Medicare does not cover:

1. Medically unreasonable and unnecessary services and supplies
2. Noncovered items and services
3. Services and supplies denied as bundled or included in the basic allowance of another service
4. Items and services reimbursable by other organizations or furnished without charge

This booklet also provides information about exceptions and lists items and services Medicare may cover.

Medically Unreasonable and Unnecessary Services and Supplies

Medicare does not pay for medically unreasonable and unnecessary services and supplies to diagnose and treat a beneficiary’s condition. Some examples include:

- Hospital furnished services that, based on the beneficiary’s condition, could have been furnished in a lower-cost setting, such as the beneficiary’s home or a nursing home
- Hospital services exceeding Medicare length-of-stay limitations
- Evaluation and management services exceeding those considered medically reasonable and necessary
- Excessive therapy or diagnostic procedures
- Unrelated screening tests, examinations, and therapies that the beneficiary has no symptoms or diagnoses, except for certain screening tests, examinations, and therapies
- Unnecessary services based on the diagnosis of the beneficiary such as, acupuncture and transcendental meditation
- Items and services administered to a beneficiary for the purpose of causing or assisting in causing death (assisted suicide)

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

Exceptions

These items and services may be covered:

- [Medicare Preventive Services](#)
- Transitional Care Management
- Chronic Care Management
- Advance Care Planning

Medicare may cover items and services administered to alleviate pain or discomfort, even if such use may increase the risk of death, if not furnished for the specific purpose of causing death.

Noncovered Items and Services

A. Custodial Care (such as long-term care services and supports)

Medicare Fee-For-Service does not cover custodial care in the beneficiary's home or an institution. However, Medicare Advantage Organizations (MAOs) can cover custodial care as part of supplemental home and community-based services.

Custodial care is personal care that requires **no** trained medical or paramedical personnel continuing attention and serves to assist an individual in the activities of daily living, such as:

- Walking
- Getting in and out of bed
- Bathing
- Dressing
- Feeding
- Using the toilet
- Preparing a special diet
- Supervising normally self-administered medication

Long-term care includes non-medical care for people who have a chronic illness or disability. This includes non-skilled personal care assistance, like help with everyday activities, including dressing, bathing, and using the bathroom. Medicare and most health insurance plans, including Medicare Supplement Insurance (Medigap) policies, don't pay for this type of care, sometimes called "custodial care." Some beneficiaries may be eligible for this type of care through Medicaid. Long-term care can be provided at home, in the community, in an assisted living facility, or in a nursing home.

Exceptions

Medicare may cover individual reasonable and necessary services under Part B even though Part A denies coverage of a beneficiary's overall hospital or SNF stay, because it is determined to be custodial care. For instance, Part B may cover periodic visits by a physician to their patient if the services are reasonable and necessary to the treatment of the patient's illness or injury even though there is a finding the care furnished to the hospitalized or SNF patient is custodial care. Similarly, custodial care does not preclude payment for a Part B claim for medically necessary ancillary services.

Care furnished to a beneficiary who elected hospice care is considered custodial only if it is unreasonable and unnecessary for managing the terminal illness and related condition. Some MAOs may cover selected non-skilled supplemental benefits for certain beneficiaries if they compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable emergency room use.

B. Items and Services Furnished Outside the United States

Medicare does not cover most items and services delivered outside the U.S. including when the beneficiary purchased the item in the U.S. or purchased the item from an American firm. Additionally, Medicare will not pay for a medical service subcontracted to another provider or supplier outside the U.S.

Medicare does not pay for provider professional services outside the U.S., except for certain limited services. The Centers for Medicare & Medicaid Services (CMS) recognizes these as U.S. jurisdictions for Part A and Part B services:

- The 50 States
- The District of Columbia
- The Commonwealth of Puerto Rico
- The U.S. Virgin Islands
- Guam
- The Commonwealth of the Northern Mariana Islands
- American Samoa
- Territorial waters adjoining the land areas of the U.S. (for services furnished on board a ship)

A hospital is considered outside the U.S. if it is not physically located in one of the jurisdictions listed above, even if owned or operated by the U.S. Government.

