Medicaid Non-Covered Services

PURPOSE

This policy contains general information about Medicaid non-covered services.

APPLICABILITY

ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled on the date of service with ND Medicaid. Servicing providers acting as a locum tenens provider must enroll with ND Medicaid and be listed on the claim form. Please refer to provider enrollment for additional details on enrollment eligibility and supporting documentation requirements.

ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the ND Medicaid MMIS Portal or through the Automated Voice Response System (ARVS) by dialing 1.877.328.7098.

General Provider Policies

The General Provider Policies details basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled in ND Medicaid.
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

The Procedure Code Look-up Tool can be used to identify if a CPT® or HCPCS code is covered by ND Medicaid, along with code-specific details such as ORP requirements, Service Authorization requirements, Telehealth applicability, and current rates.

NON-COVERED SERVICES

Please note: This is **not** an all-inclusive list.

- Abortions (exceptions are rape, incest, or to save the life of the mother);
- Acupuncture;
- Alcoholic beverages;

- Autopsies;
- Body piercing;
- Dental implants;
- Drugs that are not approved by the FDA, including regimens when all medications in the regimen do not have FDA approval;
- Equine therapy;
- Experimental and investigational service, procedure, or products (this includes if the member has primary insurance, and the primary insurance denies the service, procedure, or product as experimental.);
- Exercise classes;
- Fertility preservation for iatrogenic infertility such as cryopreservation of eggs, embryos, sperm, or ovarian/testicular tissue, and other procedures like radiation shielding and ovarian transposition;
- Health services paid by another source i.e. Workers Compensation claims, eyeglasses covered by a Fraternal Organization;
- Health services for obtaining or maintaining a medical marijuana registry identification card;
- Health services which require service authorizations that were not obtained according to program policy and rules;
- Health services not in compliance with guidelines and limitations;
- Health services, other than emergency health services, provided without the full knowledge and consent of the member or the member's legal guardian, when consent is required;
- Health services for which a physician's order or a referral from a practitioner of the healing arts or PCP are required but not obtained;
- Health services not documented in the member's medical record or plan of care;
- Health services of a lower standard of quality than the prevailing community standard of the provider's professional peers. (Providers of services, which are determined to be of low quality, must bear the cost of these services);
- Hippotherapy;
- Home modifications to accommodate mobility (example: wheelchair ramp, etc.);
- Hypnotherapy;
- Infertility (diagnostic, medical, surgical, or pharmaceutical services related to infertility);
- Instructional materials and books;
- Massage therapy;

- Missed appointments (providers may bill clients for missed appointments if this is the standard practice for all patients);
- More than one office, hospital, long-term care facility, or home visit by the same provider, per member per day, unless medically necessary;
- Music therapy;
- Non-CLIA certified lab services;
- Non-face-to-face services, except for services listed in the Telehealth policy;
- Nutritional supplements for the purpose of weight reduction;
- Out of state services that were not prior approved;
- Paternity testing;
- Member convenience (example: moving patient to facility closer to home);
- Payment for a private room in a nursing facility or basic care facility;
- Pharmacogenetic panel tests for therapy selection, such as panel tests for psychotropic, analgesics, or ADHD stimulant medications;
- Plan of care oversight activities;
- Removal of healthy tissue or organ;
- Reversal of sterilization;
- Routine circumcisions for dates of service prior to October 1, 2023;
- Services not documented in the member's health care record;
- Services for members ages 21 through 64 in an Institution for Mental Disease (IMD);
- Services rendered via telehealth that are not approved telehealth services;
- Services performed outside of the practitioner's scope of practice as defined by state laws;
- Services that are not medically necessary;
- Services received by a member on the Coordinated Services Program (CSP) that were not referred by the CSP provider;
- Services denied by a third-party payer because third-party requirements were not followed;
- Tattoo or tattoo removal;
- Team conference without the member present;
- Transportation for non-medical appointments;
- Weight loss programs and exercise programs; and
- Vocational or educational services, including functional evaluations or employment physicals, except as provided under IEP, Medicaid services billed by the school

The Procedure Code Look-up Tool can be utilized for finding coverage information on specific CPT® and HCPCS codes.

REFERENCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations

RELATED POLICIES

- Procedure Code Look-up Tool

FREQUENTLY ASKED QUESTIONS

Q: Can a member be balanced billed for services that are denied as non-covered?
A: Yes, a member may be billed for services that are denied on the Medicaid Remittance Advice with the following Claim Adjustment Reason Codes/Remittance Advice Remark Codes:

- PR (Patient Responsibility) / 96 Non-Covered Charges: and
- PR (Patient responsibility) / 204 service/equipment/drug is not covered under the member's current benefit plan.

CONTACT

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POLICY UPDATES

May 2025

Section	Summary
	Added information on fertility preservation

October 2025

Section	Summary
Non-covered Service	Added Hippotherapy as a non-covered service. Removed drug testing that is not medically indicated. ND Medicaid follows LCD L36668 for determining medical necessity for urine drug testing. Drug testing that is

	not deemed medically necessary will be denied as a contractual obligation to the provider, and not as a non-covered service. Removed Advanced Care Planning; this service is covered as of July 1, 2025.
Related Policies	Added link to the Procedure Code Look-up Tool landing page
FAQ	Added question/answer related to balance billing members.
	Format updated.