



ITEMS & SERVICES NOT COVERED UNDER MEDICARE

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Updates

Note: No substantive content updates.

Introduction

This booklet outlines the 4 categories of items and services Medicare doesn't cover and exceptions (items and services Medicare may cover). This material isn't an all-inclusive list of items and services Medicare may or may not cover.

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

The term "patient" refers to a Medicare beneficiary.

Categories of Items & Services Not Covered Under Medicare

Learn about these 4 categories of items and services Medicare doesn't 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 discusses exceptions and lists items and services Medicare may cover.

Medically Unreasonable & Unnecessary Services & Supplies

Medicare doesn't pay for medically unreasonable and unnecessary services and supplies to diagnose and treat a patient's condition. Some examples include:

- Hospital furnished services that, based on the patient's condition, could have been furnished in a lower-cost setting, such as the patient'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 for which the patient has no symptoms or diagnoses, except for certain screening tests, examinations, and therapies
- Unnecessary services based on the diagnosis of the patient, such as transcendental meditation
- Items and services administered to a patient to cause or assist in death (assisted suicide)

Services must meet specific medical necessity requirements in the statute, regulations, 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 patient complaint that makes the service reasonable and necessary.

Exceptions

Medicare may cover these items and services:

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

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

The [Physician Fee Schedule Relative Value Files](#) webpage shows coding and payment for items and services that Medicare may cover.

Noncovered Items & Services

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

Medicare Fee-for-Service doesn't cover custodial care in the patient's home or an institution.

Custodial care is personal care that requires **no** trained medical or paramedical personnel continuing attention and serves to help 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

WHO COVERS?

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, don't cover long-term care.

Supplement Insurance (Medigap) policies, don't pay for "custodial care." Some patients may be eligible for this type of care through Medicaid.

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

Exceptions

Medicare may cover individual reasonable and necessary services under Part B even though Part A denies coverage of a patient's overall hospital or skilled nursing facility (SNF) stay, because it's 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 treat the patient's illness or injury even though the hospitalization or SNF stay isn't covered because it's for custodial care. Similarly, custodial care doesn't preclude payment for a Part B claim for medically necessary ancillary services.

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

B. Items & Services Furnished Outside the United States

Medicare doesn't cover most items and services delivered outside the United States (U.S.) including when the patient purchased the item in the U.S. or purchased the item from an American firm. Additionally, Medicare won't pay for a medical service sub-contracted to another provider or supplier outside the U.S.

Medicare doesn't pay for provider professional services outside the U.S., except for certain limited 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 onboard a ship)

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

Exceptions

Medicare 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. One of these conditions must also exist:
 - 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 arose and traveling by the most direct route without unreasonable delay between Alaska and another state.
- Emergency or non-emergency inpatient hospital services furnished by a hospital outside the U.S. if the hospital is closer to, or substantially more accessible from, the patient's U.S. residence than the nearest participating U.S. hospital.
- Physician and ambulance services by a covered foreign inpatient hospital when they meet these criteria:
 - 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 onboard a ship in a U.S. port or furnished within 6 hours of when the ship arrived or departed. If services don't meet this requirement, Medicare considers them furnished outside U.S. territorial waters, even if the ship is of U.S. registry.

C. Items & Services Required as a Result of War

Medicare doesn't cover items and services required because of war or an act of war that occur after the effective date of the patient's current entitlement.

D. Personal Comfort Items & Services

Medicare doesn't cover personal comfort items because these items don't meaningfully contribute to treating a patient'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 patient requests a personal comfort item, inform them there's 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 can't require the patient 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 SNF or general psychiatric hospital when they can't 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're:

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

E. Routine Physical Checkups; Certain Eye Examinations, Eyeglasses & Lenses; Hearing Aids & Examinations; Chiropractor Services; & Certain Immunizations

Medicare doesn't cover these routine items and services:

- Routine or annual physical checkups, with certain exceptions

- Physical examinations performed without a specific sign, symptom, patient 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
- Chiropractors' services other than manual manipulation of the spine to correct a subluxation of the spine specified as legal in the state where performed
- 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 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 the function of cochlear structures or the auditory nerve and give electrical energy to auditory nerve fibers and other neural tissue via implanted electrode arrays
- Osseointegrated implants that replace the function of the middle ear and give mechanical energy to the cochlea via a mechanical transducer as prosthetic devices if the hearing aid is medically inappropriate or the patient can't use them due to:
 - Congenital malformations
 - Chronic disease
 - Severe sensorineural hearing loss
 - Surgery

F. Cosmetic Surgery

Medicare doesn't cover cosmetic surgery and expenses incurred by cosmetic surgery. Cosmetic surgery includes any procedure to improve the patient'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 for treating severe burns
- Surgery for repairing the face after a serious automobile accident
- Surgery for therapeutic purposes that coincidentally serve some cosmetic purpose

G. Items & Services Furnished by the Patient's Immediate Relatives & Members of the Patient's Household

Medicare doesn't pay for items and services furnished by the patient's immediate relatives and members of the patient's household since these items and services are ordinarily furnished at no charge 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
- 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 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)

Additionally, Medicare doesn't pay for these items and services:

- Prohibited patient 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 patient

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 doesn't pay for items and services by non-physician suppliers that have a prohibited relationship with the patient and are unincorporated, regardless of whether the supplier is owned by a sole proprietor related to the patient or owned by a partnership where one of the partners is related to the patient. This payment restriction doesn't apply to a corporation (other than a professional corporation), regardless of the patient's relationship to the corporate stockholders, officers, or directors, or to the individual who furnished the service.