Exceptions

These services may be covered:

- Emergency inpatient hospital services at a foreign hospital that may be closer to, or more accessible from, the emergency site than the nearest U.S. hospital. One of these conditions must also exist:
 - The beneficiary was physically present in the U.S. at the time of the emergency.
 - The beneficiary was physically present in Canada when the emergency arose, and they were traveling by the most direct route without unreasonable delay between Alaska and another State.
- Emergency or nonemergency inpatient hospital services furnished by a hospital outside the U.S. provided the hospital is closer to, or substantially more accessible from, the beneficiary's U.S. residence than the nearest participating U.S. hospital.
- Physician and ambulance services by a covered foreign inpatient hospital when these criteria are met:
 - The physician is legally authorized to practice in the country where they furnish the services
 - The ambulance supplier meets Medicare's definition of an ambulance
- Services furnished on board a ship in a U.S. port or furnished within 6 hours of when the ship arrived or departed. If services do not meet this requirement, they are considered furnished outside U.S. territorial waters, even if the ship is of U.S. registry.

C. Items and Services Required as a Result of War

Medicare does not cover items and services required because of war or an act of war that occur after the effective date of the beneficiary's current entitlement.

D. Personal Comfort Items and Services

Medicare does not cover personal comfort items, because these items do not meaningfully contribute to the treatment of a beneficiary's illness or injury or the functioning of a malformed body member. Some examples of personal comfort items include:

- Radios
- Televisions
- Beauty and barber services, with certain exceptions

When a beneficiary requests a personal comfort item, inform them there is a specified charge for the item. The specified charge may not exceed the customary charge, and future charges may not exceed the amount specified. You cannot require the beneficiary to request noncovered items or services as a condition of admission or continued stay.

Exceptions

Medicare may cover certain basic personal resident services in a Skilled Nursing Facility (SNF) or general psychiatric hospital when they cannot perform them for themselves. Some examples include:

- Shaves
- Haircuts
- Shampoos
- Simple hair sets

Medicare may consider these ordinary resident care and covered costs reimbursable under Part A when they are:

- Furnished by a long-stay institution
- Included in the flat rate charge
- Routinely furnished without charge to the beneficiary

E. Routine Physical Checkups; Certain Eye Examinations, Eyeglasses, and Lenses; Hearing Aids and Examinations; and Certain Immunizations

Medicare does not cover these routine items and services:

- Routine or annual physical checkups, with certain exceptions
- Physical examinations performed without a specific sign, symptom, beneficiary complaint, or third-party requirements such as insurance companies, business establishments, or Government agencies
- Eye examinations for prescribing, fitting, or changing eyeglasses
- Eye refractions furnished by practitioners for any purpose
- Eyeglasses and contact lenses
- Hearing aid examinations
- Hearing aids
- Immunizations, with certain exceptions

Exceptions

Medicare may cover these items and services:

- Physician services to diagnose and treat an eye disease, such as glaucoma or cataracts
- Incident to physician services in conjunction with an eye disease
- One pair of eyeglasses or contact lenses after each cataract surgery with insertion of an intraocular lens

- Vaccinations directly related to the treatment of an injury or direct exposure to a disease or condition, such as anti-rabies treatment or immune globulin
- Vaccinations specifically covered by statute, such as seasonal influenza virus, pneumococcal, or hepatitis B
- A reasonable supply of antigens (not more than a 12-month supply) prepared for a beneficiary by a doctor of medicine (MD) or a doctor of osteopathy (DO) after examining the beneficiary and determining a treatment plan and dosage regimen
- Cochlear implants and auditory brainstem implants that replace the function of cochlear structures or the auditory nerve and provide electrical energy to auditory nerve fibers and other neural tissue via implanted electrode arrays and osseointegrated implants that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer are covered as prosthetic devices if the hearing aid is medically inappropriate or cannot be used due to:
 - Congenital malformations
 - Chronic disease
 - Severe sensorineural hearing loss
 - Surgery

F. Cosmetic Surgery

Medicare does not cover cosmetic surgery and expenses incurred by cosmetic surgery. Cosmetic surgery includes any procedure to improve the beneficiary's appearance.

