

Title 23: Division of Medicaid

Part 200: General Provider Information

Chapter 2: Benefits

Rule 2.2: Non-Covered Services

- A. The Division of Medicaid does not cover certain items and services including, but not limited to, the following:
1. Items or services which are furnished gratuitously without regard to the beneficiary's ability to pay and without expectation of payment from any source, including, but not limited to:
 - a) Free diagnostic services provided by a health department, and
 - b) Services provided as part of a health fair.
 2. Services provided by the following except as specified by the State Plan or a 1915(c) waiver:
 - a) Anyone legally responsible for a beneficiary/participant,
 - b) An individual, corporation, partnership or other organization which has assumed the responsibility for the care of a beneficiary, but does not include the Division of Medicaid, a licensed hospital, or a licensed nursing home within the state,
 - c) The following family members:
 - 1) Spouse,
 - 2) Parent, step-parent or foster parent,
 - 3) Child, step-child, grandchild or step-grandchild,
 - 4) Grandparent or step-grandparent,
 - 5) Sibling or step-sibling, or
 - d) Anyone who resides in the home with the beneficiary regardless of relationship.
 3. Services provided by a registered nurse (RN) or licensed practical nurse (LPN) to their family members, as defined in Miss. Admin. Code Part 200, Rule 2.2 A.2.c).

4. Services denied by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or its designee.
 5. Services, procedures, supplies or drugs still in clinical trials deemed as investigational or experimental in nature.
 6. Procedures, products and services for conditions and indications not approved by the Federal Drug Administration (FDA) and/or that do not follow medically accepted indications and dosing limits supported by one (1) or more of the official compendia as designated by the Centers for Medicare and Medicaid Services (CMS) including, but not limited to:
 - a) Physician administered drugs and implantable drug system devices,
 - b) Skin and tissue substitutes, and/or
 - c) Implantable medical devices.
 7. Any operative procedure, or any portion of a procedure, performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.
 8. Reconstructive breast procedures performed to produce a symmetrical appearance.
 9. Infertility studies, procedures to enhance fertility including reversal of sterilization, artificial or intrauterine insemination, or in-vitro fertilization.
 10. Gastric surgery techniques or procedures for the treatment of obesity or weight control, regardless of medical necessity.
 11. Routine foot care in the absence of systemic conditions.
 12. Prosthetic or orthotic devices, and orthopedic shoes except crossover claims allowed by Medicare.
 13. Services provided to Specified Low Income Medicare Beneficiaries (SLMB), Qualified Medicare Beneficiaries (QMB), and Qualifying Individuals (QI) except as described in Miss. Admin. Code Part 200, Rule 3.4.
- B. The Division of Medicaid does not cover items or services not directly related to the treatment of an illness or injury, including, but not limited to:
1. Television except as described in Miss. Admin. Code Part 207,
 2. Massage,
 3. Haircuts except as described in Miss. Admin. Code Part 207,

4. Interest on late pay claims,
 5. Telephone contacts/consultations,
 6. Missed or cancelled appointments, or
 7. Wigs.
- C. The Division of Medicaid does not reimburse for items and services ordered, prescribed, administered, supplied or provided by providers, entities, or financial institutions who:
1. Have been excluded by the Department of Health and Human Services (DHHS),
 2. Have been excluded by Medicare,
 3. Are no longer licensed by their governing board(s),
 4. Are respiratory therapists requesting direct payment for services,
 5. Are freestanding substance abuse rehabilitation centers,
 6. Are free-standing psychiatric facilities.
 7. Are located outside of the United States,
 8. Are not currently enrolled as a Mississippi Medicaid provider, or
 9. Have not conducted criminal history records checks on each employee of the entity hired since 1989 who provides, and/or would provide direct patient care or services to adults or vulnerable persons in accordance with the Mississippi Vulnerable Persons Act.
- D. The Division of Medicaid does not cover the following three (3) Never Events in the inpatient hospital, outpatient hospital and other types of healthcare settings:
1. Wrong surgery or other invasive procedure performed on a beneficiary,
 2. Surgical or other invasive procedure performed on the wrong body part, or
 3. Surgical or other invasive procedure performed on the wrong beneficiary.
- E. The Division of Medicaid does not cover inpatient hospital Health Care-Acquired Conditions (HCACs) as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric beneficiaries.

- F. The Division of Medicaid does not cover nursing facility services, hospice services or enrollment in more than one (1) Home and Community Based Services (HCBS) waiver program including, but not limited to:
1. Elderly and Disabled (E&D) Waiver,
 2. Independent Living (IL) Waiver,
 3. Assisted Living (AL) Waiver,
 4. Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver, or
 5. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver.
- G. Services not specifically listed or defined by the Division of Medicaid are not covered, unless part of the expanded Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
- H. The Division of Medicaid does not reimburse for any exclusion listed elsewhere in the Miss. Admin. Code Title 23, Mississippi Medicaid Bulletins, or other Mississippi Medicaid publications.

