DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®

Official Information Health Care Professionals Can Trust

Items and Services That Are Not Covered Under the Medicare Program

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PREFACE

This publication provides information about the four categories of items and services that are not covered under the Medicare Program and applicable exceptions (items and services that may be covered). The discussion is not intended to provide an all-inclusive list of all items and services that Medicare may or may not cover.

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

When “you” is used in this publication, we are referring to Medicare providers and suppliers.

This booklet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This booklet was prepared as a service to the public and is not intended to grant rights or impose obligations. This booklet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

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Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

TABLE OF CONTENTS

THE FOUR CATEGORIES OF ITEMS AND SERVICES THAT ARE NOT COVERED UNDER THE MEDICARE PROGRAM AND APPLICABLE EXCEPTIONS 1

Services and Supplies That Are Not Medically Reasonable and Necessary 1

Non-Covered Items and Services 3

- Items and Services Furnished Outside the United States (U.S.) 3
- Items and Services Required as a Result of War 4
- Personal Comfort Items and Services 4
- Routine Physical Checkups; Certain Eye Examinations, Eyeglasses and Lenses; Hearing Aids and Examinations; and Certain Immunizations 5
- Custodial Care 6
- Cosmetic Surgery 7
- Items and Services Furnished by the Beneficiary's Immediate Relatives and Members of the Beneficiary's Household 7
- Dental Services 8
- Non-Physician Services Furnished to Hospital and Skilled Nursing Facility Inpatients That Are Not Provided Directly or Under Arrangement 9
- Certain Foot Care Services and Supportive Devices for the Feet 10
- Investigational Devices 12
- Services Related to and Required as a Result of Services That Are Not Covered 12

Services and Supplies That Have Been Denied as Bundled or Included in the Basic Allowance of Another Service 13

Items and Services Reimbursable by Other Organizations or Furnished Without Charge 13

- Services Reimbursable Under Automobile, No-Fault, or Liability Insurance or Workers' Compensation (the Medicare Secondary Payer Program) 13
- Items and Services Authorized or Paid by a Government Entity 14
- Items and Services for Which the Beneficiary, Another Individual, or an Organization Has No Legal Obligation to Pay For or Furnish 14
- Defective Equipment or Medical Devices Covered Under Warranty 15

BENEFICIARY NOTICES OF NONCOVERAGE 16

RESOURCES 18

THE FOUR CATEGORIES OF ITEMS AND SERVICES THAT ARE NOT COVERED UNDER THE MEDICARE PROGRAM AND APPLICABLE EXCEPTIONS

The following four categories of items and services that are not covered under the Medicare Program are discussed in this publication:

1) Services and supplies that are not medically reasonable and necessary;
2) Non-covered items and services;
3) Services and supplies that have been denied as bundled or included in the basic allowance of another service; and
4) Items and services reimbursable by other organizations or furnished without charge.

Where applicable, exceptions (items and services that may be covered) are also included in this discussion.

1) Services and Supplies That Are Not Medically Reasonable and Necessary

Services and supplies that are not medically reasonable and necessary to the overall diagnosis and treatment of the beneficiary's condition will not be covered. Some examples include:

- Services furnished in a hospital that, based on the beneficiary's condition, could have been furnished in a lower-cost setting (for example, the beneficiary's home or a nursing home);
- Hospital services that exceed Medicare length of stay limitations;
- Evaluation and management services that exceed those considered medically reasonable and necessary;
- Therapy or diagnostic procedures that exceed Medicare usage limits;
- Screening tests, examinations, and therapies for which the beneficiary has no symptoms or documented conditions, with the exception of certain screening tests, examinations, and therapies as described on page 2 under Exceptions;

- Services not warranted based on the diagnosis of the beneficiary (for example, acupuncture and transcendental meditation); and
- Items and services administered to a beneficiary for the purpose of causing or assisting in causing death (assisted suicide).

In general, Medicare-covered services are those services considered medically reasonable and necessary to the overall diagnosis or treatment of the beneficiary's condition or to improve the functioning of a malformed body member. Services or supplies are considered medically necessary if they meet the standards of good medical practice and are:

- Proper and needed for the diagnosis or treatment of the beneficiary's medical condition;
- Furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition; and

- Not mainly for the convenience of the beneficiary, provider, or supplier.