Exceptions

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

- Surgery performed for the treatment of severe burns
- Surgery to repair the face following a serious automobile accident
- Surgery for therapeutic purposes that coincidentally serve some cosmetic purpose

G. Items and Services Furnished by the Beneficiary's Immediate Relatives and Members of the Beneficiary's Household

Medicare does not pay for items and services furnished by the beneficiary's immediate relatives and members of the beneficiary's household since these items and services are ordinarily furnished gratuitously because of their relationship. A beneficiary's immediate relatives include the following relationships:

- 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
- Spouse of grandparent or grandchild

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

Members of the beneficiary's household include the following who share a common abode with them 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)

Additionally Medicare does not pay for these items and services:

- Prohibited beneficiary relationship to the physician or supplier furnishing services and an unrelated individual, partnership, or professional corporation submits the charges
- Those services furnished incident to a physician's professional service when the ordering or supervising physician has a prohibited relationship to the beneficiary

A professional corporation:

- Is completely owned by one or more physicians or is owned by other health care professionals as authorized by State law
- Conducts the practice of medicine, osteopathy, dentistry, podiatry, optometry, or chiropractic

Any incorporated physician or group of physicians constitutes a professional corporation. Medicare will not pay for items and services by non-physician suppliers that have a prohibited relationship with the beneficiary and are not incorporated, regardless of whether the supplier is owned by a sole proprietor related to the beneficiary or owned by a partnership where one of the partners is related to the beneficiary. This payment restriction does not apply to a corporation (other than a professional corporation), regardless of the beneficiary's relationship to the corporate stockholders, officers, or directors, or to the individual who furnished the service.

H. Dental Services

Medicare does not cover items and services furnished through the care, treatment, filling, removal, or replacement of teeth or the structures directly supporting the teeth. The structures directly supporting the teeth are the periodontium, including:

- The gingivae
- The dentogingival junction
- The periodontal membrane
- The cementum
- The alveolar process

The beneficiary's hospitalization status has no direct bearing on payment for a given dental procedure.

Exceptions

Medicare may cover some dental services such as:

- An X-ray taken in treating a fractured jaw or facial bone
- A tooth extraction to prepare the jaw for neoplastic disease radiation treatments

I. Inpatient Hospital or SNF Services Not Delivered Directly or Under Arrangement by the Provider

Medicare normally excludes coverage for non-physician services to Part A or Part B hospital inpatients or Part A SNF inpatients provided indirectly by the hospital/SNF or under arrangement.

Refer to the [SNF Consolidated Billing](#) webpage for more information about billing SNF bundled services as part of the prospective payment system.

Exceptions

Medicare may cover these items and services:

- 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

Medicare may cover these items and services furnished to Part A SNF inpatients by an authorized provider or supplier if not provided directly or under arrangement:

- 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
- Beneficiary hospice care related to a terminal condition
- Radioisotope services
- Some customized prosthetic devices
- Some chemotherapy and chemotherapy administration services
- These categories of exceptionally intensive outpatient services (along with transportation from the SNF to the hospital and back when the resident's medical condition requires an ambulance) are beyond the typical scope of SNF care plans and require the intensity of the hospital (including a Critical Access Hospital) setting to safely and effectively furnish them (accordingly, this exception does not apply when these services are furnished in an ambulatory surgical center):
 - 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

J. Certain Foot Care Services and Supportive Devices for the Feet

Medicare normally does not cover these foot care services and devices:

- Treatment of flat foot
- Routine foot care, including:
 - Cutting or removing corns and calluses
 - Trimming, cutting, clipping, or debriding nails
 - Other hygienic and preventive maintenance foot care, such as cleaning and soaking feet, use of skin creams to maintain ambulatory or bedridden patient skin tone, and any other service performed in the absence of localized illness, injury, or symptoms
 - Orthopedic shoes and other supportive feet devices

Exceptions

Medicare may cover these devices and services:

