The Division of Medicaid (DOM) will provide coverage for covered services when it is determined that the medically necessary criteria and guidelines listed below are met.

"Medically necessary" or "medical necessity" shall mean health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the patient's medical condition; **and**
- compatible with the standards of acceptable medical practice in the United States; **and**
- provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms; **and**
- not provided solely for the convenience of the beneficiary or family, or the convenience of any health care provider; **and**
- not primarily custodial care; **and**
- there is no other effective and more conservative or substantially less costly treatment service and setting available; **and**
- the service is not experimental, investigational or cosmetic in nature.

All Mississippi Medicaid program policies, exclusions, limitations, and service limits, etc., apply. The fact that a service is medically necessary does not, of itself, qualify the service for reimbursement.