Services must also meet specific medical necessity criteria defined by National Coverage Determinations and Local Coverage Determinations. For every service billed, you must indicate the specific sign, symptom, or beneficiary complaint necessitating the service. Although furnishing a service or test may be considered good medical practice, Medicare generally prohibits payment for services without beneficiary symptoms or complaints or specific documentation.

Exceptions

- Annual Wellness Visit;
- Initial Preventive Physical Examination (also known as the "Welcome to Medicare Preventive Visit");
- Colorectal cancer screening;
- Screening mammography;
- Clinical breast examinations;
- Screening Pap tests;
- Screening pelvic examinations;
- Prostate cancer screening;
- Cardiovascular disease screenings;
- Diabetes screening tests;
- Glaucoma screening;
- Human Immunodeficiency Virus (HIV) screening;
- Bone mass measurements;
- Medical nutrition therapy (for certain beneficiaries diagnosed with diabetes, renal disease, or who have received a kidney transplant within the last 3 years);
- Diabetes Self-Management Training (for beneficiaries diagnosed with diabetes);
- Vaccines;
- Ultrasound screening for abdominal aortic aneurysm;
- Intensive behavioral therapy for cardiovascular disease;
- Intensive behavioral therapy for obesity;
- Counseling to prevent tobacco use for asymptomatic beneficiaries;
- Screening for depression;
- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse; and
- Screening for sexually transmitted infections (STI) and high intensity behavioral counseling to prevent STIs.

Items and services administered for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, may be covered provided they are not furnished for the specific purpose of causing death.

2) Non-Covered Items and Services

A) Items and Services Furnished Outside the United States (U.S.)

Most items and services furnished or delivered outside the U.S. are not covered, including when the beneficiary was within the U.S. when the contract to purchase the item was made or the item was purchased from an American firm. Payment will not be made for a medical service (or a portion thereof) that was subcontracted to another provider or supplier located outside the U.S.

Medicare pays for provider professional services that are furnished in the U.S., except for certain limited services as described below under Exceptions. The Centers for Medicare & Medicaid Services (CMS) recognizes the following as being within the U.S.:

- The 50 States;
- The District of Columbia;
- The Commonwealth of Puerto Rico;
- The Virgin Islands;
- Guam;
- The Commonwealth of the Northern Mariana Islands;
- American Samoa; and
- 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 it is not physically located in one of the jurisdictions listed above, even if it is owned or operated by the U.S. Government.

Exceptions

The following services are covered:

- Emergency inpatient hospital services furnished at a foreign hospital provided the foreign hospital is closer to, or more accessible from, the place the emergency arose than the nearest U.S. hospital that is adequately equipped and available to deal with the emergency. One of the following conditions must exist:
  - The beneficiary was physically present in the U.S. at the time of the emergency that necessitated inpatient services; or
  - The emergency arose in Canada while the beneficiary was traveling, by the most direct route and without unreasonable delay between Alaska and another State;
- Emergency or nonemergency inpatient hospital services furnished by a hospital located 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 that is adequately equipped to deal with and available to treat the illness or injury;

- Physician and ambulance services furnished in connection with a covered foreign hospitalization. Payment will not be made for any other Part B outpatient, medical, and other health services that are furnished outside the U.S.;
- Services furnished onboard a ship in a U.S. port or furnished within 6 hours of when the ship arrived at or departed from a U.S. port. Services that do not meet this requirement are considered furnished outside U.S. territorial waters, even if the ship is of U.S. registry;
- Physician and ambulance services furnished in Canada and covered by the Railroad Retirement Board to a Railroad Retirement beneficiary in connection with covered hospital services; and
- Services for a beneficiary who has elected the religious nonmedical health care benefit; however, the receipt of medical services may revoke the religious nonmedical health care benefit.

B) Items and Services Required as a Result of War

Items and services that are required as a result of war or an act of war and that occur after the effective date of the beneficiary's current entitlement are not covered.

C) Personal Comfort Items and Services

Personal comfort items will not be covered 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 are:

- Radios;
- Televisions; and
- Beauty and barber services, except as described below under Exceptions.

When a beneficiary requests a personal comfort item, you should inform him or her that there is a specified charge for the item. The specified charge may not exceed the customary charge, and future charges may not be more than the amount specified. You cannot require the beneficiary to request non-covered items or services as a condition of admission or continued stay.