- Orthopedic shoes integral to a leg brace
- Therapeutic shoes furnished to diabetics
- Services necessary and an integral part of a covered service, such as the diagnosis and treatment of ulcers, wounds, or infections
- Treatment of foot warts including plantar warts
- Treatment of mycotic nails:
 - For an ambulatory beneficiary, the physician attending the beneficiary's mycotic condition must document:
 - Clinical evidence of toenail mycosis
 - The beneficiary has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate
 - For a non-ambulatory beneficiary, the physician attending the beneficiary's mycotic condition must document:
 - Clinical evidence of toenail mycosis
 - The beneficiary suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate
- Presence of a metabolic, neurologic, and peripheral systemic disease, such as (this is not an all-inclusive list):
 - Diabetes mellitus*
 - Arteriosclerosis obliterans
 - Buerger's disease
 - Chronic thrombophlebitis*
 - Peripheral neuropathies involving the feet:
 - Associated with malnutrition and vitamin deficiency:*
 - ✓ Malnutrition (general, pellagra)
 - ✓ Alcoholism
 - ✓ Malabsorption (celiac disease, tropical sprue)
 - ✓ Pernicious anemia
 - Associated with carcinoma*
 - Associated with diabetes mellitus*
 - Associated with drugs and toxins*
 - Associated with multiple sclerosis*

- Associated with uremia (chronic renal disease)*
- Associated with traumatic injury
- Associated with leprosy or neurosyphilis
- Associated with hereditary disorders:
 - ✓ Hereditary sensory radicular neuropathy
 - ✓ Angiokeratoma corporis diffusum (Fabry's)
 - ✓ Amyloid neuropathy

* Medicare covers routine procedures for this condition, when the beneficiary is under the active care of an MD or DO who has documented the condition.

K. Investigational Devices

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

L. Services Related to and Required as a Result of Services Not Covered

Medicare does not pay medical and hospital services related to, and required as a result of, services not covered, such as:

- Cosmetic surgery
- Noncovered organ transplants
- Follow-up care or complications care requiring treatment during a hospital stay when a noncovered service is performed

Exceptions

Medicare may cover unrelated services when a beneficiary is hospitalized for a noncovered service and requires services not related to the noncovered service, such as the beneficiary breaks a leg while in the hospital for a noncovered service. Medicare may cover the services to treat the broken leg since it is unrelated to the noncovered service.

Medicare may cover reasonable and necessary medical or hospital services when a beneficiary is discharged from a hospital stay and received noncovered services and subsequently requires services to treat a condition or complication that arose from the noncovered services, such as:

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

Medicare does not pay subsequent services normally incorporated into a global fee. Medicare considers the services paid.

Services and Supplies Denied as Bundled or Included in the Basic Allowance of Another Service

Medicare does not pay services and supplies denied as bundled or included in the basic allowance of another service, such as:

- Fragmented services included in the basic allowance of the initial service
- Indirect prolonged care
- Physician standby services
- Case management services, such as beneficiary telephone calls
- Supplies included in the basic allowance of a procedure

Items and Services Reimbursable by Other Organizations or Furnished Without Charge

A. Services Reimbursable Under the Medicare Secondary Payer Program

Medicare does not pay for items and services when payment was made or one can expect reasonably prompt payment under:

- Automobile insurance
- No-fault insurance
- Liability insurance
- Workers' Compensation law or Plan of the U.S. or a State

Exceptions

Medicare may make payment if the primary payer denied the claim and provided documentation indicating the claim was denied in the following situations:

- The Group Health Plan denies service payment because:
 - The beneficiary is not covered by the health plan
 - Particular service benefits under the plan are exhausted
 - The plan does not cover the services
 - A deductible applies
 - The beneficiary is not entitled to benefits
- Benefits are exhausted, so the no-fault or liability insurer denies payment or does not pay the bill
- The WC Plan denies payment, such as when it is not required to make payment
- The Federal Black Lung Program does not pay the bill

In liability, no-fault, or WC situations, Medicare may make a conditional payment for covered services to prevent beneficiary financial hardship when:

- The prompt claim payment is not expected
- A properly submitted claim was denied in whole or in part
- The beneficiary's physical or mental incapacity prohibits submitting a proper claim with the primary insurer

When Medicare makes a conditional payment, the insurer and/or the beneficiary reimburses Medicare to the extent the insurer makes subsequent payment.