H. Dental Services

Medicare doesn't cover items and services for the care, treatment, filling, removal, or replacement of teeth or the structures directly supporting the teeth, such as preparing the mouth for dentures, or removing diseased teeth in an infected jaw. The structures directly supporting the teeth are the periodontium, including:

- The gingivae
- The dentogingival junction
- The periodontal membrane
- The cementum
- The alveolar bone (alveolar process and tooth sockets)

Regardless of whether Medicare covers the inpatient hospital services, the Plan doesn't cover medical services furnished by physicians connected to noncovered dental services.

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.
- An oral or dental examination performed on an inpatient basis as part of comprehensive workup prior to renal transplant surgery or performed in a Rural Health Center or Federally Qualified Health Center prior to heart valve replacement.
- If a dentist performs an otherwise noncovered procedure or service as "incident to," and an integral part of a covered procedure or service performed by the dentist, Medicare covers the total service performed by the dentist. For example, wiring teeth when done for treating a jaw fracture.

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 unless those services are provided either directly by the hospital/SNF or under an arrangement that the hospital/SNF makes with an outside source.

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

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 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
- Patient 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), which CMS has determined 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 (this exception doesn't apply when the patient gets these services 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 & Supportive Devices for the Feet

Medicare normally doesn't 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, using skin creams to maintain ambulatory or bedridden patient skin tone, and other services 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 patient, the physician attending the patient's mycotic condition must document:
 - Clinical evidence of toenail mycosis
 - The patient has marked limitation of ambulation, pain, or secondary infection resulting from the 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
 - The patient 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 isn't 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 patient is under the active care of an MD or DO who 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 & Required as a Result of Services Not Covered

Medicare doesn't 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 performing a noncovered service

Exceptions

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

Medicare may cover reasonable and necessary medical or hospital services when a patient is discharged from a hospital stay and got 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 doesn't pay subsequent services normally incorporated into a global fee. Medicare considers the services paid.

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

Medicare doesn't 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 patient telephone calls
- Supplies included in the basic allowance of a procedure

Items & Services Reimbursable by Other Organizations or Furnished Without Charge

A. Services Reimbursable Under the Medicare Secondary Payer Program

Medicare doesn't 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 (WC) law or plan of the U.S. or a state

Exceptions

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

- The 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 the no-fault or liability insurer denies payment or doesn't pay the bill
- The WC Plan denies payment, such as when it isn't required to make payment
- The Federal Black Lung Program doesn't pay the bill

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

- The 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 Medicare makes a conditional payment, the insurer and/or the patient reimburses Medicare to the extent the insurer makes subsequent payment.

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

Medicare normally doesn't 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. Medicare 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 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 a government program other than Medicare pays the charges or where 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](#) amounts).

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

Medicare doesn't pay when the patient, 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 patient 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 requires no donation from the patient to help offset the cost of the service, there's no enforceable legal obligation for the patient or any other individual to pay for the service.
- A device or item given at no cost to the provider of service.

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

D. Defective Equipment or Medical Devices Covered Under Warranty

Medicare doesn't 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 patient 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 Patient Notices

To transfer potential financial liability to the patient, you must give written notice to a Fee-for-Service Medicare patient before furnishing items or services Medicare usually covers but you don't expect them to pay in a specific instance for certain reasons, such as no medical necessity.

Key Takeaways

- Medicare doesn't cover items and services in these 4 categories:
 - Medically unreasonable and necessary
 - Noncovered items and services
 - Services and supplies denied as bundled or included in the basic allowance of another service
 - Items or services reimbursable by other organizations or given without charge
- Exceptions exist for each category of items and services not covered.
- Give an advanced written notice to a patient in situations when Medicare payment is expected to be denied.

Resources

- [Beneficiary Notices Initiative](#)
- [Claims Processing for Preventive Services — Chapter 18 of the Medicare Claims Processing Manual](#)
- [Coverage Criteria for Preventive Services — Chapter 15 of the Medicare Benefit Policy Manual](#)
- [Covered Services Via Medicare National Coverage Determinations](#)
- [Elder Care Locator](#)
- [Long-Term Care](#)
- [Medicare Claims Processing Manual](#)
- [Medicare Secondary Payer Manual](#)
- [Noncovered Services — Chapters 1, 6, 8, 9, 15, and 16 of the Medicare Benefit Policy Manual](#)
- [Notifying Beneficiary of Noncoverage — Chapter 30 of the Medicare Claims Processing Manual](#)
- [Preventive Services Provider Resources](#)

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