Exceptions

Certain basic personal services that residents in Skilled Nursing Facilities (SNF) and general psychiatric hospitals need and cannot perform for themselves are covered. Some examples include:

- Shaves;
- Haircuts;
- Shampoos; and
- Simple hair sets.

These services may be considered ordinary patient care and covered costs are reimbursable under Part A when they are:

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

D) Routine Physical Checkups; Certain Eye Examinations, Eyeglasses and Lenses; Hearing Aids and Examinations; and Certain Immunizations

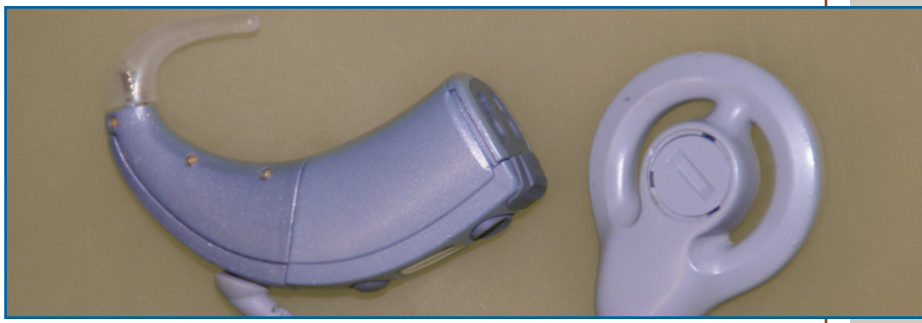
The following routine items and services are not covered:

- Routine or annual physical checkups, except as described in the Exceptions Section under 1) Services and Supplies That Are Not Medically Reasonable and Necessary on page 2;
- Physical examinations that are performed without a specific sign, symptom, or beneficiary complaint necessitating the service or that are required by third parties (for example, insurance companies, business establishments, or Government agencies);
- Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses;
- Eye refractions furnished by all practitioners for any purpose;
- Eyeglasses and contact lenses;
- Examinations for hearing aids;
- Hearing aids; and
- Immunizations, except as described in the Exceptions Section under 1) Services and Supplies That Are Not Medically Reasonable and Necessary on page 2.

Exceptions

The following items and services are covered:

- Physician services performed in conjunction with an eye disease (for example, glaucoma and cataracts);
- Services performed 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 lense;
- Vaccinations directly related to the treatment of an injury or direct exposure to a disease or condition (for example, antirabies treatment and immune globulin);
- Vaccinations that are specifically covered by statute (for example, seasonal influenza virus, pneumococcal, and Hepatitis B);



- A reasonable supply of antigens (not more than a 12-week supply that has been prepared for a particular beneficiary) a doctor of medicine (MD) or a doctor of osteopathy (DO) has prepared after examining the beneficiary and determining a plan of treatment and dosage regimen. A different physician may administer the antigens; and
- Certain devices that produce perception of sound by replacing the function of the middle ear, cochlea, or auditory nerve and are indicated only when hearing aids are medically inappropriate or cannot be utilized due to:
  - Congenital malformations;
  - Chronic disease;
  - Severe sensorineural hearing loss; or
  - Surgery.

These devices, which are payable as prosthetic devices, include:

- 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.

E) Custodial Care

Custodial care furnished in the beneficiary's home or an institution is not covered. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel and serves to assist an individual in the activities of daily living. The following activities are considered custodial care:

- Walking;
- Getting in and out of bed;
- Bathing;
- Dressing;
- Feeding;
- Using the toilet;
- Preparing a special diet; and
- Supervising the administration of medication that can usually be self-administered.

Exceptions

Individual reasonable and necessary services may be covered 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 furnished to a beneficiary who has elected the hospice care option is considered custodial only if it is not reasonable and necessary for the palliation or management of the terminal illness and related conditions.

F) Cosmetic Surgery

Cosmetic surgery and expenses incurred in connection with cosmetic surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving the beneficiary's appearance.

Exceptions

The prompt (as soon as medically feasible) repair of an accidental injury or the improvement of the functioning of a malformed body member are covered. Some examples include:

- Surgery performed in connection with the treatment of severe burns;
- Surgery to repair the face following a serious automobile accident; and
- Surgery for therapeutic purposes that may coincidentally also serve some cosmetic purpose.

