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 or hospice services for beneficiaries enrolled in a Home and Community-Based (HCB) waiver program or enrollment in more than one (1) HCB 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.

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F. The Division of Medicaid does not cover nursing facility services~~,~~ or hospice services for ~~or~~ beneficiaries ~~enrollment~~ enrolled in a ~~more than one (1)~~ Home and Community~~-~~Based (HCB) ~~Services (HCBS)~~ waiver program or enrollment in more than one (1) HCB waiver program including, but not limited to:

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