Title 23: Division of Medicaid

Part 200: General Provider Information

Part 200 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's ability to pay and without expectation of payment from any source, such as free x-rays provided by a health department.

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.

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.

4. Routine physical examinations not covered through provisions set forth in Miss. Admin. Code, Part 200, Chapter 5, Rule 5.3 Physical Examinations.

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.

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.

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.

8. Services provided by a home health agency to a beneficiary who is a resident of a nursing home.

9. 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.

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.

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.

13. Select prescription vitamins and mineral products except for prenatal vitamins for women up to age forty-five (45), fluorinated vitamins for beneficiaries up to age twenty-one (21), and certain renal vitamins for dialysis patients.

14. Services denied by the Utilization Management/Quality Improvement Organization (UM/QIO).

15. Routine circumcisions for newborn infants.

16. Interest on late pay claims.

17. Physician assistants prior to July 1, 2001.

18. Freestanding substance abuse rehabilitation centers and psychiatric facilities for beneficiaries twenty-one (21) years of age or older.

19. Reimbursement for services provided to only Qualified Medicare Beneficiaries (QMB) except for Medicare/Medicaid crossover payments of Medicare deductibles and coinsurance.

20. Medicare deductibles and co-insurance will not be paid for QMBs in non-Medicaid eligible facilities.

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.

22. Infertility studies, procedures to enhance fertility including reversal of sterilization, artificial or intrauterine insemination or in-vitro fertilization.

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

24. Routine foot care in the absence of systemic conditions.

25. Gastric surgery including any technique or procedure for the treatment of obesity or weight control, regardless of medical necessity.

26. Telephone contacts/consultations and missed or cancelled appointments.

27. Wigs.

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).

29. Services ordered, prescribed, administered, supplied or provided by an individual or entity that is no longer licensed by their governing board.

30. Items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States.

31. Services not specifically listed or defined by the Division of Medicaid are not covered, unless part of the expanded EPSDT benefit.

32. Any exclusion listed elsewhere in the Title 23 Medicaid Administrative Code, bulletins, or other Mississippi Medicaid publications.

33. Health fairs.

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.

35. Direct reimbursement to respiratory therapists as they are not eligible for enrollment as a MS Medicaid provider.

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:

    a) Physician administered drugs and implantable drug system devices,

    b) Skin and tissue substitutes, and

    c) Implantable medical devices.

B. 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.

C. The Division of Medicaid does not cover inpatient Health Care-Acquired Conditions (HCAC) 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.

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, but are not limited to:

1. Elderly and Disabled Waiver,

2. Independent Living Waiver,

3. Assisted Living Waiver,

4. Traumatic Brain Injury/Spinal Cord Injury Waiver, and

5. Intellectual Disabilities/Developmental Disabilities Waiver.

Source: Social Security Act § 1915(c); SPA 2011-006; SPA 2012-001; Miss. Code Ann. § 43-13-121.

History: 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.