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

Payment for items and services furnished by the beneficiary's immediate relatives and members of the beneficiary's household will not be made since these items and services are ordinarily furnished gratuitously because of the relationship between the beneficiary and the provider or supplier.

The following items and services will also not be paid:

- Charges for services furnished by a related physician or supplier that are submitted by an unrelated individual, partnership, or professional corporation; and
- 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; and
- Operated for the purpose of conducting the practice of medicine, osteopathy, dentistry, podiatry, optometry, or chiropractic.

Any physician or group of physicians that is incorporated constitutes a professional corporation. Items and services furnished by non-physician suppliers that have a prohibited relationship with the beneficiary and are not incorporated will not be paid, regardless of whether the supplier is owned by a sole proprietor who is related to the beneficiary or owned by a partnership in which one of the partners is related to the beneficiary. This payment restriction applies only to professional corporations, regardless of the beneficiary's relationship to any of the stockholders, officers, or directors of the corporation or to the individual who furnished the service.

A beneficiary's immediate relatives include the following degrees of relationship:

- Husband and wife;
- Natural or adoptive parent, child, and sibling;
- Stepparent, stepchild, stepbrother, and stepsister;
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
- Grandparent and grandchild; and
- Spouse of grandparent or grandchild.

If the marriage upon which a step- or in-law relationship is based becomes terminated through divorce or death, the prohibited relationship will continue to exist.

Members of the beneficiary's household include the following who share a common abode with him or her as part of a single family unit:

- Individuals who are related by blood, marriage, or adoption;
- Domestic employees; and
- Other individuals who live together as part of a single family unit (does not include roomers or boarders).

H) Dental Services

Items and services that are furnished in connection with the care, treatment, filling, removal, or replacement of teeth or the structures directly supporting the teeth are not covered. The structures that directly support the teeth are the periodontium, which includes:

- The gingivae;
- The dentogingival junction;
- The periodontal membrane;
- The cementum; and
- The alveolar process.

Whether or not the beneficiary is hospitalized has no direct bearing on if payment will be made for a given dental procedure.

Exceptions

Some dental services may be covered depending upon whether the primary procedure that the dentist performs is covered. For example, the following services are covered:

- An x-ray that is taken in connection with the reduction of a fracture of the jaw or facial bone; and
- A tooth extraction that is performed to prepare the jaw for radiation treatments of neoplastic disease.

I) Non-Physician Services Furnished to Hospital and Skilled Nursing Facility Inpatients That Are Not Provided Directly or Under Arrangement

In general, non-physician services furnished to Part A and Part B hospital inpatients and Part A SNF inpatients that are not provided directly or under arrangement are not covered.

Exceptions

The following are covered:

- Physician services furnished to hospital and SNF inpatients (with the exception of therapy, which must be provided by the SNF);
- Physician assistant services;

- Nurse practitioner services;
- Clinical nurse specialist services;
- Certified nurse-midwife services;
- Qualified clinical psychologist services; and
- Certified registered nurse anesthetist services.

The following Part A SNF inpatient services may be covered if they are not provided directly or under arrangement and are furnished by an authorized provider or supplier:

- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies (including related necessary ambulance services);
- Epoetin Alfa (EPO);
- Hospice care related to a beneficiary's terminal condition;
- Radioisotope services;
- Some customized prosthetic devices;

- Some chemotherapy and chemotherapy administration services; and
- The following services that are considered beyond the scope of a SNF when furnished in a participating hospital or Critical Access Hospital, including ambulance services related to such services (does not apply to services furnished in an Ambulatory Surgical Center):
  - Cardiac catheterization;
  - Computerized axial tomography scans;
  - Magnetic resonance imaging;
  - Ambulatory surgery that involves the use of an operating room;
  - Radiation therapy; and
  - Emergency services.

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

The following foot care services and devices are generally not covered, except as described below under Exceptions:

- Treatment of flat foot;
- Routine foot care, which includes:
  - The cutting or removal of corns and calluses;
  - The trimming, cutting, clipping, or debriding of nails;
  - Other hygienic and preventive maintenance care (for example, cleaning and soaking the feet, use of skin creams to maintain skin tone of either ambulatory or bedridden patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot); and
  - Orthopedic shoes and other supportive devices for the feet.

