Non-Covered Services (Including Services/Complications Related to Non-Covered Services)

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Instructions for Use

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Related Medicare Advantage Policy Guidelines

- Category III CPT Codes
- Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)

Coverage Guidelines

Medicare does not cover items and services unless the item or service is a defined benefit (Section 1861 of the Social Security Act), not statutorily excluded, and is reasonable and necessary for the diagnosis or treatment of an illness or injury or for the improvement in the functioning of a malformed body member (Section 1862 (a)(1) of the Social Security Act). (Accessed January 31, 2020)

Note: Depending on the member's plan, members may have supplemental benefit. Refer to the member's Evidence of Coverage (EOC) or contact the Customer Service Department to determine coverage eligibility for supplemental benefit.

Non-Covered Items and Services

Medicare does make payment under either the hospital insurance or supplementary medical insurance program for certain items and services. Refer to the following sections of the Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage for details. (Accessed February 9, 2021)

- Not reasonable and necessary (refer to §20)
- No legal obligation to pay for or provide (refer to §40)
- Paid for by governmental entities (refer to §50); also refer to the Coverage Summaries titled Services While Confined/Incarcerated and Veteran Administration (VA) and Indian Health Services (IHS)
- Not provided within United States (refer to §60); also refer to the Coverage Summary titled Emergent/Urgent Services, Post-Stabilization Care and Out-of-Area Services.
- Resulting from war (refer to §70)
- Personal comfort (refer to §80)
- Routine services and appliances (refer to §90)
- Hearing aids and auditory implants (refer to §100); also refer to Coverage Summary titled Hearing Aids, Auditory Implants and Related Procedures.
- Custodial care (refer to §110)
- Cosmetic surgery (refer to §120); also refer to the Coverage Summary titled Cosmetic and Reconstructive Procedures.
- Charges by immediate relatives or members of household (refer to §130)
- Dental services (refer to §140); also refer to the Coverage Summary titled Dental Services, Oral Surgery and Treatment of Temporomandibular Joint (TMJ).

- Services reimbursable under automobile, no fault, any liability insurance or workers' compensation (refer to §150)
- Nonphysician services provided to a hospital inpatient that were not provided directly or arranged for by the hospital (refer to §170)
- Excluded foot care services and supportive devices for feet (refer to §30); also refer to the Coverage Summary titled Foot Care Services.
- Excluded investigational devices; refer to the Medicare Benefit Policy Manual, Chapter 14 – Medical Devices. (Accessed January 31, 2020)
  Also refer to the Coverage Summary titled Experimental Procedures and Items, Investigational Devices and Clinical Trials.
  Example include, but is not limited to:
  - Category III codes (T-Codes): Category III codes will be automatically denied as investigational unless specifically addressed as covered in another LCD or Local Article. These codes are temporary codes created to track the utilization of emerging technologies, services, and procedures. For specific LCDs/LCAs, refer to the table for Category III Codes/Non-Covered Services.

Services Related To/Required As a Result of a Non-Covered Service

This section applies to services related to and required as a result of services which are not covered under Medicare.

Medical and hospital services arising from non-covered services are covered when determined to be reasonable and necessary.

- When a member is admitted to the hospital for a non-covered service:
  - Complications of non-covered procedures develop after the member has been formally discharged from the hospital providing the non-covered service.
    Example: A member undergoes a non-covered cosmetic procedure and, following discharge, develops an infection at the surgical site. Services to treat the infection are covered. This includes subsequent inpatient stays or outpatient treatment ordinarily covered under the member's health plan.
  - A complication develops that did not arise from a non-covered service or was not related to the non-covered service received by the member.
    Example: A member hospitalized for non-covered service breaks a leg while in the hospital. Services in connection with the broken leg are covered.
- When a member is admitted to the hospital for a covered service and obtains a non-covered procedure unrelated to the admission diagnosis, the services related to the admitting diagnosis would continue to be covered.

Medical and hospital services arising from non-covered service that are related to the non-covered service are not covered.

- When a member is admitted to the hospital for a non-covered service:
  - Complications that arise from, or are related to, a non-covered service before the member is formally discharged from the hospital providing that service
  - A covered service which is in preparation for a non-covered service
  - A covered service that is part of a treatment regimen for a non-covered service that requires a series of postoperative visits to a surgeon
- When a member is admitted to the hospital for a covered service and obtains a non-covered service during the same hospital stay, the non-covered service will not be covered.
  If, on the basis of the services and a comparison of the date, they are received with the date on which the member is identified as a candidate for a non-covered service, the services reasonably attributed to preparation for the non-covered service will not be covered.

Refer to the Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage, §180 – Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare. (Accessed February 9, 2021)

For a list of non-covered services, coding and claims payment guidelines, refer to the table for Category III Codes/Non-Covered Services. Compliance with these policies is required where applicable.

Supporting Information

Important Note: When searching the Medicare Coverage Database, if no LCD/LCA is found, then use the applicable referenced default policy below for coverage guidelines.

Category III Codes/Non-Covered Services Accessed May 5, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L35490 (A56902)	Category III Codes	Part A MAC	Wisconsin Physicians Service Insurance Corporation	AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY
L35490 (A56902)	Category III Codes	Part B MAC	Wisconsin Physicians Service Insurance Corporation	IA, IN, KS, MI, MO, NE
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Policy History/Revision Information

Date	Summary of Changes
05/01/2021	Template Update • Reformatted policy; transferred content to new template
02/16/2021	Non-Covered Items and Services • Replaced language indicating “Medicare does make payment under either the hospital insurance or supplementary medical insurance program for certain items and services, when the [listed] conditions exist” with “Medicare does make payment under either the hospital insurance or supplementary medical insurance program for certain items and services”

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The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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