Source: 42 USC § 1396n, 49 USC § 1185b; Miss. Code Ann. §§ 43-13-121, 43-47-7; SPA 2011-006, 2012-001; 30 Miss. Admin. Code Part 2820, Rule 1.2 S.2).

History: Added a New Miss. Admin. Code Part 200, Rule 2.2 A.2.a)-d) and C.9., reformatted and revised Miss. Admin. Code Part 200, Rule 2.2 including removing duplicative language, effective 12/01/2015; Added Miss. Admin. Code Part 200, Rule 2.2 A. 36. and Rule 2.2 D. eff. 10/01/2014; Rule 2.2 B. and 2.2 C. added to correspond with approved SPA 2011-004 and 2011-006 effective 10/01/11 and SPA 2012-001 effective 06/01/2012.

Title 23: Division of Medicaid

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Chapter 2: Benefits

Rule 2.2: Non-Covered Services

A. The Division of Medicaid does not cover certain items and services, including, but not limited to, the following:

1. Items or services which are furnished gratuitously without regard to the ~~individual beneficiary's~~ ability to pay and without expectation of payment from any source, ~~such as~~ including, but not limited to:

a) ~~Free x-rays~~ diagnostic services provided by a health department, ~~and~~

b) Services provided as part of a health fair.

2. Services provided by the following except as specified by the State Plan or a 1915(c) waiver:

a) Anyone legally responsible for a beneficiary/participant,

b) An individual, corporation, partnership or other organization which has assumed the responsibility for the care of a beneficiary, but does not include the Division of Medicaid, a licensed hospital, or a licensed nursing home within the state, or

c) The following family members:

1) Spouse,

2) Parent, step-parent or foster parent,

3) Child, step-child, grandchild or step-grandchild,

4) Grandparent or step-grandparent,

5) Sibling or step-sibling, or

d) Anyone who resides in the home with the beneficiary regardless of relationship.

~~2. Any operative procedure, or any portion of a procedure, performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.~~ [Moved to Miss. Admin. Code Part 200, Rule 2.2 A.7.]

3. Services provided by a registered nurse (RN) or licensed practical nurse (LPN) to their family members, as defined in Miss. Admin. Code Part 200, Rule 2.2 A.2.c).

144. Services denied by ~~the~~ Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or its designee.

~~3. Routine physical examinations, such as school, sports, or employment physicals that are not part of the well-child screening program for beneficiaries under twenty one (21) years of age. [Duplicative language removed, refer to Miss. Admin. Code Part 200, Rule 5.3]~~

5. Services, procedures, supplies or drugs still in clinical trials deemed as investigational or experimental in nature.

~~4. Routine physical examinations not covered through provisions set forth in Miss. Admin. Code, Part 200, Chapter 5, Rule 5.3 Physical Examinations. [Duplicative language removed, refer to Miss. Admin. Code Part 200, Rule 5.3]~~

6. Procedures, products and services for conditions and indications not approved by the Federal Drug Administration (FDA) and/or that do not follow medically accepted indications and dosing limits supported by one (1) or more of the official compendia as designated by the Centers for Medicare and Medicaid Services (CMS) including, but not limited to:

a) Physician administered drugs and implantable drug system devices,

b) Skin and tissue substitutes, and/or

c) Implantable medical devices.

~~5. Routine physical examinations not covered under benefits provided through the Roads to Good Health Wellness Program as outlined in Miss. Admin. Code, Part 200, Chapter 5, Rule 5.4 Wellness Program. [Duplicative language removed, refer to Miss. Admin. Code Part 200, Rule 5.3]~~

7. Any operative procedure, or any portion of a procedure, performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

~~6. Immunizations, except as indicated in Miss. Admin. Code, Part 224, Chapter 1 or other preventive health services that are not a part of the screening program for beneficiaries under twenty one (21) years of age. [Duplicative language removed, refer to Miss. Admin. Code Part 224]~~