Exceptions

The following devices and services are covered:

- Orthopedic shoes that are an integral part of a leg brace;
- Therapeutic shoes furnished to diabetics;
- Services that are a necessary and integral part of an otherwise covered service (for example, the diagnosis and treatment of ulcers, wounds, or infections);
- Treatment of warts on the foot (including plantar warts);
- Treatment of mycotic nails as follows:
  - For an ambulatory beneficiary, the physician attending the mycotic condition must document that:
    - There is clinical evidence of mycosis of the toenail; and

        - The beneficiary has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and
    - For a non-ambulatory beneficiary, the physician attending the beneficiary's mycotic condition must document that:
        - There is clinical evidence of mycosis of the toenail; and
        - The beneficiary suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and
- Presence of a systemic condition such as one of the following metabolic, neurologic, and peripheral vascular diseases (this is not an all-inclusive list):
    - Diabetes mellitus;*
    - Arteriosclerosis obliterans;
    - Buerger's disease;
    - Chronic thrombophlebitis;* and
    - Peripheral neuropathies that involve the feet:
        - Associated with malnutrition and vitamin deficiency:*
            - Malnutrition (general, pellagra);
            - Alcoholism;
            - Malabsorption (celiac disease, tropical sprue); and
            - 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; and
        - Associated with hereditary disorders:
            - Hereditary sensory radicular neuropathy;
            - Angiokeratoma corporis diffusum (Fabry's); and
            - Amyloid neuropathy.

*For Medicare to cover routine procedures for this condition, the beneficiary must be under the active care of a MD or a DO who has documented the condition.

K) Investigational Devices

Category A devices, as categorized by the U.S. Food and Drug Administration, are considered not medically reasonable and necessary and are therefore not covered.

Category B devices may be covered if they are considered medically reasonable and necessary and all other applicable Medicare coverage requirements are met.

L) Services Related to and Required as a Result of Services That Are Not Covered

Medical and hospital services that are related to and required as a result of services that are not covered will not be paid. Some examples of these services are:

- Cosmetic surgery;
- Non-covered organ transplants; and
- Services related to follow-up care or complications that require treatment during a hospital stay in which a non-covered service is performed.

Exceptions

When a beneficiary is hospitalized for a non-covered service and requires services that are not related to the non-covered service, the unrelated services are covered. For example, if a beneficiary breaks a leg while he or she is in the hospital for a non-covered service, the services to treat the broken leg are covered since they are not related to the non-covered service.

When a beneficiary is discharged from a hospital stay in which he or she receives non-covered services and subsequently requires services to treat a condition or complication that arose as a result of the non-covered services, reasonable and necessary medical or hospital services may be covered. Some examples include:

- Repair of complications after transsexual or cosmetic surgery; and
- Treatment of an infection at the surgical site of a non-covered service.

Any subsequent services that could be incorporated into a global fee are considered paid in the global fee and will not be paid again.

3) Services and Supplies That Have Been Denied as Bundled or Included in the Basic Allowance of Another Service

The following services and supplies that have been denied as bundled or included in the basic allowance of another service will not be paid:

- Fragmented services included in the basic allowance of the initial service;
- Prolonged care (indirect);
- Physician standby services;
- Case management services (for example, telephone calls to and from the beneficiary); and
- Supplies included in the basic allowance of a procedure.

4) Items and Services Reimbursable by Other Organizations or Furnished Without Charge

A) Services Reimbursable Under Automobile, No-Fault, or Liability Insurance or Workers' Compensation (the Medicare Secondary Payer Program)

Payment will not be made for items and services when payment has been made or can reasonably be expected to be paid promptly under:

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

Exceptions

Medicare may make payment if the primary payer denies the claim and documentation is provided indicating that the claim has been denied in the following situations:

- The Group Health Plan denies payment for services because:
  - The beneficiary is not covered by the health plan;
  - Benefits under the plan are exhausted for particular services;
  - The services are not covered under the plan;
  - A deductible applies; or
  - The beneficiary is not entitled to benefits;
- The no-fault or liability insurer denies payment or does not pay the bill because benefits have been exhausted;
- The WC Plan denies payment (for example, when it is not required to pay for certain medical conditions); or
- The Federal Black Lung Program does not pay the bill.

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

- The claim is not expected to be paid promptly;

- A properly submitted claim was denied in whole or in part; or
- A proper claim has not been filed with the primary insurer due to the beneficiary's physical or mental incapacity.