B. Items and Services Authorized or Paid by a Government Entity

Medicare normally does not pay for these items and services authorized or paid by a Government entity:

- Those furnished by a Government or non-Government provider or other individual at public expense authorized by a Federal agency, such as the Veterans Administration.
- Those furnished by a Federal provider or agency that generally provides services to the public as a community institution or agency (this does not include hospitals, SNFs, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities). Medicare may pay Federal hospitals, like other nonparticipating hospitals, for emergency inpatient and outpatient hospital services.
- Those a Federal, State, or local Government entity directly or indirectly pays for or furnishes without expectation of payment from any source and without regard to the individual's ability to pay.
- Those that a non-Government provider or supplier furnishes and the charges are paid by a Government program other than Medicare or where the provider or supplier intends to receive payment from another Government program (unless the payment by the other program is limited to Medicare deductible and coinsurance amounts).

C. Items and Services the Beneficiary, Another Individual, or an Organization Has No Legal Obligation to Pay For or Furnish

Medicare does not pay when the beneficiary, another individual, or an organization has no legal obligation to pay for or furnish the items or services, such as:

- X-rays or immunizations gratuitously furnished to the beneficiary without regard to their ability to pay and without expectation of payment from any source.
- A volunteer ambulance transport company. If the ambulance company asks but no donation is required from the beneficiary to help offset the cost of the service, there is no enforceable legal obligation for the beneficiary or any other individual to pay for the service.
- A device or item that is provided at no cost to the provider of service.

When a provider or supplier furnishes items or services without charge to indigent Medicare beneficiaries and without charge to non-Medicare indigent individuals (because of their inability to pay), this payment exclusion does not apply if the provider or supplier bills its other non-indigent individuals.

D. Defective Equipment or Medical Devices Covered Under Warranty

Medicare does not pay for defective medical equipment or medical devices under warranty if replaced free of charge by the warrantor or if an acceptable replacement was available free of charge under the warranty, but was purchased instead.

Exceptions

When a hospital or other service provider replaces defective equipment or medical devices under warranty, Medicare may cover them despite the warrantor's liability.

Medicare may pay for defective equipment or medical devices, such as:

- When a replacement from another manufacturer is substituted because the replacement offered under the warranty is unacceptable to the beneficiary or their physician
- If the warrantor supplied defective equipment or medical devices and a charge or a pro rata payment is imposed, Medicare may make a partial payment
- Medicare limits payment to the warranty amount they would have paid if they could have purchased an acceptable replacement at a reduced price under a warranty, but they paid the full price to the original manufacturer or a new replacement was purchased from a different manufacturer or other source

ADVANCE BENEFICIARY NOTICES

You must give written notice to a Fee-For-Service Medicare beneficiary before furnishing items or services Medicare usually covers but you do not expect them to pay in a specific instance for certain reasons, such as no medical necessity.

RESOURCES

Table 1. Resources

| For More Information About... | Resource |
|--|---|
| Beneficiary Notices Initiative | CMS.gov/Medicare/Medicare-General-Information/BN |
| Claims Processing for Preventive Services Chapter 18 of the Medicare Claims Processing Manual | CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf |
| Coverage Criteria for Preventive Services Chapter 15 of the Medicare Benefit Policy Manual | CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf |
| Covered Services Via Medicare National Coverage Determinations | CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html |
| Eldercare Locator | ElderCare.gov |
| Long-Term Care | LongTermCare.acl.gov |
| Medicare Claims Processing Manual | CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html |
| Medicare Secondary Payer Manual | CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html |
| MLN Catalog | CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf |
| Noncovered Services Chapters 1, 6, 8, 9, 15, and 16 of the Medicare Benefit Policy Manual | CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html |
| Notifying Beneficiary of Noncoverages Chapter 30 of the Medicare Claims Processing Manual | CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf |
| Preventive Services Provider Resources | CMS.gov/Medicare/Prevention/PrevntionGenInfo/ProviderResources.html |

Table 2. Hyperlink Table

| Embedded Hyperlink | Complete URL |
|--|---|
| Medicare Preventive Services | https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243319.html |
| Section 1862(e) of the Social Security Act | https://www.ssa.gov/OP_Home/ssact/title18/1862.htm#act-1862-e |
| SNF Consolidated Billing | https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling |

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