834. Reconstructive breast procedures performed to produce a symmetrical appearance.

- ~~7. Immunizations for adults other than flu or pneumonia not related to treatment of injury or direct exposure to a disease such as rabies or tetanus. [Duplicative language removed, refer to Miss. Admin. Code, Part 224, Rule 1.4]~~
9. Infertility studies, procedures to enhance fertility including reversal of sterilization, artificial or intrauterine insemination, or in-vitro fertilization.
- ~~8. Services provided by a home health agency to a beneficiary who is a resident of a nursing home. [Duplicative language removed, refer to Miss. Admin. Code Part 215, Rule 1.1]~~
10. Gastric surgery including any techniques or procedures for the treatment of obesity or weight control, regardless of medical necessity.
11. Routine foot care in the absence of systemic conditions.
129. Prosthetic or orthotic devices, and orthopedic shoes for beneficiaries twenty-one (21) years of age or older, except for crossover claims allowed by Medicare.
- ~~10. Hospital inpatient items not directly related to the treatment of an illness or injury, such as TV, massage, haircuts, and the like. [Moved to Miss. Admin. Code Part 200, Rule 2.2 B.1.-3.1]~~
- ~~11. Psychological evaluations and testing by a psychologist, except when performed as an inpatient hospital service and billed on a hospital claim form or as a part of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program for children under twenty-one (21) years of age. [Deleted, refer to Miss. Admin. Code Part 206]~~
- ~~12. Vitamin injections, except for B-12 as specific therapy for certain anemias such as fish tapeworm anemia, other B-12 complex deficiencies, pernicious anemia, vitamin B-12 deficiency anemia, atrophic gastritis, idiopathic steatorrhea, sprue, blind-loop syndrome, partial or total gastrectomy, pancreatic steatorrhea, and other specified intestinal malabsorption. [Duplicative language removed, refer to Miss. Admin. Code Part 214, Rule 1.3]~~
- ~~13. Select prescription vitamins and mineral products except for prenatal vitamins for women up to age forty-five fifty (45), fluorinated vitamins for beneficiaries up to age twenty-one (21), and certain renal vitamins for dialysis patients receiving dialysis. [Duplicative language removed, refer to Miss. Admin. Code Part 214]~~
134. Reimbursement for services provided to only Specified Low Income Medicare Beneficiaries (SLMB), Qualified Medicare Beneficiaries (QMB), and Qualifying Individuals (QI) except as described in Miss. Admin. Code Part 200, Rule 3.4 ~~for Medicare/Medicaid crossover payments of Medicare deductibles and coinsurance.~~
- ~~14. Services denied by the Utilization Management/Quality Improvement Organization (UM/QIO). [Moved to Miss. Admin. Code Part 200, Rule 2.2 A.4.]~~

~~15. Routine circumcisions for newborn infants.~~ [Duplicative language removed, refer to Miss. Admin. Code Part 203, Rule 4.12]

B10. The Division of Medicaid does not cover ~~Hospital inpatient~~ items or services not directly related to the treatment of an illness or injury, such as including, but not limited to:

1. ~~TV~~Television except as described in Miss. Admin. Code Part 207.,
2. ~~m~~Massage,
3. ~~h~~Haircuts except as described in Miss. Admin. Code Part 207, ~~and the like.~~

~~4~~16. Interest on late pay claims,

5. Telephone contacts/consultations,
6. Missed or cancelled appointments, or
7. Wigs.

~~17. Physician assistants prior to July 1, 2001.~~

C. The Division of Medicaid does not reimburse for items and services ordered, prescribed, administered, supplied or provided by providers, entities, or financial institutions who:

1. Have been excluded by the Department of Health and Human Services (DHHS),
2. Have been excluded by Medicare,
3. Are no longer licensed by their governing board(s),
4. Are respiratory therapists requesting direct payment for services,