A conditional payment is made on the condition that the insurer and/or the beneficiary will reimburse Medicare to the extent that payment is subsequently made by the insurer.

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

In general, payment will not be made for the following items and services authorized or paid by a government entity:

- Those that are furnished by a government or nongovernment provider or other individual at public expense pursuant to an authorization issued by a Federal agency (for example, Veterans Administration authorized services);
- Those that are furnished by a Federal provider or agency that generally provides services to the public as a community institution or agency (hospitals, SNFs, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities are not included in this category). Federal hospitals, like other nonparticipating hospitals, may be paid for emergency inpatient and outpatient hospital services;
- Those that 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; and
- Those that a nongovernment provider or supplier furnishes and the charges are paid by a government program other than Medicare or where the provider or supplier intends to look to another government program for payment (unless the payment by the other program is limited to Medicare deductible and coinsurance amounts).

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

Payment will not be made when the beneficiary, another individual, or an organization has no legal

obligation to pay for or furnish the items or services. Some examples include:

- X-rays or immunizations that are gratuitously furnished to the beneficiary without regard to his or her ability to pay and without expectation of payment from any source; and
- An ambulance transport provided by a volunteer ambulance company. If the ambulance company asks but does not require a donation 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.

When items or services are furnished without charge to indigent Medicare patients and non-Medicare indigent patients because of their inability to pay, both groups must be consistently billed.

D) Defective Equipment or Medical Devices Covered Under Warranty

No payment will be made under cost reimbursement for defective medical equipment or medical devices under warranty if they are replaced free of charge by the warrantor or if an acceptable replacement could have been obtained free of charge under the warranty, but it was purchased instead.

Exceptions

When defective equipment or medical devices are replaced under warranty, hospital or other provider services that are furnished by parties other than the warrantor are covered despite the warrantor's liability.

Payment may be made for defective equipment or medical devices as follows:

- When a replacement from another manufacturer is substituted because the replacement offered under the warranty is not acceptable to the beneficiary or to the beneficiary's physician;
- Partial payment, if defective equipment or medical devices are supplied by the warrantor and a charge or a pro rata payment is imposed; and
- Payment is limited to the amount that would have been paid under the warranty if an acceptable replacement could have been purchased at a reduced price under a warranty, but the full price was paid to the original manufacturer or a new replacement was purchased from a different manufacturer or other source.