~~5~~18. Are —Ffreestanding substance abuse rehabilitation centers, ~~and~~

6. Are free-standing psychiatric facilities, ~~for beneficiaries twenty-one (21) years of age or older.~~

~~7. Bill for Physician Assistant services provided prior to July 1, 2001,~~

7. Are located outside of the United States,
8. Are not currently enrolled as a Mississippi Medicaid provider, or

9. Have not conducted criminal history records checks on each employee of the entity hired since 1989 who provides, and/or would provide direct patient care or services to adults or vulnerable persons in accordance with the Mississippi Vulnerable Persons Act.
- ~~19. Reimbursement for services provided to only Qualified Medicare Beneficiaries (QMB) except for Medicare/Medicaid crossover payments of Medicare deductibles and coinsurance. [Moved to Miss Admin. Code Rule 2.2 A.13. and reworded]~~
- ~~20. Medicare deductibles and co insurance will not be paid for QMBs in non Medicaid eligible facilities. [Moved to Miss. Admin Code Part 200, Rule 2.2 C.8. and reworded]~~
- ~~21. Reimbursement for any Medicaid service for Specified Low income Medicare Beneficiaries (SLMB) and Qualified Individuals (QI). These individuals are entitled only to payment or partial payment of their Medicare Part B premium. [Moved to Miss. Admin. Code Part 200, Rule 2.2 A.13. and reworded]~~
- ~~22. Infertility studies, procedures to enhance fertility including reversal of sterilization, artificial or intrauterine insemination or in vitro fertilization. [Moved to Miss. Admin. Code Part 200, Rule 2.2 A.9.]~~
- ~~23. Services, procedures, supplies or drugs still in clinical trials deemed as investigational or experimental in nature. [Moved to Miss. Admin. Code Part 200, Rule 2.2 A.5.-6.]~~
- ~~24. Routine foot care in the absence of systemic conditions. [Moved to Miss. Admin. Code Part 200, Rule 2.2 A.11.]~~
- ~~25. Gastric surgery including any technique or procedure for the treatment of obesity or weight control, regardless of medical necessity. [Moved to Miss. Admin. Code Part 200 Rule 2.2 A.10.]~~
- ~~26. Telephone contacts/consultations and missed or cancelled appointments. [Moved to Miss. Admin. Code Part 200, Rule 2.2 B 5.-6.]~~
- ~~27. Wigs. [Moved to Miss. Admin. Code Part 200, Rule 2.2 B.7.]~~
- ~~28. Services ordered, prescribed, administered, supplied or provided by an individual or entity that has been excluded by the Department of Health and Human Services (DHHS). [Moved to Miss. Admin. Code Part 200, Rule 2.2 C.1.]~~
- ~~29. Services ordered, prescribed, administered, supplied or provided by an individual or entity that is no longer licensed by their governing board. [Moved to Miss. Admin. Code Part 200, Rule 2.2 C.3.]~~
- ~~30. Items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States. [Moved to Miss. Admin. Code Part 200, Rule 2.2. C.7.]~~

~~31. Services not specifically listed or defined by the Division of Medicaid are not covered, unless part of the expanded EPSDT benefit. [Moved to Miss. Admin. Code Part 200, Rule 2.2 G.]~~

~~32. Any exclusion listed elsewhere in the Title 23 Medicaid Administrative Code, bulletins, or other Mississippi Medicaid publications. [Moved to Miss. Admin. Code Part 200, Rule 2.2 H.]~~

~~33. Health fairs. [Moved to Miss. Admin. Code Part 200, Rule 2.2 A.1.b.]~~

~~34. Reconstructive breast procedures performed to produce a symmetrical appearance. The Women's Health and Cancer Rights Act (WHCRA) signed into law on October 21, 1998 does not apply to Medicaid. [Moved to Miss. Admin. Code Part 200, Rule 2.2 A.8.]~~

~~35. Direct reimbursement to respiratory therapists as they are not eligible for enrollment as a MS Medicaid provider. [Moved to Miss. Admin. Code Part 200, Rule 2.2 C.4.]~~

~~36. Procedures, products and services for conditions and indications not approved by the Federal Drug Administration (FDA) or that do not follow medically accepted indications and dosing limits supported by one (1) or more of the official compendia as designated by the Centers for Medicare and Medicaid Services (CMS) including, but not limited to: [Moved to Miss. Admin. Code Part 200, Rule 2.2 A.6.]~~

~~a) Physician administered drugs and implantable drug system devices,~~

~~b) Skin and tissue substitutes, and~~

~~c) Implantable medical devices.~~

~~**D.B.** The Division of Medicaid does not cover the following three (3) **N**ever **E**vents in the inpatient hospital, outpatient hospital and other types of healthcare settings:~~

- ~~1. Wrong surgery or other invasive procedure performed on a beneficiary,~~
- ~~2. Surgical or other invasive procedure performed on the wrong body part, or~~
- ~~3. Surgical or other invasive procedure performed on the wrong beneficiary.~~

~~**E.C.** The Division of Medicaid does not cover inpatient hospital Health Care-Acquired Conditions (HCACs) as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric beneficiaries.~~

~~F~~D. The Division of Medicaid does not cover nursing facility services, hospice services or enrollment in more than one (1) Home and Community Based Services (HCBS) waiver program. ~~These HCBS waiver programs~~ include ing, but ~~are~~-not limited to:

1. Elderly and Disabled (E&D) Waiver,
2. Independent Living (IL) Waiver,
3. Assisted Living (AL) Waiver,
4. Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver, ~~and~~or
5. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver.

~~G. 31.~~ Services not specifically listed or defined by the Division of Medicaid are not covered, unless part of the expanded Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

H. The Division of Medicaid does not reimburse for any exclusion listed elsewhere in the Miss. Admin. Code Title 23, Mississippi Medicaid Bulletins, or other Mississippi Medicaid publications.

Source: 42 USC § 1396n, 49 USC § 1185b; ~~Social Security Act § 1915(e); SPA 2012-001; Miss. Code Ann. §§ 43-13-121, 43-47-7; SPA 2011-006, 2012-001; 30 Miss. Admin. Code Part 2820, Rule 1.2 S.2).~~

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