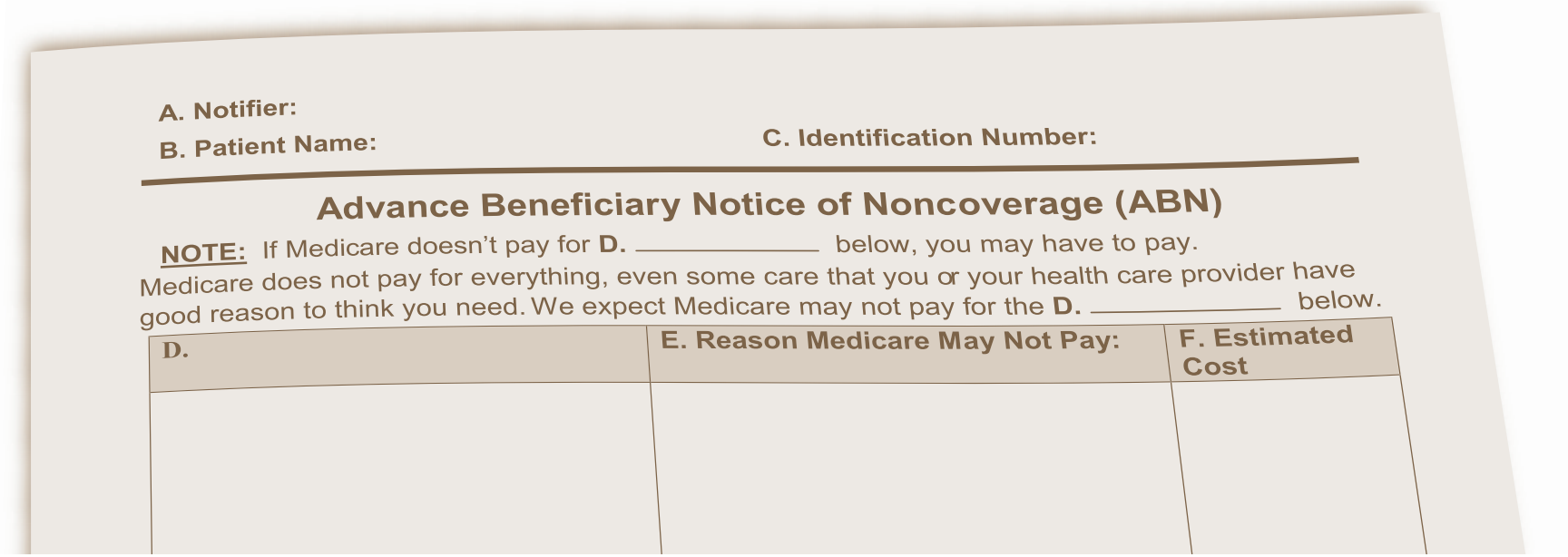
BENEFICIARY NOTICES OF NONCOVERAGE

You must give written notice to a Fee-For-Service beneficiary before you provide items or services that are usually covered by Medicare, but are not expected to be paid in a specific instance (for example, lack of medical necessity). The following CMS notices are approved for this purpose:

- Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131;
- Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN), Form CMS-10055; and
- Hospital-Issued Notice of Noncoverage (HINN).

The Home Health Advance Beneficiary Notice, Form CMS-R-296, will be discontinued on December 9, 2013, and the ABN will be used in its place as liability notification.

These notices allow the beneficiary to make an informed decision about whether or not to get the item or service that may not be covered and accept financial responsibility if Medicare does not pay. If you don't issue the ABN or similar CMS-approved notice when notice is required, the beneficiary cannot be held financially liable if Medicare denies payment. If you properly notify the beneficiary that the item or service may not be covered, you may seek payment from the beneficiary. For more information about beneficiary notices of noncoverage, visit http://www.cms.gov/Medicare/Medicare-General-Information/BNI on the CMS website.



A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

You are not required to notify the beneficiary before you provide items or services that are never covered by Medicare (for example, statutorily excluded services listed under 2) Non-Covered Items and Services on pages 3-12). You may, however, choose to issue a voluntary ABN or a similar notice as a courtesy to the beneficiary to alert him or her about their forthcoming financial liability.

If you furnish items or services to the beneficiary based on the referral or order of another provider or supplier, you are responsible for notifying the beneficiary that the services may not be covered by Medicare and that the beneficiary can be held financially liable for them if payment is denied.

A copy of the ABN or similar CMS-approved notice must be kept in the medical record.

RESOURCES

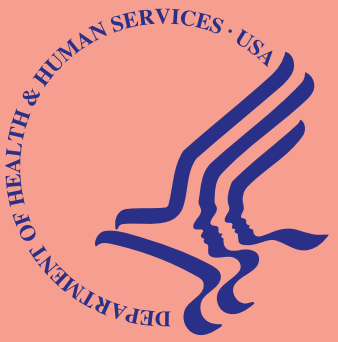
The chart below provides resource information about the topics discussed in this publication.

Resource Information

For More Information About…	Resource
Services That Are Not Covered Under the Medicare Program and Medicare-Covered Services	Chapters 1, 6, 8, 9, 15, and 16 of "Medicare Benefit Policy Manual" (Publication 100-02) and "Medicare National Coverage (NCD) Determinations Manual" (Publication 100-03) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website
Medicare Secondary Payer	"Medicare Secondary Payer Manual" (Publication 100-05) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html on the CMS website
Claims Processing Procedures for Non-Covered Services	"Medicare Claims Processing Manual" (Publication 100-04) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html on the CMS website

Resource Information (Cont.)

For More Information About…	Resource
Preventive Services	http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo on the CMS website Chapter 15 of "Medicare Benefit Policy Manual" (Publication 100-02) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf on the CMS website
All Available Medicare Learning Network® (MLN) Products	"Medicare Learning Network® Catalog of Products" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right with your mobile device 
Provider-Specific Medicare Information	MLN publication titled "MLN Guided Pathways to Medicare Resources Provider Specific Curriculum for Health Care Professionals, Suppliers, and Providers" booklet located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website
Medicare Information for Beneficiaries	http://www.medicare.gov on the CMS website



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